STRATEGIC TEAM EMPOWERMENT

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"Empower is an action verb . . . so just do it!"

Let's get radical and talk about profit sharing as a motivator rather than a reward. The title uses the term "team" instead of "employee" for the average reader's comfort zone, but I prefer to entrench the term "team" or "paraprofessional" when we embark on a participative management program. Many practices have started to provide their staff a share of the profits on a quarterly or annual basis, or as a retirement plan. This article will discuss empowerment of the paraprofessional staff, the use of an immediate reward for good work, and putting a fair share of the gross profits in paychecks every month. Income-based incentives that are repeated become expected by the staff, so if you decide to implement such a plan, call them performance pay, recognition pay, or even management fees.

INCENTIVES

Incentive is a misnomer in healthcare delivery; it is worse than a misnomer in veterinary medical healthcare delivery, it is an insult. Most staff are not on commission, nor do most veterinary practices pay enough in the first place. The majority of people join a practice team because they want to belong to a healthcare delivery system that cares for animals. In our field of endeavor, recognition and a sense of belonging are the two greatest benefits we can give our people . . . but money is still in the top six reasons for performing for almost everyone in health care!

Sharing a portion of the profit by adding it to the paychecks each month makes it much easier for staff members to see it is in their own interest to do a job well and help each other. Note that I say profit, not just an increase in gross; we cannot spend gross, only net. This assumes the practice understands profit, has a budget, and believes that programs drive budget (the dream is that a budget will never drive programs in health care). We use a “Dinner Bell” chart, based on a proactive, program-based, budget, established by the providers BEFORE the reporting period (see CH 4, *Building The Successful Veterinary Practice: Programs & Procedures*, Volume 2, or the VCI *Signature Series* monograph, *Profit Center Management*, with diskette and budget spread sheet, from the VIN Bookstore, www.vin.com). Client service improves because the staff begins to realize where the cash really comes from. Clients begin to notice the difference and practice bonding increases. Staff energy sometimes slows up when things are tight and stressed; if one person slacks up, that is seen as

money out of everybody's pocket. Not much about programs or liquidity should ever be left to chance.

Peer review is far better than paying a manager to look over the staff's shoulders. When profits are distributed, and the staff understands "income - expenses = profits", new attitudes emerge. If a technician leaves a gas machine on, there are three people on his/her case: "What are you doing? That wasted gas will cost us a bundle of money." Employee involvement keeps attendance up and costs down. At most practices, staff are always asking for work relief. In a monthly profit sharing practice, more staff means more spreading of the profits and the staff worries about that. Staff members become highly motivated to make sure that there really is a need for a new person and make sure the new team member becomes well trained early so he/she can contribute to the practice profits.

THE STRUCTURE

The basic concept is easy but the decision is hard. With the pending IRS tax rules, the monthly profit sharing may become a best choice, least tax alternative. Profits here are defined as the net excess profits AFTER the balance sheet expenses AND income statement expenses are covered. While the practice accountant can help with the "stubby pencil" review, they seldom understand programs and client service. It is really the practice philosophy that must be addressed.

Here are some guidelines to get you started:

1. **Look at the patient care and client contact operations.** What does the State Practice Act allow technicians to do, and are you using them for all the right things? Can you use technicians for internal referrals? Topics like nutritional counseling, behavior modification, parasite control and prevention, dental hygiene, and puppy/kitten training are far more profitable when done by technicians and the veterinarian can get on with exam room diagnostics, surgery, or patient care.

2. **Be bold with the bucks.** The program works when the staff can see it. Too many profit sharing plans fail because working extra hard only translates into an extra two percent in the paycheck. By handing out 15-20 percent of the *excess profits* monthly (remember that budget assumption discussed earlier), a practice leader can really see results.

3. **Share power as well as money.** The financial rewards only help if the staff participates in designing the standards by which they are judged and if they can monitor performance themselves. The staff must become accountable for outcome improvements, not just process changes. Their

at-risk concern for the practice's success will keep the standards high. An example of this would be the call-back and recheck system being a staff responsibility and exceeding an 80 percent appointment log fill (based on available examination rooms, farm trucks, etc.) becoming bonus time.

