CARE AND FEEDING OF A TRANSITION PLAN

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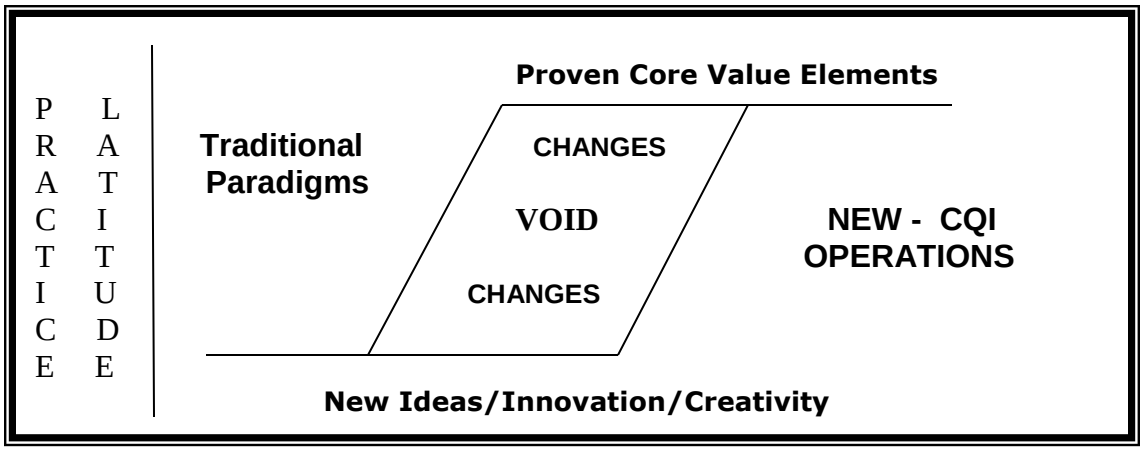
"Faced with the choice between changing one's habits and proving that there is no need to do so, almost everyone gets busy on the proof." Dr. T. E. Catanzaro

Change and rate of change are more dynamic today than ever. There are difficulties associated with trying to get people to change the way they do things. The human side of change is most often ignored, even by the best of managers, much less inside the average veterinary practice. Foot-dragging is common, blank stares are seen frequently, and subtle sabotage even occurs, turning a good plan into a disastrous mess. Tactics are needed when facing these challenges, and new techniques must be developed to deal with your practice team and yourself to change the old habits into a productive future.

"He that will not apply new remedies must expect new evils."
Francis Bacon

Often the changes you have to implement are important to the survival or success of your practice. They aren't the "*it would be nice to do*" or the "*if you can get around to it*" type of situations. In this marketplace, to change programs and stay competitive is critical, to develop new methods to increase effectiveness is rational, and to use methods to reduce overhead, so profits are easier to find, are commonplace. Change is the name of the game, starting in the 1990s and accelerating with the new millennium. The veterinary practices that cannot deal with change effectively will find themselves being squeezed out by the “new upstarts’. All change starts with “ending the old”, every transition has a “void that must be negotiated”, and every transition marks the “beginning of the future”. These are the ***three phases of every transition*** (shown below).



A management consultant who talks about helping people cope may seem unnecessary when looking for increased practice liquidity. Most veterinarians see themselves as the kind of person who tells people what to do, and they do it! In today's marketplace, it would be safer to say, "*They used to do it!*" Unquestioning compliance is seen less frequently now that the World War II era families are maturing out of the marketplace and the self-guided Baby Boomers have taken over the mainstream population. Leadership is now needed, but few "management consultants" are well versed in this field of endeavor — organizational behavior, generation gaps, and emerging Gen-X and Gen-Y staff. A team is required in this new era, a “guide across the void” is often essential (consultant, mentor, etc.), and a healthcare delivery team is needed to enhance the programs that can differentiate veterinary practices today. In 2004, the AVMA selected R. Tom Cat to roll out the new wellness initiative (www.npwm.com), and even let him write it, since he had been doing it for years anyway.

