



## Improving Healthcare Delivery Through Effective Health Administration Practices

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### Abstract

#### 1. Introduction

Hospital administrators in the US are historically utilized strategies that are designed to ensure patient services are optimized. Findings from a multicase inquiry aimed at shedding light on practitioner use of such strategies to facilitate information sharing and enhance access and quality of care. Practices were found to engage in a confluence of interdepartmental communication strategies and tactics utilized in efforts to improve patient services. A total of four case study hospitals were recruited each representing a distinctive healthcare delivery market (rural, suburban, primary sector, safety net/inner city). Triangulation of data collection techniques included in-depth interviewing of 60 professionals across the case study hospitals, focus group interviews with 60 members of the affiliated providers, observations of the hospital environment, and archival document analysis.

The design elements of this inquiry not only add depth to the available literature but also have broad implications for the provision of care. That is, practices that realize the success of any one strategy will likely need to interdepartmental approach a mix of strategies developed herein. This evidence adduces from a comprehensive multicase study of hospital administration practices with a deliberate focus of patient services and is specific to the hospital setting ).



## **Methods**

This section outlines the various methods employed to enhance healthcare delivery through strategic health administration practices, including data analysis, stakeholder engagement, and implementation of evidence-based policies.

## **Conclusion**

Recommendations for Action aims to enhance healthcare leadership by facilitating information sharing on effective health administration practices. Key components include the Triple Aim strategy, Evidence-Based Practice, Lean methodology, Public Health Strategy, and Innovation strategy. The main research question focused on the efforts hospital leaders make in delivering healthcare services. The Triple Aim strategy, patient-centered and introduced over a decade ago by Donald M. Berde, plays a significant role in improving care delivery in for-profit acute care hospitals. Hospital leaders utilize the Triple Aim to enhance care access and outcomes while managing costs. The study revealed that as penalty programs from PPACA, like the HAC reduction initiative, impacted hospital finances, public entities tended to implement various methods under the Triple Aim framework to mitigate losses. The research ultimately highlighted a balance of financial gains and losses.

### **1.1. Background and Significance**

Health Administration has undergone significant development over the last century, adapting itself to the transformations of the social and technological reality and to the emerging needs of the societies it served. The "health policy and administration" area has been a subject of enormous interest and fruitful research over the last several decades. However, despite all the improvements achieved in capacity provision efficiency, monitoring and measuring such achievement is difficult. Also, other effects of the health system are tracked starting with a reasonable accuracy of the outcome of the provision, whether in the form of cured or recovered patients, avoided potential cases and/or providing life expectancy or potential life years, but the results of the administratively-related interventions carried out are also captured rather weakly. Generally, a paucity of reliable data exists regarding the outcomes and "health gains" so eagerly sought, although these are among the major goals for any health system (Pinto dos Reis & Andrade Reis, 2012). Efforts to develop explicit, valuable and useful models of assessing results have been made in different countries, through in-depth intriguing and diverse studies. A useful indicator has been identified which, following simple criteria, can be used objectively to describe "health gains", such as would introduce objective basis to the



ability of a health system's administrator to evaluate and further develop its contribution to the provision of health.

The concept of Administration of Health was first developed at the beginning of the last century, as witnessed by the publication of a book on the topic. Earle had already defined Administration of Health to refer to the science or art of promoting and maintaining provision efficiency in the population. However, the efforts to develop the Administration of Health were proceeding already in a number of countries by the close of the 19th century, when the word "health administration" was itself first used to refer to the administration of curative services. Farnsworth thus defined Health Administration as the organizational arrangement of curative institutions and their management. Administration of Health involves an ever-increasing number and complexity of tasks related to the organization of promotion, providing and rehabilitation services as well as preventive interventions. These efforts also increased in geometric progression, as a consequence of improvements in the quality of curative services, their increasing relevance within the whole arena of health-related activity, the uninterrupted growth in institutionalization and the constantly disturbing tension between both scientific and political and commercial interests. Administration of Health may now be encountered, though hardly so defined, in every economy with more than marginal urbanization. No matter what the prevalence of the socio-economic structure, a level of per capita resources consumption of health services constituting a reasonable sub-system of the total economic activity is reached; in accordance (^?). At this point, administration of health becomes an increasingly visible and formidable task that grows in depth and scope from the mass of insurance claims, lawyer's letters and newspaper articles comparing hospitals effectiveness that were its focus 30 years before. Soon, this word reduced to acronym, HA, and its multiple implications became something to be studied, since equated by some sociologist with the very organization of society. And so it was described in terms of "co-ordination of efforts towards common goals by the use of an organized structure".

