Mid-month April 2014

I am here in Australia and Easter is coming - big weekend here - so everyone asks "What are you doing for Easter?" Funny thing - no kids so no eggs to be hid. No family, so no trips to be made. I am at the age of reminiscing, and my mind goes back to Montana in the 60s, where Easter was spring skiing - shorts and a sleeveless sweat shirt on the sunny slopes of Bridger Bowl. I had Head 210 GS skis for the snow in the bowls, and 3' shorties for the groomed slopes. It was an interesting time, since a Canadian fraternity brother from Banff (Calgary) taught me to ski early on, and I was instructing the beginners at Bridger Bowl (the Bridgers are a unique east-west stretch of Rocky mountains, so there was north facing slopes - meaning GREAT POWDER). So why do I regress here?

When teaching skiing, you have to get people to lean forward (which when rushing down a mountain side, seems crazy). The exception is when skiing deep powder and you have to float your tips, hence my Head 210 GS skis. But I regress on my regression. Most beginners just will NOT lean forward, it feels awkward and scary. I have watched even intermediate skiers on the intermediate slopes going downhill without leaning forward - they think they know better than the experts. When you lean forward, you are committing to the slope, and instead of coasting, you are carving your turns on the mountain. The stakes are higher - the decisions you make each second are crucial . . . you are fully engaged with the sport, the each at mountain, and with yourself.

Unfortunately, many skiers never learn to lean forward. Leaning back is easier, simpler, and feels safer. It feels more natural (especially if your are a Queensland water skier). Yet, this resistance to leaning forward leads to mediocre skiing.

I wrote the text, *The Practice Success Prescription: Team-based Veterinary Healthcare Delivery*, VIN Press, circa 2009, and it is in the VIN Library for free download. Yet it requires the practice leader to "lean forward" as they change their practice culture, and most do not. They download the book and try to 'cherry pick' ideas, rather than committing to the adventure by leaning forward and craving their course into that mountain.

The last two *Fortnightly Newsnotes* included articles on interpersonal skills, mentoring and bullying, but to embrace those concepts, practice leadership to commit to changing the practice culture and organizational behavior paradigms (a new Monograph in the VIN Bookstore). That is not unlike leaning forward when skiing, and in most Baby Boomer led practices, the leadership is NOT leaning forward and NOT committing to carving a new course down the mountain. The reasons are many, but it often comes down to the mentor selected for the practice leadership and practice culture redesign - most Baby Boomer led practices do NOT invest in a qualified veterinary savvy consultant, and if they do, many still revert, even after seeing their staff get excited and fired-up with the new accountabilities of team-based veterinary healthcare delivery.

Leaning forward is scary! Change is scary! Altering the interpersonal skills, mentoring and organizational behavior paradigms is NOT easy if you have never done it before. I am always amazed at the veterinary leaders who use bullying styles instead building better relationships (e.g., *Crucial Conversations* and *Crucial Confrontations*, by Patterson, et.al.). The authors of *Crucial Conversations* didn't set out to write a book on communication; rather, they began by researching the behaviors of top performers. They found that most of the time, top influencers were indistinguishable from their peers. But as soon as the stakes grew high, emotions ran strong, and opinions differed, top performers were significantly more effective. What the authors observed during this study and captured in this runaway bestseller is a distinct and learnable set of skills that produce immediate results.

The attached article take sit up a notch. *Centers of Excellence* is a foray into larger general

companion practices (multi-doctor) as well as emergency and specialty practices, and discusses how to work and play well with others. Sure sounds like "leaning forward" as you start carving a course down that mountain; and I am available for helping the transition occur in your practice.

Please note - I have added a new, economical, regional practice assistance program to my Australian consulting options, which could be exported with some coordination, titled:

TIME TO SMILE AGAIN (http://drtomcat.com/vci-programs.pml)

Have a Happy Easter, and please remember, rabbits are NOT allowed in Queensland - signs are posted at the NSW border for rabbits that can read. But there is a QLD movement to recruit Bilbies (rabbit bandicoot). :>)

Tom Cat >*-*<

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P.S. *VCI Seminars at Sea* (Alaska cruise in August, with a faculty of 8 Internationally-savvy speakers) would be a great opportunity to start that "lean forward" transition for yourself. Details are posted at http://drtomcat.com/site/view/214832_.pml.

