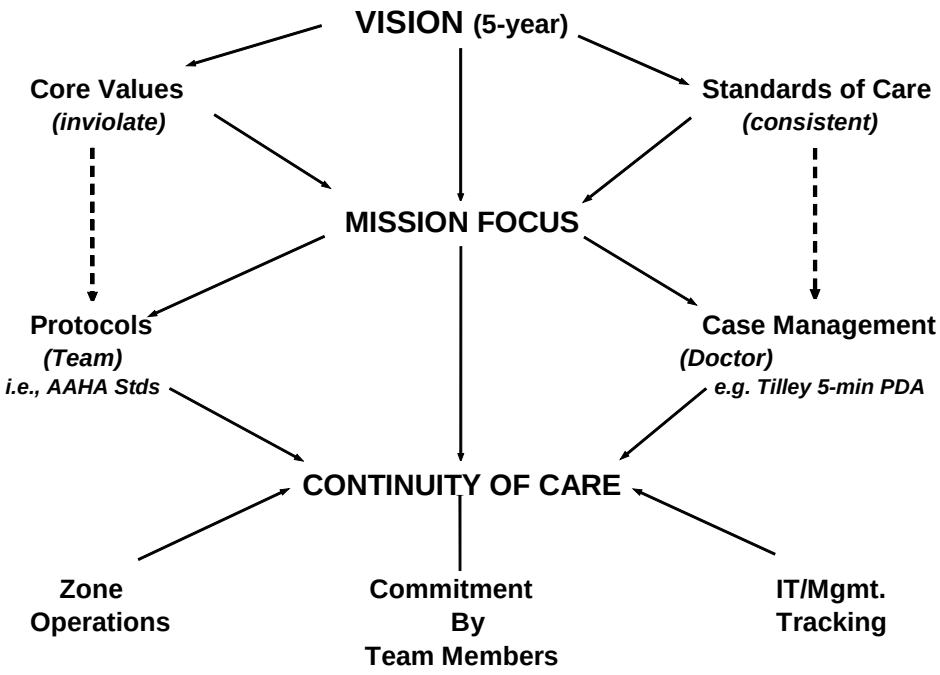
THE UNCOMMON LEADER FOR VETERINARY PRACTICES

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

Leadership Impact on Practice Flow



Reference: *Practice Operations,* VCI *Signature Series* Monograph

The above diagram is provided to show an expected "leadership flow" that has often been leadership neutral (assumed to be in place, but not obvious to the practice team) in veterinary medicine - now for a few key facts which might have been missed:

Savvy Practices are no longer doctor-centered. Regardless of practice size, savvy practice owners are leveraging their doctor time with a team of dedicated and trained staff members who understand client-centered patient advocacy (speak for what the patient NEEDS, but listen carefully to what the client says).

The Human-Animal Bond (HAB) is alive and well, but all too often, it is done as "lip service" to the theory of the HAB in the traditional veterinarian-centered companion animal practice, by those who have done very little to recognize it in the eyes of the client or staff members (e.g., Fear Free practice culture). I have published on the HAB, and stressed team-based healthcare delivery programs in the 26 appendices (available from the VIN Library, www.vin.com, as a FREE download). As we have progressed, the HAB effort became redefined as a client-centered practice bond, an expected transition

since the client has the money, not the patient. Now I have updated the VCI *Signature Series* Monograph, *The Bond-centered Practice*, to focus on a patient-centered practice, featuring a FEAR FREE practice philosophy, and the new version (2013) is now available from the VIN Bookstore, www.vin.com).

Core values are inviolate, that means, never an exception, regardless of who you think you are or what your power may be in the greater scheme of life forces. The staff must be able to depend on the Core Values when making operational decisions (without "bugging" the boss) for the good of the practice.

Mission Focus is an internal aspect of the Mission Statement (also could be a Vision Statement, which usually places the practice into the grand scheme of community evolution and support). The Mission Focus is a concise statement of caring which can be placed atop each and every program and product, and used to validate doing the right thing at the right time for the right reason and at the right price (professionalism, ethics & bioethics all come into perspective in this manner).

Doctors MUST BE Leaders! Sure, all the coordinators and managers must be leaders, but to create a "safe haven" for the staff, each and every doctor must accept they have a critical role in leadership, consistent Standards of Care compliance, and caring practice harmony. Concurrently, the **Standards of Care** (SOC) must be in writing, with the WHAT and WHY stated in a very consistent manner for every member of the team to understand and adopt. In practice, the SOC elements are recorded in the medical record as a "need", and clients are allowed to OVERTLY waive (W), defer (D), make an appointment (A), or decide to do it (X), which are also entered into the medical record after the need. If the wellness Standards Of Care (SOC) are variable, clients often get confused (and they go elsewhere) and staff gets frustrated (and they go elsewhere). Practices need to keep their initial Standards of Care efforts to wellness surveillance, preventative medicine and practice protocols, NOT case management, diagnostics or doctor prioritization of treatment modalities.

