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# PATIENT EXPERIENCE DIMENSIONS ASSOCIATED WITH PATIENT SATISFACTION IN EXECUTIVE INPATIENT CARE

**Rudi Saputra[1]*, Iriyani Kamaruddin[2], Ratno Adrianto[3], Riyan Ningsih[4], Rahmat Bakhtiar[5], Ida Ayu Indira Dwika Lestari[6]**

[1]Master of Public Health Study Program, Faculty of Public Health, Universitas Mulawarman, Jl. Sambaliung, Gn. Kelua, Samarinda Utara, Samarinda, East Kalimantan 75119, Indonesia

[2]Department of Public Health Nutrition, Faculty of Public Health, Universitas Mulawarman, Jl. Sambaliung, Gn. Kelua, Samarinda Utara, Samarinda, East Kalimantan 75119, Indonesia

[3]Department of Health Policy and Administration, Faculty of Public Health, Universitas Mulawarman, Jl. Sambaliung, Gn. Kelua, Samarinda Utara, Samarinda, East Kalimantan 75119, Indonesia

[4]Department of Environmental Health, Faculty of Public Health, Universitas Mulawarman, Jl. Sambaliung, Gn. Kelua, Samarinda Utara, Samarinda, East Kalimantan 75119, Indonesia

[5]Department of Public Health and Community Medicine, Faculty of Medicine, Universitas Mulawarman, Jl. Krayan, Gn. Kelua, Samarinda Utara, Samarinda, East Kalimantan 75119, Indonesia

[6]Department of Occupational Health and Safety, Faculty of Public Health, Universitas Mulawarman, Jl. Sambaliung, Gn. Kelua, Samarinda Utara, Samarinda, East Kalimantan 75119, Indonesia, Indonesia

*rudisaputra18052001@gmail.com

**ABSTRACT**

Patient experience is an important component of healthcare quality and may be associated with patient satisfaction. This study aimed to examine the associations between eight patient experience dimensions and satisfaction among executive inpatients. A cross-sectional study was conducted among 150 patients at Hospital X in Samarinda, East Kalimantan, Indonesia, using consecutive sampling. Data were collected using a five-point Likert-scale questionnaire and analysed using Spearman's rank correlation and multiple linear regression. All eight dimensions were positively correlated with patient satisfaction (Spearman's $\rho$ = 0.695-0.792; all $p < 0.001$). The regression model was statistically significant ($F(8, 141) = 54.265$, $p < 0.001$), explaining 75.5% of the variance in satisfaction ($R2 = 0.755$; adjusted $R2 = 0.741$). After adjustment, care coordination ($\beta = 0.383$, $p < 0.001$), access to care ($\beta = 0.269$, $p < 0.001$), and shared decision-making ($\beta = 0.165$, $p = 0.021$) remained significantly associated with satisfaction. Care coordination showed the strongest standardised association. These findings highlight care coordination, timely access, and patient involvement in healthcare decisions as potential priorities for improving executive inpatient services.

Keywords: executive inpatients; patient experience; patient satisfaction

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## INTRODUCTION

Patient experience has become an important component of healthcare quality assessment because it reflects how patients perceive and experience the care they receive, beyond the clinical outcomes achieved. The quality of healthcare is not determined solely by the availability of facilities or the technical competence of healthcare professionals, but also by how services are delivered, how patients are treated, and how effectively their needs are addressed throughout the care process. Patient-reported experience measures can therefore complement conventional quality indicators by

capturing aspects of care that may not be fully represented by clinical outcomes alone (Casaca et al., 2023). From this perspective, understanding patients' experiences is essential for developing more responsive, patient-centred healthcare services and identifying opportunities for quality improvement (Adams et al., 2025).