Change happens so frequently today that one system isn't complete before a different system is being tried elsewhere. Books like *Thriving on Chaos* became best sellers, but very few front-line workers show much interest in strenuous or changing programs. (The term "high commitment" is a misnomer, since it is what the boss wants and the understaffed, underpaid, and unappreciated team can't continuously deliver.) In fact, giving people more "home" time is a newly emerging employment "benefit". To make matters worse, there is very little room for communication error in today's competitive marketplace. Accidents don't happen, they are caused, and litigation occurs. Wrongful discharge cases are common, disability claims are usually approved, and workman's compensation rates have soared.

Veterinarians are generally functional managers, procedure-based experts. When AAHA looked at the consistency of delivery of the Standards of Care (circa 2003), they called it the “Compliance Study”, inferring it was a client shortfall. Anyone who read the full study knew it was internal to the practice delivery systems. (AAHA showed a “potential” loss of more than $630,000 per doctor per year, because of poor delivery paradigms.) The average group of doctors shy away from making changes, because the people side of the equation does not work well for them. They are the same ones who ask about “national averages” to justify their mediocrity. (An average is just the worst of the best — or — the best of the worst, neither of which is a pride builder.) Most do not have the training or desire to be a psychologist, behaviorist, or even a contemporary leader in the new millennium. Students becoming veterinarians were indoctrinated with a pack mentality during school — ALWAYS follow the process — they were raised by wolves! Most practice managers were developed inside the practice (the “Peter Principal”?), were used as process managers, and do not want to spend time on the “people stuff”, they just want the results expected by the practice owner. As a consultant, I sympathize. But after almost two decades of working with practices, three things have become very clear, even in the simplest of situations:

First — **Leaders need followers**. Things do not get done without understanding and using the "people stuff". Getting change to occur within a practice team cannot be an impersonal process. It must be inspirational and

motivating, there must be a participative process, as well as a clear outcome model, before the transition is started. With Gen-X and Gen-Y, individual, self-directed training is essential, with trainers ready to help, using time-lines and outcome-based training objectives.

Second — **You do not need a graduate degree to manage a transition.** You need a progressive and realistic written plan. The team needs a clear set of expectations and milestones to measure success. There needs to be a discomfort/dissatisfaction with what exists now. This plan is dynamic and fluid, ready to adapt to the emerging practice, community, and team needs. This is called “strategic response” in client-centered service, rather than the traditional strategic planning seen in industry.

Third — **If you are not part of the solution, you are part of the problem**. If someone, even the most junior member of the staff, is not willing to be part of the solution, such as practicing continuous quality improvement, that person will continue to be part of the practice problem and a distraction to team harmony. The principle of “training to trust” means staff are learning skills and knowledge, and can be recognized and rewarded on a regular basis for their achievements.

This article is an introduction to change management and transition planning. It is not the outcome. Every transition plan must be tailored to practice strengths and community needs. Concurrently, the competitive environment must be assessed and the practice philosophy must be clarified, shared, and embraced. The concerns and warnings reflected in the latter part of this article are real, they come from experience, and will occur if LEADERSHIP is not an ongoing practice concern in the management changes. A good practice consultant can assist in the planning, help with advice when crossing the voice, and offer some critical tools. But in the final analysis, it is the responsibility of every member of the practice team to make it happen.

SUBJECTIVE SYMPTOMS AND OBJECTIVE SIGNS

"Every beginning is a consequence; it ends something else."
Paul Valley

The most difficult part of any transition plan is not letting go of the old way, or even buying into the new way. The most difficult part of a transition is when the practice is between the old and new. The usual impatience for results makes this transition time more difficult, because neither the old ways nor the new ways seem to work satisfactorily. If this phase was quick, most practices could wait it out. But, in fact, it has taken most practices their entire existence to get into the hole they are in, and the transition to a new plane of operations is not rapid. Our veterinary journals are loaded with 1500 to 2500-word “sound byte” articles, painting a picture, but usually inadequate for implementation assistance.

