Delegation, Empowerment & Standards of Care
For Developing Self-directed Work Teams

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I think any veterinary practice makes a serious mistake when they make a distinction and say, "You are staff, you are a manager, and you are a leader." So my philosophy is that we are all leaders! Surveys show 79% of general practice veterinary staff members usually have a daily client contact. Each of us must also be responsible managers or stewards of resources entrusted to us. A veterinary practice would make a serious mistake to think that anyone could be one and not the other. Dr. Tom Cat

Situational leadership is what we should be doing as leaders of a practice team; the right style of leadership for the situation and person(s) involved. The neophyte thinks there are two styles, autocratic and democratic. This goes back the 1960 text *The Human Side of Enterprise*, Douglas McGregor where he introduced the Theory X and Theory Y thesis on how managers perceive motivational cultures. The modern theory actually started with Kurt Lewin (1939) led a group of researchers to identify different styles of leadership. This early study has been very influential and established three major leadership styles. The three major styles of leadership are:

Authoritarian or autocratic

Participative or democratic

Delegative or Free Reign

AUOTCRATIC:

This style is used when leaders tell their employees what they want done and how they want it accomplished, without getting the advice of their followers. Some of the appropriate conditions to use it are when you have all the information to solve the problem, you are short on time, and your employees are well motivated. Some people tend to think of this style as a vehicle for yelling, using demeaning language, and leading by threats and abusing their power. This is not the authoritarian style, rather it is an abusive, unprofessional style called "**bossing people around**." It has no place in a leader's repertoire. The authoritarian style should normally only be used on rare occasions. If you have the time and want to gain more commitment and motivation from your employees, then you should use the participative style.

DEMOCRATIC:

This style involves the leader including one or more employees in the decision making process (determining what to do and how to do it). However, the leader maintains the final decision making authority. Using this style is not a sign of weakness; rather it is a sign of strength that your employees will respect. This is normally used when you have part of the information, and your employees have other parts. Note that a leader is not expected to know everything — this is why you

employ *knowledgeable* and *skillful* employees. Using this style is of mutual benefit — it allows them to become part of the team and allows you to make better decisions.

DELEGATIVE:

In this style, the leader allows the employees to make the decisions. However, the leader is still responsible for the decisions that are made. This is used when employees are able to analyze the situation and determine what needs to be done and how to do it. You cannot do everything! You must set priorities and delegate certain tasks. This is not a style to use so that you can blame others when things go wrong, rather this is a style to be used when you fully trust and confidence in the people below you. Do not be afraid to use it, however, use it **wisely!** NOTE: This is also known as laissez faire (or lais·ser faire), which is the noninterference in the affairs of others. [French: laissez, second person pl. imperative of laisser, to let, allow + faire, to do.]

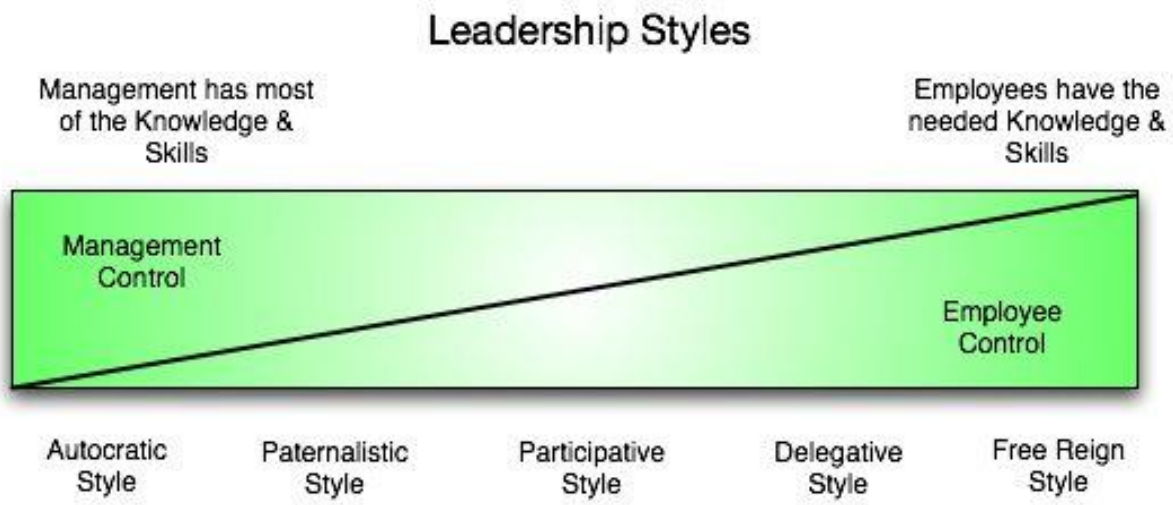
FORCES AT PLAY

A good leader uses all three styles, and a few more as we will discuss below in situational leadership styles, depending on what forces are involved between the followers, the leader, and the situation. Some examples include:

- Using an authoritarian style on a new staff member who is just learning the job. The leader is competent and a good coach. The staff member is motivated to learn a new skill. The situation is a new environment for the staff member, but usually one he/she has dreamed of for a long time.
- Using a participative style with a staff team who knows their job. The leader knows the problem, but does not have all the information. The trained and dedicated staff members know their jobs and want to become part of the team.
- Using a delegative style with a key player who knows more about their specific job than you. You cannot do everything and the staff members need to take ownership of their job(s)! In addition, this allows you to be at other places, doing other things.
- Using all three: Telling your healthcare team that a procedure is not working correctly and a new one must be established (authoritarian). Asking for their ideas and input on creating a new procedure (participative). Delegating tasks to the various zones in order to implement the new procedure (delegative).

Forces that influence the style to be used included:

- How much time is available?
- Are relationships based on respect and trust or on disrespect?
- Who has the information — you, your employees, or both?
- How well your employees are trained and how well you know the task.
- Internal conflicts.
- Stress levels.
- Type of task. Is it structured, unstructured, complicated, or simple?
- Laws or established procedures such as OSHA or training plans.



Indiv: Directive – Persuasion – Coaching – Delegation – Mentoring – Consulting – Joining
Group: FORMING – STORMING – NORMING - PERFORMING

The above model is underpinned with a similar situational leadership model as used by Hersey and Blanchard. The **Situational Leadership Theory**, is a leadership theory developed by Paul Hersey, professor and author of the book *Situational Leader*, and Ken Blanchard, leadership guru and author of *The One Minute Manager*, while working on the first edition of *Management of Organizational Behavior* (now in its 9th edition The Theory was first introduced as "Life Cycle Theory of Leadership" During the mid 1970s, "Life Cycle Theory of Leadership" was renamed "Situational Leadership theory." This is the model I adapted for use in my first text: *Building the Successful Veterinary Practice: Leadership Tools* (Volume 1), Blackwell/Wiley & Son Publisher, and my successive *Signature Series* Monographs on Leadership (available from VIN Bookstore, www.vin.com).

In the late 1970s/early 1980s, the authors both developed their own Models using the Situational Leadership theory; Hersey - Situational Leadership Model and Blanchard et al. Situational Leadership II Model. **The fundamental underpinning of the Situational Leadership Theory is there is no single "best" style of leadership.** Effective leadership is task-relevant and that the most successful leaders are those that adapt their leadership style to the Maturity ("the capacity to set high but attainable goals, willingness and ability to take responsibility for the task, and relevant education and/or experience of an individual or a group for the task) of the individual or group they are attempting to lead/influence. That effective leadership varies, not only with the person or group that is being influenced, but it will also depend on the task, job or function that needs to be accomplished. **The Hersey-Blanchard Situational Leadership Theory rests on two fundamental concepts; Leadership Style of the individual and the group's Maturity level.**

The newest *Signature Series* Monograph placed in the VIN Bookstore (www.vin.com) was ***Human Resources & Organizational Behavior*** (circa Dec 2010), and while is an extensive review of the theories, it also has an electronic tool kit to help with practice implementation.