In the practice flow, protocols (the WHO and HOW, stemming for the SOC and established operational guidelines) allow routine work to be systemized and approved by the staff. **Protocols belong to the team**, and cannot be unilaterally changed by any one individual. The new AAHA Standards for Certification provide a great starting point.

Effective case management is why doctors went to school for so long; they tailor the healthcare plan (we used to call these 'estimates', so we could confuse our clients with price instead of value) to the patient's needs. In acute curative case management, the doctor may decide to waive (W) or defer (D) some wellness items, which will again be OVERTLY recorded in the medical record, so any member of the team can pick up the case and not embarrass the previous provider, themselves, the practice, or the client. In case management, only the attending doctor alters the healthcare plan, unless the case in transferred to another doctor.

Continuity of Care means all medical records are written for the next person, not just for reminding the attending doctor or attending nurse/technician of some patient needs or case aspects. Continuity of care means similar care for similar cases at a similar fee

HINT: *case management is a doctor's requirement for full brain engagement, while protocols belong to the team, and cannot be covertly altered by any doctor.*

Three elements act as check and balances to the **Continuity of Care** of a quality healthcare delivery system:

- **Zone Operations** - the is where staff have clear duty site job descriptions and standards, within their specific zone, and are accountable for the outcomes (that means that can reallocate the duties and process to ensure quality improvement is continuous)
- **Individual Commitment** - doctors and staff, from the management to the animal caretakers, are usually committed to their calling and must be equally committed to practice vision, core values, and standards of care. They must fully embrace the protocols and support the case management healthcare plan. Each provider must respect one another, have pride in their performance and continually strive to improve their personal competency and the quality of healthcare delivery within the client-centered patient advocacy mission focus of the practice.
- **IT/Management Tracking** - computers are only as good as the data being input, and output data is only as good as the skill of the leadership in aligning programs and procedures to client and patient needs. The text, *Managing from the Heart*, Bracey, et. al., is a great place to start reviewing the leadership approach; Milo Frank's text, *How to Get Your Point Across in 30 Seconds or Less*, provides a great "thought organizing" protocol; and *Crucial Conversations*, Patterson, et. al., is an outstanding communication techniques text.

Respect for schedules, coordinators and zone operations, as well as clear identification of the expected outcome(s) (including staff training and empowerment for responsibilities and/or accountabilities, rather than just process), is a function of leadership, and every doctor is expected to embrace these principles at all times. So the next question in developing great leadership is "why is it so hard?"

THE ANSWER

Why is developing great leadership so hard? Because every doctor was taught case management in veterinary school and NOT leadership. There is no training in the curriculum for leadership, and by definition, most academic professors have NO EXPERIENCE is team leadership, or even developing practice teams for that matter.

Practice owners need leadership training, and while a few consultants have been trained in leadership, most are just conveying didactic principles that have worked elsewhere. Conferences with leadership speakers are not a substitute for practical practice leadership training. My first text, *Building the Successful Practice: Leadership Tools* (Volume 1), Blackwell/Wiley& Sons, was an attempt

to increase awareness of the leadership systems needed in practice, and listed a skills set in Appendix B developed from the programs I have attended, taught and written. The following is a Leadership Model I have used to show the relationships and interactions:

SYNERGY LEADERSHIP MODEL

THE SYNERGY FACTOR		
People with titles start here ↓		
TANGIBLES: Clinical & business processes account for 35 percent of organizational performance	**Financial Performance** **Safety, Bioethics, Ethics** **Clinical Quality (SOC)**	These three elements result from living the ➢ Strategic Action Plan ➢ Zone protocols ➢ Program-based budget
Bridge between tangibles & intangibles	↕ **SYNERGY** ↕	The "magic factor" of the organization
INTANGIBLES: Human relations account for 65 percent of organizational performance	**Harmony/Team Fit** **Pride in Performance** **Mutual Respect** **Train to Trust**	These four elements are the source of a sense of purpose and meaningful work as a result of living the vision, values, and practice mission focus.
↑ Real Leaders Begin Here		

Reference: *The Next Level Of Renewed Leadership,* VCI *Signature Series* Monograph

The above Model shows that the tangibles rest on the intangibles. The intangibles support the tangible gains. Without the synergy bridge (organization spirit), the four intangibles and three tangibles become just seven "observed" factors of a successful organization. The neophytes center on the tangibles. They are easy to measure, while most people who "know the words", but do not understand the dynamics, only address the intangibles at the time of crisis. The

tangibles are very important, they are the fruit of dedicated people working hard to be the very best. It is the savvy leader who understands that quality fruit can only grow from healthy seeds, which represent the intangibles.

