Al-Najah National University
Faculty of Graduates Studies

ENGAGING PATIENTS AND HOSPITAL HEALTHCARE WORKERS WITH MEDICAL RRCORDS ANALYSIS IN THE BALANCED SCORECARD IMPLEMENTATION

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Dedication

This effort is dedicated to the purest spot on this Earth, I want to thank my late grandmother, who I will always love. My greatest love and gratefulness to you all.

Acknowledgements

I am deeply grateful for the guidance and support that illuminated my path throughout this research endeavor. This paper stands as a testament to the collective effort and encouragement of cherished family and friends, whose unwavering support propelled us forward.

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We sincerely thank the esteemed faculty members and advisors at An-Najah University who contributed their expertise and insights to enrich our thesis.

Lastly, I extend my gratitude to all who lent their support and encouragement, contributing to the completion of this thesis.

Declaration

I, the undersigned, declare that I submitted the thesis entitled:

ENGAGING PATIENTS AND HOSPITAL HEALTHCARE WORKERS WITH MEDICAL RRCORDS ANALYSIS IN THE BALANCED SCORECARD IMPLEMENTATION

I declare that the work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

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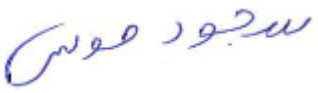
Signature:	
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ENGAGING PATIENTS AND HOSPITAL HEALTHCARE WORKERS WITH MEDICAL RRCORDS ANALYSIS IN THE BALANCED SCORECARD IMPLEMENTATION

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Abstract

Background: The Balanced Scorecard (BSC) has been increasingly adopted as a strategic framework for evaluating healthcare performance, emphasizing service quality, patient satisfaction, and organizational effectiveness. The framework assesses performance across four perspectives: financial, customer, internal processes, and learning and growth. Although widely implemented internationally, limited research has addressed its integration with medical records in Palestine. This study aimed to assess patient experiences and healthcare workers' (HCWs) attitudes toward healthcare delivery at An-Najah National University Hospital in Nablus, Palestine, using BSC principles to provide localized evidence for healthcare improvement.

Methodology: A cross-sectional study was conducted between November and December 2024at An-Najah National University Hospital. Two structured and validated self-administered questionnaires were distributed: one to HCWs and another to patients. The patient survey evaluated perceptions of service quality, satisfaction, and engagement with medical records, while the HCWs' survey measured work engagement and attitudes toward BSC implementation. A total of 185 patients and 195 HCWs participated. Data were analyzed using SPSS, employing descriptive statistics, Pearson correlation, and multiple regression analysis.

Results: Strong correlations were found between patient activation and positive attitudes. The mean service quality score was 75.4%. Price information experience scored 72%, while pricing satisfaction was slightly lower at 66.3%. Among HCWs, high engagement was reflected in the Utrecht Work Engagement Scale Dedication (93.3%). However, areas such as workload–time–life balance (59.2%) highlighted opportunities for improvement.

Conclusions: Service quality and access to medical records were significant contributors to patient satisfaction. Integrating medical records into BSC implementation can enhance

engagement among both HCWs and patients by improving transparency and performance monitoring. These findings provide evidence to guide hospital-level healthcare policy and align future improvements with international benchmarks.

Keywords: Patient Engagement, Patient Satisfaction, Healthcare Workers, Medical Records, Balanced Scorecard (BSC), Healthcare Performance, Palestine.

Chapter One

Introduction and Theoretical Framework

1.1 Introduction

The Balanced Scorecard (BCS) is a strategic performance management framework that allows an organization to execute its vision and strategy by translating the same into measurable goals and objectives. It measures organizational performance along four dimensions: financial, customer, internal processes, and learning and growth, all of which combine to provide a balanced view of both financial and non-financial indicators. Developed in the early 1990s by (Kaplan & Norton, 2001), the BSC has now been used across sectors including health care. Its main purpose is to match Organizational events with a strategic focus (Tarver, 2022).

As participation by those directly engaged results in service quality and results, involvement in healthcare management is crucial. Only a few studies have provided evidence of underutilization of medical records in such engagements; instances include (Amer, Hammoud et al., 2022).

Incorporating medical records that improve BSC implementation, this paper contributes to this study thereby increasing patient and healthcare worker (HCW) engagement. Organizational strategy in health care management has been seen to be very dependent on patient and health care worker involvement. A tool for strategic performance management, BSC helps an organization turn its vision and plan into action. Financial, customer, internal processes, and learning and growth are four main viewpoints under which it offers a balanced set of performance metrics.

The BSC allows an organization to consider both financial and non-financial indicators of performance, hence multifaceted views on performance. Besides, it aligns activities toward the attainment of the set strategic objectives. Developed in the early 1990s by Kaplan & Norton (2001), it has gained increasing popularity as a tool for strategic planning and performance measurement within different sectors, including healthcare (Clavel, Paquette et al., 2021).

The application of the BSC in healthcare has been increasing because organizations want to try their best to improve patient outcomes and operational efficiency. In this way, health organizations can have a view of the holistic performance when the dimension measures associated with patient experience, clinical quality, financial performance, and employee satisfaction are combined together. Moreover, the BSC facilitates vertical communication and alignment of objectives and helps in sharing a common understanding of the strategic priorities with all hierarchies in an organization (Amer, Hammoud et al., 2022).

The Developed by Kaplan & Norton in the early 1990s, the Balanced Scorecard (BSC) provides a whole approach for assessing corporate performance from four angles: financial, internal procedures, learning and expansion, client. It has become a major instrument in healthcare for strategic planning, performance monitoring, and quality improvement (Amer, Kurnianto et al., 2023). Emphasized the interdependence of organizational support, healthcare worker (HCW) well-being, and patient care outcomes (Amer, Hammoud et al., 2022; Lou, Montreuil et al., 2021) .

Amer, Hammoud et al. (2022) examined healthcare performance indicators during the epidemic and highlighted shortcomings in getting patients and medical staff actively engaged in Balanced Scorecard (BSC) ratings. This research tries to fill that void by creating methods to increase their involvement and elevate healthcare quality evaluation. The BSC framework still provides a structured approach to healthcare performance measurement in times of crisis, such as the COVID-19 pandemic. However, its successful application is heavily dependent on active engagement by both patients and HCWs. Works like Amer, Hammoud et al. (2022) have shown the importance of integrating stakeholder feedback into the performance measurement processes. Although direct analysis of medical records with stakeholder involvement may be insightful, our study does not assess this explicitly. We concentrate instead on the perceptions and engagement of patients and HCWs in service quality under the Balanced Scorecard approach.

Developed by Kaplan & Norton in the early 1990s, the Balanced Scorecard (BSC) is a strategic performance management framework that converts vision into measurable goals. from four points of view: learning and growth, internal processes, financial, and customer. Widely used in healthcare, it helps to match organizational operations with strategic direction and raise care quality (Clavel, Paquette et al., 2021; Tarver, 2022).

Substantial opportunity exists in technology and digital participation tools to improve BSC implementation. Interactive dashboards and user-friendly interfaces can use medical record data to simplify collection, Analysis and input help to make evaluation procedures more representative and practical (Amer, Hammoud et al., 2022). However, cultural and contextual elements fundamentally shape the framework's application. Context-sensitive approaches are required by resources, staff training, and patient demographics; rural hospitals frequently use more basic instruments while urban centers use sophisticated analytics (Amer, Hammoud et al., 2022).

Despite its benefits, the participation of healthcare providers (HCWs) and patients in BSC procedures is still underappreciated, especially in terms of the inclusion of medical records. Building on earlier results (Amer, Hammoud et al., 2022), this study suggests the inclusion of medical records to promote HCW and patient involvement, therefore Improving performance measurement's efficacy and advancing strategic healthcare management.

The application of the BSC in healthcare has been on the rise because organizations want to try their best to improve patient outcomes and operational efficiency. In this way, health organizations can have a holistic view of performance when the dimension measures associated with patient experience, clinical quality, financial performance, and employee satisfaction are combined together. Moreover, the BSC facilitates vertical communication and alignment of objectives and helps in sharing a common understanding of the strategic priorities with all hierarchies in an organization (Amer, Hammoud et al., 2022). Originally created in the early 1990s by Kaplan & Norton, the Balanced Scorecard (BSC offers a multi-dimensional framework for assessing performance from financial, consumer, internal process, and learning points of view. It connects strategic objectives to quantifiable results, hence presenting a whole perspective of both financial and non-financial performance (Kaplan & amp; Norton, 1990s; Amer, Hammoud et al., 2022). Particularly with the advent of digital technologies and artificial intelligence, the BSC has become well known in healthcare as a strategic planning and quality improvement tool. which facilitate predictive analytics and real-time monitoring.

The relevance of healthcare worker (HCW) and patient well-being became clear throughout the COVID-19 epidemic, stressing the need of resilient and flexible management solutions. Maintaining HCW well-being and guaranteeing high-quality care

required organizational support from personal, institutional, and systemic resources (Amer, Hammoud et al., 2022; Lou, Montreuil et al., 2021). BSC implementation in healthcare presents challenges including resistance to change, data fragmentation, and insufficient stakeholder involvement (Psarras et al., 2001; Kaplan & Norton, 2001). Strong change management, clear communication, incentive programs, and capacity-building projects are needed to solve these problems.

Looking ahead, including artificial intelligence and machine learning into the BSC framework presents interesting chances to improve performance management via predictive insights and data-driven decision-making, thereby changing BSC from a retroactive to a proactive instrument in healthcare administration (Sterling, 2023; Inamdar, et al., 2011).

1.2 Problem Statement

Good hospital performance evaluation is absolutely vital for guaranteeing patient satisfaction and top-quality care. Conventional assessment techniques, however, frequently ignore patient input, hence missing insightful ideas that could better match services with patient needs (Berger, et al., 2020). Even though patient involvement in medical decisions is well known, their opinions are still underrepresented in Balanced Scorecard (BSC) frameworks, where the line between patient participation and engagement is sometimes ambiguous.

Equally crucial is the involvement of healthcare personnel (HCWs), whose energetic contribution in performance assessment directly influences patient results and organizational performance. Including patient and healthcare professional (HCW) engagement into BSC execution, this study aims to increase the thoroughness and efficacy of performance evaluation in healthcare by addressing these shortcomings.

1.3 Significance of the Study

Including significant patient and healthcare worker (HCW) engagement helps the Balanced Scorecard (BSC) to be more successful in healthcare. While encouraging ownership and accountability, active HCW engagement matches staff responsibilities with strategic goals; integrating patients adds an essential patient-centered point of view to performance evaluation. Using methods like participative workshops, focused surveys,

and focus groups helps to enable a dialogue-driven approach that gathers operational and care-quality insights from both sides. Clear communication Evidence from Palestinian settings, including approved instruments such BSC-PATIENT and BSC-HCW1, shows how realistic and beneficial this inclusive strategy is, therefore helping policymakers on improving organizational performance and quality of healthcare (Amer, Hammoud et al., 2022).

1.4 Study Objectives

1.4.1 General Objective

Research Question

What is the relationship between patient and healthcare worker (HCW) engagement in the Balanced Scorecard (BSC) assessment and outcomes related to patient satisfaction, healthcare quality, and organizational performance at a teaching hospital in Nablus, West Bank?

1.4.2 Specific Objectives/Hypotheses

H_1: Patient Engagement Hypothesis

Higher levels of patient engagement in BSC-related assessments are associated with increased patient satisfaction and perceived quality of care**.**

H_2: HCW Engagement Hypothesis

Greater involvement of healthcare workers in BSC implementation correlates positively with improved organizational performance indicators (e.g., efficiency, service delivery effectiveness).

H_3: Combined Engagement Hypothesis

The combined participation of patients and HCWs in BSC-based evaluations explains greater variance in healthcare quality and organizational performance than either stakeholder group alone.