BUILDING A TEAM OF EXCELLENCE

Leaders should not think of themselves as simply managers, supervisors, etc.; but rather as "team leaders." Thinking of yourself as a manager or supervisor places you in a position of traditional authority based solely on respect for the position, which in turn places you in a position of power. By understanding the personal work preferences and motivations of your team members, you as an individual, rather than your position, will earn their real respect and trust. All the tools discussed in the *Signature Series* Monographs (31 monographs, with electronic tool kits, are in the VIN Bookstore) and the two FREE TO DOWNLOAD texts in the VIN Library, such as counseling and planning, provide the basic structure for developing a team. But to go from a group to a team requires a few extra steps are needed, and they center on the practice owner and Medical Director, the real visionary leaders of the practice.

This means that the people in your employ are not simply followers who blindly go where you go, but rather are a group of dedicated healthcare professionals who are supportive of collaboration in order to achieve common client-centered, patient-centered and/or practice-centered goals through mutual knowledge, skill sharing and can-do attitudes.

What is a Team?

In general business or social terms, a team is a group of people coming together to collaborate. This collaboration is to reach a shared goal or task for which they hold themselves mutually accountable. A group of people is not necessarily a team. A team is a group of people with a high degree of interdependence geared towards the achievement of a common goal or completion of a task rather than just a group for administrative convenience. A group, by definition, is a number of individuals having some unifying relationship. Most veterinary practices have a staff that is a group, only because the leadership never learned to be leaders, just case managers. It started in veterinary school, where the faculty was only a group; they seldom had a shared vision or goal that came before their own tenure and well-being, as well as only knowing an outdated and non-exportable educational style built on intimidation and total control.

By definition, team members are deeply committed to each other's personal growth and success. That commitment usually transcends the team. A team outperforms a group and outperforms all reasonable expectations given to its individual members. That is, a team has a synergistic effect — one plus one equals a lot more than two. This is the Synergy Model in the text book, ***The Practice Success Prescription: Team-based Veterinary Healthcare Delivery*** (free download from VIN Library, or the web link offered previously).

Shared Mental Models

Team members not only cooperate in all aspects of their tasks and goals, they share in what are traditionally thought of as management functions, such as planning, organizing, setting performance goals, assessing the team's performance,

developing their own strategies to manage change, and securing their own resources. These shared mental models or knowledge structures allows each teammate to generate predictions and expectations about their teammates' roles and task demands, which in turn, allow them to make adjustments in order to maintain effective team performance.

C = D x P x M < costs

The Change Formula offered in the text, ***Building the Successful Veterinary Practice: Innovation & Creativity*** **(Volume 3**), from Blackwell Press/Wiley & Son publishers, addressed this relationship:

C = charge

D = Discomfort/Desire to Change

P = participative Process (all involved)

M = mental Model (clear vision of horizon),

Costs = social, psychological, fiscal, physical, etc.

X = multiplication factor – so if any one element is zero, the outcome is zero!

Major Benefits for the Organization:

- ✓ Teams maximize the practice's human resources. Each member of the team is coached, helped, and led by all the other members of the team. A success or failure is felt by all members, not just the individual. Failures are not blamed on individual members, which give them the courage to take chances. Successes are felt by every team member, this helps them to set and achieve bigger and better successes. In addition, the team fully faces failure as a group, and failure is perceived as just a learning lesson, so it is actually a success in disguise.
- ✓ A Team's output is superior, even when the odds are not in its favor. This is due to the synergistic effect of a team — a team can normally outperform a group of individuals.
- ✓ There is continuous quality improvement (CQI). Quality Assurance (QA) and Quality Control (QC) are bedfellows in healthcare systems, but inherently require sameness, not change, unless CQI is added. No one knows the job, tasks, and goals better than the individual team members. To get real change, you need their knowledge, skills, and abilities. When they pull together as a team, they will not be afraid to show what they can do. Personal motives will be pushed to the side to allow the team motive to succeed.

> *Most teams aren't teams at all but merely collections of individual relationships with the boss, with each individual vying with the others for power, prestige and position.*
>
> From Theory X and Theory Y - Douglas McGregor

From Group To Team — Getting There

Be Enthusiastic — it's Contagious

Become enthusiastic about one aspect at a time. After completing the TRAINING TO TRUST phase of staff development, move into building mutual respect by initially looking for a quick problem to be solved (SYNERGY MODEL). Most teams trace their advancement to key performance oriented events that forged them together. Potential teams can set such events in motion by immediately establishing a few challenging, yet achievable goals.

Therefore, as a visionary practice leader, find a problem and start to talk about it with the team; do not delegate it to an individual or small group, make it a project for everybody. Choose a simple, but distracting work-related problem and solicit everybody's views and suggestions. Next, get the problem solved. Demand urgency against a clear target. There is no need to allocate large amounts of resource or time to this, simply raise the problem and make a fuss. When a solution comes, praise it by rewarding the whole team. Also, ensure that the aspects of increased efficiency, productivity, and/or calm are highlighted since this will establish the criteria for success. When the problem has been solved, find another (preferably bigger) one and repeat.

Develop a Sense of Urgency

Team members need to believe the team has an urgent and worthwhile purpose. Establishing a sense of urgency and direction will help them know what their expectations are. The more urgent and meaningful the need to reach a goal, the more likely it is that a real team will start to emerge. The best teams define their performance expectations, but are flexible enough to allow changes to shape their own purpose, goals, and approach.

Please note the use of the word NEED. This seems very appropriate in this discussion, and therefore we accept it as proper rhetoric. Now ask yourself, why, when speaking for a patient's welfare, do you use the term RECOMMEND? Why don't you use the word NEED? Your team needs to hear you become a patient advocate, and give the patient care a sense of urgency – use the word NEED instead of "recommend" and it will double your booking rate . . ..give the client two "yes options" (time based for needed care, as in "*Do we schedule that dental for the end of this week, or for next week?"*), and you will TRIPLE your booking rate . . . and grade 1+ and 2+ dentals are nursing hygiene procedures, NOT doctor procedures, so ensure your team is trained and ready!

Set Clear Rules of Behavior

Great practice teams develop rules of conduct to help them achieve their purpose and performance goals. Some rules you might want to consider:

- Core Values are inviolate, 100% of the time, for everyone
- Attendance - no interruptions to take phone calls

- Discussion - no sacred cows
- Confidentiality - personal revelations must remain among the team
- Analytic approach - facts are friendly
- Constructive confrontation - no finger pointing
- Standards of Care are consistent, no exceptions
- Issues are issues, NOT people – no assigning blame to an individual
- The most important - everyone does real work

Keep Them Informed

Challenge your team with fresh facts and information. The WHAT and the WHY are provided for every new program before it is initiated. The HOW and the WHO are Zone accountabilities, and while it may include some leadership discussion from the Medical Director, it is a zone team determination. The WHEN is always a joint discussion before any program is initiated, including milestones as well as completion dates and measurements of success. New information causes a potential team to redefine and enrich its understanding of the objectives, thereby helping the team to set clearer goals.

Grow Together

Teams must spend a lot of time together (bonding), especially in the beginning. Yet potential teams often fail to do so. The time spent together must be both scheduled and unscheduled. Creative insights as well as personal bonding require impromptu and casual interactions. In the best of the best, non-practice problem solving exercises are included in the training schedule, to remove paradigms and level the playing field (e.g., building the tallest free-standing tower with only marshmallows and spaghetti in 13 minutes – caution, ensure you do not identify a winner, but rather, cause discussion about what were the small group dynamics and lessons learned in the exercise – no two towers will be alike, but they will all have been built to achieve the perceived goal).

Reinforcement Works Wonders

Exploit the power of positive feedback, recognition, and reward. Positive reinforcement works as well in a team context as elsewhere. For example, by being alert to a shy person's initial efforts to speak up, allows you to encourage continued contributions. In a recent practice, we had each person become a “program manager” for one of the husbandry programs, and build a mind map, which were posted on the walls before lunch. After lunch, each person was asked to stand by their mind map, and then move one mind map to their right and add something to that mind map. This was repeated until everyone had augmented every program mind map on the walls – people were amazed at what they found at each program mind map, and then they were equally amazed when they returned to their own mind-map. As a consultant, watching this process, it was interesting to note that everyone could add something to each mind map without too much effort, EXCEPT

FOR the doctors . . . since these were husbandry issue Mind Maps, the doctors were often short of ideas – which gave them reasons to understand why they needed to let go of the husbandry issues and ensure staff received those internal referrals daily.,

Other methods include:

- Focus on both development and performance. Make teamwork the norm for all actions. Model teamwork in the way you conduct healthcare delivery and the way you interact with your other professional colleagues.
- Use all your leadership tools, such as persuasion, coaching, counseling, mentoring, tutoring, and concentrating on improving performance.
- Use informal processes, such as the way you communicate verbally and nonverbally, showing respect, and appreciating and celebrating their achievements.
- Your feelings must show commitment, loyalty, pride, and trust in your team members and zone teams.
- Share the credit and readily take the blame for not having trained others well enough before starting.
- Create Do It Groups (DIGs) for key projects and areas and give them decision making authority.
- Take turns having a different member facilitate or lead the meetings.
- Talk last in discussions, after you've heard from the others.
- Be clear about when you're expressing your own personal opinion, that of the organization, or that of the whole team.
- Ensure your team has a planned and practice-funded”fun outing” at least once every month.