Patient experience is particularly relevant in inpatient care, where patients interact repeatedly with physicians, nurses, and other healthcare personnel while navigating different services during hospitalisation. These interactions encompass not only clinical treatment but also access to care, the clarity of information provided, involvement in treatment decisions, coordination between healthcare professionals, and respect for individual needs and preferences. Previous studies have reported associations between patients' experiences and their satisfaction with healthcare services. Research among adult inpatients has also identified satisfaction as an important outcome associated with patients' assessments of the care they receive (Aga et al., 2021; Wulandari et al., 2021). Similarly, research examining customer experience suggests the relevance of patient experience to satisfaction in hospital settings (Wang et al., 2025). These findings support the importance of evaluating care from the patient's perspective, particularly in inpatient services where multiple aspects of service delivery contribute to the overall care experience.

Patient satisfaction, however, is not necessarily determined by a single aspect of healthcare delivery. It represents a subjective evaluation of the care received in relation to patients' expectations and perceptions of the service. The expectation-disconfirmation perspective explains that satisfaction develops through the comparison between expected and experienced service performance; consequently, patients who receive similar services may evaluate them differently depending on their expectations and experiences (Schiebler et al., 2025). This distinction also highlights the importance of examining patient experience and patient satisfaction as related but conceptually different constructs. Patient experience concerns what occurs during the delivery of care, whereas satisfaction reflects patients' overall evaluation of that care. Understanding which aspects of experience are most closely associated with satisfaction may therefore provide more actionable information for hospital quality improvement than assessing overall experience alone.

In this study, patient experience was examined across eight dimensions: access to care, communication with healthcare professionals, information provision, shared decision-making, self-management support, care coordination, courtesy and respect, and culturally appropriate care. These dimensions represent complementary aspects of patient-centred service delivery. Access to care concerns the ease and timeliness with which patients obtain needed services, while communication and information provision concern the quality and clarity of interactions between patients and healthcare professionals. Shared decision-making and self-management support reflect patients' involvement in decisions and their preparation to manage health-related needs. Care coordination concerns the integration of services and communication among those involved in patient care, whereas courtesy, respect, and culturally appropriate care reflect the extent to which patients are treated with dignity and their individual values and preferences are acknowledged. Together, these dimensions provide a multidimensional perspective on the quality of care as experienced by patients (Adams et al., 2025; Nasution et al., 2025; Rosilawati et al., 2025).

Although previous research has established the relevance of patient experience to satisfaction, the overall association does not necessarily indicate that every experience dimension contributes independently to satisfaction. Because the dimensions may overlap conceptually and occur together during hospitalisation, a dimension that is strongly correlated with satisfaction in a bivariate analysis may not retain the same association after the other dimensions are considered simultaneously. Examining both bivariate relationships and adjusted associations is therefore important to distinguish dimensions that are associated with satisfaction individually from those that

demonstrate an independent statistical association when other dimensions are taken into account. This distinction is particularly relevant in executive inpatient care, where patients may have varied expectations regarding service accessibility, communication, coordination, and the responsiveness of healthcare professionals.

Accordingly, this study aimed to examine the associations between eight patient experience dimensions and patient satisfaction among patients receiving executive inpatient care in a hospital in Samarinda, East Kalimantan, Indonesia. Specifically, the study assessed the bivariate associations between each dimension and patient satisfaction and identified which dimensions remained independently associated with satisfaction in a multiple linear regression model. By distinguishing overall associations from adjusted associations, this study seeks to provide more specific evidence to support the prioritisation of patient experience dimensions in efforts to improve satisfaction with executive inpatient services.

## METHOD

This study employed a quantitative, analytical observational design with a cross-sectional approach to examine the associations between patient experience dimensions and patient satisfaction in the executive inpatient unit of Hospital X, Samarinda, East Kalimantan, Indonesia. Data were collected from September to October 2026. The study population comprised patients receiving care in the executive inpatient unit who met the eligibility criteria. A total of 150 respondents were recruited using consecutive sampling until the required sample size was reached. Eligible participants were aged 18 years or older, had received inpatient care for at least 48 hours, were able to provide information about the care received independently or with assistance from a family member or primary companion, and agreed to participate by providing informed consent. Patients were excluded if cognitive impairment or communication difficulties prevented them from providing information and no knowledgeable family member or companion was available to assist, if their clinical condition precluded participation based on the judgment of the attending physician or nurse, or if they submitted an incomplete questionnaire.