1.5 Study Variables

- Independent Variables: Patient engagement in BSC and HCW engagement in BSC.
- Dependent Variables: Patient satisfaction, perceived quality of care, and organizational performance metrics.

1.6 Literature review

Healthcare Worker Engagement

Improving healthcare employees' motivation, engagement, and performance—which directly affects the quality of patient care and organizational effectiveness—depends critically on job satisfaction (Kim, et al., 2021; Jahrami, et al., 2011). Among many other influences, including leadership approach, communication, career development chances (van Pelt, et al., 2020), and workplace conditions, While insufficient staffing and autocratic leadership raise burnout and turnover (van Pelt, et al., 2020), effective communication promotes commitment and pleasure.

Job satisfaction fits the "learning and growth" aspect within the Balanced Scorecard (BSC) model, therefore highlighting employee development and well-being as major performance drivers (Amer, Hammoud et al., 2022). Satisfied employees are more involved in performance projects, receptive to change, and cooperative in patient-centered care. Transformational leadership, defined by Mentorship and empowerment improves morale and involvement even more (Kim, et al., 2021)..

Furthermore, preserving happiness and avoiding stress-related productivity losses call for enough resources and a supportive framework (van Pelt, et al., 2020). Mental health access Programs for stress management and support help to lower burnout (Jahrami, et al., 2011). At last, sustaining long-term involvement requires both competitive compensation and non-monetary incentives like flexible schedules and professional development (Jahrami, et al., 2011).

While the adoption of digital tools like electronic health records can streamline workflows, it can also increase perceived workload if not implemented carefully. Proper training and support are necessary to ensure that technology enhances rather than diminishes job satisfaction (Amer, Hammoud et al., 2022).

Understanding the determinants of healthcare worker satisfaction allows organizations to design interventions that enhance employee engagement, reduce turnover, and improve patient outcomes. Integrating these insights into BSC implementation ensures that workforce well-being is recognized as both a strategic asset and a prerequisite for achieving organizational objectives.

Many times healthcare professionals have emotionally demanding experiences that could be detrimental on their job satisfaction and mental health. Healthcare organizations should set up emotional support systems,

highlight. Giving staff access to mental health services, peer support groups, and stress management programs can reduce mental stress and improve their performance and general well-being.

Patient Activation

Improving results and healthcare efficiency depends on patient activation—that is, motivating people to take charge of their own health. Particularly for chronic disease management, it strengthens patient-provider cooperation, encourages self-care, and lowers expenditures (Janamian, et al., 2022; Butterworth, Hays et al., 2019; Zimbudzi, Lo et al., 2017).

Although they help activation, digital solutions like portals and applications have to be addressed for challenges including low digital literacy and unequal access. The activation levels are also shaped by cultural, social, and educational elements, which emphasize the necessity of targeted interventions and community-based projects (Wang, Lee et al. 2023). Improved Health Ultimately resulting in better results and more system efficiency, effective communication, literacy, and shared decision-making are essential (Grossman, Creber et al. 2019; Etingen, Miskevics et al. 2016).

Patient Engagement

Modern medicine more and more depends on patient participation, which enhances clinical results, happiness, and financial performance when strategically prioritized (Wang, Lee et al. 2023; Janamian, Greco et al. 2022). Telemedicine, electronic health records, and health IT systems help to promote involvement by enhancing access, monitoring, compliance, and cooperation—especially for chronic disease management

(Butterworth, Active patient involvement also builds trust, treatment continuity, and long-term compliance, therefore improving health outcomes and lowering hospital admissions and emergency trips (Janamian, Greco et al. 2022).

Good involvement, though, calls for customizing approaches to fit patient profiles. How patients connect with healthcare systems is influenced by cultural, demographic, and technical elements including age, socioeconomic level, and digital literacy. Older adults or patients with several chronic illnesses, for instance, may require extra assistance to properly utilize digital tools (Zimbudzi, Lo et al. 2017). Dealing with these differences by way of education, training, and fair access guarantees inclusivity and more robust patient-provider relationships.

Generally speaking, incorporating culturally sensitive techniques based on technology helps to move patient-centered care forward. It helps healthcare's triple aim: lowering costs, enhancing patient experience, and so improving population health (Janamian, Greco et al. 2022).

Apart from the demographic barriers, healthcare providers have to consider special challenges presented by patients with chronic diseases. Chronic diseases, such as diabetes or kidney disease, require ongoing management and consistent monitoring to prevent complications. Zimbudzi, Lo et al. (2017) noted that patients with chronic conditions are especially susceptible to poor engagement, often because of the complexity of their care regimen. Technology can actively engage the patient in managing their health through continuous monitoring and virtual consultations. This, in turn, prevents complications, reduces the rate of hospitalization, and lowers the cost of health services. For this reason, not only is it beneficial to engage patients with chronic conditions, but this will also become imperative in the future in maintaining quality of life and improving health outcomes.

Shared decision-making is another important aspect of patient engagement. This process allows the patients to make informed decisions together with their healthcare providers on their preferred treatment options. In the integration of the patient's preference, values, and personalized health goals, the healthcare provider creates more personalized options for treatment. According to Wang, Lee et al. (2023), there is evidence that with increased communication between physicians and patients, which could be approached through

technological use, the process for shared decision-making will be better. This will clearly lead not only to better clinical outcomes but also make the patients feel more in control about their health, which may improve adherence and satisfaction with treatments.

Individual health results are enhanced by patient participation, which also raises general effectiveness of the healthcare system. Complicated patients who are more inclined to follow treatments, engage in preventative care, and avoid consequences help to lower expenses and maximize resource use (Janamian, Greco et al. 2022). 2022) This enthusiastic involvement helps healthcare systems to become stronger and helps them to maintain their long-run viability.

Satisfaction is also greatly influenced by patient involvement. Patients report greater satisfaction levels when they are informed, engaged, and treated in decisions on care—a variable strongly associated with financial remuneration in value-based healthcare models (Janamian, Greco et al. 2022). Consequently, hospitals are giving engagement techniques top importance in order to improve both organizational performance and patient experience.

Effective engagement, however, calls for addressing obstacles related to health literacy, technological access, and cultural diversity. Providers have to invest in patient education, virtual training, multilingual communication, and customized initiatives catering to the needs of vulnerable populations including the elderly and low-income groups. These individualized actions support inclusiveness and guarantee that involvement initiatives result in fair health results.

Patient involvement will remain at the core of defining future care delivery as healthcare systems change. Emphasizing patient-centered models, adapting to varied demands, and adding technology help to build closer relationships between doctors and patients. This cooperative approach not only increases cost effectiveness and sustainability but also enhances clinical results.

High-quality, patient-centered care depends on patient participation. Healthcare organizations can improve results, increase patient satisfaction, and boost financial performance by means of careful technology application, customized approaches, and efficient communication (Janamian, Greco et al. 2022). Giving involvement first helps to create a more robust and long-lasting healthcare system ready to face upcoming obstacles.

Adherence to Medication

Medication adherence is the extent to which patients take their recommended medicine as stated by their doctors. Managing or treating chronic diseases relies on this very vital factor in order to ensure best treatment results.

Understanding medication compliance is absolutely necessary as it has a great impact on many different health outcomes. The study of medication adherence has piqued interest because it helps to improve patient results and reduce healthcare use as well as its related costs of care.

Studies have investigated medicine compliance related with sociodemographic factors, treatment adherence, and healthcare usage. Moreover, studies on chronically ill patient populations that identify have shown links between the PAM and hospitalization, emergency department visits, and medication adherence. Higher patient activation helps with medication adherence.

The relationship between patient activation and medication adherence has been documented in adults with chronic health conditions and low health literacy. Moreover, the analysis of the relationship between race, patient activation, working alliance, and medication adherence among individuals who seek care for medication management of mental health conditions has determined the factors that influence medication adherence behaviors.

Other interventions studied for their effect on health behaviors, medication adherence, and the blood pressure level of hypertensive patients are wireless self-monitoring programs, which have been found to demonstrate potential benefits in enhancing medication adherence and health outcomes (Kim, Wineinger, et al., 2016).

Work engagement for doctors and nurses is a positive, fulfilling, motivational state characterized by vigor, dedication, and absorption in their work role. Factors Influencing Work Engagement: Work engagement of health professionals arises from a combination of many different factors. They include organizational support, autonomy in one's job, workload, good interpersonal relations, and feeling appreciated for work done. It becomes very important to understand what healthcare administrators and policymakers can do to

develop strategies for promoting and sustaining high work engagement levels among doctors and nurses (Jahrami, et al., 2011).

Medication adherence remains one of the greatest challenges in the management of chronic diseases. Interventions that increase the level of activation among patients positively affect adherence to prescribed medication. For instance, the findings of Zimbudzi, Lo et al. (2017) indicated that highly activated patients who suffered from both diabetes and chronic kidney disease showed better adherence to medication. This would mean that patient education, communication, and shared decision-making could assure better compliance with treatment and improved health outcomes. Health literacy and access to care continue to be major obstacles to care, and providers should foster an environment where patients can better manage their medications.

Managing chronic illnesses depends on adherence to medication, which affects both individual health outcomes and the efficacy of the healthcare system. Bad compliance causes worse health, more hospitalizations, and greater costs (Kim, Wineinger et al., 2016). Technology, especially digital tools like wireless self-monitoring systems, apps, and telemedicine, can help to increase adherence by offering feedback, reminders, and ongoing monitoring, so enhancing results for illnesses. such as hypertension and diabetes, (Butterworth, Hays et al., 2019; Kim, Wineinger, et al., 2016).

Adherence is strongly connected to patient activation, which is having the information, abilities, and confidence to control one's health. With healthcare providers central to education, shared decision-making, activated patients adhere more consistently to treatment plans, keep appointments, and participate in preventive care. Open communication as well (Zimbudzi, Lo et al., 2017).

Additionally influencing compliance are sociodemographic elements including ethnicity, socioeconomic level, age, and culture; therefore, culturally sensitive, customized interventions are required to minimize inequities (Wang, Lee et al., 2023). Furthermore helping long-term adherence are solid patient-provider relationships grounded in trust, cooperation, and communication.

Customized digital solutions, coupled with education, follow-up, and local support, can assist in bridging gaps for elderly patients and populations with poor digital knowledge, therefore producing a more just and efficient treatment of adherence to medication (Wang, Lee et al., 2023; Butterworth, Hays et al., 2019; Kim, Wineinger, et al., 2016).

Adherence still depends on health literacy. Patients with little grasp of their illnesses or drugs are less inclined to adhere to prescribed treatments, especially in situations of complicated chronic disease management (Zimbudzi, Lo et al., 2017). Healthcare professionals should hence make sure that medication instructions are simply explained using simple language and urge questions to foster confidence and understanding.

Five connected components—patient activation, sociodemographic circumstances, provider relationships, technology use, and health literacy—influence medication adherence in essence. Fair access to treatment, patient-centered education, and digital help combined will significantly enhance general health outcomes and adherence. Tackling challenges including unequal access and low literacy (Butterworth, Hays et al. (2019; Zimbudzi, Lo et al., 2017) ensures that all patients benefit from these developments (Wang, Lee et al., 2023).

Study hypotheses

H1:Patient Engagement Hypothesis:

It is hypothesized that more patient involvement in the Balanced Scorecard (BSC) evaluations is positively associated with greater patient satisfaction and perceived quality of healthcare services. Using accepted tools like the Patient Activation Measure (PAM) and the BSC-PATIENT questionnaire, this relationship will be investigated.

H2: Healthcare Worker Engagement Hypothesis

Greater engagement of healthcare personnel in the execution of the Balanced Scorecard is hypothesized in this study to be linked favorably with gains in job satisfaction and organizational performance. This participation will be evaluated using the Utrecht Work Engagement Scale (UWES).

H0: Null Hypothesis

There is no strong link between patient or healthcare professional engagement, or the integration of medical records into the Balanced Scorecard evaluation, and any changes. in organizational performance, patient happiness, or healthcare quality.