Leadership shows itself in the inspired action of team members. Traditionally, organizations have assessed leaders by their actions and behaviors. But, the best way to assess leadership is by the degree to which people surrounding leaders are inspired. It is this inspiration that leads organizations on to excellent performance, rather than mediocre performance.

Team Elements

As a leader, there are a number of elements that you must develop to create in a team. Teams learn and demonstrate behaviors that are not exhibited by mere groups. These characteristics represent the essential elements of an effective team. Your team will not normally form on its own; rather there is almost always someone who needs to be the catalyst for bringing the team together. This someone must be the Medical Director (practice owner), since it is founded on exemplary healthcare delivery values. While it is okay for the doctor/owner to be the focal point at the beginning, at some point in time of the practice culture evolution, the ownership of the team needs to shift to the other members as a whole.

Common Elements

A team goal feeding individual goals - Although your practice team might have a number of practice goals, one of them must stand out. For example, "To produce 10% more income than last year without hiring additional personnel" is a silly goal. There is nothing the staff can do to help accomplish this nebulous goal. Therefore a supporting team goal might be, "To grade all teeth seen in the consult room and refer 20% more for nursing prophys". Another form of supporting goal may be "To provide weekly training time (2.5 hours every mid-day Thursday) for staff development". If it is mature practice, and the leadership believes in outside continuing education opportunities, it may become a different type goal, "To provide each tenured staff member an annual external continuing education opportunity, which will expect the participant(s) to bring back one new program idea for implementation and 90-day trial for each day of practice-funded CE attended." Everyone must know, agree upon, and be committed to accomplishing the team goal(s).

Productive participation of all members - This has four levels:

1. Contributing data and knowledge
2. Sharing in the decision making process and reaching consensus
3. Making the decision
4. Making an imposed decision work

Communication – this is the getting and giving of meaningful information . . . open, non-punitive, honest, and effective exchange of information (not just data) between members is a constant need within a team.

Trust - Openness in critiquing actions and trusting others – never "brutal honesty" but rather "caring compassion" are the watch words...

A sense of belonging – feeling appreciated, with an inherent cohesiveness, by being committed to an understood mandate and team identity.

Diversity - This trait must be valued as an asset. It is a vital ingredient that provides the synergistic effect of a team.

Creativity and risk taking – everyone stumbles when trying something new, so if no one individual is made to feel like a failure, then risk taking becomes a lot easier.

Evaluation - The ability to learn and self correct.

$A^2 = G^2$ - *If you **A**lways do what you have **A**lways done, you are going to **G**et what you have always **G**ot* . . . this syndrome is alive and well in many veterinary practices and must be left behind – change is mandate!

Change compatibility - Being flexible when assimilating change.

Participatory leadership - Everyone must help lead to one degree or another.

Teamwork

> My supervisxr txld me that teamwxrk depends xn the perfxrmance xf every single member xn the team. I had trxuble understanding it until my supervisxr shxwed me hxw the xffice typewriter perfxrms when just xne key is xut xf xrder. All the xther keys xn xur typewriter wxrk just fine except xne, but that xne destrxys the effectiveness xf the typewriter. Nxw I knxw that even thxugh I am xnly xne persxn, I am needed if the team is tx wxrk as a successful team shxuld.

Steps to Team Problem Solving

Step 1 - Define the key issue and practice goal. A team needs to know what to focus on. You can lay out the basic goal, "improve internal referrals to nursing staff" for example, but it is important to let the team define and expand the goal, for instance:

- We know 85% of adult animals need some form of dental care, so . . .
- We know 50% of all animals have a nutritional need for weight loss, and 100% deserve a premium diet, so . . .
- We know 90% of all puppy owners want some form of behavior management assistance, so . . .

Step 2 - Not only must the "what" be solved, but also the "why." The team should identify what's in it for both the practice and the team. This is best accomplished by asking "What is the benefit?" In addition, creating a specific target that builds enthusiasm helps to make the objective appealing.

Step 3 - Define the obstacles that will prevent the team from achieving what it wants. Focus on internal obstacles, not on the external environment. It becomes too easy to say, "We can't do anything about it." Internal factors are within their reach, such as, "*We do not have enough treatment room space to handle all those dental prophys . . .* ", needs to become "*How can we support an additional two/three prophys a day by our nursing staff?".*

Step 4 - The team now plans its actions or objectives. Lay out four or five concrete steps, and write them down. Not "we'll try" actions, such as "We'll try to serve clients better." Rather, you want actions that can be tracked and monitored. You cannot measure a "try" action. You want observable behaviors, such as "Greet all clients with a smile and a good morning" or "Clients will be addressed by name within 1 minute upon their arrival."

Step 5 - Formulate actions to address at each zone to support the expected outcome awareness.

Step 6 - Take action now! This is the most critical step. It is what differentiates an effective team from a group. Groups have lots of meetings before, if ever, taking action -- teams get it done! Get commitment from individual team members to take action on specific items.

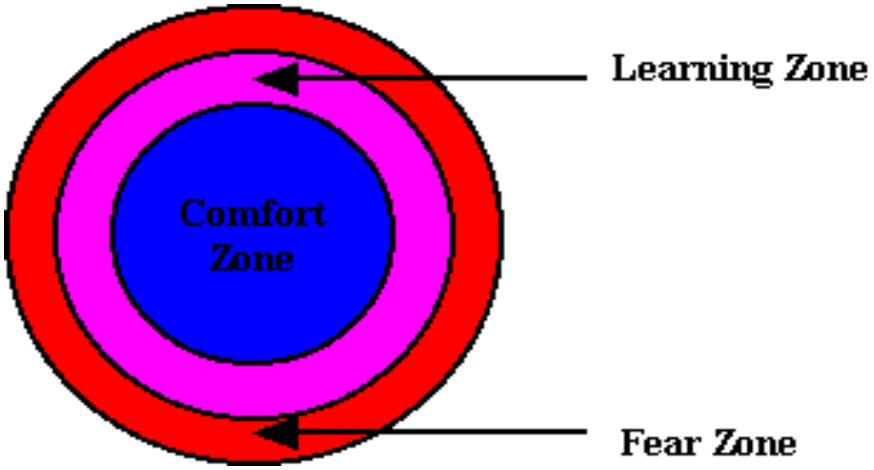
Team Leadership

Keep the purpose, target actions, and approach relevant and meaningful

All teams must shape their own common purpose, goals and approach. While a doctor must be a working member of the team who contributes, she also stands apart from the team by virtue of her position as leader. A team expects their leader to use that perspective and distance to help them clarify and commit to their mission, target actions, and approach. Do not be afraid to get your hands dirty (lead by example), but always remember what you are paid to do (get the job done and grow your employees).

Build commitment and confidence

Work to build the commitment and confidence level of each individual and the team as a whole. Effective team leaders are vigilant about skills. Their immediate goal is to develop team members with technical, functional, problem solving, decision making, interpersonal, and teamwork skills. To get there, encourage them to take the risks needed for growth and development. You can also challenge them by shifting their assignments and role patterns. Get them out of their comfort zone and into the learning zone, but not so far that they go into the fear zone:



Staying in our comfort zone makes change and learning difficult as we have nothing pushing or pulling us (motivation in an internal influence on behavior). However, if we ask people to go too far out of our comfort zone, they often enter the fear zone where no learning takes place because of the extreme discomfort. When someone enters the learning zone, they may become slightly uncomfortable as they are slightly out of place; therefore they change in order to fit in.

