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2016

Proceedings: Cornell Symposium: Hospitality, Health & Design HHDS2016 In Search of a Healthy Future

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Recommended Citation

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Keywords

senior living, health management, senior housing, health care, housing design, health facilities, Cornell University, symposium

Disciplines

Environmental Design | Gerontology | Health and Medical Administration | Hospitality Administration and Management

Comments
Required Publisher Statement

CORNELL SYMPOSIUM
HOSPITALITY HEALTH&DESIGN

IN SEARCH OF A HEALTHY FUTURE

OCTOBER 9 - 11, 2016
CORNELL UNIVERSITY
ITHACA, NY

Symposium Proceedings

PROCEEDINGS: CORNELL SYMPOSIUM HOSPITALITY, HEALTH & DESIGN HHDS2016

CORNELL INSTITUTE FOR HEALTHY FUTURES

IN SEARCH OF A HEALTHY FUTURE

Symposium Co-Chairs
Rohit Verma
Mardelle Shepley
Brooke Hollis

PREFACE

Although the words "hospitality" and "hospital" invoke very different emotions, they stem from the same root word in Latin, *hospes*, meaning "guest" or "host." While the hospitality and healthcare industries have evolved quite differently over the centuries, they continue to share many common characteristics. For example, both industries need to take care of the unique needs of their guests by proving comfortable lodging, food-service, privacy / security, and many other similar amenities and supplementary services. Each industry can provide unique opportunities for companies operating in the other industry because of evolving customer preferences / business dynamics, and changing regulations and policies. Many new industry segments are emerging at the interface of hospitality and healthcare – they include senior housing and care; wellness and medical tourism; and concierge medicine; to name a few.

The purpose of this conference therefore is to bring together academic scholars and industry leaders who have interest in exploring the rapidly evolving dynamics of **hospitality** and **healthcare** industries. Furthermore, we believe that **design thinking** provides an effective approach for exploring this exciting topic from both academic and practitioners' perspectives.

Industry executives and academic scholars are invited to submit proposals for presentations, panels, tutorials, and workshops for the **Cornell Hospitality, Health, and Design Symposium (HHDS2016): *In Search of a Healthy Future*** scheduled for October 9 – 11, 2016, at the beautiful Cornell campus in Ithaca, New York. All topics that relate to the overarching theme of the symposium are welcome. Similar to our earlier conferences (Cornell Hospitality Research Summit - 2010, 2012, and 2014), an essential element of HHDS2016 is to bridge the gap between academic research and practice, and provide opportunities for engaged discussions between scholars and industry leaders.

Therefore, the symposium will feature equal number of speakers from both industry and academia during each session. Both presentation content and speaking expertise will be considered in selection, with priority given to research based on **real-world business topics** OR **high-quality academic work**.

This symposium is co-chaired by Rohit Verma, Mardelle Shepley, and Brooke Hollis. The advisory board for HHDS2016 comprises of senior executives from the hospitality, health, and design industries, and academic scholars from leading universities around the world.

Hospitality Bridging Healthcare (H2H ©) for the Patient/Guest Experience in Medical Tourism and Wellness Settings

Frederick J. DeMicco, Ph.D., R.D. and Giulia Mantovan, M.Sc.

The Lerner College of Business & Economics, Department of Hospitality Business Management, the University of Delaware

Abstract

This paper provides an overview for a new course as part of a curriculum design for a new major in Hospitality Bridging Healthcare or H2H ©.

The course is designed for synchronous, asynchronous or a blended learning format. Below provides a plan for a 12 week course (or a shorter course delivery time frame). The presentation at the 2016 Cornell's Healthy Futures Conference and in this paper shares the entire outline for the course and is presented below.

Key Words

Healthcare   Hospitality   Systems Model   Medical Tourism   Patient Experience

Overview of the Course

The course Hospitality Bridging Healthcare (H2H (c) is divided into three sections. SECTION I provides the overview of healthcare and hospitality and how the two have become, rightfully so - intertwined. Consumers expect quality in all of the products and services they purchase, and their healthcare purchase is no different. SECTION II of the course will examine some examples of healthcare facilities and how they integrate and bridge hospitality and healthcare. Picture a Venn diagram (Figure 1) with interlocking circles, with each circle representing healthcare and hospitality (Cetron, M., DeMicco, F.J. and Davies, O. (2010).   The intersection of the circles provides the opportunity to raise the bar on patient/guest services for quality and positive and beneficial health and wellness outcomes. The goal of this section II is to introduce Hospitality Bridging Healthcare (H2H) and Medical Tourism & Wellness and the importance of providing high quality patient/guest services. Included will be an overview of the Mayo Clinic as a system with many processes that have to be managed with optimal patient/guest services in mind. This section also provides an overview of the Affordable Care Act (often referred to as "Obamacare"), which is driving the delivery of high quality patient/guest services (which are tied to federal reimbursement for healthcare at hospitals today). The patient/guest service and guest loyalty practices and techniques for delivering a total guest experience will be described in several class modules. At the conclusion of Section II will be a discussion of trends and future areas for Medical Tourism and Wellness and H2H.

Figure 1
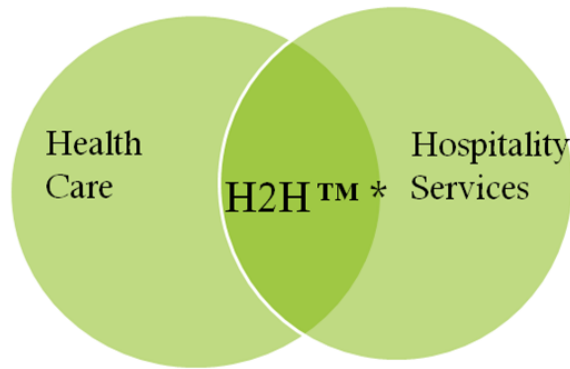
* H2H ™ : **Hospitality Bridging Healthcare**
DeMicco & Poorani

Frederick J. DeMicco /2015

The final part of the course, SECTION III, will analyze case studies and best practices in hospitality bridging healthcare provides some examples of the possibilities for hospitality bridging healthcare with some real world examples, and some case studies to help in designing, discussion of and planning H2H into these operations.

H2H © Course Objectives

Upon completion of the course, the student will be able to:

1. Apply a continuous quality improvement approach and systems model thinking to lead innovative and sustainable patient/guest outcomes that promotes improved health and hospitality (H2H) services delivery.
2. Communicate in writing and verbally about the Affordable Care Act (ACA) and how it is transforming healthcare.
3. Describe how to apply the Systems Model approach to healthcare and be able to write about and diagram the key inputs, throughputs, outputs and feedback loop in The healthcare (and hospitality) system leading to a holistic patient/guest quality care and services experience.
4. Apply best practices and tangible methods in the H2H system from Disney, Cleveland Clinic and the Mayo Clinic to enhance the patient/guest service experience.
5. Describe health communication principles and insights for quality H2H Delivery.
6. Understand and apply the medical spa concept in healthcare – exploring the role of the Registered Dietitian (RD).
7. Describe research studies on Domestic Medical Tourism: A Neglected Dimension of Medical Tourism Research and a study evaluating the Performance of the Hotels in the Vicinity of the Selected World's prominent Hospitals.
8. Describe international H2H and medical tourism and wellness practices around the world (including China, Switzerland, Costa Rica and other global leaders in medical tourism and H2H practices).
9. Understand the future trends that will impact H2H and medical tourism and wellness and apply strategic management tools for leadership in this field.

Methods of Instruction

This course will use a blended learning format to promote the comprehension of key course concepts and demonstrate mastery of knowledge gained in the course. Sessions will feature weekly synchronous class meetings and some asynchronous instructional modules, assignments, and case study analyses.

Course Content

Module 1: Introduction to Hospitality Bridging Healthcare
What is the current state of the healthcare industry, and why bringing hospitality services into the medical and healthcare setting matters.

Introduce the concept of medical tourism and wellness and why patient/guest services is tied to performance outcomes and to reimbursements.

Leadership roles that future university graduates need to assume in the H2H settings in the management and service delivery to patient/guests.

Overview of what are the key components of a hospitality system? Including checking/check out, the front desk, the guest room, and the services including housekeeping, environmental, engineering, food service and how this relates tangentially to a healthcare environment.

How is Hospitality linked to Healthcare around the world? Some examples and international best practices.

A first look at how healthcare hospitality can be linked to a career in this field.

Module 2: Introduction to the Systems Model and how this Model is Applied to Healthcare and its bridge and link to Hospitality Management

The Systems Model and how it fits well into H2H as a leadership tool to understand the process of patient/guest services delivery is shown in Figure 2 and Figure 3 below.

Figure 2 the H2H © Systems Model

(F DeMicco ©)
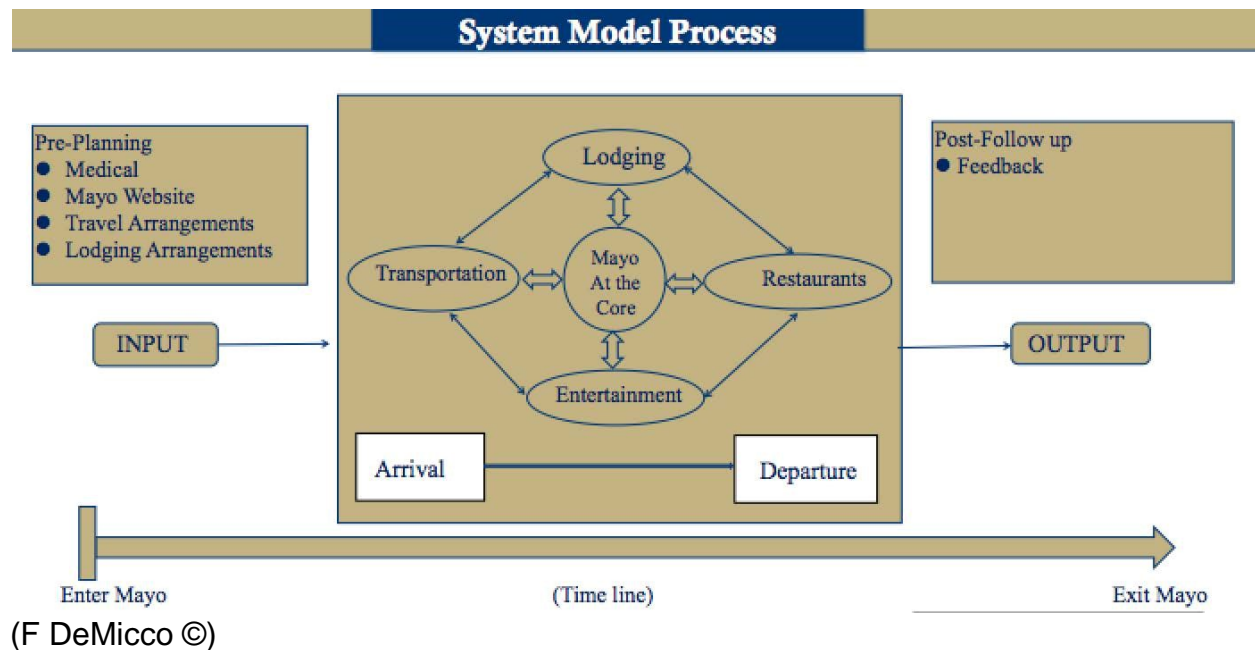
An introduction to the concept of medical tourism and wellness using the Destination Mayo Clinic/Destination Medical Community (DMC) - the billion dollar model and plan to revolutionize healthcare delivery integrating hospitality best practices in Minnesota. Below, Figure 4 also provides a glimpse via an artist's rendering of DMC of the future

.

Figure 3 A Systems Model for Medical Tourism & Wellness (H2H ©)
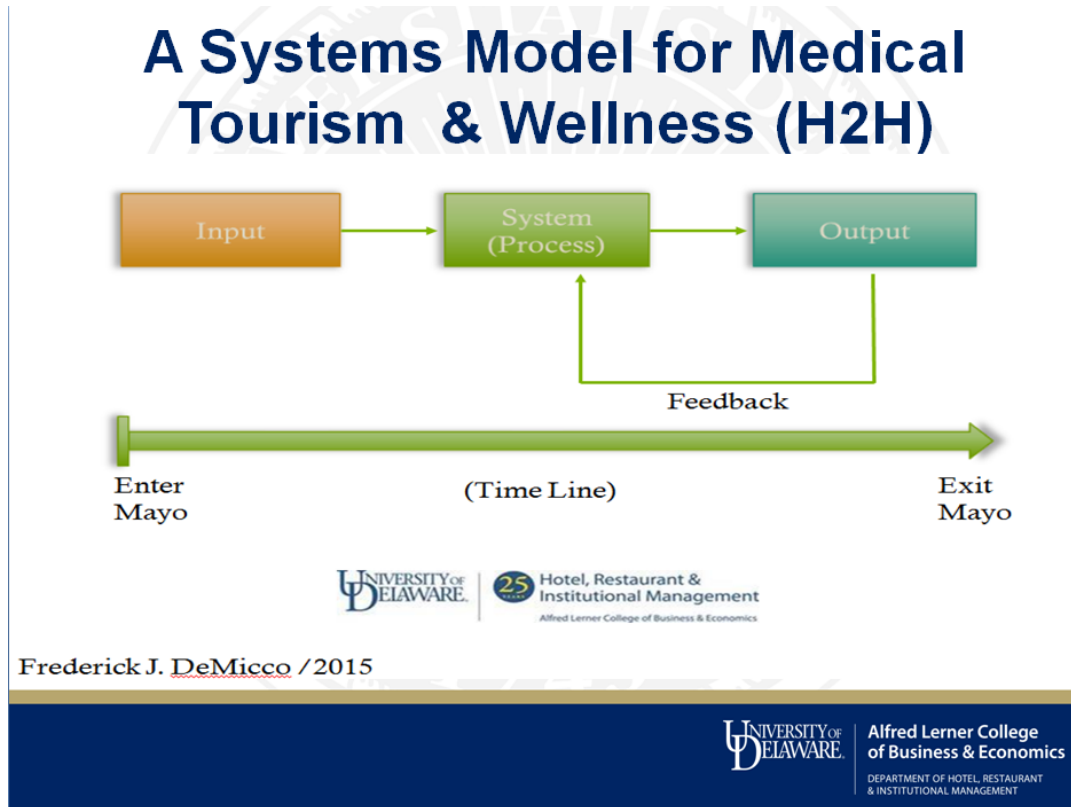
Figure 4 Destination Mayo Clinic: A Look towards the Future

The H2H © course objectives and the remaining modules with the course outline are presented below in the following slides.

COURSE OBJECTIVES

Upon completion of the course, the student will be able to:

1. Apply a <u>Continuous Quality Improvement</u> approach and systems model thinking to lead innovative and sustainable patient/guest outcomes that promotes improved health and hospitality (H2H) services delivery.

2. Communicate in writing and verbally about the <u>Affordable Care Act (ACA)</u> and how it is transforming healthcare.

3. Describe how to apply the <u>Systems Model</u> approach to healthcare and be able to write about and diagram the key <u>processes</u> - inputs, throughputs, outputs and feedback loop in the healthcare (and hospitality) system leading to a holistic patient/guest quality care and services experience.

4. Apply best practices and tangible methods in the H2H system from Disney, Cleveland Clinic and the Mayo Clinic to enhance the patient/guest service experience.

5. Describe health communication principles and insights for quality H2H Delivery.

6. Understand and apply the medical space concept in healthcare – exploring the role of the Registered Dietitian (RD).

7. Describe research studies on Domestic Medical Tourism: A Neglected Dimension of Medical Tourism Research and a study Evaluating the Performance of the Hotels in the Vicinity of the Selected World's prominent Hospitals.

8. Describe international H2H and medical tourism and wellness best practices around the world (including Korea, China, Switzerland, Costa Rica and other global leaders in medical tourism and H2H practices).

9. Understand the future trends that will impact H2H and medical tourism and wellness and apply strategic management tools for leadership in this field

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COURSE CONTENT

Module 1: Introduction to Hospitality Bridging Healthcare

- What is the current state of the healthcare industry, and why bringing hospitality services into the medical and healthcare setting matters.
- Introduce the concept of medical tourism and wellness and why patient/guest services is tied to performance outcomes and to reimbursements.
- Leadership roles that future university graduates need to assume in the H2H settings in the management and service delivery to patient/guests.

UNIVERSITY OF DELAWARE. | Alfred Lerner College of Business & Economics
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- Overview of what are the key components of a hospitality system? Including checking/check out, the front desk, the guest room, and the services including housekeeping, environmental, engineering, food service and how this relates tangentially to a healthcare environment.

- How is Hospitality linked to Healthcare around the world? Some examples and international best practices.

- A first look at how healthcare hospitality can be linked to a career in this field.

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- Module 2: Introduction to the Systems Model and how this Model is Applied to Healthcare and its bridge and link to Hospitality Management
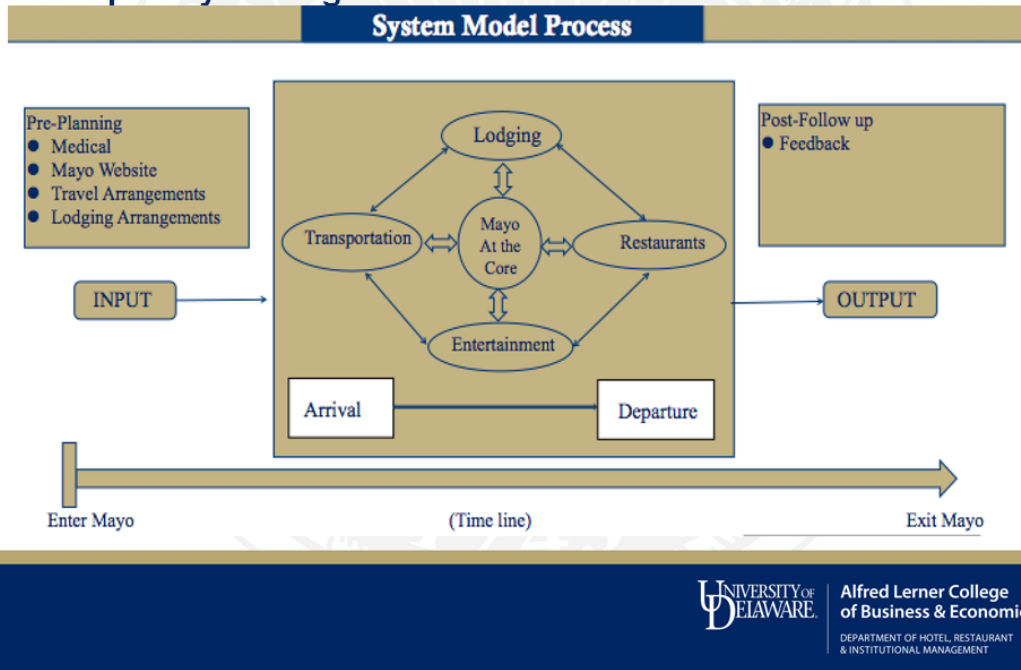
- **Module 3: The Affordable Care Act** (ACA) in Healthcare: How Hospitality Fits in as an Indispensable and vital service.
- Overview of the ACA: What is it, what it does and why is it relevant to H2H.
- How the ACA protects the patient/guest in a medical setting.
- Why hospitality services are integral to the ACA
- The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- HCAHPS Composite measures
- A realistic preview of the HCAHPS Survey and the Patient Experience. Student application and role playing in the H2H environment.

- **Module 4: Leadership in the H2H Setting: Best practices from other industries**
- A Disney approach to H 2 H and medical tourism and Wellness.

- If Disney Ran your Hospital. What tools will they bring to ramp up patient/guest services? Examples from Disney from Dr. DeMicco applying his Ductorate Degree skill set to healthcare and from Fred Lee (trainer and author).

- Why the frequently used 1 to 5 Likert rating scale is counterproductive to delivering excellence and what needs to be done to bring about patient/guest loyalty in an increasingly competitive healthcare marketplace.

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- How to anticipate patient/guest needs and say "Yes".

- How to write an Effective Service Script for "cast members" in the H2H settings.

- Students will develop a creative and practical service script for application in a real world H2H setting and perform this.

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- **Module 5: Bringing Hotel Hospitality Service Skills to Healthcare: The Guest Service GOLD 7 Step Training Program**
- Bringing Hotel Hospitality Service Skills to Healthcare: The Guest Service GOLD 7 Step Training Program
- The Power of the Patient/Guest story and how to make them feel welcome, comfortable and well communicated with.
- Intuition for serving patient/guests not just caring for them: What is the difference and why is it important?
- Patient/guest service Initiative, delivery, follow through and recovery.
- Student case study to design a The Guest Service GOLD 7 Step Training Plan for a real world environment.

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- **Module 6: Health Communication: Insights for Quality Hospitality Bridging Healthcare (H2H) Delivery**
- **Why a health communication skill set is important in the H2H environment.**
- **Individual Differences in Patients and how to use personalized communication tools.**
- **Cultural Differences toward health and healthcare communications (e.g. Islam, Hispanic, Asian, African Americans).**
- **The importance of understanding how online communication impacts different demographic and cultural patient/guests.**
- **Future research needs: A discussion and suggestions from the class.**

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- Module 7:   The Medical Spa in Healthcare-Exploring the Role of the Registered Dietitian and Nutrition
- Trends shaping the Medical Spa and the evolving world of healthcare delivery
- Medical Spa characteristics, services, considerations. Medical Spas, a new concept or not?
- How Medical Spas addresses a continuum of Health Goals.
- Medical Spas Services are delivered by Varied Health Professionals (a look at the medical doctor, RN's, personal trainers, RD's).

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- Module 8: Research Case Studies in H2H and Medical Tourism and Wellness
- Domestic Medical Tourism Opportunities: A Neglected Dimension of Medical Tourism Research
- Evaluating the Performance of the Hotels in the Vicinity of the Selected World's prominent Hospitals an Empirical Research Project
- Case Study: Club Med(ic): If This Is Wednesday, It Must Be My Hip Replacement - Future Trends
- Case Study: Research by Professors and Switzerland Partnership Lead to New Innovations in Medical Tourism and Wellness.
- Case Study: Best Experience Practices in Medical Tourism.
-

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- **Case Study: Best Experience Practices in Medical Tourism.**

- **Case Study: Medical Tourism Opportunity in China. Using the Strategic Model Analyses Tool.**

- **Case Study - Medical Tourism in Costa Rica: Recovery, Rainforests, and Restructuring: Opportunities for Hotels Bridging Healthcare (H2H).**

(Course outline developed and © by Frederick J. DeMicco, PhD, RD, Professor of Hospitality and Healthcare Management 2015)

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Conclusion

In healthcare, approximately 75 % of hospital/Healthcare services are hospitality related services (DeMicco, F.J. and Poorani, 2016; Cetron, DeMicco & Davies, 2010). This paper provided an overview for an introductory/foundation course as part of a new curriculum design for an innovative major in Hospitality Bridging Healthcare or H2H ©.

In the future, hospitality graduates, along with health management, nursing, dietetics graduates will have the opportunity to manage and lead the entire H2H © system on medical campuses. Their hospitality management skills, knowledge and experiences honed and learned, will serve them well upon university graduation to lead complex H2H © enterprises.

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CO-CREATING INTEGRATED HEALTH-HOSPITALITY HYBRIDS FOR ACROSS THE LIFESPAN

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ABSTRACT

Salutogenesis ensures that physical environments promote wellbeing across people's lifespan. Although this has influenced medical architecture, it has not yet penetrated into the domain of urban development. Despite the gradual decrease of medicalization of healthcare facilities, a conceptual gap remains between hospitality and healthcare facilities. This paper explores the possibilities of synergistic domains between healthcare and hospitality facilities. Using the architectural typology interpretation of a dementia village as a case study this paper explores how to create hybrids between healthcare and hospitality facilities that contribute to the silver economy while providing the ageing population with better built environments.

INTRODUCTION

In Europe, the 15-20 year difference between life expectancy and healthy life years led to setting up a target of adding two more healthy life years by 2020 (Lagiewka 2012). A key framework for achieving this has been the European Innovation Partnership on Active and Healthy Ageing known as EIP on AHA (EIP on AHA 2016). It aims to address barriers that might prevent this target from being reached (European Commission 2016). It promotes synergies, bringing together disciplines right from the conceptualization of a project. Part of its actions has been the 2016 Call for Commitments, a project aiming at bringing together stakeholders across industries, i.e, finance, built environment, healthcare provision, tourism etc, including the entire decision making spectrum, i.e., from end-users to governance, and across geographical regions. Due to its experimental, innovative and bottom up nature it displays a higher degree of flexibility and freedom compared to most European Actions.

In line with the synergetic spirit of EIP on AHA, this paper constitutes one of the collaborative, multidisciplinary activities generated by an approved

Commitment running from 26/09/2016 until 01/08/2019. The Commitment falls into the broader area of 'Innovation Age-Friendly Buildings Cities & Environments' and more specifically in the Action Group D4 and is called 'Inclusive Urban and Rural Communities (Inclusive Urban and Rural Communities 2016). The Commitment explores the interaction of health and wellbeing with the physical environment. One of its areas of focus is hospitality. More specifically, it brings together three main axes related to wellbeing and AHA and in particular the interface between health, tourism and the built environment. It is in agreement with the conclusions of our targeted review on multidisciplinary and user-inclusive approaches to inform architectural research and education, at least at post-graduate level, on the need for environments that are inclusive for people across the lifespan (Chrysikou et al 2016). This is in agreement with an increasing discussion on the limits of universal design to accommodate the needs of several vulnerable groups and especially the least represented, as research on fall prevention and AHA indicates (Herman 2016, Gutman 2016). It also complements the work on hotel industry opportunities to cater for the needs of people at early stages of Dementia and their partners, which has been conducted by our commitment partners (Blanas et al 2016). This paper builds on the above actions and evidence based research, uses as Case Study the first and most internationally acknowledged village-type accommodation for dementia, De Hogeweyk (CNN 2013, BBC News 2012, The Guardian 2012).

From the architectural perspective, there are several parallel, mainly overlapping theoretical approaches that focus on the research and implementation of evidence based Eco-psychosocial interventions aiming to support the mechanisms that generate health or help combat disease. These are known as medical or therapeutic architecture, generative space or salutogenic design, a term that initially derived from the theory of Salutogenesis originated the field of Medical Sociology (Antonovsky 1979, Antonovsky 1987). This term refers to the possible impact of environmental interventions to increase wellbeing and sense of social coherence. These models do not claim to substitute medical intervention or treatment. On the contrary, their aim is to support staff, carers and patients by decreasing the amount of effort needed to overcome stressful situations as well as by providing complimentary support. This ecopsychosocial support is more important in conditions that Christensen (2009) describes as having low diagnostic and interventional accuracy such as the umbrella of mental health, including Alzheimer's (Zeisel 2010). In the case of Dementia, Zeisel proposed the manipulation of the physical environment through elements of positive and negative distraction as a way to promote cognition. The importance of the physical environment, its spatial configuration and quality of construction in the

context of the urban scale, is well document by Marmot (The Marmot Review 2010, Marmot 2015).

SALUTOGENESIS AND HEALTHCARE ARCHITECTURE

Employing design for health benefits is an established practice in healthcare architecture since the 80's (Verderber 1986, Zeisel et al 2003, Shepley 2009). Key findings, especially on the use of daylight (Joarder et al 2003) views and nature (Ulrich et al 1991, Alvarsson et al 2010, Verderber 1986) effects of art (Upali 2012), may prove useful in other forms of the built environment such as hospitality, malls, social housing among other. However, we do not support overgeneralisations from one area to another, as research on the transfer of normalization from autism to acute mental health has indicated that such loans should be subject to critical review and further research before any application (Chrysikou 2014). Yet, a growing body of knowledge on design for vulnerable populations, on perception and neuroscience, combined to the increased tendency for people to receive care in the community and closer to home indicates that the impact of the field could be much larger than just hospital design.

Similarly, work conducted on other forms of the built environment such as the work of space syntax on social housing (Hanson 2001, Hillier and Hanson 1998) could shed more light on the way we design for healthcare. Finally, all of these work streams could find in the area of hospitality a new place for implementation and research.

Until recently there has been limited exchange of information between these sectors of nonresidential architecture, yet for reasons that are beyond the scope of this publication, this appears to change. This is the case of healthcare architecture, especially in the UK, that after the functionalistic, capital-expenditure friendly Nucleus hospital typology (Francis et al 1999), was influenced by the salutogenic theory, patient friendly perspective of the Plane Tree hospital and consumer oriented approaches of the US private healthcare sector and started introducing "hotel-like" aesthetics and design solutions, such as the single en-suite patient bedroom or the use of carpet and art, even in public hospital design or, alternatively, residential references driven by the homelike approach of normalization theory for developmental disabilities. Yet, we hardly ever noticed hotel architecture claiming to be physically restorative, hospital-like or clinical.

Despite this relative, cross-disciplinary rigidity in aesthetics, morphology and typology and taking into account the current demographic change, we strongly support that these areas of architectural research and

practice, instead of progressing in parallel, could be enriched if allowed evidence base, and in our case salutogenic principles, to penetrate through their design and even create hybrids and innovative building concepts. Places for AHA as well as places for neurodiversity could benefit from more fluidity as the collaborative and entrepreneurial approach of EIP on AHA is advocating. This trend is still at early stages, yet we already see research by design products at concept level such as the dementia friendly supermarket till (Lab4 Living 2015) or materialized innovation, such as the case of De Hogeweyk.

THE HOGEWEY DEMENTIA VILLAGE (OR DE HOGEWEYK)

The Hogewey Dementia Village derived from the replacement of a care home and was aimed to introduce a non-institutional, patient-friendly approach to the concept of care home. As the name demonstrates, it was conceptualized as a village, generating a brand name for dementia accommodation that has been since transferred to other parts in the world, including the UK and Italy. According to one of the founders it aimed to recreate a neighbourhood (CNN 2013). In fact, salutogenesis was the key principle of this first dementia village, as one the founders considered a normative, institutional care home as a place that her "father luckily would never need", and from this stemmed their motivation to demolish the existing care home and replace it by a village. Under that influence, they introduced normalization theory principles aiming to improve patients' quality of life in a homelike environment.

After a detailed study of the architectural plans and visits that resulted in a qualitative architectural auditing, triangulating between two architectural methodologies: a) salutogenics to detect therapeutic elements and b) spatial analysis to detect spatial hierarchies and host vs inhabitant relations. These involved the public and semi-public areas of the village. The village develops inwards of a continuous-fencelike-building, which doubles as clear boundary between the village and the outskirts of actual village of Weesp (figure 1), where Hogewey sits geographically and a means providing balance between privacy and anti-ligature. This is in agreement between the initial objectives of De Hogeweyk: a non-institutional, i.e., providing qualities such as privacy, interpretation of a care home, i.e, providing safety and security. Also, under the umbrella of salutogenesis, the concept used spatial elements as therapeutic means, such as the village concept from the normalization stream of the salutogenic umbrella, as opposed to a clinical model. In this village they incorporated thematic aesthetics and employed perception clues through art, which is not an element of normalization, yet derives from the salutogenic negative/positive distraction design principles developed by Zeisel (2010).

Architectural morphology-wise Hogewey chrematistics include the following:

- accessibility through a single entry point as opposed to a multiple network of possible entry and exit points that is even the case in medieval castle-type villages, which tend to have a more controlled entry point network compared to most urban structures.
- lacks the organic growth and flexibility of a village, as villages (as opposed to urban developments) are normally built piece by piece over the years according to individual needs, family growth etc.
- places the inhabitant as the guest rather than the host, despite the fact that (s)he remains a resident of the village for the rest of the lifespan.
- is organized according to seven distinct aesthetic themes, which have been preselected by the planning team rather than a more flexible, user-led approach.
- follows a core and cluster model of a centralized multi-functional, public core with satellite accommodation clusters that is a not-uncommon form of nonresidential architecture typologies.
- the house residents do not share family bonds but follow the norms of strangers house-sharing, similar to student accommodation.

Figure 1: A general bird's-eye view of Hogewey

These traits and in particular the controlled access, the power of the host, who does not stay 24/h even if the facility is staffed around the clock, over the inhabitant, who does, the predetermined form and capacity, and the thematic classification of the accommodation provision, indicate a pre-programmed, rather structured typology. This structure is softened by ecopsychosocial features to increase the inhabitants' control and sense of control. For instance, De Hogeweyk demonstrates extensive use of art and visual clues to ease self-orientation (figure 2), inclusion of elements of normality such as a high street with commercial and social functions, the use of normal –as

opposed to uniforms- clothing from staff, without compromising the safety or the clinical outcome. Via architectural traits such as the visual permeability of public spaces and lack of physical barriers of movement, it cultivates the enabling of free access. This is achieved mainly through the extensive use of glazing and the extensive use of automatic doors in both horizontal and vertical communications.

Figure 2: Visual clue for better self-orientation of the users
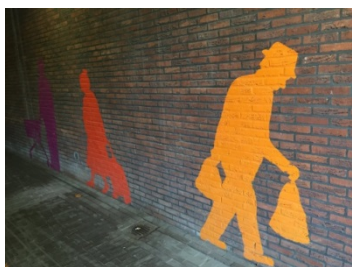
The core and cluster typology bears references to a common typology of current hospital campuses (MARU 1996), yet medical architecture is not the only area that the core and cluster model has been applied. The emphasis on the areas that are accessible to residents vs support and staff areas, including offices, differs from most healthcare typologies, where medical or staff offices and support areas play key role for spatial hierarchies. The staff-only accessible areas in this case are visually obscured, even though they are located close to the entrance and lack direct connectivity to patient areas. This transfers the message, in an ecopsychosocial manner, that staff is there to support but patients come first. This diversification from the medical model and in combination to the use of visual clues, either through the theme houses or the almost theatrical set of the "high street", bears similarities to a more hedonic type of accommodation, i.e, the holiday resort. The core and cluster model, of a central communal core and satellite accommodation clusters is a typology that fits that model too.

Indeed, Hogewey employed salutogenics but not as much normalization as the term village implies. The typology, as our auditing shows is nonresidential, contradicting the village and the normalization concepts. Still, it does not contradict the salutogenic element. So, we observe already a hybrid of hospitality typology and residential function and we propose to extend the argument and combine the hospitality typology with the dementia patient group, the salutogenic concept and the hospitality function and create something new --as the existing hospitality for dementia comprises normative, asylum-like "accessible" hotels with some training to staff but ignore the therapeutic aspects of space.

CONCLUSIONS

We revisited the spatial planning of a dementia village in an effort to understand if the innovative so-called village typology was indeed a new multidisciplinary approach of designing for dementia, a village-type hybrid

offering a new approach to the design for AHA in general, including facilities for tourism. Yet, the model was in fact closer to typologies already established in the hospitality industry and more specifically the resort typology. It is important to clarify that this discussion referred to the typology in terms of spatial planning and not to the actual function, which remained a care home. Yet, this innovative spatial planning paved the ground for the revisiting of care settings and the use of space to soften institutional structures through spatial planning and design. A more elaborate analysis, using space syntax could indicate if this resort-like typology ran deeper in the social structure of that particular care home.

From this realization we came up with two research ideas that we plan to explore as part of our Commitment actions. The first refers to the initial hypothesis of the village. What if there were a village to cater for the short or longer term needs of people with dementia, or at least at some stages of it? One incorporating the socio-friendliness of organically developed town centres, with walking-distance facilities such as the corner-shop and social meeting points, such as the café in the central square, could be created in an existing almost deserted village. This concept is worth exploring and potentially experimenting at rural areas of Europe. The second refers to taking this protected, neurodiversity informed, resort type of accommodation and adapting it for hospitality accommodation for people with dementia. It practically means building on the existing idea of hotels for dementia but in a manner that incorporates space to the concept, together with employing specially trained staff and universal accessibility devices that the existing literature and practice suggests.

Finally, regarding healthcare and hospitality, more synergies could promote the wellbeing and the physical and mental restoration of people. Having an example of a care home resembling a resort, we reverse the question: How a dementia friendly resort would look like? In line to our Commitment we are designing our next steps to combine medical architecture, tourism and gerontology to create new short or longer term staying models, utilizing the silver economy to build safe environments where people interact and live to the fullest possible that their condition would allow. The built environment could assist in an integrating way.

ACKNOWLEDGMENTS

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CRITICAL SUCCESS FACTORS FOR PLANNING AND DESIGNING A WELLNESS RESORT

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ABSTRACT

A wellness resort guest has high expectations but not necessarily in the same way as a regular 5-star resort guest would have. Their focus is on the quality of programming and the overall cohesiveness of the on-property experience as opposed to excellent accommodation and fine dining. Wellness destinations that meet their needs and indeed deliver this immersive and authentic experience will be rewarded with guests who visit more, stay longer, and spend more money per day. Some considerations, which may at first appear distorted from a planning perspective and alien to traditional developers, are critical for successful wellness resort development. These factors will be discussed in this article.

