

Working Paper of the Institute for Facility Management

Model for a holistic, interdisciplinary and interprofessional recovery-focussed service provision in health organisations – Translation of the German original

Nicole Gerber

nicole.gerber@zhaw.ch

March 2021

Translation:

Nicole Gerber, John Bennett

Keywords: service provision in healthcare organisations, customer orientation, patient experience, line of visibility, line of interaction

IFM – Institute for Facility Management
School of Life Sciences and Facility Management
Zurich University of Applied Sciences
Campus Gruental
CH-8820 Waedenswil
Switzerland

ISSN Number: 1662-985X

Online available on <https://www.zhaw.ch/de/lifm/forschung/facility-management/working-papers/>

The research group «FM in Healthcare»

The research group «FM in Healthcare» (FM in HC) at the Institute of Facility Management (IFM) at the Zurich University of Applied Sciences (ZHAW) explores and processes – on a strategic, tactical and operational level – topics of person-related services in the healthcare context. Analyses are carried out, practicable solutions are developed and their implementation are accompanied by us together with partners in industry and other knowledge institutions. The approaches are based on international best practices and on scientific fundamentals.

Further information: <https://www.zhaw.ch/en/lspm/institutes-centres/ifm/about-us/hospitality-management/fm-in-healthcare/>

The author

Dr. Nicole Gerber graduated in business administration and information systems. She manages and supports different projects, mainly in the area of non-medical support services in healthcare organisations, lectures on project management in different institutions and coordinates several expert groups in this area. She is a member of several committees, publishes on a regular basis and gives national and international talks.

Contact

ZHAW Zurich University of Applied Sciences, Life Sciences & Facility Management

Institute of Facility Management, Competency group Hospitality Management

Dr. Nicole Gerber

Seestrasse 55 / RA / 8820 Waedenswil, Switzerland

+41 (0)58 934 53 91

nicole.gerber@zhaw.ch

<http://www.zhaw.ch>, www.zhaw.ch/ifm, www.zhaw.ch/=geri

Abstract

In this working paper, the «Model for a holistic, interdisciplinary and interprofessional recovery-focussed service provision in health organisations» is presented. It is based on principles such as patient/customer orientation, patient/customer experiences, various service contributions, visibility of the service provision vs. non-visibility, degree of interactions with patients/customers, and medical and non-medical contribution to recovery. The goal is the creation of a foundation for a new, common understanding of service provisions in healthcare organisations.

Keywords:

service provision in healthcare organisations, customer orientation, patient experience, line of visibility, line of interaction

1. Starting position

In classical management literature, often a differentiation is made between primary services/core processes, secondary services/support processes and management services/processes (Porter, 1985; Rüegg-Stürm, 2003). That making such distinctions is only partially adequate for healthcare was discussed within the service allocation model for non-medical services in hospitals – LemoS (Gerber & Kuchen, 2019) – and a correspondingly apt allocation to medical core services, strategic management services and medical, non-medical and management support services was suggested. A slightly different approach was chosen in the context of service management by Fliess (2009, p. 194). She differentiates between activities e.g. according to potential activities, secondary support activities, invisible “backstage” activities, visible “onstage” provider activities as well as customer activities, and separates them by implementation, pre-planning, internal interaction, lines of visibility and customer interaction. The idea to divide the services visible for customers and the non-visible services with a «line of visibility» is also applied in the context of blueprinting (Bornewasser, 2013; Braun von Reinersdorff, 2007; Schubert, 2013; von Felten, Coenen, & Schmid, 2012).

In projects aiming to systematically and holistically develop particularly the non-medical service provision in healthcare organisations, it has, however, been observed that the models mentioned above only partially fulfil the need of the complex practice. In particular, the increasing patient centricity and the merging of the different disciplines have hardly been described. A suggestion in relation to a common understanding of the different patient and customer roles for people who (have to) get treated in a healthcare organisation and the corresponding differentiating needs for service provision has been made (Gerber, 2020). Still missing, however, is a common, overall discipline and interprofessional understanding of service provision in relation to the «line of visibility» in the course of the patient journey.

