EVOLUTION OR REVOLUTION vs. WORKING DIFFERENTLY

Thomas E. Catanzaro, DVM, MHA, LFACHE
Dipomate, American College of Healthcare Executives
CEO, Veterinary Consulting International
DrTomCat@aol.com; www.drtomcat.com

The future belongs to those who see possibilities before they become obvious. John Sculley, CEO, Apple Computer

The days of experience are being replaced by the days of new challenges. The skills and habits of yesterday cannot answer all the needs of tomorrow. Emergency practice went from the “fire engine” production practice, to a “rotary” shared by multiple practitioners, so some could sleep a few nights a week. Then companion animal demands started increasing, and the “rotary” sharing of night call shifted to the smaller critters too. Then some bright young man decided there was demand for an emergency practice, a practice that opened only in the evenings and on weekends, and the general practice doctors happily referred those night calls to the young man who filled a niche market. Then came the specialty practitioner, who could not find a home in academia, and was looking for somewhere to practice his/her trade of highly specialized veterinary healthcare delivery . . . and somehow noticed the emergency practice was not being used during the weekdays. A symbiotic relationship started to form between specialty practices and emergency practices, so facility and equipment overhead could be minimized, as well as 24-hour care becoming available for the specialist’s patients.

Ever wonder why some of the most brilliant and ambitious leaders derail their careers, while those with less obvious "I.Q." skills climb the leadership ladder? Since 1987, I have been visiting practices and coaching veterinary healthcare leaders in the 'real world settings' they have created for themselves and their practices. In the early years, I attributed it to lack of exposure to alternatives, since veterinarians seldom stretch outside their own walls - their "knothole" view of the world was usually VERY restricted! But it was not an I.Q. or experiential factor, it was a shortfall in their innate emotional intelligence (EI). Most veterinarians scored well in high school and university entrance exams (those are I.Q. elements), but with a shortfall in emotional intelligence, they ended up inadvertently harming their careers as a result of unhealthy behaviors and habits.

Because good leaders, by definition, achieve organizational goals through others, you'd like to assume veterinary practice owners have superior people skills. However, all too often, this is not the case.

- FIRST - in veterinary school, they were taught they were accountable, 24/7, 365, and were trained in case management - seldom was the veterinary healthcare team ever mentioned, much less leadership skills (most academics have tenure, not leadership savvy).

- SECOND - when starting a veterinary practice, there is seldom money for staff, so the veterinarian learns to do it all themselves. As they incrementally

add staff members, seldom do they consider upward mobility or expanded capabilities of the new staff member; they just look to reduce their own stress and schedule demands.

- THIRD - most continuing education venues post-graduation are scientific, with minimal hands-on team-building experiences or interaction exercises, so they do not come away with real experiences reflecting better team development.

Let's give you a chance explore this further - read the following scenarios and then ask yourself, , "What emotion(s) do I feel?":

- You were selected to oversee the implementation of expanded practice hours, possibly 24/7, due to your analytical and execution skills. Your colleagues tell the boss that you spend your time lecturing instead of listening to the team members. You interrupt others and work from your own agenda, often putting down feedback as "that is wrong".

- You are known as the person who always says 'yes' and takes on extra work or completes the tasks of others. You feel unappreciated and burned out. You wish you could have just one three-day weekend to yourself.

- You are in a meeting and the practice manager, or a colleague, takes credit for your program's success. This seems to happen often, especially with this person.

- The medical director is progressive and well meaning, often implementing new programs, but sometimes without adequate training and feedback before implementation. The practice manager downplays the veterinarian's lack of people-skill style to his vet-centered history in the practice. You are now "in the middle" and in a quandary of how to provide feedback.

There is NO escaping our emotions! Whether we like what we feel or not, we are emotional creatures, especially in a profession which most of us entered as a "calling" rather than an economic windfall decision. Daniel Goleman, author of *"Working with Emotional Intelligence"* and *"The Brain and Emotional Intelligence: New Insights"* is the leading authority on EI. Goleman's premise is that sensitivity to emotional states (one's own and others) and effective relationship skills (EI) are critical competencies in today's healthcare environments. But wanting it does not equate to getting it.