INTRODUCTION

According to the Global Wellness Institute (2016), the global wellness economy is growing rapidly. This report noted that within the last two years, the global wellness industry has increased by approximately 10.6%, reaching a value of $3.72 trillion in 2015, while within the same period, the world economy dipped by roughly 3.6%. The wellness industry now represents 5% of the total global economy and nearly half of total global health expenditure.

Within the global wellness industry, some of the fastest growing markets from 2013 to 2015 were: preventive or personalised medicine and public health at 23.5%, fitness and mind-body at 21.4%, wellness lifestyle real estate at 18.6%, wellness tourism at 14% and healthy eating, nutrition and weight loss at 12.8% (Global Wellness Institute 2016).

Global wellness growth is driven by a variety of factors, including the ever-increasing middle class which possesses disposable income, of which a significant amount is spent on lifestyle. Also, the ageing population trend continues to be strong, and chronic diseases are on the rise in a majority of countries around the globe. Consumers are becoming

more educated on health and well-being, which results in a growing demand for experience "rooted in meaning, purpose, authenticity and nature" (Global Wellness Institute 2016).

WHAT IS A WELLNESS RESORT

A wellness resort is a facility with the primary purpose of guiding individual spa-goers to develop healthy habits. Historically a seven-day stay consisting of a comprehensive programme which may include spa services, physical fitness activities, wellness education, healthful cuisine and special interest programming with the goal of stimulating lifestyle transformation. (ISPA 2015).

Wellness resorts are often compared to traditional resorts, as they both offer a core of similar facilities and service platform, such as well-appointed and comfortable guest rooms, food and beverage outlets, spa and wellness facilities and conference and business centre. However, wellness resorts and traditional resorts are not the same and can be differentiated through the following main features:

- While hotels sell rooms, wellness resorts sell wellness programmes.
- Food and beverage is usually included in the programmes being offered.
- Wellness resorts discourage or disallow short stays below three nights as this makes it hard for the benefits of programmes to be measured.
- The underpinning of the resorts' programmes is a focus on a particular wellness tradition or the combination of various wellness traditions including but not limited to TCM, Ayurveda, Naturopathy, Emotional Healing and Healthy Cuisine offerings.
- Wellness resorts often exhibit a high level of environmental consciousness, which is demonstrated through sustainable development and operating practices.
- Wellness resorts promote social connection of guests through an intense offering of physical and educational programming.

KEY SUCCESS DESIGN FACTORS

Overall cohesiveness of the on-property experience

The overall cohesiveness of the on-property experience is reflected through the seamless integration of its facilities and service platform, but also through the natural flow of the resort and its alignment with the flow of energy. The entire property must be designed concerning this flow,

which also reflects the movement of the guests throughout their whole wellness journey.

For example, imagine a guest making their way to a morning meditation session. The physical path that guest takes needs to be a subconscious lead in to the session, by offering them peace, quiet, and a physical journey which aligns with the arrival of morning.
Eg: orientation to the sunrise, etc.

Moreover, every design principle and detail within the wellness resort should be a part of the guests' overall experience. Depending on the resorts location this maybe achieved by stunning views, beautiful foliage, or perhaps a design that reflects the principles of Feng Shui or similar.

The use of water within traditional resorts can be aesthetically pleasing or a space filler. However, well placed water features or paths of running water within a wellness resort may be placed or orientated to offer a more spiritual representation and physical soothing properties for guests.

Non-contact spaces

In a traditional resort, areas are designed to optimise guests spending decisions, whether it is in the restaurant, spa, bar, boutique, activities and excursions. The objective of a developer is to design spaces in a way to maximise the profits that hotel guests bring in.

In wellness resorts, designers must create spaces that will enhance the overall experience of the guest instead of focusing on instant spending. Non-contact areas must be included in the design of the resort. They are public spaces where guests are not confronted with decision-making processes. They can just sit and relax, meditate and maybe read a book. In a traditional resort, such spaces do not exist or are very limited, as their perceived value is low. The spaces allow guests to reconnect with themselves and to contemplate and plan their next visit.

Facilities must match projected programming

Guests will spend 90% to 100% of their time within the confines of the property; therefore, the product must support this intensified usage. This implies that the facilities must match projected programming and capture rate of guests. For example, a wellness resort will offer more treatment rooms in its spa and wellness centre as compared to a traditional hotel with an equal amount of guest rooms (treatment capture rates in wellness resorts will exceed 90% comparable to a city hotel at 5 to 8% and a traditional leisure resort at 10 to 15%). Other examples would include

larger fitness studios and spaces for fitness activities, more equipment in the gym. It is not unusual for the wellness reception to far exceed the size of the main wellness resort arrival space, this is simply because guests will spend most of their time in this area.

Authentic usage of local culture

There is a growing need for people to experience a stronger connection to nature, communities, other individuals and things that reflect authenticity. As a continuation of the thoughtful design required to create the wellness experience it is important that this authenticity is an integral part of the process.
The choice of materials, equipment and treatments, will allow guests to judge the sincerity and mission of the resort in its goal to provide a true culturally appropriate wellness experience.
In addition the resorts' use of sustainable resources and practices reflects heavily on the message being conveyed to guests. A wellness resort has to be as sustainable as possible, and this can be achieved through its eco-friendly design, green operations and respect for local culture and heritage.

Differences in financial performance

There is a difference in the financial results and operating platforms of wellness resorts and traditional hotels.
First, the offering; in wellness resorts, guests book treatment programmes and not rooms; and in most cases, the resort is an all-inclusive type. Since visitors buy extensive packages and stay over longer periods, the average expenditure per day and guest is often much higher than in a traditional resort.

Secondly, repeat guest comparison; wellness retreats focus on overall holistic guest experiences as opposed to instant spending patterns seen in traditional hotel settings. The percentage of repeat guests in established wellness resorts is significantly higher than those seen in regular hotels. However, the initial investment to achieve this may be higher which will require a longer period to achieve return on investment.

Thirdly, seasonality; wellness resorts need not be impacted by seasonality like traditional resorts are. Guests visit because of the wellness programs that the resort is offering, the weather and other traditional factors which affect a leisure holiday play a secondary role. This of course is subject to the destination or country itself not being affected by seasonal reductions in connectivity.

CONCLUSION

Concluding, it can be seen that the global wellness economy has experienced strong growth over the past few years, and is expected to continue increasing rapidly. This has given rise to wellness resorts, which are built exclusively for guests seeking to develop healthy habits and extend their wellness routine into their daily lives. However the current offering of wellness resorts is limited to standalone properties around the world and therefore there is an opportunity to bring additional properties to market.

Our findings indicate the following four key success factors in planning and designing wellness resorts.

Firstly, the resort must provide an immersive experience for guests, which is enabled through a seamless integration of facilities and service platform, as well as a specialist design that leaves room for non-contact spaces.

Secondly, all facilities need to be created to match the programming and capture rate of guests, which is significantly higher than in traditional resorts. Successful wellness resorts understand how to make guests stay longer, have a higher average daily spend and return more often.

Thirdly, wellness resorts need to be designed to create a connection to nature, and respond to the guests' increasing desire for authenticity and 'real' local culture, which can be expressed through eco-friendly and sustainable design.

Finally, it is clear that wellness resorts differ from traditional resorts in their financial performance, which is due to their offering, higher initial investment will lead to higher repeat guests, higher average spend and seasonality proof product.

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RESTORATIVE AND EMOTIONAL EXPERIENCE IN TOURISM ENVIRONMENT

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ABSTRACT

The purpose of the current work is to introduce to industry the contribution of a human-environment interaction (HER) approach in the design of tourism environments to improve the customer experience.
The physical layout of lobbies in resorts and hotels has a remarkable impact on the customer, either from both a psychological and a behavioural level. The current research is conducted with the purpose to investigate how to improve restorative and emotional experiences through the physical environment of lobby in a tourist resort. Specifically, manipulating height and presence of nature in a lobby for getting a restorative benefits –reducing stress and recovery from directed attention fatigue- and an emotional impact for predicting making decision and behaviours from clients.

INTRODUCTION

The physical layout of lobbies in resorts and hotels has a remarkable impact on the customer, from both a psychological and a behavioural level. *What is the ambience of a certain lobby? How do I I feel like in this place?* And *What kind of behaviour does this place afford?* Are questions, which can find a response, considering the fit between the person (i.e., goals and needs) and the environment (e.g., structural complexity, illumination, presence of natural elements). This research studies interactions and responses in people by perceiving physical attributes in a tourism environment, in order to improve and get a memorable experience.

According research aims, the study used two methods to get data from regenerative and emotional responses. A Self-report based on preferences, emotional and regenerative items were designed in order to get regenerative state of people. A second method was also applied to identify emotions across time by analyzing their facial expressions, while they are watching a stimulus.

Nature and Built Environment

A physical environment has the potential to affect on human well-being and eventually health, and the impact of nature on well-being is well known (Hartig, Mitchell, de Vries, & Frumkin, 2014), in terms of psychological benefits, such as stress reduction, attention restoration and positive emotions (Kaplan & Kaplan 1989; Staats, & Hartig, 2004). In addition, human beings are evolutionary predisposed to react positively to nature -*biophilia hypothesis*-. Following few studies conducted in tourism environments, especially in indoor touristic environments, this research studies the impact of nature on well-being in leisure environments. The results obtained may be crucial to investigate types of psychological processes that they can impact, or not to clients during their stays in hotels and resorts.

Also, features of built environments, which may be looked for in a leisure experience, are considered. Height of the ceilings in an indoor environment may be a valuable physical characteristic of the touristic environment. Practitioners in tourism field consider height as an important attribute of the resort environment, specially, in a lobby space (Rutes, Penner, Adams 2001). However, we do not find scientific studies have to discover its impact on human functioning and preferences. For this reason, the second independent variable of study is height in lobbies of hotels, and its regenerative and emotional benefits on people.

Regenerative environments

It is a psychological process involved in subjective well-being, and according Hartig (2005) "a restorative environment is one which can help to restore depleted emotional and functional resources and capabilities. The assumption that recovery from stress takes place in the absence of stressors is a simplification of the recovery process. Some environments may facilitate restoration more completely than other".

Even this research is based on cognitive process of regenerative process; restorative studies are commonly conducted according two frameworks of study:
• Visual Perception. Diminished psycho-physiological stress in relation to restoration in the natural Environment. (Ulrich 1983)
• Cognitive framework. Recovery process from directed attention fatigue. This framework developed the "Attention Restoration Theory (ART)", and it is based on four forms of restoration, such as, "being away"; "fascination"; "compatibility"; and "coherence" (Kaplan & Kaplan 1989).

One of the main motivations for tourist traveling in a resort is for getting a recovery state from their routines stress, and in addition the lack of regenerative studies that put in relation the touristic environment and guests were the causes to conduct the current study. The few tourism studies on regenerative understanding have been focused on employees stress state (Law, Piearce, Woods 1995).

After reviewing literature in regenerative environment we found out that there is also a lack in indoor environment and in tourism studies have not been studied deeply "yet, researchers and practitioners interested in psychological benefits of nature experiences outdoors have paid relatively little attention to indoor plants" (Bringslimark, Hartig, Patil 2009).

Emotional responses

It is a Psychological process involved in subjective well-being. Authors According several authors emotions is an "affective mental short term states that arose in response to an, external or internal, antecedent stimulus event as relevant to major concerns of the organism, and that change over time" (Ekman 1994; Frijda 1986; Scherer 2005).
Sherer (2005) explained emotions as multi-component process (physiological changes, subjective feelings, appraisal processes, communicative components and motivational component) able to change over time. According this framework, all environments are constantly revaluated over time and one of the lacks in emotional studies is just how to understand this process of interaction with environments. This study is focused on the importance of exploring the emotional responses (e.g., positive or negative) elicited by a tourism environment during the ongoing interaction, in order to link emotional responses with decision making and future behaviors of clients in hotels.

RESEARCH STUDY

In the present study researchers proposed that human emotional responses and a psychological restoration may vary between exposure to nature and height in indoor environment. The study strives to uncover the impact on clients while they are perceiving nature and height of ceiling in the lobby of hotel in shaping the customer experience. A high level of presence and low presence represented the nature as independent variable. High and low ceiling were the two levels of study as second independent variable. Either nature or height were to analyze to figure out their restorative benefits, in terms of reduction of stress; and emotional impact, in terms of positive or negative emotional responses.

Based on the premises above, researchers list below part of the hypothesis proposed in HHDS2016, according the two frameworks of study:

- To investigate the impact of nature and height in touristic indoor environments on human emotional responses.

  (H1). High presence of natural elements and higher ceilings elicits more pleasant affective response than settings with low presence of nature and lower ceilings in tourist indoor environments.

  (H2). High presence of natural elements and higher ceilings elicits more approach intentions compared to settings with low presence of nature and lower ceilings in tourist indoor environments.

- To investigate the benefits of experiencing nature and height in touristic indoor environments on perceived restoration.

  (H3). Settings with more natural elements and higher ceilings elicit more psychological benefits, in terms of perceived restoration, than settings with fewer natural elements and lower ceilings in touristic indoor environment.

  (H4). Settings with different degree of natural elements and height elicit distinct psychological benefits, in terms of types of restoration.

Stimuli

The study was an experiment with a 2 (nature) x 2 (height) within subjects design. Researchers selected ten micro-environments placed in two lobbies of resorts in Cuba (Varadero) and recorded a video of 1 minute of duration for each. All environmental variables were evaluated by two researchers, such as, complexity, crowding, presence of nature, height and natural lighting. The result was four environments which got concordance (cohen's Kappa, $\kappa < 0.7$) of levels between the physical attributes of nature and height.

See below the environments features (see Figure 1):

Environment 1 (canteen area). Low nature and low height

Environment 2 (bar area). High nature and high height

Environment 3 (hall area). High nature and low height

Environment 4 (lift area). Low nature and high height

Figure 1: Tourist indoor environments selected

Source: Authors

METHOD

The study designed a self-report based on restoration and affective items and used automatic facial expression recognition, in order to get data of types of emotion, emotional valence and arousal level.

Self-report

Based on restorative and emotional responses, the self-report developed 24 items, which 6 items are focused on perceived pleasantness (Mehrabian and Russell, 1975) with 9-points scale (from -4 to +4). 1 item of behavioural preferences and 1 more item of affective preferences were design with 7-points scale (White, Smith, Humphryes, Pahl, Snelling, Depledge 2010). The four forms of restoration represented 16 items with a 7-points scale. The items were split in 2 items to being away, 5 items to fascination, 4 items to coherence, and 5 items to compatibility (Hartig, Korpela, Evans and Garling 1997).

Facial expression software

A software able to identify types and intensities of emotions over time was used in the experiment, in order to understand the emotional process of first perception in the tourism environments selected. The software analyses facial expressions recorded while the participant watched the stimuli. The outcome data are represented by six value of each emotion

by second recorded of stimulus. The software gave us the possibility also to study micro-behaviours of participants, in order to make correlations between type of emotion and what they are looking at, second by second.

The software operates based on an automatic 3D facial expression recognition system, in order to identify the six basic emotions found by Ekman: Happiness, Sadness, Surprise, Anger, Disgust and Scared, plus a new added emotion, Contempt. Ekman and Friesen (1971) considered these emotions to be universal emotions.

Furthermore, based on Russell's Circumflex Model of Affect (1980), the software provides information about whether the participant feels pleasant or unpleasant and is active or inactive. This information is known as valence and arousal. Valence indicates whether the emotional state of the subject is positive or negative. Also, a heatmap over the Circumflex Model visualizes which of the emotions were present most often during the test. Arousal on the other hand indicates whether the participant is active (+1) or not active (0). Arousal is based on the activation of 20 Action Units of the Facial Action Coding System (FACS).

Figure 2: Software of automatic facial expression recognition and emotions
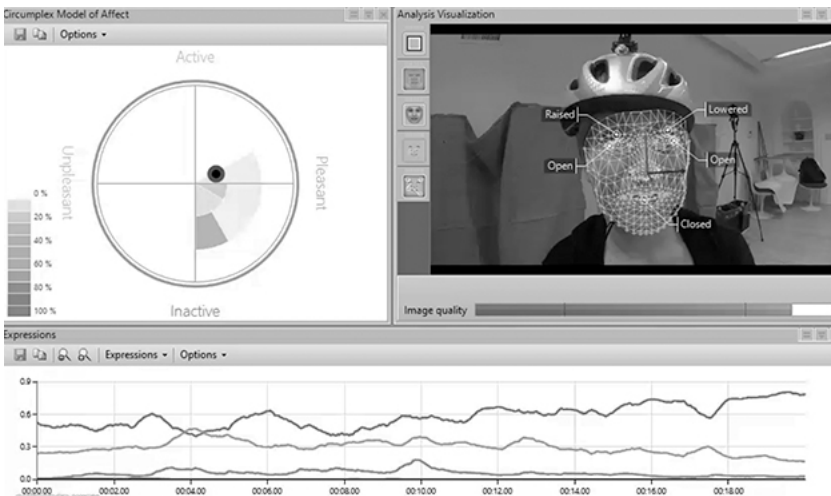
Source: Authors

Participants

Thirty-eight participants were recruited from Psychology Experiment Sign-Up System. All of them are college students split between males (n=6) and females (n=32) and the average age is in the range of 19 to 25 years old. They received $15 in exchange for participation.

Setting and procedure

The experiment was conducted in a soundproof laboratory located at a large Northeastern university in the United States. Participants were asked to read and sign the consent form if they agreed to participate in the study, then to sit in front of the TV and wear a helmet with a go-pro facing their face with proper lighting. The video with the stimuli was installed in the computer controlled by the researchers. Each participant was advised to be relaxed and act naturally while they were watching the four video stimuli, but also avoid speaking and looking to other side. The experiment started when the participant say "ready", then the researcher run the video and press "record" of go-pro. All participants should fill out the self-report after watching each stimulus. The participants take 5 minutes of resting between stimuli. The stimuli presented were randomized across participants. Each participant spent approximately 30 minutes.

RESULTS

The results follow the two frameworks of study, such as, restorative benefits and emotional impact according the fourfold hypothesis developed previously.

- Impact of nature and height in touristic indoor environments on human emotional responses.

(H1). Settings with higher natural elements are assessed by participants as significantly more pleasant compared to settings with less vegetation (t[37] =-5.700; p <.001). No significant differences resulted in the pleasantness evaluation between setting with high ceilings and those with low ceilings.

A repeated-measures ANOVA was applied to test the existence of significant differences in the evaluation of pleasantness between the four micro-environmental conditions. (F [3] = 13.744; p <.001; η2 = .271). Hall is the environment where participants felt significantly more pleasant compared to other conditions.

According the results of H1, people feel more pleasant in environment with presence of nature than environments represented by height of ceiling. In addition, environments represented between high or low presence of nature, people feel more pleasant in environments with high level of nature.

(H2). Settings with higher natural elements are assessed by participants as significantly more preferred compared to settings with less vegetation

(t[37] =-7.054; p <.001). No significant differences resulted in the preference evaluation between setting with high ceilings and those with low ceilings.

A repeated-measures ANOVA was applied to test the existence of significant differences in the evaluation of preference between the 4 environmental conditions (F [3] = 15.849; p <.001; η2 = .312). Hall is the environment where participants preferred significantly more engagement to stay compared to other conditions.

According the results of H2, people prefer to stay in environment with presence of nature than environments represented by height of ceiling. In addition, environments characterized between high or low presence of nature, people have more engagement to stay in environments with high level of nature.

- Benefits of experiencing nature and height in touristic indoor environments on perceived restoration

(H3). Participants reported that they would feel significantly more regenerated in settings with more natural elements compared to settings with less vegetation (t[37] =-6.059; p <.001). No significant differences resulted in perceived restoration between setting with high ceilings and those with low ceilings.

A repeated-measures ANOVA was applied to test the existence of significant differences in the perception of restoration between the 4 environmental conditions. (F [3] = 17.851; p <.001; η2 = .325). Hall is the environment where participants felt significantly more restoration compared to other conditions, except that for bar. Conversely, canteen is the worst condition compared to the others, in terms of resources for perceiving restoration.

According the results of H3, people feel more perception of restoration in environment with presence of nature than environments represented by height of ceiling. In environments represented between high or low presence of nature, people get more restorative benefits with high level of nature.

(H4). Differences between the type of restorative processes related to the experience of indoor tourism environment were considered. Results show a significant difference between the four restorative processes (F [1] = 24.956; p <.001; η2 = .416), whereas coherence was the most significantly associated to the environments taken into consideration and compatibility was the less related to the indoor touristic environments.

LIMITATIONS

The study has found two types of limitations (stimuli and facial expression software) that should be solved for future experiments.

Stimuli

All scenes from the use of real environments have been used in the present study. Thus, some problems with internal validity have been addressed by keeping constant all the factors that may constitute potential confounders in the experiment. Researchers suggest in future developments of the present study may consist in using simulated environments (e.g., using virtual reality), in order to provide a compromise between maintaining internal validity and ensuring ecological validity.

Facial expression software

The tool requires a suitable training to guarantee an accurate use and data interpretation.
Some problems in automatic coding of facial expressions (confusion between similar emotions) may happen. In this study emotions of "sad" is confused with concentration of participants.
Researchers suggest a multi-methodological assessment of emotions (e.g., testing the convergence between observational and self-reported data).

CONCLUSIONS

The role played by nature on processes involved in human well-being is confirmed. Results shed light on the impact of physical environment on restoration processes as well as emotional responses to touristic indoor public spaces.
When intercating with height (low ceilings), lack of greenery elements elicits the most negative affective responses and provides the less psychological benefits, in terms of perceived restoration.
Analysis of spontaneous facial expressions demonstrates to be a valid tool for addressing relevant questions concerning research in tourism, as it opens to new lines of research on touristic environment and users' behavior.

ACKNOWLEDGMENTS

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HOSPITALITY AS A PIVOTAL ASPECT OF THE WELLBEING ECONOMY

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ABSTRACT

This paper examines the role of hospitality in the contemporary, globalized world. It is argued that commercial hospitality will be central in the upcoming transformation or well-being economy characterized by meaning and reciprocity. Hospitality, as attitude and not only in the sense of behavior, will be pivotal for organizations to survive in the near future. Drawing on the literature in a variety of disciplines this paper explores how the multiple roles of hospitality may contribute to the transition to the wellbeing economy. This paper attempts to reveal several themes for further research and posits that hospitality goes beyond the hospitality industry, more particular it introduces hospitality in the healthcare industry.

INTRODUCTION

Traditionally it has been acknowledged that services especially hospitality services distinguish themselves from products and other services. Characteristics of these services are, amongst others, the core value produced in the buyer-seller interaction, the intangibility, the inseparability of production and consumption, the heterogeneity, the consistency or difficulty to achieve and maintain consistency of services (Reisinger, 2001). As a consequence a close correlation accrues between service quality and customer satisfaction and has been subject of ample study among social scientists (Fick & Ritchie, 1991; Grönroos, 2000; Gutek, 1995; Jr. & Taylor, 1992; Kumar, Smart, Maddern, & Maull; Normann, 2000; Parasuraman, Zeithaml, & Berry, 1985; Rahman, Khan, & Haque, 2012; Reisinger, 2001; White, 1998; Yilmaz, 2010).

The emergence of the experience economy (Nijs & Peters, 2002; Piët, 2003; Pine & Gilmore, 1999) evokes the interest in the customer/guest journey of hospitality services. The actual consumption as well as the rest of the process i.e. pre- and post-consumption, in short the whole process, subsequently becomes part of the experience. Moreover, digitalization, the increasing transparency, collaborative and co-designing consumer markets urges the hospitality industry to enter into an evolving marketing concept: customer experience marketing (Homburg, Jozić, & Kuehnl, 2015). The customer, guest or user experience as it is known outside the hospitality industry focuses on physical and emotional aspects such as task efficiency and effectiveness measures (tangible) and emotions, perceptions and attitudes (intangibles) (Nenonen, Rasila, Junnonen, & Kärnä, 2008). Whereas customer satisfaction is outcome- or result-oriented, customer experience is process-oriented including all the aspects during the experience (Schmitt, 1999).

Customer or - as the hospitality industry prefers to put it - guest friendliness and orientation seems no longer to be the sole hospitality industries' trait as the user experience focus underlines. However, as guest orientation belongs to the DNA of the hospitality industry, other industries and sectors may profit from its perennial experience. Looking back at hospitality in ancient times it concerned respect, justice and human rights of the other in most societies (Pohl, 2011). *Hospitality*, as Pohl states, *involved welcoming strangers into personal space, usually one's home but also one's community, and offering them food, shelter, protection and respect (ibid.: 482).*
Furthermore, she asserts hospitality offers a useful framework for thinking about building trust, fostering wellbeing and strengthening communities.

TOWARDS A GLOBALIZING WELLBEING ECONOMY

Trust is needed to develop rapport, to be able to cooperate successfully, and to construct coherent societies (Castells, 2000; Edelenbos & Klijn, 2007; Fukuyama, 1999; Grimshaw, 2005; Lombarts, 2011; Mistzal, 1996; Woolthuis, Hillebrand, & Nooteboom, 2002). The renowned sociologist Robert Putnam argues that trust is essential to build social capital, which is required for bonding and bridging. Bonding occurs when establishing close relationships between friends and peers, bridging supports the formation of positive connections between people out of the own peer group and strangers (Putnam, 2000). More recently Putnam has been studying the relationship between trust and diversity. He concludes that more diversity in a community is associated with less communal trust resulting in less happiness and lower perceived quality of life (Putnam, 2007). Needless to substantiate that bonding and bridging are vital in a progressively globalizing world with a blurring of individuals with diverse ethnic backgrounds.

In may 2012 the social-cultural planning board (SCP) published an extensive report treating happiness as a central aspect of the well-being of citizens (Campen, Bergsma, Boelhouwer, Boerefijn, & Bolier, 2012). Happiness would have a serious impact on costs and therefore it would be imperative to explore it. However, the report stated, little research has been conducted in the Netherlands. Examining the definition of happiness, the Dutch Happiness Professor Ruut Veenhoven describes it as: "*the degree to which an individual judges the overall quality of his own life favorably*" (R. Veenhoven, 1984; R. Veenhoven, 1991; Ruut Veenhoven, 2011). Veenhoven distinguishes four qualities of life, which he classifies in the following categories:

Qualities of Life

	Outer qualities	Inner qualities
Life chances	Livability of the environment	Life-ability of the individual
Life Results	External utility of life	Inner appreciation of life

Source: (R. Veenhoven, 2000)

Policy-makers but also employers can influence conditions for happiness such as aspects of security, democracy, education opportunities etc., in brief conditions for the quality of living. Life-ability, also capability, depends more upon one's own perspective with regard to personal growth and development. And it is often placed in comparison to one's environment. Utility is about one's contribution to society. It differs from person to person how is looked upon one's contribution. The inner appreciation is commonly described as happiness, satisfaction and/or well-being.

According to Alflen people experience hospitality if they:
- Feel welcome;
- Are treated humanly;
- Have autonomy;
- Have own responsibilities
- Have freedom of choice (2008)

To summarize, it appears that there is a relation between trust, happiness, successful cooperation, coherent societies, and costs and well-being. In short with hospitality in the classic sense according to Pohl (2011).

HOSPITALITY IN THE HEALTHCARE INDUSTRY

A sector facing tremendous transformations is the healthcare industry (Bakas, 2013; Idenburg & Schaik, 2010). Demographic changes and the change from curative towards

preventive healthcare are among the key trends these authors envision. Subsequently healthcare providers and systems have to adapt to new requirements and amongst others to financial challenges. Cross-fertilization of innovative ideas shared between the healthcare and hospitality sector could be beneficial for both sectors. One of the crucial issues for the healthcare industry to reduce cost while maintaining high quality will be to instill a culture of service: caring for both patients and staff, creating memorable experiences, investing in employees and coaching them on their talents are just a few of the important aspects (Hollis & Verma, 2012). Similarly, Alflen stresses upon the fact that an important factor of the wellbeing or well feeling of people in the healthcare concerns the hospitality experience and more particularly the 'human touch'. Likewise, she underlines the need to learn from organizations in the hospitality industry such as hotels and elucidates that hospitality concepts demand an integral approach including intangible and tangible aspects. As a starting point the 4P-model hereunder can be used to develop a vision on hospitality.
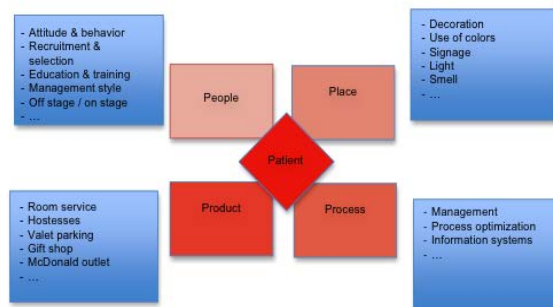
Figure 1 4-P model of Twijnstra & Gudde (Alflen, 2008)

Combining the above ideas with the research as executed in the Raak research project of preventive wellness (Lombarts, 2013), further research on hospitality in the Dutch healthcare industry will be undertaken. Subjects like healthy ageing, life-care or continuous care retirement communities, food-services facilities, innovative product-market-partnership combinations, recruiting and training healthcare staff, new business models for healthcare organizations can serve as a starting point for further research. Setting the agenda, the 'what', will be a collaborative process, which will take place with both professionals from the hospitality industry and professionals from the care sector. The 'how', the research methods I would possibly like to apply I will outline hereunder.

POSSIBLE RESEARCH METHODS

Rohrer (2014) made a useful overview of research methods applied in customer journey and user experience and elaborated on which type of method would be most suitable given the key question and context. She articulates that most research project would benefit if the researcher would chose, apply, and combine multiple research methods and insights. Moreover, taking into consideration that hospitality research strives to influence individual and/or organizational attitudes; hence (organizational) culture, and the fact that the research preferably would be executed in *real time and location* contexts, agile methods will be utilized. While agile methods such as scrum were most commonly used in the field of software (development) research (Conboy & Fitzgerald, 2004), these methods are increasingly introduced in organizational culture research (Iivari & Iivari, 2011; Maximini,

2015). The exact how and what, the advantages and disadvantages of the combination of these methods should be investigated more thoroughly and will be subject of research.

A LANDSCAPE OF USER RESEARCH METHODS
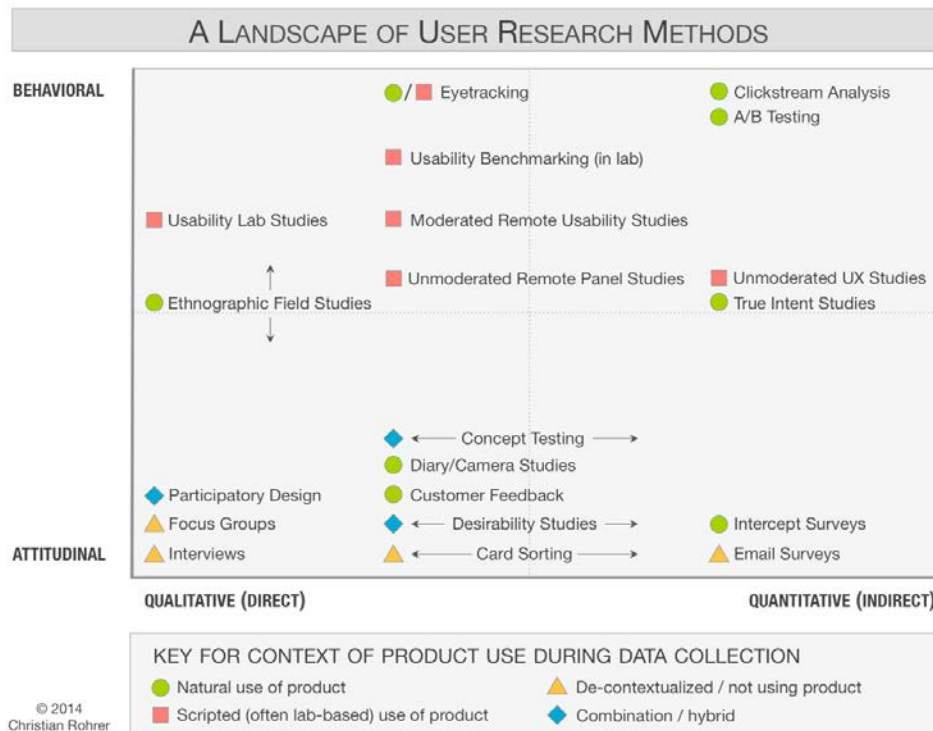
QUESTIONS ANSWERED BY RESEARCH METHODS ACROSS THE LANDSCAPE
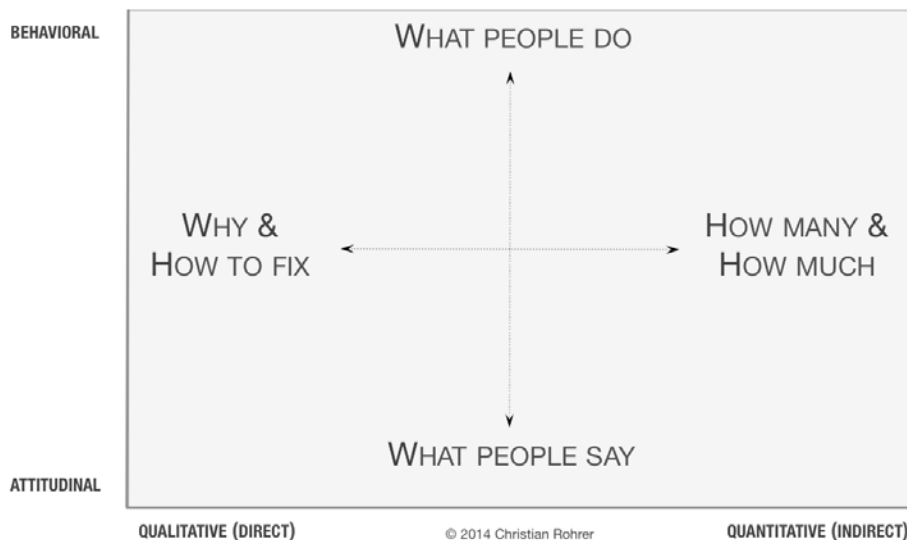
TO CONCLUDE

In this paper I briefly touched on the points on which I would like to set up a line of research, and which builds on my previous research projects. The Dutch healthcare sector needs urgently to retrain costs. Introducing hospitality will result in happier people, patients as well as employees. Moreover it will enhance social return on investment, and I posit that this will finally results in decreasing costs. Further research needs to substantiate this.

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SERVICE DESIGN PROJECTS OF HOSPITALITY IN HEALTH CARE: HOW TO ELECIT INPUT FROM SEEMINGLY SATISFIED CLIENTS

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ABSTRACT

It has often been stated that customers nowadays are rather critical about service provision. They know what they want, and are able to express their needs. However, this paper shows that this generalization is not justified; it describes two cases studies in health care settings, a nursing home and a health resort. Both institutions are somewhat outdated, and were hoping to gain recommendations to improve their service level. However, customers that were interviewed were positive and satisfied and provided little input. The paper will describe a number of techniques that may help institutions to elicit useful feedback from such seemingly satisfied customers.

INTRODUCTION

In the late 1980's Donald Berwick (1989, cited in Pflueger, 2016) was the first to call improvement as an ideal in healthcare (p. 53). Widespread support resulted in the emergence of an international movement to import industrial for continuous quality improvement principles to healthcare in order to continuously improve the quality of care. This movement envisioned the patient not just as someone with a vote or a voice but also as a consumer that products and services could be made for and adapted to (Milstein, Galvin, Delbanco, Salber, and Buck, 2000). In order to do so, information is required about the consumer that is actionable, and about specific processes that providers can seek to improve (Marshall, Shekelle, Leatherman and Brook, 2000). Thus, the customer survey emerged. The underlying assumption in customer experience research is that users/guests are able and willing to express their needs, or at least give signals that could lead to the identification of (unmet) needs and desires. However, in some cases this precondition cannot be met, such as in the case of socially desirable answering, subconscious influences in the perception of hospitality, or physical/mental challenges that limit the possibility to coherently express ones experiences, like Alzheimer's disease.

Furthermore, according to Pijls-Hoekstra, Groen, Galetzka, and Pruyn (2015) there is scant evidence that the experience-related words authors

use to describe hospitality indeed reflect how consumers experience it. Their study showed that literature on service experiences seldom takes the guest perspective into account: the majority of the literature focuses on hospitality from the viewpoint of the host. The host provides safety and security, is generous, friendly, and able to empathize with the guest.

Another critique comes from Christensen and Bower (1996). They argued that listening too carefully to customers, results only in marginal incremental product changes, rather than more substantial improvements that might attract new customers. This could be the result of the survey design: a rational assessment of satisfaction with services received and of customers' conscious needs. For innovation, uncovering latent needs may prove to be a richer source for substantial improvements.