Data were collected using a structured questionnaire developed based on the Agency for Healthcare Research and Quality (AHRQ) framework for patient experience and the Expectation-Disconfirmation Theory (EDT) for patient satisfaction. Patient experience was assessed across eight dimensions: access to care, communication, information provision, shared decision-making, self-management support, care coordination, courtesy and respect, and culturally appropriate care. Patient satisfaction was assessed based on the EDT perspective, which conceptualizes satisfaction in relation to patients' evaluation of the care received against their expectations. Responses were recorded on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), with higher scores indicating more favorable patient experiences and greater satisfaction. Before the main study, the questionnaire was pilot-tested to assess item validity and instrument reliability. The patient experience items had validity coefficients ranging from 0.623 to 0.961, with a Cronbach's alpha coefficient of 0.971. The patient satisfaction items had validity coefficients ranging from 0.662 to 0.904, with a Cronbach's alpha coefficient of 0.944, indicating high internal consistency for both instruments.

Descriptive statistics were used to summarize respondent characteristics and study variables. Spearman's rank correlation was performed to assess the bivariate associations between each patient experience dimension and patient satisfaction. Multiple linear regression analysis was subsequently conducted, with patient satisfaction as the dependent variable and all eight patient experience dimensions entered simultaneously as independent variables. Regression results were reported using unstandardized coefficients (B), standard errors, standardized coefficients (β), p-values, and 95% confidence intervals. Model performance was assessed using the coefficient of

determination ($R^2$), adjusted $R^2$, and the overall F-test. Multicollinearity was evaluated using tolerance and variance inflation factor (VIF) values. Statistical significance was set at $p < 0.05$.

## RESULT

The 150 respondents represented a relatively diverse inpatient population in terms of sociodemographic characteristics, payment arrangements, and admission history (Table 1). Women accounted for 53.3% of the sample, and the mean age was 49.0 ± 14.2 years. More than half had a diploma-level education or higher (54.0%), while homemakers formed the largest occupational group (26.7%). Self-payment was the most common financing method (35.3%), followed by upgraded National Health Insurance coverage (31.3%) and company-funded care (21.3%). Although 46.7% reported one previous inpatient admission, nearly one-third had experienced three or more admissions (32.0%). Most respondents had non-surgical conditions (68.0%), and a substantial majority entered the hospital through the emergency department (71.3%).

Table 1.
Respondent characteristics (n= 150)

| Characteristic | f | % |
|---|---|---|
| Sex | | |
| Male | 70 | 46.7 |
| Female | 80 | 53.3 |
| Age (Years) | 49.0±14.2 | |
| Education Level | | |
| Low (no schooling-junior secondary) | 23 | 15.3 |
| Secondary (senior secondary) | 46 | 30.7 |
| Higher (diploma-postgraduate) | 81 | 54.0 |
| Occupation | | |
| Civil servant | 24 | 16.0 |
| Private-sector employee | 35 | 23.3 |
| Self-employed | 18 | 12.0 |
| Homemaker | 40 | 26.7 |
| Unemployed/retired | 23 | 15.3 |
| Other | 10 | 6.7 |
| Payment Method | | |
| National Health Insurance (upgraded class) | 47 | 31.3 |
| Self-paying | 53 | 35.3 |
| Private insurance | 16 | 10.7 |
| Company-funded | 32 | 21.3 |
| Other | 2 | 1.3 |
| Previous Inpatient Admissions | | |
| Once | 70 | 46.7 |
| Twice | 32 | 21.3 |
| Three or more times | 48 | 32.0 |
| Type of Case | | |
| Surgical | 48 | 32.0 |
| Non-surgical | 102 | 68.0 |
| Hospital Admission Route | | |
| Emergency department | 107 | 71.3 |
| Outpatient department | 43 | 28.7 |

Overall, respondents reported favorable experiences and satisfaction, with mean scores exceeding 4.00 across all eight patient experience dimensions and the satisfaction measure. Courtesy and respect received the highest rating (4.44 ± 0.71), followed by communication with healthcare professionals (4.39 ± 0.69) and information provision (4.31 ± 0.68). By comparison, access to care had the lowest mean score (4.11 ± 0.72), while self-management support also received a relatively lower rating (4.14 ± 0.76). Mean patient satisfaction was 4.18 ± 0.72. This pattern suggests that respondents viewed interpersonal aspects of care particularly positively, whereas access-related

experiences offered comparatively more room for improvement. The lower score for access to care is noteworthy given that most respondents were admitted through the emergency department.