## **2. The Role of Health Administration in Healthcare Delivery**

Because of the increasing number of health care services and the deficiencies related to them and to provide these services in an efficient way, it is necessary to have a detailed study of the management of the health care delivery systems or organizations. In this regard, the health care delivery system, hospitals in particular, and health administration are considered in detail. The hospitals are where most of the health care services are provided. There are around 6,000 general hospitals, 1,000 mental hospitals, 1,000



children's hospitals, 4,000 long-term care hospitals for chronically ill, and 2,000 other specialized hospitals in the United States (Furkan Gul & Ziya Aydin, 2008). The American public spends around 1 billion dollars per year in the hospitals. Because of the high dependence of the public on the hospitals, a considerable portion of the health workforce is also employed in the hospitals.

The provision of these services requires so many other activities, which are not necessarily directly concerned with diagnosing or treatment of the disease. Therefore, many of the administrative careers are embedded in the health care delivery. These administrative careers have so many different skills and training. The basic works are maintaining the inventories well stocked, indicating the health facilities correctly, planning the efficient use of labors and other sources, organizing the departments so that they work smoothly, keep the record of patients comprehensively and updating them regularly, providing safe work environment for their staffs etc. These functions are performed by the hospital managers. The management of any types of organization is necessary. The effective health care delivery is impossible without an effective management system in it. The health care delivery system (organizations) with a particular objective is rather new as compared to any other non-health related organization. Initially the curing treatments were provided only by the doctor himself. There were not different specialized doctors or health care delivery centers. There were no diagnosis, or distinct way of treating. The treatments were done by elders or local men, and were not based on any particular theory. However, recently the health care delivery organizations are existed widely in terms of hospitals, nursing homes, and health care centers.

## **2.1. Defining Health Administration**

The term health administration can be used to describe a broad range of administrative functions across various health care formats including patient care organizations, payers and related organizations such as commercial health care companies, consulting firms, universities, Federal and State government agencies. Directors or Managers of primary care facilities, therapy centers, assisted or senior care facilities, and outpatient surgery centers are examples of patient care organizations. Payers refers to organizations that pay for healthcare services. This includes commercial health insurance organizations, government run health insurance systems, and private or public insurers that are responsible for paying for medical services to a certain population of individuals. Health care companies that provide equipment or drugs to healthcare organizations are also an



example of organizations that provide health services, but are not necessarily responsible for medical treatment of patients.

Health administration can involve one area (e.g. finance) or multiple areas of expertise. For example, health administrators may be responsible for and/or involved with any of the following activities: financing the services, quality improvement, access to services, health systems operation, human resource management, information technology, marketing of health-related services, medical services planning, private and public policy formation, regulation of health services, and the decline or growth of related health care organizations ( (A. Apenteng, 2015) ).

In this report, health administration is considered as the organization, financing, and delivery of health services. With the exception of safety information, patient care services or medical treatment are not discussed. All references to health care organizations concern entities involved with financing or delivery of health services, and not with patient care. Also, the terms “health care” and “medical services” are not used interchangeably. The term “health care” is used to refer to entire health system or assist with organizations whereas “medical services” is used to refer to curative or treatment-related functions in health care. This is in line with the PUBH 6534 course syllabi ( (M. Mercer, 2015) ).