In two case studies we have found that users/guests are not always able or willing to express their needs. The first case study involves the guest experience of the servicescape of a health resort in Russia. The servicescape, a term first coined by Bitner (1992), is a conceptual framework for exploring the impact of the physical environment of both customers and employees in service organizations. The second case involves the evaluation of hospitality performance of a nursing home in the Netherlands. In both case studies the organizations involved were actively looking for ways to improve their hospitality performance. The clients however, did deliver little input. Users involved were extremely positive and non-critical towards staff, services offered, and the environment. This is surprising as the facilities were outdated, and designed and decorated from the perspective of functionality rather than hospitality.

In this paper we will focus on methods that will enhance the user input in service design projects focused on hospitality in health care. Our research has shown that mystery guests, within the same age group but not dependent on the health care organization they evaluate, are valuable participants in service design projects. Another prerequisite is the input from the organization itself, especially those employees that are in direct contact with the users. The paper discusses two cases studies with non-critical and extremely positive customers, followed by a discussion of the benefits of Service Design Thinking in eliciting input for service improvement or service innovation projects.

CASE 1: A RUSSIAN HEALTH RESORT

This study involved the guest experience of the servicescape of a health resort in Russia. This Russian Health Resort is an example of Soviet Communist Architecture, and was built in 1984. It has a capacity for treating 1.000 patients per day, and has a hotel with 350 rooms (single and double). Among the facilities offered are: Spa with mud baths clinic; Clinical laboratories for functional diagnostics; Range of therapies: e.g. ozone therapy, hirudo therapy, laser therapy, reflexology, physical therapy;

Amenities, such as healing swimming pool, Finnish and Russian saunas, herbal tearoom.

Facing competition with modern wellness resorts, the health resort involved in this study actively sought ways to improve their hospitality performance. The study combined different methods: interviews with clients, medical staff and management, as well as photo observation of the physical environment. Respondents represented the largest customer segment, namely women, average age 56, raised in the communist era.

The photo observation shows that decoration and design are functional, rather than hospitable (See Figures 1 and 2). Yet the respondents were extremely positive, as the interview quotes blow the figures illustrate.

Figure 1: Basic hotel rooms
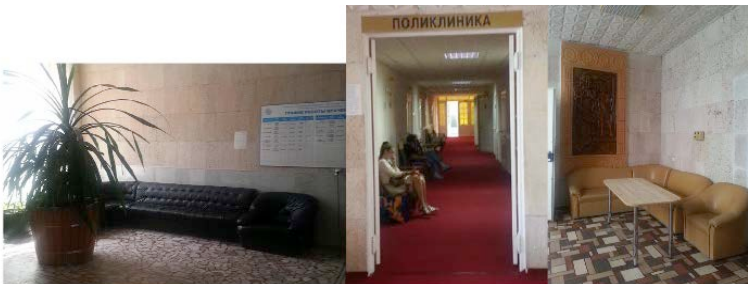
Figure 2: Functional waiting areas

"A very homey atmosphere that makes me feel glad and relaxed."
"No! I like all the rooms very much. I never feel a lack of aesthetics. In my opinion, the interior design is good."
 "Overall the atmosphere is great. To me all the halls are visually attractive. I especially like the decoration of the reception area."

"Very pleasant interior design. The colors of the walls are very nice, not extremely bright. That is really wonderful."
 "All the facilities and lifts are comfortable. If I feel tired I can always use the sofas. I am very surprised that there are lots of places to sit."

A possible explanation for this positive attitude is that the communist upbringing of the Russian respondents hindered them to freely speak their mind, or even resulted in a non-critical attitude in general.

Mannheim (1972) has argued that generational identity is formed during the formative years of an individual's life, i.e. youth (15-25 years). He states that a generation is a social entity, members of which have a certain 'bond' and 'generational consciousness'. During their formative period the respondents experienced the authoritarian socialization of the Russian communist party. The public interest was considered to be more important than the personal interest. This repressive atmosphere led to a make-do attitude, accepting what could not be changed (Mishler & Rose, 2007).

CASE 2: A DUTCH NURSING HOME

The second case in which we encountered respondents that were too satisfied to deliver input for improvement, was a study performed for a Dutch institution for elderly care. The building dates from the 1970's, and offers 170 units for assisted living, nursing home care for 20 clients, residential care for 80 clients, as well as 10 rooms used for short stay rehabilitation and guest rooms.

In the Dutch elderly care market institutions increasingly compete for clients, using hospitality as value proposition. There is even a quality label for "hospitable care" that uses star-ratings similar to hotels, to illustrate the level of service a client may expect. In 2014, this particular institution received a 4 star rating, especially for their empathic and friendly staff. The institution however, wants improve its hospitality performance to a 5 star-level. To do so, upgrading of the physical environment is unavoidable. The study combined different methods: mystery guests, interviews with clients, family representatives, staff, and management, as well as photo observation of the physical environment. The average client is aged over 80 years. Figure 4 shows some of the results of the photo observation. In Figure 5 the images as communicated via the company website are shown for comparison.

Figure 3: Photo observation nursing home

Figure 4: Images from company website

Like in Case 1, the residents interviewed were very pleased and satisfied. The only frequently mentioned suggestion for improvement was the need for a 2-room (individual) apartment, as the standard apartments only have one room. A separate sitting room and bedroom creates a more hospitable environment, with a more homely feeling and more privacy. Privacy is important for residents, as has also been stated by Richter and Etemad-Sajadi (2016). Residents that live in renovated two-room apartments are fully satisfied with their living facilities.

In this study we combined multiple sources to identify possibilities for improvement as was requested by the organization. We found that relatives are a valuable source of information, as they have a good insight in the daily operations, and are emotionally involved with the residents. Therefore they are able to pinpoint options for improvement, and in most cases these

people feel free to speak out. Besides this, mystery guests, selected from the same age group but without the burden of dependency, proofed to be a valuable source of information. Like no other, these mystery guests are able to empathize with the residents, and they dare to speak their minds. The photo observation offered a change to explore how fresh eyes (comparable to first time visitors) experience the environment.

Residents however, gave little input for improvement. It seems that the dependency of residents on the staff and organization makes residents less critical. One client phrased it like this*: "you do not want to be known as that difficult person."* These respondents belong to the so-called Silent Generation. During their formative years they experienced the hardship of the Second World War, with both repression and scarcity of resources. These circumstances have shaped their values. Values are cognitive individual preferences or abstract beliefs; they are shaped by the environment, social developments and by age. Values reflect socialization, and guide people's behavior. According to Schwartz's value theory (1992), motivationally distinct value types can be distinguished along two dimensions: Openness to Change (stimulation, self-direction, hedonism) versus Conservation (tradition and security) and Self-Enhancement (achievement, power, and hedonism) versus Self-Transcendence (universalism and benevolence). Research into the values of this generation has shown that they are rather conservative, and rather low in self-enhancement and openness to change (Groen, Lub, and Bal, 2015). This generation is known for being less demanding than younger generations. Table 1 presents a selection of quotes from the sources described above.

Table 1: Comparison of quotes

	Residents	Family	Mystery guests	Observation
Building	'It is a good place to live.' 'I really like the flower baskets.'	'The overall ambiance is nice, especially with the flower baskets.' 'The smell is not really pleasant.'	'First impression negative.' 'Not a nice atmosphere, unclear layout.' 'Low ceiling.'	'Building dimensions are unpleasant: low ceilings and unclear layout.' 'out-dated color scheme'.

	Residents	Family	Mystery guests	Observation
Apartment	'I feel like being on a holiday, look at that view!' 'I like it here.' 'I only have one room, it's too small.'	'The room is too small and out-dated.' 'Physically disabled people have trouble using the balcony.'	'Room needs refurbishing.' 'What a boring room. I never watch TV, but here I am lucky to have one.'	'Very small rooms.' 'Out-dated decoration' 'Lack of maintenance, broken equipment and furniture.'
Traffic space	'I sometimes feel unsafe at night.' 'I feel totally safe, I never lock my door.'	'Serving trolleys on the hard floor coverings make too much noise'	'Few seats at the reception desk.' 'Horrible acoustics' 'Unclear layout of the central hall.'	'All corridors look alike, I have no sense of direction.' 'The corridors smell of urine.'
Privacy	'In the beginning it is difficult, now it is fine.'	'I was pleasantly surprised by the privacy offered, my relative found a home here.'	'Balcony offers no privacy.'	'If you step on the balcony you can walk to other apartments.'

SERVICE DESIGN THINKING

The positive experiences with more creative data gathering methods led us to Service Design Thinking (SDT). Service Design Thinking is an integrative approach that considers the user or guest as its focal point for both the process as the potential solution (Brown, 2009), using insight derived from customer intimacy to improve services. In the core the difference with traditional customer research is that:

"The design thinking approach forces you to stay in the question and not define exactly what the problem is…This ends up producing a much better understanding of the problem you're trying to solve." (MacDevitt, cited in Liedtka, 2014).

The process starts with searching for unmet needs and wants, expectations and desires of people, by empathizing with users/guests in order to understand their world and motivations. Service design helps to innovate or improve services to make them more useful, usable, and desirable for clients, and to make them more efficient as well as effective for organizations (Moritz, 2005; ISS, 2016). SDT is based on four questions – What is? What if? What wows? What works? Each question relates to a different stage of the design thinking process. "What is?" examines current reality. "What if?" uses the insights from the first stage to envision multiple options for creating a new future. "What wows?" helps to decide where to focus first, and "What works?" is interaction with actual users through small experiments. These four questions have an accompanying set of ten design tools to help managers navigate the question space (see Figure (Liedtka, 2014).
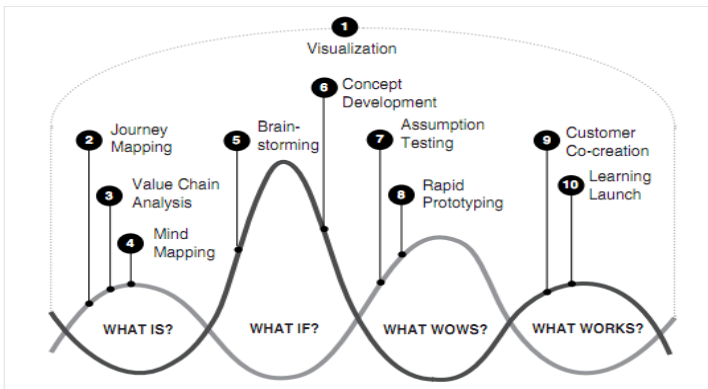
Figure 5: Service design tools, Liedtka, 2014, p.42

The research described in this paper is positioned in first phase. Question is, would SDT have led to more input if applied in the cases described before? What would we have done differently? And especially, how can SDT help to elicit unmet, unconscious needs of seemingly satisfied customers?

In both cases, respondents represented a particular persona. Unlike existing demographic segments, personas are a suitable tool design experiences that support the needs of particular groups of customers' (Temkin, 2010). Each persona experiences his or her own customer journey, with distinct touch points, contact moments between customer (persona) and the organization that delivers the service. A touch point not only describes what happens where, but also how the persona experiences

this touchpoint. Several techniques may be used to find relevant touch points and resulting emotions.

The technique 'walk a mile in my shoes' (https://vimeo.com/114153991) combines the client's narrative with empathizing by the researcher. The client tells about a particular activity or service using a thinking-out-loud-protocol; the researcher may empathize by doing undergoing the same activity or service, while wearing an age simulation body suit. This combination will enable the researcher to experience the clients' physical and sensory limitations, and increase his/her understanding of the client's narrative, and thereby lead to new insights and ideas for improvements in the health care setting.

Eye tracking is a second method for uncovering exactly where users' attention is drawn too. The process involves asking participants to carry out a task and measuring where their eyes are pointing. Eye tracking is an excellent way of identifying what attracts visual attention and what does not. (http://www.userfocus.co.uk)

Thirdly, the Customer Journey is a systematic approach designed to help organizations understand how prospective and current customers use the various channels and touch points, how they perceive the organization at each touch point and how they would like the customer experience to be (Nenonen, Rasila, Junnonen, & Kärnä, 2008). It requires researchers to work together with all stakeholders within an organization, and discuss the whole process, not just one aspect. For instance, Richter and Etamad-Sajadi (2016) have shown that for clients of a nursing home the decision to move to the home, the intake, and the first day are very important elements in the customer journey.

CONCLUSION

Not all customers or clients are able to or want to express their criticism regarding services. For various reasons they may rather state that they are satisfied with what is offered, even if the objective observer would clearly see aspects that need improvement. In that case, interviews are not delivering the required information. Mystery guests with the same age and background can be used, as they can be objective and do not depend on the organization that they observe. Service Design Techniques that stimulate empathizing with the customers are most suitable, as these involve not only the clients themselves, but also the staff of the organization; the results may not only be useful for improving the services, but may also be eye openers and allow employees and management to look at their services from the point of view of the users instead of the organization itself.

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IS HOSPITALITY ENOUGH FOR SENIOR LIVING?

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ABSTRACT

The hospitality approach has become a very popular topic in the senior living field. It's seen as an approach that can attract baby boomers and eliminate the institutional feel that exists in many traditional communities. However, simply applying the concepts and operational structures of a hotel or resort can create a similar type of institution, albeit one with better food and nicer amenities. Hospitality-based amenities and services play an important role, but are just one piece of the puzzle. Senior living settings require a special approach – a blend of hospitality, community building, and a focus on supporting meaningful purpose.

IT'S NOT A HOTEL

As we work to transform communities to become more appealing to current and future prospects, it can be tempting to simply layer the service-rich offerings of a hotel or resort over the operations of a senior living community. However, this narrow approach misses some of the key differences between a hotel and a community living setting for older adults.

Hotels and resorts provide experiences away from home and as a respite from the normalcy of day-to-day life. Conversely, senior living communities are *home* to the people who live there. Many people thoroughly enjoy a stay in a five star hotel. But who would really want to live in a hotel permanently?

What hotels and resorts lack, and what is desperately needed in senior living environments, is an inclusive community culture with opportunities for meaningful purpose.

Rather than thinking of our communities as resorts or hotels, we may be better served if we think of them as small towns or villages – comprised of complex social systems with a core structure of interdependence – where each individual understands that they are a part of the whole and have a vital role in creating a thriving, successful community.

PEOPLE NEED TO BELONG

Human beings, no matter what their age, have a basic need to belong and to be part of something (Maslow 1943). Unfortunately, as people age, many find their opportunities for social engagement dwindle. Their support system get smaller as friends and neighbors pass away or move, or as they begin to experience physical or cognitive challenges that limit their ability to be engaged with the outside community. Put simply, our worlds often begin to shrink as we age.

As this happens, isolation and loneliness may creep in – which has been shown to be extremely dangerous. Isolation is as deadly as smoking, more deadly than obesity, doubles the risk of dementia, shortens life spans, and increases the likelihood of re-hospitalization (Holt-Lunstad et. al. 2010; Wilson et al. 2007; Misty et al. 2001). This presents a dangerous list of risk factors for the older adult population.

Some older adults recognize this danger and seek out communal living in a retirement community. Unfortunately, simply being in proximity to other people does not guarantee social engagement. A recent study conducted at a life plan community (also known as a continuing care retirement community) found that 25 percent of residents residing in independent living identified themselves as socially isolated.

Senior living settings are complex environments. Often, older adults are facing their own fears of aging and aging-related debilities. While ageism is rampant throughout our society, some communities have found that ageism is even more pronounced among the older population, a theory that makes sense when considering the definition of ageism coined by psychologist Todd D. Nelson that explains that ageism is "prejudice against our feared future self" (2005).

This "fear" Nelson describes results in heightened social comparisons against negative aging stereotypes. Older adults who are fearful of losing cognitive or physical abilities are using the health of those around them to determine their own relative health, which leads to downward contrast comparisons (Loeckenhoff 2016). These are the kind of ageist statements like *"At least I'm not blind like Mary,"* or *"I don't belong here, these people are old."* While these ageist statements are serving as a coping mechanism for the healthier adults, if left unchecked, the culture of a senior living community can become fraught with cliques and bullying. Those living with physical or cognitive challenges can be marginalized and ostracized by their healthier or more independent neighbors. Even

when individuals are not the recipients of overt bullying or ostracism, they may begin to self-isolate to avoid social rejection.

BECOMING A COMMUNITY BUILDER

Creating a senior living community requires more than a beautiful building design and appealing amenities. It's critical that we also become skilled community builders, committed to creating environments where people belong and where individuals are honored, no matter what challenges they may be living with.

This requires intention and an unwavering commitment to creating inclusivity and a true community. It may also necessitate revising the old customer service adage from 'the customer is always right' to 'the customer is always right except when there is harm being done to others'. If the actions of a resident are negatively impacting the culture or other individuals, we have an obligation to address the situation through honest conversations and education.

Clermont Park: a case study

Clermont Park Retirement Community in Denver, CO, discovered this first hand when beginning to create an inclusive culture. Education was the first step.

Residents and team members learned about the damage that is done when people are marginalized and ostracized. A new norm was introduced in which ageism and ableism (prejudice against people living with physical or cognitive challenges) were no more acceptable than racism or sexism. Slowly, the culture began to shift as residents realized that their actions were not aligned with the values they held. Residents from all areas of the community, and with differing cognitive and physical abilities, came together as one to celebrate that unity. Residents now own and maintain that culture, educating others if they hear or see any statements or behaviors that minimize the value of another person.

As the community continued bringing together people living with different challenges and at different points in their lives, residents and team members realized that they also needed to address the way in which they handled the death of a resident. In the past, as in many communities, death was hidden away, with the undertaker removing the resident quietly so as not to upset others. Once the community became open to discussing death, they realized they couldn't honor the richness of life without properly addressing the death and loss of a friend or neighbor.

The community developed personalized and highly meaningful rituals such as processionals of residents, family and team members that accompany the mortician through the front doors when a deceased resident is taken out of the building.

While the goal of a resort or hotel is to create a consistently positive and happy experience, real life happens in a senior living community. People get sick and people die. When we try to sanitize and hide the unpleasant or frightening aspects of growing older, we diminish the wholeness of life. We must encourage the healthy development of meaningful rituals that accompany life's difficult times.

To some, this raw and honest approach might seem frightening. But Clermont Park has found that people are drawn to this culture, because the fear that sparks ageism – that we will lose our abilities and be forgotten about – is removed when everyone is valued and accepted. In addition, the community is highly marketable, attracting the coveted 'young and active' senior along with a more traditional prospect, and maintains a consistent community occupancy level of over 98 per cent.

Blurring the lines

Blurring the lines between team members and residents is another powerful step in developing a healthy community. While a hotel or resort structure is organized with clearly defined lines between staff and guests and often forbids fraternization between the groups, many innovative senior living organizations have recognized that one of the most powerful opportunities for community building – including promoting intergenerational relationships – is right under their noses. They've realized that a truly engaged community requires removing the walls between staff and residents. Interaction is encouraged by designing dining spaces, fitness centers and other amenities to be enjoyed by residents and team members alike.

We must also work at shifting our culture to encourage authentic relationships rather than a more surface-level customer service approach. Training programs that encourage staff to think of themselves as "cast members" or "on stage" may work well in a resort, but senior living requires a different approach. In an environment where residents and family members experience highly emotional life-altering events such as illness and death, some organizations have found that being able to interact and communicate with a real human being, one who is encouraged to bring their true self to the job, brings the opportunity for genuine support and understanding.

'DOING FOR' CAN DO HARM

In addition to bringing a focus on community building, we must also strive to create and support opportunities for purpose. Having meaning and a 'reason for being' is a basic human need (Maslow 1943).

Customer service, no matter how excellent, can actually undermine and disempower those we are trying to serve by focusing solely on "doing for" or "creating experiences for" people rather than giving them an opportunity to do for themselves and create their own experiences.

In addition to encouraging learned helplessness among residents, we may also be undermining our own efforts to change the view of senior living in the marketplace. One of the main fears of aging, and of moving to a senior living community, is the potential loss of independence (Prince and Butler 2007). When we sell a "worry-free" lifestyle and a vision of older adults sitting back without a care in the world, we may be unwittingly reinforcing these fears. We may also be impacting the way society views older adults. The aging of the baby boomer population has brought these views to the forefront. The population shift is called a "silver tsunami" - suggesting that a large older population is a disaster, and reinforcing prescriptive age stereotypes where older adults shouldn't be using up scarce healthcare resources or keeping jobs from younger millennials. The prevalence of these terms reinforces the idea that older adults no longer have purpose in our society.

We must focus on creating communities that challenge this pervasive thinking by introducing the concept of older adults being a large and untapped wealth of human capital - rather than a burden and a drain on society.

THE POWER OF PURPOSE

By focusing on older adults as people who still have purpose and meaning, we will do more than improve the culture in our communities. Research indicates that we will also improve overall health and wellbeing (Rush University Medical Center, 2009).

Meaningful purpose has been shown to reduce the risk of developing mild cognitive impairment and Alzheimer's disease, increase longevity and protect against heart disease (Boyle et al. 2010).

The opportunities for cultivating purpose and meaning start at the beginning of a new community's development. Some providers have found that their most vibrant communities are created during the design process. The typical desire to plan spaces according to how designers *think* residents will live are eschewed in favor of providing a "blank canvas" of flexible common and outdoor spaces that can evolve into what the residents and team members want from their community.

Holly Creek: a case study

Holly Creek, a life plan (or continuing care retirement) community in Denver, learned this powerful lesson after the community was designed and opened. A massage room had been a key part of the lifestyle design for the community, but once the community opened, it was rarely used. Rather than trying to force an amenity that residents weren't excited about, leadership was open to other opportunities for the space. When a resident moved in who used to run a radio station, he started talking about the possibilities for creating a station at the community. Momentum and support for the concept grew and that massage room is now home to HCRK, a completely resident run radio station that is a main communication venue and a very unique selling point of the community.

In addition to promoting resident decision-making in the use of common area spaces, Holly Creek leadership encourages residents to be involved in operational problem solving. When the community experienced struggles with team member retention, leadership noticed an interesting trend in their analysis of team member satisfaction and exit surveys. Time and time again, when asked, "What do you value most about your job?" team members responded with "the residents."

The Holly Creek Executive Director, Jayne Keller, described the realization as a light bulb going off: residents were one of their most powerful retention tools. Residents and team members came together and created what is now called the "Keepers Committee," a group that designs and implements retention strategies such as handwritten appreciation notes to team members, parties, and other events. While this committee is still in its infancy, leadership anticipates an initial improvement in team member retention of 12 per cent.

A NEW APPROACH

Hospitality-based services and amenities are essential to the success of senior living communities, but are just a small piece of the intricate operations that encourage the aging population to thrive and stay healthy in old age. As outlined in Table 1 below, we must focus on a new and

adapted approach that also includes the concepts of community building and creating opportunities for meaningful purpose. It is by using this approach that we can create environments that embody the true meaning of 'community' cultures where older adults live well and thrive.

Table 1: A new approach

Traditional Approach	New Approach
Doing for, caring for	Doing with, supporting, care partnering
Elders as recipients of services and care	Person-directed services, active and meaningful role in society
Cast members, on stage, separate from residents	Authentic relationships
Segregation of residents	Inclusive culture
Spaces designed for specific purposes	Flexible spaces, creating the "canvas"
Paternalism	Empowerment
Aging = limitation and decline	Aging = possibilities and growth

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Utilizing Data to Transform the Patient Experience of Healthcare:

How real-time data capture can create a patient experience that feels relevant and consistent over time
By Paul Roscoe

Hospitals are complex physical and digital sites where humans, technology and information interact in dizzying networks, generating an enormous amount of data about a patient's experiences, clinical journey, and personal preferences. A range of platforms exist today for collecting and organizing this data — EMRs are ubiquitous clinical tools, rounding tools are widely utilized to collect first-hand feedback from patients, grievance processes contribute another piece of the puzzle, and HCAHPS and other surveys are deployed to gather feedback from patients and family members. Social media reviews are increasingly another, and often untapped, source of insight.

Despite this wealth of clinical and personal information collected across encounters, health systems remain unable to build a complete picture of any given patient's needs, desires, and concerns that provides true understanding. Further, health system executives lack comparative metrics to effectively discern trends at a patient population level. They also lack tools to effectively improve those metrics.

Impact of Consumerism

Initiatives to increase patient satisfaction and affinity are often based on out-of-date and anecdotal information. For health systems with the collective will to accommodate patient needs and preferences and create differentiated satisfying experiences, collecting and curating disparate experience-related data in a single, accessible location will be the key.

This is critical, more so now than ever, as consumerization becomes an important dynamic in healthcare. Healthcare organizations are increasingly looking to the more advanced practices utilized in other industries to learn how to deliver experiences that attract and retain lifelong customers. Competition among health systems for patients now empowered with choice is driving healthcare organizations to get smarter and more aggressive in their desire to offer services that consumers increasingly expect in every other aspect of their lives.

Healthcare brands can learn a great deal from organizations outside of healthcare and their success in looking at consumer experience broadly to proactively understand and address consumer needs. By capturing real-time data and equipping staff with tools, training and tactics to make patients feel known, valued and heard, health systems can create a total experience that feels relevant and consistent over time.

Great brands know that the brand experience is about far more than a transaction — it's a journey that starts far before purchase and continues long after. Forward-thinking organizations within and outside of healthcare focus on creating data-driven consumer experiences, and on making cultural,

technological and educational changes required to deliver those experiences. This large-scale strategy holds the potential to dramatically change the way patients feel about the experience of healthcare.

To make this consumer-centric goal a reality, healthcare organizations will need to develop the ability to not just understand but to even anticipate patient preferences and fears prior to a clinical encounter, and suggest actions that are truly helpful and welcome. Health systems can begin to create coherent consumer narratives by gathering and analyzing more comprehensive patient information and feedback data, such as asking what an individual patient likes, dislikes, and cares about.

Collecting Real-Time Data

Imagine if a hospital were aware of a patient's preferred nickname, or could anticipate a fear of needles, and was able to comfort that patient in real time and with empathy. Collecting soft data such as mood—during and after a clinical journey's end— allows a hospital system to identify dips in aggregate satisfaction and to take action to remedy those structurally and at the level of the individual experience. For instance, if patient mood is consistently registered as poor after staff hand-offs, a health system might take steps to understand flaws in their care transitions. The knowledge might also help staff to identify individual opportunities for service recovery.

Consider the "journey" of a first time mother preparing to deliver her child. Health systems can thoughtfully design an experience for this patient that combines facts about her individually, and the preferences of other mothers with a similar background. We can look at her past experience and pull that data forward to inform the new journey: when did she engage with an obstetrician? Has she written a birth plan and what does it include? What are her anticipated plans around feeding? Based on these data points, this patient's journey could include customized interactions such as a pre-admission phone call to let her know about hospital education offerings for new parents, texts containing information on optimizing prenatal care and nutrition, and an in-person conversation to discuss specific choices she will make as part of her delivery.

Hospitals will ultimately need to employ or contract new kinds of staff to balance patient experience with clinical efficiency as they seek to deliver this new level of tailored service. Today, nurses often deal with many patient concerns relating to their non-clinical needs. While these interactions are critical to ensuring a positive experience, highly trained clinicians may not be the most efficient staff to handle such issues.

US health systems are anxious to understand what will be required to shift from a traditional 'service delivery' structure into a modern consumer experience that meets the expectations of discerning customers. The elements of that transition – a longitudinal perspective, collection and curation of a wide range of experience-related data, focused analytics and creation of new service offerings – are attainable and hold the promise to transform our healthcare system, yielding tremendous benefits for both patients and health systems.

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NEXT GENERATION CYBER HEALTHCARE SERVICE MODEL

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ABSTRACT

This paper explores alternative delivery models to capture the value of next generation cyber healthcare services. The strategy entails leveraging cyber design and operational experience from commercial and government sectors that involve end-to-end delivery of assured and non-assured services. A combination of technology push and market pull, including advanced analytics and proliferation of Internet of Things is driving the growth of future cyber healthcare sector. Higher value add will come from chaining standalone cyberhealth capabilities in different market segments to create an integrated and user-centric experience for future consumers of cyberhealth.

INTRODUCTION

The United States has the highest global healthcare spending per GDP in the developed world. It is projected to grow at 5.8 per cent per year from 2014 to 2024, averaging 1.1 per cent higher than the annual GDP. As a reult, the healthcare expenditure will reach 19.6 per cent of the GDP by 2024 from 17.4 per cent in 2013 (CMS, 2014).This cost trajectory is unsustainable and healthcare will continue to be a major burden for businesses and individuals.

The long term goal is to investigate alternative paradigms to help contain healthcare costs through cyber enabled services. In particular, this paper seeks to
- explore low risks models in creating value added cyber healthcare services in a user-centric ecosystem that benefits both consumers and providers,
- leverage design, delivery, and operational experience from commercial telecom, internet and government sectors to improve the quality of care and manage cost in the next generation of healthcare delivery.

The remaining sections will elaborate on the following aspects of next-generation value-added healthcare services
- social, market and technology trends,

- ecosystem and value chain across a range of critical and non-critical services
- value-driven and user-centric design, and
- end-to-end assurance, operation, security and privacy

TECHNOLOGY PUSH, MARKET PULL AND NEW SOCIAL NORM

In the past, industry incumbents such as telecom, media and energy, typically provide incremental augmentation to their core businesses and services until disruptive forces reconstitute the marketplace. The disruption of traditional industry models by new digital models has been attributed to bankruptcy, acquisition and cessation of over 50 per cent of Fortune 500 companies since 2000 (Accenture, 2015).

The social, market and technology trends (Shih 2010), (World Bank, 2015), (Accenture, 2015) are increasing intertwined. Rapid and continuous evolution makes managing their interactions and mutual influences a challenge, especially from the perspective of introducing new products or services. The cyber healthcare ecosystem resembles many characteristics of the telecom, internet, media and government sectors. As such we anticipate its transformation will follow in a similar path.

Disruption is likely to come from non-healthcare sectors creating complementary and/or adjacency market (Kwan, Patel and Sergeant, 2014), (Accenture, 2015). Established healthcare providers are well positioned to engage with new entrants to manage and exploit potential disruptions (Schneider, Gertsch and Bugnon, 2013). The changes involve

- shift in social trend towards a "me-centric" paradigm in cyber services, exacerbated in parts by proliferation of Internet of Things,
- differentiated consumer needs, ranging from current retirees and baby boomers to millennials and generation X,
- industry structure that supports unbundling of production, distribution, retail and consumption.
- increased integration across social-cyber-physical systems supported by advanced analytics and business intelligence.

ECOSYSTEM AND VALUE CHAIN

An increasingly connected world is helping to fuel the growth in Internet of Things for healthcare, including medical wearables as well as value-added services like remote monitoring of patients and elderly care (Schneider, Gertsch and Bugnon, 2013). Consequently, the next generation cyber healthcare services will face similar design, end-to-end operations and delivery infrastructure challenges as the commercial telecom/internet and

government sectors in assuring important services such as emergency 911 service and mission critical operations.

Structurally, the future cyber healthcare service ecosystem resembles that of the Internet of Things and the connected world of Internet, as depicted in Figure 1. In practice, its value chain may be enhanced through leveraging current and future connected services such as in communications, vehicular networks, and service analytics. Potential areas for value creation in the ecosystem are:

- edge hardware to enable seamless interaction with end users, such as user devices, wearable, home networking, autonomous machines and connected cars,
- delivery infrastructure to support differentiated service quality, including delivery timeliness, value versus volume of data.
- end-to-end service and operations capabilities, including new applications, business intelligence and analytics, and security.
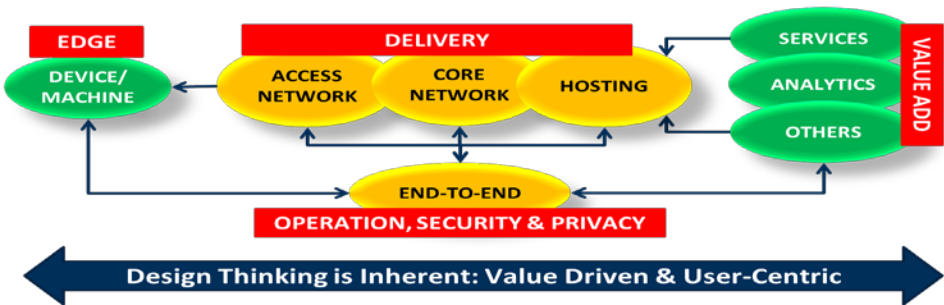
Figure 1: Ecosystem of a connected world

VALUE DRIVEN AND USER CENTRIC DESIGN

Design thinking is inherent in the creation and operation of telecommunications and Internet-based services as many of these services (both end users and providers) have stringent performance metrics and/or regulatory requirements. Value-driven and user-centric design can be applied to enhance design thinking for next generation cyber-enabled healthcare services through established theory and practice in high availability service design and end-to-end operations, especially for critical and high impact services. Value-centric design developed by the government sector focuses on prioritizing areas of importance and with perceived business value. A user-centric and technology-driven ecosystem that is well integrated (horizontally and/or vertically) across the service chain will improve quality of care and help contain the operating costs of healthcare services.

END-TO-END SERVICE ASSURANCE, OPERATION AND SECURITY

Most importantly, the next-generation of Internet-enabled healthcare services needs to be delivered reliably and economically across the service/supply chain. The end-to-end service infrastructure and operational impacts are dependent on the required quality and critically of a service. In this aspect, lessons learned from the commercial telecom/Internet and government sectors as well as emerging areas of Internet of Things are highly applicable in the new world of Internet healthcare delivery. Eliminating human involvement in the loop through automated operation support systems, remote diagnostics and continuous monitoring are key design innovation and operation capabilities that significantly reduce the cost of telecommunication services.

AN ALTERNATIVE SERVICE MODEL

As depicted in Figure 2, introduction of new connected services is challenging and costly, with no guarantee of success especially in the contested applications world. The traditional vertical service lifecycle process involving service development and deployment to continuous operation management and maintenance is resource intensive. The situation is further exacerbated by the intricate and at times unanticipated interactions across social, market and technology factors influencing the connected world.
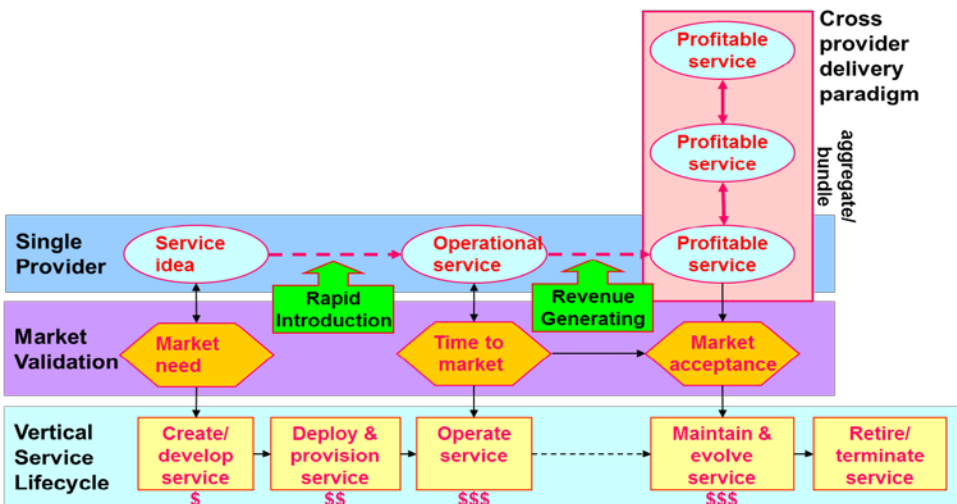
Figure 2: Alternative low risks model for aggregating across existing high demand/profitable services

In this aggregation model, services that are profitable and/or with market acceptance are selected for bundling or integration to jump start the introduction of new services. The benefits are as follows

- leverage existing operational and profitable services to create value
- low risk/cost model for introducing new services
- potential for quick return on investment
- expand customer base through partnership
- wider service selection
- potential for innovative bundling/packaging

The initial target market for value add involving new or non-established healthcare providers is the minimally or non-regulated segments that exhibit lower entry barriers and risks.

CONCLUSIONS

Cross service aggregation paradigm is a promising alternative for rapid introduction of value added services. It leverages operational and profitable services to maximize return, as well as to provide a low risk/cost model for creating new services. It also facilitates expansion of customer base and service offerings through partnership, including innovative bundling in analytics, intelligence and management.

Key challenges in infrastructure interoperability need to be addressed as they are critical to the future of national cyber healthcare and international competiveness. New innovations are needed to drive change in market and/or regulatory structure. Essentially, what is the Uber, self-drive car or voice over Internet equivalent in the cyberhealth industry?

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MOTIVATIONAL INTERVIEWING FOR HEALTHY SERVICE ENCOUNTERS

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ABSTRACT

This paper examines the problem of communicating with guests and clients in a marketplace dominated by "the customer is always right," which promotes resentment and undermines customer agency. Instead, a more useful tagline, "the customer is capable," could enhance customer relations as clients are seen less as objects to be acted on and satisfied, and more as mindful co-creators who bring their knowledge and problem solving skills to the service encounter. This paper proposes motivational interviewing, a conversational method used in counselling, as a way to optimize customer capability in hospitality, health, and other services.