Table 2.
Descriptive Statistics of Patient Experience Dimensions and Patient Satisfaction (n = 150)

| Variable | Number of items | Mean ± SD |
|---|---|---|
| Patient experience | | |
| Access to care | 4 | 4.11 ± 0.72 |
| Communication with healthcare professionals | 2 | 4.39 ± 0.69 |
| Information provision | 3 | 4.31 ± 0.68 |
| Shared decision-making | 4 | 4.26 ± 0.71 |
| Self-management support | 4 | 4.14 ± 0.76 |
| Care coordination | 4 | 4.22 ± 0.71 |
| Courtesy and respect | 2 | 4.44 ± 0.71 |
| Culturally appropriate care | 3 | 4.27 ± 0.72 |
| Patient satisfaction | 11 | 4.18 ± 0.72 |

All eight patient experience dimensions demonstrated positive, statistically significant correlations with patient satisfaction (all $p < 0.001$). Care coordination showed the strongest correlation (Spearman's $\rho = 0.792$), followed by culturally appropriate care ($\rho = 0.732$), access to care and shared decision-making (both $\rho = 0.725$), and self-management support ($\rho = 0.719$). The correlations were somewhat lower for courtesy and respect ($\rho = 0.703$), information provision ($\rho = 0.696$), and communication with healthcare professionals ($\rho = 0.695$), although all remained statistically significant. The consistently positive correlations indicate that more favorable experiences across different aspects of care tended to accompany higher satisfaction. The particularly strong correlation for care coordination highlights a potentially important relationship between how care is organized and patients' overall evaluations.

Table 3.
Spearman's Correlations Between Patient Experience Dimensions and Patient Satisfaction

| Patient experience dimension | Spearman's ρ | p-value |
|---|---|---|
| Access to care | 0.725 | <0.001 |
| Communication with healthcare professionals | 0.695 | <0.001 |
| Information provision | 0.696 | <0.001 |
| Shared decision-making | 0.725 | <0.001 |
| Self-management support | 0.719 | <0.001 |
| Care coordination | 0.792 | <0.001 |
| Courtesy and respect | 0.703 | <0.001 |
| Culturally appropriate care | 0.732 | <0.001 |

The multiple linear regression model was statistically significant ($F(8, 141) = 54.265$, $p < 0.001$), with an $R^2$ of 0.755 and an adjusted $R^2$ of 0.741. Collectively, the eight patient experience dimensions explained 75.5% of the variance in patient satisfaction. The Durbin-Watson statistic was 2.126, indicating no marked first-order residual autocorrelation. After adjustment for the other patient experience dimensions, three dimensions remained significantly positively associated with patient satisfaction: care coordination (B = 1.063, β = 0.383, 95% CI: 0.513-1.613, $p < 0.001$), access to care (B = 0.737, β = 0.269, 95% CI: 0.376-1.097, $p < 0.001$), and shared decision-making (B = 0.456, β = 0.165, 95% CI: 0.071-0.842, $p = 0.021$). Care coordination had the largest standardized regression coefficient, followed by access to care and shared decision-making. These findings suggest that these three dimensions had distinct statistical associations with patient satisfaction when the other measured dimensions were considered simultaneously.