2. Goal of the working paper

The author suggests that service provision in healthcare organisations should be aligned differently in the future. Digitalisation is already causing an increasing merger of disciplines in some areas. The trend to more cooperation should not only be pursued in regard to a goal-oriented treatment in favour of all people who (have to) go to healthcare organisations, but also premised on becoming more effective so that fewer resources (human, material, time and financial) are wasted.

With the presentation of a model for a holistic, interdisciplinary and interprofessional recovery-focussed service provision in health organisations, the goal of the working paper is that the foundation for a

discussion towards such an understanding of service provision is rooted for all participants in the recovery of people – be it directly or indirectly.

3. Model for a holistic, interdisciplinary and interprofessional recovery-focussed service provision in health organisations

Before the model for a holistic, interdisciplinary and interprofessional recovery-focussed service provision in health organisations is introduced, the underlying principles are presented.

3.1 Principles / Basic understanding

The following basic understanding and principles underlie the model for a holistic, interdisciplinary and interprofessional recovery-focussed service provision in health organisations:

Patient/customer orientation in healthcare services

Services in healthcare organisations are, more and more, being provided in a patient-/customer-oriented way, with active participation and focused on the overall experience, which is causing increasing customer orientation (Ernst, Brähler, & Weissflog, 2014; Fancott, 2011; Fischer, 2017; fmc, 2015; Gatterman, 2012; Gerber, 2020; Ghafur & Schneider, 2019; Immohealthcare, 2019; Health Quality Ontario, no date; Parzer-Epp, Cosandey, & Dümmler, 2019; Passoth, 2018; Pfister & Steiger, 2014; Schüpfer, 2015; Vahlensieck, 2018; Vetterli, 2017; Vogel, 2006). People who (have to) go to a healthcare organisation for recovery can, depending on the situation, occupy the role of patients and/or customers (cf. Figure 1).

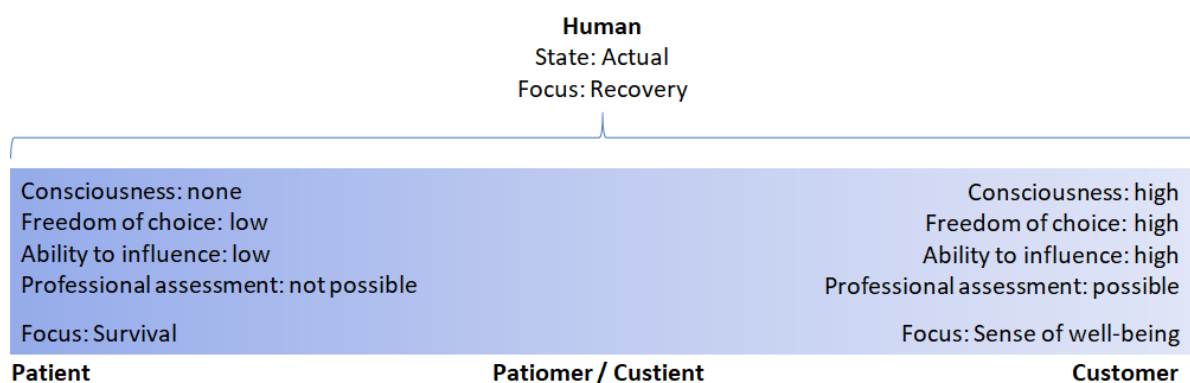


Figure 1: Manifestations of the role of people who (have to) receive treatment in a healthcare organisation (Source: Gerber, 2021, p. 3)

Different service contribution in healthcare organisations

In healthcare organisations, a multitude of different services are necessary to fulfil the purpose of recovery. In order to cope with this complexity, Gerber & Kuchen (2019) suggest an extension of the common

management theory, usually comprising core, management and support services, by segmenting the support services into Management support services, Non-medical support services and Medical support services (cf. Figure 2).

