



Engagement and Perceptions of Middle Managers in PhilHealth Benchbook II Accreditation: Evidence from a Tertiary Hospital Case Study

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Abstract

This study examined middle managers' engagement and perceptions regarding the implementation of PhilHealth Benchbook II accreditation in a tertiary hospital in Metro Manila, Philippines, and assessed whether engagement is associated with more favorable accreditation perceptions. Using a quantitative cross-sectional descriptive–correlational single-site case study design, a structured survey was administered to 30 middle managers from nursing and non-nursing departments. Descriptive statistics summarized respondent profile, engagement, and perceptions; Pearson correlation tested the association between engagement and perceptions; and group comparisons examined differences by demographic and departmental categories. Results indicated that middle managers were generally engaged in Benchbook II implementation ($M = 3.96$, $SD = 0.75$) and expressed positive perceptions of accreditation ($M = 4.09$, $SD = 0.54$). Resource constraints (staffing, budget, equipment) emerged as the most frequently reported challenge (63.3%), while anticipated benefits were framed primarily in terms of improved patient care (53.3%) and enhanced institutional credibility (33.3%). Engagement was significantly and positively correlated with perceptions ($r = .588$, $p = .001$), suggesting a reinforcing relationship between participation and accreditation appraisal. Engagement differed significantly by department affiliation ($p = .035$), while perceptions did not significantly vary across most demographic groupings. Overall, findings suggest that accreditation buy-in among middle managers is strong, but implementation reliability is moderated by capacity constraints and documentation/process burden. Institutional strategies should prioritize resourcing, documentation governance, and department-sensitive support structures to sustain accreditation readiness and quality improvement outcomes.

Keywords: *PhilHealth Benchbook II; hospital accreditation; middle managers; work engagement; implementation climate; resource constraints; quality improvement; Philippines*

1. Introduction

Healthcare accreditation has emerged as a cornerstone of health system reform worldwide, serving as a critical mechanism to institutionalize quality, ensure patient safety, and promote operational excellence. In an era defined by the pursuit of Universal Health Coverage (UHC), accreditation frameworks transition from being mere compliance checklists to becoming strategic tools that align financial incentives with measurable improvements in care delivery and outcomes. The Philippine healthcare system, underpinned by the landmark Universal Health Care Act (Republic Act 11223), exemplifies this trend. Here, the Philippine Health Insurance Corporation (PhilHealth) has deployed its Benchbook II accreditation system as a central lever to transform service quality across over 1,600 hospitals nationwide.

PhilHealth Benchbook II represents a significant evolution from its predecessor, shifting the paradigm from an input-based assessment of resources to a comprehensive, outcome-oriented evaluation of clinical processes, governance, and patient safety systems. This framework encompasses over 100 quality indicators spanning domains such as patient rights, infection control, medication management, and organizational leadership. The stakes are substantial; as of 2023, PhilHealth reimbursed approximately PHP 140 billion in claims, with an annual allocation of PHP 5 billion earmarked as incentive funding for accredited institutions. Consequently, achieving and maintaining Benchbook II accreditation is not merely a regulatory hurdle but a strategic imperative with direct implications for a hospital's financial sustainability, reputation, and capacity to deliver high-quality care.



However, the pathway to successful accreditation is fraught with systemic and operational challenges. National data indicates that only 65% of tertiary hospitals currently hold full accreditation, with the remaining 35% grappling with compliance issues. Commonly cited barriers include infrastructural gaps, chronic staffing shortages, budgetary constraints, and complexities in interpreting evolving standards. Furthermore, the administrative burden of documentation and the need for continuous performance monitoring can strain institutional resources. These challenges underscore that accreditation success is less about the standards themselves and more about the human and organizational systems built to implement them. It is within this critical implementation gap that the role of middle management becomes paramount.

In the complex architecture of healthcare organizations, middle managers occupy a uniquely pivotal position. Acting as the essential nexus between executive strategy and frontline execution, they are the "sense-makers" and "translators" of organizational change. They are responsible for operationalizing abstract accreditation standards into concrete departmental protocols, motivating staff, managing compliance documentation, and fostering a culture of continuous quality improvement (QI). Empirical studies consistently highlight that the engagement and perceptions of middle managers are decisive factors in the success of quality initiatives. For instance, when middle managers feel empowered, adequately supported, and positively perceive the value of an initiative, their teams demonstrate higher levels of compliance, innovation, and commitment.

Despite their critical role, middle managers remain a relatively underexplored cohort in healthcare accreditation research, particularly within the Philippine context. Extant literature on PhilHealth Benchbook II has predominantly focused on policy analysis, patient outcomes, or broad institutional challenges, with insufficient granularity on the lived experiences of the managers tasked with its day-to-day enactment. This gap is significant. Without understanding the drivers of middle managers' engagement—their motivations, perceived barriers, and interpretive frameworks—hospitals may design accreditation strategies that are logically sound but practically falter due to misalignment with on-the-ground realities. How do middle managers perceive the value and burden of Benchbook II? What factors enhance or hinder their active engagement in the accreditation process?

Their insights are not merely anecdotal; they constitute vital operational intelligence that can refine implementation strategies, optimize resource allocation, and ultimately determine whether accreditation translates from a certificate on the wall to a tangible improvement in patient care.

This study addresses this gap through a focused case study on a large, private tertiary care hospital in Metro Manila, Philippines. This hospital is a longstanding participant in the PhilHealth accreditation system and provides a rich context for examining managerial dynamics. By investigating the engagement levels and perceptions of middle managers regarding the PhilHealth Benchbook II accreditation, this research seeks to generate nuanced, context-rich insights. It moves beyond assessing mere compliance to explore the human and organizational dynamics that underpin successful accreditation endeavors.

