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Aligning Financial Sustainability with Quality Patient Care through Balanced Stewardship: A Qualitative Inquiry with U.S. Health Care Leaders

Emmanuel N. Maseno, Caitlin Byrd

College of Management and Human Potential, Walden University, Minneapolis, MN, USA
Email: emaseno2019@gmail.com

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Abstract

Health care leaders make resource decisions that affect both the financial position of their organizations and the quality of care patients receive, yet some leaders lack strategies to align financial sustainability objectives with quality patient care. This qualitative pragmatic inquiry explored how U.S. health care leaders described that alignment in specific decisions, using value-based care as the conceptual framework. Semistructured interviews with seven leaders across home health and hospice, acute care, academic, long-term care, and safety-net settings were analyzed thematically. This article reports balanced stewardship, one of five themes, which drew on five participants and comprised three subthemes: (a) Quality as a nonnegotiable standard in financial decision making, (b) Return-on-investment logic for clinical investments, and (c) Resource prioritization under financial constraints. Participants described weighing expected clinical benefits against costs, although none of the accounts established a financial return independently. One leader described prioritizing care within staffing capacity set at a higher organizational level. The findings describe reported reasoning rather than measured effects. Practical implications include documenting quality floors, separating measured from estimated costs in investment proposals, making service-line criteria explicit, and agreeing on access measures that prompt review of staffing constraints. The findings may support positive social change by helping leaders protect patient access when resources are limited.

Keywords

Balanced Stewardship, Value-Based Care, Financial Sustainability, Health Care Leadership, Quality Patient Care

1. Introduction

Health care leaders make decisions about the resources needed to provide quality care while preserving the financial capacity to keep delivering services. These responsibilities meet in operational choices about staffing, clinical equipment, patient assessments, and whether particular services can continue. How leaders handle such choices matters because financial health and care quality are connected, even though the relationship varies across organizations and measures.

Hospital research has examined this connection at the organizational level. Better measured quality has been associated with stronger financial performance among U.S. hospitals (Enumah et al., 2022), although the wider evidence remains heterogeneous across settings and measures (Dubas-Jakóbczyk et al., 2022). Associations of this kind describe organizations in aggregate. They do not by themselves show how a leader decides whether a particular clinical investment is affordable or how spending is justified when its financial return is uncertain.

Decisions about individual services show the same tension in a more concrete form. In a national survey of rural hospitals providing obstetric care, administrators reported weighing clinical safety and financial viability, and local need for maternity care weighed heavily in decisions to maintain services (Kozhimannil et al., 2022). Choices of this kind place organizational viability and community clinical need within the same decision, which is where leadership judgment becomes visible.

Value-based care offers a framework for examining these responsibilities together (Porter & Teisberg, 2006). Porter (2010) defines value as patient outcomes relative to the costs of achieving them, with costs assessed across the full cycle of care. Leusder et al. (2022) found that measuring costs for only part of a care pathway limited the information available for value-based decisions. Leadership accounts can help explain how clinical and financial considerations enter decisions when that information is incomplete.

This article examines balanced stewardship, one of five themes from a broader qualitative research project on health care leadership. The theme draws together participants' accounts of protecting quality while making financial decisions and of setting priorities when resources were limited. It offers a focused account of how leaders approached alignment in their work and where that alignment reached its limits.

1.1. Statement of the Problem

The specific business problem guiding the research project was that some health care leaders lack strategies to effectively align financial sustainability objectives with quality patient care. In practice, the difficulty lies in bringing clinical priorities into financial decisions while accounting for available resources, competing responsibilities, and uncertainty about costs and benefits. The problem is managerial as well as financial, because it arises in the decisions leaders make about specific services, staff, and equipment.

Research on health care management identifies conditions that make this problem harder to address. In outpatient physical therapy organizations, managers' attention to clinical quality competed with operational responsibilities (Hoekstra et al., 2021). Hospitals have also implemented value-based care selectively, often adopting only some of its components (van Staalduinen et al., 2022). Together, these findings suggest that alignment depends on both managerial attention and how value-based care is put into practice.

This article focuses on how leaders described addressing the alignment problem in specific decisions. Examining their reasoning can clarify (a) what they sought to protect, (b) how they justified expenditure, and (c) how organizational constraints shaped the options open to them. That focus keeps the article at the level of leadership practice rather than organizational performance.

1.2. Purpose of the Article

The purpose of this article is to examine how health care leaders described aligning financial sustainability with quality patient care through balanced stewardship. The article draws on a qualitative pragmatic inquiry with seven U.S. health care leaders and reports one theme to which five of them contributed. Guided by the value-based care framework, it examines three subthemes: (a) quality as a nonnegotiable standard in financial decision making, (b) return-on-investment logic for clinical investments, and (c) resource prioritization under financial constraints.

Across these subthemes, the article considers the reasoning participants used and the information they relied on, as well as the limits they encountered when clinical and financial responsibilities were difficult to reconcile. Its aim is a contextual understanding of these leadership practices that can inform how leaders approach resource decisions in their own organizations. The contribution rests on participants' reported experiences and decision reasoning rather than on a measured causal link between their actions and financial or clinical outcomes.

2. Literature Review and Conceptual Framework

2.1. Value-Based Care as the Conceptual Framework

Value-based care provides the conceptual framework for this article. Porter and Teisberg (2006) argue that competition in health care should center on the value delivered to patients, judged by results, rather than on efforts to shift costs among system participants. Porter (2010) makes the concept operational: value is judged by the outcomes achieved for patients with a given medical condition and by the total cost of the care that produced them. The framework therefore treats quality and cost as parts of one relationship, which suits research on leaders who answer for both. Defining value this way does not remove the practical conflicts between quality commitments and financial constraints that leaders encounter; it provides a standard against which those conflicts can be judged.