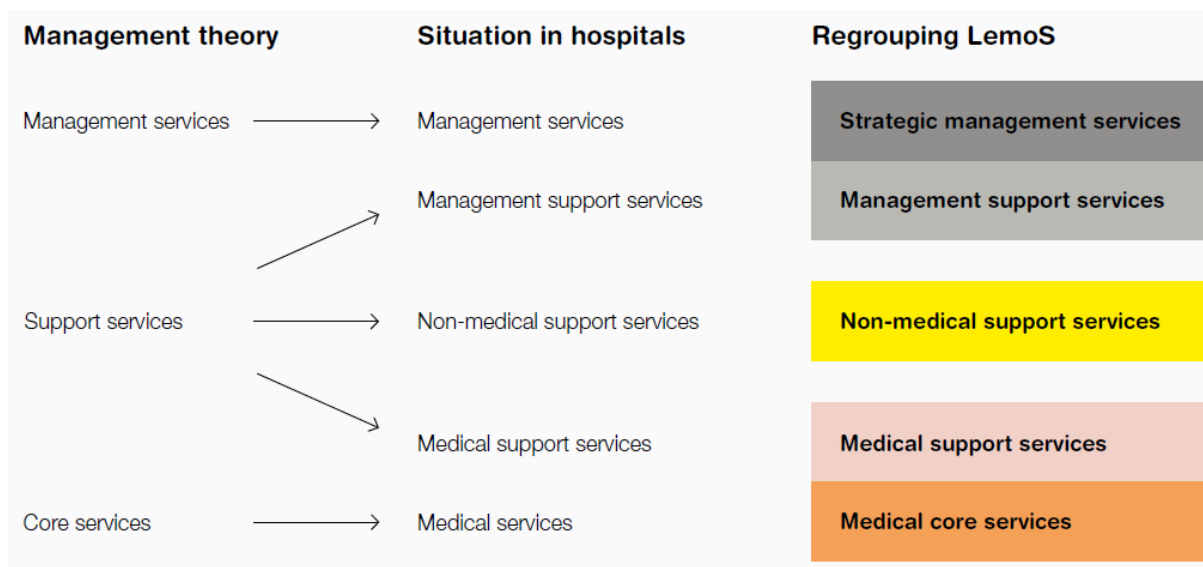


Figure 2: Illustration of the different service groupings (Source: Gerber & Kuchen, 2019, p. 9)

On this basis, the corresponding services in the service catalogue of non-medical Services (LekaS) were described in detail (Gerber & Kuchen, 2019) – Figure 3 summarises the content.

Strategic management services				Project management
Sustainability Quality management Risk management Corporate identity Resources/Sourcing management Asset/Portfolio strategy ICT management				
Management support services				
Finance & Controlling Human Resource Management Legal counsel & contracts Marketing & Communication Secretarial services ICT services				
Non-medical support services				
Tactical resource management				
Logistics Procurement Storage Transport services & distribution Disposal & Recycling	Infrastructure Operation & preventative maintenance Space management & provision Supply and disposal of energy & water	Hygiene, Safety & Security Cleaning & Disinfection Preparation of medical products Ensuring of health & safety Security	Hotel services Catering Provision of textiles Accommodation management & operation of properties Various hotel services	
Medical support services				
Pharmacy, Laboratory, Pastoral Care & Social Service, Research & Teaching, Patient Scheduling Services (Incl. Patient Administration, Bed & Patient Scheduling)				
Medical core services (according to DIN 13080:2016-06)				
Diagnostic and Therapy: Emergency, Outpatient Clinic, Medical Services, Functional Diagnostics, Endoscopy, Laboratory Medicine, Diagnostic Imaging and Interventional Radiology, Nuclear Medicine, Surgery, Childbirth, Radiology, Supporting Treatments, Morgue/Pathology				
Care: General Care, Maternity and Post-Natal Care, Intensive-Care, Dialysis, Paediatrics, Isolation Nursing, Care of the Mentally Ill, Nuclear Medicine Care, Care on Admission, Geriatric Care, Day Clinic, Palliative Medicine, Rehabilitation, Comfort Ward				

© ZHAW IFM, Authors: Gerber, N. & Kuchen, O.