The findings promise contributions on multiple fronts. Theoretically, the study will enrich the literature on healthcare management and organizational behavior by applying and testing frameworks of managerial engagement within a unique Global South accreditation context. Practically, it will provide hospital administrators and policymakers with evidence-based recommendations to bolster middle management capacity, thereby enhancing accreditation readiness and sustainability. Understanding the frontline managerial perspective can inform more supportive and effective accreditation design and implementation strategies.

Objectives of the Study

This study aims to explore the engagement and perceptions of middle managers on the implementation of the PhilHealth Benchbook II accreditation at the case study hospital. Specifically, it seeks to achieve the following objectives:

To determine the demographic and professional profile of the middle managers in terms of age, sex, departmental affiliation (nursing/non-nursing), position, length of service, and degree of involvement in accreditation activities.

To assess the level of engagement of these middle managers in the PhilHealth Benchbook II accreditation process across key dimensions: planning and strategy alignment, implementation and compliance oversight, monitoring and



evaluation, and staff coordination and communication.

To identify the perceptions of middle managers regarding the accreditation process, focusing on its operational impact, encountered challenges, clarity of requirements, and perceived areas for improvement.

To examine the significant relationship between the middle managers' level of engagement and their perceptions of the PhilHealth Benchbook II accreditation.

To determine if significant differences exist in engagement levels and perceptions when managers are grouped according to their demographic profile.

To propose a data-informed action plan designed to enhance middle managers' participation, effectiveness, and leadership in implementing and sustaining PhilHealth Benchbook II accreditation standards.

2. Review of Related Literature

Healthcare accreditation represents a pivotal strategy for standardizing and improving care quality, patient safety, and organizational performance globally. Successful implementation, however, is a complex organizational change process that hinges significantly on the agency and actions of middle managers. This review synthesizes literature from healthcare management, organizational studies, and related fields to explore the multifaceted dynamics of accreditation implementation. It is structured around five interconnected themes: (1) the conceptualization of middle managers as strategic change agents; (2) systemic challenges that constrain compliance; (3) determinants of managerial engagement; (4) perceptions of accreditation value; and (5) the organizational context shaping outcomes.

2.1 Middle Managers as Strategic Change Agents and Sense-Makers

The implementation of complex quality reforms like accreditation relies critically on healthcare middle managers. Positioned uniquely between executive strategy and frontline operations, they are not merely administrative conduits but pivotal change agents whose engagement determines the successful translation of policy into sustainable practice (Slootmans et al., 2025; Al Ansari, 2021). Their role is fundamentally one of strategic sense-making and translation, interpreting

broad accreditation standards, such as those in the PhilHealth Benchbook II, to fit local organizational contexts and operational realities.

Theoretical and empirical literature underscores this function. While not exclusively focused on healthcare accreditation, organizational studies highlight the role of active human sense-makers in dynamically shaping meaning within organizations, a process in which middle managers are essential (Izak et al., 2021). This aligns with broader management perspectives that frame middle managers as brokers or bridges who translate policies into practice, a role evident in sectors like food policy where intermediaries connect ideas and stakeholders to enable implementation (Giambartolomei et al., 2021). Furthermore, the concept of translation capacity at an institutional level emphasizes the importance of coordinated activities to adapt and disseminate standards, a function to which healthcare middle managers directly contribute (Ren & Li, 2023).

The effectiveness of middle managers in this translational role can be understood through three key strategic dimensions:

Facilitators of Organizational Alignment

Successful implementation hinges on aligning strategic goals with frontline workflows. Atento et al. (2025a), in a conceptual framework for integrating analytics, identify organizational alignment as a critical moderator between strategic capability and outcomes. They note that misalignment between clinician and administrator priorities can derail initiatives. In accreditation, middle managers—often clinically trained administrators—are central to reconciling the operational imperatives of the Benchbook with the practical realities and professional norms of their departments, thereby forging the necessary alignment for genuine compliance.

Builders of Internal Governance Credibility

The credibility of external accreditation outcomes is endogenous to internal governance integrity. Extending principles of diplomatic credibility to institutional operations, Atento (2025b) argues that credible outcomes are products of consistent and principled internal governance. For a department head, this translates to building internal legitimacy for the accreditation process by ensuring the transparent, consistent, and principled application of Benchbook standards. This role mitigates the "visibility without autonomy" paradox



by embedding strategic directives into trustworthy daily routines, converting policy mandates into locally legitimate actions.

Pragmatic Operational Innovators

The change agent role requires a practical toolkit for strategic innovation. The case study by Teodosio et al. (2025) demonstrates how strategic tools like the Blue Ocean Strategy's ERRC (Eliminate, Reduce, Raise, Create) Grid can be operationalized by leaders to escape competitive traps. Analogously, middle managers in hospitals can employ such deliberate analysis to move beyond mere compliance. By identifying redundant processes to eliminate, documentation burdens to reduce, quality indicators to raise, and new care coordination practices to create, they actively redesign workflows. This transforms accreditation from a passive audit exercise into an active strategy of value innovation for their unit.

In synthesis, the literature positions the healthcare middle manager in accreditation as a strategic linchpin: a facilitator of organizational alignment (Atento et al., 2025a), a builder of internal governance credibility (Atento, 2025b), and a pragmatic innovator applying strategic tools to reconfigure clinical-administrative value (Teodosio et al., 2025). Their engagement is therefore not a supportive function but a central determinant of whether accreditation standards become institutionalized or remain as superficial, discordant mandates. This study seeks to explore this agency within the specific context of implementing the PhilHealth Benchbook II.

2.2 Systemic and Resource-Based Challenges to Accreditation Compliance

The path to robust accreditation compliance is frequently obstructed by deep-seated systemic challenges that constrain organizational capacity, particularly in lower-resource settings. While factors like management support and training are influential, a lack of fundamental resources—including insufficient staff, limited budgets, inadequate equipment, and poor infrastructure—consistently emerges as a primary barrier. Studies from diverse contexts such as Saudi Arabia, India, Yemen, and Southeast Asia highlight constraints like shortages of personal protective equipment, high staff turnover, and underdeveloped health information systems as key impediments (Alturbag & Alyahya, 2025; Kumar et al., 2025; Mansoor et al., 2024; Nasution et al., 2025). Public hospitals in

low- and middle-income countries face pronounced difficulties due to aging infrastructure and financial limitations, which complicate meeting accreditation standards (Kumar et al., 2025; Dharmagunawardene et al., 2025). Addressing these foundational gaps is widely cited as critical for sustainable compliance (Alturbag & Alyahya, 2025; Dharmagunawardene et al., 2025; Hezbiyan et al., 2025).