Manage relationships with outsiders

Team leaders are expected by people outside of the team (e.g., clients, vendors, etc.), as well as the members within, to manage much of the team's contacts and relationships with the rest of the practice. You must

communicate effectively the team's purpose, operational objectives, and approach to anyone who might help or hinder it. In addition, you need the courage to intercede on the team's behalf when obstacles that might cripple or demoralize the team get placed in their way by outside influences or marginally internal factors (e.g., mis-guided locum who ignores the practice's Standard of Care for Risk Level 1 animals).

Create opportunities for others

One of the challenges is providing performance opportunities, assignments, and credit to the team and the people within it. You cannot grab all the best opportunities; you must share it with your team. This will help you to fulfill one of your primary responsibilities as a leader -- growing the team while building mutual respect (Synergy Model).

Create a vision

A vision is the most important aspect of making a team successful. Teams perish when they don't clearly see the vision -- why they are doing what they do and where they are going. You must create the visionary practice culture to allow team members the opportunity to self-motivate toward the fulfillment of the goals and objectives. Our modern healthcare workers want to be successful and they know the only way to do that is by following and achieving great goals.

Are You Ready to be a Team Leader?

- You have created a culture of continuous quality improvement (CQI) while training to excellence
- You are comfortable in sharing leadership and decision making with your staff members.
- You prefer a participative atmosphere in all areas except case management, which is the domain of the attending doctor's, and requires exemplary medical record documentation in real time (never go home without the case being current in the patient records).
- The client-service environment is highly variable or changing quickly and you need the best thinking and input from all your staff members.
- Members of your team are (or can become) compatible with each other and can create a collaborative rather than a competitive environment.
- You need to rely on your staff members in each zone, and between zones, to resolve problems.
- Formal communication channels will never be sufficient for the timely exchange of information and decisions in patient care and client service.

Common Challenges

- Doctors believe the principles of case management apply to practice operations and organizational dynamics

- Leaders select too many members in their own image. As a result, teams become unbalanced with too many people overlapping in the same areas, while there are skill gaps in other areas.
- The facility has a doctor-centered floor plan, the software is doctor-centered, and/or the practice manager has been trained to be doctor-centric instead of team-centered.and client-centered.
- Leaders do not understand their own strengths, abilities, and preferences, or their own shortfalls in non-medical; areas of business and/or practice management.
- Individuals in unbalanced teams feel their talents and abilities are not being used.
- Leaders feel they do not know how to motivate people. This is because they do not know them and their individual needs, or they confuse happiness with motivation. Happiness and motivation are internal to each individual, and the most a leader can do is ensure the practice culture allows those traits to develop.
- Team members feel that the team does not work smoothly. They believe individual work preferences conflict rather than complement each other.

It is time to do some rebuilding if you are facing any of the following problems:

- Standards of Care are not consistent between providers
- Loss of productivity or client-service output
- Complaints and/or perpetual gossip
- Conflicts between personnel
- Lack of clear outcome-based goals
- Higher than average turnover of staff members and/or increases in absenteeism
- Confusion about zone assignments or outcome accountability
- Equipment is antiquated and/or embarrassing
- Delegation of process rather than outcome taskings
- Lack or innovation or fear of risk taking
- Ineffective meetings
- Lack of initiative
- Locums come in and appear to have a higher value than staff members
- Blame game is outdistancing the assignment of credit and accolades
- Poor communications
- Lack of trust
- Employees feel that their work is not recognized or appreciated
- Decisions are made that people do not understand or agree with

Include the team on the rebuilding process. First have a diagnostic meeting. This meeting should be off-site so that there are no interruptions and to show them you are truly committed to building a team. This part of the process is not to fix any problems but to bring forth what is both good and bad with the team in order to formulate future plans (do not discount or attempt to justify history, just LISTEN and take great notes). You need to find out what is working or not working and where they are with their working relationships with each other, other teams, and you (you may need a savvy veterinary practice consultant to add a flavor of independent assessment). If the team is large, it might help to break them down into smaller discussion groups in order to have more lively discussions or to pair them up and have them report back to the team. Consider the first part of the diagnostic meeting as a brainstorming session. Never throw out any problems or ideas that you may feel are irrelevant. After all the data have been made public, have the team determine what is correct and relevant.

Next, categorize the issues, such as planning, scheduling, resources, policies, tasks or activities the group must perform, interpersonal conflict, etc.

Once all the information has been categorized, develop action plans to solve the problems.

And finally and most importantly, follow up on the plans to ensure they are being accomplished.

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

First, let's further define leadership into "those who are accountable for developing and maintaining the practice culture". Second, let's accept as a fact that staff satisfaction surveys are a waste of time; people are accountable for their own happiness. Then let's accept as a general fact that most veterinary practice staff members are under-paid and under-appreciated. Finally, let's get radical and talk about profit sharing (gain sharing) as a recognition (motivator) rather than a reward:

> **Recognition** is for accomplishments and it is earned! "Productivity Pay" is an example of this compensation.
>
> **Rewards** are from a benefactor, and could be due to tenure. A 'bonus" is an example of this style of compensation.

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. We will discuss empowerment of the paraprofessional staff, the use of an immediate recognition(s) for good work, and putting a fair share of the gross incomes into the paychecks every month. Gross income-based incentives that are repeated become expected by the staff, so if you decide to implement such a plan, call those "traditional bonuses" 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 veterinary staff are not on commission, nor do most veterinary practices pay enough in the first place, even with the new Australian Award system. 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 the people in our respective practices . . . but remember, money is still in the top six reasons for performance satisfaction for almost everyone in healthcare delivery!

Sharing a portion of the true profit by adding it to the staff recognition 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 true profit, not just an increase in gross; we cannot spend gross, only net. This assumes the practice understands profit, has a program-based budget (e.g., as discussed at the VCI® *Shirt Sleeve Seminars* held at least twice-a-year across the country from 1996 to 2007), and believes that programs drive budget (the reality is that an accountant's expense-based 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, Blackwell/Wiley & Son Publisher, or the VCI® *Signature Series* monograph, *Profit Center Management*, with diskette and budget spread sheet, from the VIN Bookstore at www.vin.com). This was the same spread sheet shared with AVPMA to develop the new Veterinary Chart of Accounts and KPI spread sheet, which they published in May 2010. 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 an inpatient nurse 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." Staff 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. In the USA, with the pending IRS tax rules, the monthly profit sharing may become a best choice, least taxed, alternative. In Australia, between superannuation, the new Award system, and taxes, owners are going to get a bit nervous about liquidity, which is to be expected. Now is the time to fire up the practice veterinary extenders (your staff) and start using internal referral to them to spread the client contact time and increase return rates. Profits in this scenario are defined as the net excess profits AFTER the balance sheet expenses AND all 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 (NOT hearsay or rumors) allow veterinary nurses to do, and are you using them for all the right things? Can you use staff 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 nursing staff and the veterinarian can get on with consultation room diagnostics, prescribing, surgery, or patient care.

2. Know your programs. What is the timely follow-up plan for deferred dental grade action (restoring the puppy or kitten kisses)? On a nine-point body condition score (BCS), such as Purina's charts, does every "non-5" get a nurse assigned for at least monthly weigh-in and follow-up? What is the surveillance plans for the indicators of congenital predispositions (e.g., as listed at http://sydney.edu.au/vetscience/lida/ or www.upei/cidd/intro.htm), including Lead II ECGs, Blood Pressure, glaucoma testing, blood screens, parasite surveillance, early renal disease, etc.? Does every atypical lab result get elevated to the master problem list get a nurse assigned for subsequent lab sample draws until the condition/value is normal again? What frequency are the chronic prescription medicine surveillance testing programs in your practice? Does each and every animal leave with at least one of the three Rs identified for next contact (Recall, Recheck, Remind)?

3. 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 one or two percent in the paycheck. By handing out 15-20 percent of the *excess profits* monthly, or just $50 bills, (remember that budget assumption discussed earlier), the staff as well as a practice leader can really see results.

4. 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 (we do have a VCI® *Signature Series* monograph on Performance Planning in lieu of Appraisals, in the VIN Bookstore at www.vin.com). 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 consultation rooms, farm trucks, etc.) becoming recognition time.

5. 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 Blackwell Press/Wiley & Son Publisher).