Version 4.1

Figure 3: Service Allocation Model for Non-Medical Services in Hospitals (LemoS), Version 4.1 (Source: Gerber & Kuchen, 2019, p. 10)

Complex service provisions in general and particularly in healthcare organisations

The production of services is generally classified as being complex (Bullinger & Meiren, 2001; Corsten & Gössinger, 2007; Corsten & Stuhlmann, 2001; Fliess, 2009; Kleinaltenkamp, 2001; Maleri & Frieztzsche, 2008; Sampson, 2012). This particularly applies for the provision of services in healthcare organisations (Corsten & Salewski, 2013; Darzentas & Petrie, 2019; Malmberg, et al., 2019; Palozzi, Falivena, & Chirico, 2019; Prendiville, 2019; Rise Fry, 2019; Romm & Vink, 2019; Rygh & Clatworthy, 2019; Vink, Prestes Joly, Wetter-Edman, Tronvoll, & Edvardsson, 2019). Here, the different contributions to the overall performance become indistinct in a number of ways:

- **Visibility of the service provision vs. non-visibility**

In service engineering, the distinction is made between services which are visible for the customers or patients and those which are not. For this, the «line of visibility» is applied, which divides the two contexts (Fliess, 2009). In healthcare organisations, medical-care-therapeutic contributions can be visible (e.g. doctor's visits, therapy, wound care), but also non-medical ones (e.g. catering, cleaning or maintenance activities in patient rooms, logistics activities on the ward) or management-services (e.g. administration/correspondence, image building activities). In comparison, some contributions to the service provision for customers or patients are non-visible for the medical-therapeutic-care context (e.g. preparation of the surgery instruments or medications, alignment of the patient reports) as well as for the non-medical (e.g. preparation of specific meals, logistics of material) or the management context (e.g. resource and sustainability management).

- **Interaction with the patient / customer**

Fliess (2009) also differentiates between contribution of service provision in relation to the interaction with the customer and uses the «line of interaction» for this: services can thus be generated together with the customer or also without a customer interaction. In healthcare organisations, interactions with the patient/customer are possible for the medical-therapeutic-care service provision as well as for the non-medical or management activities (e.g. choice of the menu, choice of hospitality services, explanations of billing). Also, service provisions without interaction of the customer/patient are possible in the medical-therapeutic-care context (e.g. interpretation of laboratory examinations, patient administration) as well as in the non-medical context (e.g. repair of defective devices, preparation of meals).

- **Medical and non-medical contribution to recovery**

Not only medical-therapeutic-care services can contribute to the recovery, but also non-medical services (Andrede, Lima, Sloan Devlin, & Hernandez, 2016; Reymond & Manz, 2020; Riefenstahl, 2015; Vollmer & Koppen, 2015). While some medical services can clearly be classified as core processes in a classical sense as they contribute to the recovery according to medical principles, there are also non-medical services which can encourage recovery (e.g. colour of materials, room design,

nutrition, hygiene, hospitality or empathic communication of all staff). In contrast, there are services with support character in the medical (e.g. surgery material provision, medical literature administration) as well as the non-medical or management area (e.g. room management, procurement logistics, human resource management).

Overall, it has to be noted: The exact allocation of service provision activities in healthcare organisations is only possible to a limited extent. Very often, there are “grey areas”: A service may or may not be visible for any given patient, depending on the timing of the provisioning act, or a patient may not actively perceive a particular service at all. In addition, in different healthcare organisations, different services are offered and, depending on the organisational form, are provided in a different manner, or the service provision is available in different ways. A model has to take into account these variables.

3.2 Model conception

With the above-mentioned aspects

- patient-/customer-orientation / patient-/customer-experience
- different service contributions
- visibility of the service provision vs. non-visibility
- interaction with patients/customers
- medical and non-medical contribution to recovery

as a basis, Figure 4 illustrates the correspondingly suggested model for a holistic, interdisciplinary and interprofessional recovery-focussed service provision in health organisations, independently of the present affiliation of professions and disciplines.

