Chapter 8: Clinical Support Services

Teaching Goals

This chapter discusses the organization of healthcare processes beyond physician and nursing care that are integral to patient diagnosis and treatment. Teaching goals may differ for this chapter, depending on the student’s amount of healthcare experience and on whether the student is a clinician. For traditional students without much healthcare work experience, Figure 8.1 (p. 295 in the book) provides a nice summary of the diagnostic and therapeutic services that comprise the clinical support services (CSSs) in a large healthcare organization.

Figure 8.2 (p. 296) is central to the successful operation of these services. Although each CSS may be unique in the service it provides, each must perform the clinical and managerial functions in this figure. A test of students’ comprehension would be to ask them to give examples of each managerial and clinical function as they apply to any specific CSS.

Classroom discussion may center on how CSSs work with nurses and doctors in providing appropriate, efficient, and effective care. How do CSSs control their cost? What is their role in the clinical service lines? Refer to Figure 8.11 (p. 323) to point out the accountability matrix in an organization with service lines.

This is a good chapter for the use of case studies that identify opportunities for improvements (OFIs). An OFI can help students drill down into the issue, allowing them to conduct a root cause analysis. Because most root causes involve interprofessional communication (miscommunication or lack thereof), multiple CSSs, nurses, and physicians are needed as members of a performance improvement team. (See “Cases and Longer Exercises for case suggestions.)

On pages 323-326 is a discussion of compensation of physician and nonphysician CSS managers. An important challenge for today’s healthcare executive is the subject of physician compensation and ways to incorporate physicians into the management structure. It is important to highlight this part of the chapter and to perhaps engage the class in a discussion about issues surrounding the topic, including setting physician compensation and compensation models that may work.

Buried in the budget function is the origin and handling of capital and new program requests (see Figure 8.8, p. 314). The capital and new program budget is actually addressed in four chapters—Chapter 3 (guidelines and final approval by the governing board), Chapter 8 (originating requests), Chapter 11 (final review and rank order), and Chapter 14 (internal consulting assistance for proposals). Students should fully understand the figure and its implications at this point and learn more as they progress.

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Finally, the balanced scorecard approach is depicted in Figure 8.13 (p. 328), with some sample measures. What might be some additional measures?

We like to focus our examples and best practices on the CSSs, which tend to have the largest numbers of associates, highest degree of complexity, largest capital expenditures, and the greatest potential for patient and physician satisfaction. These CSSs are emergency departments, operating rooms, imaging services, and medical laboratories. One class assignment may be to divide the class into groups. Each group would study a selected CSS and report on some of the problems (and offer possible solutions) for the CSS.

In a Few Words

Most seriously ill patients require support well beyond what a doctor and a nurse can give alone. They draw that support from several services that in many ways are the core contribution of the modern hospital—pathology (or laboratory), imaging, operating theaters, anesthesiology, pharmacy, rehabilitative therapies, social service, and others. Each of these can and does exist apart from the hospital; the organization’s role is to assure quality, effectiveness, coordination, and efficiency, providing a comprehensive “one stop shopping” that is superior to independent providers. To do this, the healthcare organization must first create an environment where qualified professionals want to work. Then it helps these professionals perform eight functions: ensuring quality of service; promoting effective use; managing the physical facility; providing patient- and physician-friendly amenities; scheduling and coordinating care; continuously improving; budgeting; and recruiting associates.

Chapter Outline

Achieving evidence-based medicine
- Reaching Six Sigma standards for accuracy and safety
- Eliminating underuse and overuse of CSSs
- Keeping up with changing technology

Providing “brag about” comprehensive service
- Coordinating multiple clinical support needs
- Computerized order entry and results reporting
- Convenient consultation for physicians and nurses
- Managing the complex patient with multiple diseases or conditions

Recruiting and retaining qualified CSS professionals
- Making the organization the best place to work
- Rewarding performance improvement
- Providing continuing education

Outsourcing and contracting for CSS
- Keeping CSS costs and service comparable to competition
- Devising relationships that benefit both parties
- Expanding CSS through telemedicine and rural hospital support
Powerpoint Slides
See Learning Tools.

Questions to Debate
Slides of the individual questions are downloadable. We have prepared some summary thoughts on the content of class discussion. Obtain this information by writing (conventional mail) on academic letterhead to:

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1. Consider a pharmacy serving a large healthcare organization and measured by the six dimensions of Figure 8.11. Which measures are the highest priority? Should an improvement program focus on these measures, or a broader set? How would you motivate the pharmacy team to improve?