Today we see the old USSR in transition confusion. What seemed a rational thing has become an international crisis. They saw a great idea and grabbed for it, but no one was ready. The culture did not know how to accept the new accountability — except the Mafia, who were already working independently from the state, so they could evolve more quickly and establish themselves at critical link-points, such as docks, transportation, etc. These communist cultures have encountered new challenges and dangers similar to what a veterinary practice should expect in transition. (Their process base made adaptation almost impossibly difficult.) Training is needed to prepare for the changes, and transition must be a planned, sequential set of "baby steps" toward the new horizon. The “natives are restless” becomes an “uprising” if the transition plan factors of this article (and the practice philosophy) are not clearly explained, discussed, and understood between the leadership and the staff. Here is what is expected in the USUAL practice transition efforts without strong leadership:

1. Anxiety rises and motivation falls. The disorientation and self-doubt of the people make them resentful and self-protective. Energy is drained away from the change efforts.

2. Absenteeism and vacation use rises. Productivity suffers, trust in the organizational leadership slips, and scheduling a time to address emerging issues with the staff or partial team elements becomes harder.

3. Old weaknesses, long patched over, resurface. The forgotten weak link becomes the stumbling block for all, petty complaints increase, and communication problems get worse.

4. Leadership signals become mixed. Systems are in flux and, therefore, perceived as unreliable. Priorities are forgotten, tasks go undone, turnover begins to rise.
5. The team becomes polarized. Ambiguities exist between systems, and the people become two groups: those who want to rush forward and those who want to go back. As such, consensus breaks down, discord increases, and organizational loyalty suffers.

6. The practice becomes vulnerable to attack from outside. The people respond slower to outside influences and competitive threats. Transition sabotage may become practice sabotage.

Leadership understands the above six distractions and takes steps to prevent them, usually by expanding the operational accountability for outcomes, increasing open discussion, and making improved feedback systems commonplace. Developing small work teams, assigning small “change/improvement tasks”, which can be completed in 30 to 60 days, has been one effective method to get everyone involved at some level. Some call these small work teams, Do It Groups (DIGs). Good leaders count the number of DIGs in operation, and the success rate of the DIGs. Great leaders work

behind the scenes, one-on-one, to motivate individual staff members to volunteer their strengths for specific DGS. We want 60 percent-plus success.

If there is any challenge to the transition leader, it is to assess the history from an objective position. When you seek the alternatives, you cannot allow people to argue for their limitations, or previous practice shortfalls or challenges. If you do, they will be yours forever. Approach your practice with all the skills of a trained diagnostician, and with the inquiring mind of a practical clinician. Do not become weighted down with listening for the zebra hoof beats or counting the pennies. Rather, address those things that appear to impact the majority and monitor the dollar impacts.

CASE ASSESSMENTS AND TREATMENT PLANS

> *"An adventure is only an inconvenience which is rightly understood. An inconvenience is an adventure wrongly understood."* C.K. Chesterton

A "systems gap" is the *comfort zone void* between the old and the new. It is the scariest of times. When pursuing a transition plan, the "systems gap" is manageable if you have a guide. In fact, it is critical that "leadership" replaces "process" during this time, and looks at desired outcomes from across the void. The systems gap is only an indication of a need for a tailored training program, one required to get the staff, or a staff member, to a position of trust. Each team member deserves the trust of others, but trust is earned through personal training to excellence. (In health care, achievement of competency is excellence — it cannot be a bell curve, or a scale of 1 to 10. Excellence is a “go-no go” achievement.) The transition plan isn't a spare time activity, it is a diagnostic requirement to formulate the management treatment plan critical for success. The argument that there isn't enough time for such efforts is based on a serious misunderstanding of the situation. "Systems gap" management actually saves time in the long run, because it means you will not have to institute the change a second time when the first time didn't work. It also means the practice won't come apart in the process of crossing the gap from old to new, because the people will hold onto the leader's coat tails, wanting to share in the dream of the practice's future, until they are trained to a degree of competency (excellence) required for them to make it happen themselves!