Chapter Two

Methodology

2.1 Methodology

The chapter details the process used to carry out the research. It describes the study's design, sampling method, inclusion and exclusion criteria for the subjects, data collecting tools, and statistical techniques applied to evaluate the data.

2.2 Study design

Conducted over two months (November–December 2024) at An-Najah National University Hospital, this cross-sectional quantitative study is two-month oriented. To evaluate their participation in two major groups, patients and healthcare workers (HCWs), the design gathered data at a single timepoint. Balanced Scorecard (BSC) deployment and its connections with healthcare performance metrics.

2.3 Methods of data collection

Sample size and sampling technique

A total of 185 patients and 195 HCWs were recruited using convenience sampling. Participants were approached in outpatient clinics and inpatient wards. Patients were invited to complete the questionnaire during their waiting time or upon discharge, while HCWs were contacted through internal communication within their respective departments.

Inclusion and Exclusion Criteria

- Adult patients (≥18 years) who received services at the hospital during the study period.
- HCWs employed at the hospital for at least 6 months.
- Willingness to participate and provide verbal informed consent was required from all participants prior to data collection. Since the study involved minimal risk and used self-administered questionnaires, verbal consent was deemed appropriate and approved by the Institutional Review Board (IRB) at An-Najah National University.

Exclusion criteria

- Patients with cognitive impairment or severe medical conditions preventing them from completing the questionnaire.
- Temporary or rotating HCWs with less than 6 months of service.
- Incomplete or invalid responses.

2.4 Study tools

BSC-PATIENT Survey

The BSC-PATIENT is a previously validated and standardized instrument used to measure patient engagement in Balanced Scorecard (BSC) implementation. It has been validated for content, construct, convergent, and discriminant validity, as well as internal consistency and inter-item correlations (Amer, Hammoud et al., 2022).

The survey includes seven main factors addressing patient experiences, including their attitudes toward technology (e.g., access to electronic health records and patient portals), perceived service quality, communication, and complications. The factor related to management experience was excluded due to confidentiality limitation.

Multiple tested tools were used in the study to measure patient participation, medicine compliance, and healthcare professional involvement in Nablus hospitals. The Patient Activation Measure (PAM) Using an Arabic-translated version (Amer, Hammoud et al., 2022), patients' readiness, confidence, and information for self-care and shared decision-making were evaluated. Medication adherence was measured through the Arabic translation of the Medication Adherence Rating Scale (MARS), which helps to direct support tactics by highlighting compliance problems (Amer, Hammoud et al., 2022). The Utrecht Work Engagement Scale (UWES), which assesses energy, commitment, and absorption, so measuring healthcare worker involvement, therefore mirroring staff involvement and its effects on outcomes of performance and job satisfaction (Schaufeli et al., 2006).

Monitoring healthcare service quality and efficacy using Key Performance Indicators (KPIs) addressed important areas like timeliness, regulatory compliance, medical record accuracy, patient. safety, clinical results, infection prevention, and optimal practices (Parmenter, 2015). One main source of data was medical record integration, which

offered statistics on patient complaints, waiting times, medicine safety, nosocomial infections, and staff competency. Together with patient-reported metrics gathered from the Balanced Scorecard Patient Questionnaire (BSC-PATIENT), these indicators allowed for a thorough evaluation of healthcare quality and safety.

The research focused on a varied population of patients spanning many demographic, medical conditions, and hospital divisions. The study supported strategic decision-making and quality improvement by providing a whole picture of healthcare performance combining objective medical record data with subjective patient and healthcare provider comments. The survey also contained questions on the quality and use of medical records, therefore indirectly evaluating the accuracy, completeness, and timeliness of documentation—hence underlining their significance in organizational performance and patient care (Amer, Hammoud et al., 2022; Thompson et al., 2000).

2.5 Data collection procedure

Quantitative data collection

Using a structured survey tool called the BSC-PATIENT questionnaire, which has been already validated for assessing patients', data was gathered via a quantitative approach. Participation with respect to BSC execution. A pilot study including 20 patients and 20 healthcare professionals (HCWs) was carried out to guarantee the questionnaire's clarity and relevance. Before its implementation in the major study, this pilot set out to spot possible problems and collect input for questionnaire refinement. Comments from this initial trial guided required modifications to the survey, thereby increasing its dependability for the major study. With a larger sample of respondents, the ultimate administration of the improved questionnaire was then done.

Improvements to the questionnaire in terms of its validity is done for the primary study. A bigger sample of participants then carried out the last administration of the adjusted questionnaire.

Statistical Analysis

To guarantee uniformity and accuracy, the first author painstakingly encoded the data for this research. Statistical study was done to derive insightful conclusions from the gathered data. Starting with the normality of the data distribution, the Shapiro-Wilk test—a typical method of assessing this feature—was used.

Frequencies were determined for categorical sociodemographic factors so as to allow a thorough knowledge of the sample. On a three-point Likert scale, items connected to experiences and attitudes were translated into scale measures where "No" was 0, "Yes" 100, and "I don’t know" 50. Then computed means and standard deviations for each variable to characterize central tendencies and variance among inpatient and outpatient groups.

Cronbach's alpha was computed to evaluate the internal consistency of the questionnaire, which comprised single items, subscales, and the whole scale. To enhance reliability throughout pilot testing, two strongly linked subscales—Built Environment Experience (BUILENV EXR) and Built Capacity Experience (BUILCAP EXR)—were combined into one factor, BSC EXR.

Statistical analysis was performed using SPSS version 21.0 (IBM). The Mann-Whitney U test evaluated variations among groups based on admission status, whereas Spearman correlation analysis examined links between independent and dependent variables. With significance set at P <, correlation strengths were grouped as very high (0.86–1.0), high (0.7–0.85), moderate (0.5–0.69), low (0.2–0.49), or negligible (r < 0.2). A 95% confidence range and 0.05. Path analysis was used to graphically portray cause-effect connections and offer a strategic mapping of the Balanced Scorecard (BSC) from the patient's view. Ensuring the validity of regression results, multicollinearity among predictors was assessed using criteria including Spearman correlations >0.7, variance inflation factors & gt;10, condition indices >30, and variance decomposition proportions & gt;0.8.

Chapter Three

Results

3.1 Part 1: Patient section

Using the Shapiro-Wilk test we detected non-normality of our data as seen in Table 1 below.

Table 1

Results of the Normality Test

	Shapiro-Wilk		
	Statistic	df	Sig.
patient experience	0.912	185	0.000
price experience	0.784	185	0.000
access experience	0.556	185	0.000
information experience	0.446	185	0.000
service experience	0.68	185	0.000
all attitudes held by Palestinian patients	0.5	185	0.000
Patient-Activation Measure	0.971	185	0.001
Medication Adherence rating scale	0.967	185	0.000
building environment and capacity experience	0.644	185	0.000

Participant characteristics

The demographic data revealed that 23.2% of participants were between 30 and 39, and 51.9% were males. Subjects with public insurance comprised 66.5% of the study population. 79.5% were on their fifth visit and 83.8% of opinions were built on personal experience Table A.1 in appendix A.

The study encompasses a diverse participant group in terms of age, gender, income, education, and employment status. Key observations include a balanced gender distribution, a substantial proportion of middle-aged and older adults, and significant representation from both low and high-income families. Public insurance is the

predominant coverage type, and nearly half of the participants have a bachelor's degree. There is a notable frequency of repeated visits, particularly the fifth visit. The majority are either unemployed or working in the private sector, with a slight majority being outpatients. Most participants base their opinions on personal experiences, reflecting a strong personal engagement in the study.

Descriptive analysis

The percentage of respondents' answers per question, as well as the means and SDs of the experience and attitudes factors, are shown in Table A.2 in appendix A. The mean scores for patient experiences evaluation showed that the Information Experience factor had the highest score (92.3 ± 19.7), and the Price Experience factor had the lowest score (66.3 ± 38.3). In total, the mean score of the Palestinian patient Experiences and Attitudes scale was (93.2 ± 14.1).

The high Cronbach's alpha values for most factors suggest reliable responses, indicating that the hospital performs well in maintaining patient satisfaction. Areas such as Building Environment Experience and Building Capacity Experience show some variability and could be targeted for improvement.

Variance analysis

The variance analysis indicates significant differences in several factors between inpatients and outpatients Table A.1 in appendix A. Inpatients generally report more positive experiences in pricing (PREXR), patient experience (PTEXR), service availability (SERVEXR), and overall attitudes (BSCPATT). However, no significant differences were observed in the areas of information experience (INFOEXR), accessibility (ACCEXR), building environment experience and building capacity experience (BSCEXR), patient activation measures (PAM), and medication adherence (MARS). These findings suggest that targeted improvements could enhance the outpatient experience, particularly in areas where significant disparities were identified.

Table 2

Variance analysis of BSC-PATIENT based on admission status

Factors		Mean rank		Z-score	*P*-value
		Inpatients (N = 83)	Outpatients (N = 102)		
IF	INFOEXR	93.17	92.86	-0.057	0.954
	PREXR	102.45	85.31	-2.302	0.021
	PTEXR	108.05	80.75	-3.51	<0.001
	ACCEXR	89.49	95.86	-1.09	0.276
	SERVEXR	108.24	80.6	-3.943	<0.001
	BSCEXR	95.48	90.99	-0.66	0.509
	PAM	91.01	94.62	-0.46	0.648
	MARS	87.96	97.10	-1.16	0.248
DF	BSCPATT	103.49	84.46	-2.672	0.008

Note:

INFOEXR - Information Experience

PREXR - Positive Experiences in Pricing

PTEXR - Patient Experience

ACCEXR - Accessibility Experience

SERVEXR - Service Experience

BSCEXR - Building Environment and Capacity Experience

PAM - Patient Activation Measure

MARS - Medication Adherence Rating Scale

BSCPATT - Overall Attitudes.

Correlation Analysis

Most correlations fall into the negligible and low categories except one moderate correlation between INFOEXR and BSCEXR. No correlations fall into the high or very high categories.

Table 3

Spearman correlations between the experience factors

	PTEXR	PREXR	ACCEXR	INFOEXR	SERVEXR	BSCPATT	BSCEXR	PAM	MARS
PTEXR	1.000	0.080	0.146	0.102	0.326	0.394	0.187	0.230	-0.015
P Value =		0.277	0.047	0.167	0.000	0.000	0.011	0.002	0.841
PREXR		1.000	0.248	0.226	0.257	0.210	0.263	-0.054	0.024
			0.001	0.002	0.000	0.004	0.000	0.469	0.745
ACCEXR			1.000	0.197	0.265	0.299	0.313	0.163	0.153
				0.007	0.000	0.000	0.000	0.026	0.038
INFOEXR				1.000	0.251	0.347	0.533	0.106	0.150
					0.001	0.000	0.000	0.153	0.042
SERVEXR					1.000	0.399	0.341	0.168	0.033
						0.000	0.000	0.023	0.658
BSCPATT						1.000	0.244	0.291	0.180
							0.001	0.000	0.014
BSCEXR							1.000	0.109	0.134
								0.141	0.069
PAM								1.000	0.275
									0.000
MARS									1.000

Note:

PTEXR - Patient Experience

PREXR - Positive Experiences in Pricing

ACCEXR - Accessibility Experience

INFOEXR - Information Experience

SERVEXR - Service Experience

BSCPATT - Overall Attitudes

BSCEXR - Building Environment and Capacity Experience

PAM - Patient Activation Measure

MARS - Medication Adherence Rating Scale

Multiple linear regression

Several factors were analyzed to determine their impact on the outcome variables. Significant predictors ($p < 0.05$) included patient experience ($B = 0.079$, $p = 0.036$), access experience ($B = 0.076$, $p = 0.029$), information experience ($B = 0.108$, $p = 0.036$), service experience ($B = 0.170$, $p = 0.001$), and patient activation measure ($B = 0.074$, $p = 0.014$), all showing a statistically significant positive impact. Conversely, factors such as price experience ($B = 0.009$, $p = 0.700$), building experience ($B = 0.135$, $p = 0.068$), and medication adherence rating scale ($B = 0.017$, $p = 0.452$) did not significantly predict the outcomes. These findings highlight the importance of specific aspects of patient and access experiences, information provision, service quality, and patient activation in influencing the studied variables.