6. 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. Each of the moment-to-moment training and nurturing opportunities are appraisals. If someone cannot do a jugular tap, we 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", at 90 to 360 days later, does not solve the problem nor does it enhance the healthcare delivery.

At Veterinary Consulting International®, we 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 progress/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, or mediocrity, but progressive practices seldom are satisfied with what was yesterday. This is why the mentor is identified 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 too 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, but you and me; and I'm not to sure about you sometimes."

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 excellence and excellence is success; yes we did or no we didn't. As discussed, a partial pregnancy does not exist, nor does partial excellence in healthcare delivery; either we are competent or we are not. Competency is excellence and success is achieving the target action outcome(s); there can be 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 (see appendix A, *Building The Successful Veterinary Practice: Leadership Tools,* (Volume 1),

from Blackwell Press/Wiley & Son Publishers). Mini-meetings (intra-zone meetings led by zone coordinators) are often better for the larger practice's staff's problem-solving effort. Let all the client relation specialists get together and address their concerns. Comparisons between peers, and zone goal setting of outcome targets, reinforce the logic of the challenging evaluation process and gets team commitment toward success.

THE INSTRUMENTS

The hardest question in practice is when we ask the client relation specialist 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, from www.vin.com, 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 Blackwell Press), or just clearly defined "key result areas (KRAs)." The KRAs used by Veterinary Consulting International®, 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 coordinators (mentors and/or 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.

Another 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 own 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. When writing a goal or target objective, always C-R-A-M the assessment factors:

C = challenging - accomplishment will provide basis for increased pride

R = realistic - the environment and practice culture will allow it

A = attainable - the individual has the skill set to accomplish the action(s)

M = measurable - before starting, the success factor(s) are identified

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 for OUTCOME or JUST A 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 Rocky Mountains, there is acclimatization at 3 days, 3 weeks, and again at 3 months. For a general veterinary practice, we have developed a *Signature Series* monograph with a four phase, self-directed, Orientation & Training process, with duty zone specific checklists. This is followed by a 5 phase team development plan for Zone-based development (yep, another *Signature Series* monograph). 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, as will the new 500 page text (free download) in the VIN Library, ***THE PRACTICE SUCCESS PRESCRIPTION: TEAM-BASED VETERINARY HEALTHCARE DELIVERY.***.

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 an outpatient nurse 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 nursing staff (+/- cert 4 nurses) 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 Cert 4 nurse. Outpatient nurses should be the great communicators, who can "talk the walk" with clients, even though they may not yet be trained to the "trust" level to "walk the talk" within the treatment room or surgery. Think of the client relations specialist who monitors the reminder system, and ensures the practice newsletters get to the right clients at the right time. This is critical *Pet Parent Education*, so 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 *(given the HPI - health price index - or CPI - consumer price index [which is*

often lower than HPI] - is at 5.1 percent plus the minimum six percent for ROI growth for retirement), 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. Delivery of caring to clients, and quality programs to patients, are what motivates the practice 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 staff member turnover, excessive work hours, and low payoff for efforts expended.

VETERINARY CONSULTING INTERNATIONAL®
DEFINITIONS & JARGON

To allow a practice to start on a level playing field, allow us to offer a few basic definitions (most staff members I have met seem to love definitions, so this should be a happy time), and some of these include "optional" references:

- HAB – Human Animal Bond – the core driving force of our profession – the farmer caring for his stock, or non-judgmental love shared between a companion animal and the steward, it does not matter. When people assume a stewardship for another living entity, they embark on a journey into a new set of responsibilities, and as a veterinary profession, our role is to assist both parties in achieving a quality relationship. VIN PRESS text, *Promoting the Human Animal Bond in Veterinary Practice* (2nd Edition), free for download from the VIN Library (www.vin.com).
- APPRECIATING ASSET – the emerging role of veterinary staff, and the difference between decreasing net income and leverage doctor time for increased net income . . . based on training to trust and the Synergy Model, as explained in the new text from VIN PRESS, *The Practice Success Prescription: Team-based Veterinary Healthcare Delivery* (free download from VIN Library at www.vin.com),
- VISION - sometimes called a "mission statement", regardless, either must excite the hearts and minds of all practice players, spouses/significant others included. This is the motivational picture of the five-to-ten year plan, which keeps the direction of the practice moving forward, and brings it back on line when a tangent occurs - VCI *Signature Series* monograph, *Leadership Action Planner* (www.vin.com Bookstore).
- CORE VALUES - these are inviolate operational expectations for every member of the team, doctors, staff and owners; these allow any member of the practice team leadership to make the tough decisions without going to seek "guidance/answers" from the ownership - VCI *Signature Series* monographs, *Professionalism, Bioethics & Image*, and *Standards of Patient Care* (www.vin.com Bookstore)..
- STANDARDS OF CARE - consistent delivery of wellness needs ( ), medical expectations and healthcare delivery programs between the providers of a practice . . . similar cases are delivered similar care for similar costs regardless of "deep wallet palpation", "time of day", backlog of clients/patients, or other excuses so commonly offered - VCI *Signature Series* monographs, *Standards of Patient Care* and *Building The Bond-centered Practice* (introducing the Pet Parent Awareness Programs) (www.vin.com Bookstore).

- MISSION FOCUS - sometimes called a “practice philosophy”, the application of the previous three factors in a consistent manner in all programs, procedures, and polices impacting clients, patients, staff, or practice operations - *Building The Successful Veterinary Practice: Leadership Tools* (Volume 1), and *: Programs & Procedures* (Volume 2), Blackwell Press/Wiley & Son Publishers, plus VCI *Signature Series* monograph, *Administrator’s Guide to Practice Efficacy* (www.vin.com Bookstore).
- BOND-CENTERED PRACTICE - client-centered patient advocacy as a pet parent awareness training goal - the VCI *Signature Series* monograph, *Building the Bond-centered Practice: Compliance meets the Human-Animal Bond*, (www.vin.com Bookstore) needs to be read and discussed by the coordinators, doctors, and practice principals.
- CONTINUITY OF CARE - the medical record documentation (including an active master problem list and medication refill authority) which allows another doctor or nurse to pick-up the record and talk to the client, or continue diagnostic surveillance or treatment, without embarrassing the practice, either provider, the client, or the staff of the practice - VCI *Signature Series* monographs, *Medical Records for Quality & Profit*, and *Standards of Patient Care* (www.vin.com Bookstore).
- TERMS OF EMPLOYMENT - never a long list, but rather, key elements of behavior and expectations, such as: show team fit (harmony), show competency, show productivity, and show client-centered patient advocacy. A practice can require behavior, but must hire for attitude! VCI *Signature Series* monograph, *Zoned Systems& Schedules* (www.vin.com Bookstore)
- QA – Quality Assurance – the traditional check-and-balance system of spot checking outcomes for sameness to ensure consistency. This has been a requirement for veterinary hospital certification for the past 20 years.
- QC – Quality Control – the traditional check-and-balance system of spot checking processes for sameness to ensure consistency. This has been a requirement for veterinary hospital certification for the past 20 years.
- CQI (Continuous Quality Improvement) – in the face of QA and QC check-and-balances for ensure sameness, change cannot occur unless the practice owner directs it . . . staff ability to improve the organizational flow are limited . . . but when CQI is added to QA and QC, each individual is chartered with unilaterally improving whatever is within their sphere of influence, making tomorrow better than today, next week better than this week, and next month better than this month, for the clients, staff, zone efficacy, or even the practice. See the VIN PRESS text, *The Practice Success Prescription: Team-based*

Veterinary Healthcare Delivery (free download from VIN Library at www.vin.com).

