



Management

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**Barrier-Oriented Management in Acne Services: A Conceptual Model for
Quality, Cost-Efficiency, and Client Retention**

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Abstract: Purpose. To develop a conceptual managerial model of the Barrier-Oriented Acne Approach (BOAA) for esthetic service enterprises and explain how a clinically grounded skin-barrier sequence can be connected with service-process design, resource allocation, quality consistency, service recovery, and long-term relationship value. **Methods.** A problem-oriented narrative synthesis covered 25 scholarly sources on business process management, customer experience, service quality, service-failure recovery, dynamic capabilities of small and medium-sized enterprises, value-based management, acne treatment cost-effectiveness, and skin-barrier support. Only works published by 31 October 2024 were included. Managerial constructs, clinical constraints, and causal-logical links were extracted; the six BOAA stages were translated into enterprise functions and theoretically compared with a reactive service pathway. No enterprise records, financial statements, client surveys, clinical observations, or statistical tests were used. **Results.** The model comprises baseline risk assessment, protocol design, resource allocation, staged delivery, quality and cost-control checkpoints, and retention-oriented continuous improvement. Three theoretical mechanisms were specified. Preventive coordination may support resource



discipline; standardized checkpoints may create conditions for consistent execution; and continuity with transparent communication may support trust and voluntary repeat service. The model also separates planned follow-up from service recovery and places safety, informed choice, professional scope, and referral criteria ahead of economic objectives. These relationships are conceptual propositions rather than measured effects. **Conclusions.** BOAA is presented as a conceptual system for managing the complete acne-related esthetic service pathway, not as evidence of lower costs, higher profitability, or improved retention. Its contribution is the integration of clinical risk logic with process, resource, service-quality, and relationship logic. Enterprise-level effects require subsequent empirical validation.

Keywords: risk assessment, resource allocation, customer journey, process standardization, professional boundaries, relationship value, continuous improvement.

**Бар'єрно-орієнтоване управління послугами у сфері терапії акне:
концептуальна модель оптимізації якості, витрат і збереження клієнтів**

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Анотація: Мета. Розробити концептуальну управлінську модель Barrier-Oriented Acne Approach (BOAA) для підприємств сфери естетичних послуг та обґрунтувати, яким чином клінічно визначена послідовність оцінювання стану шкірного бар'єра може бути інтегрована в проектування сервісного процесу, розподіл ресурсів, забезпечення стабільності якості, відновлення послуги після сервісного збою та формування цінності довгострокових відносин із клієнтом.

Методи. Проведено проблемно орієнтований наративний синтез 25 наукових джерел, що охоплюють управління бізнес-процесами, клієнтський досвід, якість послуг, відновлення після сервісних збоїв, динамічні спроможності



малих і середніх підприємств, ціннісно орієнтоване управління, економічну ефективність лікування акне та підтримання шкірного бар'єра. До концептуальної бази включено лише праці, опубліковані не пізніше 31 жовтня 2024 року. На основі опрацьованих джерел виокремлено управлінські конструкти, клінічні обмеження та причинно-логічні зв'язки, після чого шість етапів ВОАА трансформовано в управлінські функції підприємства й теоретично зіставлено з реактивною моделлю надання послуги. Дослідження не передбачало використання даних підприємств, фінансової звітності, результатів опитувань клієнтів, клінічних спостережень або статистичного тестування.

Результати. У результаті синтезу сформовано шестистадійну архітектуру управління, яка поєднує вихідне оцінювання ризику, проектування протоколу, розподіл ресурсів, поетапне надання послуги, контрольні точки якості й витрат та безперервне вдосконалення. У межах цієї архітектури визначено три теоретичні механізми. По-перше, превентивна координація може сприяти послідовнішому розподілу й використанню ресурсів. По-друге, стандартизовані контрольні точки створюють організаційні передумови для стабільності виконання сервісного процесу. По-третє, безперервність взаємодії та прозора комунікація можуть підтримувати довіру клієнта й формувати передумови для його добровільного повторного звернення. Крім того, модель чітко розмежовує плановий супровід і відновлення послуги після сервісного збою, водночас підпорядковуючи економічні рішення вимогам безпеки, інформованого вибору, дотримання професійних меж та своєчасного направлення клієнта до лікаря.