As an alert, the following was just sent by our cruise coordinator, Randy Norris, to a recent inquiry (randy.norris@frosch.com):

We have limited availability on the cruise, but I do have a few balcony staterooms available. Total cost per person, including all port charges, government taxes, transfers to/from the ship and gratuities…$2,223.53. This quote does not include airfare. We also are offering an optional pre-cruise tour of Denali and a post-cruise tour of the Canadian Rockies. If you are considering something else, please let me know.

PLEASE - Book now and avoid being squeezed out of this great CE adventure!

Mid-month April Attachment:

CENTERS OF EXCELLENCE
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People are like stained glass windows; they sparkle and shine when the sun is out, but when darkness sets in, their true beauty is revealed only if there is light within. Elizabeth Kubler-Ross

Why in the world would a consultant who wants to talk about “centers of excellence” start with a quote from the leading author in Death, Dying and Grief? The answer is basically an observation of what has been happening to our profession. The Veterinary Teaching Hospitals (VTH) used to be our “centers of excellence,” yet all the recent studies show new graduates are not prepared for the real world of practice. They have amassed a significant debt, and have not learned to influence decisions by clients for the welfare of the pet. Most all of the new graduates, interns and residents seem to understand the esoteric logic of academia, but have not learned how to work and play well with others; most would have a hard time getting a “D” in sandbox play. This is also seen in many of the specialists leaving academia, since they were the “trainers” of the interns, residents, and new graduates.

THE TRUTH OF THE DEMOGRAPHICS

A true center of excellence is more than large facilities, good doctors, and expensive equipment. We cannot expect people raised in academia to understand the business and client relations required in private practice. Just about four decades ago, before the expansion of the clinical-based board specializations, many land grant, college-based Veterinary Teaching Hospital (VTH) professors had come out of private practice and into the teaching hospitals; now they go from graduation, to internship, to residency, to academic appointment, to tenured professor, so personal clinical productivity is no longer an expectation. Concurrently, while the Veterinary Teaching Hospitals have become centers of excellence for tertiary care, some of the privately-owned specialty practices are becoming the centers of excellence for profitable veterinary business models.

The one-veterinarian practice is disappearing, and multi-doctor practices are emerging. The challenge is the old one-doctor owner only had to discuss changes with the person in the mirror, but when the leadership base is expanded, the savvy practice owner understands that a change in operational programs requires a change in organizational behavior. According to Dr. Glen Richards, the visionary CEO of our corporate consolidator in Australia (as published in the The Australian newspaper earlier this month), "over half the Australian practices are still operating if they were in the 1970s and 1980s." In the USA, we have seen the same challenge; practice owners expand and do not change their personal "discuss it with the mirror" behavior. So this article is discussing what larger specialty practices have learned, and what successful multi-veterinarian practices have emulated.

A true center of excellence requires the presence of an integrated program of delivering quality health care, including the ability and commitment to measure quality of care on a continual basis and compare it with an external benchmark; high levels of client satisfaction due to better continuity of care; availability of a more comprehensive array of services; ability to handle the full range of complications; and lower cost based on improved efficiency and productivity through the implementation of standards and staff-based facility operations.

While the concept of centers of excellence is not new, it is gaining more attention as veterinary specialists, multi-owner facilities, and multi-doctor practices begin to exhaust their abilities to increase revenues by the “traditional” methods. One of our consulting partners is a sole-owner surgical practice where the ownership takes home about $1.6 million a year. We also consult with a seven million dollar grossing partnership (it was less than $3 million when we started working with them) that still refuses to manage all elements of the practice, or even measure productivity by the individual owner, so they must rob Peter to pay Paul, thereby reducing their individual personal take-home

income to less than a quarter million apiece. We have one university VTH where the neurologist was a true work enthusiast, and actually asked how she could help the fiscal condition of the VTH; after assessment, we told her to take one less case a day, since she was losing more than $1000 on every billed case. These examples are not unusual, since most VTH systems collect a much smaller portion of their costs in fees than private practices (the worse case VTH we have encountered has been $400,000 annual gross collections for more than one million dollars of veterinary healthcare service sales).

THE BOARD'S ROLE

Leadership and performance assessments have become established business tools, but are still rare occurrences in healthcare, veterinary or human! Many veterinarians avoid feedback on performance, or go through such assessments without a clear idea of the process and how to maximize the feedback they receive. Many times this has been caused by the sender, who is going through a process they have read about without really understanding the core elements of the philosophy. For ANY assessment to be successful, it is important to define expectations up front, take an active role in the nurturing and developmental process, and then to build on strengths as the assessment process is shared.