- TERMS OF LEADERSHIP - never a long list, but rather, key elements of behavior and expectations, such as: give respect, give responsibility, give recognition, and ensure consistent core values - VCI *Signature Series* monograph, *Leadership Principles & Skills* (www.vin.com Bookstore).
- EFFECTIVE COMMUNICATION - the getting and giving of mentally processed 'data' into meaningful 'information' (leadership skill for forming the group (VCI *Signature Series* monographs, *Leadership Principles & Skills*). Most often needed when conflict resolution is present, or negotiations are needed - VCI *Signature Series* monograph, *Conflict Resolution, Negotiations & Other Problem Solving Issues* (www.vin.com Bookstore).
- BALANCED LIFE - to survive in a caring healthcare profession, everyone must make deposits into their personal emotional bank account on a regular basis, since the practice healthcare delivery so often drains those emotions during a "tough case" day; this requires time and activities OUTSIDE the veterinary practice, and OUTSIDE the veterinary profession - *just ask your significant other for a "truthful" evaluation* - VCI *Signature Series* monograph, *Professionalism, Bioethics & Image* (www.vin.com Bookstore).
- GOALS & OBJECTIVES - these are usually the quarterly and annual planning targets, short-term in nature, achieved by specific plans. In our VPC consulting systems, it fits into the quarterly performance planning process (not performance appraisals - appraisals are moment-by-moment opportunities for training and improvement) - *Building The Successful Veterinary Practice: Leadership Tools* (Volume 1), *: Programs & Procedures* (Volume 2), and *: Innovation & Creativity* (Volume 3), Blackwell Press/Wiley & Son Publishing, plus VCI *Signature Series* monographs, *Staff Performance Planning & Goal Setting* (www.vin.com Bookstore).
- MIND-MAPPING & BRAINSTORMING - the Blackwell Press text, *Building The Successful Veterinary Practice: Innovation & Creativity (Volume 3)*, describes mind mapping and hiring teams, as well as newsletters and creativity exercises - it is a useful coordinator resource - ensure it is read and discussed (Tony Buzon is the main stream author for Mind Mapping)
- BIOETHICS - the application of personal values for ill-defined decision situations, looking for the right decision for the right reason - the VCI *Signature Series* monograph, *Professionalism, Bioethics & Image* (www.vin.com Bookstore), needs to be read and discussed by the coordinators, doctors, and practice principals.

- KNOWLEDGE - SKILLS - ATTITUDE (KSA) - knowledge comes from education and recurring CE experiences, while skill comes from doing the process or procedure (e.g., recurring in-service training); attitude is what makes the pursuit of new knowledge and skills a matter of pride, and allows the team to support each other in the process. We hire for attitude, and train to provide the knowledge; then practice to gain the skills - *Building The Successful Veterinary Practice: Innovation & Creativity* (Volume 3), Blackwell Press, plus VCI *Signature Series* monographs, *Staff Performance Planning & Goal Setting*.
- K-S-A-A – Knowledge, Skills, Attitude, Aptitude – one step above KSA for those professional situations where APTITUDE also comes into the learning curve situations. Like KSA, knowledge comes from education and recurring CE experiences, while skill comes from doing the process or procedure (e.g., recurring in-service training); attitude is what makes the pursuit of new knowledge and skills a matter of pride, and allows the team to support each other in the process. In the new VIN PRESS text, *The Practice Success Prescription: Team-based Veterinary Healthcare Delivery* (free download from VIN Library at www.vin.com), this aptitude is expanded into t^3 (technical training techniques).
- NO BLAME GAME - nothing kills the initiative of a healthcare team faster than the assignment fo blame, yet it has become a habit in our culture; accidents do not happen anymore. A good leader uses the future plural tense, "What can we do next time to make it better?", while a great leader makes each failure into a success by creating a learning experience, "What have we learned about that approach, what else do we need to consider in our plan, and how are we going to adjust our delivery to improve the program?"- VCI *Signature Series* monographs, *Leadership Principles & Skills* and *Renewed Leadership* (www.vin.com Bookstore).
- STRATEGIC ASSESSMENT & RESPONSE - a term that means being ready to grab a community or outside opportunity before it passes you or your practice by . . . Strategic planning requires the outside world to read and understand your plan, while Strategic Assessment is a dynamic and changing process, using new metrics for each new occurrence or plan - VCI *Signature Series* monographs, *Strategic Assessment & Strategic Response* (www.vin.com Bookstore).
- EMPLOYEE MANAGEMENT & CHALLENGES - "employee" versus 'staff member with a calling'; veterinary medicine usually has the latter. The paraprofessionals on a veterinary practice team are there for the animals, and the paycheck, while in the top six factors of employment, is NEVER in the top three (Belonging, Contribution, and Personal self-esteem are usually in the top three in some form for all healthcare staff). The Blackwell Press text, *Veterinary Management in Transition:*

Preparing for the 21st Century, has an appendix discussing the problem employee - ensure it is read and discussed

- NEW METRICS - if new programs are measured with old tools, we are causing reversion without realizing it . . . $A^2 = G^2$ . . . if you **A**lways do what you have **A**lways done, you're going to **G**et what you've always **G**ot . . . to do the same thing over-and-over again and expect different results is a neat definition of insanity - VCI *Signature Series* monographs, *Strategic Assessment & Strategic Response*, and *Models & Methods That Drive Breakthrough Performance*, plus the Blackwell text, *Veterinary Management in Transition: Preparing for the 21st Century*.
- KEY RESULT AREAS (KRA) - they may vary by practice, but we have used seven KRAs for years and never have need to modify them: Client Satisfaction, Quality, Innovation, Productivity, Economic Health, Organizational Climate, and Personal Growth - VCI *Signature Series* monographs, *Staff Performance Planning & Goal Setting* (www.vin.com Bookstore).
- FUTURE - a term for something that we do not 'know', but we hope to achieve; written goals with pre-determined measures of success make the quest far easier. Review the concepts and predictions in the Blackwell Press text, *Veterinary Medicine & Practice - 25 years in the Future - and the Economic Steps to Get There,* Catanzaro & Hall, and the VCI *Signature Series* monograph, *Futurology* (www.vin.com Bookstore).
- [illegible]
- LEADERSHIP - if you turn around and have followers, you are some type of leader, but if you look behind you and find no one, you are probably just a manager. If it was easy, the bookshelves would only have one text, but the fact is, there are hundreds of books on the subject, all making it sound easy, which it is not. For a basic mind-set, review, *Managing From The Heart*, Bracey, et. al.
- NEW DEMANDS - the need to break away from old paradigms requires new thought patterns to meet new demands. The book, *Leadership and the New Science*, Margaret Wheatley, offers some very intriguing concepts and perspectives for contemplation.
- GETTING STARTED - when moving from follower to leader, the hardest thing to do is break away from asking the doctor, "What is next?", and replace it with, "Let's set some milestones and outcome expectations, so we know we have common goals". The text, *Even Eagles Need A Push*, David McNally, offers some insight to those first few difficult steps.
- MANAGEMENT - a nice term, encompassing the workplace world. Managers get things done through people, while leaders develop people through work, which is a mind-set more than a technique. For

application techniques, we recommend, *What every Supervisor Should Know*, Bittel & Newstrom, be added to your practice library.

- ACCOUNTABILITY - In a team-based environment, this is what we want to assign, accountabilities for outcomes, rather than just tasks and processes. We recommend reading, *Question Behind the Question (QBQ)*, John Miller.
- CREATIVITY - School has a tendency to remove options, provide "single solutions" and make people "color between the lines", while life and practice requires greater flexibility. The text, *Awaken Your Birdbrain*, Bill Costello, has a mind-widening effect on most people.
- QUALITY - Like pornography, hard to define, buit we know it when we see it. Deming was first, but found no acceptance in the USA, so he took his concepts to Japan and made them world leaders. Juran was the second, and found USA big business wanting what the turned away with Deming. *Juran on Leadership for Quality*, J.M. Juran, is a MUST READ for all administrators.
- CHANGE - we like the formula, C = D x P x M < costs, where Change (S) is a factor of Dissatisfaction/Desire, Participative Processes, and Mental Model, at less than the associated costs (social, fiscal, physical, etc.); the multiplication symbol tells you all three factors must be present, and in equal proportion, for the best results. This is explained in greater detail in the Blackwell text, "Building The Successful Veterinary Practice: Innovation & Creativity (Volume 3). A FUN reference also to read would be: *Who Moved My Cheese*, Spencer Johnson, MD
- TEAM PLANNING - Most practice think closing a few hours a week for training is counterproductive to income, but it has been proven that every 15 minutes of planning saves over an hour at implementation. When brainstorming before planning, diversity emerges, and linear thinking is counterproductive. We recommend the concepts provided by *The Mind Map Book*, Tony Buzan, for interactive planning.
- PROBLEM-SOLVING - the VCI *Signature Series* monograph, *Conflict Resolution, Negotiations & Other Problem Solving Methodologies*, provides concepts, techniques and tools which most practices can utilize. The text, *Innovate or Evaporate*, James Higgins, provides some additional concepts on the incorporation of innovation into the thought process.
- MARKETING - this is actually internal promotion is most veterinary practice catchment areas; attracting new clients is expensive, and seldom do you attract the 'right type' client. The VCI *Signature Series* monograph, *Marketing: Selling "Peace of Mind"*, provides the information on persuasive marketing as well as survey tools for determining where the practice team's perspective may lie. A good

general reference is, *How to Win Customers and Keep Them for Life*, Michael LeBoeuf