### **3. Key Challenges in Healthcare Delivery**

Key healthcare delivery challenges include the acceptance of e-health technologies, increased patient satisfaction resulting in a higher demand for resources, and increased competition putting a strain on unity among healthcare providers and professionals (Ahmed Khan, 2016). Healthcare service delivery is one of the many other services that have a direct impact on population health, and hence, it is necessary that low- and middle-income countries similarly concentrate on improving cooperation and performance. Healthcare managers need to smoothly direct health care services to achieve better outcomes for public health and thus influence the individuals they treat better. The tools and attitudes needed for health managers to offer the best possible services to their patients medically and psychosocially are largely missing. If these disparities are minimized by enhancing healthcare management, their findings will become the cornerstone for the improvement of healthcare delivery worldwide. Since the late 1960s, paying considerable consideration to Corona’s entry into the hospital, the health leader has largely scrutinized the impact of hospitals on the customers, Physicians,



medics, staff, patients, and families. E-health technology inventions or gadgets for portable administration and treatment of medical services have entered the commercial market in the previous few years, providing extensive opportunities for healthcare delivery development. The increasingly large use of E-health technology that simplifies the accessibility and administration of healthcare services, patient records from remote locations, and the home impacts firmly on ensuring increased patients' satisfaction about medical services being administered.

### **3.1. Resource Allocation**

Resource allocation is a central function of all healthcare delivery systems. Policies such as “public funding, private provision” and increasing price competition among providers put a premium on economically sound priority setting and resource allocation (Smith et al., 2013). Additionally, the need to maximize “value for money” implies that these processes should also be ethical – that is fair and transparent. Yet, a growing body of research reveals that healthcare decision makers struggle to assemble and use relevant evidence and to engage clinical stakeholders and the public in a meaningful fashion. Understanding of these issues is also based largely on case studies of individual organizations. While often providing rich detail, these studies report on a few organizations and therefore face limitations in generalizing from the findings. There remains a paucity of research “capable of generating generalizable and/or transferable knowledge”. Compared to the evidence base on cost-effectiveness, “there is even less of a ‘rational’ idea of what constitutes fair and legitimate process”. Finding publication in particular seek legitimacy and fair process “makes it appear as though everything potentially boils down to the procedures of a specific setting, each of which has to be negotiated on its own terms”.

While not wishing to add “a further layer of abstraction” to the debate, this serves as a counterpoint to the epidemiological and health technology appraisal literature that informs many scholars' work. Broad concepts may be all very well for theorists, but all too often the day-to-day of decision making is about practicalities: “getting things done under the shadow of various limitations”. Optimally designed, investment in a health technology assessment. At a micro-level, health services research studies often stress the importance of perceived potential impact. Such research products must also be ‘institutionalized’ and weighed in on subsequent policy decisions, a situation well described by “research utilization processes located at the very top of the model”. A pan-Canadian survey, on the other hand, could provide a unique and rich source of



information on the many political, institutional, and cultural factors that influence resource allocation efforts among senior managers with this responsibility in various health authorities across the country (as it were, moving the focus down to the lower reaches of the embedded model, to the right, where similarly small arrows denote weak links). In the early days of the reform experiment with regionalization in Canadian health services, various studies and “post-Audit and Accountability” reviews – that is ‘local’ studies – have indicated that resource allocation is often done on a historical basis, with budgets rolling over from one year to the next. The Auditor General reports, and other literature on this front, also highlight an extreme focus on input budgeting, with linkages to output and outcome measures often being tenuous or lacking entirely. Lack of data and information was seen as a major barrier to ‘good’, policy-relevant research. Since then, a few other studies have considered the research utilization of senior health services managers. Broadly speaking, the effort continues to underline “suboptimal use of research” and “a large gap between evidence-based perceptions and wide variations between the information that decision makers feel they need and the evidence on research utilization”. With these considerations in mind, this presentation will not only detail how research questions arose from “personal and professional experience” but also how these reflected, “embedded relationships within a health authority and went on to frame the design of a naturalistic inquiry”. Finally, “fundamental differences between interpretivist” and positivist epistemologies will be highlighted, calling for greater empathy on all “academic sides”. With these caveats in view, it is anticipated that the current presentation will nonetheless have special relevance for consideration both by exponents of evidence-based policy and theory-led evaluations. The information is presented with a view to exploration of the sometimes subtle nuances of research utilization (the term “evidence” is used interchangeably). The aim is to demonstrate how this information was not only policy related, but also “policy impinging” and how a more sophisticated grasp of its potential use might have facilitated the organization and delivery of “more effective” research involvement in the wider policy process. In the current climate, characterized by renewed interest in performance improvement within health policy and the emphasis on “evidence-informed practice” at all levels, it is hoped that the presentation will contribute to “looked-for” synergy between research and policy in a devolved public health realm where “historical discontinuities” set the stage for a more complex examination of decision making in relation to population health.