The current management guru thinking is that the most comprehensive assessments give you feedback from different types of people - including your direct team, your peers, lateral service specialists, and the administrative supervisor(s). Sad to report, for Gen-Y staff, it is often from their peer group from social media, totally uninformed individuals supporting the Gen-Y staff member's perceptions of "fair". The real assessment should have a broad enough base to allow open feedback, such as - career development, intellectual abilities, management style, team skill development, interpersonal communication styles, emotional profile, and personality/behavior make-up and traits. In the normal world, this is called "open feedback," in management it is often called "360 degree assessment," and in the practice, it is usually called "a pain." Regardless of what you call it, after it has been done, you should be able to:

¬ know that it has been a positive effort, discussing the good aspects that need to be expanded upon; it should not be a negative, fault finding, exercise
¬ connect daily actions, thoughts, and perceptions to career/work goals
¬ increase self-knowledge and become more aware of the routine thought processes
¬ determine how others perceive you, both personally and professionally
¬ learn to better manage others' perception of your behavior and actions

If you approach the feedback process with the right attitude and the right information, you too can expect to achieve improvements, The following are a few tips for maximizing the value of the feedback experience:

 Select the right organization for the feedback. It is important to select the facilitator and individual(s) who will conduct the feedback exercise. This is not a project for the "do it yourself" practice manager. The organization should have a history of facilitating the feedback process in veterinary medical situations, they need to respect the social contract associated with healthcare delivery, and they must appreciate the "calling" which most veterinary professionals and paraprofessionals carry with them into this career. Most important, the facilitator should have a personal style with which the Board is comfortable.
 State what you want and why in the first interview. Before the Board initiates a facility-wide feedback system, they must decide what they are hoping for and why. Ask, "What do we want to

achieve? What do the players in the practices want from us?" The trite answer of wanting to know the strengths and weaknesses does not usually warrant the cost of bringing in an outside facilitator. There must be more. If the plan is to identify paraprofessional coordinators and managers to cause the doctors to have more productive time, then state that clearly . . . Have outcomes in mind before starting.

 Understand the different types of feedback that will be received. There are two types of feedback, destructive (negative comments) and constructive (positive ideas). Some people call these "strengths" and "weakness" when they do strategic assessments of the business environment, and use the terms "opportunities" and "threats" when they look outside the business entity. When a Board wants a facilitator to coordinate a 360-degree feedback assessment of key players, personalities and perceptions color the process in many cases. If the Board has been stingy on recognition, benefits, or even pay raises, managers and practice leaders are seen in a dimmer view. Sometimes this is reported as someone having weak fiscal skills, when in fact, the Board has never shared budget authority with anyone. It is important to note, each assessment of the practice entity or the senior administrators/managers is actually a reflection on the Board's ability to make their key people successful.

 Use the feedback to structure specific outcome plans. Reports for the sake of reports sets the wrong tone - how the information will be used to "make a better tomorrow" reduces the blame setting and forces people to make commitments for future action. In some cases, the new directions will be contrary to some of the staff, and they need to be allowed to go on a quest for a better personal environment; this is called "dehiring" in some of our reference texts. It is not that you hire bad people, it is that the environment/culture of the veterinary entity grows in a direction different from which the individual desires, and that is why they deserve to be set free to seek other opportunities. A good Board empowers people, while a great Board empowers teams; empowerment is for the new and improved future outcomes, not just doing the processes of the past.

 Follow-up with your colleagues. Everyone on the Board of a specialty group should be seeking information from the referring practices to assess the reputation of the facility. If it is a large general practice with extended evening "urgent care" hours, clients need to be contacted personally and the reputation assessed. Some of the information about the practice will have a tendency to cause "knee jerk" reactions, but resist the urge! The information from others is how we learn of the perceptions, and perceptions are REALITY for the people who hold those feelings. Following up with peers, direct reports, and coordinators within the practice can also help develop strategies to improve relationships and plan the practice's self-development.