Висновки. ВОАА запропоновано як концептуальну систему управління цілісним шляхом надання естетичної послуги, а не як емпіричне підтвердження скорочення витрат, підвищення прибутковості або утримання клієнтів. Науковий внесок моделі полягає в інтеграції клінічної логіки оцінювання ризику з процесною, ресурсною, сервісною та відносинною логікою управління. З огляду на концептуальний характер моделі її практичний вплив на якість послуг,



витрати, поведінку клієнтів та економічні результати підприємства потребує окремої емпіричної перевірки.

Ключові слова: оцінювання ризику; розподіл ресурсів; клієнтський шлях; стандартизація процесів; професійні межі; цінність відносин; безперервне вдосконалення.

Introduction. For an esthetic service enterprise, an acne-related service is simultaneously a professional intervention, a sequence of client touchpoints, and a resource-consuming business process. Business process management treats value delivery as an end-to-end flow of interdependent activities rather than as isolated tasks [1, p.49–51]. Customer-journey research likewise locates experience across pre-service, service, and post-service touchpoints [2, p.75–77]. Assessment, communication, product selection, staged delivery, follow-up, correction, discontinuation, and referral can therefore be examined as one managerial pathway. If those activities are not coordinated, variation in staff actions and unplanned recovery work may arise; this is a theoretically plausible organizational mechanism, not a measured effect in the present article.

Service quality provides a second basis for the model. SERVQUAL distinguishes reliability, responsiveness, assurance, empathy, and tangibility [3, p.23–25], while a healthcare-specific framework adds safety, professionalism, and process consistency [4, p.608–610]. For small and medium-sized service enterprises, value creation also depends on sensing client needs, learning, integrating knowledge, and coordinating constrained resources [5, p. 591]. Risk-oriented management further supports prior identification, treatment, and monitoring of uncertainty [6, p.10–11]. Recent publications in the target journal address technological innovation, business-process transformation, adaptive personnel management, and consumer value [7, p. 1–2; 8, p.8–10; 9, p. 10–11; 10, p.1–2]. These are general-sector findings; the BOAA model uses them only as theoretical constructs and does not transfer their numerical results to esthetic enterprises.



Relationship management and recovery complete the economic context. Evidence from private healthcare services links perceived quality with loyalty and retention [11, p. 101], and service-failure research distinguishes failure recognition, recovery actions, and post-recovery evaluation [12, p.2599–2601]. Acne cost-effectiveness research confirms that resource use and treatment completion are legitimate economic categories [13, p.2177–2179], whereas value-based management defines value in relation to outcomes and the resources used to obtain them [14, p. 2477]. None of these sources demonstrates that BOAA lowers costs or increases retention. The problem addressed is how a clinically grounded sequence may be translated into process design that articulates resource discipline, service quality, recovery, and relationship value while clinical safety remains prior.

Analysis of Recent Research and Publications. Business process management supplies the model's unit of organization. Dumas et al. describe a lifecycle that includes process identification, discovery, analysis, redesign, implementation, monitoring, and control [1, p.16–18]. The construct adopted here is the end-to-end pathway with explicit responsibilities and checkpoints; it permits the six BOAA stages to be mapped as linked enterprise functions. The model does not import assumptions about automation or measured efficiency.

Customer-journey theory explains continuity across contacts. Lemon and Verhoef conceptualize customer experience as cumulative across touchpoints rather than confined to one transaction [2, p.75–77]. The adopted causal-logical link is that assessment, delivery, follow-up, correction, and referral must be represented within one pathway if continuity is to be analyzed. This link supports the service-continuity component of BOAA but does not establish repeat-purchase behavior.

Service-quality and service-recovery research specifies the control constructs. Parasuraman et al. provide the reliability, responsiveness, assurance, empathy, and tangibility dimensions [3, p.23–25]; Ali et al. adapt quality reasoning to healthcare by emphasizing safety, professionalism, and process consistency [4, p.608–610]. Harriet et al. examine the relationship among service quality, loyalty, and retention [11, p.