The leadership principle of redefinition works great during a "systems gap". Dr. Tom Cat has been instrumental in building new nomenclature in this profession, causing people to look at their operations from a new perspective. At Veterinary Consulting International, we have centered on the team-based healthcare delivery model, and the leadership needed to keep the culture changing. Most people will use the mental training models of this transition to resolve problems regularly throughout the rest of their lives. Look at the recent examples: An anesthetic misadventure means the surgery patient died, flight attendants used to be stewardesses, target neutralization is the new term for tactical obliteration, which replaced "destroyed it". We are seeing change cause extinction of pay phones, used book stores, piggy banks, telemarketing, record stores, camera film, gay bars, newspapers, and even coin-operated arcades. In

1983, there were NO CELL PHONES, and now, most everyone has this electronic leash attached to them.

In a veterinary practice, the veterinarian has usually been in full control during the development years and must learn to let go to expand beyond a 1.5 doctor productivity. This “letting go” is not easy for anyone, especially a doctor who equates every decision as a case management threat to his/her license, and a consultant must often be the catalyst. With transition leadership, entering the training-nurturing phase, providing accountability for changes (outcomes), establishing empowerment programs (DIGs), and similar definitions have become leadership terms that cause followers to become excited about changing.

A good leader will provide structure and strength during times when people are likely to feel lost and confused. They will create a temporary system for the "systems gap" time frame and will embrace functional flexibility (**ARF** = **a**bsolute **r**igid **f**lexibility), rather than "the rules". The management techniques will become people-oriented and outcome-based, using transition systems tenets such as:

1. **Protect people from further changes while they regain their balance.**
   This is the reason we never put more than three change concepts into someone's work place in any given month. Coherent change is much easier to understand than disjointed ideas, so large changes need to be stair-stepped into existence.

2. **Review existing policies and procedures to eliminate confusion.**
   This is especially important during the times of fluidity. The old "rules" need to become flexible enough to adjust to the needs of the systems gap and the people traversing this gap. Are the policies handrails for a bridge across the systems gap, or are they barriers on the bridge that must be hurdled? Mae West once stated, *"When choosing between two evils, I always like to try the one I've never tried before."* This is a great idea when crossing the systems gap, since it is new territory for one and all.

3. **New operational relationships are needed.**
   They are needed to let everyone make changes in their duties to cause continual quality improvement (CQI). Empower the individual, disengage the old hierarchy, establish 30 to 90-day task forces to unilaterally address and resolve issues. Use temporary titles or "acting" managers as needed to give ownership to the team members.

4. **Set short-range goals WITH each person.**
   Target check points along the transition plan to gauge success. Americans work best with 90-day goals and objectives. The long-range goals are just a stress time when people become discouraged easily, so find something specific each day for which to commend them. Give them a sense of achievement and movement. Even if you have to stretch the

point a bit, this helps counter the lost feeling when transversing a systems gap.

5. **Don't set up failures by expecting high levels of productivity.**
Watch out for this one when trying to defrost the old habits. It takes time to defrost the old habits and reshape them into a new format, and it even takes longer to refreeze the new procedure into the new systems. Seeking realistic outcomes based on the joint determination of measurable outputs will be a key to success.

6. **Determine the training needed by managers.**
This will help to make the transition a success. However, you must then provide the training. Be proactive while seeking new skill levels, don't assume the staff can change if they haven't been given the vision of a new model or the freedom to change the process to make it happen. This means funding additional outside training, assigning outcome accountability, and releasing authority for most veterinary practices. Train the trainers, and then allow the trainers time to mentor the others. (Teachable moments are required for success.)

7. **Problem solving requires innovation and creativity.**
We actually hire people to solve problems, not just do the job. But most veterinary practices have drained those traits from their staff members during their first few months of employment. This must be restored! Linus Pauling once said, "*The way to get good ideas is to get lots of ideas and throw away the bad ones*." IBM showed that you needed to implement at least 60 percent of the ideas or else the sources dry up and cease to function for the good of the organization.

STARTING THE PLAN

"There go my people. I must find out where they are going so that I can lead them." Alexander Ledru-Rollin

Beginnings are strange things. People want them to occur, but fear the occurrence when it is happening. After the seemingly pointless wanderings across a systems gap, people are greatly relieved to arrive at any point that is termed "the end". Yet, because the beginnings are so scary, when you must release the old habits and security systems, anxiety is the rule not the exception. When I left the AAHA staff, there were those around me (family and colleagues) who wanted a similar system immediately. They were not ready for the transition to an independent and private business. The firm confidence and convictions of the leader can cause a systems gap to be bridged, but it requires making the break from the known and stepping into the unknown, howsoever that decision is defined by the person who makes the step.