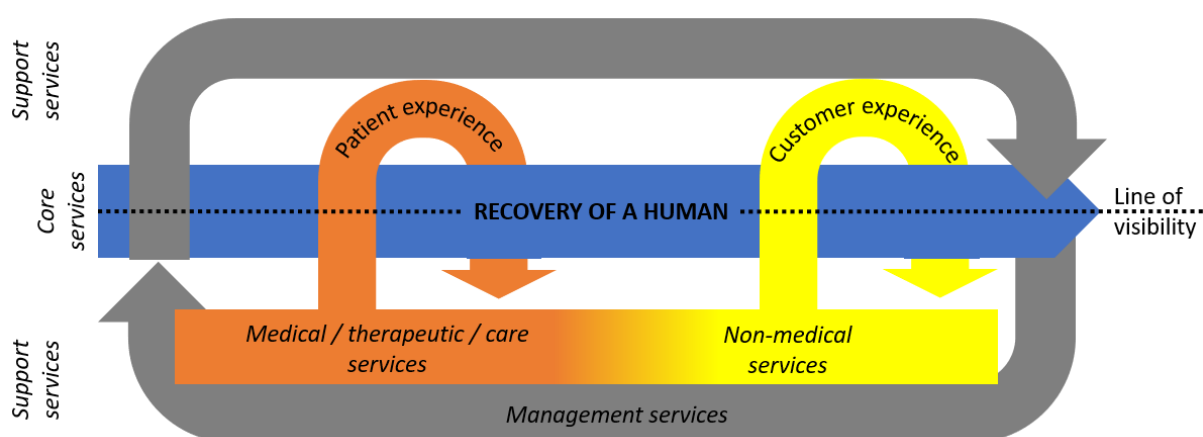


Figure 4: Model for a holistic, interdisciplinary and interprofessional recovery-focussed service provision in health organisations

Explanations of the mode content:

- The **recovery of people** is the **central focus** of all service providers – this fact was also taken into account in a visual perspective.
- Contributions to the service provision are **medical-therapeutic-care, non-medical and management services** - the colouring scheme follows the Service Allocation Model for Non-medical Support Services in Hospitals – LemoS 4.1 (Gerber & Kuchen, 2019).
- Services which are **visible** for the patients/customers are located above the «line of visibility». Visible services can be medical-therapeutic-care, non-medical or also management services.
- Service which are **not visible** for the patients/customers are below the «line of visibility». Not visible services can be medical-therapeutic-care, non-medical or also management services.
- The more directly a service contributes to the recovery of a person, the more this service can be classified as a **core service**.
- The less directly a service contributes to the recovery of a person, the more this service is classified as a **support service**. Support services can be provided in a medical-therapeutic-care, a non-medical or a management context.
- The more a service is assessable and choosable for a person who goes to a hospital in order to get treated, the more it should be provided with the view to the **customer experience**. Core as well as support services in relation to the customer experience can be provided in a medical-therapeutic-care, non-medical as well as management context.
- The less a service is assessable and choosable for people who (have to) go to a hospital in order to get treated, the more it should be provided with the view to the **patient experience**. Core as well as support services in relation to the patient experience can be provided in a medical-therapeutic-care, a non-medical as well as a management context.
- The single service provision contexts are not always clearly separable or distinguishable; the transitions are sometimes fluid as the service provision may overlap.

4. Outlook

With the model and the corresponding explanations, it should be made clear that the service provisions in healthcare organisations have to be newly aligned. The often strict separation between professions and disciplines of the past has to be reappraised with a common focus on service provision and associated processes have to be redesigned. Particularly with the current digital transformation within healthcare (as well as within society in general) and the corresponding changes in work procedures, understanding of roles and fields of activities, this should be used for a realignment and for a common dialogue. For that, an appropriate culture change of the whole organisation and of all stakeholders is necessary.

In the medium-term, a corresponding assessment of the satisfaction of patients and customers should be considered as a basis for a continuous verification and discussion of service provision.