The essence of EI is awareness, transparency, and vulnerability. EI is the ability to cope with setbacks, remain optimistic, elicit charisma (positive attraction) and stay purposeful even when things are not going well. EI does not mean that you have to be "soft" or "emotional." EI simply gives you the tools to identify and build on strengths (yours and others), remove barriers, understand limits (yours and others), focus on solutions, and when necessary, call the foul!

FOUR CORE EI SKILLS

Two Behavioral Lenses		Two Primary Competencies	
		Self	Others
	Awareness	Self-awareness	Social Awareness
	Management	Self-management	Relationship Management

ENTER THE EXPANDED-HOURS DRAGON

The new era of veterinary specialty has been prompted by organizations such as VECCS, and the “out of hours” emergency practices have been giving way to 24/7 Urgent Care facilities. Sharing facilities format have given way to building mega-facilities to house all the specialists and the Urgent Care services. The only facility problem is that the academic Veterinary Teaching Hospital (VTH) is the wrong model for a private practice, multi-specialty complex. Teaching hospitals need hallways to move large groups of students, and to divide research fiefdoms for tenured professors. At construction costs which often exceed $150 a square foot, hallways and circulation space need to be minimized, receiving and treatment support must be centralized between the occupants, and there needs to be a single Board controlling the policy and precedent of the facility. This has not been taught in our VTH environments.

I consulted with a small, one-doctor, leasehold practice, in a depressed community, which had plateaued for 18 months. Since most clients commuted to work via bus or train, weekdays were slow, yet Saturdays were pure chaos. We empowered the team, got them to buy-in to the new vision, and trained them as veterinary extenders with in-house training programs as well as outside wet labs. We then embarked on appropriate pricing dental prophys, DG1+ and DG2+, for the staff to complete while the veterinarian was doing outpatient services and other duties. We built up the liquidity so we could hire a client relations specialist, and then a part-time associate. Once the part-time associate was integrated into the Standards of Care and practice's operational culture, we moved the operational format to include Tuesday and Thursday evening hours (Wednesday was a big community church night and welfare checks came on Thursday). We increased liquidity so the part-time associate could be full time (yes, it was trial and error finding the right person), with each vet working about a 35-hour week. Saturdays were less chaotic, and Tuesday and Thursday nights became busy outpatient times.

In one central hospital, when we entered as consultants to do the feasibility assessment, the existing ophthalmologist stated very clearly that he did not need any other member of the complex and would not participate in the rental of the common use or shared use areas. It only took the new board a few months to see the fallacy in that logic; the new replacement ophthalmologist has been cooperating very well ever since.

In a multi-practice owned central emergency hospital, surgical space was utilized by the owners of the outlying practices. They were supposed to schedule the surgery space use, but a few always wanted “drop-in” privileges,

and came in as “owners” and redirected operations to their own benefit. A few others wanted to handle their own early evening emergencies at their own clinic, and then refer later in the night, yet they wanted a full share payment for emergency use and kept reducing central facility staff so there was more profit. We were called in by the Executive Committee due to the dysfunctional operations. We found that while the lack of core values was the key source of the problem, lack of Executive Committee support for the operating standards was what was draining the staff and the liquidity. The “inmates were ruling the asylum,” and the Executive Committee did not want to address the issues. We developed a Governance Board structure, core values, clear policy and precedence for operational delegation to the hospital administrator, and a routine follow-up system to ensure the new Board kept their word until they learned the new ways were better.

In one multi-specialty complex, when we were doing the utilization review for a new facility, the radiologist thought he was the center of the world, just like when he was a tenured professor. He did not understand that radiology was usually a support function for most healthcare delivery in a multi-specialty complex. He even demanded that every X-ray taken be read by him, and he would bill all the specialists for this service . . . we had the board buy all the radiology equipment and then tell the radiologist what the utilization plan was going to be.

We were conducting a follow-up consulting program a multi-specialty practice, and Dr. DTC, ACVECC, was brought along to provide some emergency and critical care development in the emergency practice staff of the complex. During the after-hours training, Dr. DTC noted the sound of animals in pain, and offered the surgeon his assistance. The surgeon deferred assistance. A few minutes later, the sounds of pain again penetrated his training mode, and he again offered the surgeon assistance in pain management; the surgeon again declined. This exchange was repeated a few more times, with the same non-responsiveness, and as we departed for the evening, Dr. DTC requested my opinion on how to deal with a specialist who was also the owner, and yet neglected pain management. I suggested a quiet one-on-one the following morning, between the surgeon and Dr. DTC. Long story short, after that meeting, it is one of the quietest specialty practices we consult with, and pain is no longer an acceptable option with any patient. A governance Board system could have addressed this if the standards of care had not been so closely controlled by the owner/surgeon.