Change management has three factors that must be balanced: 1) discomfort/dissatisfaction with the present, 2) a process to follow during the change, and 3) a systems model to match. The fourth factor, cost, is a limitation, not a balance. There must be a benefit to the change that outweighs the cost (social, physical, fiscal, and mental). Like the strategic planning programs of the 1980s that didn't work well, this traditional change management concept does not include the people factor, unless each leader understands that "process" means an integrated participative process. Beginnings cannot be effectively forced according to someone else's values, but they can be encouraged, supported, and reinforced. Beginnings actually are “ends of what went before”, and this causes fear of failure. Doctors have a morbid fear of failure. Staff fear the unknown, because, *“What response occurs from the doctors?”* Leadership must address these fears as if they were real. Perceptions are reality. There is no transition switch that turns people on and off. Each has different reasons for participating, but a good leader can create the environment and provide nourishment for the growth of the individual team members.

There are six basic steps in this team nurturing process:

1. **Explain the basic purpose behind the outcome you seek.**
   People have to understand the logic of the specific outcome before they put their minds to work on the individual performance outputs needed to support the transition plan changes. They WHY and WHAT are leadership responsibilities before embarking on the transition.

2. **Paint a clear and graphic picture of how the outcome will look and feel.**
   People need to experience the outcomes in their own imaginations before they can commit their bodies to the process. These outcomes must have clear success measures and a realistic time-line for transition that the staff perceive as achievable.

3. **Lay out a step-by-step plan for phasing in the outcome.**
   This is what we nurture from our new coordinators, as we build a written transition plan for a practice. People need a clear idea of how they can get where they need to go. The HOW and WHO are zone accountabilities, and should not be tasked. Most people in America need the stepping stones laid out across the void, over an extended period of time, so they can get "used to the idea" BEFORE they start the transition.

4. **Give each person a part to play in both the transition plan and the outcome itself.**
   People need a tangible way to contribute and participate. Every staff member has to become part of the solution process, or they will feel they were “left behind” during the transition.

5. **Jointly determine realistic measurements of progress and completion.**
   Set these within a framework of time, dates, and quantitative measurements. Along the way, plan to celebrate the milestones and recognize the efforts frequently. Behavior rewarded is, in fact, the behavior that will be repeated!

6. **Have the staff member write personal goals and success measurements.**
   These are best placed into each person's quarterly performance plan. A written goal is real and far more likely to be pursued than a verbal wish or a tirade about the past. Forward planning, not reiteration of past problems, will cause the changes needed to prosper.

The above six factors can become a translated implementation plan for sensitive leaders. That is, methods to use during the transition to encourage and nurture practice team members. The four tenets for the leader to embrace are 1) to be consistent, 2) ensure quick successes, 3) symbolize the new identity, and 4) celebrate the success.

SET THE TONE AND THE PACE

"Example is not the main thing in influencing others, it is the only thing."
Albert Schweitzer

Everybody talks about "managing change" and "resistance to change", but unless you try to understand what is going on inside the people who have to make the change work, transition will never occur. You must try to understand the emotional impact associated with change, and what can be done to keep it from disrupting the entire practice. The leadership tone, the preparation for change, and the clear vision of what will be the outcome are critical to keeping the transition on track.

This is easier said than done. Each of the four leadership tenets (consistency, responsiveness, image, and celebration) have pitfalls waiting for the unexpected. Examples of common pitfalls frequently seen by Dr. Tom Catanzaro during his last 20 years of consulting include:

If you preach teamwork, but then reward individuals.

If you preach client service, but reward blindly following rules.

If you preach risk-taking, but then reward error-free work.

If you preach feedback, but attack criticism.

If you preach innovation, but reward "doing your job".

If you preach empowerment, but must approve everything.

If you talk the talk, but don't walk the walk.