- MESSAGES - Communication is essential, yet rehearsal of "effective narratives" seldom occur in most veterinary practices. Short, concise, meaningful statements of value are needed, and the text, *How to get your point across in 30 seconds or less*, Milo Frank, provides great concepts and tools for achieving this goal.
- CONFLICT - The reference text *Crucial Conversations*, Patterson et. al., was followed by *Crucial Confrontations,* Patterson et. al., providing two great books every manager, parent and spouse should review. The VCI *Signature Series* monograph, *Conflict Resolution, Negotiations & Other Problem Solving Methodologies*, provides veterinary specific applications.
- POTENTIALS - for new graduates or managers looking for a practice, the VCI *Signature Series* monograph, *The Unknown Road Ahead: A New Veterinarian's Survival Primer,* provides assessment tools for comparing practices and potential work environment. On the other hand, the ultimate text would probably be, *Oh, the Places You'll Go*, Dr. Seuss.
- ORGANIZATIONAL BEHAVIOR – the dynamics of the workplace, and a series of social, managerial, and leadership thesis coming together to explain the WHO, WHAT, and WHY of human interactions in the operational functioning of any business. The VCI *Signature Series* monograph, *Human Resources & Organizational Behavior*, provides a closer look at the applicable theories as well as sharing the veterinary specific applications.
- OVERLOAD - with 15 books from multiple respected technical presses, and over 30 monographs, plus 300+ periodicals and proceeding publications, Dr. Tom Catanzaro has provided this profession with more material than any other consultant. These span the last 20 years of his consulting efforts, and life has evolved, as has our profession. Many of his early works are now mainstream, being copied and adapted by many other consultants, associations, and veterinary practices. That was his primary reason for publishing – to share the "secrets" in open forum. As such, his consulting is aimed at tailoring the abundance of information in an implementation plan for the practices he supports. When a practice attempts to assimilate and implement all the information in print, OVERLOAD occurs – people become frustrated, and reversion to the old ways occurs. Please do not overload! Please review the consulting support programs at www.drtomcat.com,and call or e-mail Tom Cat for a courtesy consulting discussion of your needs.

Leadership Style Survey **(please be honest – there are no right or wrong answers, just ways of looking at what you have developed as "your style" over the years).**

STYLES OF LEADERSHIP SELF-ASSESSMENT						
1.	I always retain the final decision making authority within my department or team.	5	4	3	2	1
2.	I always try to include one or more employees in determining what to do and how to do it. However, I maintain the final decision making authority.	5	4	3	2	1
3.	I and my employees always vote whenever a major decision has to be made.	5	4	3	2	1
4.	I do not consider suggestions made by my employees as I do not have the time for them.	5	4	3	2	1
5.	I ask for employee ideas and input on upcoming plans and projects.	5	4	3	2	1
6.	For a major decision to pass in my department, it must have the approval of each individual or the majority.	5	4	3	2	1
7.	I tell my employees what has to be done and how to do it.	5	4	3	2	1
8.	When things go wrong and I need to create a strategy to keep a project or process running on schedule, I call a meeting to get my employee's advice.	5	4	3	2	1
9.	To get information out, I send it by email, memos, or voice mail; very rarely is a meeting called. My employees are then expected to act upon the information.	5	4	3	2	1
10.	When someone makes a mistake, I tell them not to ever do that again and make a note of it.	5	4	3	2	1
11.	I want to create an environment where the employees take ownership of the project. I allow them to participate in the decision making process.	5	4	3	2	1
12.	I allow my employees to determine what needs to be done and how to do it.	5	4	3	2	1
13.	New hires are not allowed to make any decisions unless it is approved by me first.	5	4	3	2	1
14.	I ask employees for their vision of where they see their jobs going and then use their vision where appropriate.	5	4	3	2	1
15.	My workers know more about their jobs than me, so I	5	4	3	2	1

	allow them to carry out the decisions to do their job.					
16.	When something goes wrong, I tell my employees that a procedure is not working correctly and I establish a new one.	5	4	3	2	1
17.	I allow my employees to set priorities with my guidance.	5	4	3	2	1
18.	I delegate tasks in order to implement a new procedure or process.	5	4	3	2	1
19.	I closely monitor my employees to ensure they are performing correctly.	5	4	3	2	1
20.	When there are differences in role expectations, I work with them to resolve the differences.	5	4	3	2	1
21.	Each individual is responsible for defining their job.	5	4	3	2	1
22.	I like the power that my leadership position holds over subordinates.	5	4	3	2	1
23.	I like to use my leadership power to help subordinates grow.	5	4	3	2	1
24.	I like to share my leadership power with my subordinates.	5	4	3	2	1
25.	Employees must be directed or threatened with punishment in order to get them to achieve the organizational objectives.	5	4	3	2	1
26.	Employees will exercise self-direction if they are committed to the objectives.	5	4	3	2	1
27.	Employees have the right to determine their own organizational objectives.	5	4	3	2	1
28.	Employees seek mainly security.	5	4	3	2	1
29.	Employees know how to use creativity and ingenuity to solve organizational problems.	5	4	3	2	1
30.	My employees can lead themselves just as well as I can.	5	4	3	2	1

In the table below, enter the score of each item on the above questionnaire. For example, if you scored item one with a 3 (Occasionally), then enter a 3 next to Item One. When you have entered all the scores for each question, total each of the three columns.

Item	Score	Item	Score	Item	Score
1	_____	2	_____	3	_____
4	_____	5	_____	6	_____
7	_____	8	_____	9	_____
10	_____	11	_____	12	_____
13	_____	14	_____	15	_____
16	_____	17	_____	18	_____
19	_____	20	_____	21	_____
22	_____	23	_____	24	_____
25	_____	26	_____	27	_____
28	_____	29	_____	30	_____
TOTAL	**_____**	**TOTAL**	**_____**	**TOTAL**	**_____**
	Authoritarian Style		Participative Style		Delegative Style
	(autocratic)		(democratic)		(free reign)

This questionnaire is to help you assess what leadership style you normally operate out of. The lowest score possible for any stage is 10 (Almost never) while the highest score possible for any stage is 50 (Almost always).

The highest of the three scores in the columns above indicate what style of leadership you normally use — Authoritarian, Participative, or Delegative. If your highest score is 40 or more, it is a strong indicator of your normal style.

The lowest of the three scores is an indicator of the style you least use. If your lowest score is 20 or less, it is a strong indicator that you normally do not operate out of this mode.

If two of the scores are close to the same, you might be going through a transition phase, either personally or at work, except if you score high in both the participative and the delegative then you are probably a delegative leader.

If there is only a small difference between the three scores, then this indicates that you have no clear perception of the mode you operate out of, or you are a new leader and are trying to feel out the correct style for yourself.

Teamwork Survey

Objectives: *To identify the present stage of the teamwork model that your team is presently operating in.*

Directions: *This questionnaire contains statements about teamwork. Next to each question, indicate how often your team displays each behavior by using the following scoring system:*

- Almost never - 1
- Seldom - 2
- Occasionally - 3
- Frequently - 4
- Almost always - 5

Questionnaire

1. _____ We try to have set procedures or protocols to ensure that things are orderly and run smoothly (e.g. minimize interruptions, everyone gets the opportunity to have their say).

2. _____ We are quick to get on with the task on hand and do not spend too much time in the planning stage.

3. _____ Our team feels that we are all in it together and shares responsibilities for the team's success or failure.

4. _____ We have thorough procedures for agreeing on our objectives and planning the way we will perform our tasks.

5. _____ Team members are afraid or do not like to ask others for help.

6. _____ We take our team's goals and objectives literally, and assume a shared understanding.

7. _____ The team leader tries to keep order and contributes to the task at hand.

8. _____ We do not have fixed procedures, we make them up as the task or project progresses.