In one emergency hospital, established in a store front leasehold, an opthomologist wanted to lease the clinical space during the day. The emergency practice was shareholder-owned, and the share holders saw it as a “profitable offer.” It took two years to get the flow established so the specialist was clear from the facility before the emergency team started operations. If there was an informed governance board, these issues would have been established before the first day of occupancy.

One well established multi-disciplinary specialty practice contracted with a veterinary architect to design their new building, and by the time the planning smoke cleared, the specialists had added over 20% circulation space so large

hallways could divide their areas . . . they needed an experienced consultant to save them that cost, which now, after a couple years of occupancy, they are scratching their heads at the cost of all that wasted space. In an effort to "save time," the board had made the decision to use the expertise of the architect, who gets paid based on the cost of the facility, not based on the effectiveness of the plan. A second opinion from an established veterinary consultant, with facility management certification (e.g., Board Certification by ACHE), would have saved 20% of the multi-million dollar cost of construction, a great return on investment.

These are all issues where a clear and well-developed governance board could have been used to resolve the issues. Most shareholder boards of multi-practice facilities or emergency practices, just want a return on their investment. Some want to milk the cash cow out every month, and there are a few shareholders who want to take hands-full of hamburger out of the cow while it is being milked out by the other share holders. These examples are not usually the people who want to ensure quality healthcare, or even an appropriate practice/facility culture. Board members must leave their own shoes at the door, and assume the role of a practice advocate when they enter the board room; the board ONLY exists between falls of the gavel.

SIX TARGETS OF OPPORTUNITY

Our veterinary healthcare system is fundamentally flawed in its design. It relies on outmoded methods of work, such as linear scheduling of doctors as if they were still driving utes (pick-up trucks) from farm to farm. The system set up for the staff support has often been a failure, as with doctor-centered practices scheduling based on doctor whims versus facility capabilities and staff becoming veterinary extenders (e.g., seen as ward/service-specific nurses, nurse practitioners or physician assistants in human healthcare). Practices hire people for their strengths, provide inadequate in-service training, pick on their weaknesses, and then blame them for shortfalls; when anyone "blames," they abdicate personal accountability for resolution. We have already proven that working harder will not improve quality, while concurrently it has proven that it can disrupt over 50 percent of the families. We can learn to work differently, and it must start by redesigning the systems that we have become so comfortable with over time.

To aid in the transformation of the current systems, we have started to publish the VCI *Signature Series* monographs for the "do it yourself" veterinarians. In the case of governance boards (*Leadership Action Planner* monograph and Chapter 2, *Veterinary Management in Transition: Preparing for the 21st Century*, from Iowa State University Press), they must focus and align their environments toward providing healthcare delivery that is:

- **Safe:** as Dr. Bill Kay always said to the incoming AMC residents, *"First, do no harm"* . . . avoid injuries to patients and staff from care and services intended to help them. The practice's Safety Committee must be empowered to be an active sentinel of dangerous conditions.

- **Effective:** providing services based on the best scientific knowledge to all who could benefit, refraining from providing services to those not likely to benefit (avoiding under-use as well as overuse of available equipment).

- **Client-Centered:** providing responsive care that is respectful and responsive to the client's needs and values, while ensuring that patient welfare guide all clinical decisions and care (give two "yes" options - usually time of access choices - record waivers and deferrals).

- **Timely:** reducing wait time, implementing nurse-centered triage programs, avoiding the perception of harmful delays for both those receiving care and those administering the healthcare delivery.

- **Efficacious**: avoiding waste while providing care that does not vary because of client characteristics (e.g., socioeconomic) or patient threat/attitude (e.g., Chow Chow); ensuring what is needed is recorded in the records, and the client's response is duly noted in sequence.

