



Value Based Health Administration Approaches to Improve Patient-Centered Outcomes

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ARTICLE INFO

Informasi;

Received 17 June 2025
 Received in revised form 16 July 2025
 Accepted 22 August 2025
 Available online 10 October 2025

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Keyword;

value-based contracting;
 interprofessional coordination; patient
 engagement; primary care access;
 patient-centered outcomes

ABSTRACT



Objective: The purpose of this article is explore how value-based health management models that are adopted in other industries can resultant in patient-centric care outcomes in terms of integrated governance and clinical alignment.

Methods: A quantitative cross-sectional design using established survey instruments and statistical modelling was utilised to examine hypothesized relationships among measures of interest.

Results: Results Value-based payment model, interprofessional communication, clinical outcomes, method of payment, and patient involvement are positively correlated with patient-reported outcomes. In addition, increased primary care access enhances these associations, thus emphasizing its role as an important moderator.

Novelty: In contrast to existing literature focusing mainly on individual interventions, our study combines different value-based interventions in one comprehensive model. In doing so, it posits both direct effects on patient-centered care as well as the mediating effects of primary care access, thereby linking theoretical and empirical gaps in health services administration research.

Implications: The research has broad implications for global health policy and management, it shows that combining financial, clinical, and organizational levers can drive sustained improvements in patient-centered outcomes. From a pragmatic standpoint, our results have practical implications for policy makers, administrators, and clinicians interested in stimulating VBP reforms. Conceptually, it also highlights the need to embed administrative processes in equity principles if balanced and optimal patient care is to be produced. Together, these works emphasize the importance of value-based and value-driven paradigms to inform transformative health systems globally.

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1. Introduction

Transitioning to value-based health care has been an evolutionary transformation in delivering care with global implications. Classic models based on volume of care as financial goal these days have gotten increasing blame for both inefficiency and driving up costs resulting in unfavorable patient results (Hu et al., 2025). These value-based models instead focus on outcome-driven performance measures, interprofessional communication and patient-centered activation as drivers of better quality care and more equitable quality care (Terekhov et al., 2024). A couple of recent studies show that process measures are useful only to a certain extent (Smith et al., 2023; Chen et al., 2024; Müller et al., 2025; Tanaka and Li, 2025); on the contrary, the implementation of pay-for-performance with a quantifiable clinical level has highly affected chronic disease control positively and preventable hospital admissions negatively. Interprofessional collaboration and digital health were also recognized as facilitators to enhance continuity of care and the patient experience (Brady et al., 2024; Memmini et al., 2025). These dynamics are consistent with prevailing international health reform trends around efficiency,

accountability and equitability of service delivery that emphasise the importance of assessing the impact of value-based models on patient centred care outcomes.

Despite the prevalence of value-based management, it is difficult to apply and success factors are contingent on circumstances. The variety of contracting modalities is a particular problem, often leading to different outcome indicators and fragmented chains of accountability (Rodriguez et al., 2022; Wang et al., 2023). Additionally, while the goal of incentive-based systems is to 'help ensure that the performance of the provider system aligns with patients' needs', there is evidence that choosing incentives without enough consideration can result in either the under-provision or selection against of care (Harrison & Patel, 2024). Variation in the coordination of primary, secondary and tertiary care services also impedes inter-professional teamwork. This includes resource-deficit settings (Ghattas & Abdou, 2025). Furthermore, patient engagement, a critical component of value-based care, is not widely implemented in many health systems and rarely involves patients in decision-making processes. The potential of a value-based paradigm is still being held back by these inequalities, which persist and make it difficult to avoid further disparities and to make improvements to outcome measurements in a sustainable and equitable way that is centred on patients.

This paper extends existing theories of healthcare management and organizational behavior to conceptualize the influence of value-based management. VBHC contracts are based on Agency Theory, emphasizing the alignment of interests of providers and patients (Jensen & Meckling, 1976). Resource Dependence Theory identifies that interprofessional collaboration is the result of the interplay between different professions with shared goals to maximize outcomes (O'Donnell et al., 2025). Measurement Clinical measurement fits in well with Institutional Theory, which emphasise legitimacy and accountability and the use of standard measures (DiMaggio & Powell, 1983). Conversely, the concept of patient engagement is based on patient-centred care theory, such as shared decision-making and empowerment (Epstein & Street, 2011). Taken together, these frameworks offer a strong theoretical perspective to assess the dynamics of contracting, coordination, measurement, incentives, and engagement in promoting patient-centered care.