4. **Center on Tomorrow!** No one can correct yesterday unless we build toward tomorrow. The question needs to be, “How can we improve?” versus “Why did you do that?”. “What can we do to prevent that from happening again?” is a far better leadership question than “Why did we do that?” Performance planning for the next 90-days needs to replace performance appraisals for the past year (the VCI *Signature Series* monograph, *Performance Planning*, with diskette of short and long performance planning forms, from the VIN Bookstore, www.vin.com, provides the details of this leadership and nurturing perspective, as does CH 6, *Building The Successful Veterinary Practice: Programs & Procedures*, Volume 2, from Wiley & Sons).

5. **Don't fret about abuses of the system.** The worry is natural but misplaced. Very few people have entered our profession because they want to ruin a practice. Staff suggestions are made to help the practice improve, not to irritate the owner or manager. They need limitations and clear expectations, but they do not require thumb screws and babysitting. The staff members need nurturing! If you treat people like adults -- with respect -- they will act worthy of your trust and surpass your expectations.

REVERSE TWIST

Performance appraisals by staff and peers -- that's a reverse twist. But is it? If we look at the veterinary practice environment, each member of the team is under constant appraisal by clients, by peers, by everyone from the lowest to the highest paid. If we recognize this as a fact AND are building a participative management team, then we should initiate appropriate action to get feedback desired.

As a leader, I believe *appraisals* are essential, but in real time only. The moment-to-moment training and nurturing opportunities are appraisals. If someone cannot do a jugular tap, take the time to teach the landmarks and spend a few extra minutes to ensure the team member learns. That is an appraisal which leads to increased pride and confidence. To grade the inability to draw blood as "poor" 90 to 360 days later does not solve the problem nor does it enhance the health care delivery.

During my consulting efforts, I usually advocate performance planning at the beginning of the quarter rather than performance appraisals at the end. The

person sets some personal goals, specifically target actions, they want to accomplish within the next 90-days; this is marked by establishing specific measurements of success which are agreed upon at the beginning. They are assigned a mentor who will assist them in achieving success. Their target action is joined with the practice goals, and in most cases posted with them, to ensure the entire team is aware of and supporting the effort. At the end of the quarter, the person evaluates their own success, and also gets the first chance to redefine the problem and look at a new way to accomplish the target action if it went astray during the quarter.

FEEDBACK

The feedback we need must be balanced -- the good, the bad, and the average. Average is nice if we are looking for the status quo, but progressive practices seldom are satisfied with what was yesterday. This is why the mentor is assigned for review and coaching during the quarter, and why the other staff members (doctors, too) are asked to be aware of the target actions of the quarter; their role is feedback and support. In health care, competency is a single standard of excellence, not a scale from one to ten. Either we stopped the bleeding or we didn't, either the X-ray was diagnostic or it wasn't, either we cured the animal or we didn't; partial pregnancy does not exist in the real world. We train people to a level of competency which deserves our trust . . . train to trust!

We all make mistakes, especially if we try something new. That is the way we gain experience and experience is what reduces mistakes. Too many practices, especially when pursuing internal promotion/marketing ideas, reward risk-avoidance rather than risk-taking team members. Anyone who is afraid to make mistakes will usually not grow and learn. Often these individuals are the ones who resist change for it is seen as different and thereby a potential error if tried.

Feedback tells us if we are playing it too safe and stifling the team. It tells us if we are moving to fast and leaving the others behind in a cloud of confusion. The appraisal process helps each of us calibrate our actions to the expectations of those around us. It allows us to step back and determine if "they" see what we think "we" see. It goes back to the old adage, "The whole world seems to be chasing the wrong things, except you and me; and sometimes, I'm not too sure about you."

METHODOLOGY

In the traditional, after-the-fact, appraisal mentality, the reverse twist would let each person complete the "standard" practice appraisal on each member of the staff. The completed appraisal could be private or public depending on practice comfort zones. The private responses could simply be to put the completed

appraisals in labeled envelopes, probably near the time sheets. The public appraisal requires thick skin, a sense of humor, and a true commitment to team building. It is based on the fact that there are no false perceptions, only conflicting observations; it is also based on the assumption there is an effective team leader who keeps discussions positive and in perspective.