Beyond discrete resource shortages, research reveals that these challenges are often interconnected, creating a syndemic of pressures that reinforce one another. Bermido et al. (2025), in a thematic review of health professions education, identify a system of reinforcing pressures—including burnout, resource scarcity, and competing demands—that operate synergistically. This framework applies directly to hospital accreditation, where challenges like staffing shortages, excessive administrative burden, and clinical priorities are rarely independent. For example, a nursing shortage exacerbates workload, limiting time for the documentation and quality improvement projects mandated by standards like the Benchbook, thereby creating a vicious cycle of stress and non-compliance. This interconnectedness suggests that fragmented, single-domain interventions are unsustainable, necessitating a systemic view of accreditation hurdles.

Further compounding these operational pressures are fundamental weaknesses in the healthcare workforce pipeline, which create a fragile foundation for implementing demanding standards. Atento et al. (2025b), analyzing global health workforce gaps, highlight the paradox of a large nominal workforce strained by maldistribution, migration, and competency misalignment. In practical terms, this "supply fragility" means a department may be formally staffed, but with personnel who are underprepared for specific quality documentation or overburdened by clinical duties. Consequently, middle managers must divert disproportionate energy toward basic workforce readiness and task coverage rather than strategic quality enhancement, representing a systemic drain on engagement and effectiveness.

Finally, systemic inertia can manifest as a critical disconnect between formal compliance mechanisms and genuine operational integration. Atento (2025c), in a study of market efficiency, describes a state of "semi-strong inefficiency" where publicly available information fails to be fully incorporated into practice due to inertial barriers.



Within hospitals, this is observed when accreditation policies are formally adopted on paper but not internalized into daily routines and decision-making. This imposes a dual burden on middle managers: they must implement the standard while also constantly bridging this "conviction gap" to align the unit's ingrained culture with external requirements—a challenge rooted in the organization's historical pathways and collective habits.

In summary, systemic challenges to accreditation are multifaceted and interdependent. They originate in foundational resource scarcities, are intensified by a syndemic of interconnected operational pressures (Bermido et al., 2025), are exacerbated by underlying workforce fragilities (Atento et al., 2025b), and are perpetuated by institutional inertia that separates policy from practice (Atento, 2025c). For middle managers, these are not isolated obstacles but defining elements of their operational environment, fundamentally shaping the feasibility of accreditation and the strategies required for meaningful engagement.

2.3 Determinants of Managerial Engagement in Accreditation Initiatives

The degree to which middle managers actively champion systemic initiatives like accreditation is not automatic but is shaped by a confluence of cognitive, perceptual, and contextual factors. Engagement is a multi-layered construct initiated by individual awareness, modulated by perceptions of utility, and critically enabled or constrained by both personal capacity and the surrounding organizational ecosystem. Understanding these determinants is crucial for explaining the variation in managerial energy and strategy during implementation.

Engagement is fundamentally predicated on a foundational awareness and understanding of the initiative. Espelita et al. (2025), in a study on monetary policy, demonstrate a moderate positive association between public awareness of a complex system and subsequent perceptions of its effectiveness. This model is directly analogous to accreditation. A middle manager's detailed knowledge of the Benchbook II standards, their rationale, and required procedures serves as a critical cognitive first step. Without this awareness, accreditation can appear as an arbitrary set of rules, fostering disengaged, checkbox compliance. As Espelita et al. (2025) found that awareness also correlated with longer-horizon financial behaviors,

it suggests that deeper managerial understanding may similarly predict sustained, strategic efforts toward accreditation goals rather than merely short-term, tactical tasks.

Beyond knowledge, engagement is mediated by the perceived effectiveness and relevance of the initiative to core responsibilities. Rao et al. (2025), examining AI adoption in education, found a significant gap between the use of general digital tools and the adoption of advanced adaptive systems, influenced by stakeholders' perceptions of the tool's effectiveness for core outcomes. Translating this to healthcare, managers may universally "use" the Benchbook as a mandatory framework but variably "adopt" its deeper quality improvement philosophies. Their engagement intensifies if they perceive its indicators and processes as effective tools for solving real departmental problems—such as reducing errors or improving patient flow—rather than as abstract reporting requirements. This perception of instrumental utility is a key determinant of proactive versus passive engagement, and it is heavily influenced by whether managers feel valued and see credible leadership championing the initiative (Srimulyani & Hermanto, 2022; Lo et al., 2024).

However, the capacity for such engaged participation is intimately tied to both individual well-being and organizational support structures. Agang-Ang et al. (2025), studying medical student distress, identified specific behavioral and lifestyle factors correlated with burnout. For a manager, chronic workload, poor work-life balance, and high stress deplete the cognitive and emotional resources necessary for thoughtful leadership. A manager experiencing exhaustion is less capable of mentoring staff or innovating processes. Thus, factors like manageable workloads and personal well-being directly impact engagement quality (Elizalde et al., 2024; Elsharif et al., 2025).

Critically, the organizational context can amplify or mitigate these individual determinants. Adequate support, including resources, training, and mentorship, is essential for motivating managers and enabling the application of their knowledge (Boutcher et al., 2022; Mustafa et al., 2022). A positive organizational culture and empowering leadership foster an environment where managers feel motivated and psychologically safe to engage deeply (Srimulyani & Hermanto, 2022; Lo et al., 2024). Conversely, barriers such as lack of time, insufficient support, and high workload are consistently cited as primary disablers of engagement (Elizalde et al., 2024; Elsharif et al.,



2025). Therefore, sustainable engagement requires multi-level strategies that combine leadership empowerment with practical resource allocation (Issah et al., 2025; Elizalde et al., 2024).