101], while Foroudi et al. organize service-failure research around failure, recovery, and post-recovery consequences [12, p.2599–2601]. BOAA uses these works to define checkpoints and distinguish planned follow-up from recovery; it does not treat their empirical associations as effects of the proposed model.

Resource and value perspectives explain why the model includes allocation and learning functions. Rashidirad and Salimian identify sensing, learning, integrating, and coordinating as dynamic capabilities relevant to value creation in service-sector small and medium-sized enterprises [5, p. 591]. Garkava et al. provide the preventive sequence of risk identification, response, monitoring, and communication [6, p.10–11]. Sokhatska and Zavhorodnia contribute the link between innovation and service-process development [7, p.1–2]; Lobunets et al. treat digital transformation as business-process change [8, p.8–10]; Tryfonova et al. emphasize adaptive managerial routines and personnel coordination under uncertainty [9, p.10–11]; and Braiko et al. frame consumer value and relationship continuity as management categories [10, p.1–2]. These constructs justify resource coordination and feedback without implying that the model reproduces sector-level performance estimates.

Economic interpretation is bounded by the type of evidence. Mavranezouli et al. evaluate resource use and outcomes for clinical acne-treatment alternatives [13, p.2177–2179], and Porter defines value as outcomes relative to resources expended [14, p. 2477]. BOAA borrows the relational logic between resources and value, not the clinical cost estimates or a claim of cost-effectiveness. Accordingly, preventive inputs, correction costs, and relationship value remain categories for future measurement rather than observed indicators.

Clinical publications establish operational constraints. Zhou et al. support baseline attention to epidermal-barrier integrity [15, p.2065–2067]; Schachner et al. specify barrier-supportive regimen logic [16, p.2902–2904]; and Draelos et al. describe adjunctive barrier restoration during acne treatment [17, p.554–556]. Reynolds et al. define evidence-based treatment and professional safety boundaries [18, p.1006.e3–1006.e5]. Karamon et al. contribute management of local side effects [19, p.1091–



1093], Araviiskaia et al. the adherence role of adjunctive dermocosmetics [20, p. 1], and Khammari et al. the tolerability checkpoint for retinoid-related sensitivity [21, p.1313–1315]. Narsa et al. organize strategies for reducing retinoid irritation [22, p.3–5], Bae et al. support structured acne assessment and grading [23, p.65–67], Jaiswal et al. summarize contemporary treatment options [24, p.4–6], and Moradi Tuchayi et al. provide adherence and follow-up interventions [25, p.2091–2093]. These works justify assessment, staged delivery, reassessment, discontinuation, and referral, but none establishes an enterprise-level economic effect.

The literature therefore remains divided by unit of analysis. Management studies define process, quality, recovery, resources, and relationship value, whereas dermatological studies define barrier status, tolerability, treatment boundaries, and adherence. The reviewed works do not provide a shared enterprise architecture that links these elements within an acne-related esthetic service pathway. This theoretical separation, rather than a lack of clinical studies or service-management research in isolation, motivates the proposed synthesis.

Identification of Previously Unresolved Parts of the General Problem. The first unresolved part is a mismatch in units of analysis. Acne research predominantly organizes evidence around skin condition, treatment, tolerability, and adherence, whereas management research organizes evidence around end-to-end processes, resource coordination, quality, recovery, and relationship value. Considered separately, neither body of work explains how a small esthetic enterprise can translate a clinically justified sequence into an operational service architecture.

The second unresolved part concerns the boundary between managerial and clinical decisions. A management model must organize assessment, communication, resources, follow-up, correction, and recovery without turning clinical vulnerability into a sales opportunity. It must also show where discontinuation, referral, and informed choice override cost-control or retention objectives. Existing management frameworks do not specify those clinical limits, while clinical publications do not assign enterprise responsibilities or resource checkpoints.