Two features of the framework matter for this article. First, value is defined

from the patient's perspective, so outcomes rather than inputs or processes are the reference point for judging whether spending is worthwhile (Porter, 2010). Second, Porter (2010) cautions that cost reduction pursued without regard to outcomes can produce false savings and limit effective care. Together, these features set a demanding standard for leaders, who must judge expenditure by its effect on patients while often lacking cost information that spans the care cycle.

Bao and Bardhan (2024) examined Medicare Shared Savings Program accountable care organizations using data from 2013 to 2021. Using a relative measure of value based on clinical resources and quality measures, they reported stagnation in value and associations between lower value scores, physician-only leadership, and larger numbers of participating entities. The authors suggested that difficulties coordinating care across providers might partly explain these patterns, while cautioning that their results did not establish causation. Their findings provide organizational context for examining how leaders pursue value across interdependent services.

2.2. Value-Based Payment and the Conditions of Leadership

U.S. value-based payment programs also shape the financial conditions under which leaders work. Reviewing the evidence on hospital value-based payment programs, Kim et al. (2022) reported that many of these programs may widen disparities by penalizing hospitals, including safety-net hospitals, that treat larger shares of low-income and minority patients. Using fiscal year 2021 data, Liu et al. (2024) modeled the health equity adjustment planned for the Hospital Value-Based Purchasing program from fiscal year 2026 and estimated that 119 of 1206 penalized hospitals (9.9%) would move to bonus status, with the largest aggregate net gains going to safety-net hospitals. Together, these analyses indicate that the financial rewards attached to value can depend on patient mix as well as performance, and that program design can either add to or offset the pressure on safety-net hospitals. That condition is relevant to the safety-net context represented in this research project.

2.3. Value-Based Care in Leadership Decisions

Research with U.S. hospital executives connects value-based performance to leadership capability. In a national cross-sectional survey of executives from acute-care hospitals in the Hospital Value-Based Purchasing program, with 129 executives representing 190 hospitals, Bonazelli et al. (2024) found that executives perceived their leadership competencies as affecting organizational performance under the program. Organizational awareness, collaboration, team leadership, human resource management, and information and technology management were the competencies respondents considered most important, and they called for leadership development suited to the program's demands. In the executives' own view, then, value-based performance depends partly on how leaders understand their organizations and work across functions.

Qualitative research with U.S. leaders shows how organizational arrangements shape those priorities. Khullar et al. (2024) interviewed leaders of 49 accountable care organizations in the Medicare Shared Savings Program. Leaders described a focus on annual wellness visits, coding practices, and care transitions, and they engaged clinicians through both relationships and metrics. Some leaders of hospital-associated organizations also reported incentives that were misaligned between the hospital and the accountable care organization. These accounts suggest that leaders interpret value-based goals through the financial structures around them, a point that bears directly on the decisions this article examines.

2.4. Application to This Article

The framework and the literature together inform the interpretation of this article's findings. Porter and Teisberg (2006) and Porter (2010) provide a lens for considering patient outcomes alongside the resources required to deliver care, which informs the reading of leaders' quality commitments, their investment reasoning, and the uncertainty they faced when prioritizing resources. The U.S. literature adds evidence on the organizational characteristics associated with value, on potential inequities in payment programs and proposed adjustments to them, and on leaders' perceptions of the capabilities and incentives that shape their work (Bao & Bardhan, 2024; Bonazelli et al., 2024; Khullar et al., 2024; Kim et al., 2022; Liu et al., 2024). Against this background, this article examines how health care leaders in the research project described reasoning through decisions about assessments, equipment, services, and staffing.

3. Research Question

The research project addressed one overarching question: What strategies do health care leaders use to effectively align financial sustainability objectives with quality patient care? This article reports balanced stewardship, one of five themes that answered that question, and examines how leaders described the reasoning behind specific decisions within it. The remaining four themes, which concern operational capacity and staffing, revenue integrity, governance structures, and technology enablement, fall outside the scope of this article.

4. Methods

4.1. Design

The research project used a qualitative method and a pragmatic inquiry design. A qualitative approach suited the aim of examining leaders' experiences, perceptions, and decision processes within their own organizational settings, and a pragmatic orientation directed attention to strategies, conditions, and consequences rather than to theory testing (Ramanadhan et al., 2021). The value-based care framework guided the interview focus and the interpretation of themes (Porter, 2010; Porter & Teisberg, 2006).

4.2. Participants and Recruitment

Participants were seven U.S. health care leaders who met three eligibility criteria: at least 2 years of leadership experience in a U.S. health care setting, direct responsibility for strategies affecting financial performance and patient care, and self-reported success during screening in implementing strategies that align financial sustainability objectives with quality patient care. The first author recruited participants through purposeful sampling, using email invitations, LinkedIn, professional associations, conference contacts, and participant referrals, with snowball sampling as a supplement. Each interested leader completed a brief eligibility screening before an interview was scheduled. The screening asked each leader to state their years of experience in roles involving financial performance and quality patient care and to confirm that they had implemented strategies in this area; leaders whose replies showed at least 2 years of such experience and confirmed implementation were eligible. This confirmation was the basis for the criterion described above as self-reported success; the screening did not separately assess the outcomes of those strategies. The participants held roles ranging from department supervisor to senior executive across home health and hospice, acute care, academic, long-term care, and safety-net settings. Five of the seven contributed to the balanced stewardship theme (see Table 1).

Table 1. Participant characteristics.