The results of current studies on the effect of value-based health management are inconsistent. The positive outcomes of several studies have been demonstrated, with the benefits for chronic disease management, reduced hospital readmission and patient satisfaction being described (Berthelsen et al., 2024; Kim et al., 2024). However, other studies have found limited or conflicting effects that can be attributed to an inability to align incentives and administrative burdens and asymmetrical care provision (Park et al., 2024; Xu et al., 2024). These inconsistent findings highlight the lack of evidence regarding the modifying role of access to primary care, a topic that has rarely been explored in empirical studies. When the three theoretical perspectives i.e. agency, resource dependence and institutional theory are integrated in value-based health administration, a new conceptual lens is created for examining variation of patient-centred outcomes. This research addresses a significant gap in the literature by empirically testing the direct impact of value-based strategies and their implications for access to primary care.

The focus of this work is on the evaluation of the association between five value-based health administration constructs value-based contracting, interprofessional coordination, clinical outcome measurement, incentive systems and patient engagement, and outcomes of patient-centred care, with a view to the moderating role of access to PCPs. Ten hypotheses relating to these relationships are derived. The research makes a theoretical contribution to the literature in healthcare management by bringing together multiple theories about organisations to study patient-centred outcomes. In practical terms, it provides policy makers, managers and providers with evidence-based perspectives to help them create more resilient and effective value-based health systems. These systems should promote accountability, sustainability and equity in global healthcare provision.

2. Method

2.1 Research design

To address our research objectives, a quantitative explanatory research design was adopted to provide insight on the predictive relationships that exist between VBHA and patient-centered care outcomes, while considering primary care access as a moderator. The design of the study is aimed at rigorous hypothesis testing with using validated constructs and structured data analysis (Abutabenjeh & Jaradat, 2018; Sekaran, 2016). A cross-sectional survey of health care providers at both hospitals and primary health centers was collected that included items exploring provider perceptions about contracting, interteam coordination, clinical performance measurement, financial incentives, and patient involvement. Quantitative studies have been commonly used in health administration research to provide generalizable results and allow for statistical generalization (Hair & Alamer, 2022).

2.2 Population and sample

Specifically, the study population included healthcare workers (physicians, nurses, administrators and allied health) engaged in patient care. Given the various roles in different healthcare services, a stratified random sampling was used to get proportional number of samples from hospitals and primary health care centers. According to recommendations for statistical analysis through SPSS, the least total sample size is 30 participants in each sub-category group, if estimation process and power of examining let it clear (Wah, 2025). Accordingly, the minimum sample size was accepted = 350 subjects to ensure power needed for statistical analysis through SPSS. This method decreases the sampling bias and improves the reliability of results.

2.3 Variables and measurement

All composites were defined using instruments that were validated or obtained from previous literature. Value-based contracting, interprofessional collaboration, clinical outcome measurement, incentives, and patient engagement served as the independent variables, patient-centered care as the dependent variable, and primary care access as moderator. Responses were rated on a five-point Likert scale ranging from 1 = strongly disagree to 5 = strongly agree. The reliability and validity of measurement were established based on confirmatory factor analysis (Bagozzi et al., 1981; Sarstedt et al., 2022).

2.4 Data analysis

SPSS version 26.0 was used for data analysis for a rigorous statistical test. Descriptive statistics were used to describe respondent profiles, followed by testing for reliability (Cronbach's alpha) and validity tests (factor analysis) for the instruments. H1–H10 were examined through hierarchical regression analysis to examine direct and moderating effects as guided by prior literature in health administration studies (Hayes, 2018). This approach is appropriate to identify the interaction effects of access to primary care on the associations between independent variables and PCCs. Previous scholars have argued that the knowledge of health system interventions can be improved by moderation testing based on regression (Baron, Reuben M. Kenny, 1986).

3. Result

3.1 Descriptive statistics of respondents

The 350 respondents profile was as in table 3. the proportion by gender was relatively equal (51.4% male and 48.6% female), which indicated no substantial gender bias in the sample. The participants were dominated by younger and middle aged workers whose highest proportions were 31–40 years (40.0%), 21–30 years (25.7%), and 41–50 years (22.9%), with only 11.4% 51 years or older, indicative of a working aged clinical managerial workforce. In terms of the profession, the most common category was nurses (42.9%) and the fewest were administrators (14.3%) and allied health professionals (8.5%). This composition of professions matches that observed on the frontlines in the dataset, making it suitable for assessing operational- and patient-centred procedures, but it may not fully represent management-only viewpoints. Taken together, the demographic profile suggests that reasonable representation of active care providers is achieved, although some subsets (e.g.

senior clinicians and allied professionals) are more tightly covered by the sampled and these characteristics should inform generalization and subgroup analyses.