Within the reviewed source set, no framework was identified that combines four elements in one decision architecture: baseline clinical risk, enterprise process design and resource allocation, quality and recovery checkpoints, and relationship-oriented learning under a non-negotiable safety boundary. The novel theoretical contribution of the proposed model is this integration. It specifies mechanisms and decision limits; it does not formulate statistically testable effects or claim that BOAA reduces costs, increases profitability, or improves retention.

The **purpose of the article** is to develop a conceptual managerial model of the Barrier-Oriented Acne Approach for esthetic service enterprises, translate its six clinical stages into enterprise-process functions, explain the service-quality, resource, cost-control, recovery, and relationship mechanisms, compare the model with reactive and clinically structured pathways, and define its clinical and ethical boundaries.

Results

Conceptual Basis and Research Design

The article is a conceptual management study based on a problem-oriented narrative synthesis rather than a systematic review or empirical test. The information base comprised peer-reviewed publications indexed in Scopus, Web of Science Core Collection, and PubMed, supplemented by targeted searches in Google Scholar, publisher platforms, and the archive of the target journal. Search combinations included “business process management” AND service, “customer journey”, “service quality”, “service recovery”, “consumer value”, “SME dynamic capabilities”, “acne” AND “skin barrier”, “dermocosmetics” AND acne, and “acne adherence”. Searches were conducted in English and Ukrainian.

The temporal boundary was 31 October 2024 inclusive. Sources were retained when they contributed at least one of the following: an enterprise-process construct, a service-quality or recovery mechanism, a resource or value relationship applicable to small service enterprises, or a clinical constraint relevant to acne-related esthetic care. Peer-reviewed articles and a scholarly monograph were eligible. Publications dated 1 November 2024 or later, promotional materials, sources without verifiable



bibliographic metadata, Russian-language publications, works published in Russia or Belarus, and items lacking direct thematic relevance were excluded. The final conceptual corpus comprised 25 sources.

Construct extraction was qualitative. Each source was coded in a working matrix by unit of analysis, managerial or clinical construct, proposed relationship, decision boundary, and corresponding BOAA stage. Management constructs included process lifecycle, customer journey, service-quality dimensions, service recovery, dynamic capabilities, risk management, resource use, consumer value, and relationship continuity. Clinical constructs included barrier integrity, tolerability, assessment, staging, adherence, discontinuation, and referral. No effect sizes, enterprise indicators, or clinical outcomes were pooled.

Model building proceeded in five steps. First, the six clinical BOAA stages were restated as enterprise functions. Second, responsibilities, resource inputs, decision points, and permissible adjustments were assigned to each function. Third, process-management, service-quality, recovery, resource, and relationship constructs were mapped to those functions. Fourth, the integrated model was contrasted with a reactive pathway and a clinically structured BOAA pathway. Fifth, theoretical mechanisms and boundary conditions were formulated and checked for consistency across the figures and tables. This sequence yields an explanatory conceptual architecture, not a causal estimate.

The unit of analysis is one conceptual acne-related esthetic service pathway from initial assessment to completion, discontinuation, or referral. The reactive pathway is an analytical contrast rather than an empirical control group. Clinical safety, informed choice, scope-of-practice limits, and referral criteria are prior constraints and cannot be subordinated to cost control or client-retention objectives. Enterprise records, client surveys, clinical observations, financial accounts, ethical approval, statistical procedures, and data-analysis software were not required because no empirical study was conducted.



Definition of the Revised BOAA Management Model

The revised model replaces a purely clinical comparison with an enterprise-process comparison. In the reactive pathway, assessment and resource planning are weakly formalized and correction follows a complaint or adverse response. In the managerial BOAA pathway, risk assessment, planned resources, staged delivery, and quality checkpoints precede recovery and provide documented grounds for decisions. This contrast combines process-lifecycle, risk, and service-recovery constructs [1, p.16–18; 6, p.10–11] and remains analytical rather than empirical (Fig. 1).