Participant	Leadership role	Care setting	Contributed to balanced stewardship
P1	Regional clinical executive	Home health and hospice (multi-agency)	Yes
P2	Senior nursing executive	Academic medical center	Yes
P3	Senior hospital executive	For-profit acute care hospital	Yes
P4	Director of nursing	Long-term care	Yes
P5	Senior nursing executive	Acute care hospital (multi-hospital system)	No
P6	Senior physician executive	Acute care hospital (multi-hospital system)	No
P7	Rehabilitation department supervisor	Safety-net hospital system	Yes

Note: Roles and settings are generalized and organizational identifiers are omitted to protect confidentiality. All participants had at least 2 years of leadership experience in a U.S. health care setting.

The planned sample was at least six leaders. The first author kept a running saturation log recording whether each interview produced new codes, added depth, or repeated established patterns, and treated saturation as a documented judgment rather than a fixed numeric threshold (Jennings & Yeager, 2025). The sixth interview was the first to produce no new codes; it repeated established patterns while adding depth to existing codes, and the first author judged saturation to have been reached at the level of theme families. A seventh interview was conducted as a confirmatory check, with an eighth planned only if the seventh intro-

duced meaningfully new codes or signaled a new theme family. A new code was treated as meaningfully new when it no longer fit within an existing theme family and would have required a new theme, rather than adding detail to an established one. The seventh interview repeated established codes and added detail from an outpatient safety-net setting, including three new codes concerning attendance, access barriers, and scheduling. These additions fit within the existing theme families and did not require a new theme, so recruitment closed after seven interviews. Because only one interview represented this setting, its setting-specific detail may not reflect saturation for outpatient safety-net contexts.

4.3. Data Collection

The first author conducted semistructured interviews by Zoom, using a standard protocol with six open-ended questions and follow-up probes. Each interview followed the same sequence: an introduction to the research project, confirmation of informed consent and permission to audio record, a reminder that participation was voluntary, the interview questions, and an explanation of the member checking that would follow. The first author audio recorded each interview and reviewed each transcript against its recording for accuracy. Publicly available health care sector documents, including quality and safety reports, publicly posted performance summaries, and annual or quarterly reports, served as secondary data to supplement and contextualize the interviews. The first author selected external-facing documents that described financial stewardship and quality priorities, including national sources such as Centers for Medicare & Medicaid Services (CMS) documentation of the Hospital Value-Based Purchasing Program (CMS, 2024) and the American Hospital Association's (2025) report on hospital costs. Documents tied to particular organizations are not named, because naming them could identify participants. For example, CMS documentation showing that the program ties part of Medicare payment to quality performance corroborated participants' accounts that quality scores affected reimbursement, while the American Hospital Association's data on workforce costs provided context for participants' staffing decisions.

4.4. Data Analysis

The first author used thematic analysis to identify patterns of meaning across the dataset (Naeem et al., 2023). The analysis took a codebook approach to thematic analysis, in which open codes were consolidated into focused codes and code families and then stabilized with defined inclusion and exclusion rules. The first author applied Braun and Clarke's (2021) six phases as a flexible, recursive process: (a) familiarization with the data, (b) generating initial codes, (c) searching for themes, (d) reviewing themes, (e) defining and naming themes, and (f) producing the report. Initial coding took place in a Microsoft Excel workbook, after which all seven transcripts were imported into NVivo 14 for systematic code development, theme organization, and matrix coding queries that tracked how each

theme appeared across participants. The first author coded the transcripts inductively, using participants' own phrasing where it carried analytic meaning. Analytic memos recorded the strategy each participant described, the conditions shaping it, and its intended financial and patient-care consequences. After the themes were finalized, the first author mapped each one to the constructs of the value-based care framework: (a) outcome hierarchies, (b) integrated practice units and care delivery, (c) cost measurement across the full cycle of care, and (d) aligned incentives.

The final codebook contained five themes. Balanced stewardship comprised three reported subthemes drawing on 11 coded references from five participants. A fourth, single-source subtheme was set aside, and its one reference was retained as organizational context, giving the theme 12 coded references in total.

4.5. Trustworthiness

Several procedures supported the credibility and dependability of the analysis. After each interview, the first author emailed each participant a summary of the interpreted responses for member checking. The second author served as the second independent observer. She reviewed the initial interviews for potential interviewer bias and reviewed the coding and theme development against the interview data. This review served as a check on the coding and theme development rather than independent double coding, so no inter-rater reliability statistic was calculated. The first author also compared interview themes with relevant public documents for triangulation and maintained an audit trail of research logs, reflexive journal entries, coding decisions, and theme revisions. The first author's experience supporting clinical teams in U.S. health care settings helped build rapport with participants. These procedures made analytic decisions traceable, although they do not remove the limits of self-reported accounts discussed later in the article.

4.6. Ethical Considerations

Walden University's Institutional Review Board approved the research project (approval number 10-24-25-1240840). Participants gave informed consent, could withdraw at any time without consequence, and received no incentives. Pseudonyms (P1 to P7) replaced participant names, identifiable organizational information was redacted, and recordings, transcripts, and documents were stored encrypted in a password-protected folder.

This manuscript was developed by the authors from the first author's doctoral research project. During its preparation, the first author used Claude and ChatGPT to assist with checking citations and references. All research activities, including data collection, transcript verification, coding, theme development, and interpretation of the findings, were conducted by the authors. The authors reviewed all assisted work and take full responsibility for the content of this publication.

5. Findings

The findings report balanced stewardship, one of five themes identified in the broader research project. Financial sustainability and quality patient care were examined as participants described them in interviews. The broader research project also reviewed publicly available health care sector documents to supplement and contextualize the interviews. The findings presented here concern participants' reported decisions and experiences; they do not provide an independent evaluation of the effects of those decisions on organizational finances or patient outcomes. The theme is interpreted through the value-based care framework that guided this research project (Porter & Teisberg, 2006), with Porter (2010) providing the explicit account of patient outcomes relative to care-cycle costs.