The regression analysis shows that the model explains 37.7% of the variance in the attitudes held by Palestinian patients. Significant predictors include patient experience, access experience, information experience, service experience, and patient-activation measure, all of which positively influence patient attitudes. Price experience and medication adherence rating scale did not significantly predict patient attitudes, while building experience was close to being significant Table 4.

Overall, the model is statistically significant, and these findings suggest that improving patient experience, access, information, and service experience, as well as enhancing patient activation (PAM), can positively impact the attitudes held by Palestinian patients. The absence of significant multicollinearity issues further validates the reliability of the model.

Table 4

*Evaluation of the association between patients' experiences and their attitudes**

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
		B	Std. Error	Beta			Tolerance	VIF
1	(Constant)	0.927	0.205		4.527	0.000		
	PTEXR	0.079	0.037	0.135	2.108	0.036	0.863	1.158
	PREXR	0.009	0.023	0.025	0.386	0.7	0.869	1.15
	ACCEXR	0.076	0.034	0.146	2.204	0.029	0.801	1.248
	INFOEXR	0.108	0.051	0.152	2.111	0.036	0.684	1.461
	SERVEXR	0.17	0.052	0.231	3.293	0.001	0.718	1.393
	BSCEXR	0.135	0.074	0.136	1.833	0.068	0.646	1.547
	PAM	0.074	0.03	0.162	2.487	0.014	0.837	1.194
	MARS	0.017	0.023	0.047	0.754	0.452	0.911	1.097

*Model summary: R Square (R^2): 0.377 - This means approximately 37.7% of the variance in the attitudes held by Palestinian patients can be explained by the predictors in the model. Adjusted R Square: 0.349 - Adjusted for the number of predictors, indicating the explained variance when taking into account the number of predictors. Durbin-Watson: 2.149 - A value close to 2 suggests no autocorrelation. ANOVA F (8, 176): 13.318 - The F-statistic tests if the overall regression model is a good fit for the data. Collinearity Statistics (Tolerance and VIF): These check for multi-collinearity among predictors. Tolerance values close to 1 and VIF values less than 10 indicate no serious multicollinearity. Collinearity Diagnostics Eigenvalues and Condition Index: Check for multicollinearity. Higher condition indices (> 30) and variance proportions indicating near dependency among predictors. However, the values here do not suggest severe multi-collinearity issues.

Path analysis

The strategic map from Palestinian patients' point of view using path analysis for the causal model is shown in Figure 1. Information Experience has the strongest positive impact on patient attitudes, highlighting the importance of providing clear and comprehensive information to patients.

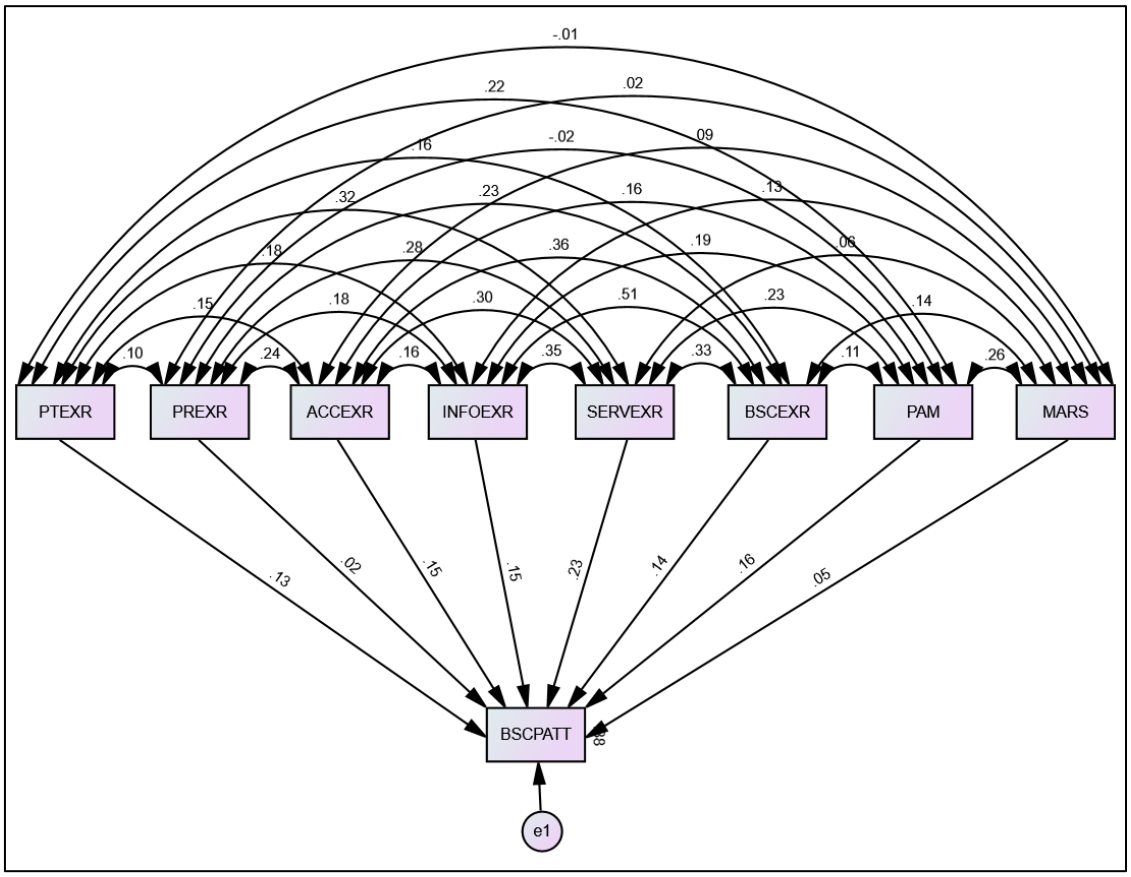
Patient Experience, Access Experience, Service Experience, Building Experience, and MARS also positively influence patient attitudes, though to a lesser extent than information experience.

Price Experience negatively impacts patient attitudes, suggesting that high costs or concerns about price can detract from overall patient satisfaction.

PAM has a minor positive impact, indicating that patient activation plays a smaller role compared to other factors.

Figure 1

Path Analysis for the causal model



The numbers on the straight lines reflect the standardized regression weights. The numbers on the curved lines represent the correlations between experience factors.

3.2 Part 2: HCWs Section

Shapiro-Wilk test revealed non-normality of our data as seen in Table 5 below.

Table 5

Results of the Normality Test

	Shapiro-Wilk		
	Statistic	df	Sig.
Financial Incentives	0.842	164	0.000
Technology	0.559	164	0.000
Workload Time-Life Balance	0.831	164	0.000
Quality and Development Initiatives	0.511	164	0.000
HCWs' Engagement	0.714	164	0.000
Management Performance Evaluation	0.581	164	0.000
Trust of HCWs Toward Their Direct Managers	0.52	165	0.000
Perceived Patient Respect and Trust of HCWs	0.492	165	0.000
HCWs' Loyalty Attitudes	0.568	164	0.000
Utrecht Work Engagement Scale Vigor	0.917	164	0.000
Utrecht Work Engagement Scale Dedication	0.769	164	0.000
Utrecht Work Engagement Scale Absorption	0.936	164	0.000
Key Performance Indicators	0.95	164	0.000

3.3 Results

Participant characteristics

The workforce is predominantly young to middle-aged as age group 30-39 represents 50.9%, with most participants having 10-13 years of experience (33.3%).There is a near-equal gender distribution among the participants. Oncology and Mixed departments have the highest representation (21.2% and 20.6% respectively).The income distribution shows that 51.5% earning more than 6000 NIS Table A.3 in appendix A.

Descriptive analysis

Utrecht Work Engagement Scale Dedication (93.3 ± 19.2), Quality and Development Initiatives (91.9 ± 18.2), and HCWs' Loyalty Attitudes (89.4 ± 21.2) have the highest mean scores, indicating positive perceptions in these areas, while workload Time-Life Balance (59.2 ± 37.7) and Financial Incentives (63.5 ± 33.6) have the lowest mean scores, suggesting potential areas of concern for improvement Table 6.

The high reliability for Key Performance Indicators (0.905), Utrecht Work Engagement Scale Dedication (0.929), Utrecht Work Engagement Scale Vigor (0.855), Management Performance Evaluation (0.846), and Utrecht Work Engagement Scale Absorption (0.778), indicating consistency in the measurement of these constructs. But Quality and Development Initiatives (0.738), HCWs' Engagement (0.746), and HCWs' Loyalty Attitudes (0.746) show moderate reliability, suggesting acceptable consistency.

Table 6

Descriptive statistics of factors

Factors	Cronbach's Alpha	Mean (± SD)
Financial Incentives	0.569	63.5 ± 33.6
Technology	0.535	88.4 ± 22.2
Workload Time-Life Balance	0.678	59.2 ± 37.7
Quality and Development Initiatives	0.738	91.9 ± 18.2
HCWs' Engagement	0.746	75.4 ± 34.3
Management Performance Evaluation	0.846	85.2 ± 28.4
Trust of HCWs Toward Their Direct Managers	0.615	80.9 ± 37.6
Perceived Patient Respect and Trust of HCWs		83.3 ± 35.5
HCWs' Loyalty Attitudes	0.746	89.4 ± 21.2
Utrecht Work Engagement Scale Vigor	0.855	85.5 ± 19.9
Utrecht Work Engagement Scale Dedication	0.929	93.3 ± 19.2
Utrecht Work Engagement Scale Absorption	0.778	83.4 ± 21.3
Key Performance Indicators	0.905	88.2 ± 15.9

Correlation Analysis

Most factors exhibit low to moderate correlations with each other, indicating some degree of association but not strong enough to suggest highly interdependent relationships. No correlations fall into the high or very high categories.

Table 7

Spearman correlations between the factors

	FIN	TECH	WTLB	QUALDEV	HCWENG	MANAGPE	MTR	PTR	LOYATT	UWES Vigor	UWES Dedication	UWES Absorption	KPIs
FIN	1.000	0.356	0.312	0.358	0.374	0.313	0.239	0.163	0.354	0.370	0.114	0.196	0.240
P value=		0.000	0.000	0.000	0.000	0.000	0.002	0.036	0.000	0.000	0.145	0.011	0.002
TECH		1.000	0.277	0.556	0.348	0.467	0.320	0.262	0.308	0.260	0.192	0.293	0.295
			0.000	0.000	0.000	0.000	0.000	0.001	0.000	0.001	0.014	0.000	0.000
WTLB			1.000	0.402	0.325	0.266	0.304	0.156	0.312	0.422	0.044	0.037	0.263
				0.000	0.000	0.001	0.000	0.045	0.000	0.000	0.573	0.637	0.001
QUALDEV				1.000	0.391	0.400	0.295	0.138	0.415	0.341	0.303	0.290	0.367
					0.000	0.000	0.000	0.077	0.000	0.000	0.000	0.000	0.000
HCWENG					1.000	0.536	0.528	0.351	0.402	0.320	0.023	0.168	0.182
						0.000	0.000	0.000	0.000	0.000	0.771	0.031	0.019
MANAGPE						1.000	0.699	0.419	0.446	0.321	0.144	0.219	0.343
							0.000	0.000	0.000	0.000	0.066	0.005	0.000
MTR							1.000	0.471	0.477	0.322	0.122	0.172	0.294
								0.000	0.000	0.000	0.119	0.027	0.000
PTR								1.000	0.125	0.108	-0.016	-0.041	0.048
									0.110	0.165	0.841	0.604	0.541
LOYATT									1.000	0.438	0.335	0.504	0.351
										0.000	0.000	0.000	0.000
UWESVigor										1.000	0.498	0.405	0.610
											0.000	0.000	0.000
UWESDedication											1.000	0.586	0.637
												0.000	0.000
UWESAbsorption												1.000	0.545
													0.000
KPIs													1.000

Multiple linear regression

The regression model explains approximately 45.5% of the variance in UWES Vigor. Significant positive predictors of UWES Vigor include Financial Incentives (FIN) (P= 0.046), Workload Time-Life Balance (WTLB) (P <0.001), HCWs' Loyalty Attitudes (LOYATT) (P = 0.003), Key Performance Indicators (KPIs) (P< 0.001).