In the prospective performance planning process (beginning of the quarter planning), the staff members are expected to help and provide feedback during the process; there is no 20-20 hindsight situation like the traditional appraisal process. The team works toward success during the quarter, rather than only talking the game. They must walk the talk during the quarter, or they have no right to talk at the end. In fact, the old style of grading (1 to 10, outstanding-excellent-good-fair-average-poor, A-B-C-D-F, etc.) cannot be maintained with performance planning. Competency is success; yes we did or no we didn't. A partial pregnancy does not exist, nor does partial excellence in health care; either we are competent or we are not. Competency is excellence and success is achieving the target actions; there is no compromise. With performance planning, a "ten" employee does not exist, since every person works on continual improvement (target actions) and the leadership is helping them get better on a continual planning process for improved performance of the practice.

Staff meetings can be the sharing time for the boss's positive evaluations, but the better use of staff time is to use meetings to solve problems. Mini-meetings are often better for the larger practice's staff's problem-solving effort. Let all the receptionists get together and address their concerns. Comparisons between peers then reinforces the logic of the challenge evaluation process and gets team commitment toward success.

THE INSTRUMENTS

The hardest question in practice is when we ask the receptionist what the clients are saying -- expect some hard data back. Do not settle for the "all is fine" comments, but don't knee-jerk because one client did not like your exam table manner. Let consensus become cause for action. When a similar question is asked by the doctor of the staff, silence is the sign of disaster...their fear is stifling feedback. The environment is not conducive for problem solving. Leadership must be brought to bear, and in a consistent long-term manner!

The performance planning process can use forms (e.g., as with the VCI *Signature Series* monograph, *Performance Planning*, with diskette of short and long performance planning forms, which provides the details of this leadership and nurturing perspective, and so does CH 6, *Building The Successful Veterinary Practice: Programs & Procedures*, Volume 2, from Wiley & Sons), or just clearly defined "key result areas (KRAs)." The KRAs used during consults, and the

above referenced forms, include: client satisfaction, economic health, quality, innovation, productivity, personal growth, and organizational climate. These KRA areas are the starting point for supervisors, they need one idea in each category each quarter. The paraprofessional staff only needs to select one or two ideas to target per quarter. They define what the specific element will be for themselves, and then discuss a rational measurement of success with their mentor.

The last instrument to use is your personal goals and objectives list(s). Once the peer and staff appraisals or performance plans are completed, take the comments and select three to five positive actions that you want to add to your performance plan during the next quarter to better support the staff efforts. Write them on 3" X 5" note cards -- one for the car visor, one for the desk, and one for the bathroom mirror. Look at them frequently and evaluate your actions in achieving those goals and objectives. Writing them does not make them happen, but not writing them gets far worse results.

Reverse twist or straight from the hip, we all need others to help us see more clearly. Initiate some form of team feedback or participative management today --- a method that is at the edge of your comfort zone. Push for a better tomorrow.

EMPOWERMENT of OUTCOME or PROCESS?

At this juncture of changing your practice culture, please be careful. Each member of any practice team is EMPOWERED at some level of healthcare delivery, and in some practices, it has been centered on “turning the crank”, while in others, it has developed decision makers who allow the doctors to spend more time in medicine and surgery. A “manager” tends to empower getting the process done, while a “leader” empowers people to achieve the outcome.

Managers get work done through people;
Leaders develop people through work.

The most common veterinary syndrome has been when NO ONE seems willing to take the risk of doctor alienation; everyone just wants be told the process they are supposed to do. This is often called “other duties as assigned”, and then they just wait to be told what to do.

FACT #1 - Staff members have been taught that they are not independent, and in fact, they feel they are not trusted to think or stretch outside the established process, associates and doctors alike . . . this is why leaders must start with sharing the "WHY" of the vision.

FACT #2 - Staff needs information, and when that information has always been close held, even when establishing fees, they just wait. Leaders need to get the team to rise to a new level, and revive the thought process, but like a trek up the mountains, it is one step at a time . . . and it is not the steps that stop the progress, it is the grain of sand in the shoe that causes people to quit their trek . . . those small, aggravating, distractions . . . those small fears that are enlarged when they are hit with a lightning bolt from a doctor.