5.1. Balanced Stewardship

Balanced stewardship described a leadership orientation in which financial sustainability and quality patient care were treated as interconnected obligations. Five of the seven leaders contributed to this theme. Their accounts described efforts to protect clinical quality, justify investments, and allocate scarce resources, alongside limits on what leaders could fund or demonstrate financially. Quality did not invariably prevail over financial constraint. P4, a director of nursing, described ensuring that quality of care "is not compromised" while attending to financial responsibilities, explaining that the two obligations go "hand-in-hand." P3 and P7 described circumstances in which financial limits restricted the services or staffing available. Balanced stewardship took three forms: (a) treating quality as a nonnegotiable standard, (b) reasoning about the anticipated return on clinical investments, and (c) prioritizing resources under financial constraints.

Organizational context shaped the responsibilities participants described. P7, a rehabilitation department supervisor in a safety-net system funded through grants and tax dollars, reported being "tasked with being as fiscally responsible with our funds as possible" while serving a largely uninsured and underinsured population. This account situated financial responsibility within a commitment to community access. It is retained as context from one participant rather than as a separate subtheme (see Table 2).

Table 2. Balanced stewardship and its subthemes.

Subtheme	Participants	Coded references
1.1 Quality as a nonnegotiable standard in financial decision making	P1, P4	4
1.2 Return-on-investment logic for clinical investments	P1, P2	3
1.3 Resource prioritization under financial constraints	P2, P3, P4, P7	4

Note: Participants are identified as P1 through P7, corresponding to transcripts Int01 through Int07. Counts are drawn from the coding record. Theme 1 as a whole drew on five of the seven participants and 12 coded references. The three subthemes account for 11 references; one additional reference provides the P7 organizational context. Participants could contribute to more than one subtheme.

5.1.1. Quality as a Nonnegotiable Standard in Financial Decision Making

Two of the seven leaders described clinical quality as a floor beneath which financial reasoning could not travel. P4 framed the director's task as ensuring that quality of care "is not compromised" while still attending to the financial consequences of that care, and treated measurement as the mechanism rather than the constraint, advocating "using the data to analyze how effective are the services that you're giving." In this account, quality operated as a condition on financial decisions rather than as one consideration to be traded against others.

P1 showed what accepting an assessment cost could involve. In home health, the documents needed to assess a patient sometimes did not arrive, and P1 instructed clinicians to visit because "it's very difficult to evaluate a patient on paper." P1 acknowledged that "sometimes that's a non-billable visit," explaining, "we have to pay them to go, but we pay them to go and collect the data." The account describes paying to obtain clinical information despite the possibility that the visit could not be billed.

For P1 and P4, the quality commitment shaped what spending could be accepted within their discretion. P1 described a specific decision to obtain assessment information despite a possible billing loss, while P4 described measurement as the means of checking whether services were effective. Through a value-based care lens, both leaders treated patient outcomes as a limit on financial reasoning, and for P1 that limit justified paying for clinical information the organization might not recover (Porter, 2010; Porter & Teisberg, 2006).

5.1.2. Return-on-Investment Logic for Clinical Investments

Two of the seven leaders reasoned about clinical spending as investment rather than as expense. P2 described the discipline directly, explaining, "I've tried to focus a lot on return on investment," and evaluating spending on nursing teams, equipment, and clinical resources against "improved patient quality, which then you can often measure in decreased length of stay, or ... decreased complications for the patient." P2's reasoning connected the financial case for investment with its anticipated clinical benefits, bringing budget and clinical considerations into the same decision.

P2 illustrated this reasoning through a proposed equipment purchase. The organization treated a growing number of patients weighing more than 500 pounds and rented the beds, chairs, stretchers, and commodes their care required. Renting introduced delays in equipment reaching the bedside, which, in P2's account, "impacts the quality of their experience and the quality of their outcome." P2 compared recurring rental spending with the anticipated benefits of ownership, arguing that patients "would then have more improved access to it, and we would have better outcomes for our patients." The account describes an investment justification based on expected access, quality, and financial benefits. It does not report an approved purchase, measured outcome improvement, or a realized return on investment.

P1 described a prospective version of the same logic, embedded in software ra-

ther than argued case by case. Cost per visit was loaded into the electronic medical record alongside payer source, whether the organization was paid per visit or through a lump sum under the Patient-Driven Groupings Model. P1 explained that the predictive tool "will tell us how many visits." Once the clinician calendar was plotted, leaders "know at the end of it whether it's going to be in the green or the red." P1 qualified the cost inputs, explaining that "sometimes that's accurate, sometimes it's not," depending on staffing and on whether contract or employed clinicians delivered the care. Earlier in the interview, P1 explained that the tool estimated the "Skilled clinical visits that patient will need in order to achieve their outcomes, their desired outcomes and goals," and that staying within that range "predicts that we'll be able to make the patient outcome." The planned visits were therefore the clinical resource committed to the patient, and the projection showed whether that plan could be sustained financially.

Both accounts connect anticipated clinical consequences with expected costs. P2 presented an argument for investment, and P1 described a case-level projection dependent on its cost inputs. These practices can be read alongside the framework's concern with value and Porter's account of care-cycle measurement (Porter, 2010; Porter & Teisberg, 2006).

5.1.3. Resource Prioritization under Financial Constraints

Four of the seven leaders described prioritization using clinical and financial considerations, making this the broadest subtheme. Their accounts located decisions at different organizational levels. Some leaders assessed commitments within their own authority, while others responded to decisions taken above them and prioritized within the remaining capacity. The form and sequence of prioritization varied across the four accounts.