- **Client-centered Patient Advocacy**: always speak for what the patent needs, and then fall silent and listen to what the client wants. Stressed clients do not want options, they want to know what is needed, now! The traditional good-better-best treatment option logic presented to clients was only economic-based options, not what was best needed for the patient's welfare and quality of life. Stay true to your calling - if you do not speak clearly of what is needed for the pet's quality of life, only the patient will suffer when the client leaves confused.

If all veterinary practice owners, as well as facility boards (e.g., multi-practice complexes, multi-doctor hospitals, multi-owner, shareholders, etc.), could use the above Six Targets of Opportunity as an overreaching blueprint for establishing or reviewing their core values, surely clients would experience greater satisfaction and staff could show more pride (i.e., clients perceive staff pride as a quality factor in most healthcare settings). The VCI *Signature Series* monographs, have a series of planning forms/tools to assist in both core value development and project planning (available at the VIN Bookstore, www.vin.com). Veterinary Consulting International can assist with on-site implementation (expanding the knot-hole); the web site (www.drtomcat.com) shares the various programs and time-based fees.

The 21st-century veterinary healthcare delivery should be a staff-maintained and monitored system that provides client-centered, patient advocacy, evidence-based, and system-oriented quality care. All of this can be realized if veterinary healthcare leaders consciously incorporate these aims into the redesign of their Boards and policy/precedent operations.

IT IS IN THE PRACTICE CULTURE

To facilitate the fundamental changes, the environment in which care is delivered must be considered. Using the aims above as guidelines, the multi-doctor/practice complex administrators should target the following four areas of the facility environment in their Board feedback reporting system:

The infrastructure that supports the dissemination and application of new clinical knowledge and technologies. Providing evidence-based care will significantly improve quality . . . to provide such care, the leadership must develop new tools so that referring clinicians can be rapidly made aware of the benefits and adopt the best practices for the patients as standards of care. In a lateral perspective, alternative care techniques are emerging that assist in chronic care . . . local sources need to be identified early.

The information technology infrastructure is redesigning healthcare delivery and continuity of care. To reduce errors and improve client confidence, clinical, financial, and administrative transactions must become automated. Most all of the current veterinary software systems are forensically inadequate, but before the end of the decade, most handwritten clinical data could be eliminated by the next generation of software development. Significant progress is being made in Progress Note driven linkages, automated inventory systems, and PDA-type input devices, as well as related tools to ensure protection from forensic liability and multiple entry requirements in the software systems.

Payment policies work against practice liquidity. The traditional habit of cash at discharge reduces the perception of affordable pet care. Practices must develop linkages with third-party payment systems (e.g., Pet Insurance, Care Credit, etc.); these systems cannot require discounts or membership fees if practice liquidity is to be maintained. All stakeholders in the veterinary healthcare delivery system must reexamine payment policies to develop methods that provide fair payment for good clinical management of the types of patients being seen. Financial services must be aligned with the implementation of quality care processes of the best practices and achievement of better/faster patient recovery.

Preparation of the veterinary healthcare workforce must be a concurrent evolution. Clinical education must be restructured to accommodate the aims of the 21st-century healthcare system, which includes improved client communication skills, team development, outcome measurements, and individual performance accountability. Because systems thinking will be a cornerstone of the transformed veterinary healthcare system, the practice staffs will need client-centered skills to transfer skills and knowledge that are perceived as values deserving of appropriate fee schedules and treatment plans. Management and medicine will become more closely linked, and doctor commitments will drive the elevation of income, thereby reducing the traditional expense percentage management systems.

Redesigning veterinary healthcare operations in multi-veterinarian cultures, using these four Board policy and precedent angles, requires a skilled communicator, hopefully with a high EI quotient. This will allow a better chance for creation of a system that uses the best knowledge which is being focused intensely on the best patient care, and that works across the practice's diverse veterinary healthcare providers and delivery settings.