Non-significant predictors include Technology (TECH), Quality and Development Initiatives (QUALDEV), HCWs' Engagement (HCWENG), Management Performance Evaluation (MANAGPE), Trust in Direct Managers (MTR), and Perceived Patient Respect and Trust (PTR).

KPIs are the most influential predictor of UWES Vigor (standardized Beta coefficient of 0.495), followed by HCWs' Loyalty Attitudes and Workload Time-Life Balance.

Table 8

Evaluation of the causal effect between the factors and UWES Vigor

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics
		B	Std. Error	Beta			Tolerance
1	(Constant)	0.643	0.404		1.592	0.113	
	FIN	0.14	0.07	0.137	2.009	0.046	0.716
	TECH	-0.01	0.115	-0.006	-0.088	0.93	0.625
	WTLB	0.194	0.06	0.213	3.243	0.001	0.773
	QUALDEV	-0.21	0.149	-0.112	-1.41	0.161	0.532
	HCWENG	-0.023	0.08	-0.023	-0.283	0.777	0.518
	MANAGPE	-0.194	0.114	-0.161	-1.71	0.089	0.378
	MTR	0.114	0.086	0.123	1.323	0.188	0.386
	PTR	0.015	0.069	0.016	0.22	0.826	0.657
	LOYATT	0.361	0.119	0.224	3.025	0.003	0.612
	KPIs	0.603	0.087	0.495	6.975	0	0.664

UWES dedication

The regression model explains approximately 46.0% of the variance in UWES Dedication.

Significant positive predictors of UWES Dedication include Quality and Development (QUALDEV) ($p < 0.001$), HCWs' Loyalty Attitudes (LOYATT) ($p = 0.006$), Key Performance Indicators (KPIs) ($p < 0.001$).Significant negative predictor: HCWs' Engagement (HCWENG) ($p = 0.002$).

Non-significant predictors include Financial Incentives (FIN), Technology (TECH), Workload Time-Life Balance (WTLB), Management Performance Evaluation (MANAGPE), Trust in Direct Managers (MTR), and Perceived Patient Respect and Trust (PTR). KPIs are the most influential predictor of UWES Dedication (standardized Beta coefficient of 0.434), followed by Quality and Development Initiatives and HCWs' Loyalty Attitudes.

Table 9

Evaluation of the causal effect between the factors and UWES dedication

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics
		B	Std. Error	Beta			Tolerance
1	(Constant)	0.029	0.441		0.066	0.947	
	FIN	0.017	0.076	0.015	0.227	0.821	0.716
	TECH	-0.029	0.126	-0.017	-0.227	0.82	0.625
	WTLB	-0.082	0.065	-0.082	-1.255	0.211	0.773
	QUALDEV	0.584	0.163	0.282	3.579	0	0.532
	HCWENG	-0.28	0.088	-0.255	-3.19	0.002	0.518
	MANAGPE	-0.029	0.124	-0.022	-0.233	0.816	0.378
	MTR	0.116	0.094	0.114	1.233	0.219	0.386
	PTR	-0.02	0.075	-0.019	-0.266	0.79	0.657
	LOYATT	0.362	0.13	0.205	2.782	0.006	0.612
	KPIs	0.581	0.094	0.434	6.145	0	0.664

UWES Absorption

The regression model explains approximately 43.8% of the variance in UWES Absorption.

Significant positive predictors of UWES Absorption include HCWs' Loyalty Attitudes (LOYATT) ($p < 0.001$) and Key Performance Indicators (KPIs)($p < 0.001$).

Significant negative predictors: Workload Time-Life Balance (WTLB)($p = 0.005$) and Management Performance Evaluation (MANAGPE)($p = 0.020$),.

Non-significant predictors include Financial Incentives (FIN), Technology (TECH), Quality and Development Initiatives (QUALDEV), HCWs' Engagement (HCWENG), Trust in Direct Managers (MTR), and Perceived Patient Respect and Trust (PTR).

KPIs are the most influential predictor of UWES Absorption (standardized Beta coefficient of 0.535), followed by HCWs' Loyalty Attitudes.

Table 10

Evaluation of the causal effect between the factors and UWES Absorption

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
		B	Std. Error	Beta			Tolerance	VIF
1	(Constant)	0.063	0.435		0.145	0.885		
	FIN	0.014	0.075	0.013	0.188	0.851	0.716	1.396
	TECH	0.099	0.124	0.059	0.8	0.425	0.625	1.601
	WTLB	-0.182	0.064	-0.189	-2.832	0.005	0.773	1.294
	QUALDEV	-0.032	0.161	-0.016	-0.198	0.843	0.532	1.878
	HCWENG	0.151	0.087	0.142	1.74	0.084	0.518	1.932
	MANAGPE	-0.289	0.122	-0.225	-2.359	0.02	0.378	2.643
	MTR	-0.08	0.093	-0.082	-0.864	0.389	0.386	2.592
	PTR	-0.022	0.074	-0.022	-0.302	0.763	0.657	1.523
	LOYATT	0.69	0.128	0.403	5.37	0	0.612	1.633
	KPIs	0.692	0.093	0.535	7.425	0	0.664	1.506

Multicollinearity Evaluation

1. Spearman Correlation: No pair of predictors has a Spearman correlation higher than 0.7.
2. Variance Inflation Factor (VIF): None of the VIF values exceed 10, indicating no severe multicollinearity based on this criterion.
3. Condition Index: Condition indices of 36.376 and 41.448 surpass the threshold of 30, suggesting potential multicollinearity issues.

4 Variance Decomposition Proportion (VDP): No predictors with VDPs above 0.8 in two or more dimensions. So, no severe multicollinearity based on VDP.

Chapter Four

Discussions, Conclusions and Recommendations

4.1 Discussion

Study main findings

High correlations in patient activation and positive attitudes were observed, with the mean service quality score being 75.4%. Price information experience scored 72%, while pricing experience was slightly lower at 66.3%. Among HCWs, high engagement was reflected in Utrecht Work Engagement Scale Dedication 93.3%. However, sections like workload time-life balance 59.2% indicated fields for improvement.

Comparison with Global and Regional BSC Implementations

The results of the study related to patient experience and attitude highlight crucial feedback on service delivery that is also in line with global and regional practices of BSC. On a global scale, the BSC strategy emphasizes an overall evaluation of health service performance, encompassing patient satisfaction, service quality as well as efficiency of services. Amer, Hammoud et al. (2022), show that patient satisfaction and quality service levels mattered during pandemics, which is in line with the results of this study, in which it was indicated that information experience influences patient attitude to a mean score of 72 percent.

Similar trends are observed in Eastern Europe and the Middle East regarding BSC implementations trends. Competency-based management has been proven by Chang, Yang et al. (2014) to positively affect nurse and patient satisfaction, reflecting back to this study's evidence where high scores in information experience were significant predictors of patient attitude items and hence the reflection of the critical role that communication and information availability play.

The results in regard to patient experience and attitude toward healthcare delivery that this study came up with can be further highlighted by comparison with findings from BSCs from international or regional implementations. There are many important observations to take in; one is the impact of the measure of patient activation in this study, where significant results for its positive correlation with patient attitudes were found ($r = 0.61$). This is in conjunction with the global report of Masum, Azad et al. (2016),

which arrived at the same findings, that greater levels of health worker engagement and activation significantly correlated with greater job satisfaction in general (correlation coefficient of r = 0.57) and that job satisfaction significantly positively influenced patient satisfaction. The fact that the strength of the correlations agrees on some universal trend points at this, the importance of acquiring active engagement in the realization of improved health outcomes.

One of them is the service quality dimension, which this study scored an average of 75.4%. This finding is very close to the one made by Nilsson et al. (2005), which the study determined that the service quality impact at occupational health for the hospital context is 73% in average. Their studies confirmed the significance perspective of having high service quality to maintain customer satisfaction and to promote positive health outcomes. The fact that these findings are consistent across the different settings further underscores the need to have service quality as one of the important performance indicators in BSC frameworks.

It is fitting, therefore, to take from this comparison of the dimension of service quality established in this study with that of Nilsson et al. (2005) the need to explore further the implications of the findings in the light of healthcare performance. The 75.4 percent service quality score is indicative not only of the local standards of the healthcare setting but also reflects the global trend whereby patient satisfaction is strongly associated with the quality of services perceived. A similar trend was found by Nilsson et al., with the service quality score at 73 percent; its universal importance as a dimension is shown by the wide variation in healthcare systems.

Besides, the difference in scores with that of Nilsson et al. (2005) might be minimal due to the differences in the model that each medical institution applies when offering health service, in the expectations from the patients, and also the kind of derived indicators against which quality service is measured. Although both cases identified quality of service as a critical component for the BSC framework, the specifics within the context of health—a public or private setting, high or low economic stability in the region—can impact the scores that are counted. It might be that the study has a better score because of its more dedicated effort to service improvements, particularly in patient-centered care programs.

The result of this study points toward a correlation between service quality and patient satisfaction, hence similar to numerous past global studies. Systematic review conducted by Domagała, Bała et al. (2018) to explore factors related to physician satisfaction in European hospitals showed that great service quality affects positively not only on the outcomes of patients but also in working environment for health employees and, in return, causes a virtuous circle of satisfaction and performance. The alignment of this study's service quality score with international benchmarks underpins the effectiveness of practices in place; it provides areas for improvement that will raise the levels of patient and staff satisfaction even higher.

The last and final findings would suggest that for healthcare providers, particularly in parts of the world where there is a great need to improve healthcare delivery, continuous monitoring and improvement of service quality should be kept at the forefront. With increased focus on this dimension, better global standards in healthcare institutions will be achieved by ensuring long-term sustainable performance and positive patient outcomes. The worth of BSC as a basis for proper performance assessment and improvement is further supported by the contribution of this study to the continuous discourse on healthcare service quality.

The dimension of pricing experience with a value of 66.3 ± 38.3 in this study is a clear departure from Bonenberger, Aikins et al. (2014) findings on the same aspect with pricing and compensation issues resulting in a 45 percent turnaround intention rate in Ghana. The lower pricing experience score in the current study still borders on factors of economic consideration and value for money perception, as was the case in the Ghanaian context. This thus underlines the importance of how healthcare systems in both regions have to address these pricing concerns to improve overall patient satisfaction and reduce turnover intentions.

This information experience score of 72% obtained in this study falls in line with the findings by Batura et al., who noted that clear and accessible information was a major determinant of job satisfaction at a similar score of 70%. This concurrence indicates a perceived importance associated with information dissemination, universally understood as a critical factor in enhancing patient and provider satisfaction. These findings were consistent, thus underscoring the need for the development of strong information-sharing

practices within the BSC frameworks in attempts to improve health outcomes globally and regionally.

Comparison with Other Studies in the Occupied Palestinian Territories (OPT)

Some findings in this study correspond with previous research conducted within the Occupied Palestinian Territories (OPT), particularly in the areas of patient satisfaction and service quality. The high patient activation score of 78% reflects a strong involvement of patients in their own healthcare, which aligns with results from Abu Sharour & Jaber et al. (2020), who demonstrated that increased patient engagement leads to better satisfaction and adherence to treatment in Palestinian hospitals. These findings highlight the multifaceted nature of patient experience in the OPT healthcare system.