INTRODUCTION

> If two or more people encounter each other [one] of them will speak, or give some other indication of acknowledging the presence of the other. This is called the transactional stimulus.
> (Eric Berne, *Games People Play*, p. 29)

Communication between customers and frontline employees plays a key role in the success of service businesses such as hospitality and healthcare. Customers arrive at the business expecting that service staff will be able to deliver the products and services provided by the business through the encounter. If problems or issues arise, then such employees are equipped with answers and solutions in order that the service system can function smoothly. These encounters or "moments of truth" (a term coined in 1981 by Jan Carlzon, president of Scandinavian Airline Systems) provide employees and their businesses with opportunities to impress and exceed customer expectations thereby accruing customer loyalty, positive word-of-mouth marketing, and other benefits. The promise and guarantee that businesses would do anything to deliver superior service reinforced the slogan, "The customer is always right," gave customers such reassurance, and traditional service businesses such as hospitality and travel move to the forefront of the service revolution as depicted in the bestseller, *Service America,* in the early nineteen eighties. But there have been drawbacks to this strategy.

STRESSFUL ENCOUNTERS

Comfort in the sense that frontline staff will do whatever it takes to please them has led some customer to have unrealistic expectations or unreasonable demands of service providers, as depicted in the comic strip below. Huang and Maio (2013) note that hospitality operations are prone to illegitimate guest complaints, which then have negative results for the companies, their frontline employees, and other customers.

Source: www.underwhelmedcomic.com/comic/the-customer-is-always-right/

In the sociology classic, *The Managed Heart: The Commercialization of Human Feeling*, Hochschild (1985) describes the stress and strain that staff experience in their effort to constantly display positive attitudes and nonverbal behaviors that customers expect. Using results from her qualitative study of airline employees, she suggests that the service creed has become so ingrained in consumer culture that any unfreezing of the service performance can be viewed as a slight by customers.

As a result of this miscommunication in service encounters, frontline employees have become cynical about their work, openly question the convention that the customer is always right, and even discount the ability of customers to play a useful role in the satisfactory delivery of service, as depicted in the comic below:

Source: blog.identropy.com/IAM-blog/bid/67219/The-Customer-Is-Not-Always-Right

SERVICE ENCOUNTER REDEFINED

The poor communication and relationship between customers and service staff as played out in popular culture and the internet does not bode well for service industries at a time of increased competition and channels of information and service delivery. Research by the Brookings Institution, for example, highlight the critical role of frontline staff in healthcare operations as they seek to meet the new standards resulting from the reforms in healthcare set by federal government agencies (Patel, et al. 2014). The same challenge exists for hospitality operations and retail business that compete in our increasingly "omnichannel" and 24-hour service environment (Ostrom, et. Al 2015).

This paper proposes that the slogan, "the customer is always right" must be revised to create a new type of relationship and style of communication between customers and service employees. This relationship shifts from one of resentment and culpability to one where customers are seen as capable co-creators in the service encounter. When viewed as capable, customers are not mere passive recipients of service, but they bear some responsibility of actively formulating the service experience. In return, frontline staff would view customers with less resentment and skepticism as they rely on the positive communication exchanges. While this model might seem distant given the current state of customer service, it has been adopted in services such as counselling as counsellors help clients adopt behaviors that are more desirable. Their method is called motivational interviewing.

MOTIVATIONAL INTERVIEWING

Motivational Interviewing is a counselling method that lets clients decide for themselves the depth of a problem and what needs to be done about it (Miller & Rollnick, 2012). The method was originally applied to habits such as smoking and alcoholism, but in recent years has been used in situations requiring a more collaborative, goal-oriented style. Empathy and acceptance are key ingredients, as well as the assumption that clients bring certain knowledge and insight to the service situation that will be beneficial to the service provider, rather than the service provider "righting" all the problems for the clients.

The method of engaging clients is based on the OARS model:

(O) Open-ended Questions - Such questions allow clients to open up and become more conversational rather than merely answer questions to the specifications of the service provider.

(A) Affirmations - This shows empathy towards clients and the views they bring to the encounter. It does not mean that the service provider will agree or accept what the client presents, but that the client is given respect and appreciation.

(R) Reflective Listening - This may be one of the more difficult parts of the model due to our inclination to have answers and impose solutions on a situation. Reflective listening requires patience and deliberation as the service provider engages the client to ensure proper interpretation of the messages exchanged.

(S) Summarization - This step helps to reassure the client that what was said is understood and it allows the service provider to fill in gaps in the information presented. Based on the summaries, the service provider can give recommendations for the client moving forward.

It is unlikely that most client and staff encounters in hospitality or health services will have the amount of time as in a counselling situation. That is remedied by the use of *brief interventions* which is an abbreviated form of motivational interviewing when time constraints do not allow for in-depth conversations.

CONCLUSION

The unhealthy state of customer service today requires new models of communication that ensures more meaningful interaction between clients or customers and service personnel. Whereas the motto, "the customer is always right," dominated the era of mass production and marketing, a more nuanced model of customer engagement is more appropriate today. This paper proposes that a belief that "the customer is capable" shifts some of the responsibility for producing desirable service outcomes to the client or customer. Through the motivational interviewing, more beneficial conversations based on empathy and respect for clients as well as service providers will help service operations meet those service standards while giving clients greater satisfaction that their input contributed to the success of the service encounter.

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HEALTHCARE, HOSPITALITY AND PROFIT POOLS: INTANGIBLES REQUIRED FOR SUCCESS ACROSS INDUSTRY SECTORS

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ABSTRACT

Paper reviews intangibles theory, ranging from big data through knowledge assets to intelligence, establishing the potential value from each and best practices for managing. Metrics are offered for assessment of firms and industries according to these intangibles. Based on the metrics, intangibles practices can be identified in all the industry sectors across the healthcare profit pool as well as from hospitality sectors. Similarities are identified (retail pharmacies have most in common with hospitality firms), with implications for strategy and intangibles systems (chiefly big data and explicit knowledge management systems)..

BACKGROUND

The study of intangible assets in organizations has a lengthy history though interest has accelerated sharply in recent years. Intellectual property, in particular, has been studied for decades though it constitutes only a part of the field. But such associations highlight why a close link exists between intangibles and innovation, especially in early work.

Schumpeter (1934), for example, stressed the important of knowledge combination in creating innovation, as did Nelson and Winter (1982), emphasizing the broader role of intangibles in economic growth. According to the resource-based view of the firm, for the organization itself to grow, it needed to harness unique, sustainable resources creating hard-to-copy competencies (Wernerfelt 1984). As resources such as capital, labor, and technology became ubiquitous, a group of scholars became convinced that intangibles might be the key available resource. The knowledge-based theory of the firm suggested that knowledge and related intangibles were the key to competitive advantage (Grant 1996).

At about the same time, information technology (IT) scholars were exploring the nature of intangible assets. A hierarchy was developed, credited to Ackoff (1989) and others. According to the DIKW hierarchy, intangibles ranged from raw data to more organized information, then on to knowledge (information subjected to reflection) and finally to wisdom

(insight). For much of the 1990's and into the new century, attention focused heavily on the knowledge component of this hierarchy. The related fields of knowledge management (KM) and intellectual capital explored how to define, measure and better manage knowledge assets, essentially know-how developed about how to perform jobs, create an organizational culture, and establish external relationships. In particular, Nonaka and Takeuchi (1995) brought the concepts of explicit and tacit knowledge from sociology (Polanyi 1967) and applied them to business. Explicit knowledge could be captured and catalogued, including through IT systems, and thus easily shared with others. Tacit knowledge was more personal, difficult to communicate, and thus more difficult to effectively share, especially at scale. One of the important implications was that the different kinds of knowledge were best managed with different tools. While explicit knowledge could be shared through systems, tacit knowledge typically needed to be exchanged person-to-person.

We could write pages, of course, on the additional literature concerning KM, including the variables affecting the nature of the knowledge assets in a particular organization and those affecting the success of KM systems. But the short version is that into this background has come the current interest in big data and business intelligence/analytics. From the perspective of this paper, these trends have added to the range of apparently valuable intangibles in firms as well as to the range of systems needed to effectively manage them.

In some ways, this wider view of intangibles goes back to the DIKW hierarchy, adding back in the data, information, and wisdom/intelligence pieces largely ignored in the KM literature. Some scholars have noticed. Kurtz and Snowden (2002) proposed a different view of intangibles, reorganizing them according to centralization of the assets (capture by the organization) and their distribution (direct sharing without going through the central core). This can be further reconfigured, once again, as a hierarchy, running from data/information to explicit knowledge, then on to tacit knowledge and finally to insight/intuition (Simard 2014). For a number of reasons, we again see the last category as akin to intelligence.

TYPES OF INTANGIBLES

What's interesting about this formulation is that the characteristics of the intangibles and means of managing them become even clearer (Rothberg and Erickson 2017; Erickson and Rothberg 2017). Big data, in and of itself, is chiefly just moved around the organization and its extended network. Decisions, especially operational- or marketing-related, are taken based on readings. When key performance indicators are established, actions may be mandated for when data shows some variance from desired

performance levels. But little or no analysis of the data/information takes place, only transfer between units.

Explicit knowledge can also be transferred between individuals or between an individual and the organization.   This is know-how gained from experience or reflection, but of the sort that can be easily explained to another person or captured and shared by means of IT systems. Explicit knowledge can be documented in procedures or process documents, readily shared with employees with similar functions across the organization. Although there is reflection when the individual learns the new knowledge, the KM system is set up mainly for sharing. There is usually little to no additional analysis or learning once the explicit knowledge is captured.

Tacit knowledge is more individual.   What has been learned by that individual may be hard to explain or transfer to another except, perhaps, in a person-to-person fashion (mentoring, communities of practice). As such, the learning is hard to scale up to spread throughout the organization but it can be quite valuable, in part because it is rarer. Organizations need to think about systems encouraging individuals to learn new things and share personally with co-workers, when possible.

Intelligence can result in innovations or new ideas that can have substantial impact on the company as a whole. But the process of coming up with new insights is another issue. Intuition or the innovative "eureka" moment is hard to teach another, so the knowledge of how to create new insights is deeply personal. Communicating the process may be all but impossible. Again, organizations will want to establish systems feeding inputs to the unique individuals who can discern new ideas from them, but a plan to transfer their personal intuitive process may be impossible to execute.

METRICS

In looking to identify industry conditions and make appropriate recommendations for an intangibles asset strategy, we have collected a set of metrics to identify when each of these intangibles is present. When a particular type of intangible is necessary for competing in an industry, organizations will want to install systems capable of effectively managing it.

Big data, for example, has been identified by the amount of computing capacity present in industry firms. A prominent study by McKinsey Global Services (Manyika, et. al. 2011) has been quite useful in this regard, showing industries with high levels of big data, including on a per firm basis. Financial services such as investing and banking, for example, show the

highest levels of per firm data holdings, suggesting the generation and storage of data at levels far above other industries. Absent evidence of any other type of intangible, such numbers suggest only a big data system is necessary (to move data around and monitor against KPI's).

Knowledge can be assessed in any number of ways, so many that there is some disagreement concerning the best ways to do so. But in order to measure knowledge holdings across a large number of firms, as opposed to case studies, financial statements are often used. In particular, we've always preferred a variation on Tobin's q, market capitalization to replacement value of assets (Tobin and Brainard 1977). In our case, we've found that market cap to book value and/or market cap to assets can use readily available financial data to provide some idea of intangibles by looking at firm value less tangible assets. Both variations usually agree though the latter eliminate debt as a factor in the measurement (Erickson and Rothberg 2013, Erickson and Rothberg 2012).

A high value on the knowledge metric, exclusive of evidence on other types of intangibles, is indicative of well-developed explicit knowledge. Tacit knowledge usually doesn't scale up enough across the organization to show up in this metric, so high levels of intangibles according to the market cap/book or assets will indicate considerable explicit knowledge, usually in operations or consumer relationships.

Indications of the higher-level intangibles of the hierarchy are found in high scores on an intelligence metric. In this case, we have employed an assessment of competitive intelligence (CI) activity, both the number of CI professionals and the level of proficiency of the operation, to gauge intelligence capabilities. Intelligence, as noted, requires individual expertise in sorting through varied inputs, whether data, information, knowledge, or already existing intelligence, and forming new insights. If an organization is capable of doing so in the CI realm, it likely has the capabilities to do so in other areas (marketing intelligence, business intelligence, innovation) as well.

Further, a high intelligence metric combined with a high knowledge metric implies both explicit and tacit knowledge in an organization. The firm shows scaled up explicit knowledge in the KM score as well as some evidence of more personal knowledge development in the intelligence score. A high intelligence metric without any indication of an associated knowledge capability indicates insight/intelligence only (though it is sometimes associated with big data as well). This is not as odd as it sounds. There are industries with huge amounts of data, subjected to analysis, but analysis that can only be performed by unique individuals with special insight tools to uncover patterns and associations in the data. This

would essentially be the business analytics side of big data/business analytics.

In short, based on a mix of measures, we can differentiate from scenarios in which very little is being done in developing intangibles, those with demonstrable explicit knowledge is apparent but nothing at a more personal level, those with big data and personal insight but little knowledge, and those with all types of intangibles.

FRAMEWORK DEVELOPMENT

To better explain, consider Table 1. Data are based on the McKinsey study mentioned earlier, as well as financial results 2006-2010 for almost 2,000 firms listed on North American exchanges, and survey results 2006-2010 from CI consultancy Fuld & Company. Note that indicators can range anywhere along the axes represented in the table, the category approach is applied for ease of exposition.

Table 1: Intangibles Metrics, Scenarios

	Low Intelligence	High Intelligence
High Knowledge	Low CI metric High KM metric Some big data (Consumer products, retail)	High CI metric High KM metric Some big data (Pharma, software)
Low Knowledge	Low CI metric Low KM metric Some big data (Utilities, transport)	High CI metric Low KM metric Often high big data (Financial services)

The two extreme categories are easiest to understand. When knowledge and intelligence are both low, there is little to be gained from aggressively and expensively going after knowledge development or new insights. Some use of big data to enhance operational efficiencies may be appropriate, so a system for sharing data/information around the firm or its extended network makes some sense, but IT systems for explicit knowledge, tacit knowledge initiatives, or analytical/learning systems for intelligence would likely add little value. Typically, we see mature industries, often regulated, with little new under the sun in this group.

At the other end of the spectrum, when knowledge and intelligence are both high, everything is present and valued. Data, information, and explicit knowledge are shared throughout the firm to optimize processes and customer relationships. Analysis groups are also present to discover new

insights and innovations, so tacit knowledge development and intelligence initiatives are also aggressively employed. Firms need not only monitored sharing systems but also analytical/intelligence systems. Creative, innovative industries such as pharmaceuticals and software are typical of this category.

The other two groupings are less intuitive but no less interesting. High knowledge, low intelligence means a lot of knowledge is developed and shared around the organization but firms (and competitors) are seemingly not interested in deeper analysis or insights from that knowledge. Operational efficiencies and actionable customer knowledge are critical, but discerning deeper understanding is not. In particular, since we're looking at a CI metric, companies are not aggressively pursuing data, information, and knowledge from competitors. Why? Probably other barriers to copying and using the knowledge, including size, installed capacity, and/or strong brands. What we see in this category are the big consumer product brands (beverages, household products, packaged food) and retailers. What Walmart and Procter & Gamble do is no secret, and they do it very well. But it's also hard for a competitor to duplicate, so they continue to optimize their data, information, and explicit knowledge without necessarily investing in analysis systems.

The final category shows low knowledge but high intelligence. These industries have highly developed analysis operations to gain learnings from intangibles, including those from competitors. But very little is shared in terms of knowledge. Big data, on the other hand, is massive in some of these industries. In this case, we believe that new insights are rare but important and competitive advantage comes from proprietary tacit knowledge and intelligence. As noted earlier, these are hard to share with others in the firm but the skill to analyse inputs and create new offerings, new approaches, new processes is very valuable. Personal, creative brilliance is the key, discerning new insights from the waves of big data or other inputs. Hence, there is little point in trying to develop knowledge systems though key personnel are valued highly. Financial services, awash in data and focused on infrequent new investment strategies or new customer offerings are typical of this group.

HEALTHCARE AND HOSPITALITY

What does this framework have to do with healthcare and hospitality? Industries, specific sectors within industries, and specific firms should ask themselves how to best manage intangibles. The first step is identifying which intangibles are important in their sector, then asking whether their firm has the systems and experience to manage those critical intangibles. Whether big data systems transferring data and information (McAfee and

Brynjolfsson 2013, Manyika, et. al. 2011), explicit knowledge management systems, chiefly IT-based (Matson, et. al. 1982), more face-to-face tacit knowledge management systems (Brown and Duguid 1991) or learning systems (Argyris 1992, Senge 1990) that can be used for intelligence, there are specific answers for specific circumstances. And individual firms are better placed or not to deliver on those answers. A strategic approach to intangibles management helps in coming to a conclusion.

One strategy tool used in assessing industry cross-sector opportunities is the profit pool (Gadiesh and Gilbert 1998a, 1998b). Reflecting an entire industry value chain, a profit pool visualizes revenue by sector vs. margins by sector. One of the key insights is the attractiveness of high margin sectors rather than high volume sectors. In healthcare, for example, hospitals are a high-volume, low-margin sector while pharmaceuticals, diagnostics, and healthcare IT are all lower-volume, high-margin sectors (Eliades, et. al. 2012).

While that can be very useful for strategic planning, our objective here is to take the same basic idea and evaluate industry sectors according to intangibles metrics. From that basis, we can evaluate fit with similar assessments from hospitality, where and how profit pool sectors have similarities or not. Data specific to healthcare and hospitality are drawn from the sources noted earlier. Results are presented in Table 2.

Table 2: Intangibles Metrics: Healthcare and Hospitality

	Low Intelligence	High Intelligence
High Knowledge	Retail pharmacies Distribution	Pharmaceuticals Med Tech Diagnostics
Low Knowledge	Hospitals Other Providers	Insurance

Interestingly, big data is fairly high throughout the industry. At the one extreme, with low knowledge and low intelligence, hospitals and other providers are increasingly moving toward big data solutions though they have not adopted effective explicit knowledge sharing systems. Those are seen, instead in retail and wholesale distribution. Insurance, as is typical of financial services, has significant big data, little knowledge, but high-value individuals looking for rare innovations (rapidly copied due to rampant competitive intelligence activity). All intangibles are present in pharmaceutical manufacturing (generic, mainstream, and biotech), medical technology, and in vitro diagnostics. This is not surprising in industry

sectors dependent on both innovation, regulated processes, and sophisticated customer relationships.

Hospitality industry sectors, on the other hand, generally fall where indicated by the ellipse. These include hotels, restaurants, and gaming and all have fairly similar metrics (high knowledge, low intelligence, and some big data).

DISCUSSION AND CONCLUSIONS

What's the meaning? The health care sectors in the low intelligence categories have operational processes (retail/wholesale logistics, hospitals) that can be helped with monitored and shared data and information. But while wholesale/retail processes are repeatable and so subject to explicit knowledge development and sharing, hospitals are usually a mix of repetitive and more project-oriented (job shop) processes. So some can be helped with explicit knowledge but providers are more likely to have to deal with processes on an activity-by-activity basis. More personalized learning does take place among the higher skill levels, but that is extremely difficult to share, especially given the time constraints that limit the identification and capture of tacit knowledge or the deep analysis necessary for creative insights.

Beyond operational processes, the retailers and wholesalers also have significant customer relationships. Distributors, with organizational customers, have worked to optimize relationships via information systems. Retailers are increasingly using loyalty programs to develop their own close relationships with consumers. All such relationships lead not only to big data but also to explicit knowledge about how to please those customers. Some, such as Walgreen's, CVS, and even Walmart also have strong consumer brands (another indicator of strong customer knowledge).

This is where the link with hospitality sectors is clearest. Hotels, restaurants, and gaming companies have established processes generating data and explicit knowledge. But, even more importantly, all are especially well-known for strong brands and exemplary loyalty programs, at least at the highest levels. That's important not only for the data and information generated by such programs but the learning that takes place. Explicit knowledge is developed on how to please each individual consumer (Caesar's, for example, can experiment with marketing mix variables to ascertain individual preferences that increase resort visits and customer lifetime value). While healthcare, especially hospitals and other providers often have deep databases on customers, the data aren't always well-managed and, again, are just not analysed for further learnings. Best practice healthcare providers monitor data and alert

patients about upcoming visits, but the tailoring that gains more customer satisfaction is lacking.

Even more importantly, the sector participants who do have consumer knowledge capabilities should probably be seen as potential infiltrators of the hospital and other provider space. Indeed, healthcare retailers listed above are already entering the service provider space with in-store clinics. While only simple services and tests at present, they have the process capabilities to efficiently run any standardized operation as well as the consumer relations mentioned earlier. There are indications of higher ambitions, as illustrated with the ill-fated Walgreens/Theranos lab testing partnership that ended after the latter's well-publicized difficulties. If these competitors are successful, hospitals might increasingly be left with the harder to manage non-standard emergencies and complicated care provision. If hospitality type brands and customer relationships can't be replicated by hospitals, more and more of the volume may move to those participants with a demonstrated ability to better manage the necessary intangibles.

This paper provides a glimpse of new tools we have to assess the presence of intangibles in industry sectors and individual firms. To the extent that the intangibles, whose value comes largely from the heads of employees who generate them or know how to analyse them, are critical to competitive advantage, better understanding them will be increasingly important. In the case of the link between healthcare and hospitality, intangibles can make clear where synchronicities may exist across industry sectors. In particular, hospitality sectors are most similar to retail pharmacies, a potentially important connection for other healthcare sectors looking to benefit from linkages.

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OPERATIONS MANAGEMENT AND OLDER LIFE: CONCEPTUAL AND PRACTICAL CHALLENGES ON THE *CARE-WHERE* LANDSCAPE

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ABSTRACT

This paper explores some key 'older life' themes through the lens of (service) operations management; thus connecting OMs scholarly and practitioner community to this fundamental global challenge and, hopefully, providing the basis for some novel insights. It comprises three main sections. The first two develop a conceptualization of the 'older life' landscape, focusing on two dimensions, the meaning and management of Care and Location and place (i.e. where), The final section explores the integrative aspects of this 'care-where' landscape (ie. issues where questions of home impact questions of care, and vice versa) and uses this as a way of identifying OM-relevant opportunities and challenges.

1. INTRODUCTION

Average population life expectancies are increasing by, effectively, five hours a day (Kirkwood 2006). The needs of ever more people as they age will create significant service provision challenges and opportunities across the world. In 'older life', people want a sense of purpose and a sense of well being even if they are living with health conditions. Equally, people want to live as independently as possible while still being connected to others and feeling at home wherever they are living (Khan 2013). Now consider the extant service provision landscape. It is large and complicated; in the US for example there is a $300 billion "long-term care" industry providing services to people with significantly varying needs and finances, from support at home services to residential dementia care, etc. It is also increasingly resource-intensive. In countries with socialised medical and care systems, like the UK, it has been estimated that more than 40 percent of healthcare spending is devoted to people over 65 and future growth in demand for services will inevitably put a significant burden on future taxpayers (nb. Federal and state funding in the guise of Medicare and Medicaid are the primary funders of long-care in the US). Another demographic trend that will directly impact care provision, especially in advanced economies, is that declining birth rates mean there will simply be far fewer caregivers. Add to that the lack of status associated with many carer jobs and a significant capacity shortfall is already a pressing operational concern.

What this paper aims to do is explore some key 'older life' themes through the pragmatic lens of (service) operations management; thus connecting OMs scholarly and practitioner community to this fundamental global challenge and, hopefully, providing the basis for some novel insights. The paper comprises four main sections. The first two develop a conceptualization of the 'older life' landscape, focusing on two dimensions, the meaning and management of:

1. Care, reflecting initially on individuals as recipients of care and questions of person-centricity, then by drawing on service-dominant logic, incorporating critical issues of relationships and finally extending discussion to question of the role of formal (typically carer-centred) and informal (typically older person-centred) networks.
2. Location and place (i.e. where), starting with the fundamental (physical, social and individual) importance of home, then reflecting on the "other places" where older life happens.

The third section explores the integrative aspects of this 'care-where' landscape (ie. issues where questions of home impact questions of care, and vice versa) and uses this as a way of identifying OM-relevant opportunities and challenges. The paper concludes with some suggestions for future OM work in this area of fundamental public and private sector concern.

2. THE MEANING AND MANAGEMENT OF CARE

The provision, and receipt, of care is only one dimension of older life but it offers a good starting point because it aligns strongly with OM concerns regarding the design, delivery and improvement of services. In formal terms, the 'need' for care services arises out of a person's *inability* to complete ADLs, or activities of daily living. ADLs include tasks such as bathing, eating, dressing, or other frequent activities that are essential to independence. Inability to complete these activities triggers informal care (family members or friends) or formal care (through the long-term care industry). This seems straightforward but actually defining care is a non-trivial task. The majority of the relevant literature lies within the medical and/or public policy spheres, and adopts a 'provider-active' point of view, exploring the challenges faced by governments, healthcare organizations (e.g. hospitals, care and nursing homes, assisted-living firms, etc.) and care professionals "producing" services for older people. In part this asymmetric perspective reflects the fact that even in private sector markets healthcare professionals typically have more knowledge (and power) than their clients, in elderly care this can also include deploying the authority of the state and, consequently, it can be difficult for clients

(and carers, regulators, managers, etc. – any people with less institutional status) to influence their behaviour. This is not to say that such an approach is indifferent to its care recipients. Patient care is, of course, a critical characteristic of healthcare professional status and self-regulation (*venditor emptor?*) rather than external regulation is the mechanism for balancing embedded client power/knowledge asymmetries. More specifically there is also an important body of work in the policy, practice and academic literatures, particularly in nursing (e.g. McCormack, 2004), that has long advocated a "person-centric" view of elderly care. This notion that care producers must seek to better understand, respect and work with care recipients as individuals forms the first building block in our care discussion.

2.1. Individuals and Care

There is an extensive body of literature that has long advocated a 'patient-centered' approach to (medical) care. In broad terms, this refers to the process of "understanding the patient as a unique human being" (Balint 1969) which is important, in part as something of a corrective to the asymmetries detailed above, but also because even something as medically 'objective' as a 'hip' fracture, will not be experienced in the same way by two different people. For example, it *may* cause far more distress to an active individual living at home than someone in a Nursing Home who is already being supported with a range of ADLs (cf. Mead and Bower 2000). For the purposes of this discussion we will adapt the multi-dimensional developed by Stewart et al. (1995) model. They suggest that person-centric care is a process where the carer:

- seeks to understand the whole person;
- enhance professional-person relationships;
- explores both disease and illness experience and, finds common ground regarding management - incorporating prevention and health promotion - in cases where medical treatment is involved

This final element ties to a related, significant body of literature of direct relevance to 'older life' care, patient engagement. This concept – again partly addressing traditional knowledge/power asymmetry – seeks to combine both a patient's knowledge, skills, abilities in managing his or her own health and care (increasing their level of activation in the official terminology) with interventions designed to promote positive patient behavior such as eating well or exercising regularly. Yet for all the emphasis on 'knowing the customer' and service 'co-production' (Bitner et al 1997), it can be argued that the discussion of person-centered care is still embedded in what has been called the 'goods-dominant logic' (GDL) of services. Take an assisted-living residence (ALR) as an illustration

(ALR is a catchall name for a variety of services that balance housing with support for some ADLs such as bathing and dressing). Even if the ALR offers residents a variety of service options - such as alternative food menus, different housekeeping arrangements, etc. – the salient fact is the ALR typically predefines both the tangible and intangible aspects of the service environment (long) before the customer becomes involved. Critics of the GDL approach (e.g., Kristensson et al., 2008; Lusch et al., 2007; Vargo and Lusch, 2004) argue that it *overly* privileges the organisation as the centre of value creation, ignoring the importance of reciprocity and mutual dependence between firms and consumers. Now consider a hospitality example: someone who loves a very soft pillow arriving in a hotel room where, as typical, pillows have been provided. The customer is not satisfied with these pillows but, rather than 'make a fuss', she settles for what she assumes is the 'best available' pillow. As a result complete information is not being exchanged, the customer is (slightly?) dissatisfied and the hotel loses the opportunity to find out about the customer's pillow-related needs. An alternative view, the so called service-dominant logic (SDL), use this critique as its point of departure and argues that service value is always co-created through an interactive process (Lusch et al., 2007; Prahalad and Ramaswamy, 2004a,b; Spohrer and Maglio, 2008) and that theoretical and pragmatic progress should emphasize processes of joint effort and collaboration and balanced and interdependent roles between the producer and the consumer. In the next section we explore what insights might be generated by an SDL-based characterization of (elderly) care services.

2.2. Relationships and Care

Care relationships exist at multiple levels including those between patients, their families, staff from all disciplines, and the wider community and they are a critical medium for exchanging information, feelings and concerns. A common critique of care, especially but not exclusively, for older people is that it is fragmented, built upon a series of interactions with multiple people in multiple settings (nurses, therapists, and physicians in a hospital, skilled nursing in an ALR, in the home with a home health agency, etc.). The negative consequences of fragmented care include "duplication of services, inappropriate or conflicting care recommendations, medication errors, patient and caregiver confusion and distress, and higher costs of care, due to re-hospitalization and use of the emergency department that might have been prevented via the facilitation of a smooth transition from hospital to home." (Parry et al. 2003). An SDL perspective would advocate recognizing from the outset that care (treatment, etc.) always involves a network of different actors. In general healthcare terms, best practice often invokes notions of holism; a 1992 US Heath Task Force for instance proposed the adoption of a

'relationship-centred care' model that would reflect the 'importance of interactions amongst people as the foundation of any therapeutic or healing activity' (Tresolini et al., 1994, p. 22). When this logic is placed at the centre of service design, such as happens in the process for newly diagnosed cancer patients at Integris Health in Oklahoma City, the results can be radically different. Patients and their families stay in one room on a single day, and are visited sequentially by various professionals who will be involved in their care – physicians, nurses, dieticians, social workers, care coordinators, and others. This avoids the problem of scheduling multiple different meetings on different days and, critically, associated anxieties (Berry *cited in* Jointer and Lusch 2016).

Within OM, relationships are predominantly analysed using a dyadic lens (Holma, 2012) but, in line with the SDL, there is growing recognition that exchange situations involve multiple actors. Focusing on triads may be helpful. Gunawardane (2012) for example, noted how it was the structural arrangements associated with a managed care health plan (HMO) in Los Angeles County (the "buyer"), serving approximately 300,000 Medicare and Medicaid (Medi-Cal) members (the '"customers"), contracting for services with a series of "providers" (the "suppliers"), that was the cause of various quality, compliance and customer satisfaction issues. Specifically, after being "showered with welcome letters, orientation calls, handbooks and health care information" on becoming a member, the caretaker role of the health plan effectively ceases and gets transferred to each provider ("bridge transfer"). It was not that the health plan purposely neglected its member issues but it had not set up suitable organizational structures and mechanisms to monitor and influence service over time resulting in a process of "bridge decay" (Li and Choi 2009). Scholars have also explored the use of triadic structures, describing how firms should 'create' triadic ties for both competitive and co-operative reasons (e.g. Choi et al., 2002; Brandenburger and Nalebuff, 1996). In a related manner, dementia care researchers frequently designate the ties between physicians, patients, and caregivers as a care triad (e.g. Jensen and Inker 2015) – in large part to emphasise the need for an inclusive approach to communication and care (ie. to avoid excluding patients and/or caregivers in dialogue and decisions).

2.3. Networks and Care

If we broaden our perspective still further to reflect on networks and older care we encounter another set of issues, benefits and challenges. Using the older person as the focal node, these networks can be broadly divided into 'forward facing' informal care networks and 'supplier facing' formal social and medical care networks.

- *Informal Networks.* Building on the SD logic, the network unit of analysis helps incorporate informal (older person-centred) friend and family networks in our understanding of the complexities of care needs and support mechanisms. Studies (e.g. Fiori et al 2007) have classified a range of older-person centric network types - differentiated on the basis of structural features such as network size, frequency of contact, etc. - and described associations with wellbeing. People with diverse (family and friend) networks generally exhibit the highest levels of wellbeing whereas restricted or socially isolated people generally exhibit the lowest wellbeing. It is almost a cliché of elderly care that married older adults have better psychological and physical well-being than unmarried individuals (e.g. Kiecolt-Glaser and Newton 2001) but Fiori et al (2007) noted that some forms of compensation for "marital status" exist with friend-focused networks.
- *Formal Networks.* Many (most?) individual care experiences are themselves defined by formal carer-centred networks. Care pathways create a whole host of ties (e.g. informal carer - doctor, doctor - hospital specialist; hospital specialists - hospital specialists; hospital specialist - ALR managers - complementary service providers, like physiotherapists, etc. etc.) and the extent to which these vary in terms of, for example, strength of regulation and integration, the level of social cohesion and common values, etc. will self-evidently impact overall care.

3. THE MEANING AND MANAGEMENT OF PLACE IN OLDER LIFE?

Where people live matters. Whatever their age, an individuals' sense of place and how they fit with their environment, are central to a meaningful sense of identity (Rowles 2008). Consequently, there is a considerable body of research on the meaning of home among elders although, rather like the discussion of care, it is a conceptually and empirically diverse literature. Once again therefore, we need to consider a series of critical 'building blocks' in seeking to understand the meaning and management of place in older life.

3.1. Home is the most important place

The vast majority of older adults in western countries live independently in the community and not in institutions. For example, in the U.S. and Germany, about 95 percent of people aged 65 years and older live in private households (Bundesministerium für Familie Senioren Frauen und Jugend [Federal Ministry for Family Affairs, Senior Citizens, Women and Youth], 2001; U.S. Bureau of the Census, 1996). Likewise, the majority of

older adults in Canada aged 75 years and older live in individual houses are highly attached to their living environment (Canada Mortgage and Housing Corporation, 2005, 2006) and want to age in their home. Moreover, older people spend more time at home than younger people. Indeed, recent data suggest that elders (65 years and older) spend on average 80 percent of their daytime at home (Baltes et al., 1999; Küster, 1998). Understanding the meaning of "home" in later life becomes a critical conceptual task (cf. Dahlin-Ivanoff et al 2007; Leith, 2006; Molony, 2010; Rowles and Chaudhury, 2005; Serfaty-Garzon, 2010) but, like care, it is a complex concept imbued with personal meaning and that goes beyond physical boundaries to include neighborhoods/communities (Chaudhury and Rowles, 2005; Cloutier-Fisher and Harvey, 2009; Donohoe, 2011). Based on a synthesis of the literature, Oswald and Wahl (2005) offer a "Heuristic Framework on Domains of Meaning of Home in Old Age", classifying three aspects of home in later life:

- *physical* aspects, which include the physical components of the house, the community, and the body-centered processes;
- *social* aspects, which include home as a place of connection and socialization; and,
- *individual* aspects, which include behavioral, cognitive, and emotional components.

Home health care services - delivered to people in their homes through a visiting nurse or care service – are consequently the most significant areas of long-term care provision. These home-centric activities also include Geriatric Outpatient clinics and community-based options such as Adult Day-Care, facilities coordinating daily programs of social and medical support during the day for those still residing in their own homes or with their families.

3.2. Other Types of Residence (Not Home)

In the last twenty years across most developed countries, there have been significant policy shifts influenced by individual preference and cost concerns regarding where older adults with ADL limitations live. Nursing homes (medically oriented residences for very frail seniors requiring 24-hour care; also referred to as specialized nursing facilities) are increasingly focused on short-term post-acute care and care for persons with severe health problems and dependencies, rather than on long-term custodial care. In the US for example, state Medicaid programs are now required to provide care in the least restrictive setting feasible. Similar cost concerns and preferences have led to increases in less medically oriented residential alternatives serving primarily an older private-pay clientele. Such settings provide a number of services for those no longer

able or willing to perform activities needed to live in traditional community settings. Consequently, the eco-system of place in older life is reasonably complicated and dynamic. For example, estimates from the provider-based 2010 National Survey of Residential Care Facilities (NSRCF) indicate that there are nearly 730,000 residents of care settings that provide an alternative to nursing homes, 90 percent of whom are 65+.

4. TOWARDS AN INTEGRATED CARE/WHERE LANDSCAPE

Exploring the critical notions of *care* and *place/home* as separate dimensions reveals the complexity inherent in what, on the surface, might appear to be straightforward constructs. More helpfully, the review also highlights a number of points of connection between the two dimensions suggesting there may be additive, integrative insight to be gained in combining the two areas into a single 'landscape'. Although it is 40 years since Lawton and Nahemow (1973) conceptualized "aging well" as a Person (P)–Environment (E) interchange, Wahl et al (2012) point out that the "role of the immediate physical, spatial, and technical environment has largely been neglected in gerontological research. The impact of neglecting *where* in considerations of care could be considerable. Consider, for example, the question of how to interpret ADLs? From a simple (producer-active?) care perspective, they provide an invaluable measurement of need and therefore indicate what level of support should be provided. From a 'where' perspective however, ADLs are of critical behavioral and emotional importance in defining what it means to be "at home". ADLs are not purely functional but their performance are critical routines in an individuals day and, emotionally, to still be able "to take care of their home is a source of pride and joy for older adults" (Bigonnesse et al 2014). In other words, in seeking to care for someone by helping with a task, there is a risk that this can undermine sense of self and psychological wellbeing. Similarly, consider how networks (friends, etc.) feature strongly in both the defining characteristics of care (as part of patient centricity, in questions of patient activation, etc.) and in the social dimensions of the Oswald and Wahl (2005) definition of home.