In conclusion, managerial engagement in systemic initiatives is initiated by cognitive awareness (Espelita et al., 2025), modulated by perceptions of practical effectiveness (Rao et al., 2025), and constrained or enabled by a dual layer of individual capacity (Agang-Ang et al., 2025) and organizational support structures (e.g., Elizalde et al., 2024; Srimulyani & Hermanto, 2022). These determinants operate in tandem, explaining variation in commitment and persistence. This study explores their interplay within the specific context of implementing the PhilHealth Benchbook II.

2.4 The Mediating Role of Perceptions of Accreditation Value

The perceived value of an accreditation system is not inherent in its design but is constructed through the interpretations and experiences of those who implement it. For middle managers, these perceptions—ranging from viewing standards as a strategic lever for improvement to dismissing them as a bureaucratic burden—critically determine the vigor and authenticity of compliance efforts. Literature reveals that value perception is shaped by a combination of operational framing, the critical link between attitude and practice, and the alignment of standards with deeper professional values.

A primary factor influencing perception is the strategic or operational framing of the accreditation by organizational leadership. Research by Atento (2025a) on integrating Sustainable Development Goals into education found initiatives were often framed instrumentally for "instructional continuity" rather than strategically for deeper educational goals. This dichotomy applies directly to healthcare accreditation. The PhilHealth Benchbook II can be perceived as either a pragmatic compliance mechanism for reimbursement or as a strategic catalyst for genuine quality transformation. The former framing encourages a minimalistic, checkbox approach, while the latter fosters managerial engagement and innovation. This aligns with empirical surveys where quality management professionals and administrators often hold favorable attitudes, viewing accreditation as a tool that enhances organizational performance and institutional reputation rather than merely a financial

or administrative burden (Joseph et al., 2021; Alhawajreh et al., 2025).

The pivotal link between perception and action is further elucidated by models focusing on the pathway from knowledge to behavior. Temporada et al. (2025), in a study on disease prevention, applied the Knowledge-Attitude-Practice (KAP) model and found a strong positive correlation between attitude and practice, whereas knowledge alone was a weak predictor. This underscores that for middle managers, merely knowing accreditation standards is insufficient. Their attitude—whether they perceive the process as legitimate and meaningful—is the dominant determinant of implementation quality. A positive attitude correlates with striving for substantive compliance, a perspective reflected in qualitative research where nurse managers acknowledge accreditation's role in fostering improved workflows, team collaboration, and transparency, despite challenges like increased paperwork (Mutlu & Mat, 2025; Hezbiyan et al., 2025).

Finally, perceptions of value are deeply rooted in their alignment with professional and communal values. Espelita & Atento (2025), analyzing how community values translate into choices, provide a relevant parallel. Middle managers filter the accreditation's value through their core professional values related to patient care, autonomy, and clinical excellence. When standards are seen as resonating with these values—by clearly improving patient outcomes or care coordination—they are perceived as intrinsically valuable. Conversely, misalignment breeds resentment. This explains the spectrum of perceptions observed across roles; while administrators may see reputational benefits, clinical staff may focus more on care quality impacts, with overall consensus that accreditation supports quality improvement and public trust (Joseph et al., 2021; Hashish et al., 2025; Iqbal et al., 2023).

In synthesis, perceptions of accreditation value are a powerful mediator of implementation quality. These perceptions are influenced by strategic framing (Atento, 2025a), are more directly linked to practice through attitude than knowledge (Temporada et al., 2025), and are contingent on alignment with professional community values (Espelita & Atento, 2025). Empirical evidence generally finds middle managers perceive accreditation as a valuable tool for enhancing care and institutional standing, with acknowledged challenges seen as manageable trade-offs for these



benefits (Joseph et al., 2021; Alhawajreh et al., 2025; Mutlu & Mat, 2025). For the middle manager, therefore, their perception of the Benchbook's value is an active interpretation that fundamentally shapes their role as either an enthusiastic advocate or a reluctant enforcer in the accreditation process.

2.5 Organizational Context and the Pathway to Sustainable Outcomes

The ultimate success of an accreditation initiative is measured not by a certificate alone, but by its integration into the organizational fabric and its tangible impact on performance. This pathway from implementation to outcome is fundamentally shaped by the organization's strategic adaptability, its measurement philosophy, and its capacity to trace systemic results—all of which are underpinned by the critical elements of departmental culture and institutional trust.

The process begins with strategic organizational adaptation to the new accreditation requirements. As demonstrated in a case study by Atento & Atento (2025), adapting to external shifts requires an honest internal diagnosis using frameworks like SWOT to leverage strengths and address weaknesses. For a hospital, this means leadership must audit existing capabilities against the Benchbook's demands. However, the effectiveness of this strategic adaptation is heavily mediated by the existing departmental culture and institutional trust. A positive, collaborative culture emphasizing shared goals and continuous improvement provides the essential foundation for successful adaptation and implementation (Signo, 2025; Al-Muttairi, 2025). Conversely, weak management support and low trust undermine this process, reducing accreditation's potential impact (Alturbag & Alyahya, 2025; Alhawajreh et al., 2023).

Furthermore, capturing meaningful outcomes requires a holistic measurement philosophy that transcends simple audit metrics. Atento et al. (2025c) propose a Narrative Health Analytics (NHA) framework, advocating for the integration of qualitative stories with quantitative data to assess true impact. This approach aligns with the understanding that staff commitment and leadership support—key cultural components—are critical for accreditation to improve quality and safety outcomes (Alhawajreh et al., 2023; Hussein et al., 2021). The narratives from middle managers about process changes and challenges become vital data, reflecting the depth of implementation. Institutional trust, fostered through transparent communication,

enables the collection of these honest narratives and mediates the relationship between accreditation activities and organizational performance (Albaroudi et al., 2025; Al-Muttairi, 2025).