P4 illustrated the operational level through wound care. The budget covered two specialized support surfaces where four were needed, and P4 described a clinical conversation about wound stage and expected healing time before a purchase decision. Where a wound was expected to close in roughly two weeks under good care, P4 proposed renting: "instead of us buying a mattress that is expensive, or a specialized equipment that is expensive, let's rent it." In this example, the expected clinical trajectory informed the choice between rental and purchase within a constrained budget.

P3 described a more ordered assessment of whether a service line could be offered. The account began with what P3 understood as the hospital's stabilization obligations under the Emergency Medical Treatment and Labor Act. P3 then considered capital requirements, noting that neurointervention "requires heavy, heavy investment," together with specialist availability and call coverage, staff capacity and training, and supporting infrastructure such as a catheterization laboratory and supply contracts. P3 described proceeding to community need and projected patient volume when those requirements could be met.

For P3, the difficult case was a service the community needed but a 259-bed hospital could not sustain. An unsustainable line "becomes a drain," and the or-

ganization could "end up potentially actually losing money and having to close bigger services." In P3's reasoning, declining one service could protect the viability of existing services. This was an anticipated risk, not an observed closure outcome.

P7 described prioritization under a constraint the leader did not set. When ambulatory care services ran over budget by approximately 56 positions, approved backfills for two physical therapists who had resigned were withdrawn, a decision P7 understood as an alternative to layoffs. P7 described concerns about waiting times and continued advocacy, reporting that the department kept "fighting for those positions and just justifying them with our finance department as often as we can."

Within the remaining discretion, P7 enforced an attendance policy translated into the languages spoken by the patient population so that missed appointments did not consume a slot "that another person could utilize off of the waitlist." These actions show continued advocacy and an effort to manage available capacity. At the time of the interview, the positions had not been restored, and P7 described the attendance policy and full schedules as the measures within the department's control.

P2 identified a limit in demonstrating the financial benefits attributed to quality improvement: "I can't actually show that I saved money, so I have to believe in my heart that we didn't spend money." Using an illustrative assumption of $50,000 per central line infection, P2 reasoned that avoiding ten infections could represent $500,000 in avoided costs. This was a hypothetical calculation, not a verified reduction in expenditure. P2 described "calculated savings that I can't really demonstrate fiscally," linking that difficulty to multiple simultaneous changes and the way nursing costs were billed.

Across the four accounts, the form of prioritization depended on where authority sat. P4 and P3 weighed clinical and financial requirements within decisions they could shape, P7 prioritized within capacity fixed at a higher level, and P2 supported quality improvement without being able to demonstrate its financial return. These decisions connect with value-based care where leaders held discretion, bringing expected clinical benefit and resource requirements into one judgment, while capacity and authority set elsewhere limited the options available (Porter, 2010; Porter & Teisberg, 2006).

5.1.4. The Limits of the Alignment

Three accounts clarify the limits of the alignment. P2 could describe potential cost avoidance without demonstrating a corresponding reduction in expenditure. P1 questioned the cost inputs used for projections under different staffing arrangements and also accepted potentially nonbillable assessment costs. P7 described the withdrawal of approved clinical backfills and continued efforts to justify their restoration. Clinical and financial responsibilities remained in tension in these accounts.

The gap between decision reasoning and measurement matters when interpreting these accounts through value-based care. Porter (2010) places patient out-

comes and care-cycle costs at the center of value measurement. The participant accounts bring this measurement problem into the work of leadership: decisions about assessments, equipment, and staffing still had to be made while financial estimates were uncertain or authority was restricted.

5.2. Summary of the Findings

Balanced stewardship describes how five of the seven leaders approached interconnected financial and clinical responsibilities. The three subthemes capture stated quality commitments, reasoning about the anticipated return on clinical investments, and resource prioritization under financial constraints. Their expression varied across participants: P1 described accepting a potentially nonbillable assessment visit, P1 and P2 used prospective financial reasoning, P3 assessed service viability, and P7 continued to advocate after backfills were withdrawn. Read through the value-based care framework, these findings connect leaders' concern for quality with the costs and organizational limits surrounding care (Porter, 2010; Porter & Teisberg, 2006). Balanced stewardship is the analytic characterization used here to explain those reported experiences. The findings establish neither realized financial returns nor improvement in outcomes across a complete care cycle.

6. Discussion

The findings describe leadership decisions made within a relationship that hospital research has measured at the organizational level. Akinleye et al. (2019) linked composite financial performance with composite quality and safety measures in 108 New York State hospitals. Enumah et al. (2022) analyzed 4331 US hospitals from 2013 to 2018; hospitals in the best readmission quintile had operating margins 0.95 percentage points higher than those in the worst quintile in the same-year analysis. Dubas-Jakóbczyk et al. (2022) found positive associations in almost half of 60 empirical publications, alongside considerable variation in measures and settings. The qualitative findings help explain how leaders reason about these interconnected responsibilities, while the observational literature leaves the direction of causation unresolved.

6.1. Quality Commitments within Competing Responsibilities

P1's assessment decision and P4's stated quality floor show how two participants sought to protect clinical considerations within their discretion. Hoekstra et al. (2021), drawing on 40 managers and leaders across 26 outpatient physical therapy clinics in five organizations, found less comprehensive attention to clinical quality than to operations. Managers held accountable for quality metrics used more systematic quality oversight. This comparison suggests that a quality commitment should be considered alongside the organizational expectations and authority through which it can be exercised.