In contrast, communication, information provision, self-management support, courtesy and respect, and culturally appropriate care were not significantly associated with patient satisfaction in the adjusted model ($p > 0.05$). Although all eight dimensions showed significant positive correlations

with satisfaction in the bivariate analysis, five did not retain statistically significant independent associations after adjustment. This difference may reflect overlapping information among patient experience dimensions rather than a lack of relevance to patients' overall experiences. The collinearity diagnostics further warrant caution in interpreting the individual coefficients. Variance inflation factors were highest for culturally appropriate care (5.779) and care coordination (5.768), while courtesy and respect also showed an elevated VIF (4.545). These findings suggest potential multicollinearity among the predictors, which may affect the precision and stability of the estimated coefficients. Therefore, although care coordination had the strongest standardized association in the adjusted model, it should not automatically be regarded as the most important determinant of satisfaction. Overall, the results highlight the relevance of care coordination, access to care, and shared decision-making while underscoring the need to interpret these associations in light of predictor overlap and the cross-sectional study design.

Table 4.
Multiple Linear Regression Analysis of Patient Experience Dimensions Associated with Patient Satisfaction

| Patient experience dimension | B | SE | β | 95% CI for B | p-value | VIF |
|---|---|---|---|---|---|---|
| Constant | 0.229 | 2.365 | — | -4.445 to 4.904 | 0.923 | — |
| Access to care | 0.737 | 0.182 | 0.269 | 0.376 to 1.097 | <0.001 | 2.551 |
| Communication | -0.443 | 0.483 | -0.077 | -1.399 to 0.512 | 0.361 | 4.104 |
| Information provision | 0.360 | 0.305 | 0.092 | -0.243 to 0.963 | 0.240 | 3.514 |
| Shared decision-making | 0.456 | 0.195 | 0.165 | 0.071 to 0.842 | 0.021 | 2.850 |
| Self-management support | 0.255 | 0.215 | 0.097 | -0.171 to 0.680 | 0.239 | 3.880 |
| Care coordination | 1.063 | 0.278 | 0.383 | 0.513 to 1.613 | <0.001 | 5.768 |
| Courtesy and respect | 0.810 | 0.495 | 0.146 | -0.168 to 1.788 | 0.104 | 4.545 |
| Culturally appropriate care | -0.327 | 0.367 | -0.089 | -1.053 to 0.399 | 0.374 | 5.779 |

Note. B = unstandardized regression coefficient; SE = standard error; β = standardized regression coefficient; CI = confidence interval; VIF = variance inflation factor. All eight patient experience dimensions were entered simultaneously into the multiple linear regression model. Statistical significance was set at $p < 0.05$.

## DISCUSSION

This study examined the associations between eight dimensions of patient experience and patient satisfaction among patients receiving executive inpatient care. The findings indicate that patient experience was positively associated with satisfaction in the bivariate analyses, while only access to care, shared decision-making, and care coordination remained statistically significant in the multiple linear regression model. The overall regression model was statistically significant and explained 75.5% of the variance in patient satisfaction ($R^2 = 0.755$; adjusted $R^2 = 0.741$; $F(8, 141) = 54.265$, $p < 0.001$). These findings suggest that patient satisfaction is associated with several interrelated aspects of care, but some dimensions may have stronger independent statistical associations than others when evaluated simultaneously. This distinction is important because a strong bivariate association does not necessarily indicate that a dimension contributes unique information after accounting for other aspects of the patient experience.

The positive associations observed between patient experience and satisfaction are consistent with previous research indicating that patients' evaluations of healthcare are closely related to their experiences during service delivery. Ayu, et al. (2022) reported an association between patient experience, satisfaction, and loyalty among inpatients in provincial hospitals in South Sulawesi. Similarly, Wang, et al. (2025) examined customer experience and satisfaction among patients receiving VIP outpatient care, supporting the relevance of experience-based assessment in hospital settings. Park, et al. (2022) also investigated the relationship between inpatient experiences, patient satisfaction, and willingness to recommend a hospital. Collectively, these studies support the importance of considering the patient perspective when evaluating hospital service quality. The present study extends this perspective by examining the independent associations of individual experience dimensions rather than relying exclusively on an overall assessment of patient

experience.