Now consider the Dutch Buurtzorg organization (Shorda and Koster 2104; Monsen 2013) that has attracted widespread interest for its high performance and innovative use of self-managing nurse teams. Although a home care organisation, the organization is founded on a series of integrative *care-where* principles. First, it expects its nurses to deliver a full range of medical *and* support services; whereas most providers use less expensive/trained personnel to support ADLs. This approach minimises a traditional source of dissatisfaction, the fragmentation of care that can be associated with various caregivers coming at different times on different days to provide different services. Second, the model is both strongly neighbourhood-based and maximizes patients' independence

through training in self-care and the active creation of networks of neighbourhood resources. For example, after some clients complained to their nurses that there were never any sporting events for "people like them" one of the nurse teams got together with insurers and town officials to organise the Rollatorrace event (a race for people with Zimmer frames). Third, in seeking to support the client in his/her social environment and promote self-care and independence, all client engagements start with a holistic assessment of needs; including medical, long-term conditions and personal/social care needs. Care plans are drafted from this assessment. Formal carers are identified and plans made for coordinating care between providers but clients' networks of informal care are also mapped and these are actively included in plans.

5. OM AND THE OLDER LIFE (CARE/WHERE) LANDSCAPE

In this section we will begin to reflect on OM challenges/opportunities highlighted by the *care* and *where* landscape.

- Supply Chain/Network Management. Older life frequently involves moving across care pathways and, less frequently but still commonly, from one place to another. Sometimes these moves are temporary (e.g. spending time in hospital after an accident), some are permanent but what this illustrates is that older life is characterized by a series of Care/Where transitions across a range of formal and informal supply chains/networks. Coleman (2003) gives the example of a frail older person who sustains a hip fracture. She "may require treatment from a diverse range of care professionals in a variety of settings. In each transition there is increased exposure to poor care quality and problems of care fragmentation. Consider how, when investigating operational failures encountered by hospital nurses, Tucker's (2004) study suggested "most operational failures stem from breakdowns in the supply of materials and information across organizational boundaries" (p.151).

- Product and Service Design. One area of relevant OM research/practice that has already been explored in elderly care settings (e.g. De Blok et al 2013, 2010) is service modularization. In the fragmented world of senior care world of senior care, modular approaches offer the prospect of coping with emergent complexity and cost. Elderly care, from a GDL perspective, could be the process – previously discussed in the pillow exemplar - of offering a pre-defined menu of standard treatment processes (e.g. Meyer et al. 2007) that together result in each patient receiving a unique care package. Of course, such as approach can be positioned as contradicting the core tenets of a more person-

centric approach to care; where it is critical to allow professionals to listen to their clients, build a relationship and be given the space to make individual judgments (Lanjananda and Patterson 2009).

- Quality/Improvement. There is already a significant body of work exploring the overlap between core (ie industrial) OM quality concerns and healthcare in general. To date however there has been much more limited research looking at quality/improvement in older life settings (Miller et al 1998) and significant gaps in basic operational delivery appear to persist. In a recent special issue of the Journal of Applied Gerontology for example, Castle et al. (2016) found, in their survey of 767 US Nursing Homes, that only one in five nurse aides reported complying with hand washing regulations "all of the time" and only four in 10 facilities appeared to ensure that such hand washing was performed. This represents another area for significant OM future contribution.

6. CONCLUDING COMMENTS AND FURTHER RESEARCH

There is a significant and growing body of OM work that explores the challenges facing, and proposes solutions for, healthcare systems. What this paper has argued is that the service management challenges associated with ageing and older life represent an extension of this body of work (e.g. replicating quality management studies in nursing homes?) but also, in describing the care/where space, highlighted that it includes significant novel challenge as well. This is not an empirical paper but the concepts and ideas presented (especially in section 5) are intended to provide a starting point for further theory-driven empirical research. They are not intended to be exhaustive. For example there is no mention of ICT and other technologies (such as robotics: Broadbent et al 2009). Equally, we have not discussed workforce planning and scheduling (another area of significant OM healthcare activity) or performance measurement (except in terms of supply network governance).

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To save space, full reference list available on request from the author.

Acknowledgements

RESEARCH ON WELLNESS TOURISM:A 42 YEARS REVIEW

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ABSTRACT

This study reviewed 465 articles on wellness tourism from 45 English-language academic journals within and outside of health and tourism from 1978 to 2012. Content analysis of the selected articles identified three main themes: wellness tourist markets (demand), wellness tourism industry development and promotion (supply), and wellness tourism impacts (external environment). Data shows that with the development of wellness tourism, an increasing number of scholars pay attention to the impact of wellness tourism. With the breakneck advancement of globalization, scholars around the world shift their emphases on wellness tourism markets to wellness tourism industry development and promotion, and currently to wellness tourism impacts. Moreover, the number of articles about these three themes also keeps increasing with the development of the world. Trends and gaps in the literature on wellness tourism were identified.

INTRODUCTION

The concept of wellness initially emerged in reaction against what is called the medical model of health; it describes health or wellness as the absence of illness, infirmity or decrease of the mind of body (Culley, 2002). Scholars around the world have not reached a consensus of definition of wellness tourism. But it is universally acknowledged that wellness tourism, or could be called health tourism, is the travel to promote health and well-being through physical, psychological, or spiritual activities (Dimon, 2013), which is often correlated with medical tourism because health interests motivate the traveler striving to improve or maintain health and quality of life, often concentrating on prevention physical and psychological disease which echoes that of wellness tourism. The first recorded medical tourism travelling dates back thousands of years when Greek pilgrims traveled from all over the Mediterranean to the small territory in the Saronic Gulf called Epidauria the sanctuary of the healing god Asklepios to obtain medical treatment (History of Medical Tourism).

As World economic situation since 2007 has increased an extra pressure on people's psycho-physical state of health (Koncul, 2012), people are gradually forced to seek a new ways of relaxation and re-energizing themselves. Under such circumstances, tourism sector has done remarkably well by offering the new model called Wellness. This new trend appeals to world-wide increasing number of people traveling to destinations that provide wellness facilities. Koncul insisted the rise of 'wellness' concept first ascribing to the efforts of WHO pushing forward an integrated concept of "well-being" and "fitness" into its global health policy and second due to the increased human awareness of personal health. The investigation of Lim et al (2016) based on 573 samples examined the differences between visitor motivations and satisfaction between first-time visitors and return visitors to a recreation wellness tourist attraction site in South Korea, and data testified that the purpose of relaxation and rest is one of the main reasons motivating first-time visitors to choose wellness tourism.

Moreover, coincidence with the continuous advancement of the tourism industry, tourism industry has transformed from simply sightseeing visiting to entertaining and sports tourism with the main purpose of building up health, which leads this new trend of the development of tourism industry (Liu et al, 2012).

The growth of aging population and the stable increase of income is also a reason rapidly facilitating the wellness tourism market (Yan, 2008). Yan took China as an example and found wellness tourism has enriched the content of tourism, promoted tourism activities in a new way, and set up a new lifestyle for aging population.

Actually, wellness tourism market is flourishing globally. Heung et al (2013) discovered although wellness tourism in China is in its infancy, whose natural and cultural resources are the foremost offerings of the country's wellness tourism, which can offer new opportunities and strengthen the overall competitiveness of Chinese tourism industry. Nahrstedt (2004) believes wellness is a new perspective for leisure centers, health tourism, and spas in Europe on the global health market, and highlights the history of the European leisure-based health systems. Gonen (2010) found that health tourism plays an essential role in national economies from the case study of Turkey. Pafford (2009) revealed the high number of uninsured or underinsured Americans traveling abroad such as, India, and Thailand for affordable medical tourism. It is projected to become a $21 billion a year industry by 2011.

If wellness tourism developed in a proper form, it can contribute to human transformation, growth and development, and change human behavior and our relationship with the world Smith (2013) deemed the experiences offered by travel and tourism that can change travelers as human beings and their relationships and interactions with natural, socio-cultural, economic, political and technological environments.

REVIEWS

Previous studies and meta-analyses have exerted marvelous influence on an overall understanding of wellness tourism. From 465 collected previous works, the author finds that wellness tourism spans a wide field of health-oriented tourism, such as, medical tourism, sport/fitness tourism, adventure tourism, wellbeing ("Yang sheng") tourism, cosmetic surgery tourism, SPA tourism, rural tourism, and so forth.

Medical tourism is a growing worldwide phenomenon of wellness activity. In order to illustrate medical tourism, Hanefeld et al (2014) reviewed the literature with reference to the UK National Health Service (NHS) as an example of a Public Health Care System with 100 papers from September 2011 to March 2012, revealing specific types of tourism depending on treatment, eg, dentistry, cosmetic, or fertility. Patient motivation is complex and while further research is needed, factors beyond cost, suggesting that UK patients travel abroad to receive treatment. Travelers view medical tourism as travel abroad in order to obtain non-emergency medical services. From the perspective of scope, Crooks et al (2010) studied the patient's experience of medical tourism from 216 works.

In order to access medical tourism for health care, patients from high-income nations visit low- and middle-income countries across international borders. Imison et al (2013) from electronic copies of Australian television (n = 66) and newspaper (n = 65) items from 2005-2011 about medical care overseas discovered Australian media coverage of medical tourism was largely focused on Asia, featuring cosmetic surgery procedures and therapies unavailable domestically. Due to the better quality, lower cost, domestically unavailable as well as no wait-time destinations for non-emergency medical care, patients like to travel abroad for medical tour. Chaung (2014) uses the main path analysis to analyze the significant development trajectories, important literature, and recent active research areas in medical tourism. Abd Manaf (2015) examined service quality, perceived value, overall satisfaction and future intention among medical tourists who seek treatment in Malaysian private hospitals. From 173 responses from questionnaire analyzed by SPSS 17, finding identifies important constituents of medical tourism which may assist policy-makers and hospital managers in better understanding the industry.

Yu (2014) retrieved 52 papers from tourism journals and medical journals indexed by SSCI or SCI, and found papers from medical journals focus on social effects, legislation and policy, medical and health issues, while papers from tourism journals concentrate on tourism and tourists' psychology. This finding is conducive to the understanding of medical tourism research and may contribute to facilitate sustainable medical tourism development. Ning De-huang and Liu Juan (2013) made a review of the development of International medical tourism which reflected that researches in medical tourism conducted by foreign researchers in recent years, concentrating on contents, categories, influencing factors, development effect and tourists' motivational behavior.

Aside from medical tourism, sport tourism is also a common wellness activity. Matter-Walstra（2006） found leisure sport, and especially ski/snowboard tourism demands great

flexibility in hospital beds, staff and resource planning in these areas through the evaluation of 135 local and nonlocal residents between 2000 to 2002 .

Moreover, there also exist some "sport tourism", "health tourism", "forest tourism", "sport tourism"," diet therapy" on health tourism Liu Xuan et al (2012) searched these key words in full-text databases in China Journal Net and other databases from 2000 to 2010, and results from 619 articles or dissertations show Chinese health tourism is still in the initial stage of its development.

All in all, the above literature reviews provide a good opportunity to deeply and comprehensively understand what is wellness tourism, and to what extent does wellness tourism develop, why there are an increasing number of people choose wellness tourism in different countries. There is no denial that these studies are invaluable resources beneficial for scholars in future research. But these works have not laid emphasis on

(1) Investigate international journals and articles on Wellness tourism;

(2) Find out the authored scholars on Wellness tourism

(3) Illustrate the relationship and networks of authors publishing research on Wellness tourism

(4) Summarize the trends through the category of marketing of wellness tourism, wellness tourism industry development and promotion and wellness tourism impacts in the works on wellness tourism

METHDOLOGY

In order to get a broader view of the scholarship on wellness tourism, this paper chooses 465 papers from the ISI Web of Science (www.isiknowledge.com), and some authoritative journals, like Southern Medical Journal, Journal of Travel Medicine, and Bmc Public Health, and Annals of Tourism Research, Tourism Management and Journal of Travel Research, international conference papers and so forth pertinent to wellness tourism. A total of 465 articles were collected by searching the key words: "Wellness tourism", "Medical tourism", "Health tourism", "SPA tourism" and so on.

Data were classified and analyzed from three aspects. The first and basic goal of this paper is to study the content of the chosen articles and books, which includes the aspects about the publication years, authors, impact factor of the journals, institutional affiliations, and then put them into categories. This paper lays stress on the quality of the selected articles. The order of authorship was not recorded; as to the multiple authors of the journal, each author was given the same credit as a researcher publishing as a sole author. Moreover, quantitative measurement is the basis of the research productivity and centrality ranks of researchers reported.

In order to achieve a wider viewpoint of the scholarship on wellness tourism, this paper studies analyzed some databases to collect related articles instead of combing through specific journals. ISI Web of Science (www.isiknowledge.com) was chosen due to its international recognition and authoritativeness. Furthermore, this paper also chose non-tourism related journal, such as Journal of Vacation Marketing, Amfiteatru Economic, Asia Pacific Viewpoint, Public Personal Management, Revista de Historia Industrial and so on. The time span of the collected papers was from 1974 to 2016 to specifically study the development of wellness tourism.

Second, this study will apply social network analysis to the analysis of authorship relationships as well as the collaboration among researchers by UCINET software (Analytic Technologies, Harvard, MA). The centrality and power of the authorship Networks would be calculated.

Third, the chosen 465 articles were classified into dominant thematic categories by the approach proposed by Miles and Huberman (1994), which focus on data reduction, data display and verification of the data, the three flows of analytical activity. At the data reduction stage, this paper adopted a 'word count' technique. It is essential to complete content analysis of each journal title so as to enable the full paper to get access to classify the word count. On the basis of the reduction work, it was initially proposed that there were three broad theme categories: marketing of wellness tourism (demand), wellness tourism industry development and promotion (supply), and wellness tourism impacts (external environment). These three theme categories were to be the research topics.

Actually, this approach enables the data to be more clearly and visible at the initial stage in research. In order to refine the setting of topic subcategories, abstracts, first paragraph, and conclusion part needed to be read so as to make an appropriate category. This treatment is beneficial to the further development of the classification of subcategories and, consequently, verification of research findings.

RESARCH RESULTS

The research chooses 465 articles as the samples that met the current criteria of English-language articles published in refereed international journals. Table 1 displays that research on wellness tourism increased from 1974 to 2016, and especially since 2010. Moreover, more than half (66.7%) of the articles were published in the six years from 2011 to 2016. Figure 1 apparently outlines this trend of growing research interest in wellness tourism.

Table 1. Number of Articles by Publication Year and Period

Publication year	Number	%
1974-1990		

1974	1	0.2%
1977	2	0.4%
1978	1	0.2%
1980	1	0.2%
1982	1	0.2%
1988	1	0.2%
1989	1	0.2%
1990	1	0.2%
Subtotal	9	1.9%
1991-2000		
1993	1	0.2%
1994	1	0.2%
1997	2	0.4%
1998	1	0.2%
1999	2	0.4%
2000	4	0.9%
Subtotal	11	2.4%
2001-2010		
2001	3	0.6%
2002	2	0.4%
2003	7	1.5%
2004	7	1.5%
2005	5	1.1%
2006	11	2.4%
2007	16	3.4%
2008	18	3.9%
2009	19	4.1%
2010	47	10.1%
Subtotal	135	29.0%
2011-2016		
2011	65	14.0%
2012	38	8.2%
2013	50	10.8%
2014	52	11.2%
2015	76	16.3%
2016	29	6.2%
Subtotal	310	66.7%
Total	465	100.0%

Journals Consisting of Publications of Research on Wellness Tourism

The first purpose of this paper is to identify the academic journals publishing research articles on wellness tourism. There are 17 papers were published in the journal of tourism management; 8 papers in medical tourism and public tourism respectively. Aside from the journals of Tourism Management, Medical tourism, Public Health, there are 21 kinds of journals, such as social science &medicine, lancet, Iranian journal of public health attracting many authors to publish their works. Table 2 shows the top24 numbers of the papers published in tourism journals on wellness tourism. The journal of Tourism Management ranks No.1 among all the journals, and there is no much difference in published article numbers between the rest of the journals.

The non-tourism journals, such as business, economic journals took up a significant 21.08 per cent of all the articles on wellness tourism. The results testified the findings published on these journals were also essential to review such scholarship outside of wellness tourism (Table 3).

Table 2 Tourism/Health Journals Publishing papers on Wellness Tourism

Names of Journals (24)	Number
TOURISM MANAGEMENT	17
MEDICAL TOURISM	8
PUBLIC HEALTH	8
SOCIAL SCIENCE & MEDICINE	7
JOURNAL OF VACATION MARKETING	3
LANCET	7
IRANIAN JOURNAL OF PUBLIC HEALTH	5
JOURNAL OF TRAVEL MEDICINE	6
ZEITSCHRIFT FUR TOURISMUSWISSENSCHAFT	7
DEVELOPING WORLD BIOETHICS	6
HEALTH COMMUNICATION	5
ASIA PACIFIC JOURNAL OF TOURISM RESEARCH	5
JOURNAL OF TRAVEL & TOURISM MARKETING	5
GLOBALIZATION AND HEALTH	5
BMJ-BRITISH MEDICAL JOURNAL	5
HEALTH TOURISM: SOCIAL WELFARE THROUGH INTERNATIONAL TRADE	4
JOURNAL OF MEDICAL ETHICS	4
INTERNATIONAL JOURNAL OF HEALTH SERVICES	6
MATURITAS	3

CANADIAN FAMILY PHYSICIAN	5
INTERNATIONAL JOURNAL OF TOURISM RESEARCH	4
WILDERNESS & ENVIRONMENTAL MEDICINE	3
TOURISM ANALYSIS	2
AUSTRALIAN DENTAL JOURNAL	2
GLOBAL HEALTH ACTION	2
	133

Table 3. Non-Tourism /Health Journals Publishing papers on Wellness Tourism

Names of Journals (21)	Number
SIGNS	6
AMFITEATRU ECONOMIC	3
ASIA PACIFIC VIEWPOINT	2
JBIS-JOURNAL OF THE BRITISH INTERPLANETARY SOCIETY	2
PUBLIC PERSONNEL MANAGEMENT	1
REVISTA DE HISTORIA INDUSTRIAL	1
SYLWAN	1
WATER SCIENCE AND TECHNOLOGY	1
AMERICAN JOURNAL OF BIOETHICS	1
TRANSYLVANIAN REVIEW	1
EXPERTISE, AND TESTIMONY	1
AMERICAN JOURNAL OF PHYSICAL ANTHROPOLOGY	1
CANCER CYTOPATHOLOGY	1
AMERICAN ANTHROPOLOGIST	1
HUMAN REPRODUCTION	2
PERSPECTIVA GEOGRAFICA	1
TRANSFORMATION - FUTURE PROSPECTS	1
EKONOMSKA ISTRAZIVANJA-ECONOMIC RESEARCH	1
SOCIAL POLICY & ADMINISTRATION	1
BIOETHICS	3
	32

Author Productivity and Authorship Relationships

This study secondly aimed to identify scholars who had authored research articles on Wellness tourism. A total of 742 author names were associated with the 465 articles. Of them, 84 are individual authors. Of the 465 articles, 84 (18.0%) were sole authorships,

and 381 (81.9%) were multiple authorships. Specifically, 102 articles (21.9%) had two authors, 136 (29.2%) completed by three authors, 95 (20.4%) had four authors and 48 (10.3%) had five or more authors.

Among the 465 authors, 358 (76.9%) contributed to only one article, whereas the rest 107 (23.1%) authored two or more articles. Among the authors with multiple contributions, 59 had two, 24 had three, 16 authors had four and 87 had five articles. The most prolific authors were Snyder, Jeremy., Crooks, Valorie, A. and Johnston, Rory, Turner, Leigh , Connell, John ;Carrera, P and Lunt, Neil, the most prolific authors (Table 4).

The third objective of this study is to illustrate the relationships and networks of authors publishing research on wellness tourism.

Table 4. Author Article Productivity

Rank	Frequency of author name	Author name
1	30	Snyder, Jeremy
2	28	Crooks, Valorie A
3	18	Johnston, Rory
4	15	Turner, Leigh
5	13	Connell, John ;Carrera, P
6	10	Lunt, Neil

Author regions and university affiliations

Table 5 shows that the distribution of the authors could be found in 50 regions across the world. The largest group was the authors from USA (n = 162). The second largest group is from Canade (n = 102) and Malaysia (n = 51) ranked third in frequency, England(n = 48) and Taiwan (n = 46) follow suit with the similar numbers of authors. From Table 5. It is easy to find authors USA and Canada made tremendous contributions to the scholarship on wellness tourism.

Simon Fraser University from Cananda takes up the largest number of these authors (n = 54). University of Minnesota from USA is the second largest group (n = 18), and University of Sydney (n = 13) in Australia ranked third. The top 10 universities in terms of author frequency were in Canada, USA, Australia, England, Malaysia, Taiwan, Netherlands (Table 6).

Table 5. Regions of Authors

Region	Numbers	Rank
USA	162	1
Canada	102	2

Malaysia	51	3
England	48	4
Taiwan	46	5
Australia	37	6
India	23	7
Singapore	22	8
Croatia	19	9
South Korea	17	10
Thailand	17	10
Romania	14	11
Iran	14	11
Netherlands	14	11
Germany	12	12
Mainland China	12	12
Italy	10	13
Hong Kong	9	14
France	9	14
Mexico	7	15
Ireland	7	15
South Africa	6	16
Spain	6	16
Turkey	5	17
Israel	5	17
Russia	5	17
Lithuania	4	18
Jamaica	4	18
Poland	4	18
Hungary	4	18
Sweden	4	18
Colombia	4	18
New Zealand	4	18
Austria	3	19
Belgium	3	19
Brazil	3	19
Nigeria	3	19
Ukraine	3	19

Scotland	3		19
Bahrain	2		20
Slovakia	2		20
Greece	2		20
Serbia	2		20
Lebanon	2		20
Iceland	2		20
Argentina	1		21
Czech Republic	1		21
Latvia	1		21
Switzerland	1		21
Tunisia	1		21

Table 6. Author University Affiliations

Author university affiliations	Regions	Number of authors	Rank
Simon Fraser University	Canada	54	1
University of Minnesota	USA	18	2
University of Sydney	Australia	13	3
University of York	England	10	4
Harvard University	USA	8	5
International Islamic University Malaysia	Malaysia	8	5
University of Alberta	Canada	8	5
Central Taiwan University of Science and Technology	Taiwan	6	6
Wageningen University & Research Centers	Netherlands	6	6
The Ohio State University at Columbus	USA	5	7
University of the Incarnate Word	USA	5	7
The Hong Kong Polytechnic University	Hong Kong	4	8

Research Themes

The fourth study objective in this paper was to describe the predominant themes within the chosen 465 articles. Content analysis of the selected articles identified three main

themes: wellness tourist markets (demand), wellness tourism industry development and promotion (supply), and wellness tourism impacts (external environment).

Among the three research themes, wellness tourism impacts (n=245) occupied a large proportion of the research articles, and wellness tourism industry development and promotion (n=132) ranked the second. Table 7 shows that with the development of wellness tourism, an increasing number of scholars pay attention to the impact of wellness tourism. With the breakneck advancement of globalization, scholars around the world shift their emphases on wellness tourism markets to wellness tourism industry development and promotion, and currently to wellness tourism impacts. Moreover, the number of articles about these three themes also keeps increasing with the development of the world. For instance, articles about wellness tourism during 2011-2016 have reached to 58 which is much higher than that in 1974-1990 (n=1) and 1991-2000(n=2); articles about wellness tourism impact during 2011-2016 have reached to 169 which is almost 34 times larger than that in 1974-1990 (n=5) and 1991-2000(n=5). All these facts verify that wellness tourism has been positively emerging not only in the focus of tourism development, but also in the focus of scholarship research.

It is almost universally acknowledged that wellness tourism or international medical tourism is a recently emergent industry with a promising future. Market size, market share and market strategy, market in Asia, Europe, America and so on have attracted scholar to concentrate on wellness tourist market; Concerns on prostate biopsy, childhood vaccination, oral health, and medical tourism, legal climate of other medical tourism, psychology, tourism, health and wealth, ethic challenges and so forth are the common research points in the study of the development of wellness tourism. Impact of Medical tourism on the healthcare development of a country, on health human resources, on health care equity and access in low-and Middle-income countries, on health worker migration, or on economic and so forth are also arouse scholar s' awareness in the research.

Table 7. Research Themes of Collected Articles from 1974-2016

Themes	Topics	1974-1990	%	1991-2000	%	2001-2010	%	2011-2016	%	Total	%
Marketing of wellness tourism	Behaviors	-	-	-	-	-	-	2	0.7%	2	0.5%
	Marketing	-	-	-	-	3	2.6%	10	3.6%	13	3.2%

Development environment of wellness tourism / Wellness tourism impacts											
Development environment of wellness tourism	Motives	-	-	-	-	-	-	-	1	0.4%	1	0.2%
	Subtotal	-	-	-	-	-	3	2.6%	13	4.6%	16	3.9%
	perspective	-	-	-	-	-	8	6.9%	11	3.9%	19	4.6%
	Development	-	-	-	-	-	15	12.9%	31	11.1%	46	11.2%
	Supply	1	16.7%	-	-	-	2	1.7%	22	7.9%	25	6.1%
	Policy	-	-	-	-	-	5	4.3%	20	7.1%	25	6.1%
	Promotion	-	-	-	-	-	5	4.3%	9	3.2%	14	3.4%
	Barrier	1	16.7%	4	44.4%	10	8.6%	21	7.5%	36	8.8%
	Ethic	-	-	1	11.1%	4	3.4%	12	4.3%	17	4.1%
	Subtotal	2	33.3%	5	55.6%	49	42.2%	126	45.0%	182	44.3%
Wellness tourism impacts	Community	-	-	-	-	3	2.6%	9	3.2%	12	2.9%
	Industry	2	33.3%	1	11.1%	23	19.8%	37	13.2%	63	15.3%
	Ecological impacts	-	-	1	11.1%	2	1.7%	5	1.8%	8	1.9%

Education	-	-	-	-	4	3.4%	9	3.2%	13	3.2%
Technology	-	-	-	-	-	-	3	1.1%	3	0.7%
Social impacts	2	33.3%	1	11.1%	3	2.6%	5	1.8%	11	2.7%
Economic impacts	-	-	-	-	8	6.9%	20	7.1%	28	6.8%
Case/Event	-	-	1	11.1%	18	15.5%	44	15.7%	63	15.3%
Destination	-	-	-	-	3	2.6%	9	3.2%	12	2.9%
Subtotal	4	66.7%	4	44.4%	64	55.2%	141	50.4%	213	51.8%
Total	6	1.5%	9	2.2%	116	28.2%	280	68.1%	411	100.0%

Table 8. Ranking and Frequencies of Research Keywords

Rank	Frequencies	Keywords
1	118	Medical tourism
2	37	Health Tourism
3	20	tourism
4	10	health
5	9	health care
6	8	Medical travel; Wellness tourism

Marketing of Wellness Tourism

Customer always ranks first. So in order to explore the international wellness tourism market, some scholars have already conducted some research. Taking wellness tourism market in India as an example, Crooks (2011) discovered the market of medical tourism

relied a lot on successfully informing potential patients about procedure options, treatment facilities, tourism opportunities, travel arrangements, and destination countries through the promotion by a wide range of marketing materials such as flyers, booklets, as well as websites.

Destination is the market location for tourists across borders internationally to receive wellness tourism. The attraction of destination is the key point to take up the market of wellness tourism. Community communication could impact the decision of tourism destination. Abubakar (2016) studied virtual community membership has a strong influence on a tourist's behaviors and the way information is transmitted. Drawing on trust transfer theory, this study tests the influence of electronic word-of-mouth on destination trust and travel intention from a sample of 216 tourists in Cyprus. The findings from regression analyses suggest that electronic word-of-mouth on positively related to travel intention and destination trust; and destination trust is positively related to travel intention. Hemdi (2016) also investigated the influence of word-of-mouth to others (family, friends, and relatives) and conceptualized future destination choice refers to the revisit intention and the intention to spread the positive word-of-mouth to others.

How does the destination of wellness tourism hold its competitiveness of market? Increasing globalization inevitably has intensified competition between tourism destinations and regions. Gross (2015) considered the importance of regional networking and strategic management as a key factor to secure competitive advantages because health tourism is no longer sufficient to secure a strong market position. It is critical for the cooperation of all stakeholders to utilize core competencies, especially in rural health destinations.

Government also plays a dominant role in the promotion of market which could be reflected in the growth in Asia as medical tourism destination in the recent years facilitating the interest of numerous governments to join in the bandwagon. Wong (2016) provides pertinent comparative analysis of the medical tourism destinations, such as Malaysia, Thailand, Singapore and India in SWOT analytical model. Malaysia and Thailand have a good mixture of medical, tourism and wellness to be an excellent medical tourism destination while Singapore and India need further development in some of these elements. Meeting or exceeding the medical tourists' expectations and requirements are the priority of medical tourism destination marketers in ensuring a successful medical tourism industry development.

While most of the journals laid emphases on how to do the marketing of wellness tourism, seldom kept a watchful eye on legal climate of medical tourism destination as wellness tourism involves patient's intentional travel to privately obtain medical care in another country. Crooks (2015) liability or immigration law, physician licensing corporate ownership and reputational protection on the prospective legal and regulatory implications of the developing medical tourism consulted with diverse lawyers. Locher (2015) by comparing

Germany and Australia, these two very different health tourism destinations found specific health tourism characterized in different destinations from a supply but also a demand perspective at least in parts be explained by marked differences in a country's health care system.

Crooks (2016) made a critical reflection on Loh's "Trends and structural shifts in health tourism" and provided a descriptive study of the evolution of the size distribution of agricultural holdings in England and Wales based on the fitting of a lognormal density function to the size distribution in each year that distributional issues are central to the political economy of agriculture.

To sum up, in order to explore the wellness tourism market, the tourism destination should keep its attraction to tourists, moreover, procedure options, treatment facilities, tourism opportunities, travel arrangements, virtual community, regional networking and strategic management, government policy are also the influential factors.

Development environment of Wellness Tourism

Undoubtedly, challenges go hand in hand with the development of wellness tourism. Policy, barrier, ethic, welfare, background of the industry, the current national situation, issues of concern, evaluation system, business process, entrance system, macro-policy are the inevitable factors to be considered.

International medical tourism is a burgeoning and promising industry. Asia is gradually becoming the major destination of medical tourism. Choi, Keetag(2015) highlights the background of the industry, the current situation, issues of concern, and directions to pursue for the systematic development of the growingly popular South Korea medical tourism industry. As to development of Chinese market, in 2009, Professor Liu et al in Tsinghua University based on Thailand, Singapore, India, China, and Japan, the five Asian countries medical tourism policy identified the theoretical significance of medical tourism in international health, and asserted that it is feasible in China. In 2011, Liu raised concerns about the backward development of international medical tourism in Beijing compared with the promising medical tourism market in American. While five years later, the work team constituted by Liu Ruiqi (2016), Xue Guofeng (2016), Ma Xingshu(2016), Liu Yongsheng (2016) together with Professor Liu had done a detail and excellent research on China international medical tourism services on the building of institute evaluation system, business process, entrance system, macro-policy. And find China has rich tourism resources, ecological resources, and a high level of medical treatment in the first tier cities, with the unique advantages of traditional Chinese medicine, suitable for the development of international medical tourism. It will render much significance and benefits if China seizes the opportunity of the rapidly developing international medical tourism, and pour much effort in promoting international medical tourism service, optimizing domestic industrial construction which at the same time will drive other industries to advance.

From other viewpoint, Rashid (2015) studied the worries of prostate biopsy, childhood vaccination, oral health, and medical tourism; Crooks (2015) concerned on legal climate of other medical tourism, psychology, tourism, health and wealth, ethic challenges.

In a word, in the developing and promotion of wellness tourism, there are so many problems to be taken into consideration, such as ethic, legal climate, medical, background of the industry, the current national situation, issues of concern, evaluation system, business process, entrance system, macro-policy and so on.

Impact of Wellness Tourism

What are the impacts of wellness tourism?

Wellness tourism influences the economic development of a country. Pafford (2009) revealed the high number of uninsured or underinsured Americans traveling abroad for affordable medical tourism in the 21st Century. It is projected to become a $21 billion a year industry by 2011. International facilities in India, Thailand, and elsewhere are obtaining Joint Commission International (JCI) accreditation and aggressively marketing to Western customers and insurance agencies and advertising high quality standards and personalized service. So how does wellness tourism effect the development of a country? Uma (2011) realized 2007 saw about 450,000 patients from abroad visit India for medical treatment denoting the rosy future of medical tourism industry, which highlighted the importance of tourism as well as medical tourism in particular to a country like India generally. Chen (2013) hold medical tourism impacted low- and middle-income destination countries which may largely remain out of reach for the majority of the local patients, so the developed sending countries have the responsibility to adopt public policies to decrease demand on the part of their citizens for medical tourism.

In addition, it will also exert impact on people. Snyder et al (2015) insisted that the international practice of wellness tourism impact the global distribution of health workers by potentially reducing the emigration of health workers from destination countries for medical tourists and affecting the internal distribution of these workers. How about elderly benefits in wellness tourism? Wellness tourism impact beneficiaries disclosed in the preliminary study of Mrcela Elderly (2015) showed that beneficiaries (age 65+) exhibit specific characteristics that influence the distribution of health tourism market and suggested that beneficiaries recognized and appreciated the effect of the natural remedies and attractions available at the given destination. Medical tourism may also render challenges to decision-making that impact and are impacted by the physician-patient trust relationship-a relationship on which the foundation of beneficent health care lies.

All in all, government policy will pose positive impact on the development of wellness tourism, while wellness tourism may negatively influence healthcare of locals in relatively poor countries from the rich sending countries of tourists for medical tourism, or

therapeutic relationship, beneficiaries, but it may also positively promote the economic development of the destination countries.

CONCLUSION

This paper makes a literature review of 465 articles on wellness tourism, or medical tourism from 1974 to 2016 to report the background of wellness tourism and authorship analysis about the literatures on wellness tourism from some authoritative database or journals, such as ISI Web of Science (www.isiknowledge.com) and some authoritative journals, like Southern Medical Journal, Journal of Travel Medicine, and BMC Public Health, and Annals of Tourism Research, Tourism Management and Journal of Travel Research, international conference papers, and so forth pertinent to wellness tourism. Of the 465 articles, 84 (18.0%) were sole authorships, and 381 (81.9%) were multiple authorships. Synder, Jeremy was the most prolific author with 30 works. All the paper could mainly be summarized in three themes: wellness tourist markets (demand), wellness tourism industry development and promotion (supply), and wellness tourism impacts. Data shows that with the development of wellness tourism, an increasing number of scholars pay attention to the impact of wellness tourism. With the breakneck advancement of globalization, scholars around the world shift their emphases on wellness tourism markets to wellness tourism industry development and promotion, and currently to wellness tourism impacts. Moreover, the number of articles about these three themes also keeps increasing with the development of the world.

In order to explore the wellness tourism market, the tourism destination should keep its attraction to tourists, moreover, procedure options, treatment facilities, tourism opportunities, travel arrangements, virtual community, regional networking and strategic management, government policy are also the influential factors. And in the developing and promotion of wellness tourism, there are so many problems to be taken into consideration, such as, prostate biopsy, childhood vaccination, oral health, and medical tourism, legal climate, background of the industry, the current national situation, issues of concern, evaluation system, business process, entrance system, macro-policy and so on. Finally, government policy will exert positive impact on the development of wellness tourism, while wellness tourism may negatively influence healthcare of locals in relatively poor countries from the rich sending countries of tourists for medical tourism, or therapeutic relationship, beneficiaries, but it may also positively promote the economic development of the destination countries.

LIMITAIONS

Limitations unavoidably exist in the present study. The first limitation is the limited number of the research databases and journals. It is probably that the sample number is too small to stand for the general trend of wellness tourism from 1974 to 2016. In addition, this study

is unable to take the articles in non-English or non-Chinese into account, therefore, it may be more convincible to increase the number of samples and expand the time span or language span of the research articles so as to get more insights.

The second limitation is that this study has just only categorized all the 465 articles into three themes. It is possible that this category is too general to make a clear and specific understanding of the universal characteristics of wellness tourism around the world, thus a more detailed classification into topics of these three themes would create a clear outline of wellness tourism.