P1's willingness to fund a potentially nonbillable visit has a broader organiza-

tional parallel in rural obstetric care. Kozhimannil et al. (2022) described commitments to maintain services for community need despite financial difficulty. In a companion analysis of the same 2021 survey, 29 of 81 hospitals responding to the profitability question reported that their retained obstetric unit had not operated with a profit margin in 2019 (Busse et al., 2025). The survey category is nonprofitable, which need not mean a financial loss in every case. These accounts compare decisions made at different levels: maintaining a community service and paying for an individual assessment.

6.2. Investment Reasoning and the Limits of Cost Information

The economic burden associated with adverse outcomes helps explain the appeal of P2's investment reasoning. Kum Ghabowen et al. (2024) estimated a mean 30-day readmission cost of approximately $16,037 across the selected US conditions examined in their review and simulation-based synthesis. This estimate concerns readmission costs, whereas P2's illustrative calculation concerned central line infections. A cost associated with an adverse event is also different from a cash saving attributable to preventing it. That distinction is central to P2's difficulty in demonstrating avoided expenditure.

Of the 215 publications on cost measurement in value-based health care reviewed by Leusder et al. (2022), 110 (51.2%) measured hospital costs, while the remaining publications relied on reimbursement amounts. The review documented incomplete care-pathway costing and differences in what publications called costs. P2's difficulty can be considered alongside these measurement limitations, without assuming that all avoided costs are inherently unmeasurable.

Forecasts also depend on their methods and data. Cher et al. (2021) reported average absolute episode-spending prediction errors of $8456 using the standard Medicare method and $7521 using empirical Bayes estimation, with improved accuracy in 19 of 23 episode types. Their hospital episode analysis excluded home health spending. Klunder et al. (2026), reviewing 50 publications on health care cost forecasting, identified inconsistent use of time-aware validation and limited reporting of real-world deployment. These methodological concerns offer context for P1's uncertainty about staffing assumptions in the loaded visit costs; P1's account itself provides no measured forecasting error rate.

6.3. Resource Prioritization, Authority, and Service Viability

The contrast between P3's service-line assessment and P7's response to withdrawn backfills shows why authority matters when interpreting financial decisions. Albert and Eklund (2026) analyzed 1064 US hospitals and 6218 executives, finding that the association between managerial composition and hospital prices varied by organizational level. Li et al. (2024), in interviews with nursing managers at one hospital in China, described staffing influences at hospital, department, patient, and nurse levels, including departmental budget constraints. These different settings provide context for the participants' accounts of exercising discretion

within decisions made elsewhere.

Formal priority-setting tools represent one way of structuring such choices, although Ahumada-Canale et al. (2023) identified organizational and implementation barriers to their use in hospital decisions. The rural obstetric literature offers a more specific comparison for service viability. Among respondents from hospitals that had closed obstetric units, commonly reported influences included physician shortages, financial losses, clinical safety concerns, and liability costs (Busse et al., 2025). In the overlapping survey analysis, 51 of 79 responding administrators, or 64.6%, identified local community need as their highest priority in deciding whether to maintain obstetric care (Kozhimannil et al., 2022). P3, by contrast, described assessing community need after checking whether the hospital could meet capital, staffing, and infrastructure requirements. This comparison points to a distinction between the importance assigned to a criterion and its place in a decision sequence. It does not show that the surveyed administrators used P3's sequence, or that P3 ranked community need first.

Policy research further distinguishes organizational survival from the retention of particular services. Carroll et al. (2022) found that Medicaid expansion was associated with lower rural obstetric-unit closure odds during the first two years, with no sustained association thereafter; the broader hospital-closure association was concentrated among hospitals without obstetric units. Owsley et al. (2024) found an increase in the total number of unprofitable service lines at public hospitals after new participation in the 340B Drug Pricing Program, a federal program that allows eligible safety-net hospitals and clinics to buy outpatient drugs at a discount. These findings show why service availability deserves separate attention from overall hospital finances. They provide context for P3's concern about service viability, rather than evidence that declining one service protects others.

P7's continued advocacy followed a decision to withdraw approved backfills. Bolton et al. (2025), in a scoping review of 20 articles on leadership and nurses' moral distress, described expectations that nurse leaders advocate for patients and staff and the tensions middle managers can experience between organizational levels. That literature offers an adjacent perspective on advocacy, while P7's account concerns a specific staffing dispute. At the time of the interview, the positions had not been restored, and the account does not establish moral distress. A useful question for further research is how leaders sustain staffing advocacy after an adverse allocation decision and what conditions permit that advocacy to change capacity.

6.4. Linking the Findings to Value-Based Care

Table 3 draws the three subthemes back to the value-based care framework and pairs each connection with an example from the participant accounts. The framework treats value as the patient outcomes achieved relative to the costs of care across a full care cycle (Porter, 2010; Porter & Teisberg, 2006). Each subtheme

engaged a different part of that relationship: the outcome standard, the comparison of expected outcomes with costs, and the allocation of limited capacity when costs and benefits could not be measured with confidence. The examples show where leaders applied value reasoning within their discretion and where uncertain information or restricted authority limited how far that reasoning could go.

Table 3. Balanced stewardship subthemes and the value-based care framework.

Subtheme	Conceptual bridge to value-based care	Example from the data
1.1 Quality as a nonnegotiable standard in financial decision making	The emphasis on patient outcomes in value-based care provides a lens for interpreting P1's and P4's stated quality commitments when considering expenditure.	P1 sent clinicians to assess patients in person when the visit might not be billable; P4 treated quality as a condition on financial decisions and used data to assess service effectiveness.
1.2 Return-on-investment logic for clinical investments	Value-based care relates patient outcomes to the costs of achieving them; P1's and P2's accounts brought expected clinical consequences and expected costs into the same decision.	P2 compared recurring equipment rental for patients weighing more than 500 pounds with the expected access and outcome benefits of ownership; P1 used visit costs and payer source to judge whether a case would end "in the green or the red."
1.3 Resource prioritization under financial constraints	Value-based care connects patient outcomes with the resources used to achieve them. These accounts illustrate allocation decisions shaped by available capacity, uncertain financial estimates, and differences in decision-making authority.	P4 matched rental or purchase of support surfaces to expected healing time; P3 assessed capital, staffing, and infrastructure requirements before community need; P7 continued to justify withdrawn positions; P2 could not demonstrate the savings attributed to infection prevention.