Bibliography

- Andrede, C. C., Lima, M. L., Sloan Devlin, A., & Hernandez, B. (2016). Is it the Place or the People? Disentangling the Effects of Hospitals' Physical and Social Environments on Well-Being. *Environment and Behavior*, 48(29), 200 - 323.
- Bornewasser, M. (2013). Prozessreorganisation im Krankenhaus: Lassen sich auch logistische Konzepte der Industrie im Krankenhaus umsetzen? In R. Bouncken, M. Pfannstiel, & A. Reuschl (Hrsg.), *Dienstleistungsmanagement im Krankenhaus I - Prozesse, Produktivität und Diversität*. Wiesbaden: Springer Gabler.
- Braun von Reinersdorff, A. (2007). *Strategische Krankenhausführung - Vom Lean Management zum Balanced Hospital Management*. 2., unveränderte Auflage. Bern: Verlag Hans Huber.
- Bullinger, H.-J., & Meiren, T. (2001). Service Engineering – Entwicklung und Gestaltung von Dienstleistungen. In M. Bruhn, & H. Meffert (Hrsg.), *Handbuch Dienstleistungsmanagement - Von der strategischen Konzeption zur praktischen Umsetzung*, 2., überarbeitete und erweiterte Auflage (p. 149 – 175). Wiesbaden: Gabler.
- Corsten, H., & Gössinger, R. (2007). *Dienstleistungsmanagement*. 5. vollständig überarbeitete und wesentlich erweiterte Auflage. München Wien: R. Oldenbourg.
- Corsten, H., & Salewski, H. (2013). Dienstleistungsmodularisierung im Krankenhaus - Theoretischer Rahmen und Anwendung. In R. Bouncken, M. Pfannstiel, & A. Reuschl, *Dienstleistungsmanagement im Krankenhaus I - Prozesse, Produktivität und Diversität* (p. 99 - 100). Wiesbaden: Springer Gabler.
- Corsten, H., & Stuhlmann, S. (2001). Kapazitätsplanung in Dienstleistungsunternehmen. In M. Bruhn, & H. Meffert, *Handbuch Dienstleistungsmanagement - Von der strategischen Konzeption zur praktischen Umsetzung*, 2., überarbeitete und erweiterte Auflage (p. 177 – 192). Wiesbaden: Gabler.
- Darzentas, J., & Petrie, H. (2019). Patient Self-Service Paradigms in Hospital and Healthcare Service Design Settings. In M. A. Pfannstiel, & C. Rasche, *Service Design and Service Thinking in Healthcare and Hospital Management - Theory, Concepts, Practice* (p. 447 – 462). Springer Nature Switzerland.
- Ernst, J., Brähler, E., & Weissflog, G. (2014). Beteiligung von Patienten an medizinischen Entscheidungen – ein Überblick zu Patientenpräferenzen und Einflussfaktoren. *Gesundheitswesen*, 76: 187 – 192. DOI <http://dx.doi.org/10.1055/s-0033-1361150>.
- Fancott, C. (2011). *Interventions and measurement tools related to improving the patient experience through transitions in care: A summary of key literature*.
http://www.hqontario.ca/portals/0/Modals/qi/en/processmap_pdfs/resources_links/Care%20Transitions%20Literature%20Review.pdf.
- Fischer, A. (2017). Serviceorientierung: Der Patient im Fokus. In J. F. Debatin, A. Ekkernkamp, B. Schulte, & A. Tecklenburg, *Krankenhausmanagement – Strategien, Konzepte, Methoden*. 3., vollständig aktualisierte und erweiterte Auflage (p. 267 - 277). Berlin: Medizinische Wissenschaftliche Verlagsgesellschaft.
- Fliess, S. (2009). *Dienstleistungsmanagement - Kundenintegration gestalten und steuern*. Wiesbaden: Gabler.
- fmc. (2015). *Patientenbilder 2024. Denkstoff No 2 – Patientenbilder 2024*. Neuägeri: fmc – Schweizer Forum für Integrierte Versorgung. Neuägerli: fmc.
- Gatterman, M. I. (2012). Whiplash - A Patient-Centered Approach to Management. *St. Louis: Elsevier Mosby*, 1-5.
- Gerber, N. (2020). *Patient or customer-centred service provision? Both – it depends! (translation of the German original)*. Waedenswil: Working Papers. Zurich University of Applied Sciences, Institute of Facility Management.