FUTURE

Although the research scope of the wellness tourism is very wide, it lacks deep exploration and the research in its essence of law. Articles are fragmented, lack of integrity and systematic. In addition, the law of the development of health tourism, the environmental capacity of health tourism, health tourism management and mechanism of profit distribution for health tourism are less mentioned in researches. Innovation in this field and international cooperation, talent cultivation also lack in research. And in China, the methods used in health tourism research are single; scholars still use the traditional description and analysis methods. What's more, the level of achievement is not very high and the applicability is not strong, theoretical foundation of the wellness tourism in China is weak, resulting that there is little theoretical research on high level and there isn't any published study on the wellness tourism system today.

The author maintains that the content of the wellness tourism research mostly lies in the development of a single area, health tourism resources, market development and suggestions of marketing. There is also a little part of research on the health tourism theory and the science of health in tourism. We all know, there are many areas in China have healthy and rich tourism resources, but considered the unreasonable management and underdeveloped, there are still many problems. We are still in the primary stage of health tourism research and development of product. I believe that the follow-up study should focus on interdisciplinary, integration of industries.

Refer to South Korea which use Korean drama to make "cultural invasion" to other countries, resulting "Korean wave" prevalent in Chinese, Russia, Japan, European and American countries. Plus, with the improving level of medical technology and service in South Korea, especially the plastic surgery there, tourists that go to South Korea increase constantly. We named it "Transformation tourism". According to the data provided by South Korea for the past 6 years, a total of 1 million global tourists went to South Korea for medical tourism. Among them, the number of medical tourists that went to Korea in 2013 was 211218, Chinese tourists accounted for 26.5%, has become a major source of medical tourism in Korea. This number is 10 times more than the number of 2009. According to the survey, in 2013, the money that Chinese tourists spending on medical

tourism reached 600 million Yuan, which means that per capita expenditure is more than 10 thousand Yuan, and this cost accounts for 25.8% of the total cost of China tourists in Korea.

Traditional Chinese medicine is a kind of unique health tourism resource, because of its simple, convenient, cheap, and effective, less side effects, it is more and more accepted by the public. Especially in European and American markets. Such as in the Rio Olympics, wherever the athletes from, they all did cupping which is a traditional Chinese therapy used to activate blood before their competition, besides, it is really hard and expensive to experience this kind of therapy if you are not in China because people in other countries have no chance to study. At the same time, traditional Chinese medicine, Tai Ji, Qigong, cupping, ear candling, etc. These kind of treatment technique, each of which has a unique therapeutic effect, so the development potential of the traditional Chinese tourism, if not more, better than South Korea's transformation tourism. I have to say, China now is in a good time (people can earn more money than before, which means that they have more pressure. So tourism has gradually become a necessity) and have good places (rich tourism resources and unique traditional Chinese medicine technology) and good people (the support of policy and a large number of outstanding talents in this industry). It will be a good direction to do research on Development of traditional Chinese medicine tourism at such a right time.

Thus, following are some advices in future research of wellness tourism.

Analyzing the wellness tourism in developed countries and compare them to China.

Considered that China's wellness tourism industry is not well-developed and its big market, scholars should put more emphasis on this part. Do some qualitative research in well-developed countries so as to find out how to build, develop, ripen the wellness tourism market in China.

Analyzing the tourists in terms of their nationality or the territory they live in.

(Dissecting their psychology so as to find out propagating mechanism in traditional Chinese medicine culture.)

The point that makes the traditional Chinese medicine tourism not well-developed is not because the medical resources are not in the right place or have no good connection with the tourism industry, it is more about the concept of wellness tourism have not been widely set up. We can say that most people not realize the effect of traditional Chinese therapy. Therefore, an incomplete wellness tourism system results the study in China apt to do the research in theory. However, Chinese medicine is a fatal attraction to the people especially from western or European countries, because of its mystery as well as the effect that western medical can not achieve even can not explain, people desire to try this unique medical concept. So scholars should investigate and study the psychology of those potential tourists. At the same time, in terms of other countries are well-developed in wellness tourism such as south Korea, finding out how to strengthen the influence of

wellness tourism resources (Plastic surgery in Korea, Chinese medical in China, advanced medical technology in America, SPA in Thailand, Yoga in India, etc.) or how to make them prevalent in other countries, how to use different mediums to infuse those concepts into people's mind, as using the Korea TV drama program to make the plastic surgery prevalent all over the world.

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THE CULTURE TRANSFORMATION JOURNEY

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ABSTRACT

This paper outlines the culture transformation journey. It identifies what culture is, the seven steps to a healthy culture, and the benefits of an environment of trust, respect, and common values. Determining an effective way to measure culture is the first step and becomes a benchmark from which to improve. Taking care of employees and providing them a voice in the workplace results in engaged employees and leads to extraordinary customer experiences. It's a differentiator and will ultimately result in exponential revenue growth. Putting people first equals financial success versus the more common approach in today's business world of the other way around.

INTRODUCTION

Culture has become a buzz word lately. In its simplest form, leaders recognize that a healthy workplace environment, one that is based on trust, in which each employee feels valued and recognized for their work, leads to employees becoming engaged in the business. Strong employee engagement results in customers having a better experience; they spend more, return more often, and recommend the service or company to their friends.

Positive experiences for employees, and subsequently customers, impact a company's revenue and profit. Good Company found that organizations with disengaged employees saw a decline in operating income of 33 percent (Good&Co 2013). Similarly, Harvard Business Review published an article titled "Putting the Service-Profit Chain to Work," which reported that companies with happy customers, as measured by loyalty, saw an improvement in profitability of up to 85 percent (Heskett et al. 1994).

With this direct impact on the financial results of the organization, it only makes sense to explore how to begin the journey of culture transformation.

Peter Drucker said, "Culture eats strategy for breakfast." This statement not only signifies the importance of culture in the success of an organization, but it also indicates the priority of culture as the nucleus

from which everything else stems. Without a healthy culture, it will be difficult or even impossible to execute a strategy. Having a strongly defined, positive culture means that all members of the team are working together, with little distractions getting in the way. The environment is free from fear such as fear of speaking up or fear of repercussions.

THE ROLE OF ORGANIZATIONAL CULTURE

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The easiest way to define culture is as 'the way things are done around here.' It's expressed through values and exhibited in people's behaviors. Just like every society has expected practices and norms of how to act and behave, so does every organization have a unique set of accepted ways of doing things, including behaviors that are tolerated or not, within the organization.

Whether talked about or not, every organization has its own unique culture. Given its ever-present nature, culture can be seen as intangible, which makes it difficult to try to identify. However, culture is also a process, and with prioritizing its importance and constant attention, it is possible to get your arms around it. Once harnessed, it can be leveraged to unleash unlimited potential within leaders, team members, and the organization as a whole. As the culture becomes more defined, positive, and healthy, employees are happier, and the sweet spot of extraordinary customer experience grows.

The journey towards a healthy culture is transformative and takes time, attention, and commitment, especially when distractions begin to take priority. Working with a number of organizations in the past in developing a healthy culture, I've developed the following step-by-step process to transform a vague, undefined culture into a vibrant, positive, and healthy culture:

IT STARTS AT THE TOP

Developing a strong, healthy culture is not a complicated process. The key is consistently embracing the concept, modeled by the most senior person within the organization, whether it's the president, CEO, or general manager. They need to embrace the importance of culture as integral to the success of the organization and communicate it constantly in all messaging, as well as incorporate it into everything, from decision making to recognized acceptable behavior. The human resources department has a role in incorporating the identified culture into practices such as hiring procedures, on-boarding of new staff, performance reviews, etc.; however, the president must embrace the concept and take ownership to truly have an impact that permeates throughout the organization.

WHAT GETS MEASURED GETS DONE

Determine a way to measure the culture of the organization. This will provide a benchmark to improve upon as well as insight into what is really going on. Measurement tools, such as the one developed by the Barrett Values Centre, quantify culture into a single number that identifies the health of the organization. Within the acceptable range of this score, team members are able to bring their 'whole-self' to work and are passionately engaged in what they do. At the other extreme, a score identifying an unhealthy culture typically means employees are disengaged and are often looking for other jobs. Employee turn-over is high, and usually, it is difficult to find replacements as people don't want to work there. It also suggests that there needs to be at least one leadership change and at the most extreme, the organization is probably headed toward financial disaster.

IDENTIFY THE CORE VALUES OF THE ORGANIZATION

Culture is expressed largely through the values of the leaders within the organization. To identify the core values of the organization, gather the personal values of each leader as well as their view of the values represented by the organization. Reduce and refine all of them into five 'core values'. Having a short list that everyone agrees on will make it

easy to remember and will become the guiding principles for decision making and tolerated behavioral norms.

ASK THEM

The real acid test for these core values is if employees see them as relevant, or even if they acknowledge them at all! Ask employees what they see as the values, beliefs, and acceptable behavior in the organization through an anonymous survey. Embed into it the core values identified by leadership to determine if team members see it as part of the current culture. Also, ask employees how their ideal environment would look.

Culture entropy is the decline, decay, or chaos in the organization and is expressed through what are called limiting values. These are negative behaviors that get in the way of productivity and include things like gossip, bureaucracy, and excessive cost control. The more limiting values, the higher the culture entropy otherwise known as chaos or disorder.

UNCOVER HIDDEN ISSUES

How one person defines 'accountability' might be something quite different from another employee's definition. Understanding what each employee means by each value, especially the limiting values, is critical to figuring out how to improve. Facilitated sessions uncover conflicts or ambiguities in the language and lead to finding patterns and similarities to bundle together values that have similar meanings.

Solutions begin to surface and lead to an action plan with timelines, accountability metrics, and prioritization to tackle the most important issues first and letting the 'nice-to-haves' fall to the bottom.

REVIEW, REFINE, AND REVISE

Recap and discuss the results with senior leadership and ensure their commitment to the action plan, refining the prioritization and timelines as necessary. Identify leadership issues and develop a plan to improve practices, including any personnel changes. Senior leadership needs to enliven on a consistent and regular basis the core values into all communications and incorporate them into all processes and procedures in the organization, such as hiring processes, onboarding, performance reviews, etc. These core values will also become the moral compass to define repercussions for unacceptable behavior.

ANNUAL CHECK-UP

Conduct an annual survey of team members to understand the progress of the culture transformation journey. The follow-up survey, using the initial measurement as the benchmark, will determine if the issues are resolved and if new ones have developed.

At one organization where we began the culture transformation journey, checking back one year later, the leader had gotten busy, and none of the action plans had been implemented. The results were that 80 percent of the employees that had taken the survey had left the organization. Imagine the impact that had on recruitment time and cost, gaps in customer service, and morale for the remaining staff.

What is especially interesting about the Barrett model is that it asks employees to identify their desired work environment. Without fail, employees want to work where the values are focused on the 'common good' verse 'self-interest.' Values such as accountability, customer collaboration, and making a difference are most common compared to financial stability and efficient processes. This means that employees and leaders want to work in an environment that is healthy, giving more to fellow employees and customers and most importantly, they want to make the world a better place.

The benefits of moving the culture needle are employees who are happy, enjoy their work, and are excited to be there. It causes a ripple effect. Employees come home after a day of being treated with respect and trust; they treat their family members with greater respect and value.

Customers who are treated better spend more when they are on-site, return often, and tell all their friends about it. Extremely satisfied customers become passionate about the organization and can't imagine their life without the product or service. The results are exponential financial growth, something that would put a smile on every president or CEO's face.

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AN ACADEMIC-PROFESSIONAL PARTNERSHIP DESIGNED TO IMPROVE PATIENT-CENTERED CARE FOR HOME HEALTH PATIENTS

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ABSTRACT

This paper discusses the collaborative efforts between an academic (Andrew Gallan) and a professional home health organization (Advocate at Home) in designing strategic initiatives and tactics for improving patient-centered care. Through a combination of data analytics, patient interviews, and home health ride-alongs, insights were generated to improve and measure compassionate care behaviors among the front-line staff. Efforts have been made to establish new metrics, novel behavioral assessments, and improved hiring practices. The entire organization has undergone significant engagement and culture change as a result.

INTRODUCTION

This presentation will cover two important, relevant concepts:
1. How Advocate at Home has worked to redesign relationships with home health patients and families through a collaboration with an academic advisor.
2. How professional organizations and academics can design a collaboration that cocreates value for both sides.

OVERVIEW OF HOME HEALTH AND ADVOCATE AT HOME

Home health care provides care to patients in their home, through visits by nurses, physical and occupation therapists, chaplains, social workers, and other health care professionals who travel from home to home to deliver the necessary care and health education for patients to manage and restore their health.

Advocate at Home, the largest integrated health care organization in the Chicagoland area, is also the largest home health provider in the area, including 12 Locations, with 750 employees including 650 engaged in frontline patient care and service roles, caring for nearly 11,000 patients at any given time. Advocate at Home provides core services such as Skilled Home Health Nursing Care, Hospice & Palliative Care, Home Medical Equipment, and Home Infusion or Intravenous Therapy. Additionally,

Advocate at Home provides innovative offerings including skilled nursing facility (SNF) care and physicians at home. The Chicagoland population is approximately 9.73 million people, stretching from the Indiana border to the Wisconsin border north to south.

Obstacles for home health providers are significant. They include educating patients and their family caregivers on self care, involving intermittent care, with provider contact occurring mostly on a one to two times weekly basis. Additional concerns, given the geography, climate, and social conditions in Chicagoland, include productivity, chaos, weather, neighborhoods and staff safety concerns, family dynamics, and an uncontrolled care environment. Patient and family issues include the conditions of their homes, their social patterns, their values, and their motivation to get well.

Advocate's Mission is depicted in Figure 1 below.

Figure 1. Advocate Health Care's Mission

Each of the three core dimensions, found in the center of Figure 1, are drawn to represent equal weight. They are defined as:
1. Safety, where the patient's voice says: "Do Me No Harm," which was measured using "Serious Safety Event Rate."
2. Quality, where the patient's voice says: "Help Me Heal," and was measured using "Health Outcomes Data."
3. Service, where the patient's voice says: "Treat Me Well," which lacked a specific metric.

To operationalize their mission, Advocate Health Care has established Behaviors of Excellence, which structure conduct across the entire organization. These behaviors are emphasized and assessed at every level of the organization. They include:

- Be Responsive
- Be Respectful
- Be Professional
- Be Accountable
- Be Collaborative
- Be Safe

ANALYTIC PROCESS AND FINDINGS

In order to evaluate the most important drivers of patient perceptions of home health care, and to develop appropriate metrics and standards of behavior for home health caregivers, the following research protocol was developed. First, a quantitative analysis of two plus years of HH-CAHPS and Press Ganey data was initiated to find strongest predictors of both Likelihood to Recommend and Overall Rating of Care. This step utilized various analytic methods, including regression analysis and structural equation modeling. Next, a qualitative exploration involved patient phone interviews and ride-alongs with home health staff to directly observe care and to interview patients.

Quantitative analysis focused on home health data first and hospice data second. The analysis included all HH-CAHPS Categories including, (a) Arranging Home Health and Scheduling Visits; (b) Managing Home Health, including Rescheduling, Problems, and Billing; (c) Nurse Care; (d) Therapists; (e) Personal Issues of Patients and Families; and, (f) Overall Ratings of Care from the Patient Perspective. The datasets included both CMS mandated items as well as Press Ganey supplemental items. Later, hospice data were analyzed as well, demonstrating consistency in findings with those from home health.

Key findings shows that it's ALL important, meaning that most items were statistically significant, no surprise given the size of the dataset. Hygiene factors, those that are necessary but not sufficient to bring about high levels of satisfaction among patients, included answering the phone, showing up when planned, and calling to reschedule when appointments. However, the motivating factors, those that drive high levels of satisfaction and delight, included three specific items. These are aspects of a patient's care experience that are the strongest drivers of ratings. These three items were formed into a composite measure for service. They became what Advocate at Home now calls the *Compassionate Caring Index*. This metric is an average score of the three questions:

- "Degree to which staff addressed your emotional needs"
- "Nurse concern for your comfort while treating or caring for you"
- "Nurse sensitivity to challenges caused by your health problem"

These findings were supported by the phone interviews Andrew conducted with patients. Recommendations from Andrew to Advocate at Home leadership included modelling the behavior you wish to see in your staff, or being the change you wish to see in others. Exhibiting servant leadership, or prioritizing the needs of others above your own, is a key to ensuring that the organization sees positive effects on employee job performance, creativity, and customer service behaviors.

Andrew then participated in ride-alongs with both home health and hospice. For home health, ride-alongs were conducted between July and October 2015, and included 18 Providers, 61 Patients, and 39 Interviews. For hospice, ride-alongs were conducted between December 2015 and January 2016, and included five providers and nine patients.

The recommendations that emerged from the ride-alongs were centered on compassionate care:
1. Overall, patients are provided high quality care by Advocate at Home, and have good relationships with their Advocate caregivers. Advocate at Home caregivers are well prepared to add dimensions of care to their visits. Additionally, they can leverage their relationships with patients in order to connect with them in new ways.
2. Advocate at Home caregivers do not feel fully connected to the organization, their branch, or their colleagues. Advocate at Home should develop, fund, and support branch activities and peer-to-peer programs to more strongly connect caregivers to the organization.
3. While Advocate at Home caregivers connect with family and other caregivers, the activities and communication are mostly limited to clinical care, not reassurance and emotional support. Provide deeper levels of assurance and empathy to family and other personal caregivers.
4. There are times when Advocate at Home caregivers interrupt patients or hear half of what they say and appear to stop listening. Listen better to learn more. Active listening is a key to developing a deeper appreciation for the patient's condition, experience, and expectations.
5. There were a significant number of instances when interviews revealed patient preferences, goals, and intentions that were unknown to the Advocate at Home caregiver. Ask a few more

questions about the patient's emotional state, goals, difficulties, and intentions.

The findings support learnings from previous phases of research, namely that compassionate care matters most, family members and other caregivers need to be supported and appreciated, and patients feel vulnerable yet happy to be at home. Further, if Advocate at Home leadership wishes to have their front-line staff provide compassionate care, develop improved listening skills, and ask better questions to identify patient goals and needs, everyone in organization needs to demonstrate servant leadership skills to the front line staff. Organizational culture change cannot be accomplished without frequent, meaningful mentoring at the front lines of care.

SERVICE EXCELLENCE COMMITTEE

As a result of these findings, a Service Excellence Committee was convened. Members included a diverse group from across the organization who were capable of enacting change in practices and evaluations.

- Denise Keefe, Division President
- Mike Commet, VP Advocate Home Products (Committee Chair)
- Michelle Warszalek, VP, Intermittent Services
- Amy Scheu, VP, Hospice & Palliative Care
- Elizabeth Calby, VP, Human Resources
- Katie Riley, VP, Clinical Services
- Christine Ricker, VP, Business Development
- Dawn Doe, VP, Post-Acute Division
- Cheryl Meyer, Director, Clinical Excellence
- Stephanie Cain, Manager, Customer Relations
- Karen James, Planning & Project Manager
- Andrew Gallan, DePaul University

The committee's roles and objectives were to create and promote a vision for the Advocate at Home patient service experience, to identify and develop organizational strategies for enhancing patient service experience. An important facet of the committee's work was to create organizational alignment to support associate success, to develop performance measures for assessing service experience and, finally, to assist leaders with goal planning and a tactical focus related to patient service. This required substantial changes in HR processes. Some of the issues identified are shown in Table 1 below.

Table 1. Human Resources Considerations at Advocate at Home

Activities	New Associates	Existing Associates
Selecting	X	
Engaging	X	X
Training	X	X
Evaluating	X	X
Incenting		X
Retaining		X

Advocate at Home's Service Future State was developed and is represented by the following statement:

We fully appreciate the patient's situation and wish to provide assurance. We identify patient goals & wishes and engage & involve patients & their families to achieve those. We combine these with outstanding clinical proficiency & compassion to achieve the highest levels of quality, safety and service. Service work integrates with and supports our Quality and Safety work.

Advocate at Home will measure progress toward the future state using both the Compassionate Caring Index and Patient Loyalty Score (willingness to recommend).

ENGAGING THE FRONT LINE STAFF

In order to begin to share the insights generated with the front line staff, a set of "Gallery Walks" were initiated, designed to start dialogue and generate awareness with the front line staff. Leadership shared insights, including higher levels of service help patients heal, the critical moments with patients being the difference, the fact that patients are vulnerable and want a relationship to help them feel staff are attentive and are concerned about them, and that Advocate at Home wants to decrease patient anxiety & increase confidence. Bringing confidence to the situation, Advocate at Home's data seemed to convey the same message as industry data are beginning to reveal.

The goals of the Gallery Walks were to share ideas and increase our awareness of patient vulnerability, identify behaviors that reduce patient anxiety and increase confidence with Advocate, identify behaviors that increase patient anxiety and decrease confidence with Advocate and to

identify barriers that might prevent us from always behaving to reduce anxiety and in caring and concerned manner.

The key takeaways from these Gallery Walks included:
- Avoid behaving in ways that might increase patient anxiety and reduce confidence in Advocate at Home.
- Associates committed to one or two behaviors that each person could begin doing differently today that would improve patient experience with Advocate, and to begin delivering higher levels of compassionate care.

Finally, a tactical plan was developed to guide specific actions and behaviors. This plan involved leveraging relationships to connect with patients more deeply and, to educate, empower & provide assurance to family & caregivers. Advocate realized that they need to present the organization to patients and their care system as highly informed, integrated and connected. Advocate realized that they needed to develop methods for staff to feel connected to the organization, their branch, and their colleagues. Advocate started working to ensure staff are engaged and able to provide compassionate care, to ensure that leaders are engaged and able to mentor and coach on this dimension as well, and to define and continually assess expected skills & behaviors.

Next steps extend beyond the timeline of this paper include:
- Training leaders on coaching and mentoring models
- Developing active listening and open ended questioning skills training
- Ensuring that leaders are trained on active listening and open ended questions, and prepared to introduce these skills to their staff
- Leaders are beginning to transfer this training to front line

A WIN-WIN RELATIONSHIP

Of course, a successful academic-professional partnership is a win-win relationship. Each side must find value in the relationship, which requires that each side compromise and support the needs of the other, while also communicating clearly specific needs that make the project worthwhile.
From Advocate at Home's point of view, it has been a winning relationship due to the following benefits:
1. Sophisticated data analysis to isolate what matters most & direct focus
2. "Outside Eyes" to objectively provide feedback on what really happens when staff are with patients
3. Credibility with regard to Andrew's body of work, university affiliation, ability to convey ideas in ways that support action

4. Perspective from other organizations and emerging research within the industry
5. External perspective to challenge leadership bias and beliefs and provide confidence new directions are on target

From Andrew's point of view, it has been a winning relationship due a variety of factors. Advocate at Home has enabled him to connect with other parts of the organization, which have supported his research, teaching, and events. These include:

1. The Center for Health Information Services, which has guest lectured in classes on Health Care Data Analytics.
2. A relationship with Bill Santulli, COO, who has been a keynote speaker for DePaul University's Health Sector Panel Series, quarterly events that have been developed by Andrew. Bill is also Andrew's sponsor for his Academic-in-Residence position at Advocate Health Care.
3. A relationship with Monica Locker, Enterprise-Wide Manager for Patient Experience, which has enabled Andrew to stay in touch with emerging patient experience issues.
4. The Russell Institute for Innovation & Research, which has provided Andrew a research associate position that has facilitated research projects in cooperation with Advocate Health Care.
5. Family Medicine at Nesset Pavilion, which has supported Andrew's research project on patient experience.

Advocate Health Care has also provided Andrew support for several research projects, including:

1. Causal Attributions in Health Care: Ride-Along Interviews with Advocate at Home
2. Patient Shadowing: Family Medicine at Nesset Pavilion
3. Service Reliability and Service Excellence, a project emerging from Andrew's Academic-in-Residence position with Advocate Health Care during Fall 2016.

For Andrew, perhaps the biggest benefit of the partnership has been that he has had the benefit of a transformative experience, where he has been capable of learning, applying his skills and expertise to make a difference in the lives of patients, and deepening his expertise in patient experience, home health, and health care data analytics.

Buildings that make Us Blossom; The Living Building Challenge in Health and Hospitality Infrastructure

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ABSTRACT

A glance into the Living Building Challenge, arguably the most stringent sustainable building standard in the world.

THE LIVING BUILDING CHALLENGE

The Living Building Challenge is a philosophy, advocacy tool, and certification program that addresses development at a variety of scales.

The core underlying principle of the Living Building Challenge is that buildings should mimic nature and natural systems—and the Challenge uses the metaphor of the flower to illustrate that.

Like a flower, all elements of the built environment are rooted in place. Yet unlike typical buildings, a flower has place-based solutions to meet all of its needs and to maintain balance with its surroundings.

If a building is informed by its eco-region and limited to resources within its place, that building will generate energy with renewable resources on site, capture and treat water, operate efficiently, work cooperatively with its community, act as feedstock for new development at the end of its life, and be beautiful.

The Living Building Challenge is an attempt to codify the metaphor of the flower into a performance standard, using both left and right brain thinking. It creates infrastructure that regenerates its surrounding ecosystem and is resilient to changes in local climate and energy and water infrastructure.

Living Building Challenge framework may be applied to three different types of projects. Renovations, which are partial building updates such as tenant improvements, partial residential remodels or historic rehabilitations of a portion of a building. Landscape or Infrastructure projects include roads, bridges, plazas, sports facilities, trails, and open-air "park-like" structures such amphitheaters -and associated restrooms. Buildings are roofed and walled structures created for permanent use—either new or existing. The core framework of the Challenge is its arrangement into seven categories, known as Petals.
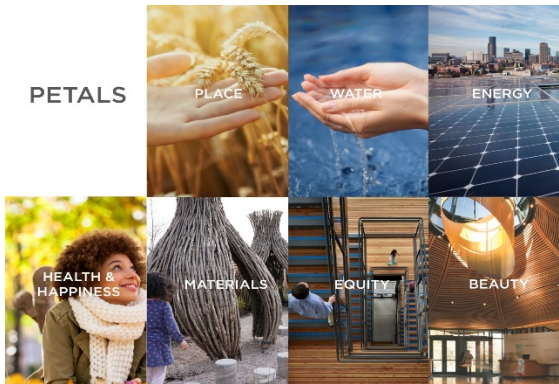
Those knowledgeable about green building will notice some familiar topics, like energy or materials. But the Living Building Challenge aims to be as holistic as possible, addressing things like happiness, equity, and beauty. Each petal is then broken into Imperatives. Imperatives address the specific requirements for each Petal. These are like the credits within a particular LEED category, except all imperatives within a petal must be achieved to earn that petal.

Using the metaphor of a flower means something different for each project in each location. But all Living Building projects represent designs that strive to create healthier occupants and surrounding ecosystems.

On the right, the Omega Center in Rhinebeck, NY was the first Living Building in the world. Their campus hosts tens of thousands of visitors each year for courses on holistic approaches to wellbeing.

On the left is a view inside the Willow School's Health, Wellness, and Nutrition Center in Gladstone, NJ- where I managed the Living Building Challenge and LEED process for almost 5 years. The Willow School building is in its occupancy phase and pursued full Living Building Certification version 2.0. Willow School was founded in 2001 and has a

reputation for its forward thinking sustainability curriculum and buildings. This building featured a commercial kitchen, teaching kitchen, gardens, classrooms, and movement area.

Projects that pursue the two petals reviewed here may target two different levels of certification. Full Living Building Challenge Certification means a project has achieved every applicable Imperative of the Living Building Challenge. Eleven buildings worldwide have achieved full Living Building status as of October 2016.

Petal Certification is a project that has achieved at least three Petals, including one of the three core Petals—Water, Energy, or Materials—as well as Limits to Growth and Inspiration and Education. The Limits to Growth Imperative prohibits development on ecologically sensitive habitat such as prime farmland, old growth forest or wetlands. Inspiration and Education is also required because each project should be a catalyst for change within its own community. Fourteen projects worldwide have achieved Petal Certification as of May 2016.

Living Building Challenge certification is unique in that it is based on actual performance instead of modeled outcomes. For example, projects must submit utility bills—not energy models. Projects must be fully operational for at least twelve consecutive months prior to audit.

While all of these imperatives may have rigorous parameters, Petal Certification is absolutely achievable with technologies and information available today, and yields numerous benefits to building occupants and the environment.


HEALTH AND HAPPINESS PETAL

For most people in the developing world, life is spent mainly inside. The average American spends 90 percent of their life indoors.

Over time, our basic needs for fresh air, daylight, and views to nature have been supplanted in many buildings by something more mechanistic. This disconnect from nature is only intensified by the toxicity of building interiors, which we are exposed to a majority of our lives.

The Living Building Challenge seeks to right this balance with buildings that promote health and make people happy.

The Civilized Environment Imperative, imperative seven, requires there to be operable windows in all occupied spaces to ensure access to fresh air, daylight and views. And each occupied space should have at least one window-wall. In projects where available space is in high demand, providing views and operable windows in all occupied spaces can be a

challenge. Careful master planning can eliminate common conflicts with this requirement, but team may also need to get creative about the intent of their spaces.
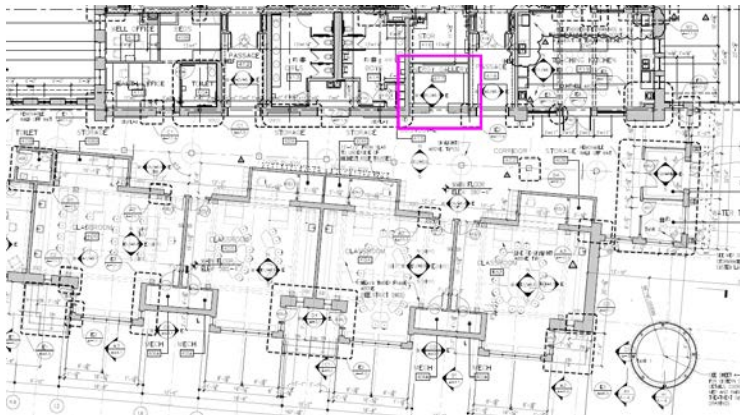
At the Willow School, this room highlighted in the pink square was intended to be a small meeting/conference room. However, as a completely interior space, they couldn't provide windows or views at a seated height. So the team turned this area into an energy gallery, where the building's systems and performance are one display with artwork and the story of the school building. The team created alcoves at the building entrances which provide views, operable windows, and a small meeting areas for teachers & students.

The Healthy Interior Environment Imperative, imperative eight, includes requirements for eliminating smoking, ventilating damp areas, and using non-toxic cleaning products as well as more common sustainability measures like dirt track-off systems and air quality testing after occupancy.

Carbon monoxide and carbon dioxide need to be measured by building systems on an ongoing basis, and ventilation programmed to respond when levels become too high.

Indoor Air Quality (IAQ) testing measures levels of particulates like dust and total volatile organic compounds (TVOCs) that humans can breathe in. These tests for compliance with established limits occur after nine months of occupancy. Despite the term "organic," TVOCs include man-made & naturally occurring chemicals that volatize into the air at room temperature and are frequently unhealthy.

Volatile Organic Compound levels will depend greatly on building products, furnishings, cleaning products, and the items brought in by the occupants themselves. So the achievement of this Imperative is contingent on careful material and furnishings selections, as well as clear

communication to occupants about healthy operations to ensure that harmful items are not brought into the building.

Biologist EO Wilson coined the term "Biophilia" in 1984 and defines it as "the innate tendency to focus on life and lifelike processes." Subsequent research suggests that this connection became biologically embedded in humans as we evolved, and is therefore critical to human comfort.

Health and hospitality spaces have really started to embrace this theory, acknowledging improved patient recovery and mood when placed in recovery rooms with views of the outdoors, plants, etc. [1,2,3] So, the Biophilia Imperative, imperative nine, should come as no surprise to professionals in this field. However, it is difficult to capture the essence of this empirical Imperative; so in the Living Building Challenge it becomes more of a narrative that describes how the project team worked collaboratively to include elements of biophilia, which often starts with a discussion reminding the team that humans are a part of nature. Because of this, humans thrive in natural settings- or spaces that reflect nature's patterns & practices. Stephen Kellert, a social ecologist and author on the subject of biophilia, outlines six elements of biophilic design to guide the process, shown in the image below.
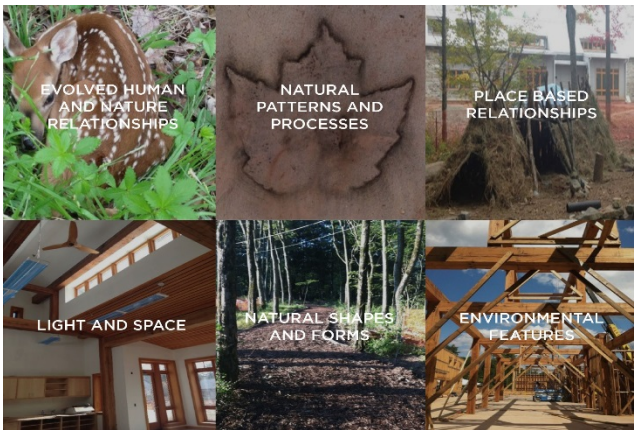
MATERIALS PETAL

Materials selection has some of the broadest impacts on design, construction, and occupancy. It deeply influences—and is influenced by—each of the other Petals in Living Building Challenge. The Materials Petal has the most Imperatives, and each Materials Imperative reflects a distinct issue.

The Precautionary Principle is the underlying theme of this Petal. It posits that "if an action or policy might cause severe or irreversible harm to the public or to the environment, in the absence of a scientific consensus that harm would not ensue, the burden of proof falls on those who would advocate taking the action."[4] In layman's terms, it is the "better safe than sorry" approach.

The Red List, Imperative 10, is a perfect example of the Precautionary Principle. It comprises some of the worst-in-class materials and chemicals that are ubiquitous in the built environment. These are carcinogens, persistent organic pollutants, and reproductive toxicants, many of which are bio-accumulative, meaning that they build up in organisms and the broader environment, often reaching alarmingly high concentrations as they travel up the food chain.

This Imperative prohibits use of these chemicals within Living Building projects. Please note that there are a number of exceptions that apply, which are best explored during a more in depth materials workshop but are available on the Living Building Challenge dialogue pages.

There are temporary exceptions for numerous Red List items due to current limitations in the materials economy. Refer to the Materials Petal Handbook for complete and up-to-date listings.

The project cannot contain any of the following Red List materials or chemicals:

- Alkylphenols
- Asbestos
- Bisphenol A (BPA)
- Cadmium
- Chlorinated Polyethylene and Chlorosulfonated Polyethlene
- Chlorobenzenes
- Chlorofluorocarbons (CFCs) and Hydrochlorofluorocarbons (HCFCs)
- Chloroprene (Neoprene)
- Chromium VI
- Chlorinated Polyvinyl Chloride (CPVC)
- Formaldehyde (added)
- Halogenated Flame Retardants (HFRs)

- Lead (added)
- Mercury
- Polychlorinated Biphenyls (PCBs)
- Perfluorinated Compounds (PFCs)
- Phthalates
- Polyvinyl Chloride (PVC)
- Polyvinylidene Chloride (PVDC)
- Short Chain Chlorinated Paraffins
- Wood treatments containing Creosote, Arsenic or Pentachlorophenol
- Volatile Organic Compounds (VOCs) in wet applied products

When project teams did a deep dive into the Living Building Challenge Red List, they discovered that the seemingly simple list of 22 chemicals actually represents 45 chemical groups with multiple aliases, accounting for 777 distinct chemical registry numbers. To facilitate identification of Red List-free materials, the Institute has established a transparency-driven ingredients label and product database, called Declare. Manufacturers declare what ingredients are in their products, accelerating

the market for Red List-free materials. To date, over 300 products are included in the Declare database.

Depending on the transect of your project, The Living Building Challenge allows certain Imperatives to be achieved through Scale Jumping, where solutions are provided at a neighborhood, district, or small community scale.

The United Nations Environment Programme (UNEP) published a report in which demonstrated that 13 to 18 percent of a building's carbon impact occurs prior to occupancy. And as LBC projects are built for greater operational efficiencies, the percentage of impact relative to the whole is even greater. This is significant, especially when we consider that many buildings are constructed to last 75 to 100 years. We can curb some of the carbon impacts by making better and different decisions about material procurement and assembly.

Imperative 11 requires projects to offset the carbon generation of their construction by purchasing carbon offsets. Offsets represent the purchase of actual renewable energy generation—solar, wind, geothermal, tidal, and other sources.

The Responsible Industry Imperative, imperative 12, requires any wood used in the project to be either FSC-certified, salvaged, or harvested on-site. It also requires use of Declare database products. The Imperative also requires project teams to advocate for third-party sustainable standards for industries that do not yet have standards in place, such as quarrying, metal, and minerals.

Imperative 13, Living Economy Sourcing, is focused on decreasing carbon associated with transporting building materials and supporting local and regional economies through manufacturing. To achieve this, this Imperative requires that building materials and services be sourced close to the project.