Finally, navigating the pathway requires analytically tracing how specific activities lead to results. The methodological approach of Quinto & Atento (2025), correlating policy indicators with community outcomes, is instructive. Hospitals must actively map how accreditation tasks correlate with clinical improvements. This analytical rigor is influenced by the organizational context; differences between clinical and non-clinical departments in culture and engagement can lead to heterogeneous correlations between activities and outcomes within the same institution (Alhawajreh et al., 2025). Barriers like weak infrastructure further complicate this mapping, distorting the pathway from effort to result (Alturbag & Alyahya, 2025).

In summary, the literature frames the achievement of accreditation outcomes as a function of strategic adaptation (Atento & Atento, 2025), holistic measurement (Atento et al., 2025c), and analytical rigor in linking activities to results (Quinto & Atento, 2025). This entire pathway is either facilitated or hindered by the underlying organizational context—specifically, a supportive departmental culture, strong institutional trust, and committed leadership. For an organization implementing the PhilHealth Benchbook II, sustainable outcomes depend on this context-aware strategy, making the role of middle managers, who navigate and shape this local context, central to the outcome equation.

2.6 Synthesis of Literature

The literature collectively constructs a multifaceted framework for understanding the implementation of healthcare accreditation, with the middle manager positioned as the pivotal agent navigating a complex system of constraints, interpretations, and outcomes.

The process is initiated by systemic challenges—primarily resource scarcity, interconnected operational pressures, workforce fragility, and institutional inertia. These challenges form the constraining environment within which managers must operate. Within this context, a manager's engagement is not automatic but is determined by a triad of factors: their cognitive awareness of the standards, their perception of the accreditation's instrumental value in solving real problems, and their personal capacity—which is



heavily influenced by organizational support, workload, and well-being.

The intensity and quality of this engagement are further mediated by the manager's perception of the accreditation's value. This perception is shaped by how leadership frames the initiative (as a strategic tool versus a bureaucratic mandate), the manager's personal attitude (which is a stronger predictor of practice than knowledge alone), and the alignment of the standards with their professional values. A positive perception fuels advocacy, while a negative one leads to minimal compliance.

Ultimately, the pathway to meaningful outcomes—sustainable quality improvement—depends on the organizational context. Success requires strategic adaptation to the accreditation demands, measurement systems that capture qualitative and quantitative integration, and analytical rigor in linking activities to results. This entire pathway is underpinned and either facilitated or hindered by the organization's culture and level of institutional trust.

In essence, the literature reveals a dynamic model: systemic challenges set the stage; individual and perceptual determinants drive managerial engagement; and the organizational context channels that engagement into outcomes. The middle manager's role as a translator, innovator, and sense-maker is central to navigating this entire chain, making their experience and agency critical to moving accreditation from a formal mandate to an integrated, value-adding organizational practice.

3. Methodology

3.1 Research Design

This study employed a quantitative, cross-sectional descriptive–correlational single-site case study design framed within a postpositivist paradigm. A structured survey measured middle managers' engagement and perceptions regarding the PhilHealth Benchbook II accreditation. The case study approach was selected because it enables an in-depth, contextualized investigation of a contemporary phenomenon within its real-life setting, supporting institution-specific insights (Yin, 2018).

3.2 Population, Sampling Frame, and Sample Size

The target population consisted of all middle managers (N=45) at San Juan de Dios Educational Foundation Inc.–Hospital, defined as individuals occupying supervisory or department-head roles between frontline staff and senior administration, across both nursing and non-nursing units.

A census approach was initially intended; however, the final sample comprised n=30 middle managers who were accessible and consented to participate during the data collection period. This represents a 66.7% response rate. To evaluate the sufficiency of this sample size for correlational analysis, a post-hoc statistical power analysis was conducted using G*Power 3.1. For detecting a moderate effect size ($\rho = 0.50$) with $\alpha = 0.05$, a sample of n=30 yields a power of approximately 0.82, which is above the conventional threshold of 0.80, indicating adequate power for the primary correlational tests (Faul et al., 2007).

3.3 Data Collection Instrument

A. Quantitative Survey:

A structured, self-administered questionnaire was developed, consisting of four sections:

- a. Demographic Profile: Items capturing age, sex, department, length of service, involvement in accreditation, and assigned Benchbook II indicator.
- b. Engagement Scale: A 12-item scale adapted from Schaufeli et al.'s (2019) UWES-9 (Utrecht Work Engagement Scale) and contextualized for accreditation activities. It measured cognitive, emotional, and behavioral engagement across four domains: Planning, Implementation, Monitoring, and Coordination ($\alpha = 0.89$ in this study).
- c. Perceptions Scale: A 15-item scale developed based on the framework of Weiner et al. (2020) on implementation climate, assessing perceptions of operational impact, challenge comprehension, and improvement areas regarding Benchbook II ($\alpha = 0.87$).
- d. Open-ended Items: Two items identifying key challenges and anticipated benefits.



B. Qualitative Interview Guide:

A semi-structured interview guide was developed for 8-10 purposively selected survey respondents to explore themes emerging from quantitative data. Questions probed experiences with resource constraints, interdepartmental coordination, and the perceived link between accreditation and staff development.

Instrument Validation: The survey underwent content validation by a panel of three experts in healthcare management and quality assurance. A pilot test with 5 non-participant middle managers resulted in a Cronbach's alpha of >0.85 for both main scales. The interview guide was refined for clarity and flow based on pilot feedback.

3.4 Data Gathering Procedure

Ethical Review and Permissions: The study protocol received an Exempt Certification from the institution's Review Board. Strict adherence to the Data Privacy Act of 2012 (RA 10173) was maintained.