- **First concept**, most all veterinary practices have good, caring, dedicated people, and they have the power and knowledge within them . . . a leader's job is to let this power out and put the light of leadership approval upon their efforts.

- **Second concept** - leaders need to promote autonomy, but there must be limits placed on the teams autonomy . . . limits are like river banks, they are needed to make the river move in the right direction . . . without limits, a river is swamp or puddle. What is the "motive" to do this?

  M = Mission focus (the client-centered patient advocacy)

  O = Organizational Systems (transition plan "what")

  T = Team Roles (transition plan "who" by coordinators)

  I = Image (self-esteem, pride - regular recognition by the boss)

  V = Values (inviolate beliefs, standards of care, safety to staff)

  E = Excellence (competency, CQI, learning organization)

- **Third concept** - Image only comes when each person sees that their contribution is making a difference . . . empowerment requires the LEADER to teach each person things they can do to become less dependent upon directed process . . . every mistake is an opportunity to increase competency . . . the secret is in the question, not in the answer . . . give them the resources an information, then only ask questions to get them to offer two "yes" options . . . if both are equally good, ask an integration question and tell them to "have at it" . . . each issue helps them become more of a self-directed operational team . . . the freedom to act carries with it an accountability for ensuring the outcomes . . . pride is seen when they exceed expectations, so ensure you start with small wins!

FACT #3 - Leadership changes must have a beginning, and the trek will be at least a year. When hiking the Rockies, there is an acclimatization at 3 days, 3 weeks, and again at 3 months. The staff members need a leader's endorsement early in the process, so they know what course is expected by the leadership, and they need to know who is heading each operational team; three weeks into the process of empowerment, they need individualized recognition and follow-up support, so they know the new issue/system will not be forgotten; and at three months, new programs will be seen as better alternatives, or they

will be tweaked to become better. The role of leadership is called mentoring; it is just a single step at a time, and it is a steady but reasonable pace for each member of the team. The appendices and leadership skills in *Building The Successful Veterinary Practice: Leadership Tools* (Volume 1) will all come into play.

FACT #4 - A leader sees the vision of what can be, and must keep it in focus for all others . . . the clarity of self-directed team means a leader cannot go back, the team can only go forward. An empowered team must become accountable for independent thought from the information a leader provides (outcome and limits), and responsible for implementing their plan of action needed to achieve the desired outcome(s) . . . the trek will be a celebration of small wins, and the true leaders must lead the cheering section.

THE NEXT STEP

The next step in the process is soul searching. Often it seems that sharing the profits, which are getting slimmer each year, is the worst choice ever offered. But a practice style assessment is needed before a final decision is made. Sometimes this requires outside eyes. We have one client (one partner of three) who was a bear, growled and fussed at everyone, knew the consultation was worthless, but since the consultation, his attitude has steadily improved. He has learned that he knew the right things, that how they were being used had some inconsistency, but that he was "good"; his partners are happier now, too.

If the Practice Act and your philosophy of practice will allow a technician to counsel a client (nutrition, dental, behavior, etc.), give vaccinations, or do other items that allow them to extend our services without the high cost of a veterinarian, then enhance the team by trying expanded services and programs centered on them (not the doctors). If they participate, then practice profit sharing is appropriate. If the technician can (or will) only work at the doctor's side like a nurse’s aide in the local hospital, then profit sharing will not motivate the independent efforts that we would hope for in a more flexible situation; alternative methods will need to be found to make the best "bang for the buck" impact on the team.

The veterinary extender can be more than just a well-trained technician. Think of the receptionist who monitors the reminder system, and insures the practice newsletters get to the right clients at the right time. If they weren't doing that, who would? If the answer to that question becomes "the veterinarian", then profit sharing might be in order again.

The bottom line is the philosophy of practice and where the practice goals say the practice is to go in the next few months or years. If status quo is adequate,

then do nothing more, but expect a deterioration of the client base, since other practices will be proactive in their service outreach plan and scope of services. If you wish to keep up with the Consumer Price Index (CPI) for inflation, you need not be innovative; you need six percent over the CPI to allow for a decent retirement program. If you wish an 11 percent growth rate (health price index (or CPI, which is often lower) at 5.1 percent plus the minimum six percent), then you can work harder, enjoy life a little less, and not expand the use of veterinary extenders within your practice.