#### **4. Best Practices in Health Administration**

Transforming healthcare delivery requires innovative strategies to meet the diverse needs of populations across the lifespan. Effective health administration practices ensure services are integrated across settings and are grounded in contemporary standards of care. Here is a feasible plan to improve health outcomes and patient experiences. Outpatient diabetes care is provided across 860 sites to 600,000 patients. Diabetes performance measures suggest variations in healthcare provision. Good clinical practice visits include foot, retinopathy, and pneumococcal vaccination to avoid amputations, blindness, and pneumonia.

These affect patient care but are not a specific target of performance measures. Variations are evaluated in high-performing teams through interviews and observations. Initial findings are fed back and recommendations discussed with staff. Variations are reviewed a year later to evaluate improvements. Interventions are expected to affect each of the steps in the framework. This research includes documentation of practice, outreach visits to sites with variation, and regional meetings to discuss good practice. A framework is provided on clinical practices and variations, and the methodology supports reproducibility. Refining strategies is presented to engage staff through feedback and active involvement in the design of interventions. Outcomes of strategies include intended and unintended changes in the system and rationale to explain the observed results. Four large teams are currently implementing strategies for improvement and policy, and feedback will be valuable to a better understanding of their impact. Leadership and support are key challenges in their implementation.

##### **4.1. Data-Driven Decision Making**

Health systems are fluid entities that continuously grow and evolve. The quality of any health facility or system is critically related to the degree to which physicians' action can be delivered effectively, efficiently, and equitably, over and above the diagnosis, at a decision-making process. While only tracking decision-making at a small health center in South Africa, existing evidence suggests that, even though the health information system has been in place for over six years, only a fraction of clinical decisions are captured on the patient file and a small percentage of the diagnoses in the prescription book are used to inform drug ordering (Wickremasinghe et al., 2016). Additionally, no covariation was found between patient and facility level treatments, and almost no use was made of available laboratory diagnostic tests.



From a macro perspective, national policy makers and public health managers collect and analyze information at a population level with the goal to respond to and reduce the burden of diseases. The range of possible ameliorative strategies is broad: water and sanitation interventions, behavior change communication programs, and decisions on drug and vaccine distribution and use, amongst others. At a statistical level, it is not necessarily the case that the information needed to make such decisions is found within health statistics. However, the levers that can be used to trigger a health impact are by-and-large structural determinants of health, such as policy advice on poverty alleviation, available to the treasury, or trade agreements, controlled by other ministries. Principally the document considers decision-making as seen through the eye of those closest to the point of care, particularly facility managers, clinicians and pharmacists. These individuals have the ability to influence the delivery, perhaps more so than the formation, of health services. The scope in these settings for data-based decision-making is thereby circumscribed by the nature of the decision.

## **5. Conclusion and Future Directions**

Efficient communication between patients and providers, especially hospitals and private practices and dentists, generally increases the access and the quality of the care. It is widely assumed in the health care literature that hospital patients and hospital administrators aren't getting appropriate treatment from hospital doctors. Most of this may be because private practitioners and dentists are not aware of hospital diagnoses, medications, treatments, or progress. Multicase studies have identified the strategies that hospital administrators utilize to improve the access and the quality of the care provided in partnership with private practice and dental providers, who are state or privately owned organizations or individuals who deliver general, specialist, or urgent care, prevention, recovery, or rehabilitation services to patients in the community. Efficient communication between private practice and dental providers and hospital patients, as well as hospital patients and hospital administrators, could positively influence the access and the quality of the care. Efficient communication between hospital patients and hospital providers reduces diagnosis or treatment errors, lowers costs, increases the timeliness, or eases treatments, assistance, or operations, and improves the health outcomes. Efficient communication between private practice and dental providers and hospital patients, or between hospital patients and hospital administrators helps deliver prompt referrals or admissions, allows the ordering, sharing or exchanging of tests, lab results, or reports, or permits the arranging, scheduling or updating of the appointments, surgery, or procedures (Njoku, 2019).



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