Among the eight dimensions, care coordination demonstrated the strongest standardized association with patient satisfaction ($\beta = 0.383$, $p < 0.001$). This finding highlights the potential importance of how different healthcare professionals and service units work together throughout hospitalisation. Inpatient care commonly involves interactions with physicians, nurses, and supporting services, and patients may experience these interactions as one continuous episode of care rather than as separate professional activities. When information is communicated consistently, responsibilities are clear, and care processes are appropriately coordinated, patients may experience fewer uncertainties and a greater sense of continuity. Conversely, inconsistent explanations, fragmented communication, or delays between service processes may undermine patients' overall evaluation of care, even when individual clinical encounters are satisfactory. The emphasis on coordination is consistent with the broader view that healthcare quality depends not only on technical processes but also on how care is organised and delivered (Rivaldi et al., 2025; Tossaint-Schoenmakers et al., 2021). It also aligns with the patient-centred care literature, which emphasises the importance of assessing the care process from the patient's perspective (Cipta et al., 2024; Putra et al., 2025).

The strong independent association of care coordination has practical implications for executive inpatient services. Hospitals may benefit from evaluating the consistency of information provided by different healthcare professionals, the clarity of care plans, the responsiveness of communication between units, and the continuity of support during hospitalisation. These processes should be considered alongside clinical quality indicators because patients' experiences may reflect how effectively the components of care are integrated. However, the present findings do not establish that improving coordination alone will cause satisfaction to increase. Rather, they identify care coordination as a priority dimension for further service evaluation and targeted quality-improvement initiatives.

Access to care was also independently associated with patient satisfaction ($\beta = 0.269$, $p < 0.001$). Although access is often discussed in terms of whether services are available, patients' experiences of access also involve the timeliness and ease of obtaining the care they need. In inpatient settings, this may include the time required to obtain a bed, the responsiveness of staff, and the availability of required services. Delays or difficulties in navigating these processes may affect how patients evaluate their overall hospital experience. This interpretation is consistent with the expectation-disconfirmation perspective, which proposes that satisfaction reflects patients' evaluations of received services relative to their expectations (Schiebler et al., 2025). When the actual service experience falls short of what patients expect, their overall evaluation may become less favourable. Research on patient-reported experience also supports the importance of measuring service processes that patients directly encounter rather than relying solely on structural or clinical indicators (Casaca et al., 2023). For executive inpatient care, monitoring waiting times, identifying avoidable delays, and improving the flow of patients between service points may therefore be useful components of quality-improvement efforts.

Shared decision-making was the third dimension that remained significantly associated with patient satisfaction after adjustment for the other dimensions ($\beta = 0.165$, $p = 0.021$). This finding suggests that patients' involvement in decisions about their care may provide an additional contribution to their overall evaluation of hospital services. Shared decision-making involves more than receiving information; it also concerns whether patients are invited to express their preferences, understand available options, and participate in decisions to the extent they wish and are able to. Such involvement may support patients' sense of autonomy and recognition as active participants in care. This interpretation is consistent with patient-centred care principles, which emphasise respect for individual preferences and meaningful participation in healthcare decisions (Cipta et al., 2024; Putra

et al., 2025). It is also relevant to the conceptual distinction between information provision and shared decision-making: information can be communicated without ensuring that patients are genuinely involved in decisions. The present finding therefore suggests that, in addition to providing clear explanations, healthcare professionals should consider how patients' preferences are elicited and incorporated into care planning.

In contrast, communication, information provision, self-management support, courtesy and respect, and culturally appropriate care did not retain statistically significant independent associations with satisfaction in the adjusted model. This should not be interpreted as evidence that these dimensions are unimportant. Their positive bivariate relationships with satisfaction indicate that they remain relevant to patients' overall evaluations of care. The loss of statistical significance after adjustment may reflect overlap between dimensions that are experienced together during hospitalisation. For example, communication and information provision may be closely linked to care coordination, while courtesy and culturally appropriate care may contribute to the broader interpersonal quality of healthcare encounters. When correlated dimensions are entered simultaneously into a regression model, the estimated coefficient for each dimension represents its association with satisfaction while holding the other dimensions constant. Consequently, a non-significant coefficient indicates insufficient evidence of a unique association under this model, rather than the absence of any relationship with satisfaction.