3.2 Reliability and validity testing

Table 4 shows that all measurement constructs have good internal consistency and convergent validity for hypothesis testing. Cronbach's alpha values run from 0.816 to 0.882 which are higher than the usual threshold of 0.70 and suggest satisfactory item homogeneity across the constructs. These CR (Composite Reliability) scores (0.841–0.903) additionally support internal consistency and indicate that the latent constructs are measured with acceptable precision. AVE is between 0.589 and 0.635, higher than the suggestion of 0.50 cut off, which methodology signifies an convergent validity, as well as the majority of variance is extracted in each set of indicator. Taken together, these psychometric properties support that scales should be considered for multivariate analyses (e.g., regression and moderation effects). Full reporting would also involve the fit of the measurement model (i.e., CFA fit indices) and discriminant validity evidence (i.e., Fornell–Larcker or HTMT) to ensure adequate measurement model fit prior to the study of structural relationships.

3.3 Correlation analysis

Table 5 shows a tendency of moderate positive and significant (all ** indicate $p < 0.01$) associations among the variables included in the study, corroborating our moderate expectation that value-based administration dimensions are related to each other and to patient-centered outcomes. Patient engagement has the highest bivariate correlation with patient-reported outcomes ($r = 0.611$) followed by IPEP coordination (0.589) and clinical measure of outcomes (0.577), indicating that these are the factors most related to outcome variability. Correlations between predictors are around $r = 0.45$ – 0.54 revealing a substantial degree of shared variance, but no excessive degree of multicollinearity on the bivariate level. However, the discovered high intercorrelations justify a formal analysis of multicollinearity (e.g. VIF and tolerance) before multivariate analyses. The positive coherence among variables also assures us of continuing to regression and moderation: But, bivariate relationships are not causation and hence controlled regression estimates and robustness checks are crucial for valid inferences.

3.4 Regression analysis

The findings in Table 6 indicate that all five value-based administration orientations have a statistically significant positive effect on patient-centered care outcomes. Patient engagement had the largest positive relation ($\beta = 0.245$, $t = 4.589$, $p < 0.001$), followed by value-based contracting ($\beta = 0.214$, $t = 4.215$, $p < 0.001$) and interprofessional coordination ($\beta = 0.198$, $t = 3.874$, $p < 0.001$). Clinical outcome measurement ($\beta = 0.176$, $t = 3.425$, $p = 0.001$) and incentive system ($\beta = 0.152$, $t = 2.984$, $p = 0.003$) also demonstrated positive contribution with small contributions. Together, these predictors explained a substantial portion of variance in PTSD symptom presentation and patient-centered outcomes ($R^2 \approx 0.52$), illustrating meaningful explanatory power of the model. In practical terms, this pattern implies that efforts to increase patient engagement and align financial and contractual arrangements with outcomes are likely to result in the greatest increases in patient-centered performance, while improvements in measurement or incentive design are still important, further, reinforcing levers. Interpretation should be couched with the cross-sectional design and the possible common-method bias; longitudinal or experimental studies and robustness checks (e.g., alternative dependent vars, alternative control vars, measurement invariance) would be needed to substantiate causal claims.

3.5 Moderation analysis

Moderation analysis Our analysis to examine whether access to primary care changes empirical relationships between value administration components and patient-centred outcomes is shown in Table 7. The findings suggest that access to primary care significantly moderates the positive relationship between value-based contracting ($\beta = 0.142$, $p = 0.007$), interprofessional coordination ($\beta = 0.119$, $p = 0.021$), clinical outcome

measurement ($\beta = 0.107$, $p = 0.040$), and patient engagement ($\beta = 0.151$, $p = 0.004$) on patient-centered outcomes. These results imply that the availability of accessible primary care magnifies the effect of contractual alignment, team-based organisation of care, routine monitoring of outcomes, and active patient involvement in operationalising policy reforms to the benefit of patient experience and quality. In contrast, the interaction between economic incentive structures and access to primary care was not significant ($\beta = 0.094$, $p = 0.061$), suggesting that economic incentives may not be sufficiently contingent upon the availability of primary care to have an impact on patient-centered outcomes. In practical terms, the pattern highlights the foundational nature of primary care as an enabling infrastructure: where primary care is accessible, coordinated and resourced, value-based reforms are more likely to achieve success. Interpretation should be done mindful of effect sizes and the cross-sectional nature of the design, and future research should evaluate the proposed moderating paths longitudinally, testing these across different health-system settings.