This Imperative identifies appropriate sourcing distances for materials, and also applies limits to the location of the primary design team. For a project in the city: 20 percent of Project's construction costs within 310 miles, 30 percent from within 620 miles, Consultants (except those with Living Future Accreditation) from no further than 1500 miles, 25 percent American-made from within 3100 miles, and the remaining 25 percent can be globally sourced..
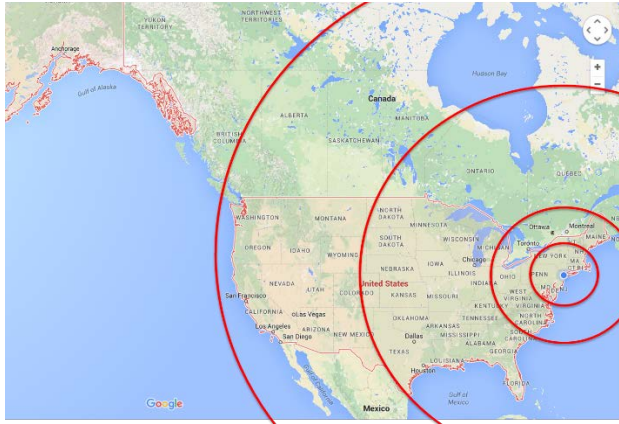
As a coastal city, New York Ccity has additional challenges because half of its radius is over the ocean.

The intent of the Net Positive Waste Imperative is not only to reduce or eliminate material waste, but also to redefine it as a wasted opportunity. The Living Building Challenge encourages a natural closed loop system which emulates natural flows—waste becomes the ingredients for the next product.

To minimize wasted materials, project teams must consider impacts during the design, construction, operation, and end-of-life phases of a development by developing a Material Conservation Management Plan. Teams are encouraged to consider appropriate durability of products. A potential focus area is the future need for adaptable reuse of a development. How can the project be flexible enough to respond to the needs of the future without being demolished?

This Imperative also sets stringent levels for material recycling and salvage to deter unnecessary contributions to landfills and reduce the creation of landfill gases. Gases such as methane, carbon dioxide, hydrogen and volatile organic compounds are created from the waste on-site and the building material's degradation over time. The waste disposal process also has its own significant carbon footprint.

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WELLNESS & HEALTH – NEW DEFINITION OF LUXURY & LIFESTYLE

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ABSTRACT

Wheatgrass smoothies, celery juice, green tea, grass-fed meats, all-natural skincare, flax & chia seeds, Ayurveda … they're all cyphers of the new luxury taking over the upper echelon of society: wellness. There is a paradigm shift in the definition of luxury and modern lifestyle as the next generation starts to come into its own. Aspirations and desires around a wellness lifestyle or perceived wellness lifestyle (healthy selfies) are becoming indicators of luxury and a life well lived. This paper showcases Gen Z trends as well as global market trends in health + wellness and its implications on the hospitality industry.

BACKGROUND

Rising health related societal concerns linked to today's modernized lifestyle of convenience eating, increase in workplace stress, depression and sedentary employment have alerted individuals, businesses, and regulations to the importance of promoting positive wellness awareness, heath maintenance and fitness resources – a shift from solely reactive to a more balanced proactive and preventative lifestyle approach to health care. Growth across the wellness, healthcare and fitness industry demonstrates that people are making significant investments into perceived health and wellness solutions.

WELLNESS QUOTIENT TRENDS

It used to be that one'd show off a new car, a new designer handbag or perhaps a smart phone. But today "health bragging" has become the only acceptable way to make a statement of how privileged one is. The phenomenon starts with gastronomy and fitness but is actually an all-encompassing lifestyle. Fitness has become another arena to compare and contrast personality and lifestyle with others. It's a social topic where people talk about what new classes they're taking or what diet regime they are on.

Wellness & Health, the buzzword of this burgeoning lifestyle trend is definitely being used as a status symbol as people are investing in

themselves as a product. To be able to flash an outfit, they want to have the flash body that goes with it and social media plays a big part in communicating with a wider circle of socialites through photos has generated more image consciousness.

People like to feel a bit superior because they feel they're more aware, educated about health & wellness and are prepared to adhere to their discipline. Posting shots of running club or early morning yoga class is worn as a badge of honour. Before, it wasn't cool to talk about the fact on diet but now, people are owning it. However health and wellness consciousness is just not about one exercise though, people are personalizing their health & wellness efforts and doing whatever suits them.

People are doing the mental arithmetic, once people would buy food for value but they're now thinking, what it's going to cost in weight, rather than just the face dollar value. It's like making an investment in self; one can go into a health food store and come out $200 poorer, but it's a self - realization because there is an evolved mind-set that justifies the spend leading a longer, happier, healthier life.

When one spends big on experiences that supposedly are good, there seems to be less guilt than when it is just a physical luxury item. People are realizing they can't look like a celebrity just by buying similar clothes, they need to embody the whole lifestyle to get that glow plus, it's a much more trendy to post about morning farm visit and yoga class on social media, than just a selfie on the couch.

WELLNESS & HEALTH: BASIC TREND OR GENERATIONAL SHIFT

Wellness, Fitness and Health consciousness is a social topic and people talk about where they're going on for workout or what new healthy meal or smoothie they've tried, they also talk about what new classes they're taking. "Feeling good" That just new the ultimate luxury and while we can't all get rich, we can all get healthy, or at least try. This evolved consciousness is beyond one generation and people are realizing that health attributes and healthy living is not meant for any one generation, its includes all of us who are together beyond generation gaps and that is the paradigm shift as people who are health and wellness conscious are striving to live until their 80s or 90s and yes they might believe they're a little superior because they're more aware, educated about food and health and are prepared to adhere to their discipline and schedule. Today as we see around us, people are personalizing their fitness and wellness efforts and doing whatever suits them. There has been a shift in the mindset of what luxury and evolved lifestyle is and in the past while one would make him/herself happy buying a luxury handbag, but now he/she spends means

and ways to be happy within themselves, rather than rely on retail therapy. Today your wellness and fitness regimen of choice says a lot about you. And just like there are Smart car types, phone types or expensive digital gadgets types, there are also yoga types and health and yoga camp types; exercise has become another arena to compare and contrast your personality and lifestyle with others and that's just beyond a trend as it is impacting all generations in this era. Energy is a key component of contemporary health and wellness lifestyles across all consumer age groups.

WELLNESS & HEALTH: GEN Z EXPECTATIONS & IMPACT

Gen Z (1995-Present) are already exerting its influence on the marketplace—and some haven't even been born yet: Gen Z already makes up around 24 percent of the US population. This generation moves seamlessly between digital behaviors and real life. They are already highly proactive participants in health and wellness and they knows a lot (or think they do), and they think a lot about being 'balanced.' More so than any other generation, Gen Z looks to exercise as a way to treat or prevent illness, and it is particularly relevant for emotional and stress-related issues. For Gen Z, technology is fun, entertaining and useful. These young consumers are learning about what is healthy from their parents and from school. They are engaging with technology across all parts of everyday life. Outside of direct family, Gen Z is more likely than all other generations to look to their online social networks for advice and bragging on health and wellness.

On the other hand, progressive health and wellness consumers are increasingly influential in redefining food culture and are a window on to the future of health and wellness as health, wellness and sustainability are starting to converge at the most progressive food retail and food service outlets and while food and beverage industry plays a vital role in meeting the expectations of this evolved consumer demands, activating health and wellness at retail and in food service means more than mere execution; it involves "strategic choices".

WELLNESS & HEALTH: HOSPITALITY V/S HEALTHCARE

In the past two decades, most consumers and companies were looking to solve primarily baseline health and wellness conditions or find new approaches to them and those approaches fell into one of two sections. The first section was health condition management, and consumers were looking for food and beverage products that would help them treat or prevent specific conditions. The second section was around weight management. At the time, consumers were very much in a reactive mode

to their approach. However today, as our lifestyles evolved with increase in health and wellness consciousness, consumers are very much proactive—and even progressive—in their approach to health and wellness which has open avenues for not only hotels or wellness /fitness centres but everything that encompasses our life. Wellness isn't about only physical well-being, wellness is the state of optimal well-being and starts with self-care. It's not simply the absence of illness, but an improved quality of life resulting from enhanced physical, social, mental, emotional, spiritual and environmental health.

Integrative Wellness is next big thing to talk about and there has been a shift from medicine vs. wellness to truly integrative healthcare opportunity and experience. It's a new outlook to merge traditional medicine and wellness to clinical wellness. For healthcare industry it's a shift from disease management to a prevention-focused mind-set while integrating Medical centre + wellness/complementary/integrative centre to promote physical and mental health transformed by good wellness behaviours like diet, exercise and mindfulness. Besides this, in China, Norway and Singapore doctors are being remunerated and recognized for preventing disease. As a global trend, wellness will also incorporate medicine for instance Mandarin Oriental Bodrum has a partnership with the Mayo Clinic for its Healthy Living Program that started early this year in 2016 to promote integrative wellness concept.

HOTEL & WELLNES OPERATIONS: MEETING THE EXPECTATIONS

Hotels today are becoming commercial lifestyle centers appealing equally to nonresident guests to come and experience at the premise be it relaxation, fitness, wellness, shopping or any other social engagement activity. Wellness encompasses all aspects of self-well-being and being happy. Hotels are 24/7 operations with a wide scope and array of services to offer not only to resident guests but also to those who will close by the community, neighborhood or social zone. Hotels would now include and focus on services and options that ease the quality of life of those around them.

Wellness enthusiasts on the other hand, like most travelers or wellness seekers, are looking to do more with less. This means greater outcomes despite shorter stays, which may be delivered through supplemental and add-on programs that maximize results within a limited timeframe. This also means that travellers are looking to access destination spas or wellness centers closer to home, so as to maximize limited travel time. With this shift in consumer behavior and preferences, hotels are strategizing their business models to be outside thinking to inside producing i.e. moving

away from thinking of what your clients want to now inventing what they want so to invent the business model of tomorrow.

Given the unique offerings of health and wellness in hospitality segment, which clearly differentiate it from traditional hotels and resorts, it stands to reason that the critical success factors necessary for the development of an authentic wellness platter for the discerning wellness enthusiast, some suggestions and recommendations are as follows:

All key facilities (product) and components (service attributes) must be included in order for programming to be successful. Shortcuts cannot be made if the true intent is to develop a competitive, internationally benchmarked, revenue generating wellness space in a hotel/resort. Authenticity is the key to success. The entire infrastructure must be designed with human scale in mind. Guests must be able to intuitively and comfortably flow from one area to the next with ample space (both indoor and outdoor, if possible) for relaxation and private reflection. Taking from the sustainability perspective, more and more, hospitality projects are employing triple bottom line strategies and environmentally conscious building practices wherever possible. Energy conservation, locally sourced materials and talent, and attention to carbon footprint are some of the more commonly recognized and employed considerations, though new sustainability efforts, designs, and technologies are constantly entering the marketplace.

WELLNESS & HEALTH AT WORKPLACE

A "wellness culture at workplace" is more than just words: it is defined not only by an array of programs that encourage and support health and wellness for employees—from stress reduction to improved diet—but also by physical and environmental features such as better-quality, safe, hygienic healthy cafeteria food and pleasant, relaxing spaces for breaks and relaxation. The benefits of a wellness culture at workplace extend beyond office walls and organizations that build a wellness culture thus acquire a workforce that is not only more focused and engaged, but that sees that culture as benefiting their careers.

Workplace stress remains a serious problem in many workplaces and can take a toll on their employee's health and productivity and may interfere with their ability to pursue a healthy lifestyle. A wellness culture magnifies the benefits that employees gain from their participation while driving increased engagement, especially if they offer a wide range of choices. The cost of not building a wellness culture—on employee happiness, stress levels and, dramatically, engagement with the employer's mission and goals. In addition, distinct differences emerge as to what employers and

employees consider the most effective approaches to wellness. Employers place far greater emphasis on stress management programs, for instance, while employees are much more likely to cite flexible work schedules.

On the other hand, from talent acquisition and retention perspective, the role of Human Resources in an organization is to recognize the issue of talent scarcity in the wellness segment, namely as it relates to hiring and retaining skilled team members capable of delivering internationally benchmarked service at a luxury standard. Given the intensely intimate nature of health and wellness services, securing the right talent is of paramount importance in determining long-term success. Thus, training and long-term retention must be a high- consideration when looking into this aspect.

SUMMARY

Wellness is the state of optimal well-being and starts with self-care. It's not simply the absence of illness, but an improved quality of life resulting from enhanced physical, social, mental, emotional, spiritual and environmental health. In the area of health and wellness awareness; it all comes down to a giant contemporary demand for advancements in pro-active health. There are many reasons why the wellness industry is, and will continue to expand. What is killing us today are life style diseases. The major causes of early deaths have shifted from infectious diseases to chronic lifestyle-related conditions. 70 per cent of which are preventable through eating right, exercise, supplementation and effective stress management.

When it's about bragging on social media on wellness, health and lifestyle that's the new luxury statement and there has been a major shift in the way we look at our lives and in "unconventional" way. It's about personal satisfaction more than just a brag. Today there are many social media and fitness tracking applications that are emerging with a thrust into our lives advocating new gen lifestyle flair. People are following these new trends greatly and widely across age groups and evolved and matured mindsets. So when it comes to selfie posts and personal photographs (self-posing or check ins) It's usually a confluence of health, body image, peer affirmation and self-actualization. As millennials craft their social media persona, body image becomes a primary concern. 73 per cent of millennials exercise to enhance their physical appearance. People who posts status updates about their diet and exercise routine or travel diaries appears to be more narcissistic and they use Facebook and other fitness social networks *like H, Pump Up, Instagram and Burn This* to share their workout selfies, to broadcast the effort they put into their physical appearance.

It's not simply overexposure but a new trend towards an improved quality of life resulting from enhanced physical, social, mental, emotional, spiritual and environmental health and it impacts and influences everyone.

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Deloitte.

The value of patient experience
Hospitals with better patient-reported experience perform better financially

Executive summary

Improving the patient experience can help a hospital improve its financial performance by strengthening customer loyalty, building reputation and brand, and boosting utilization of hospital services through increased referrals to family and friends. Furthermore, research has shown that better patient experience correlates with lower medical malpractice risk for physicians[1] and lower staff turnover ratios.[2]

Payers looking for better value are also helping to drive hospitals to focus on patient experience: Programs such as Medicare's Hospital Value-Based Purchasing Program (VBP) are financially rewarding hospitals that have better patient-reported experience scores. As a result, patient experience scores for factors as diverse as nighttime noise level and doctors' and nurses' communication skills have become a key hospital performance measure.

Because of the patient and payment factors, one might expect that hospitals with better patient experience scores might perform better financially – but the relationship has not been well studied. To gain greater insight into the association between better patient-reported experience scores and hospital financial performance, the Deloitte Center for Health Solutions conducted descriptive and regression analyses using the most widely tracked measures of patient experience – the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores – and examined their association with hospital performance measures such as net and operating margins and return on assets (ROA). To more clearly delineate the contribution of patient experience, Deloitte Center for Health Solutions controlled for hospital and local area characteristics that can also affect hospital performance, including hospital ownership, location, teaching status, payer and patient case mix. Our analyses point to two main findings:

- **Hospitals with high patient-reported experience scores have higher profitability.** Hospitals with "excellent" HCAHPS patient ratings between 2008 and 2014 had a net margin of 4.7 percent, on average, as compared to just 1.8 percent for hospitals with "low" ratings.[3]
- **The association of patient experience with financial performance is large, even after controlling for other hospital characteristics that can drive hospital performance.** Compared to other hospitals in the same market (hospital referral region (HRR)), and controlling for hospital characteristics, a 10 percentage point increase in the number of respondents giving a hospital a "top-box" (9 or 10 out of 10) rating is associated with an increase in net margin of 1.4 percent and in ROA of 1.3 percent compared to hospitals receiving a "bottom-box" (0 to 6 out of 10) rating. However, unlike lower-rated hospitals, those hospitals receiving "top-box" experience ratings also have other characteristics that are potentially associated with both patient experience and financial performance, and such factors might not be as easily replicated by lower performers.

The Deloitte Center for Health Solutions also studied the mechanisms through which the association between patient experience and hospital financial performance likely occurs. The results indicate that:

- **Hospitals with better experience levels earn disproportionately more than they spend compared to those with lower ratings.** Although higher patient experience scores appear to be associated with increases in revenue per adjusted patient day as well as in adjusted expenses, the magnitude of the effect is stronger for revenue. These results suggest that investments in patient experience increase costs but increase revenue even more, or hospitals with higher scores might have more resources to invest in patient experience.
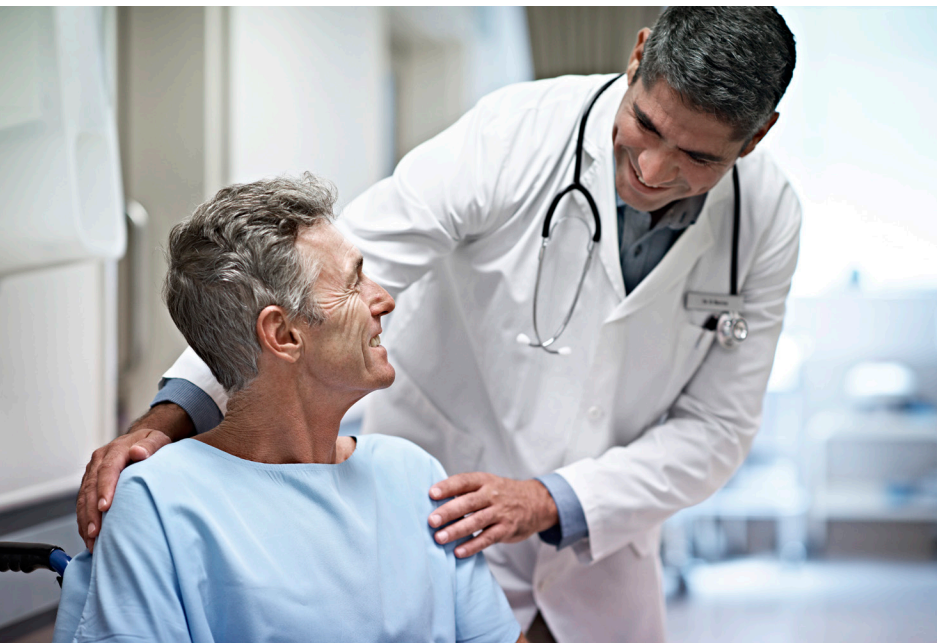
- **A highly engaged staff likely boosts patient experience, translating into better performance.** Patient experience scores pertaining to interactions with nurses have the strongest association with hospital financial outcomes.
- **VBP incentives likely contribute a small amount to the association of patient experience with hospital financial performance.** Medicare VBP incentives (tied to patient experience) account for only seven percent of the association between patient experience and hospital financial performance, as measured by net margins.

Faced with multiple priorities and resource demands, health systems and hospitals may question the business value of collecting, analyzing, and acting upon patient experience data. However, these results suggest that good patient experience is associated with higher hospital profitability, and that this association is strongest for aspects of patient experience most closely associated with better care (in particular, nurse-patient engagement). The results could also suggest that better-performing hospitals make larger patient experience investments. However, given the market shift towards patient-centered care and renewed payer emphasis on patient experience as a core element of care quality, these analyses show that hospital executives should consider investing in the tools and technologies necessary to better engage patients and enhance patient experience. Furthermore, although patient-experience scores don't always reflect quality-of-care outcomes, these analyses suggest that those aspects of patient experience most closely associated with better care (communication with nurses), also have the strongest association with hospital financial performance.

Introduction

Meeting patients' needs and earning better margins have become major focus areas for hospital executives facing payment pressures and the market shift towards value-based and patient-centered care. In a 2009 *Health Leaders* survey, over 90 percent of top-level hospital executives said that enhancing patient experience is one of their top priorities, and an overwhelming majority stated that the impact on patient experience is an important consideration in their decisions.[4]
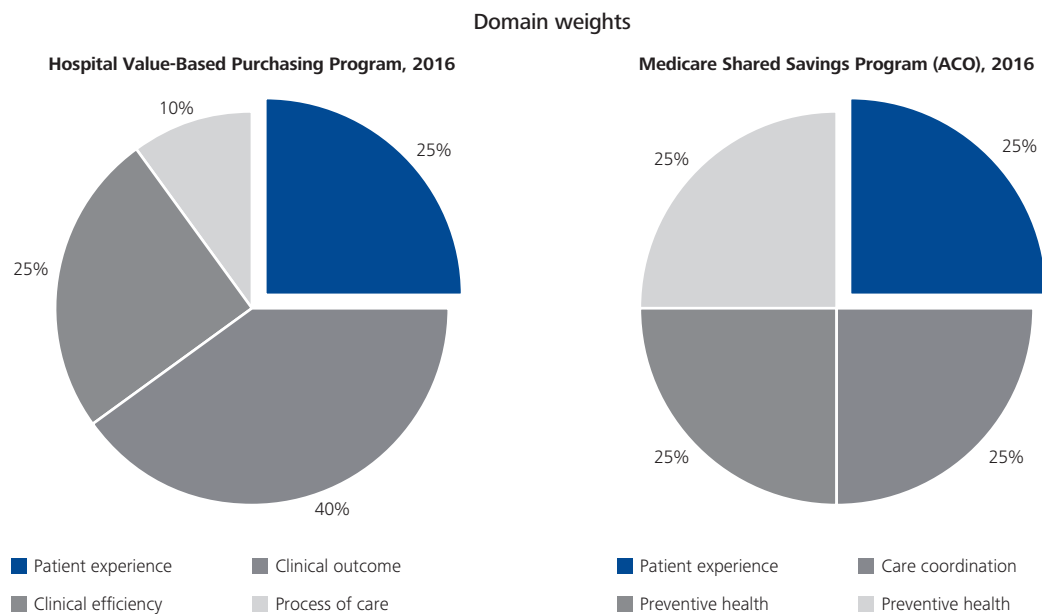
As patients increasingly "shop" for health care services, enhancing patient experience is regarded as a potential driver of hospital performance, since it may strengthen customer loyalty, build reputation and brand, and boost utilization of hospital services through increased referrals to family and friends. One of every two individuals surveyed in Deloitte's *2015 Survey of US Health Care Consumers* noted that brand and reputation were an important consideration in choosing a hospital.[5]

In addition, hospitals' reimbursements from Medicare and private insurers are increasingly tied to quality performance metrics that capture patient experience as well as clinical outcomes (Figure 1). Improving patient experience is one of the fundamental concepts underlying the Triple Aim approach to optimizing health system performance, and it is regarded as distinct from improving the technical quality and efficiency of care. Good patient experience is an

important outcome unto itself, as patients intrinsically value the interpersonal aspects of the clinician-patient relationship, such as communication, compassion, and an overall sense of being treated with dignity and respect.[6] Furthermore, although patient experience doesn't always correlate with high-quality care,[7] patient experience measures can address attributes of care that promote and increase quality.[8] For instance, eliciting the patient's perspective is considered essential in shared decision-making, understanding safety and confidentiality information, and understanding how care impacts the entirety of a patient's life.[9]

As such, many public and private payers have begun to recognize patient experience as a core element of quality. Since 2012, under the Hospital Value-Based Purchasing Program (VBP), hospital Medicare DRG payments are adjusted based on performance in three domains of care, of which patient experience currently accounts for 25 percent.[10] As Centers for Medicare and Medicaid Services (CMS) officials wrote regarding this decision, "Delivery of high-quality, patient-centered care requires us to carefully consider the patient's experience in the hospital inpatient setting." Private insurers and employers are increasingly tying payment to quality and patient experience, as well. For instance, value-based contracts represented 30 percent of Aetna's medical spend in 2014, and the insurer's goal is to increase this to 75 percent by 2020.[11]

Figure 1. Patient experience is a major component of VBC program payments

Domain weights

Hospital Value-Based Purchasing Program, 2016

10% · 25% · 25% · 40%

- Patient experience
- Clinical outcome
- Clinical efficiency
- Process of care

Medicare Shared Savings Program (ACO), 2016

25% · 25% · 25% · 25%

- Patient experience
- Care coordination
- Preventive health
- Preventive health

Source: Centers for Medicare and Medicaid Services

As a result, patient experience scores for factors as diverse as nighttime noise level and doctors' and nurses' communication skills have become a key performance measure for hospitals, as well as of at-risk pay for hospital executives. In 2014, two-thirds of not-for-profit institutions included quality incentives in their top executives' compensation (compared to only 45 percent in 2009), according to a survey by Sullivan Cotter & Associates.[12]

Despite these increased incentives for hospitals and executives, the business case for patient experience remains unclear, and relatively few hospitals score highly on patient-reported experience measures. For instance, in the new star-rating system CMS rolled out in 2015, of more than 3,500 hospitals to be evaluated only 251 got the highest score of five stars for patient experience.[13] In a different survey, over 45 percent of top-level executives noted either a lack of funding or an abundance of other (and presumably better-funded) priorities as stumbling blocks to implementing more strategies to enhance patient experience.[14]

However, our research suggests a strong association between enhancing patient experience and improving hospital performance. The results could also suggest that better-performing hospitals make larger patient experience investments. However, our analyses show that hospitals with higher patient experience ratings financially outperform lower-rated hospitals even after controlling for hospital and local area characteristics. We also identify some potential mechanisms through which the association between patient experience and hospital financial performance likely ensues. Given the market shift towards patient-centered care and renewed payer emphasis on patient experience as a core element of care quality, our analyses show that hospital executives should consider investing in the tools and technologies necessary to better engage patients and enhance patient experience – while also being mindful of their investments into other aspects of quality.

The association between patient experience and hospital financial performance is strong

Higher patient experience ratings are associated with higher profitability

To examine the relationship between patient experience and hospital performance, we analyzed hospital-level patient experience measure scores from the HCAHPS survey (see box), and hospital characteristics and local market metrics from the American Health Association (AHA) annual survey database and Truven Health.

HCAHPS survey experience scores

The HCAHPS survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care, and is administered between 48 hours and six weeks after discharge to a random sample of adult inpatients in the medical, surgical, and maternity care service lines.

Individual survey responses are adjusted for demographic patient mix and mode of administration, and are publicly reported in an aggregated manner as a set of 11 measures:
- Seven composite measures summarizing how well nurses, and respectively, doctors communicate with patients, how responsive hospital staff are to patients' needs, how well hospital staff help patients manage pain, how well the staff communicates with patients about new medicines, whether key information is provided at discharge, and how well patients understood the type of care they would need after leaving the hospital;
- Two individual measures addressing the cleanliness and quietness of patients' rooms; and
- Two global measures capturing patients' overall rating of the hospital on a 0 to 10 scale, and whether they would recommend the hospital to family and friends.

For our measures of hospital profitability, we used financial metrics (operating and net profit margins, and ROA) from the health care cost reports that hospitals are required to file with CMS (provided by Truven Health). The operating margin reflects the financial condition of a hospital's primary line of business (direct patient care), while the net profit margin shows a hospital's overall financial condition, including non-patient care revenue such as investment income and donations.

In comparing margins and ROA[15] for hospitals with different patient experience ratings, we found a strong correlation between patient experience and profitability. Between 2008 and 2014, hospitals with "excellent" overall patient experience ratings had a net margin of 4.7 percent, on average, compared with 1.8 percent for hospitals with "low" ratings. Similarly, on average, hospitals with "excellent" ratings returned 5.6 percent on assets invested between 2008 and 2014 compared to 3.4 percent for hospitals with "low" ratings. The trend has remained relatively consistent through the years (Figure 2).

How we classified hospitals on patient experience measures

For each of the HCAHPS measures, only the most positive ("top-box"), intermediate ("middle-box"), and most negative ("bottom-box") scores are publicly reported, so we constructed our HCAHPS experience variables as the percentage of respondents who chose "top-box" and "middle-box" responses.[16] The two main HCAHPS variables that we used in our regression analyses to capture overall patient experience ratings are, therefore, the percentage of respondents who gave the hospital a rating of 9 or 10 out of 10 ("top-box" responses), and the percentage of respondents who gave the hospital a rating of 7 or 8 out of 10 ("middle-box" responses).

For each of the 11 experience measures, we used the medians of the "top-box" and "middle-box" percentage of responses across all study hospitals to classify hospitals as follows:
- "Excellent" (hospitals with above-the-median "top-box" ratings)
- "Moderate" (hospitals with above-the-median "middle-box" ratings)
- "Low" (remaining hospitals)

Figure 2. Hospitals with excellent patient ratings have higher profitability
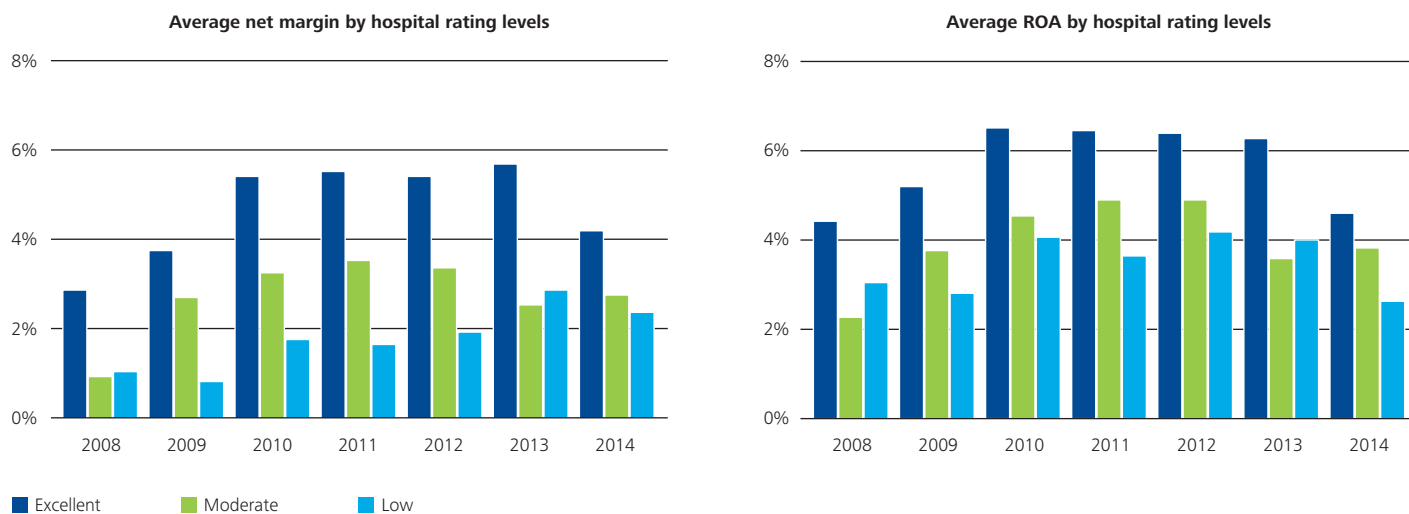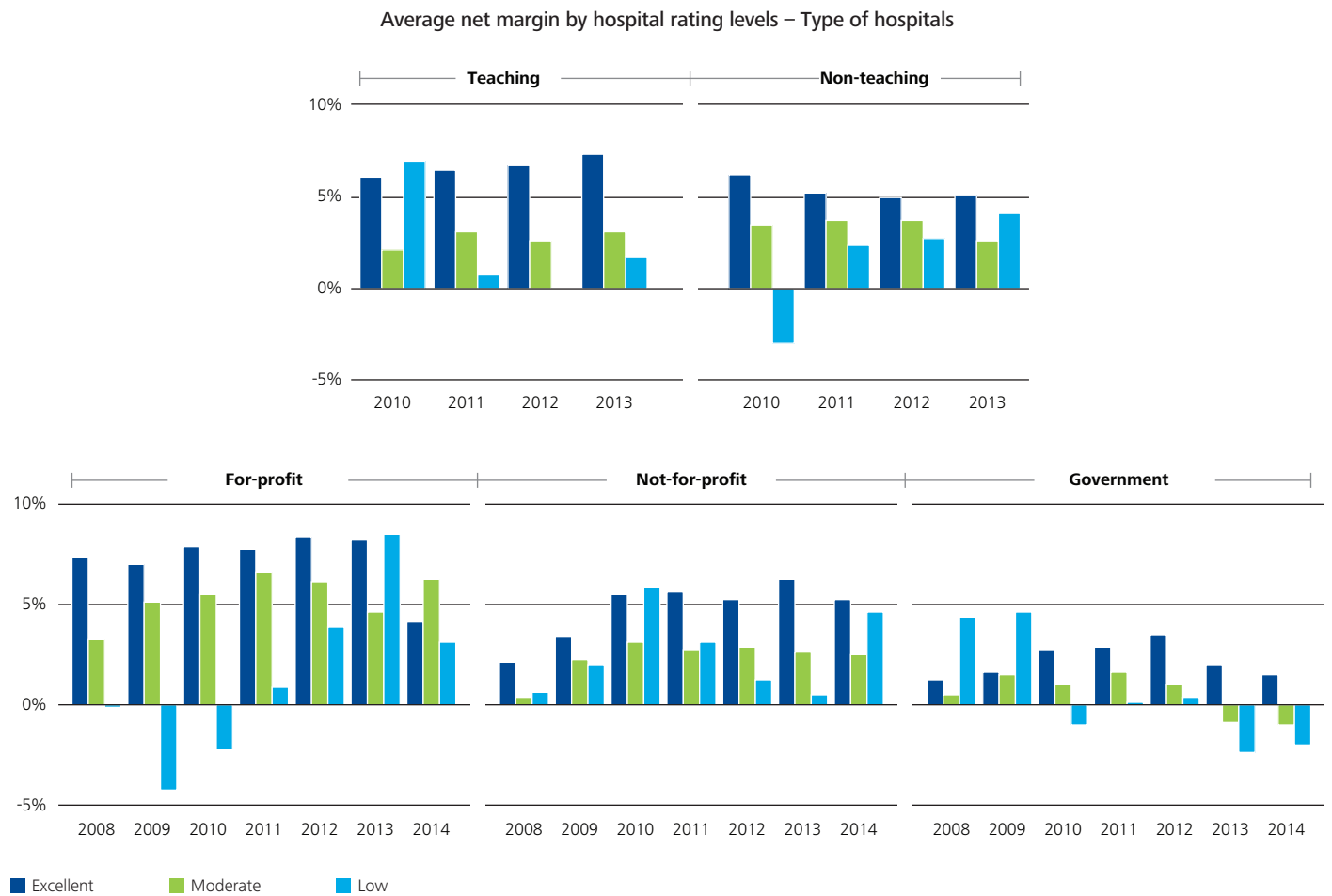

Source: Deloitte analysis of HCAHPS measures from CMS data; and financial performance data from Truven Health Medicare Cost Reports

Although both profitability and patient experience scores vary with hospital characteristics such as location (e.g., urban vs. rural), teaching status, and ownership type, the correlation between profitability and patient experience levels is present for all hospital types. For instance, government hospitals have lower margins, on average, compared with their for-profit and not-for-profit counterparts. However, government hospitals with "excellent" patient ratings have consistently larger net margins relative to hospitals with "low" ratings (2.2 percent compared to 0.6 percent, on average) (Figure 3).

Figure 3. Hospitals with excellent patient ratings have higher net margins irrespective of hospital type

Average net margin by hospital rating levels – Type of hospitals

Note: Teaching classification (Teaching vs. Non-teaching) not available for 2008 and 2009

Source: Deloitte analysis of HCAHPS measures from CMS data; and financial performance data from Truven Health Medicare Cost Reports, and hospital characteristics from AHA annual survey database

Regression analyses: Patient experience correlates significantly to hospital performance

Our descriptive analyses show that hospitals with "excellent" patient experience levels tend to have higher profitability than those with "moderate" or "low" levels, irrespective of hospital type. To better understand the importance of patient experience relative to other factors that could influence hospital profitability, we performed regression analyses (see Appendix) in which we used controls for hospital organizational characteristics (such as hospital size, urban/rural location, ownership type, teaching status, and being part of a system), for case and payer mix, as well as for local market HRR characteristics.