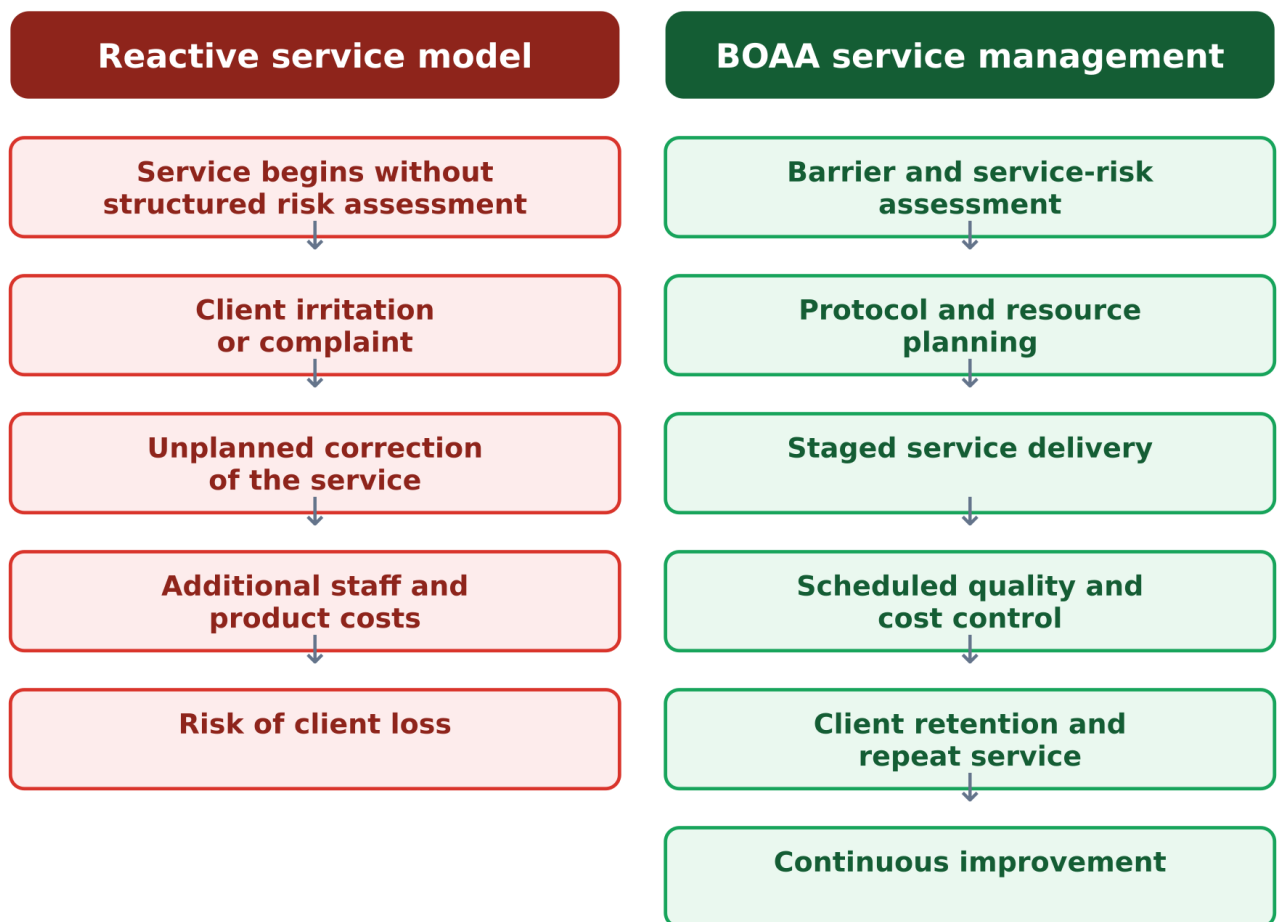


Fig. 1. Reactive and barrier-oriented models of esthetic service management

Source: developed by the author.

The complete management framework contains six linked stages. Each stage has a clinical function, an enterprise process function, and a managerial rationale (Fig. 2).



Fig. 2. Six stages of the BOAA service-management process

Source: developed by the author.

Managerial Logic of the Six Stages

Stage 1. Baseline Risk Assessment. The enterprise records skin-barrier status, prior intolerance, client expectations, contraindications, and referral triggers. As a management function, this stage supports risk segmentation and prevents an identical resource package from being assigned indiscriminately. Barrier-integrity, guideline, and acne-grading evidence justify assessment and referral boundaries [15, p.2065–2067; 16, p.2902–2904]; they do not define a universal business score.