- a. **Quantitative Phase:** The final survey was deployed via a secure Google Forms link distributed through official hospital channels. A participant information sheet preceded the survey, and implied consent was obtained upon submission.
- b. **Qualitative Phase:** Following preliminary quantitative analysis, respondents representing high, medium, and low engagement scores were purposively invited for interviews. Interviews were conducted virtually, audio-recorded with consent, and transcribed verbatim.

3.5 Data Analysis

Quantitative Data:

Data were analyzed using SPSS Statistics Version 28.

1. **Descriptive Statistics:** Frequency, percentage, mean, and standard deviation described the demographic profile and scaled responses.
2. **Inferential Statistics:**
 - a. **Pearson's r:** Tested the correlation between overall engagement and perception scores (Objective 4).

- b. **One-Way ANOVA:** Examined differences in engagement and perception scores across demographic groups (Objective 5). Post-hoc Tukey HSD tests were planned for significant findings.
- c. **Independent Samples t-test:** Specifically compared engagement scores between nursing and non-nursing departments.

Qualitative Data:

Interview transcripts were analyzed using thematic analysis (Braun & Clarke, 2006) to identify, analyze, and report patterns. This process involved:

- a. Familiarization with the data.
- b. Generating initial codes.
- c. Searching for themes.
- d. Reviewing themes.
- e. Defining and naming themes.
- f. Producing the report.

Integration:

Quantitative and qualitative findings were integrated during the interpretation phase. The qualitative themes were used to explain, elaborate, and contextualize the statistical relationships and demographic trends uncovered in the survey, providing a more nuanced understanding of the "how" and "why" behind the numbers.

3.6 Ethical Considerations

The study adhered to the principles of respect for persons, beneficence, and justice. Participation was voluntary, anonymous, and without compensation. All data were stored in password-protected files, with identifiers removed. Participants were informed of their right to withdraw at any point without prejudice.

3.7 Methodological Limitations and Mitigation

Single-Case Design: Limits generalizability beyond the study context. Mitigation is provided by offering thick description of the institutional setting and focusing on analytical generalization to theoretically relevant propositions rather than statistical generalization (Yin, 2018).



a. Cross-sectional Data: Captures engagement and perceptions at a single point in time, limiting causal inference and restricting interpretation to associations rather than directional effects. Mitigation is provided by framing conclusions as correlational and using the findings to identify implementation priorities that may be examined in future longitudinal or repeated-measures designs.

b. Self-Report Bias: Social desirability and perceptual bias may influence responses on engagement and accreditation perceptions, and common method effects may inflate observed associations. Mitigation was addressed through anonymity assurance, voluntary participation, and neutral survey administration intended to encourage candid reporting.

c. Moderate Sample Size: While sufficient for key descriptive analyses and bivariate testing within the site, the sample size limits statistical power and constrains more complex multivariate modeling. Mitigation is provided by adopting a census-oriented approach within the single institutional setting and interpreting inferential results within the contextual boundaries of the case.

4. Results and Discussion

4.1 Demographic Profile of the Respondents (N = 30)

The respondent group consisted of middle managers with a primarily mid-career to late-career profile. In terms of age, the largest share belonged to the 45–54 bracket (43.3%, n = 13), followed by 25–34 (26.7%, n = 8) and 35–44 (26.7%, n = 8), while only 3.3% (n = 1) were 55 and above. The sample was predominantly female (66.7%, n = 20), compared with male respondents (33.3%, n = 10).

In terms of tenure, most respondents reported long service, with 73.3% (n = 22) having more than 10 years in service. Another 23.3% (n = 7) reported 7–10 years, while 3.3% (n = 1) reported 0–3 years; no respondents fell under the 3–6 years category. Departmental affiliation indicated that 56.7% (n = 17) were from non-nursing departments, while 43.3% (n = 13) were from nursing.

Regarding involvement in PhilHealth Benchbook II accreditation activities, the majority indicated moderate involvement (43.3%, n = 13), followed by minimal involvement (30.0%, n = 9) and high involvement (23.3%, n = 7), while only 3.3% (n = 1) were not involved. Assignment across

Benchbook II indicator areas was distributed, with relatively higher representation in Access to Healthcare, Assessment of Patients, and Medication Management (each 13.3%, n = 4), and moderate representation in Inpatient Admission and Outpatient Registration (10.0%, n = 3) and Infection Control (10.0%, n = 3), with smaller proportions across the remaining indicator parts.

The respondent pool is characterized by substantial tenure and broad functional representation, indicating that the results primarily reflect perspectives of experienced middle managers with sustained exposure to institutional routines and compliance activities.

4.2 Level of Engagement of Middle Managers in the Benchbook II Process

Overall engagement was interpreted as Engaged with a composite mean of 3.96 (SD = 0.75). The strongest-rated engagement indicators were: “I feel my contributions to the Benchbook II accreditation process are valued” (M = 4.10, SD = 0.66) and “I am motivated to ensure our institution meets Benchbook II standards” (M = 4.07, SD = 0.78). Perceived support for compliance was likewise positive (“I receive adequate support and resources for Benchbook II compliance”: M = 3.97, SD = 0.93).

The comparatively lowest rating (though still within “Engaged”) was related to documentation manageability: “The required documentation for the accreditation was manageable and not overly burdensome” (M = 3.70, SD = 0.99).

Engagement appears robust, although documentation burden emerges as a relative friction point that can shape implementation experience even when motivation and perceived recognition remain high.

4.3 Perceptions of Middle Managers Regarding Benchbook II Accreditation

Overall perceptions were positive, with a composite mean of 4.09 (SD = 0.54), interpreted as Agree. Respondents indicated clear understanding of the Benchbook II framework (“I clearly understand the objectives and requirements of PhilHealth Benchbook II”: M = 4.13, SD = 0.63) and affirmed its contribution to quality improvement (“Benchbook II accreditation significantly improves the quality of services in our institution”: M = 4.23, SD = 0.63).



The lowest perception item (while still “Agree”) was related to process efficiency: “The accreditation process is efficient and well-managed” ($M = 3.90$, $SD = 0.66$).