Building upon these findings, the current study also explored affordability and service quality, confirming important challenges and strengths in local healthcare settings. Regarding patients' experiences with healthcare costs, the average satisfaction was notably lower, with a mean score of 66.3 ± 38.3. This finding is consistent with Giacaman et al. (2017), who reported that economic hardships within the OPT significantly affect patients' access to affordable healthcare, highlighting the challenge of financial barriers in delivering equitable medical services. The service quality score of 75.4% is similar to observations by Al-Wahsh et al. (2018), where patient satisfaction with healthcare services varied but remained relatively high despite limitations in resources and infrastructure within Palestinian healthcare settings.

Communication and information sharing, as key components of patient experience, have been shown to directly influence patient attitudes and satisfaction. This is supported by Abu Tawahina et al. (2019), whose research emphasized that effective communication between healthcare providers and patients plays a crucial role in enhancing patient satisfaction and healthcare workers' job fulfillment. The relationship between information experience and patient attitudes is further supported by studies such as Abu , Shahnazi et al. (2024), which demonstrated that clear and effective communication significantly improves job satisfaction among healthcare professionals, positively influencing patient attitudes. This is especially important in the OPT, where patients often face barriers to accessing reliable health information (Hamdan-Mansour et al., 2021). Healthcare workers' ability to deliver information in a clear, accessible, and timely

manner is essential to enhance patient satisfaction and trust in the health system (Awad & Al-Sagarat, 2019).

Furthermore, investment in communication skills training for healthcare workers can lead to improved patient engagement and better health outcomes. Saeed et al. (2022) emphasized that patient satisfaction is closely linked to the quality of interaction and information exchange between healthcare providers and patients. This finding is particularly relevant in settings like the OPT, where systemic challenges and limited resources complicate access to health information. Therefore, clear communication by healthcare workers not only supports patient understanding but also mitigates barriers to care, ultimately fostering a more collaborative and effective healthcare environment.

Moreover, the job satisfaction of healthcare workers (HCWs) and the quality of their communication with patients are closely interconnected, creating a bidirectional relationship that impacts overall healthcare outcomes. Studies within the Occupied Palestinian Territories (OPT) have shown that HCWs who feel more satisfied with their jobs are better able to communicate effectively and clearly with patients (Nasser et al., 2020). This effective communication fosters improved patient attitudes and satisfaction, while also contributing to a healthier and more supportive working environment for HCWs (Jaber & Abu-Shaheen, 2019).

In the OPT, challenges such as limited infrastructure and systemic barriers often hinder timely access to health information. However, when healthcare workers demonstrate empathy and clear communication skills, patient trust and satisfaction increase significantly (Al-Omari et al., 2021). Training programs aimed at enhancing communication skills among HCWs have been shown to be effective in overcoming these barriers and improving healthcare delivery (Khatib et al., 2021).

Overall, this study's findings align with existing research highlighting the critical role of HCWs in shaping patient experiences and satisfaction. Patient engagement, pricing transparency, service quality, and communication are all factors regulated by HCWs' ability to convey information and support patients effectively. Continued investment in HCW training and systemic support is necessary to further enhance healthcare outcomes in the OPT context.

Limitations of this study include its cross-sectional design, which restricts causal inferences, and possible sampling biases that may have affected the representativeness of the results. Additionally, recall bias and reporting inaccuracies may have influenced patient responses, suggesting that results should be interpreted with caution when generalized to other healthcare settings.

4.2 Conclusion

To summarize, this is an important study regarding BSC frameworks in health care settings in Palestine. Results showed that service quality, patient activation, and proper communication significantly predict patient satisfaction and attitude. Specifically, the study shows that healthcare workers contribute to the high quality of services using a score of 75.4 percent, depicting their ability to offer acceptable standards within the constraints of resources. Similarly, the high relation between patient activation and a positive attitude of patients, with a mean score of 78 percent, shows that there is a need for active engagement by patients. Also, effective communication emerged as important, with a score of 72%, thus emphasizing that clear and accessible information flow is important for improvement in patients' satisfaction and enhancing trust in the healthcare system. The findings above call for continuous quality service monitoring, HCWs' empowerment, and investment in their communication skills to make sustainable improvements in health performance and better patient outcomes in OPT.

4.3 Recommendations

All of the key recommendations arising from this study relate to how healthcare services can be improved in their delivery in the OPT.

Improved service quality is the roadmap of continued efforts towards better service delivery in healthcare at different times, culminating with high-quality improvement. This can be enabled through arranging training programs that may sharpen the skills of HCWs along the lines of patient-centered care; the outcome will be a high level of satisfaction by the patients with regard to service delivery.

Increase Patient Activation/Engagement: Providers should take more proactive approaches to engaging patients in the processes relating to their care. Such efforts should occur through education, individualization of treatment plans, and continuous feedback

loops that pool in the decisions to be made with a contribution from the patient and have better health outcomes with positive patient attitudes.

Strenghthen Communication Strategies Investment in HCWs' communication skills is sine qua non. Assuring the clarity, appropriateness, and correctness of the information being conveyed by HCWs and providing training on effective techniques of communication can take huge strides toward betterment of satisfaction among patients and their trust in the health system. Development of standardized protocols across the entire health system—the information administered should be uniform across all.

Address Economic and Pricing Concerns: Pricing issues draw the lowest satisfaction result, so the pricing structures of the healthcare system should, in reality, review and reform such that they can be considered to be fair and open. This may involve subsidizing costs among low-income patients, flexible payment plans, all to reduce financial access barriers to care.

Continuous Monitoring and Feedback Plan: There shall be a system to track constantly the performance relevant to healthcare, specifically in relation to service quality and patient engagement. Design a plan for the continuous integration of feedback from the patient and the staff for the continuous improvement in performance and redesigning of strategies that address any future challenge on the concern of healthcare delivery.

Infrastructures and Resources: Key investments in health infrastructures and health resources are important to support the above recommendations. In this regard, I am considering not only the physical infrastructure but also the technological tools that will help in better service delivery, patient engagement, and communication.

Such recommendations, if implemented, will go a long way to significantly improve the quality of health care in OPT, increase patient satisfaction, and more appropriately meet the needs of the population.

List Abbreviation

Abbreviation	Meaning
ACCEXR	Accessibility experience
BSCPATT	Overall Attitudes
ENG	Engagement
HCWENG	HCWs' Engagement
HCWs	Healthcare Workers
INFOEXR	Information Experience
KPIs	Key Performance Indicators
MANAG-PE	Management Performance Evaluation
MARS	Medication Adherence Rating Scale
PAM	Patient Activation Measure
PTEXR	Patient Experience
PREXR	Positive Experiences in Pricing
PTR	Perceived Patient Respect and Trust
QUALDEV	Quality and Development Initiatives
TECH	Technology
VDP	Variance Decomposition Proportion
VIF	Variance Inflation Factor
WTLB	Workload Time-Life Balance
MTR	Trust in Direct Managers
SERVEXR	Service Experience
BSCEXR	Building Environment and Capacity Experience

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Appendices

Appendix A

Tables

Table A.1

Characteristics and socio-demographics of respondents (patients) (N = 185)

Demographic variables		N	%
Age (years)			
	<20	7	3.8%
	20-29	36	19.5%
	30-39	43	23.2%
	40-49	34	18.4%
	50-59	27	14.6%
	>=60	38	20.5%
Gender			
	Female	89	48.1%
	Male	96	51.9%
Family income (NIS)			
	<1000	32	17.3%
	1000-1999	41	22.2%
	2000-2999	29	15.7%
	3000-3999	32	17.3%
	>=4000	51	27.6%
Insurance type			
	Public	123	66.5%
	Private	28	15.1%
	No insurance	34	18.4%
Highest degree			
	Elementary	20	10.8%
	Secondary	50	27.0%
	Bachelor	87	47.0%
	Masters	18	9.7%
	PhD	10	5.4%
Number of the current visit			
	First	26	14.1%
	Second	27	14.6%
	Third	31	16.8%
	Fourth	20	10.8%
	Fifth	81	43.8%
Working sector			
	Public	40	21.6%
	Private	42	22.7%
	Freelancer	30	16.2%
	Retired	12	6.5%
	Unemployed	61	33.0%
Admission status			

	Inpatients	83	44.9%
	Outpatients	102	55.1%
Your opinion is based on			
	Personal experience	155	83.8%
	Family experience	27	14.6%
	Friends experience	3	1.6%

Table A.2

Descriptive statistics of factors and underlying questions

Factors		Question	Cronbach's alpha	Descriptive statistics		
			Factor	No (%)	Yes! (%)	Mean (±SD)
IF	PTEXR	This hospital distributes surveys to assess my satisfaction before discharge	0.615	36.2	44.9	71.2 ± 24.2
		This hospital distributes surveys to assess my needs upon arrival to the hospital, admission, or during the stay		35.7	47	
		This hospital follows up with me after the discharge		10.8	75.7	
		My complaints are taken seriously into consideration and solved immediately at this hospital		7.6	68.1	
		Staff trained me on infection precaution measures such as hand hygiene, cough etiquette, isolation rational, personal protective equipment, etc		14.1	81.1	
	PREXR	I pay a reasonable price for the other medical services (laboratory, radiology, etc.) at this hospital	0.837	33	58.9	66.3 ± 38.3
		″I pay a reasonable price for the medications at this hospital		29.7	54.6	
		″I pay a reasonable price for the medical consultation at this hospital		22.2	69.2	
	BSCEXR	There is a sufficient number of chairs in the waiting area	0.349	11.9	84.9	91.42 ± 14.15
		The hospital has clean departments, corridors, rooms, bathrooms		3.2	95.1	
		The capacity of departments at this hospital including (ER, ICU, waiting room, etc.) is sufficient enough		5.4	76.2	
		This hospital has new building infrastructure (walls, ceiling, bathrooms, etc.)		0.5	96.2	
	ACCEXR	The accessibility to this hospital is easy by either public transportation or my car	0.524	7.6	92.4	86.2 ± 27.3
		The accessibility to this hospital in an emergency is easy		17.8	77.8	
	INFOEXR	Information provided to me to be used after discharge is sufficient (medication and side effects, health condition, etc.)	0.651	6.5	90.8	92.3 ± 19.7

	Oral and written information provided to me or my family during my hospital experience is sufficient		5.9	91.4	
	Information and guidance provided at admission or the first visit are sufficient		7.6	91.9	
SERVEXR	Female doctors are available at this hospital	0.664	2.7	90.3	88 ± 19.1
	There are a variety of departments at this hospital		4.9	89.2	
	Services at night, vacations, and weekends are available at this hospital		11.4	64.7	
	There are a variety of specialties at this hospital		6.5	85.4	
PAM	When all is said and done, I am the person who is responsiblefor managing my health condition.	0.913	13.5	75.7	86.1 ± 18.7
	Taking an active role in my own health care is the most importantfactor in determining my health and ability to function.		3.8	91.9	
	I am confident that I can take actions that will help preventor minimize some symptoms or problems associated withmy health condition		9.2	77.8	
	I know what each of my prescribed medications does.		17.8	69.7	
	I am confident that I can tell when I need to go get medical careand when I can handle a health problem myself.		12.4	77.3	
	I am confident I can tell my health care provider concerns I have,even when he or she does not ask.		3.8	87.6	
	I am confident that I can follow through on medical treatmentsI need to do at home.		5.9	86.5	
	I understand the nature and causes of my health condition.		1.6	89.7	
	I know the different medical treatment options available formy health condition.		15.7	69.7	
	I have been able to maintain the lifestyle changes for myhealth that I have made.		3.2	87	
	I know how to prevent further problems with my health condition.		7	81.6	
	I am confident I can figure out solutions when new situationsor problems arise with my health condition.		16.8	71.4	
	I am confident that I can maintain lifestyle changes, like dietand exercise, even during times of stress.		4.9	85.9	
MARS	I take less than instructed	0.878	23.2	68.1	71.8 ± 26.5
	I stop taking it for a while		24.3	63.2	
	I miss out a dose		37.8	49.2	
	I alter the dose		15.7	70.8	
	I forget to take it		45.4	40.5	