Stage 2. Service Protocol Design. The service sequence, responsibilities, communication points, permitted adjustments, documentation rules, and referral limits are defined before delivery. The stage applies process-lifecycle, service-reliability, safety, risk-communication, and recovery-planning constructs [1, p.16–18; 3, p.23–25]. Standardization is treated as a design condition, not proof of higher quality, and must remain adaptable to the client's condition and professional scope.

Stage 3. Resource Allocation. Staff time, consumables, barrier-support products, follow-up capacity, and documentation effort are planned according to identified risk. This stage translates clinical preparation into resource coordination and uses the SME capability and value logics described in [5, p. 591; 13, p.2177–2179]. Additional preventive inputs may offset later correction work or may increase total resource use; the model does not determine which outcome occurs.

Stage 4. Staged Service Delivery. Active components are introduced gradually within professional and clinical limits, and planned deviations with reasons for change are documented. Evidence on adjunctive dermocosmetics, sensitivity, irritation reduction, contemporary treatment, and adherence supports tolerability-focused staging and follow-up [19, p.1091–1093; 20, p. 1]. These records are operational documentation, not research data, and the sources do not establish a universal enterprise protocol.

Stage 5. Quality and Cost Monitoring. A mandatory checkpoint considers tolerability, complaints, completion, unplanned contacts, additional product use, staff time, and the need for discontinuation or referral. Service-quality, retention, recovery, cost-effectiveness, and value constructs explain why clinical, communication, and resource consequences are reviewed together [3, p.23–25; 4, p.608–610]. The checkpoint distinguishes planned follow-up from recovery after a service failure without presuming savings or complaint reduction.

Stage 6. Retention and Continuous Improvement. After pathway completion, voluntary repeat service, referral outcomes, feedback, deviations, and relationship value are considered as inputs for process revision. Customer-journey, dynamic-



capability, consumer-value, retention, recovery, and adherence research supports the learning loop [2, p.75–77; 5, p. 591; 10, p.1–2; 11, p. 101; 12, p.2599–2601; 25, p.2091–2093]. This logic must not convert clinical vulnerability into sales pressure; safety, informed choice, and professional boundaries remain prior.

Comparison with Existing Approaches

Table 1 distinguishes a reactive service pathway, a clinically structured BOAA pathway, and the proposed managerial BOAA model.

Table 1

Comparison of service-management approaches for acne-related esthetic care

Parameter	Reactive service model	Clinical BOAA	Managerial BOAA
Primary logic	Correction after a problem becomes visible	Clinical sequence focused on tolerability	Integrated clinical, resource, quality, and retention process
Risk assessment	Informal or inconsistent	Barrier status assessed clinically	Barrier and service risks documented before resource allocation
Resource planning	Reactive use of staff time and products	Not an explicit analytical element	Planned according to risk and process logic
Quality control	Complaint-driven	Clinical reassessment after 2–4 weeks	Scheduled review of clinical, service, and resource implications
Economic logic	Unstructured correction burden	Not specified	Preventive resource discipline, service continuity, and relationship value
Decision rule	Continue or correct case by case	Adjust according to tolerability	Configure the process according to risk, service standards, and professional boundaries

Source: developed by the author based on [1, p.49–51; 2, p.75–77; 3, p.23–25; 4, p.608–610; 5, p. 591; 6, p.10–11; 7, p.1–2; 8, p.8–10].



Conceptual Economic Dimensions

Because no enterprise data were collected, the model contains no estimates, financial calculations, or measured indicators. Table 2 defines the economic and managerial categories through which BOAA can be interpreted and states only theoretical relationships. The entries use non-causal wording and must not be read as evidence of achieved savings, profitability, quality improvement, or retention.