The above model has been a long time coming to veterinary medicine. Current research by the American College of Healthcare Consultants shows that only 35% of a program success is affected by the tangibles, while 65% is impacted by the intangibles. Concurrent research in American white collar work environments show that "boss initiative" have a 30 percent success rate, while "staff-based initiatives" have an 80 percent success rate. It is the healthcare commitment of employees that gives practices a bit of an edge over the white collar workplace, but the differences are similar enough to understand the syndrome we are seeing. Doctor-centered practices are counterproductive for continued growth and quality of life to co-exist.

Consider the existing tangibles our profession uses for Financial Performance: models of NCVEI, Veterinary Economics, AVMA surveys and AAHA. In most all cases, averages abound. An 'average' is simply "the best of the worst" or the "worst of the best"; in either case, it means striving for mediocrity if you use an 'average' as your yardstick. The Clinical Quality was most recently defined in the AAHA Compliance Study (2003 and again in 2006), a landmark survey showing the average doctor was missing a potential income of over $630,000 a year because of inconsistent delivery of wellness needs for the patients in their care. AAHA called their survey a 'compliance study', but any knowledgeable reader assessing the details understood immediately it was NOT client compliance, but rather, provider compliance; consistent Standards of Care within the practice's healthcare delivery system(s).

COMPLIANCE vs ADHERENCE

Compliance has been defined as what you can control within your own team and within your own practice.

Adherence has been defined as that which the client does in response to the healthcare provider statement of needs.

The **Joint Commission** has differentiated these two terms in human healthcare facilities across the United States

There is an assumed aspect of this new KPI quest, and that is that there is a paired Veterinary Chart of Accounts system in effect (e.g., Appendix F, *Building the Successful Veterinary Practice: Programs & Procedures* (Volume 2), which is an expanded version of the original AAHA Veterinary Chart of Accounts, or the AVA Veterinary Chart of Accounts (May 2010), which was an adaptation of the

above mentioned Appendix F). It is important to accept that "Management Accounting" (e.g., QuickBook, My Money, Xero, etc.) provides real time data for decision making, while "Tax Accounting" by the practice accountant is a delayed data stream following tax reporting requirements).

NEW LOOK AT KEY PRACTICE INDICATORS (KPIs)

Now that we have your attention, let me ask you how many of the following factors are tracked monthly (or quarterly) in your practice for savvy leadership decisions and staff coaching efforts:

- Sales per FTE team member (quarterly is best)
- Consult Room Booking Rate (not doctor booking rate)
- # Assymerty Exams Recorded per # patient transactions
- Number of Abnormals with CR- recorded to # patient transactions
- # of patients with pre-emptive pain scores per 100 patient transactions
- SOC Compliance Rate (X-A-D or W recorded for each “need” [CR-__]) . . . X = do it now; A = appointment made; D = deferred [until when?]; W = waived (no belief by client)
- Percent of patients leaving with at least 2 of the 4 Rs recorded (**R**ecall, **R**evisit, **R**emind, and **R**esolved)
- Percent of patients with active pet insurance policies
- Percentage Revisits assigned to attending nurse/technician
- # patient transactions to # Ortolani/Penn Hipp => # of JPS
- Telephone Shopper Conversion Rate to Client Visit
- Percent of outpatients with Blood Pressure Recorded (e.g., PetMap)
- Number of questionable BP patients admitted or brought back for further evaluation
- Number of Training Hours made available each week
- Percent of patients with pre-emptive pain score in medical records
- I.V. TKO [IOF] vs Anesthesia rate
- Percentage of atypical pre-surg blood screens brought back for follow-up
- Rate of Post-anesthesia SMS Photo Sent per anesthetic procedures
- # of Dental Scores per # of patient transactions
- Dentals booked per patient transactions (85% is maximum predicted)
- # of Dental X-Ray procedures performed per other-than-zero dental grades
- # of BCS per # of patient transactions
- Non-5 Body Condition Scores (BCS) per patient transaction rate – about 50% is maximum expected (Purina 9-point system)
- Non-5 BCS referred to nutritional advisor (Purina 9-point system)
- Return rate for nutritional advisor review of Non-5 BCS (Purina 9-point system)

- Number of FNAs
- Number of quarterly STT rechecks by attending nurse/technician
- Number of semi-annual wellcare consults conducted
- Number of wellcare consults with surveillance blood or urine screening
- Number of surveillance lab screens brought back for atypical evaluation
- Number of Family Fit Behavior Consults by nursing/technician staff
- Percent of patients fitted with appropriate head collars (http://www.youtube.com/watch?v=TWFPWj08Bhs)
- Percent of patients fitted with thundershirts (www.thundershirt.com)
- Number of Accountability positions (see attached chart) still not filled
- Number of Accountability positions with back-up person trained

ORGANIZATIONAL BEHAVIOR

The tangibles of safety, ethics and bioethics (e.g., professionalism) between the financial success and clinical quality are tangibles which cause disconnects in delivery. Disconnects occur when the staff perceives something is being done for the wrong reason, or their welfare is in jeopardy (e.g., unsafe conditions, hostile environment, etc.), or even when they perceive that the delivery method(s) took shortcuts that were not "state of the art". When safety, ethics or bioethics are violated, healthcare delivery cannot deliver financial success because staff belief levels are not there (and 79% of a practice staff has client contact daily, and their discomfort comes through instead of practice pride).