THE EIGHT STEPS TO MULTI-VET PRACTICE SUCCESS

1. Ensure the practice veterinarians sets policy and precedence ONLY between the falls of the gavel; trust in the administrative staff for implementation for outcomes. Hold specific people and groups accountable for improvements in quality or outcomes of care; chart and report on improvements monthly.
2. Devote as much time to reporting quality issues at professional provider meetings as you do to financial issues. Focus on the environment and policies needed for selected outcomes that mean most to the patients, clients, and the community.
3. Base a portion of the top management team's compensation on achieving quality and outcome objectives, not just on achieving financial goals.
4. Ensure the stakeholders have a basic understanding of Continuous Quality Improvement (CQI) criteria, and ensure each team member has CQI in their own development plan to assist in the community outreach commitment associated with being a practice leader.
5. Ensure the operational budget promotes CQI in the continuing education expectations by providing specific opportunities to increase the quality and scope of veterinary healthcare services being offered.
6. The team members start to play a more active role in researching and securing the needed information to upgrade information systems.
7. The healthcare team works with external groups in the community and nationally to create a more favorable referral system and professional community environment.
8. Ensure the entire team has an operational focus on a clear set of core values (ALWAYS inviolate) and mission focus, so if any team member starts to represent themselves instead of the combined practice entity, there are mechanisms for replacement established and the leadership initiates implementation immediately.

Multi-doctor, multi-owner, and/or multi-practice veterinary complex Boards need to center on removing the barriers of "old thinking" and "old paradigms" as they pursue healthcare governance systems that have proven effective. In the text, *Building the Successful Veterinary Practice: Programs & Procedures* (Volume 2), Blackwell/Wiley & Sons, chapter 1, describes some of the new paradigms for success in the new millennium:

- ✓ It was not cost containment - it was increased productivity!
- ✓ It is not staff recruitment and training - it was staff retention and recognition!
- ✓ It is not "within the job description" - it is exceeding expectations
- ✓ It is TRAIN TO A LEVEL OF BEING TRUSTED, not just good or okay.
- ✓ Don't respond to the competition - instead meet unmet needs

- ✓ It was never guest relations - it is client-centered service & patient advocacy
- ✓ It can never be “recommendation” - it must be “needs”
- ✓ It is not about assigning blame, it is about giving credit and recognition in a public forum; savvy leaders understand shortfalls are just reflections of their own poor training programs.
- ✓ It should never be gross income - it must be net remaining in the end!
- ✓ It is not "me", it is "we", "us", "our"; always together to common outcome targets and duty zone objectives.

LOW EI TRAITS vs HIGH EI TRAITS	
Leaders with Low EI	**Leaders with High EI**
Have low impulse control - react and sound off first	Listen first, seek input, offer advice - asks questions
Brush off or ignore people when stressed, frustrated, or overwhelmed.	Keep lines of communication open and seek advice, even when frustrated
Deny or ignore how events impact emotion and decision making	Recognize how a event can impact the emotions within the team or themselves, and the effect on decision making
Get defensive when challenged or questioned; in severe cases, culture stops questioning before it starts	Are open to feedback
Focus on tasks and ignore person/context concerns.	Show others they care about them as a person and a provider
Are oblivious to tension	Accurately pick up on the room's mood in group settings

When a management group makes quality healthcare delivery the imperative, and invests in developing the practice/facility culture by collaboration with the professional staff, the entire veterinary complex entity starts to become systems-oriented rather than process-oriented. Practice owners fall short when they are unable to translate modern knowledge into practice, or to apply new technology safely and appropriately concurrent with new third-party payment modalities. The practice leadership must address the policy and precedent of the healthcare complex (not operations), and monitor the fiscal well-being of the veterinary healthcare entity (not Average Client Transaction); they must hire the right people for top administrative jobs to ensure implementation expertise is available on a daily basis (never do it themselves). The appropriately skilled veterinary healthcare administrator, with a clear set of practice-developed core values and mission focus in mind, leads the creation of the operational systems that: eliminate rework, eliminate the risk of error, and eliminate uncertain accountabilities. Concurrently, the administrator must be constantly striving to heighten client satisfaction, increase professional fulfillment, and foster strong/effective veterinarian-nurse partnerships in patient care.

If you want a hands-on opportunity to assess your EI, I recommend a watching for courses at your local hospital on "mindfulness". Most mindfulness courses are designed to assist leaders in becoming purposefully aware of his/her thoughts, feelings, and decisions in the present moment, non-judgmentally. It serves as a pre-requisite to developing self-awareness and personal wisdom. Try to stop your immediate responses in a discussion setting by taking a long inhale, and then a slow exhale, before repeating the person's statement/position in common terms. This should derail any hijacking or refocus efforts common in a vet-centered practice setting.