Table 2

Conceptual economic dimensions of the managerial BOAA model

Dimension	Role in the conceptual model	Managerial interpretation
Resource discipline	Resources are assigned according to documented service risk rather than used only after a problem appears	Connects preventive planning with cost-control logic without claiming measured savings
Process predictability	Responsibilities, sequence, checkpoints, and permitted adjustments are specified before service delivery	Defines responsibilities and expected variation; supports consistent execution without asserting a measured quality improvement
Service continuity	Assessment, delivery, follow-up, correction, and referral are treated as one managed pathway	Links separate contacts into a coherent customer journey
Quality consistency	Clinical and communication checkpoints are integrated into the service design	Frames quality as process reliability rather than complaint response alone
Relationship value	Transparent communication and continuity are treated as conditions for trust and voluntary repeat service	Connects client value with long-term relationship management without sales pressure
Ethical boundary	Cost and retention objectives remain subordinate to safety, informed choice, and referral criteria	Prevents economic goals from displacing professional responsibility



Dimension	Role in the conceptual model	Managerial interpretation
Learning mechanism	Documented deviations and feedback are used to revise the service protocol conceptually	Supports organizational learning and continuous process improvement

Source: developed by the author based on [1, p.49–51; 2, p.75–77; 3, p.23–25; 4, p.608–610; 5, p. 591; 11, p. 101; 12, p.2599–2601; 13, p.2177–2179; 14, p. 2477].

Conceptual Value-Creation Logic

The framework links four levels of reasoning: conceptual inputs, the six-stage BOAA service process, managerial mechanisms, and three forms of economic logic. Preventive coordination explains cost-control logic, standardized checkpoints explain service-quality logic, and continuity explains relationship-value logic [1, p.49–51; 2, p.75–77; 3, p.23–25; 4, p.608–610; 5, p. 591; 11, p. 101; 12, p.2599–2601; 13, p.2177–2179; 14, p. 2477]. These links are propositions embedded in the model, not observed causal effects (Fig. 3).

Compared with business process management, BOAA adopts the end-to-end lifecycle, assigned responsibilities, checkpoints, monitoring, and revision [1, p.49–51]. Its difference is that process redesign is bounded by clinical tolerability, professional scope, discontinuation, and referral. The model therefore permits controlled adaptation but does not treat every deviation as an efficiency problem or every standardized step as suitable for every client.