 Respond appropriately to negative or positive comments. Whatever the Board learns during the feedback effort, ensure you keep a balanced assessment - the goods most often outweigh the negatives by many fold, but many Boards only hear the negative. Feedback, negative or positive, is not a cause for interference with operations, unless it is a Board policy or precedent that has caused a challenge to operations. Share the feedback in a positive perspective, even if it was negative, and allow the staff to develop the action plan for resolution of the negative or continuation of the positive. Remember, behavior rewarded is behavior repeated, and positive feedback is a morale booster, especially from a Board.

If the Board appropriately defines core values and expectations, apply them to the mission focus when making policy and precedent decisions, positive feedback should reinforce the core values and expectations. Concurrently, the Board must ensure an adequate program-based budget is developed for the staff to operate the facility and programs (see the Wiley text, Chapter 4, Building the Successful Veterinary Practice: Programs & Procedures (Volume 2), for details on program-based budgeting). A well-conducted leadership assessment can be an integral part of the team's development, and it must be seen as a long-term investment in the practice's development and growth.

COORDINATE CARE AMONG SPECIALTIES

Centers of excellence apply a multi-disciplinary approach to healthcare delivery. Under this approach, the zones of the hospitals are operated by the staff, and they ensure the doctors stay on schedule and use the equipment and support staff in the zone in a safe and appropriate manner. Admitted patients are evaluated by specifically-trained veterinarians, ancillary providers, and if necessary, clinicians from a variety of other specialties. Many specialty practices employ a social worker to help the clients through the stress-filled times of patient crisis, thereby freeing up the staff for critical and specialized healthcare delivery demands. In the case of many specialties, the patient needs “urgent care,” and there is a reluctance to refer to the VECCS specialist on staff. When a multi-specialist complex uses a team approach to manage crisis cases, the process is usually shortened, and most often, the patient recovers sooner. The multi disciplinary approach is crucial for treating patients with complex medical problems who need immediate care!

One of the most important keys to success of a center of excellence is grouping the specialties together in a seamless, integrated, and organized fashion, in both patient care and facility utilization. Currently, some multi-disciplinary, specialty groups are vying for the same patient market, which can be a major stumbling block to true integration. For example, in vascular services, interventional radiologists compete with cardiologists, who compete with surgeons, which can create an environment of minimized cooperation. Or in emergency medicine, the ER clinician doing an ultrasound, which is often done by the radiologist or internal medicine clinician during daytime hours, is based on patient need, and not "turf", for the case at hand. However, if the Board deals with these issues at first occurrence, and forces collaboration of the right specialties to find the best and most cost effective treatment for the patient, the client and the referring clinician have increased confidence in the facility’s ability to handle complex healthcare problems. For this collaboration to be effective, the specialists involved need to establish uniform clinical protocols so that a busy practitioner does not have to spend time figuring out whether and how to proceed with the best treatment plan.

When practices have the ability to use a center of excellence veterinary healthcare delivery system, they have the potential to influence the practice’s market share, improve client satisfaction, enhance the quality of care, and increase the perception of value within the community. When a practice complex centers on pacifying specific whims of specific doctors, rather than staying client-centered (clients are referring practices and animal owners), a downward spiral will develop which causes major dysfunction in operations. So as a savvy veterinary healthcare player, either on the staff or the Board, keep your focus on patient advocacy and client-centered service; talk to the referring veterinarians and exceed their expectations for information and support. Ensure you know the core values of the veterinary healthcare complex, and the expectations of the Board and hospital administrator, as well as the chief of your specific specialty.

Veterinary practices, their practitioners, and in some cases, the specialty practice staff, strive to be an integral part of a center of excellence, and have the potential to influence an organization’s market share, client satisfaction, quality of healthcare delivery, and perception of value by the community. In a team-based general companion animal practice, the staff members are empowered to represent the practice's SOC expectations; the word NEED replaces "recommendation, and a "healthcare plan" replaces the traditional outdated "estimate" process (i.e., left hand column of value discussions rather than right hand column price justifications/negotiations).

One emergency practice we deal with has caused the referring practices in the community to increase the use of TKO fluids (to keep open), just because they send virtually every animal back to the referring practice in the morning with I.V. systems flowing. These emerging progressive and patient-centered type practices, which do not mediate the standards of care based on outdated

paradigms, become a benchmark for the professional community as well as client community. The staff gains pride in the continuity and standards of care, and clients perceive that pride as quality; most clients will pay for quality as a value, since it provides a peace of mind towards the animal they steward. Peace of mind, that is all that we "sell" at a center of excellence; all else the client is allowed to buy for their surrogate family member.