Middle managers tend to endorse Benchbook II as a quality-oriented mechanism, while ratings suggest more cautious appraisal of the operational smoothness of accreditation workflows than of its purpose and value.

4.4 Challenges Encountered in Meeting Benchbook II Requirements

The most frequently cited challenge was lack of resources (staff, budget, equipment), reported by 63.3% ($n = 19$). The next most common challenge was complex or unclear requirements (20.0%, $n = 6$). Less frequently cited were staff resistance or lack of cooperation (10.0%, $n = 3$) and time constraints (6.7%, $n = 2$).

The challenge profile is resource-dominant, indicating that compliance difficulties are driven more by capacity constraints than by time scarcity alone, with clarity of requirements emerging as a secondary barrier.

4.5 Foreseen Benefits of Achieving Benchbook II Accreditation

Respondents most commonly identified improved patient care as the primary anticipated benefit (53.3%, $n = 16$), followed by enhanced institutional reputation and credibility (33.3%, $n = 10$). Only small proportions identified increased PhilHealth reimbursement rates (6.7%, $n = 2$) and better operational efficiency and processes (6.7%, $n = 2$). Notably, no respondents identified staff development and competency improvement as a foreseen benefit (0%, $n = 0$).

The benefit framing is strongly patient-care and reputation oriented, while workforce development is not salient as a perceived output of accreditation, suggesting a disconnect between accreditation work and staff-development framing or communication.

4.6 Relationship Between Engagement and Perceptions

Pearson correlation results showed a significant positive association between engagement and perceptions: $r = .588$, $p = .001$. This indicates that higher engagement levels are associated with more favorable perceptions regarding Benchbook II accreditation.

Engagement and perceptions move together in this sample, indicating that strengthened participation aligns with more favorable appraisal of the accreditation system.

4.7 Differences in Engagement and Perceptions When Grouped by Demographics

One-way ANOVA results indicated no significant differences in engagement or perceptions when grouped by age, gender, length of service, involvement level, or indicator part (all $p > .05$). However, department affiliation produced a statistically significant difference in engagement: $F(1, 28) = 4.902$, $p = .035$, while the difference in perceptions by department was not significant ($p = .219$).

Engagement varies by department affiliation, suggesting that participation intensity is shaped by departmental role demands and operational exposure. Reporting group means alongside the significance test would strengthen interpretability.

4.8 Discussion of Findings

The results portray a generally favorable organizational climate toward PhilHealth Benchbook II, but with clear operational constraints that shape how accreditation work is experienced by middle managers. Across the sample, middle managers reported being engaged in the accreditation process and expressed positive perceptions of Benchbook II as a quality-oriented mechanism. At the same time, the most frequently cited barriers—particularly resource limitations—suggest that favorable attitudes do not automatically translate into frictionless implementation.

Engagement and Perception: High Buy-In, With Process Frictions

The overall engagement rating indicates that respondents are not merely complying formally but are demonstrating a meaningful level of psychological and behavioral involvement in accreditation activities. This is reinforced by perception results showing agreement that Benchbook II improves service quality and that its objectives and requirements are understood. In practice, this configuration is important: accreditation programs often fail when staff interpret them as externally imposed paperwork exercises rather than as legitimate quality systems. Here, the data suggest that middle managers recognize the accreditation’s quality intent and are generally aligned with it.



However, two item-level patterns nuance this positive picture. First, documentation manageability registered as the comparatively lowest engagement indicator. Second, process efficiency and management was the lowest-rated perception indicator. Together, these imply that acceptance of accreditation as a concept may be stronger than satisfaction with accreditation as an operational workflow. In applied terms, the institution may already have normative commitment (belief in the value of accreditation), while still needing process redesign (workflow streamlining, clearer templates, better document governance) to reduce avoidable administrative drag.

Resource Constraints as the Dominant Challenge

The predominance of resource constraints (staff, budget, equipment) as the top challenge indicates that the key bottleneck is capacity, not willingness. This is consistent with the pattern of high engagement but lower manageability ratings: individuals can remain committed while still being constrained by staffing levels, competing operational demands, and limited logistical support. The secondary challenge—complex or unclear requirements—suggests a compliance interpretation problem that can exacerbate resource strain: when requirements are ambiguous, more time is spent clarifying, revising, and reworking documentation rather than executing stable processes.

At the same time, the relatively low frequencies for “resistance” and “time constraints” should be read cautiously. These factors may still exist but could be perceived as derivative of resource capacity. In many settings, “lack of time” is effectively a symptom of staffing sufficiency and workload distribution; respondents may have attributed time pressure to resource inadequacy rather than to time management per se.

Benefit Framing: Patient Care and Reputation Over Operational and People Outcomes

Respondents primarily framed accreditation benefits in terms of improved patient care and institutional credibility, with markedly less emphasis on reimbursement, efficiency, or workforce development. This pattern suggests a values-driven quality narrative—accreditation is interpreted as a patient-centered legitimacy and quality assurance mechanism rather than as a finance-driven or process-engineering initiative.

The absence of staff development as a cited benefit is analytically important. It may indicate that accreditation tasks are not being communicated internally as learning and competency-building opportunities, or that professional development outcomes are present but not salient to respondents. This disconnect can matter because accreditation sustainability depends partly on whether staff perceive the process as strengthening capability (skills, standards literacy, continuous improvement habits) rather than simply producing compliance outputs (documents, checklists, audit artifacts). If accreditation is experienced primarily as an institutional requirement, staff development tends to remain incidental rather than intentional.

Engagement–Perception Link: A Reinforcing Relationship

The significant positive correlation between engagement and perceptions indicates that buy-in and favorable appraisal move together in this sample. Conceptually, this can be interpreted in two plausible (non-exclusive) ways:

Engagement drives perceptions: Greater participation and role clarity may increase understanding, perceived usefulness, and perceived value of accreditation.