There are three warnings that must be shared. First, don't expect the vision to have its effect before your team members have quit the old ways and let go of the security of the past. There is no harm in sharing the vision. It actually helps when you announce the transition changes. There is a reassurance in sharing the picture of the future, but it does not make the transition happen. The transition across the systems gap will not be easy.

The second warning is about mental fatigue. Change not only hurts, but there is a tendency to stop it sooner than desired just to "get back to normal". This statement provides the greatest fear for any consultant. When bridging the systems gap, flexibility is critical. It is often essential to modify the initial picture, and that modification occasionally looks a lot like the starting point the practice left.

This leads to the third strike in transition: overwhelming the team. The initial excitement of the leader is beyond any point where the staff is, so the picture is hard to believe. The vision of what can be is clouded by everything that has passed, and they become intimidated rather than excited by the picture. Not everyone will respond to the vision, because they don't share common values or see a personal benefit. This applies even to the best of team members.

The leadership skill of giving each person a meaningful part in the outcome is centered on finding out what is meaningful to the individual, not to the practice. Although the interim targets used while bridging the systems gap may not be similar, a skilled leader will match these two elements before the final outcome, even if it takes a bit longer.

To assist the leader in bypassing the common pitfalls, there is a checklist attached. This is not a one-time checklist. It is a "before EVERY meeting" reminder list. It is designed to remind you how to survive during the bridging of a systems gap, not how to start the bridge. Each of us needs reminders and assistance, and we must call on inner strengths sometimes to handle the feedback in a positive and effective manner. This checklist is one such method to stay calibrated to the needs of your team and your practice, but it is not the best method. The best method is to listen to your team AFTER you have taught them that it is okay to provide critical feedback.

People are more than logical beings, they are a complex set of feelings and values. They can react very strongly to symbolic events, from the waving of Old Glory to the heartbreak of a movie. Movies like *Rambo* and *Rocky* played to the emotions during a "paper tiger" phase of national image. New symbols emerge almost daily in the media, yet very few practices have become "feline friendly", although the cat population has increased far quicker than the canine. How leaders and practice staff 1) define success, 2) imagine successful events, and 3) celebrate success, can make a difference in transition planning. Identifying small successes, targeting significant

outcomes, and sharing the vision are critical techniques when bridging the systems gap in a veterinary practice.

If you define today as perfection, as the "10" practice and "10" staff, then you have committed to maintaining the status quo. When scientific knowledge is doubling every two to three years in our profession, each year accounts for at least 33 percent increase in the knowledge (a significant change in most practices), which means every month requires at least a 3 percent increase in knowledge. By being complacent and accepting life as it is (based on previous standards), you establish the expectation of stasis, not the charter of change. In our profession, the physiological definition of stasis is death. Is that the goal you have set for your team by defining their activities as meeting all the practice expectations?

In determining if the transition plan concept is best for your practice, remember the words of the American management expert, Peter Drucker:

"Management by objective (MBO) works if you know the objectives.
Ninety percent of the time, no one knows what they are!"