- https://digitalcollection.zhaw.ch/bitstream/11475/22171/3/2021_Gerber_Patient-or-customer-centred-service-provision.pdf.
- Gerber, N., & Kuchen, O. (2019). *Service Allocation Model for Non-Medical Services in Hospitals (LekaS). Version 2.0. Translation of the German Original*. Waedenswil: Zurich University of Applied Sciences, Institute of Facility Management. <https://www.zhaw.ch/en/lspm/institutes-centres/ifm/about-us/hospitality-management/fm-in-healthcare/lekas/>.
- Ghafur, S., & Schneider, E. C. (2019). Engaging Patients Using Digital Technology — Learning from Other Industries. <https://catalyst.nejm.org/patients-digital-consumer-focused-industries/>.
- Health Quality Ontario. (no date). *Capturing the Patient Experience*. <http://www.hqontario.ca/Portals/0/Documents/qi/qi-capturing-patient-experience-instruction-sheet-en.pdf>.
- Immohealthcare. (2019). Technologie allein ist zu wenig. *Clinicum*. 2-19, 57.
- Kleinaltenkamp, M. (2001). Begriffsabgrenzungen und Erscheinungsformen. In M. Bruhn, & H. Meffert (Hrsg.), *Handbuch Dienstleistungsmanagement - Von der strategischen Konzeption zur praktischen Umsetzung*, 2., überarbeitete und erweiterte Auflage (p. 27 – 50). Wiesbaden: Gabler.
- Maleri, R., & Frietzsche, U. (2008). *Grundlagen der Dienstleistungsproduktion* (Fünfte, vollständig überarbeitete Auflage Ausg.). Berlin, Heidelberg: Springer.
- Malmberg, L., Rodrigues, V., Lännerström, L., Wetter-Edman, K., Vink, J., & Holmlid, S. (2019). Service Design as a Transformational Driver Toward Person-Centered Care in Healthcare. In M. A. Pfannstiel, & C. Rasche, *Service Design and Service Thinking in Healthcare and Hospital Management - Theory, Concepts, Practice* (p. 1 – 18). Springer Nature Switzerland.
- Nagel, G. (2015). *Über die Entdeckung des Patienten im 21. Jahrhundert. Denkstoff No 2 – Patientenbilder 2024*. Neuägeri: fmc – Schweizer Forum für Integrierte Versorgung.
- Palozzi, G., Falivena, C., & Chirico, A. (2019). Designing the Function of Health Technology Assessment as a Support for Hospital Management. In M. A. Pfannstiel, & C. Rasche, *Service Design and Service Thinking in Healthcare and Hospital Management - Theory, Concepts, Practice* (p. 233 – 258). Springer Nature Switzerland.
- Parzer-Epp, V., Cosandey, J., & Dümmler, P. (2019). *Klienten statt Patienten*. Von avenir-suisse: <https://www.avenir-suisse.ch/klienten-statt-patienten/> abgerufen
- Passoth, N. (2018). Stärker an Patientenbedürfnissen orientieren. Interview mit Joachim M. Schmitt. *Management & Krankenhaus*. 3/2018. Wiley, 12.
- Pfister, A., & Steiger, T. (2014). Welche strategischen Kompetenzen brauchen Patienten im Gesundheitswesen der Zukunft? Thesenpapier KHM-cap-Zukunftsforum 2014 zu Patientenkompetenzen. *Schweizer Ärztezeitung*. 95: 41, 1546.
- Porter, M. E. (1985). *Competitive Advantage - Creating and Sustaining Superior Performance*. New York: The Free Press.
- Prendiville, A. (2019). Service Design Methods: Knowledge Co-production in Health and Social Care. In M. A. Pfannstiel, & C. Rasche, *Service Design and Service Thinking in Healthcare and Hospital Management - Theory, Concepts, Practice* (p. 359 – 376). Springer Nature Switzerland.
- Reymond, S., & Manz, S. (2020). Küchenpersonal ist Teil der Pflege. *Competence 1-2/2020*, p. 17.
- Riefenstahl, R. (2015). Der Mitarbeiter als entscheidende Ressource im Patientenkontakt. In A. Fischer (Hrsg.), *Servicequalität und Patientenzufriedenheit im Krankenhaus – Konzepte, Methoden, Implementierung*. Berlin: Medizinisch Wissenschaftliche Verlagsgesellschaft.
- Rise Fry, K. (2019). Why Hospitals Need Service Design. In M. A. Pfannstiel, & C. Rasche, *Service Design and Service Thinking in Healthcare and Hospital Management - Theory, Concepts, Practice* (p. 377 – 400). Springer Nature Switzerland.
- Romm, J., & Vink, J. (2019). Investigating the “In-betweenness” of Service Design Practitioners in Healthcare. In M. A. Pfannstiel, & C. Rasche, *Service Design and Service Thinking in Healthcare and Hospital Management - Theory, Concepts, Practice* (p. 117 – 136). Springer Nature Switzerland.
- Rüegg-Stürm, J. (2003). *Das neue St. Galler Management-Modell - Grundkategorien einer integrierten Managementlehre. Der HSG-Ansatz*, 2. durchgesehene Auflage. Bern, Stuttgart, Wien: Haupt.