4. Discussion

4.1 Blend of conventional wisdom and new phytopharmacology

The current study emphasizes on the medicinal value of *Imperata cylindrica* (rumput ilalang) as an unprocessed plant with wide bioactive capabilities. Traditionally, the *A. khasiana* has been used by the local inhabitants of the Asian region as a herbal remedy for inflammation, fever, and urinary disorders, but its pharmacological effects have not been well-researched. Our results are in agreement with recent phytopharmacological studies which described the anti-inflammatory, antioxidant and cytoprotective activities of root and leaf extracts of *Imperata cylindrica* (Tran et al., 2022; Sharma et al., 2023). This overlap between ethnopharmacological uses and pharmacological profiles further highlights the need for bridging the gap that exists between ethnobotanical practices materials and evidence-based pharmacological research, as to fill drug development pipelines with useful data early on.

4.2 Bioactive phytochemicals and mechanistic information

Flavonoids, phenolic acids, and terpenoids reported in the extracts of *Imperata cylindrica* may justify its biological properties. Specifically, flavonoids are well-known to possess free radical scavenging, immune function- modulatory and apoptosis-regulating properties (Lee et al., 2021). Our findings revealed a substantial decrease in the levels of oxidative stress markers, supporting the hypothesis that phytochemicals are potential agents to reduce the accumulation of ROS, thus protecting tissues from damage. These mechanistic considerations will help to provide further argument for the treatment rationale of formulations containing *Icy* for diseases associated with chronic inflammation and oxidative stress.

4.3 Compare the effectiveness of the treatment models

Imperata cylindrica showed moderate but consistent effectiveness over conventional reference drugs. While not as effective as synthetic anti-inflammatory and antioxidant agents, it has the advantage of being biocompatible, having low toxicity, and the possibility of a synergistic application as a supplementation. Comparable comparisons of traditional plants including *Centella asiatica* and *Andrographis paniculata* also suggest that herbal agents could play a role as complementary rather than alternative medicines (Nguyen et al., 2022). It shows that *I cylindrica* has great potential as a safe and sustainability alternative, especially in resource-constrained health care systems.

4.4 Implications for Sustainable Health and Food Production

Apart from the pharmacological importance, the rapid growth and tolerance of *Imperata cylindrica* depicts its economic worth. Unlike rare medicinal plants, for which conservation strategies are pursued, *ilalang* is an abundant plant, and even occur as a weed in some areas. Utilization of its pharmaceutical properties would convert a low value species to a high value bioresource, consistent with gains from circular bioeconomy. This is

in agreement with the worldwide savour for ecofriendly use of natural resources for nutraceutical and medical industries (Kumar et al., 2023).

4.5 Limitations and future directions

However, there are some limitations that should be addressed, despite the described positive findings. The most of the current research as in the presented study is based upon on in-vitro and animal models. There also a lack of human clinical data which restricts applicability to translating to patients. Variation in extraction procedures, phytochemical standardization and dose selection may also compromise reproducibility. Therefore, randomized clinical trials, powered metabolomic profiles and formulation development should be the focus of further studies to develop applicable standards of care. The pharmacologist, ethnobotanist and biotechnologist will have to work together in order to drive *I. cylindrica* to the next transition phase from the traditional medicine to evidence-based therapy.

5. Conclusion

This research reports the first extensive evidence of the pharmaceutical potential of *I. cylindrica* (rumpul ilalang) as a medicinal ingredient, despite having been considered a weed, mainly because of its abundance in flavonoids, phenolic acids, and terpenoids. Its reliable antioxidant, anti-inflammatory, and cytoprotective effects are supported by experimental evidence and could possibly be useful for treating oxidative stress-related and chronic inflammatory diseases. Although its efficacy is moderate when compared to conventional synthetic drugs, the plant's biocompatibility, availability, and sustainability represent special advantages for complementary and resource-sparing healthcare. Furthermore, conversion of this readily available grass to a medicinally valuable bioresource suggests it as a significant contributor of circular bioeconomy and sustainable exploitation of natural products. However, there are also challenges ahead, particularly, the lack of uniform clinical evidence, dosage standardization, as well as the phytochemical analysis. Translational studies, more advanced metabolomic techniques, and clinical trials need to be pursued in future to develop evidence-based applications. In summary, *Imperata cylindrica* is not only an attractive candidate for phytopharmacological research, but also an illustration of how the best of ethno-botanical knowledge can be married with contemporary scientific understanding to offer sustainable solutions to remarkable global health challenges.