A WEEKLY CHECKLIST FOR MANAGING THE SYSTEMS GAP

Yes	Oops	Self-assessment Inquiry
___	___	Have I created enough discomfort/dissatisfaction to assist the team in desiring a change to a better practice operating condition?
___	___	Have I shared the dream and the future model with enough clarity that the staff can adequately picture their own role in the new system?
___	___	Have I done my best to explain the system gap as an uncomfortable time, which, with careful attention, can be turned to everyone's advantage?
___	___	Have I redefined the interim system (process) by choosing a new and more affirmative metaphor(s) with which to describe the transition or end point?
___	___	Have I reinforced the new metaphor(s) with training programs, policy changes, and meaningful recognitions for people to keep improving their jobs during the systems gap?
___	___	Am I protecting staff members adequately from knee-jerk changes?
___	___	When I can't protect the team from quick changes, am I redefining the changes adequately to keep them in perspective to the desired outcome(s)?
___	___	Have we created the temporary policies and procedures that are needed to ensure quality care for patients, client-centered services, and a good quality of life for the staff while we cross the systems gap?
___	___	Have we created the temporary team leaders and organizational relationships to allow decision making at lower levels while still keeping us on course through the systems gap?
___	___	Have we set enough short-term goals and milestones to serve as checkpoints and recalibration times?
___	___	Are the output expectations realistic, considering the systems gap uncertainty and other duties requiring staff attention?
___	___	Are we finding new ways each week to make people feel that they are still valuable members of the practice? Are perks and other forms of privileges not undermining the solidarity of the group effort?
___	___	Is the transition monitoring team(s) providing realistic feedback upward during the transition across the systems gap?
___	___	Are the team members still willing to experiment and take risks within intelligently conceived ventures, or are we punishing all errors?
___	___	Have I stepped back and taken stock of how things are being done in my part of the practice operation? (This is worth doing for both its own sake and the example you set for others!)
___	___	Are the resources (survey instruments, facilitators, etc.) being provided to team members that will allow them to effectively evaluate and modify their operations while we cross the systems gap?
___	___	Am I helping people build their personal skills in creative thinking, innovation, and problem solving? Are the continuous quality improvement (CQI) reinforcements being used at this time?
___	___	Have I encouraged experimentation this week? Have I rewarded risk taking, in lieu of punishing failure, within the intelligent efforts that have not panned out?
___	___	Do we transform the losses from the practice into learning experiences and opportunities for trying new ways?

___ ___ Did I set a brainstorming example this week, especially when looking at traditional problems? Am I encouraging others to challenge the defined limitations and to seek new alternatives?

___ ___ Am I regularly checking to see that we do not push for certainty and closure, where it may be more conducive to creativity to exist a little longer in the systems gap with uncertainty, questions, and the freedom to change?

___ ___ Do we use the time in the systems gap to slay the bucket brigade systems we used to "put out fires" in the past? Do we replace them with integrated programs that promote innovation and responsiveness to healthcare delivery needs?

TO DO THIS WEEK : Write yourself a memo for what you need to do for the "Oops" control within the transition.

REMEDIAL REMINDERS

WHAT & **WHY** belongs to the leadership, clear concise statements of need or action needs.
WHO and **HOW** belongs to the team(s), and must be allowed to evolve BEFORE the project/program kicks off.
WHEN is done by joint negotiation after the staff returns with the **WHO** and **HOW**, and includes development of expected milestones as well as definitive success measures.
HINT #1 - new programs need new metrics, and if you use old metrics, reversion will usually occur (new metrics are explored in the ***Models & Methods*** monograph, from VIN Bookstore, www.vin.com).
HINT#2 - the traditional project formula ***input => process => output*** is not what the new transition plan needs for success. In Transition Plan development, ***input => process => output*** **=> outcome** is the preferred project formula. Example: *admission => desex surgery => neutered animal* needs a better => *outcome*, i.e., Satisfied Client!
HINT #3 - brainstorming takes longer, and there is never a value judgment on an idea during brainstorming, everything is written down and accepted at face value (including a parking lot for ideas not related to the discussion at hand). During Project Planning, everything will shake out (forms are in ***Leadership Action Planner*** monograph, from VIN Bookstore, www.vin.com).

AFTER THE INITIAL PLAN IS COMPLETED

When the original draft transition plan offered by Dr. Tom Catanzaro expires, there will be a need for the momentum to be maintained. The easiest way to establish an updated practice plan is to build a chart (poster board as shown below) and call a staff meeting:

THE PRACTICE'S MASTER PLAN FOR PROGRESS AND CHANGE (with FUN!)											
JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

If you have personal projects, put them onto the chart before the staff meeting. Step two is to ask each person at the meeting to bring forward any key project(s) they'd like to see completed in each month. The goal is one project per month, for the next twelve months. Remind them that there may be items skipped in the transition plan — or repeat/revised applications of the "lessons learned" from the transition plan — their experiences, and good news/bad news events of the past year. We learn from the past and need to use it to plan for the future.

Keep the chart posted near the coffee pot, with the person's name(s) who is the responsible/accountable action agent. When the project has been completed, circle the name and put a single line through the project. The circle around the name is a recognition factor, so, please, do not line through the name. Things can be added later, and like a transition plan, items can be modified, shifted, deferred, but never ignored!