CAUTION - CAUTION

The CPI + retirement dollar needs, and/or the practice growth in gross, are NOT a staff motivator. Programs motivate staff.

Covert "income desires" into "patient needs" or "client needs"; only discuss programs with your staff in terms of patient advocacy and programs which benefit health and wellness.

Staff members can understand measure the number of dentals to restore puppy and kitten kisses, or the number of follow-up calls to clients who accessed the practice but resulted in only deferred or symptomatic care for patients, or the laboratory value that was out of line and needs another chemistry profile to ensure recovery has occurred.

Never, ever, forget: the only thing we sell is *Peace of Mind* for clients - all else they are allowed to buy!

But if you wish to work less, practice more, and progress in services and income, motivating your paraprofessional staff with a piece of the action can be a very interesting alternative to pulling your hair out about high employee turnover, excessive work hours, and low payoff for efforts expended.

SAMPLES OF KRA GOALS AND MEASURES

Goals	Measures Type	Indicator
Client Satisfaction		
"Gee Whiz" service	O	New client survey ratings
	O	Total client survey rating
	O	# commendations (letters/calls)
Responsiveness	O	% first reminder compliance
	O	Appointment compliance variance
	O	Lead time for surgery
	P	Council of clients participation
Defections	O	Visits per client per year
	O	% return clients
	O	# clients not responding to reminders
	O	Client turnover rate
Word of Mouth	O	% new clients by referral
	O	% transactions due to new clients
Client Partnership	P	# client-submitted ideas
	O	$ value of new client ideas
Economic Health		
Surviving	O	Positive cash flow
	0	Expense control within budget
	O	Reduction in operating expenses
	O	Inventory turn-over rate
	O	Average client transaction
	P	% income as accounts receivable
Thriving	O	Income center growth
	O	Net income
	O	% change in income
	O	Patient advocacy $ value
	P	% clients w/multiple visits per year
Prospering	P	# accessing new service(s)
	O	% net on nutritional products
	O	Increased market share
	P	% clients w/multiple visits per quarter
	O	$ put into profit sharing/retirement fund
Quality		
Pride	O	Market survey ranking
	O	# complaints
	O	# staff-referred clients
	O	4-year AAHA accreditation
Zero Defects	O	# litigation action
	O	# of rework cases
	P	Staff action on problems w/o direction
Special Interest Areas	P	# CE hours actually attended
	O	# new medical/surgery programs initiated
	P	# cases referred to colleagues
	O	# cases referred by colleagues

Goals		Measures Type	Indicator
Innovation			
Wide Participation		P	# action teams
		P	% staff making suggestions
		P	# staff-submitted new ideas
		P	% staff on action teams
High Payoff		O	$ value of staff new ideas
		O	$ value of doctor new ideas
		P	# suggestions/staff member
Implementation	P	% suggestions implemented	
		0	New program start vs. continue
Productivity			
Output		O	% inpatient cages occupied
		O	Gross revenue/staff (FTE) member
		O	Net revenue/staff payroll
		O	# transactions/provider
Resources		P	Time in meetings
		P	Appointment fill rate
		O	Staff manhours paid per transaction
		P	$ expended for upgrades
		O	% income as cost of goods sold
Service Excellence		P	Wait time/client
		O	Expenses per client
		P	% NQA staff budget spent on client issues
Personal Growth			
Staff		O	% turnover
		P	Absentee rate
		P	$ used for staff celebrations
		P	# active target actions
Optimizing		P	# training hours/staff member
		P	% budget for staff training
		O	# disciplinary actions
		O	% revenues as staff compensation
Learning		P	# staff in-serviced
		P	# new in-service topics
Organizational Climate			
Best place		O	# clients by staff referral
		P	% new hires by staff referral
Values		O	Staff opinion survey rating
		P	# staff accolades for using values
Fun		O	% staff receiving recognition awards
		P	# social events
		O	% staff participating in social events

Type of Measures:
O = Outcome Measures. Measures indicating reaching the goal.
P = Process Measures. Measures indicating progress that contribute to outcome.