		I avoid taking it if I can		25.4	65.4	
		I take it exactly as prescribed		9.7	80	
		I take it regularly every day		4.3	87	
		I take it only when I need it		24.9	63.8	
		I take more than instructed		16.2	74.1	
DF	BSCPATT	I will recommend this hospital to my family and friends	0.876	3.2	94.6	93.2 ± 14.1
		I believe I receive an accurate medical examination at this hospital		1.6	93	
		I believe this hospital offers me better treatment than the other Palestinian hospitals		2.2	80.4	
		My overall satisfaction with this hospital's performance is high		2.7	92.4	
		I believe this hospital has a high cure rate		1.6	65.9	
		I will choose this hospital again when I need a medical consultation		3.2	94.1	
		I believe the staff at this hospital are competent, knowledgeable, updated, and skilled		1.1	91.9	
		The services provided to me at this hospital have high quality		0.5	95.7	

Table A.3

Characteristics and sociodemographics of respondents (patients) (N = 165)

Demographic variables		N	%
Age (years)			
	20-29	58	35.2%
	30-39	84	50.9%
	40-49	9	5.5%
	50-59	11	6.7%
	>=60	3	1.8%
Gender			
	Female	82	49.7%
	Male	83	50.3%
Department			
	Mixed	35	21.2%
	Pediatric	7	4.2%
	Internal medicine	30	18.2%
	Surgery	34	20.6%
	ER	5	3.0%
	Oncology	39	23.6%
	Dialysis	15	9.1%
Years of experience			
	0-2	14	8.5%
	3-5	46	27.9%
	6-9	31	18.8%
	10-13	55	33.3%

	> 14	19	11.5%
Family income (NIS)			
	2000-3000	3	1.8%
	3001-4000	43	26.1%
	4001-5000	34	20.6%
	5001-6000	48	29.1%
	> 6000	37	22.4%
Profession			
	Doctor	44	26.7%
	Nurse	120	72.7%
Highest degree			
	Bachelor	122	73.9%
	Masters	16	9.7%
	PhD	27	16.4%

Appendix B

نموذج الموافقة

أنا طالب\اة في جامعة النجاح الوطنية – طالب\اة ماجستير في تخصص ادارة صحة عامة. أقوم بإجراء دراسة حول (إشراك المرضى والعاملين في مجال الرعاية الصحية مع تحليل السجلات الطبية في تطبيق بطاقة الأداء المتوازن)

الهدف من هذه الدراسة هو دراسة الآثار المترتبة على إشراك المرضى في تقييم بطاقة الأداء المتوازن (BSC) داخل مستشفيات نابلس في الضفة الغربية وتقديم توصيات قائمة على الأدلة لصانعي السياسات.

نطلب منكم المشاركة في هذه الدراسة وملء هذا الاستبيان، الذي لن يستغرق أكثر من خمس دقائق من وقتكم.

سيتم التعامل مع جميع المعلومات التي تم جمعها بأقصى درجات السرية، ولن يتمكن أحد من معرفة هويتكم، وسيتم استخدام هذه المعلومات لأغراض البحث والدراسة فقط. هذه المعلومات ستكون متاحة فقط لي.

المشاركة في هذا البحث اختيارية وغير اجبارية. يمكنكم الانسحاب من الدراسة في أي وقت تشاؤون.

لأي استفسار، يمكنكم التواصل معي (سجود موسى) على الرقم (0592023455)

أوافق بموجب هذا على المشاركة في هذه الدراسة طوعا

القسم 1

البيانات الاجتماعية والديموغرافية

1	العمر (سنوات)
A	أقل من 20
B	20-29
C	30-39
D	40-49
E	50-59
F	60 او أكثر
2	الجنس
A	ذكر
B	انثى
3	دخل الاسرة
A	أقل من 1,000
B	1,000–2,000
C	2,001–3,000
D	3,001–4,000
E	أكثر من 4,000
4	نوع التأمين
A	عام
B	خاص
C	الأونروا
D	بدون تأمين
5	اعلى شهادة تحصيلية
A	ابتدائية
B	ثانوية
C	بكالوريوس
D	ماجستير
E	دكتوراه
6	عدد الزيارات للمستشفى

A	الاولى
B	الثانية
C	الثالثة
D	الرابعة
F	الخامسة او أكثر
7	قطاع العمل
A	حكومي
B	خاص
C	حر
D	متقاعد
E	عاطل عن العمل
8	نوع الزيارة للمستشفى
A	مريض دخول الى المستشفى
B	العيادات الخارجية
9	رأيك في خدمات المستشفى يستند الى
A	تجربتك الشخصية
B	تجربة العائلة
C	تجربة الاصدقاء

القسم الثاني :العوامل الأساسية

	الفقرة	نعم	لا	لا اعلم
تجربة المريض في الرعاية الصحية				
Q1	هذا المستشفى يوزع استبيانات لتقييم رضاي قبل تسريح خروجي			
Q2	هذا المستشفى يوزع استبيانات لتقييم احتياجاتي عند الوصول إلى المستشفى، وأثناء القبول، أو خلال فترة البقاء.			
Q3	يتابع هذا المستشفى معي بعد حتى بعد خروجي.			
Q4	يتم أخذ شكاواي بجدية وحلها فورًا في هذا المستشفى.			
Q5	تدربني الطاقم على تدابير الوقاية من العدوى مثل نظافة اليدين، وآداب السعال، والعزل الرشيد، وارتداء معدات الحماية الشخصية، وما إلى ذلك			
تجربة المريض المالية				
Q8″	"أدفع سعراً معقولاً للخدمات الطبية الأخرى (المختبر، الأشعة، إلخ.) في هذا المستشفى".			
Q9″	"أدفع سعراً معقولاً للأدوية في هذا المستشفى".			
Q10″	"أدفع سعراً معقولاً للاستشارة الطبية في هذا المستشفى".			
تجربة المريض في بيئة المستشفى				
Q11	وجود عدد كاف من الكراسي في منطقة الانتظار			
Q12	يحتوي المستشفى على أقسام وممرات وغرف وحمامات نظيفة			
تجربة المريض في اتساع المكان				
Q13	إن قدرة الأقسام في هذا المستشفى بما في ذلك (الطوارئ، وحدة العناية المركزة، غرفة الانتظار، إلخ) كافية			
Q14	يحتوي هذا المستشفى على بنية تحتية جديدة للمباني (الجدران والسقف والحمامات وأماكن للسيارات وما إلى ذلك(			
إمكانية الوصول				
Q15	يمكن الوصول إلى هذا المستشفى بسهولة عن طريق وسائل النقل العام أو سيارتي			
Q16	من السهل الوصول إلى هذا المستشفى في حالات الطوارئ			
	تجربة المريض في المعلومات المقدمة			
Q17	المعلومات المقدمة لي لاستخدامها بعد الخروج كافية (الأدوية والآثار الجانبية، والحالة الصحية، وما إلى ذلك(			
Q18	المعلومات الشفهية والمكتوبة المقدمة لي أو لعائلتي أثناء تجربتي في المستشفى كافية			

Q19	المعلومات والإرشادات المقدمة عند القبول أو الزيارة الأولى كافية				
	تجربة المريض في الخدمات المقدمة				
Q20	تتوفر طبيبات في هذا المستشفى				
Q21	هناك مجموعة متنوعة من الأقسام في هذا المستشفى				
Q22	تتوفر الخدمات في الليل والإجازات وعطلات نهاية الأسبوع في هذا المستشفى				
Q23	هناك مجموعة متنوعة من التخصصات في هذا المستشفى				
اتجاهات المرضى نحو وجهات نظر وأبعاد بطاقة الأداء المتوازن					
Q24	سأوصي بهذا المستشفى لعائلتي وأصدقائي				
Q25	أعتقد أنني أتلقى فحصًا طبيًا دقيقًا في هذا المستشفى				
Q26	أعتقد أن هذا المستشفى يقدم لي علاجًا أفضل من المستشفيات الفلسطينية الأخرى				
Q27	إن رضائي العام عن أداء هذا المستشفى مرتفع				
Q28	أعتقد أن هذا المستشفى لديه معدل شفاء مرتفع				
Q29	سأختار هذا المستشفى مرة أخرى عندما أحتاج إلى استشارة طبية				
Q30	أعتقد أن الموظفين في هذا المستشفى يتمتعون بالكفاءة والمعرفة والتحديث والمهارة				
Q31	الخدمات المقدمة لي في هذا المستشفى ذات جودة عالية				

القسم الثالث: أداة مقياس تقييم الالتزام بالأدوية

#	الفقرة	اوفق بشدة	اوافق	محايد	لا اوافق	لا أوافق بشدة
1	في نهاية المطاف، أنا الشخص المسؤول عن إدارة حالتي الصحية.					
2	إن القيام بدور نشط في رعايتي الصحية هو العامل الأكثر أهمية في تحديد صحتي وقدرتي على العمل.					
3	أنا واثق من أنني أستطيع اتخاذ الإجراءات التي من شأنها أن تساعد في منع أو تقليل بعض الأعراض أو المشاكل المرتبطة بحالتي الصحية					
4	أعرف ما يفعله كل من الأدوية الموصوفة لي.					

5	أنا واثق من أنني أستطيع معرفة متى أحتاج إلى الحصول على رعاية طبية ومتى يمكنني التعامل مع مشكلة صحية بنفسي.					
6	أنا واثق من أنني أستطيع أن أخبر مقدم الرعاية الصحية عن مخاوفي، حتى عندما لا يسألني.					
7	أنا واثق من أنني أستطيع متابعة العلاجات الطبية التي أحتاج إلى القيام بها في المنزل.					
8	أفهم طبيعة حالتي الصحية وأسبابها.					
9	أعرف خيارات العلاج الطبي المختلفة المتاحة لحالتي الصحية.					
10	لقد تمكنت من الحفاظ على تغييرات نمط الحياة التي قمت بها من أجل صحتي.					
11	أعرف كيفية منع حدوث المزيد من المشاكل في حالتي الصحية.					
12	أنا واثق من أنني أستطيع إيجاد الحلول عند ظهور مواقف أو مشاكل جديدة في حالتي الصحية.					
13	أنا واثق من أنني أستطيع الحفاظ على تغييرات نمط الحياة، مثل النظام الغذائي وممارسة الرياضة، حتى في أوقات التوتر.					
أداة مقياس تقييم الالتزام بالأدوية.(MARS)						
1	أتناول أقل من التعليمات					
2	أتوقف عن تناوله لفترة من الوقت					
3	أفتقد جرعة					
4	أغير الجرعة					
5	نسيت أن آخذه					
6	أتجنب تناوله إذا استطعت					
7	أعتبره تمامًا كما هو موصوف					
8	أتناوله بانتظام كل يوم					
9	لا أتناوله إلا عندما أحتاج إليه					
10	أتناول أكثر مما أمرت به					

نموذج الموافقة

أنا طالب\ة في جامعة النجاح الوطنية – طالب\ة ماجستير في تخصص ادارة صحة عامة. أقوم بإجراء دراسة حول (إشراك المرضى والعاملين في مجال الرعاية الصحية مع تحليل السجلات الطبية في تطبيق بطاقة الأداء المتوازن)

الهدف من هذه الدراسة هو دراسة الآثار المترتبة على إشراك المرضى في تقييم بطاقة الأداء المتوازن (BSC) داخل مستشفيات نابلس في الضفة الغربية وتقديم توصيات قائمة على الأدلة لصانعي السياسات.