2. Amenities and patient scheduling are often issues that involve several CSS. Some CSS must be scheduled in specific sequences. They sometimes must be moved from place to place. Delays should be minimized, but service times are not always predictable. How does an excellent organization address these problems? What are the roles of the individual CSS?

3. The emergence of service lines has substantially changed the accountability of CSS personnel. Many professionals have dual reporting, to the service line and to the CSS, and some have drifted away from their CSS accountabilities. What is an effective model to integrate specialty training with patient-focused care? (For example, assigning respiratory therapists and ultrasound operators to a cardiovascular service line) How should the organization resolve arguments over “rights” of CSS professionals?

4. A small hospital in a well-managed healthcare system can consider three ways to obtain service. It can “stand alone,” hiring its own professionals. It can “outsource,” buying service from a local provider that would otherwise be a competitor. It can “affiliate,” arranging for training, procedures, and supervision through its system or one of its larger affiliates. How should it decide what to do? Who should be involved in the decision?

5. Technology advances rapidly in many CSS. To keep up, investments must be made in learning, training, and equipment. What are the roles of the CSS manager, the organization senior management, and governance in deciding how much to invest in keeping up? Do the functions of continuous improvement and budgeting provide
an adequate framework to decide when specific new technology is appropriate? If not, what improvements would you suggest?

**Additional Discussion Questions**

The following questions may also be used to stimulate debate:

1. **CSS functions**
   1.1. Figure 8.2 (p. 296) shows eight functions for all CSSs. Pick any one of the services in Figure 8.1 (p. 295), except pharmacy or operating room, and give examples that show what might be involved in each function.
   1.2. Is there any function in Figure 8.2 (p. 296) that you feel should be omitted? Should be assigned to some other organizational unit than the CSS itself? Does not appear in the figure? Justify briefly each part of the figure, and list any changes you would like to make.
   1.3. How many of the functions require training beyond the usual professional preparation? Where does that training come from?

2. **CSS operations**
   2.1. Why is the long-range planning for CSSs ultimately the responsibility of the governing board, and what is appropriate CSS participation? What should a healthcare organization do if an outside vendor offers superior service on the six dimensions of performance measures?
   2.2. Much inefficiency and quality loss in care occurs at handoffs and interactions between the doctor and the CSS or between CSSs, including nursing. Explain, in terms that a physical therapy manager or other CSS manager would appreciate, what the responsibility of the CSS unit is to deal with handoff problems.
   2.3. Should a CSS ever discourage use of a specific test or treatment? Why? How would the CSS go about discouraging use? Should a CSS ever encourage use of a specific test or treatment? Why? How would the CSS go about encouraging use?
   2.4. Who are the customers of a CSS? How would a CSS ascertain customer needs and satisfaction? Using Figure 8.3 (p. 299) explain to the CSS manager the goal of managing the four barriers/facilitators in the figure.
   2.5. How would you operate a patient scheduling system (Figure 8.4, p. 306) to achieve the optimum occupancy for the unit shown in Figure 7.5 (p. 270)? (See also Chapter 7 Instructor’s Manual, Questions to Discuss, number 2.2.)

3. **Performance measurement**
   3.1. A well-managed healthcare organization has a formal educational program for its CSS managers that deals with management issues, including the use of data in Figures 8.12 and 8.13 (p. 327 and 328). For an upcoming
educational program on new CSS managers, make an outline for how the organization will set goals, evaluate CSS performance, and reward CSS managers.

3.2. The finance department of your institution prepares central forecasts of CSS demand at aggregate levels, and the CSS extends these to specific levels as described on page 343. What if the two are seriously at variance? Say, the CSS manager says recent research implies a major shift from one procedure to another and an overall decline in use of both? Who makes the final decision? How would you reach a conclusion if you were responsible for the final decision?

3.3. Can the central organization ask for a specific cost-reduction goal? What would justify such a request? How would a CSS respond?

3.4. Using Figure 8.5 (p. 307), review for a CSS manager the sorts of performance data that suggest an OFI. What, other than quantitative reports, might also help identify an OFI?

Questions for Examination

These questions are less ambiguous than the discussion questions. Obtain these questions and the authors’ answers by writing (conventional mail) on academic letterhead to:

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