Note: Framework connections draw on Porter and Teisberg (2006) and Porter (2010). Examples summarize participant accounts reported in the Findings and do not represent measured outcomes.

6.5. Contribution and Interpretive Limits

The findings draw attention to the work of making decisions before complete evidence of value is available. Van Staalduinen et al. (2022) reviewed 62 publications and found variation in how value-based health care was conceptualized, with hospitals commonly implementing only one or two components. Against that background, balanced stewardship characterizes how these five leaders connected clinical commitments with financial estimates and organizational constraints. The original framework remains the interpretive lens (Porter & Teisberg, 2006), while Porter (2010) clarifies the outcome and cost measurement against which these practices can be considered. The contribution is a contextual account of leadership reasoning, with its evidential strength in participants' reported experiences rather than in a demonstrated causal effect on organizational performance.

6.6. Summary of the Discussion

The discussion placed balanced stewardship within research on hospital financial health, quality oversight, cost measurement, forecasting, and service viability. The

participant accounts add the reasoning behind specific decisions about assessments, equipment, services, and staffing, including the uncertainty and limits on authority that leaders encountered. The comparisons also drew out two distinctions: (a) between the importance a leader assigns to a criterion and its place in a decision sequence, and (b) between anticipated benefits and demonstrated returns. Read against value-based care, the accounts show leaders considering clinical consequences and costs within their available discretion, without demonstrating complete care-cycle measurement of outcomes and costs (Porter, 2010; Porter & Teisberg, 2006). The effects of balanced stewardship on patient outcomes and organizational finances remain open to further investigation.

7. Implications for Health Care Leadership Practice

The findings carry implications for health care leaders when read through the value-based care framework. Porter and Teisberg (2006) define value by the outcomes patients achieve relative to the cost of achieving them, and Porter (2010) places both measures across the full cycle of care. The participant accounts did not establish patient outcomes and full care-cycle costs together for the decisions described. P1 paid for an assessment the organization might not recover, P2 argued for equipment on the strength of expected rather than demonstrated savings, and P3 assessed a service line against projected rather than realized patient volume. For practice, the framework therefore works less as a calculation leaders complete and more as a discipline for organizing judgments made with incomplete information.

The first implication concerns how leaders set and defend a quality floor. Hoekstra et al. (2021) found that outpatient managers held accountable for quality metrics used more systematic quality oversight than their counterparts. P4's account fits that pattern, since P4 joined the commitment that quality "is not compromised" to the use of data to judge whether services were effective. A stated quality floor carries more weight in budget discussions when it rests on measures the leader reviews and can show to others. Leaders who expect to argue for spending beyond a budget line are better placed when the clinical case has already been documented.

The second implication concerns investment reasoning under uncertain cost information. Leusder et al. (2022) found that close to half of the cost measurement publications in value-based health care relied on reimbursement amounts rather than measured hospital costs, and Cher et al. (2021) showed that even improved episode-spending predictions carried average errors of several thousand dollars. P2's acknowledgment that savings could not be shown fiscally and P1's caution about the cost per visit loaded into the projection tool illustrate uncertainty in the financial information used for leadership decisions. A return-on-investment case is stronger when it states which figures are measured, which are estimated, and which rest on assumptions. That separation lets finance partners judge an argument on its evidence rather than on the confidence with which it is presented.

The third implication concerns where authority sits. Albert and Eklund (2026) found that the association between managerial composition and hospital prices varied by organizational level. Their findings provide context for considering how organizational level shapes leadership decisions, although the participant accounts here concern resource allocation and decision-making authority. P3 and P4 shaped decisions within their own discretion, whereas P7 prioritized within capacity fixed above the department. For leaders in P7's position, balanced stewardship involves efforts to protect access within available capacity while continuing to advocate for withdrawn positions. For senior executives, the implication runs the other way, because decisions about positions and budgets taken at their level determine how much room frontline leaders have to apply value reasoning at all.

Leadership Strategies for Aligning Financial Sustainability with Quality Patient Care

Based on the findings and informed by the value-based care framework, several strategies are proposed for health care leaders. First, leaders should state the quality floor that financial decisions may not breach and tie it to measures reviewed on a set schedule. Doing so turns a personal commitment, such as P4's, into a standard that others in the organization can see and apply. It also gives leaders a documented basis for exceptions, such as P1's decision to fund an assessment visit that might not be billable.

Second, leaders preparing investment proposals should separate measured costs from estimates and from assumptions, and should name the outcome measure expected to change. P2's equipment proposal and central line example illustrate reasoning based on anticipated benefits, alongside difficulty demonstrating financial savings. Agreeing in advance on what will be measured, and when, gives the organization a way to learn whether the expected return appeared.

Third, leaders who assess service lines should make the sequence of their criteria explicit, including the point at which community need enters the assessment. Kozhimannil et al. (2022) reported that 64.6% of responding rural hospital administrators identified community need as their highest priority in decisions about obstetric care, while P3 described considering community need after capital, staffing, and infrastructure requirements. Stating the sequence openly allows governing boards and communities to see why a needed service is retained or declined.