Perceptions drive engagement: When middle managers believe Benchmark II is meaningful and beneficial, they are more likely to invest effort and maintain motivation despite workload pressures.

Both interpretations are consistent with the results, and both support the same managerial implication: interventions that increase support, clarity, and recognition may improve both participation and perceived legitimacy, thereby strengthening program implementation.

Limited Demographic Differences, With a Departmental Engagement Gap

The absence of significant differences by most demographic groupings suggests that engagement and perceptions are broadly shared across age, gender, tenure, involvement level, and indicator assignment. This can be interpreted as a sign of consistent institutional messaging and a relatively uniform cultural stance toward accreditation.

The significant engagement difference by department, however, implies that the lived experience of accreditation work differs across



nursing and non-nursing contexts. This may reflect differences in workflow proximity to clinical standards, documentation intensity, patient-facing accountability, or the extent to which accreditation requirements overlap with routine departmental processes. Importantly, the department difference appears in engagement rather than perceptions, suggesting that departments may similarly value accreditation but differ in how intensely they are able (or required) to participate in it. This distinction matters: a department can “agree” with the accreditation’s value while still being structurally constrained from engaging at the same level as another department.

Integrative Interpretation

Taken together, the results indicate a middle-management cohort that largely endorses Benchbook II and is willing to support it, but whose implementation capacity is moderated by resource sufficiency and process design. The most actionable tension is not attitudinal resistance; it is the gap between quality commitment and operational feasibility, particularly in documentation systems and resource provision. The discussion also highlights an opportunity to reframe accreditation work more explicitly as capability-building—so that staff development and continuous improvement become visible outputs rather than hidden byproducts.

4.9 Implications for Practice and Policy

The findings indicate that middle managers generally support PhilHealth Benchbook II and view it as quality-enhancing; however, implementation is constrained primarily by capacity conditions (staffing, budget, equipment) and secondarily by requirement complexity/clarity. This implies that accreditation outcomes are likely to be driven less by attitudinal resistance and more by whether the institution can convert commitment into execution through adequate resourcing and structured support.

The comparatively lower ratings associated with documentation manageability and process efficiency suggest that accreditation is accepted as a quality mechanism but experienced as operationally burdensome. In practice, this points to the importance of process and documentation governance (e.g., stable evidence standards, clear document ownership, streamlined workflows) to reduce rework and compliance friction.

Finally, the significant engagement–perception association implies a reinforcing

dynamic: stronger participation aligns with more favorable views of accreditation, and vice versa. The observed engagement difference by department further suggests that engagement is shaped by functional realities and workload exposure, indicating the need for department-sensitive implementation arrangements rather than uniform expectations.

5. Conclusions and Recommendations

5.1 Conclusions

The study concludes that middle managers generally demonstrate meaningful engagement in the PhilHealth Benchbook II accreditation process and maintain favorable perceptions regarding its purpose and value. Across the respondent group, the evidence suggests a managerial cohort that recognizes accreditation as a quality-oriented mechanism and is motivated to contribute to compliance and standards attainment. This supportive stance is reflected in the overall positive perception of Benchbook II as improving service quality and in the reported clarity of its objectives and requirements. At the same time, the findings indicate that accreditation work is not experienced as uniformly smooth in execution. Documentation requirements and the operational management of the process emerged as the relative pressure points, indicating that commitment to accreditation as a concept may exceed satisfaction with the day-to-day mechanics of compliance work.

The most salient barriers to meeting Benchbook II requirements were structural rather than attitudinal. Respondents primarily identified limitations in staffing, budget, and equipment as the dominant challenge, followed by concerns regarding complexity or lack of clarity in certain requirements. Resistance and time constraints were less prominent, suggesting that the institution’s main implementation problem is not opposition to accreditation but the conditions needed to sustain compliance activities. The results further indicate that perceived benefits are concentrated in patient-centered and legitimacy-related outcomes, particularly improved patient care and enhanced institutional reputation, while operational efficiency, reimbursement considerations, and staff development are less emphasized. Notably, engagement and perceptions were significantly and positively associated, implying that participation and positive appraisal reinforce each other within the accreditation context. Differences across most demographic groupings were not statistically



salient; however, engagement varied by department affiliation, suggesting that participation intensity may be shaped by functional role demands and departmental workflow realities rather than by differences in belief in accreditation's value.

5.2 Recommendations

To strengthen accreditation implementation and sustainability, management should treat resource adequacy as a primary enabling condition rather than an ancillary concern. Given that resource constraints were the most frequently reported barrier, the institution should ensure practical staffing and logistical support for accreditation tasks, including protected time allocations during peak compliance periods, targeted administrative assistance for documentation-heavy units, and alignment of equipment and infrastructure readiness with indicator requirements. In parallel, the institution should formalize documentation governance to reduce rework and perceived burden. A centralized repository with clear document ownership, version control protocols, standardized templates, and periodic internal checks can stabilize evidence production and shift accreditation work from reactive compliance to routine operational discipline.

Because complexity or unclear requirements were also identified as a challenge, the institution should implement structured clarification mechanisms that translate standards into actionable evidence expectations. This may include indicator-specific briefings, compliance matrices linking requirements to acceptable evidence and responsible units, and rapid feedback loops to confirm whether submitted documentation meets expectations. The department-based engagement difference further suggests that a uniform engagement strategy may be suboptimal; instead, implementation arrangements should be department-sensitive, with role-appropriate workload distribution, clear departmental leads, and tailored support calibrated to the documentation and process intensity of each area. Finally, to strengthen long-term accreditation maturity, the institution should embed Benchbook II readiness into continuous quality improvement systems—internal audit cycles, departmental scorecards, and annual quality plans—so that readiness is maintained throughout the year rather than intensified only near assessment windows. The organization should also explicitly frame

accreditation participation as capability-building by linking it to professional development initiatives, internal recognition mechanisms, and standards literacy training, thereby making staff development a visible and valued outcome of accreditation work rather than an incidental byproduct.

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