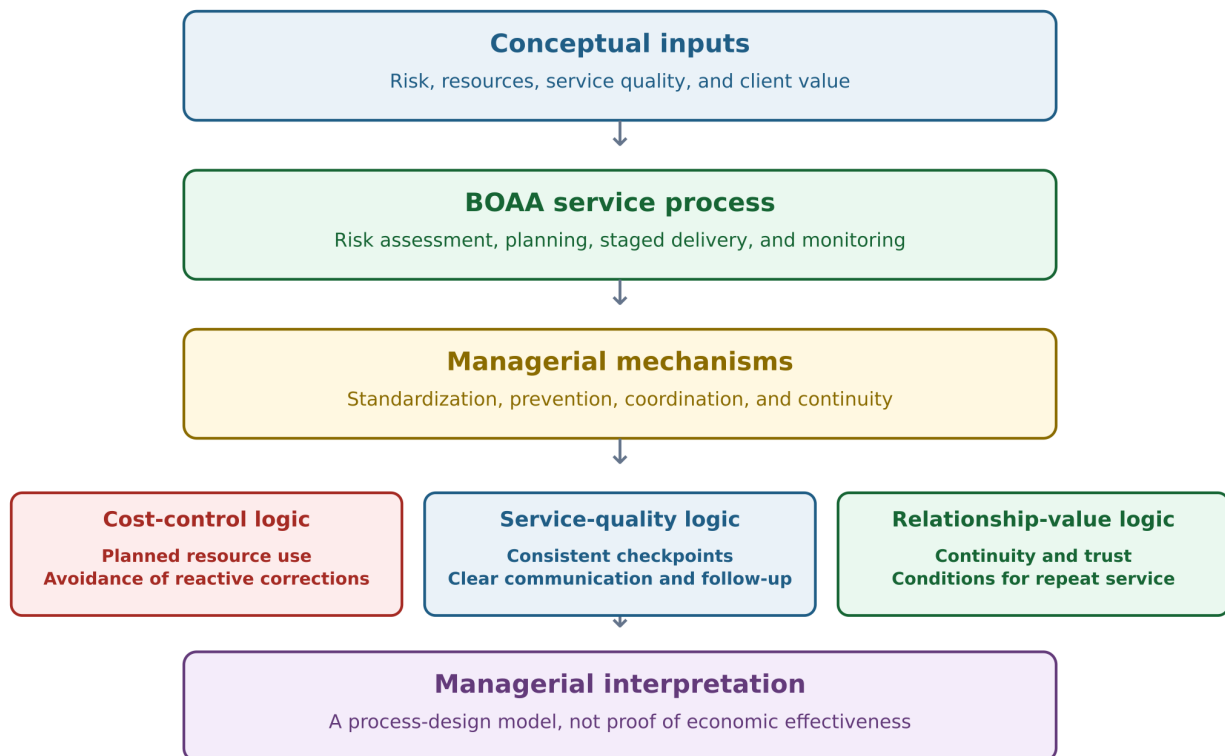


Fig. 3. Conceptual value-creation logic of the managerial BOAA model

Source: developed by the author.

Compared with service-quality theory, BOAA translates reliability, responsiveness, assurance, safety, and professionalism into design questions: whether assessment is documented, responsibilities are clear, follow-up occurs as planned, and referral limits are observed [3, p.23–25; 4, p.608–610]. It does not calculate SERVQUAL or patient-satisfaction scores. Quality consistency is consequently a proposed property of the process architecture, not an observed outcome.

Compared with customer-journey and service-recovery logic, BOAA joins pre-service assessment, service delivery, post-service follow-up, correction, discontinuation, and referral within one pathway [2, p.75–77; 11, p. 101; 12, p.2599–2601]. Stage 5 separates a planned checkpoint from recovery triggered by a failure or complaint. Continuity and transparent communication may create conditions for trust, but the model does not infer automatic loyalty, repeat purchase, or customer lifetime value growth.



Compared with resource and value-based reasoning, BOAA links risk-adjusted planning, staff time, consumables, follow-up capacity, and learning to the service pathway [5, p. 591; 10, p.1–2; 13, p.2177–2179; 14, p. 2477]. Preventive inputs may substitute for some unplanned corrections, but they may also raise total resource use. Without enterprise data, the direction and magnitude of any net effect remain unknown; cost control is a decision logic rather than a demonstrated saving.

The three propositions are therefore conditional. Preventive design may support resource discipline; coherent checkpoints may support consistent execution; and continuity may support relationship value. Clinical evidence imposes the limiting conditions of barrier status, tolerability, treatment appropriateness, adherence support, discontinuation, and referral [15, p.2065–2067; 16, p.2902–2904; 17, p.554–556; 18, p.1006.e3–1006.e5; 19, p.1091–1093; 20, p. 1; 21, p.1313–1315; 22, p.3–5; 23, p.65–67; 24, p.4–6; 25, p.2091–2093]. Applicability may also vary by regulation, enterprise size, staff competence, service portfolio, documentation capacity, and client-risk profile. These boundaries distinguish the model from a universal protocol and define the scope of future empirical testing.

Conclusions. The purpose of the article was achieved at the conceptual level. The six clinical BOAA stages were translated into an enterprise architecture comprising baseline risk assessment, service-protocol design, resource allocation, staged delivery, quality and cost-control checkpoints, and retention-oriented continuous improvement. The model's theoretical contribution is the integration of clinical risk and referral limits with end-to-end process management, service-quality and recovery categories, constrained-resource coordination, and relationship-oriented learning. Its managerial purpose is to clarify responsibilities, decision points, permissible adaptations, and the distinction between planned follow-up and service recovery. Application remains bounded by regulation, professional scope, staff competence, enterprise size, documentation capacity, service portfolio, and client-risk profile. Because no enterprise, financial, client, or clinical data were collected, the article does not demonstrate lower costs, higher profitability, fewer complaints, better



quality, or increased retention. Future research should operationalize the proposed categories and test them in appropriately designed enterprise studies before any claims of effectiveness are made.

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