Finally, senior leaders who withdraw or freeze clinical positions should agree with department leaders on the access measures, such as waitlist length or time to first appointment, that will prompt a review of that decision. P7 described continued advocacy but did not identify a defined point at which the staffing decision would be reconsidered. A shared review trigger could provide a structured route for advocacy and help executives identify emerging access problems following staffing changes. Taken together, these strategies ask leaders to make the quality standard, the evidence behind investment claims, the order of service decisions,

and the conditions for revisiting constraints visible to the people who share responsibility for them.

8. Recommendations

This research project identified balanced stewardship as one way U.S. health care leaders approach financial sustainability and quality patient care as connected obligations. Across five leaders, the theme took the form of a protected quality floor, investment reasoning built on anticipated benefits, and prioritization shaped by where authority sat. The accounts also showed limits: financial returns were not independently established, and one leader described working within staffing capacity determined at a higher organizational level. Read through value-based care, balanced stewardship asks leaders to judge outcomes and costs together when evidence about both remains incomplete (Porter, 2010; Porter & Teisberg, 2006). Organizations seeking to support balanced stewardship will need to consider how measurement systems and the allocation of decision-making authority support or constrain leaders' resource decisions.

Several directions for further research follow from these findings and their limits. The accounts came from seven leaders, of whom five contributed to this theme, and they describe reported reasoning rather than measured effects on finances or outcomes. Future research will examine the relationship between reported decision reasoning and subsequent results by pairing leaders' accounts with organizational cost and outcome records. Research with larger and more varied samples, including chief financial officers and other finance leaders, will examine whether these patterns also appear among leaders with direct financial authority.

Two narrower questions also merit attention. The first is how leaders sustain advocacy for clinical capacity after an adverse allocation decision, and what conditions allow that advocacy to change the decision, a question the Discussion raised in relation to P7. The second is whether the order in which leaders apply service-line criteria, as distinct from the importance they assign to each criterion, affects which services communities retain (Kozhimannil et al., 2022). Research on either question will extend balanced stewardship from a description of leadership reasoning toward an account of its organizational consequences.

9. Summary of Key Findings

This article reported balanced stewardship, one of five themes identified in a qualitative pragmatic inquiry with seven U.S. health care leaders. Five leaders contributed to the theme. Three reported subthemes accounted for 11 coded references; one additional reference from a set-aside, single-source subtheme provided organizational context, bringing the total to 12. The first subtheme, quality as a nonnegotiable standard, described leaders treating clinical quality as a condition on financial decisions, including P1's willingness to fund assessment visits that might not be billable. The second, return-on-investment logic, described P1's case-level financial projections and P2's justification of clinical investment through

expected benefits. Across the theme, P2 also described difficulty demonstrating the financial savings attributed to quality improvement. The third and broadest subtheme, resource prioritization under financial constraints, showed that the form of prioritization depended on where authority sat, ranging from rental decisions and ordered service-line assessments within a leader's discretion to the management of fixed capacity after positions were withdrawn. Across the accounts, leaders connected expected clinical benefit with cost in ways consistent with value-based care, although the accounts did not establish outcomes and costs across a complete care cycle (Porter, 2010; Porter & Teisberg, 2006). The findings therefore describe how leaders reasoned and decided under uncertainty, not the measured effects of those decisions.

10. Contribution to Health Care Management and Leadership Practice

This article complements quantitative research on associations between hospital finances and care quality by describing leaders' reported reasoning about specific resource decisions (Akinleye et al., 2019; Enumah et al., 2022). The participant accounts show how leaders brought clinical commitments, financial estimates, and organizational constraints into the same judgment, and where that judgment reached its limits. The distinctions drawn in the Discussion, between anticipated and demonstrated returns and between the weight and the sequence of decision criteria, give leaders and researchers more precise terms for examining value-based decisions. They also help explain why value-based care, which many hospitals implement only in part (van Staalduinen et al., 2022), can be difficult to apply fully within a single decision.

The findings may also support positive social change. Documenting a quality floor, stating the evidence behind investment claims, and agreeing on access measures that prompt review of staffing constraints may help leaders protect patient access when resources are limited. P1's home-based care account and P7's safety-net account illustrate concerns about funding assessments and maintaining appointment capacity, respectively. By making the reasoning behind these decisions more visible, health care organizations may give patients, staff, and communities a clearer view of how financial and clinical priorities are balanced on their behalf.

Author Contributions

Dr. Emmanuel Maseno conceived the research project, designed the methodological approach, recruited participants, conducted the interviews, verified the transcripts, performed the coding and thematic analysis, and drafted the manuscript. Dr. Caitlin Byrd served as doctoral mentor for the research project and provided scholarly supervision and methodological guidance throughout the research process. She also acted as the second independent observer for the analysis. She contributed to the validation of the research approach, the analytical processes, and

the interpretation of the findings. Dr. Byrd also provided critical intellectual input through the review, revision, and editing of the manuscript, ensuring coherence, methodological rigor, and alignment with scholarly standards. Both authors contributed to the interpretation and contextualization of the findings, engaged in critical review of the manuscript for intellectual and academic content, reviewed and approved the final manuscript, and accept responsibility for the integrity and accuracy of the work. Contributor roles (CRediT): Emmanuel N. Maseno: Conceptualization, Methodology, Investigation, Data curation, Formal analysis, Project administration, Writing-original draft, Writing-review & editing. Caitlin Byrd: Supervision, Validation, Writing-review & editing.

Data Availability Statement

The data supporting this article are not publicly available because they contain information that could compromise participant confidentiality. Deidentified data are available from the corresponding author on reasonable request, consistent with the participants' informed consent and Walden University Institutional Review Board approval (10-24-25-1240840). Interview recordings and information identifying participants or their organizations will not be shared.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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