نطلب منكم المشاركة في هذه الدراسة وملء هذا الاستبيان، الذي لن يستغرق أكثر من خمس دقائق من وقتكم.

سيتم التعامل مع جميع المعلومات التي تم جمعها بأقصى درجات السرية، ولن يتمكن أحد من معرفة هويتكم، وسيتم استخدام هذه المعلومات لأغراض البحث والدراسة فقط. هذه المعلومات ستكون متاحة فقط لي.

المشاركة في هذا البحث اختيارية وغير اجبارية. يمكنكم الانسحاب من الدراسة في أي وقت تشاؤون.

لأي استفسار، يمكنكم التواصل معي (سجود موسى) على الرقم (0592023455)

أوافق بموجب هذا على المشاركة في هذه الدراسة طوعا

القسم 1

المعلومات الاجتماعية والديموغرافية

1	العمر (سنوات)
A	أقل من 20
B	20-29
C	30-39
D	40-49
E	50-59
F	60 او أكثر
2	الجنس
A	ذكر
B	انثى
3	القسم
A	اقسام مختلطة
B	اخصائي أطفال
C	الطب الباطني
D	جراحة
E	الطوارئ
F	قسم النسائية
G	قسم الأورام
H	قسم غسيل الكلى
4	سنوات الخبرة
A	0–2 سنة
B	3–5 سنوات
D	6–9 سنوات
E	10–13 سنة
F	أكثر من 14 سنة
5	الدخل
A	2,000 – 3,0000 شيقل
B	3,001 – 4,000 شيقل

C	4,001 –5000 شيقل
D	5,001 – 6,000 شيقل
E	اعلى من 6,000 شيقل
6	المهنة
A	طبيب / طبيبة
B	ممرض / ممرضة
7	التحصيل العلمي
A	بكالوريوس
B	ماجستير
C	دكتوراه

القسم الثاني: العوامل الاساسية

		نعم	لا	لا اعلم
الحوافز المالية				
Q1	أتلقى حوافز مالية بناءً على أدائي			
Q2	أشعر أن راتبي يتناسب مع مسؤولياتي وكفاءاتي			
Q3	أعتقد أن واجهة نظام معلومات المستشفى سهلة الاستخدام			
التكنولوجيا				
Q4	أعتقد أن نظام المعلومات الصحية في هذا المستشفى يجعل إنشاء التقارير أسهل وأسرع وأكثر دقة			
Q5	هذا المستشفى لديه نظام تكنولوجيا/معلومات			
Q6	أعتقد أن نظام معلومات المستشفى والتكنولوجيا في هذا المستشفى يجعل عملي فعالاً ومنتجًا			
التوازن بين عبء العمل والحياة				
Q8	لدي الوقت الكافي للراحة وتناول الطعام خلال يوم عملي			
Q9	أنا قادر على تحقيق التوازن بين العمل والحياة وإدارة الوقت بشكل جيد			
Q10	أنا قادر على قضاء وقت كاف مع كل مريض			
الجودة والتطوير				
Q11	يقدم لي المستشفى التثقيف حول تحديثات الأدوية المتعلقة بتخصصي			
Q12	يقدم لي المستشفى تحديثات تعليمية فيما يتعلق بالأمراض في تخصصي			
Q13	أدوية المستشفى والمستهلكات ذات جودة عالية			
Q14	تساعدني معدات المستشفى في تقديم خدمات طبية عالية الجودة للمرضى			

Q15	الجودة هي الأولوية القصوى في هذا المستشفى				
مشاركة العاملين في مجال الرعاية الصحية					
Q16	يشركني مديري في عملية التخطيط واتخاذ القرار				
Q17	لقد تم إعطائي ما يكفي من السلطة والسلطة لاتخاذ القرارات في منصبي				
Q18	يتفهم مديري ويدعمني بشكل كافٍ عندما أواجه موقفًا صعبًا وعاجلًا				
تقييم الأداء الإداري					
Q19	يقوم رؤسائي المباشرون بشرح ومناقشة نقاط القوة والضعف في تقييمي معي				
Q20	أعتقد أن رؤسائي يتخذون القرارات الصحيحة في العمل والتي تدعم استراتيجية المستشفى				
Q21	أعتقد أن رؤسائي يتمتعون بالكفاءات المطلوبة لمناصبهم				
Q22	أعتقد أن تقييمي عادل ويعكس أدائي الفعلي مقارنة بزملائك				
الثقة بالمدراء					
Q23	أنا أثق بما يقوله لي مديري المباشر أو يعدني به				
احترام المريض ومواقف الثقة تجاه العاملين في مجال الرعاية الصحية **(PTR)**					
Q24	أعتقد أن المرضى يحترمون العاملين في مجال الرعاية الصحية في هذا المستشفى ويثقون بهم				
مواقف الولاء					
Q25	أعتقد وأشعر أنني أريد الاستمرار في العمل في هذا المستشفى لعدة سنوات				
Q26	أوصي بهذا المستشفى للزملاء الآخرين أو أشيد بالمستشفى				
Q27	أعتقد وأشعر أن رضاي العام مرتفع				
Q28	أنا فخور بالعمل مع هذا المستشفى				

القسم الثالث: المشاركة في العمل

	أوافق بشدة	أوافق	محايد	لا أوافق	لا أوافق بشدة
القوة					
في عملي، أشعر بالقوة والنشاط					
أنا متحمس لعملي					
أنا أبتعد عندما أعمل					
أنا ملهم عندما أعمل					
الإخلاص					
أنا فخور بالعمل الذي أقوم به					
أجد عملي مليئًا بالمعنى والغرض					
أشعر بالحماس تجاه عملي					
وظيفتي تلهمني					
الاستيعاب					
الوقت يطير عندما أعمل.					
أنا منغمس في عملي.					
لقد انجرفت في عملي.					
أشعر بالسعادة عندما أعمل بشكل مكثف.					

القسم الرابع: مؤشرات الأداء الرئيسية

		بشكل كبير جدا	بشكل كبير	متوسط	قليل	قليل جدا
1	إلى أي مدى تعتقد أن البيانات الطبية المسجلة في سجلات المرضى دقيقة؟					
2	كيف تقيم مدى اكتمال السجلات الطبية في التقاط جميع المعلومات ذات الصلة بالمريض؟					
3	من خلال تجربتك، ما مدى سرعة عملية حفظ السجلات الخاصة بمعلومات المريض؟					
4	إلى أي مدى تعتقد أن قسم السجلات الطبية يلتزم بالمعايير التنظيمية المعمول بها؟					
5	هل أنت على دراية بالمتطلبات التنظيمية الحالية لحفظ السجلات الطبية في منشأة الرعاية الصحية لدينا؟					
6	ما مدى جودة أداء مرافق الرعاية الصحية لدينا فيما يتعلق بسلامة المرضى، على النحو المبين في معايير اللجنة المشتركة الدولية؟					
7	هل تعتقد أن منشأتنا تنفذ إجراءات مكافحة العدوى بشكل فعال وفقًا لمتطلبات اللجنة المشتركة الدولية؟					
8	ما مدى معرفتك بمؤشرات الأداء الرئيسية المحددة التي حددتها اللجنة المشتركة الدولية لاعتماد الرعاية الصحية؟					
9	في دورك، ما مدى شعورك بالتشجيع لاقتراح تحسينات في السجلات الطبية وعمليات إدارة المعلومات؟					
10	إلى أي مدى تعتقد أن التعليقات المقدمة من الموظفين يتم استخدامها بشكل فعال لتحسين ممارسات حفظ السجلات الطبية؟					

Appendix C

Approval Letter

An-Najah National University
Faculty of Medicine & Health Sciences
Institutional Review Board

جامعة النجاح الوطنية
كلية الطب وعلوم الصحة
لجنة اخلاقيات البحث العلمي

Ref: Mas. Dec. 2023/4

IRB Approval Letter

Title of Research:

Engaging Patients and Hospital Healthcare Workers with Medical Records Analysis in the Balanced Scorecard implementations

Submitted by:
Sujood Mahmoud Mousa

Supervisor:
Hamzeh Al Zabadi , Faten Amer

Approved:
12th Dec. 2023

Your Study Title" ***Engaging Patients and Hospital Healthcare Workers with Medical Records Analysis in the Balanced Scorecard implementations***".reviewed by An-Najah National University IRB committee and was approved on 12th Dec. 2023

Hasan Fitian, MD

IRB Committee Chairman

IRB Institutional Review Board

جـامعـــة النجاح الوطنية
كليـــة الدراســـات العليـــا

إشراك المرضى والعاملين في مجال الرعاية الصحية في المستشفيات مع تحليل السجلات في تطبيق بطاقة الأداء المتوازن

إعداد
سجود محمود يوسف موسى

إشراف
أ. د. حمزة الزبدي
د. فاتن عامر

قدمت هذه الرسالة استكمالا لمتطلبات الحصول على درجه الماجستير في إدارة الصحة العامة، من كلية الدراسات العليا، في جامعة النجاح الوطنية، نابلس- فلسطين.

2025

إشراك المرضى والعاملين في مجال الرعاية الصحية في المستشفيات مع تحليل السجلات في تطبيق بطاقة الأداء المتوازن

إعداد

سجود محمود يوسف موسى

إشراف

أ. د. حمزة الزبدي

د. فاتن عامر

الملخص

هدف الدراسة: هدف هذه الدراسة إلى تقييم تجارب المرضى ومواقف العاملين في القطاع الصحي (HCWs) تجاه تقديم الرعاية الصحية في مستشفى جامعة النجاح الوطنية في نابلس، فلسطين، باستخدام مبادئ بطاقة الأداء المتوازن، بهدف توفير أدلة محلية لتحسين جودة الرعاية الصحية ورضا العاملين.

منهجية الدراسة: أُجريت دراسة مقطعية خلال شهري نوفمبر وديسمبر من عام 2024 في مستشفى جامعة النجاح الوطنية. تم توزيع استبيانين منظمين ومُعتمدين ذاتيًا: أحدهما للمرضى والآخر للعاملين الصحيين. قيّم استبيان المرضى تصوراتهم حول جودة الخدمة، والرضا، والانخراط في السجلات الطبية، بينما تناول استبيان العاملين مدى التفاعل الوظيفي ومواقفهم تجاه تطبيق بطاقة الأداء المتوازن. شارك في الدراسة 185 مريضًا و195 من الكوادر الصحية. تم تحليل البيانات باستخدام برنامج SPSS، وذلك من خلال الإحصاءات الوصفية، ومعامل الارتباط بيرسون، وتحليل الانحدار المتعدد.

نتائج الدراسة: أظهرت النتائج وجود ارتباطات قوية بين تفعيل المرضى والمواقف الإيجابية لديهم. بلغ متوسط درجة جودة الخدمة 75.4%. وبلغت نسبة رضا المرضى عن تجربة الوصول إلى معلومات الأسعار 72%، في حين كانت نسبة الرضا عن الأسعار نفسها أقل وبلغت 66.3%. أما بالنسبة للعاملين، فقد ظهر مستوى عالٍ من التفاعل في مقياس التفاعل الوظيفي – (UWES) عنصر الالتزام بنسبة 93.3%. ومع ذلك، أشارت نتائج عنصر التوازن بين عبء العمل والوقت والحياة إلى نسبة أقل بلغت 59.2%، ما يشير إلى وجود مجالات تحتاج إلى تحسين.

الاستنتاج الرئيسي: تؤكد أهمية جودة الخدمة وتقدم المعلومات في رضا المرضى. يشير يسمى باسم العالمية والإقليمية إلى مجالات تحسين الرعاية الصحية المحلية

الكلمات المفتاحية: تفاعل المرضى، رضا المرضى، العاملون في القطاع الصحي، السجلات الطبية، بطاقة الأداء المتوازن (BSC)، الأداء الصحي، فلسطين.