While some practices utilize this "charting" system to get the basic transition plan established, others feel displaying it is too demanding early in the process. Some hospital directors want to set very clear expectations in public for one and all, while others like to tailor the programs to the individual during one-on-one sessions. It does not matter which way a hospital leadership selects. It is the consistency, caring, and predictability that yields continuous quality improvement results.

As we have discussed, the quarterly planned performance system we established feeds this process — seven supervisor key result areas for each leader and one or two target areas for each staff member. The chart will feed the planned performance system. Together, continuous quality improvement (CQI) will be the leadership process of your practice's success.

THE NEW TRIAD OF PRACTICE LEADERSHIP

BEFORE THE START OF THE MONTH — Medical Director, Coordinator of Coordinators (CoC), and Training Coordinator (TC) meet.

1) They look at the coming month transition plan, and divide them, into piles, by number. That is why each issue starts on a new page. ☺

2) They look at which ZONE or ZONES gets that number item at the CofC STAND-UP or STAFF MEETING, whichever is first.

3) Remember WHAT and WHY is leadership, so the three of you (Medical Director, CoC and TC) get onto the same sheet of music by defining the OUTCOME (NEVER PROCESS) and measurement(s) of success for every item within that number set.

4) The Medical Director and TC look to see if there are any specific practice resources or references to be added to that Transition Plan number set (e.g., preferred brochure, INTERNET training site, etc.) CoC is the ZONE champion and does not allow unrealistic expectations to be developed during this discussion of measurements of success.

5) If you look at the checklist, where Issue 1 is the Training Checklists, the tasking would be to each Zone coordinator, giving them the whole set, so they know what is coming and where they are going. The CoC would point out that ONLY PHASE D gets tasked at the first meeting, and it would require all PHASE Ds to be completed and returned BEFORE PHASE C could be started in any zone.

    In the leadership PLAN, the CoC would not allow the Training Coordinator to "fill in the blanks" of any phase — that is HOW and WHO, and belongs to the zone, and the respective coordinator.

    The Training Coordinator could CONSOLIDATE trainers identified when/AFTER the TC gets all the completed zone PHASE Ds returned.\

    The CoC can force additional resources — such as WHICH LINE ITEMS do we want to volunteer for and we will put our initials in those spaces, so the Zone Coordinator (ZC) does not have to seek us out and beg.

6) Regardless of where these numbered items will be handed out, it is always CoC to ZC. Please, never confuse the CoC's accountability to human resource management.

7) If the item needs technical training, it is the TC who ensure she/he reviews the doctor's or trainer's WRITTEN TRAINING PLAN (see "Effective Teaching") for practice compatibility and integration BEFORE the trainer is presented as CREDENTIALED at the staff meeting and the recognition announcement.

8) All questions about any issue OUTCOME is ZC to CoC.

9) Most training questions will be between the trainer and TC.

10) All WHY and WHAT for SOC is presented by the Medical Director in a less-than-five-minute distinct and clear statement, reviewed by the TC for NO WAFFLING and NO HEDGING. It must be crystal clear when announced as a SOC item!

11) The CoC Stand-up cannot be allowed to become a problem solving time. It is a time for ZCs to "flaunt" what they/their zone are working on that week . In the early days, the CoC could do preparatory one-on-one with ZC before the stand-up to ensure the Zcs are ready — and to ensure they do not get embarrassed by the team process.

12) The TC cannot be allowed to write lesson plans for other trainers. The TC is NOT the trainer, only the coordinator, and may need to add other resources to help the trainer. Review is a time for the TC to discuss the discovery/teachable moment attention grabber. The TC wants the trainer to "flaunt" the trainer's new area of expertise, so other staff will look forward to seeking out that person. In the early days, the Medical Director could do preparatory one-on-one with the TC, or even the trainer, before the Lesson Plan presentation, to ensure the trainer feels comfortable with being the subject matter expert for the practice — and to ensure the trainer does not get embarrassed by the team process.

Now, sit down as Medical Director, CoC and Training Coordinator, and do the month's transition plan issues BEFORE THE NEXT CoC Stand-up, so you do not put anytone into an embarrassing position. ☺