- Rygh, K., & Clatworthy, S. (2019). The Use of Tangible Tools as a Means to Support Co-design During Service Design Innovation Projects in Healthcare. In M. A. Pfannstiel, & C. Rasche, *Service Design and Service Thinking in Healthcare and Hospital Management - Theory, Concepts, Practice* (p. 93 – 116). Springer Nature Switzerland.
- Sampson, S. E. (2012). Visualizing Service Operations. *Journal of Service Research*. 15 (2), 182 - 198.
- Schubert, E. D. (2013). Die Prozessanalyse mittels Service Blueprinting als Grundlage für ein Redesign der Prozesse eines OP-Bereichs. In R. Bouncken, M. Pfannstiel, & A. Reuschl, *Dienstleistungsmanagement im Krankenhaus I - Prozesse, Produktivität und Diversität*. Wiesbaden: Springer Gabler.
- Schüpfer, G. (2015). Service und Kundenorientierung in der Schweiz – können wir von führenden Krankenhäusern lernen? In A. Fischer, *Servicequalität und Patientenzufriedenheit im Krankenhaus – Konzepte, Methoden, Implementierung* (p. 299 – 304). Berlin: Medizinisch Wissenschaftliche Verlagsgesellschaft.
- Vahlensieck, Y. (2018). Missverständnisse gefährden Patienten. Akademien Schweiz. *Horizonte Nr. 117. Schweizerischer Nationalfonds*, 40 – 42.
- Vetterli, C. (2017). Exkurs: Den Patienten richtig bedienen – egal ob digital oder analog. In A. Angerer, R. Schmidt, C. Moll, L. Strunk, & U. Brügger, *Digital Health - Die Zukunft des Schweizer Gesundheitswesens* (p. 24 - 25). Winterthur: ZHAW.
- Vink, J., Prestes Joly, M., Wetter-Edman, K., Tronvoll, B., & Edvardsson, B. (2019). Changing the Rules of the Game in Healthcare Through Service Design. In M. A. Pfannstiel, & C. Rasche, *Service Design and Service Thinking in Healthcare and Hospital Management - Theory, Concepts, Practice* (p. 19 – 38). Springer Nature Switzerland.
- Vogel, S. (2006). Patientenpfade – heute und morgen. In A. Thiede, & H.-J. Gassel, *Krankenhaus der Zukunft*. Heidelberg: Dr. Reinhard Kaden.
- Vollmer, T. C., & Koppen, G. (2015). Architektur hilft heilen. Luxuriöser Wunsch oder beweisbare Wirklichkeit? *Klinik Wissen Management* 02/15, 22-25.
- von Felten, D., Coenen, C., & Schmid, M. (2012). *FM-Blueprinting: Schaffung von interdisziplinärer Transparenz für die Kern- und Unterstützungsprozesse*. Wädenswil: IFM Institut für Facility Management.