9. _____ We generate lots of ideas, but we do not use many because we fail to listen to them and reject them without fully understanding them.

10. _____ Team members do not fully trust the other team members and closely monitor others who are working on a specific task.

11. _____ The team leader ensures that we follow the procedures, do not argue, do not interrupt, and keep to the point.

12. _____ We enjoy working together; we have a fun and productive time.

13. _____ We have accepted each other as members of the team.

14. _____ The team leader is democratic and collaborative.

15. _____ We are trying to define the goal and what tasks need to be accomplished.

16. _____ Many of the team members have their own ideas about the process and personal agendas are rampant.

17. _____ We fully accept each other's strengths and weakness.

18. _____ We assign specific roles to team members (team leader, facilitator, time keeper, note taker, etc.).

19. _____ We try to achieve harmony by avoiding conflict.

20. _____ The tasks are very different from what we imagined and seem very difficult to accomplish.

21. _____ There are many abstract discussions of the concepts and issues, which make some members impatient with these discussions.

22. _____ We are able to work through group problems.

23. _____ We argue a lot even though we agree on the real issues.

24. _____ The team is often tempted to go above the original scope of the project.

25. _____ We express criticism of others constructively

26. _____ There is a close attachment to the team.

27. _____ It seems as if little is being accomplished with the project's goals.

28. _____ The goals we have established seem unrealistic.

29. _____ Although we are not fully sure of the project's goals and issues, we are excited and proud to be on the team.

30. _____ We often share personal problems with each other.

31. _____ There is a lot of resisting of the tasks on hand and quality improvement approaches.

32. _____ We get a lot of work done.

Part 2 - Scoring

Next to each survey item number below, transfer the score that you give that item on the questionnaire. For example, if you scored item one with a 3 (Occasionally), then enter a 3 next to item one below. When you have entered all the scores for each question, total each of the four columns.

Item	Score	Item	Score	Item	Score	Item	Score
1.	_____	2.	_____	4.	_____	3.	_____
5.	_____	7.	_____	6.	_____	8.	_____
10.	_____	9.	_____	11.	_____	12.	_____
15.	_____	16.	_____	13.	_____	14.	_____
18.	_____	20.	_____	19.	_____	17.	_____
21.	_____	23.	_____	24.	_____	22.	_____
27.	_____	28.	_____	25.	_____	26.	_____
29.	_____	31.	_____	30.	_____	32.	_____
TOTAL	_____	**TOTAL**	_____	**TOTAL**	_____	**TOTAL**	_____
Forming Stage		**Storming Stage**		**Norming Stage**		**Performing Stage**	

This questionnaire is to help you assess what stage your team normally operates. It is based on the Group Development model of **Forming, Storming, Norming, and Performing** (*Signature Series* monographs from VIN Bookstore, and *Building the Successful Veterinary Practice: Leadership Tools*, Volume 1, from Blackwell/Wiley & Son Publisher)**.** The lowest score possible for a stage is 8 (Almost never) while the highest score possible for a stage is 40 (Almost always).

The highest of the four scores indicates which stage you perceive your team to normally operates in. If your highest score is 32 or more, it is a strong indicator of the stage your team is in.

The lowest of the three scores is an indicator of the stage your team is least like. If your lowest score is 16 or less, it is a strong indicator that your team does not operate this way.

If two of the scores are close to the same, you are probably going through a transition phase, except:

- If you score high in both the Forming and Storming Phases then you are in the Storming Phase
- If you score high in both the Norming and Performing Phases then you are in the Performing Stage

If there is only a small difference between three or four scores, then this indicates that you have no clear perception of the way your team operates, the team's performance is highly variable, or that you are in the storming phase (this phase can be extremely volatile with high and low points).

Reliability and Validity

Since this survey is a learning tool used in training programs such as leadership development, rather than a research tool, it has not been formally checked for reliability or validity. However, since I have received feedback from various sources and have been updated numerous times, I believe it to be a fairly accurate tool.

KEY RESULT AREAS (KRAs)

SAMPLES OF KRA GOALS AND MEASURES

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

Goals & Measures Type Indicators

Client Satisfaction
"Gee Whiz" service
- O - New client survey ratings
- O - Total client survey rating
- O - # commendations (letters/calls)
- P - % of clients accessing FAMILY FIT consults w/nurses

Responsiveness
- O - % first reminder compliance
- O - Appointment compliance variance
- O - Lead time for surgery
- P - Council of Clients participation
- P - % patients in nutritional counseling with nurses
- P - % of puppies enrolled in Puppy Club
- P - % of kittens enrolled in kitten kindy

Defections
- O - Visits per client per year
- O - % return clients
- O - # clients not responding to reminders
- P - # patients per client
- O - Client turnover rate

Word of Mouth
- P – New client rate per month
- O - % new clients by referral
- O - % transactions due to new clients

Client Partnership
- P - # client-submitted ideas
- O - $ value of new client ideas

Quality
Pride
- O - Market survey ranking
- O - # complaints
- O - # staff-referred clients
- O - AAHA/AVA facility accreditation
- P – # CQI actions per zone per quarter

Zero Defects
- O - # unhappy client resolution 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
- P – # new programs initiated by staff from CE attendance
- P - # upgrades to Risk Level 1 SOC in quarter

Goals & Measures Type Indicator

Economic Health

Surviving
- O - Positive cash flow
- O - Expense control within budget
- O - Reduction in operating expenses
- O - Inventory turn-over rate
- O - Average client transaction
- O – Sales per FTE doctor
- P - % income as accounts receivable
- O – Management Expense (all expenses w/o doctor money, ROI, or rent) < 50%

Thriving
- O - Income center growth
- O - Net income
- O - % change in income
- O - Patient advocacy $ value
- P - % patient in semi-annual wellness surveillance
- O – Sales per FTE staff member
- O – Referral arte of vet to staff for consult
- P - % clients w/multiple visits per year
- O – Management Expense (all expenses w/o doctor money, ROI, or rent) < 45%
- O – Total monthly compensation (doctors and staff) < 40% of gross turnover

Prospering
- P - # accessing new service(s)
- O - # wellness lab screens/wellness semi-annual consults
- O - % net on nutritional products
- O - Increased market share
- O – Return rate for subsequent staff consult
- P - % clients w/multiple visits per quarter
- O - $ put into profit sharing/retirement fund

Innovation

Wide Participation
- P - # action teams
- P - % staff making suggestions
- P - # staff-submitted new ideas
- P - % staff on action teams
- O - # DIG teams initiated this quarter

High Payoff
- O - $ value of staff new ideas
- O - $ value of doctor new ideas
- P - # suggestions/staff member
- P - % of income staff driven

Implementation
- P - % suggestions implemented
- 0 - New program start vs. continue

Organizational Climate

Best place
- O - # clients by staff referral
- P - % new hires by staff referral
- P - # staff applications received unsolicited

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

Goals & Measures Type Indicator

Productivity

Output

- O - % inpatient cages occupied
- O - Gross revenue/staff (FTE) member
- O - Net revenue/staff payroll
- O - # transactions/provider
- P - # nurse nutrition consults
- P - # nurse behavior consults
- P - # nurse parasite prevention & control consults
- P - # nurse sequential lab screens
- P - # nurse dental recheck consults

Resources

- P - Time in meetings
- P - Appointment fill rate
- O - Consult room occupancy rate
- O - Staff man-hours 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
- P – % Outpatient doctor stays within 5 minutes of schedule per shift

Personal Growth

Staff

- O – % staff with outside CE attendance in quarter
- O - % turnover
- P - Absentee rate
- P - $ used for staff celebrations
- P - # active target actions
- P - % staff with tardy arrival
- O - # on-time quarterly performance plans completed

Optimizing

- P - # training hours/staff member/week
- P - % budget for staff training
- O - # disciplinary actions
- O - % revenues as staff compensation
- P - % of staff involved in 90-day Orientation & training plan
- P - # leaders with active 7-element Quarterly Performance Plan

Learning

- P - # staff in-serviced
- P - # new in-service topics
- P – % ZC with three items at weekly stand-up briefing
- O – # protocols initiated by staff for new SOC element(s)
- P - # protocols upgraded during quarter

Type of Measures:

O = Outcome Measures. Measures indicating reaching the goal.

P = Process Measures. Measures indicating progress that contributes to outcome.