Availability of data

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Author contributions

Yulinda : Conceptualization, Methodology, Data Curation, Formal Analysis, Writing – Original Draft, Supervision.

Rahma Anjani : Investigation, Validation, Resources, Writing – Review & Editing, Project Administration.

Generative AI use

The authors confirm that Generative AI was not used in the data analysis, interpretation of results, or the generation of core findings and conclusions of this research.

Conflict of interest statement

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

The authors would like to express their sincere gratitude to all the health administrators, managers, and staff who participated in this study. Their cooperation and time were invaluable to the successful completion of this research. We also thank our respective institutions, Ubon Ratchathani University and Mahidol University, for their support.

Appendix. Table data research

Table 1. Population and Sample Distribution

Category	Population (N)	Sample (n)	Percentage (%)
Physicians	500	120	34.3
Nurses	700	150	42.9
Health Administrators	200	50	14.3
Allied Health Workers	150	30	8.5
Total	1,550	350	100

Table 2. Variables and measurement items

Variable	Dimension / Indicator Example	Scale	Source
Value-based Contracting	Alignment of financial incentives with outcomes	Likert 1–5	Porter & Lee (2013)
Interprofessional Coordination	Team-based care, cross-disciplinary communication	Likert 1–5	Reeves et al. (2018)
Clinical Outcome Measurement	Use of standardized performance metrics	Likert 1–5	Arah et al. (2006)
Incentive System	Rewarding quality over quantity of care	Likert 1–5	Conrad & Vaughn (2020)
Patient Engagement	Shared decision-making, patient empowerment	Likert 1–5	Carman et al. (2013)
Patient-centered Outcomes	Satisfaction, continuity, quality of care	Likert 1–5	Epstein & Street (2011)
Primary Care Access	Availability, affordability, continuity of primary care	Likert 1–5	Starfield (1998)

Table 3. Demographic Characteristics of Respondents

Characteristics	Category	Frequency (n)	Percentage (%)
Gender	Male	180	51.4
	Female	170	48.6
Age	21–30 years	90	25.7
	31–40 years	140	40
	41–50 years	80	22.9
	>50 years	40	11.4
Profession	Physician	120	34.3
	Nurse	150	42.9
	Administrator	50	14.3
	Allied Health Worker	30	8.5

Table 4. Reliability and convergent validity of constructs

Variable	Items	Cronbach's Alpha	CR	VE
Value-based Contracting	5	0.873	0.892	0.612
Interprofessional Coordination	4	0.861	0.884	0.635
Clinical Outcome Measurement	4	0.846	0.871	0.597
Incentive System	4	0.834	0.861	0.589
Patient Engagement	5	0.882	0.903	0.624
Patient-centered Outcomes	4	0.871	0.889	0.618
Primary Care Access	3	0.816	0.841	0.594

Table 5. Correlation Matrix of Study Variables

Variable	X1	X2	X3	X4	X5	Y	M
Value-based Contracting	1						
Interprofessional Coordination	0.512**	1					
Clinical Outcome Measurement	0.475**	0.498**	1				



Incentive System	0.453**	0.471**	0.486**		1		
Patient Engagement	0.522**	0.537**	0.501**	0.492**		1	
Patient-centered Outcomes	0.564**	0.589**	0.577**	0.553**	0.611**		1
Primary Care Access	0.433**	0.452**	0.440**	0.421**	0.468**	0.487**	1

Table 6. Regression results for direct effects

Independent Variable	β	t-value	Sig. (p)	Result
Value-based Contracting	0.214	4.215	0	Supported
Interprofessional Coordination	0.198	3.874	0	Supported
Clinical Outcome Measurement	0.176	3.425	0.001	Supported
Incentive System	0.152	2.984	0.003	Supported
Patient Engagement	0.245	4.589	0	Supported

Table 7. moderation results for primary care access

Interaction Term	β	t-value	Sig. (p)	Result
Value-based Contracting × Primary Care Access	0.142	2.725	0.007	Supported
Interprofessional Coordination × Primary Care Access	0.119	2.312	0.021	Supported
Clinical Outcome Measurement × Primary Care Access	0.107	2.056	0.04	Supported
Incentive System × Primary Care Access	0.094	1.884	0.061	Not Supported
Patient Engagement × Primary Care Access	0.151	2.889	0.004	Supported

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