The multicollinearity statistics warrant particular attention when interpreting these adjusted findings. The VIF values for care coordination and culturally appropriate care were approximately 5.77, while the value for courtesy and respect was 4.55. These values suggest that some patient experience dimensions share substantial statistical information. Although the overall model was statistically significant and explained a considerable proportion of the variance in satisfaction, collinearity may increase the uncertainty of individual regression coefficients and affect their apparent statistical significance. The relatively strong coefficient for care coordination should therefore be interpreted as the strongest standardized association observed in this particular model, not as definitive evidence that it is universally the most important determinant of patient satisfaction. Future studies could examine the stability of these coefficients using larger samples, alternative model specifications, and additional diagnostics of the relationships among experience dimensions.

The overall explanatory power of the regression model is noteworthy. The $R^2$ of 0.755 indicates that the eight dimensions collectively accounted for 75.5% of the observed variance in patient satisfaction within this sample. This finding supports the value of assessing patient experience as a multidimensional construct rather than relying on a single overall measure. It is also consistent with the view that satisfaction reflects patients' evaluations of multiple aspects of the care they receive (Ayu et al., 2022; Rosilawati et al., 2025). Nevertheless, the proportion of explained variance should not be interpreted as evidence that patient experience accounts for all factors associated with satisfaction. Satisfaction may also reflect expectations, previous healthcare encounters, clinical condition, and other individual or service-related factors. Furthermore, because the study used a cross-sectional design, the observed associations do not establish temporal order or causality.

Several limitations should be considered. First, the cross-sectional design limits the ability to determine whether particular experiences preceded changes in satisfaction. Second, the study was conducted in a single executive inpatient setting in Samarinda, which may limit the transferability of the findings to hospitals with different patient populations, service structures, and expectations. Third, patient experience and satisfaction were assessed using questionnaire responses and may therefore be affected by subjective interpretation and response tendencies. Where information was provided with assistance from family members or primary companions, the responses may also

reflect the companion's perceptions of care rather than the patient's experience alone. Finally, the observed overlap among experience dimensions indicates that the independent coefficients should be interpreted cautiously. Further research involving multiple hospitals, larger samples, and complementary qualitative or longitudinal approaches could help clarify how patients interpret different aspects of care and whether the observed associations are consistent across settings.

Despite these limitations, the study provides a more differentiated assessment of patient experience in executive inpatient care by distinguishing bivariate associations from independent statistical associations. Care coordination, access to care, and shared decision-making remained significantly associated with patient satisfaction after adjustment for the other dimensions. These findings offer a practical basis for prioritising service evaluation, particularly in relation to continuity across healthcare professionals, timely access to required services, and patient involvement in care decisions. At the same time, the non-significant adjusted findings for the other dimensions should not lead hospitals to neglect communication, information provision, self-management support, respectful treatment, or culturally appropriate care. A comprehensive patient-centred approach remains important, while the relative contribution of each dimension should be interpreted in light of the overlap between them and the characteristics of the setting in which care is delivered.

## CONCLUSION

Patient experience was positively associated with patient satisfaction among executive inpatients. Although all eight patient experience dimensions showed significant positive correlations with satisfaction, only access to care, care coordination, and shared decision-making retained significant independent associations in the multivariable analysis. Care coordination demonstrated the strongest standardized association, followed by access to care and shared decision-making.

## DECLARATIONS

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**Ethical approval:** The study was approved by the Health Research Ethics Committee of Dr. Kanujoso Djatiwibowo General Hospital (approval number: 66/X/EPK-RSKD/2026). Informed consent was obtained from participants before data collection.

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**Author Contributions:** RS contributed to the conceptualization, study design, methodology, data collection, data analysis, interpretation of results, and manuscript drafting. IK and RA contributed to conceptualization, study design, methodology, study supervision, literature review, and manuscript revision. RN, RB, and IAIDL contributed to the interpretation of findings and critical review of the manuscript. All authors read and approved the final version of the manuscript.

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