Regression results reveal that a 10 percentage point increase in the number of respondents giving a hospital a "top-box" (9 or 10 out of 10) rating is associated with an increase in net margin, operating margin, and ROA of 1.4 percent, 1.1 percent, and 1.3 percent, respectively, relative to hospitals receiving a "bottom-box" rating (0 to 6 out of 10). For hospitals receiving "middle-box" ratings (7 or 8 out of 10), an increase of 10 percentage points in the number of respective respondents is associated with an increase in net margin, operating margin, and ROA of 0.7, 0.4, and 0.7 percentage points, respectively, relative to "bottom-box" rated hospitals.[17]

To evaluate the contribution of patient experience relative to other factors that could influence hospital profitability, we also calculated how much of the difference in financial performance between hospitals can be explained by differences in patient experience scores, rather than, say, location, hospital ownership type, or payer and case mix. The average net margin difference between "excellent" and "moderate" hospitals was 2.6 percent between 2008 and 2014 (Figure 4). The regression results suggest that patient experience accounts for over 60 percent of this margin difference – after accounting for the association of other internal and external factors such as hospital size, location, ownership type, teaching status, part of a system, case and payer mix – indicating that patient experience strongly
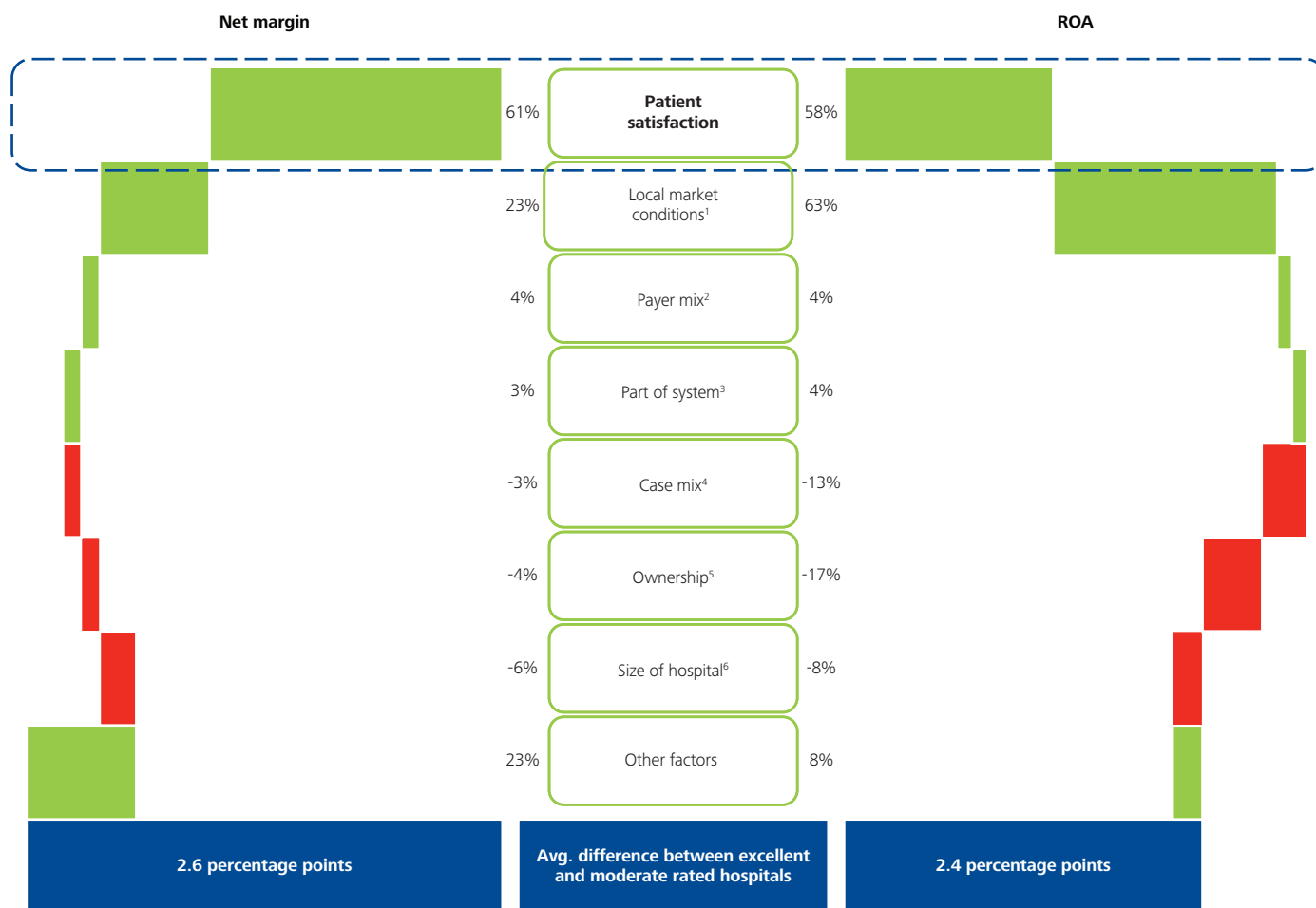
correlates to a hospital's financial performance. Although we control for numerous observable hospital and local market characteristics, there are potentially *unobservable* factors that could confound the effect of patient experience. Examples of such qualitative hospital characteristics that are potentially associated with both patient experience scores and financial performance could include hospital culture, board and management practices, and leadership quality, among others. To account for such factors that could impact financial performance, we also performed "hospital fixed effect" regression analyses (see Appendix for details). In these type of analyses, rather than contrasting the financial performance of *different* hospitals (with different patient experience ratings) in the same local market, we examined whether year-to-year changes in patient experience *for the same hospital* are systematically related to changes in that hospital's financial outcomes.

The regression results suggest that such unobservable factors may be more strongly associated with the financial performance of "top-box" rated hospitals than that of "medium-box" rated hospitals. In these analyses, a 10 percentage point increase in number of respondents giving a particular hospital a "top-box" rather than "bottom-box" rating is associated with an increase in net margins of 0.3 percent (rather than 1.4 percent in the previous regression analyses). However, for hospitals with "middle-box" ratings the increase in net margins associated with patient experience relative to "bottom-box" rated hospitals is essentially the same (0.7 percent) compared to previous regression analyses. The association of patient experience with hospital profitability in the fixed effects analyses, though still considerable, might, in fact, be an underestimate since some of these unobservable factors could also bolster the effect on patient experience. For instance, a recent *Health Affairs* article found that hospitals with boards that relied on and valued clinical quality metrics had stronger financial performance as well as better quality outcomes.[18] Such board and management practices could be complementary to, and help increase the likely financial returns on investments in patient experience. Nevertheless, such factors might not be as easily replicated by lower-performing hospitals.

Figure 4. Patient experience scores are strongly associated with hospital financial performance

Net margin		Avg. difference between excellent and moderate rated hospitals	ROA	
	61%	**Patient satisfaction**	58%	
	23%	Local market conditions[1]	63%	
	4%	Payer mix[2]	4%	
	3%	Part of system[3]	4%	
	-3%	Case mix[4]	-13%	
	-4%	Ownership[5]	-17%	
	-6%	Size of hospital[6]	-8%	
	23%	Other factors	8%	
2.6 percentage points			**2.4 percentage points**	

Source: Deloitte analysis of HCAHPS measures from CMS data; and financial performance data from Truven Health Medicare Cost Reports, and hospital characteristics from AHA annual survey database. See Appendix for a description of these variables.

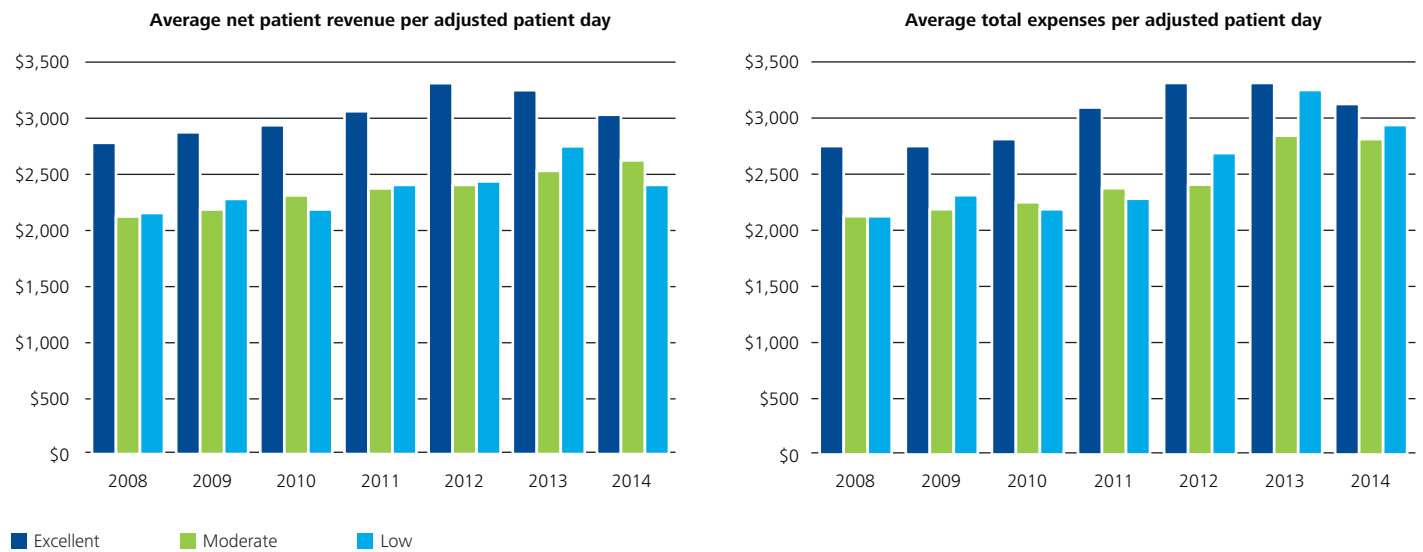## Mechanisms through which patient experience could improve hospital financial performance

What are the mechanisms through which patient experience could potentially contribute to improving hospital financial performance? Although the association between the two is complex and multi-faceted, we are able to shed light on some of the potential pathways through which it might occur.

Hospitals with better patient experience appear to focus more on revenue than costs

Organizations that outperform their peers and the market in the long term tend to focus on "revenue before costs."[19] In other words, they tend to drive profits through price and volume, rather than cost-cutting. This practice appears to hold true for patient experience-enhancing strategies, as well.
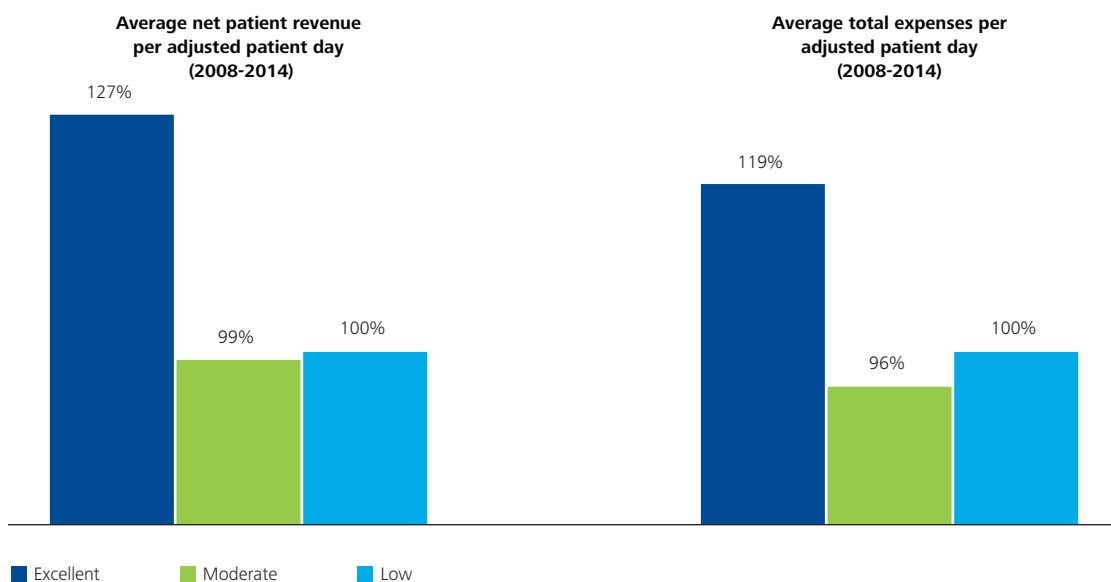
We analyzed net patient revenue and total expenses per adjusted patient day for different HCAHPS patient experience ratings. In both the descriptive analyses and when we control for hospital and market characteristics in regression analyses, we found that hospitals with better overall patient ratings had higher revenue as well as higher total expenses per adjusted patient day compared to those with lower ratings (Figure 5). For instance, hospitals with better experience levels earn $444 more revenue than those with lower ratings but spend only $357 more (Figure 6). These results suggest that while investments in patient experience increase costs they increase revenue even more; or that hospitals with higher rankings might have more resources to invest in patient experience.

Figure 5. Hospitals with better patient ratings have higher revenue and expenses per patient day

Average net patient revenue per adjusted patient day

Average total expenses per adjusted patient day

■ Excellent   ■ Moderate   ■ Low

Source: Deloitte analysis of HCAHPS measures from CMS data; and financial performance data from Truven Health Medicare Cost Reports

Figure 6. Hospitals with better patient ratings earn disproportionately more revenue per patient day than those with low ratings

Average net patient revenue per adjusted patient day (2008-2014)

127%

99%   100%

Average total expenses per adjusted patient day (2008-2014)

119%

96%   100%

■ Excellent   ■ Moderate   ■ Low

Source: Deloitte analysis of HCAHPS measures from CMS data; and financial performance data from Truven Health Medicare Cost Reports

VBP incentives may contribute little to the patient experience effect

Since Medicare's Hospital Value-Based Purchasing (VBP) program ties patient experience to higher incentive payments, we also checked whether the patient experience-hospital performance association could simply be ascribed to increased revenue from VBP incentive payments.

In our regression analyses, controlling for the VBP scores used by CMS to adjust Medicare payments to hospitals only slightly reduces the association of patient experience with net margins. In other words, even when we compare hospitals with similar VBP scores (as well as other similar hospital characteristics) the association of patient experience with net margins is still considerable.
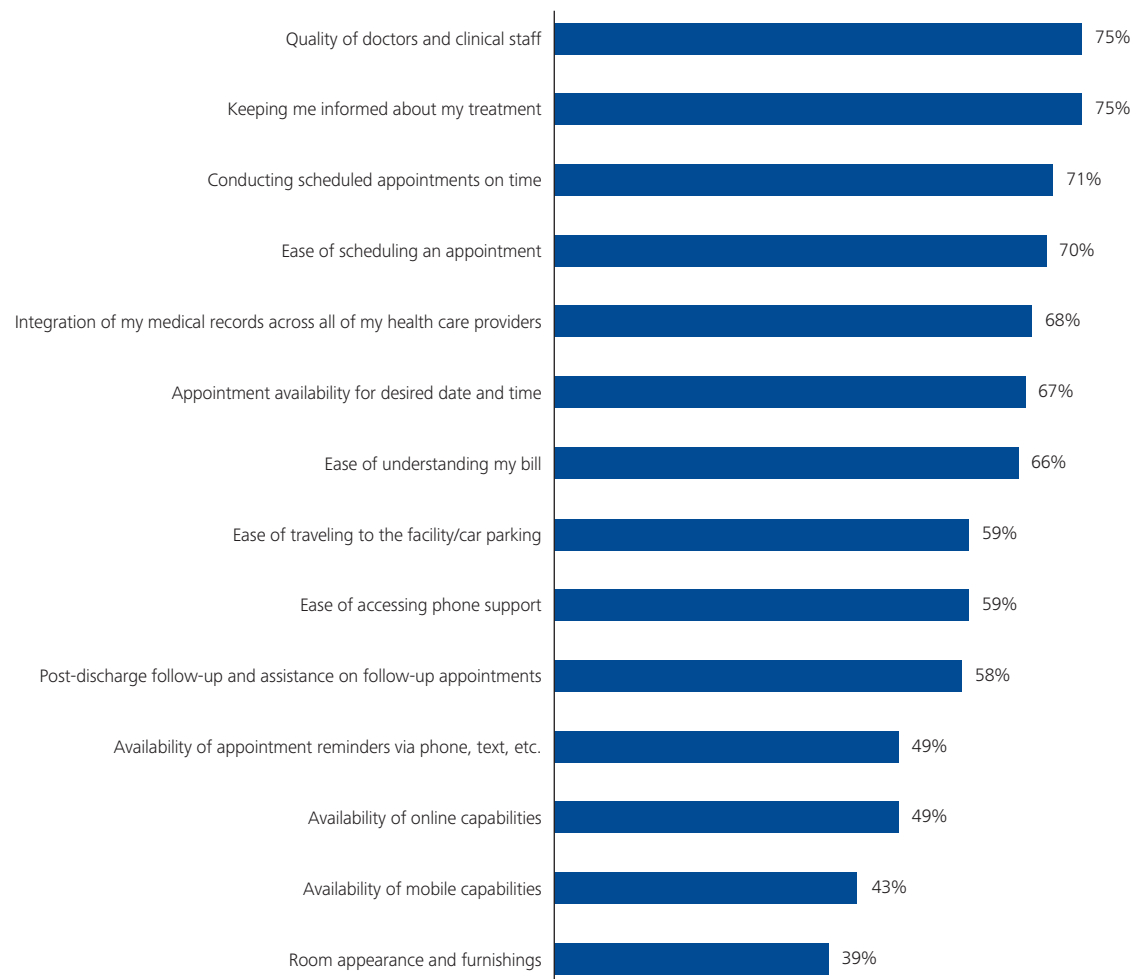
Only a small fraction (seven percent) of the association between higher patient experience and increased net margins likely is due to higher VBP payments when we compare "excellent" hospitals with "moderate" hospitals. The reason for this appears to be that hospitals with "excellent" and "moderate" ratings have relatively similar shares of Medicare patients compared to lower-rated hospitals; however, they have only slightly higher shares of patients with complex or more severe conditions or in intensive care facilities, and only slightly higher (if at all) VBP scores.

An engaged staff might boost patient experience

What are some of the main drivers of patient experience in health care? Deloitte's 2015 Survey of US Health Care Consumers found that staff engagement measures (such as quality of staff, staff communication and responsiveness, and appointment ease), among others, were the most important drivers of patient experience (Figure 7). Improving hospital staff's and, in particular, nurses' work environment may lead to improvements in patient experience. A *2009 Health Affairs* study of 430 hospitals showed that a better nurse work environment was associated with higher scores on patient-experience survey questions.[20]
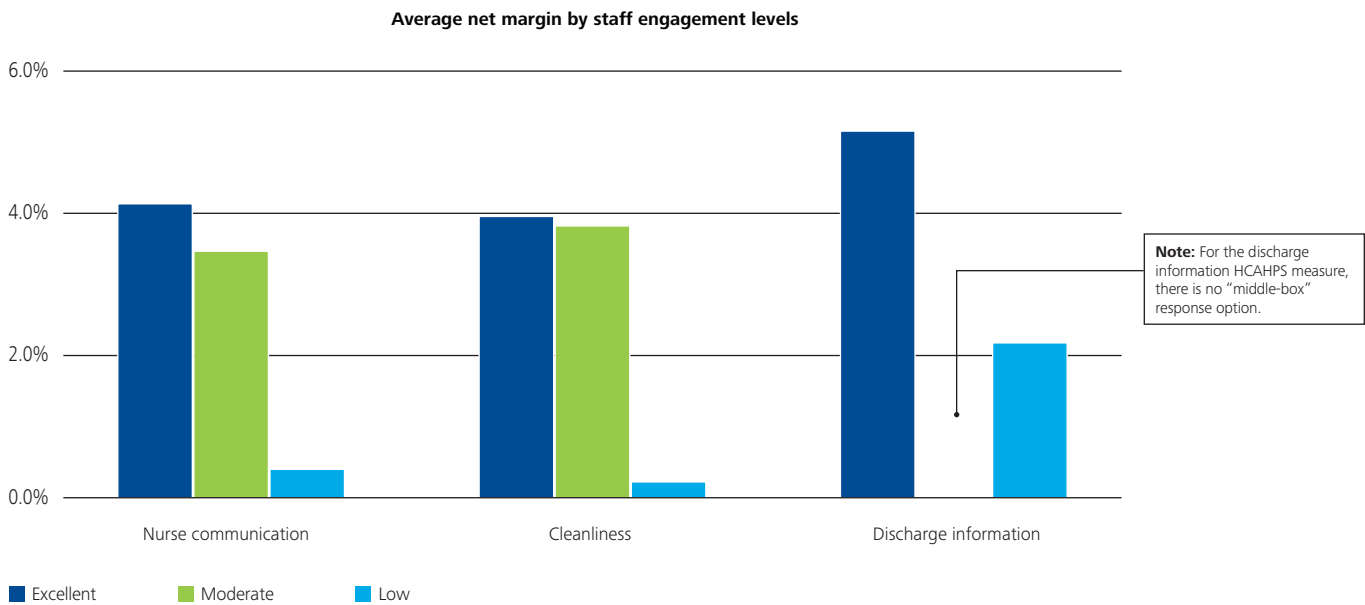
Analyses of the association between HCAHPS domains of patient experience and hospital financial performance are consistent with these survey findings. Of the eight non-global HCAHPS measures for which we had data, only nurse communication, discharge information, and cleanliness had a strong correlation with hospital financial performance in the descriptive and regression analyses (Figure 8); the association with increased profitability was strongest for high nurse communication scores.[21]

Figure 7. Important factors in patient health care experience

Factor	Percentage
Quality of doctors and clinical staff	75%
Keeping me informed about my treatment	75%
Conducting scheduled appointments on time	71%
Ease of scheduling an appointment	70%
Integration of my medical records across all of my health care providers	68%
Appointment availability for desired date and time	67%
Ease of understanding my bill	66%
Ease of traveling to the facility/car parking	59%
Ease of accessing phone support	59%
Post-discharge follow-up and assistance on follow-up appointments	58%
Availability of appointment reminders via phone, text, etc.	49%
Availability of online capabilities	49%
Availability of mobile capabilities	43%
Room appearance and furnishings	39%

Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

Figure 8. Better staff engagement is associated with higher profitability

Average net margin by staff engagement levels

Note: For the discharge information HCAHPS measure, there is no "middle-box" response option.
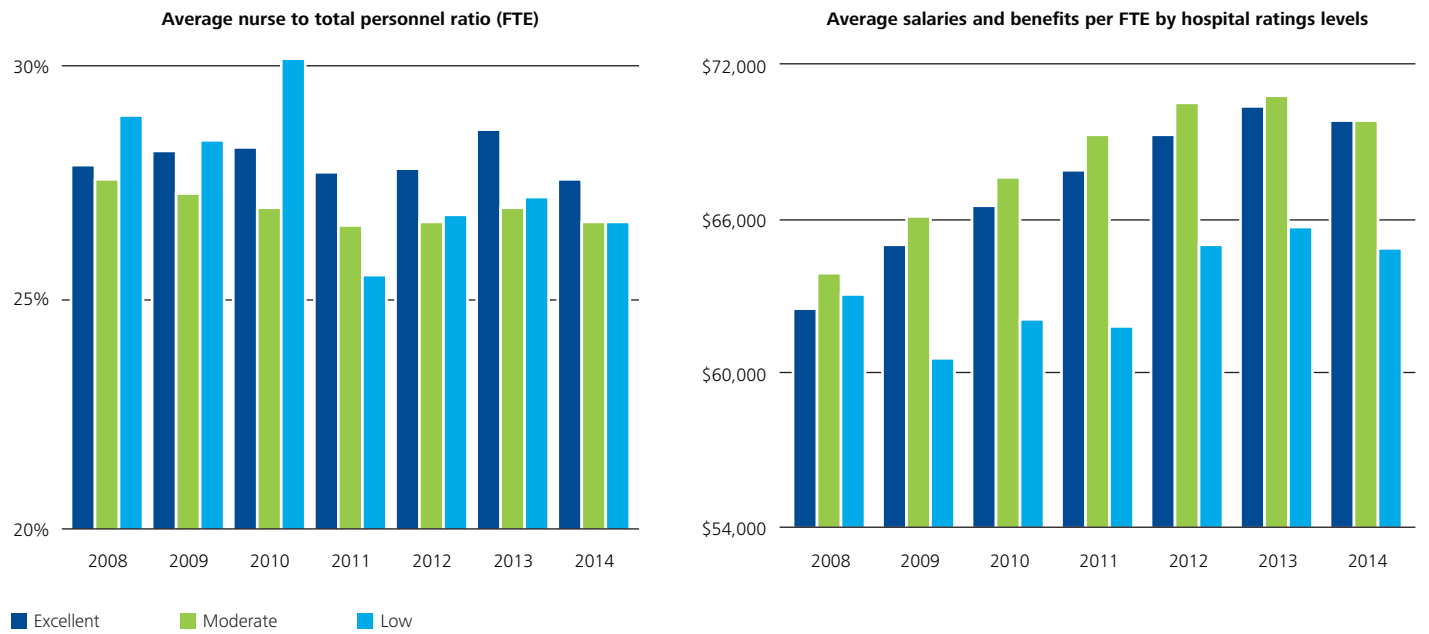
Legend: ■ Excellent ■ Moderate ■ Low

Source: Deloitte analysis of HCAHPS measures from CMS data; and financial performance data from Truven Health Medicare Cost Reports

Our analyses also show that hospitals with high patient experience levels have slightly higher nurses and physicians to total full-time equivalents (FTEs) ratios. These hospitals also tend to have higher salaries and better benefits, on average, than hospitals with lower experience ratings, but not moderately ranked hospitals (Figure 9). When we controlled for the proportion of nurses in the FTE mix (as well as total FTEs and salaries) in the regression analyses, we found that the association of the nursing staff variable with profitability was significant, and that the association of the overall experience measures with hospital performance was reduced. These results are consistent with nurse staffing as a potential lever for the association between better patient experience and increased hospital profitability.

Figure 9. Hospitals with higher engagement ratings have a higher nurse FTE ratio, higher staff salaries, and better benefits

Average nurse to total personnel ratio (FTE)

Average salaries and benefits per FTE by hospital ratings levels

■ Excellent   ■ Moderate   ■ Low

Source: Deloitte analysis of HCAHPS measures from CMS data; and financial performance data from Truven Health Medicare Cost Reports, and hospital characteristics from AHA annual survey database

Investing in patient experience

Our results show that patient experience has a strong association with hospital financial performance as measured by margins and ROA. Although the results also could be suggestive of better-performing hospitals making larger patient experience investments, hospitals with higher patient experience ratings financially outperform lower-rated hospitals even after controlling for hospital and local area characteristics. Given the market shift towards patient-centered care and renewed payer emphasis on patient experience as a core element of care quality, our results suggest that hospitals should consider investing in the mechanisms, tools, and technology necessary to better engage patients and enhance patient experience – from making appointment scheduling easier to increasing shared decision-making to offering convenient payment processes and effective care follow-up.

Patient expectations regarding engagement, transparency, quality, and the overall health care experience have been increasing (Figure 10). In the Deloitte 2015 Survey of US Health Care Consumers, over 50 percent of respondents said that they would likely switch hospitals due to inadequate information-sharing and communication, and difficulty in reaching a health professional by phone or email.[22]

Figure 10. Today's patients have higher expectations of health care providers

Are patient-reported experience measures valuable and valid or are they leading care astray?

Patient-reported experience measures and tools that track satisfaction with different care aspects are increasingly used to evaluate patient experience. Although both supporters and opponents of patient-reported experience measures agree that they are important, they disagree about their uses and potential consequences.

Valuable and valid

Patient's perspective. Eliciting the patient's perspective is essential to shared decision-making and understanding how care impacts the entirety of a patient's life.[26] In addition, patient-experience measures might capture aspects of care (such as compassion and respect) that may not affect health outcomes but might improve a patient's sense of dignity and well-being.

Transparency. Given the increasingly active role that consumers play in choosing health care providers (and the greater share of costs borne by patients), transparency is essential. Patient experience measures can provide valuable information to help patients make informed choices and help providers identify and target opportunities for improvement.

Quality and safety. Patient experience measures can address attributes of health care that promote care quality. For instance, effective patient communication with clinicians can aid in successful care planning and decisions about most clinical interventions, as well as in understanding safety and confidentiality information. Patient experience has been shown to be positively associated with many quality and safety outcomes, such as adherence to clinical guidelines, increased preventative behaviors, and lower inpatient mortality.[27] Although patient (rather than provider)-level studies exist that show a more mixed or even negative effect on care quality, with regards to CAHPS surveys, a recent study noted that they are not developed or validated for patient-level analysis, and that "no scientifically credible research conducted at the provider level…has found an empirical linkage between higher scores on patient-experience surveys and lower technical quality, inferior health outcomes, or higher costs of care."[28]

Validation. Improving patient experience (together with improving technical quality and care efficiency) is one of the fundamental concepts underlying the Triple Aim approach to optimizing health system performance, and it is recognized as such by key stakeholders including CMS. Improvement in any of the Triple Aims is regarded as a worthwhile goal, especially when it is achieved without sacrificing performance in other aims. Internationally, patient-reported experience measures are also used to evaluate health care in terms of clinical effectiveness and economic efficiencies.[29]

Leading health care astray

Subjectivity. Patient-reported experience measures are inherently subjective, and sick patients are not necessarily "cool-headed consumers."[30] Factors as diverse as sociodemographic characteristics, health status, and personality can influence patience experience.[31] Although respondent randomization in studies like HCAHPS accounts for these factors for a given provider, comparisons across providers is more complex without additional information on patient mix.

Unobservable care aspects. Certain facets of care – such as a doctor's skill and judgement, staff teamwork, and compliance with surgical protocols – cannot be directly observed by patients and, thus, cannot be accurately reflected by experience metrics.[32] For example, an anaesthetized patient's experience would not capture the skill or safety of procedures within the operating theatre. However, the patient could still rate care processes outside of the operating theatre, such as administrative procedures, ward cleanliness, and discharge practices, which would be relevant to overall quality of care.

Unnecessary or inappropriate care. Catering to patient experience might lead to the provision of unnecessary or even inappropriate care. For instance, providers might feel reluctant to deliver bad news and, therefore, hold back important information, or might feel pressured to comply with all patient requests, even unreasonable ones, such as making unnecessary referrals or prescribing brand-name medications.[33]

Unintended consequences. Too narrow a focus on patient experience may lead to unintended consequences such as cosmetic changes to improve hospital ratings, teaching to the test, and outright gaming of the system. For instance, some anecdotal evidence suggests that in pursuing higher experience ratings, some hospitals have made investments in "four-star-hotel" amenities unlikely to be related to care quality, such as valet parking, live music, flat-screen televisions, and VIP lounges to patients in their "loyalty programs."[34] Although such reports are concerning, unintended provider responses to performance measures are not uncommon and can be addressed through oversight, monitoring, and incentive design refinement.

Given today's changing industry landscape, health care providers that are able to anticipate, meet, and even exceed patient needs are more likely to be financially successful. Leadership and employee alignment and accountability for patient experience as a strategic imperative should be backed by investments that leverage digital technology as well as patient insights. For instance, investments in such areas as high-touch customer interactions and omni-channel patient access could empower patients to make quick and informed decisions. In the Deloitte consumer survey, two out of three health care customers noted that using health technology (for purposes such as measuring fitness, checking cost of care, and receiving reminders and alerts) has changed their health care behavior to a "moderate" or a "great" extent.[23]

However, patient experience investments should not come at the expense of reduced investments in clinical quality.[24] It is important to recognize that patient expectations do not always map to provider requirements (Figure 10). Patients sometimes place greater weight on care aspects that are not as strongly associated with better care outcomes; for instance, valuing more amenities rather than clinical ability. Furthermore, too narrow a focus on patient experience may lead to unintended consequences, such as making non-care-related cosmetic changes to hospitals to improve ratings, or effectively teaching to the test.[25] As such, hospital executives should be mindful of prioritizing patient experience that does not also enhance quality.

Although patient-experience scores might not always or fully reflect hospital care quality, our results suggest that those aspects of patient experience most closely associated with better care (such as communication with clinicians, especially nurses) have the strongest impact on hospital financial performance. In our analyses, improving nurses' work environments, including staffing, may lead to improvements in patient experience as well as help bolster financial performance. Enhanced nurse work environments have been shown to improve quality, as measured by fewer patient deaths, reduced failure-to-rescue rates, shorter hospital stays, and lower readmission rates.[35] As such, focusing on the commitment of hospital staff – nurses in particular – to consistent and productive engagement with patients and caregivers could assist hospitals in transitioning to a true patient-centered culture while also potentially improving quality and financial performance.

Appendix

Regression analysis

Deloitte performed regression analyses to analyze the association between HCAHPS scores and hospital financial performance. To understand the importance of patient experience relative to other factors that could influence hospital profitability we used controls for hospital organizational characteristics (such as hospital size, urban/rural location, ownership type, teaching status, and being part of a system) for case and payer mix, as well as for local market conditions.

Main regression models

Our main regression specification was of the following linear form:

Financial performance metric = f(patient experience scores, hospital organizational characteristics, case and payer mix, local market characteristics, year indicators)
where the regression variables are as follows:

- Hospital financial performance metric: either net margin, operating margin, or return on assets (ROA). We followed previous work and categorized the top and bottom percentiles of our financial measures as missing data, so as to diminish the potential for outlier values to affect the analyses[36]
- Patient experience variables:
  - "Top-box" and "middle-box" overall patient experience scores: the percentage of respondents who gave the hospital a rating of 9 or 10 out of 10 ("top-box" responses), and the percentage of respondents who gave a particular hospital a rating of 7 or 8 out of 10 ("middle-box" responses)
  - In alternate specifications, "top-box" patient experience scores for the eight non-Global HCAHPS domains for which we had data: nurse and doctor communication with patients, responsiveness of hospital staff to patients' needs, staff communication about new medicines, provision of key information upon discharge, and understanding of care needs after leaving the hospital[37]
- Payer and case mix variables: Medicare and Medicaid shares in payer mix, an indicator for disproportionate (i.e., larger than median) share of Medicaid patients relative to other hospitals in a similar location, case mix index, intensive care indicators, and non-acute share in total patient days

- Hospital organizational characteristics: indicator for the hospital being part of a system, ownership (indicators for government and not-for-profit hospital ownership) and size (indicators for small and medium hospitals)
- Local market conditions: area wage mix index, critical access indicator, urban location indicator, 457 hospital referral region indicator
- Indicators for each year between 2009-2014

In these regression models, the unit of observation is the hospital-year cell. Since we include hospital referral regions and year indicators, the association between patient experience and hospital financial performance is estimated from changes in HCAHPS experience ratings in a given hospital over time, as compared to other hospitals with similar characteristics in the same hospital referral region (HRR). We correct the standard errors for clustering on state and year.[38]

Hospital fixed-effects regression models:

The main regression model uses year and HRR indicators to account for potentially unobservable trends over years and across HRRs. Nevertheless, even with this HRR fixed-effects approach there are potentially unobservable factors (such as hospital culture, board and management practices, and leadership quality, among others) that could confound the effect of patient experience.

To account for such factors that might be less amenable to quantification, we also took advantage of the longitudinal nature of our data, and performed additional hospital fixed-effects analyses, where we replaced the HRR indicators with individual hospital indicators in our regression model. In these analyses, rather than contrasting the financial performance of hospitals (with different patient experience scores) within the same HRR, we analyzed whether year-to-year changes in patient experience for the same hospital were systematically related to changes in that hospital's financial outcomes.

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16. The "top-box" response is "Always" for the first nine measures except discharge information, "Yes" for the discharge information and "Definitely yes" for the recommend the hospital item. The "middle-box" response is "Usually" for the first nine measures except discharge information, "Probably yes" for the Recommend the Hospital item. There is no "middle-box" response in the Discharge Information composite.

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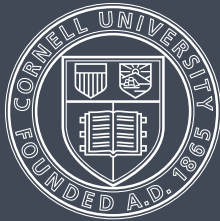
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Presentation Title: The Intersection of Facility Design, Patient Experience, and Investing in Your People: A Case Study of Mercy West Lakes Hospital

Summary: In the mid 2000's Mercy Medical Center identified the need for a more progressive and patient centered medical facility, specifically one which could fulfill the medical needs of central Iowans living outside the downtown Des Moines proper. This embarked a journey of clinical facility design research, and identifying facility best practices for not only our patient care staff, but designs which ensured a positive patient experience. Architects and Mercy senior leaders reviewed a combined 127 clinical design studies, trying to combine various facility models into one patient and staff friendly medical center. The outcome of this work was Mercy West Lakes hospital, a 146 bed full service community facility located in West Des Moines, IA. Yet even with a modern healthcare design and feel, shortly after the facility's inception HCAHPS scores were not as positive as leadership had hoped. It took a change in hospital management to help engage our patient care staff which in turn helped our patients feel more confident about their stay with Mercy. By investing in our people, we simultaneously invested in our patients. This valuable lesson of empowering front line staff to make decisions to better the patient experience proved crucial in improving consumers' view of the hospital and the effect staff could have on patients. As Mercy now looks forward to a complete re-modeling of its main tertiary campus in downtown Des Moines, these ideals are at the forefront of the hospital's work. A recent cultural re-branding of all 8,000 Mercy employees took place with training from The Ritz Carlton Leadership Center, an industry leading force in combining hospitality and service excellence principles in a healthcare environment. With Mercy hoping to have a new medical center open in downtown Des Moines by 2020, design features to improve the healing and clinical environment for patients while helping our patient care staff more easily do their work is vital for future organizational success. And this success can only be defined in how well we engage our own colleagues and give them the tools to better engage our patient population. This train of thought is extremely relevant today as by 2020 more than 25% of the population in America will be "millennials". To design a facility that meets the needs of this ever growing population from an internal and external standpoint is crucial in staying significant in the healthcare landscape. By intertwining healthcare design and internal staff training in hospitality metrics, Mercy hopes to satisfy the needs of everyone who interacts with our facilities, and organization as a whole.