The Intangibles have never been systemized in veterinary medicine. Ask yourself when you last reviewed these intangibles in a overt and meaningful manner to enhance the team performance:

- TRAIN TO TRUST - is each person provided the training they need to be trusted at assuming accountability for specific outcomes, and is that training updated and recurring to meet the practice evolution?
- MUTUAL RESPECT - when given accountability, are rewards (contingent) and recognition (subjective) utilized to reinforce the leadership's approval and confidence in the person, efforts and/or outcomes?
- PRIDE in PERFORMANCE - the individual's acceptance of accountability for outcome(s), and concurrent drive for continuous quality improvement (CQI) within their sphere of influence as well as with all clients, vendors, staff and community contacts.
- HARMONY/TEAM FIT - a practice culture which self-heals, showing minimal griping, no derogatory comments, and freely helping others

achieve outcomes within practice limitations and time constraints. Morale is high, everyone is happy to come to the practice and spend a productive duty day, and loyalty to the practice image is supported inside and outside the practice setting.

Once the intangibles have been worked through, and I do mean WORKED through, magic happens. The intangibles cannot be defined into or out-of existence. They must be perceived by the practice team members as on-going and recurring emphasis of nurturing and development of team competency and excellence. They are sequential, where training to trust precedes the respect recognition and reward to reinforce the trust, and the respect is established before pride in accountability and outcomes can occur. Once these three evolve, team fit and harmony enter into the equation, zone effectiveness is enhanced, and continuous quality improvement is possible at all levels.

SYNERGY:

When tangibles are supported and promoted by the intangibles.

When the team is accountable for CQI, not just the doctors or boss.

When 'magic' in accomplishment is perceived by all.

When the group becomes a team, the manager becomes a leader and the doctors become client-centered patient advocates as healthcare providers.

NOTE: *There are four intangible inventories provided in the Organizational Behavior monograph available from the VIN Bookstore (*www.vin.com*), and they can be reproduced from the appendices for use with the practice team. These are actually awareness inventories, without right or wrong answers, except where the leadership realizes a shortfall is occurring and commits to personal behavior changes.*

These models provide a graphic representation of the new team-based healthcare delivery initiative Veterinary Consulting International®, specifically Thomas E. Catanzaro, DVM, MHA, LFACHE, has been implementing with practice over the past few years. We see a 15 to 68% practice growth rate virtually immediately, from the practice's existing clients, when the wellness initiatives (i.e., written Standards of Care) are combined with a concerned leadership approach to team nurturing and empowerment. We also see a word of mouth increase of new clients caused by satisfied clients sharing their approval of the new programs (see attached lists used as starting point). The choice is now yours - in the words of the TV program, "DEAL" or "NO DEAL"!

The three forms attached to this article are for brainstorming within your team.

- For **ACCOUNTABILITIES**, have your team list the attributes of the potential position, without thought of name or specific person. The sample positions can be expanded or contracted, but remember, any not assigned means the owner/vet will be doing them, and that is NOT a TRAIN to TRUST example to share.

  NOMENCLATURE:

  Coordinator is accountable for ensuring resources are available within the zone, that duty standards for the zone are understood by all, and practice mission/vision/core values are lived 24/7, 365.

  Manager is trained to a level of being trusted with a program area and then assigned outcome accountability, with milestones and success measures.

  2xFL reflects the AVMA 2004 initiative for "think two visits a year for life" for all companion animals (built on the accepted premise that one dog year = 5-7 people years)

  OBSERVATION: The chart shows many positions, more than what a normal staff can be assigned with a one duty per person logic.

  FACT: Without assigning accountability to staff, the practice owner and manager retain the accountability for effective implementation.

  FACT: The reason it does not get done when staff is not trained and empowered to accept the accountability is that no one person could ever be expected do it all effectively and consistently.

  EXERCISE: Look at the chart, and the spaces, and define the skill set needed to accept accountability.

  DISCLAIMER: every practice leadership group has the option of empowering others to do the tasks, do the tasks themselves, or allow the task to go without notice or emphasis. The latter is called lost income!

  SIDEBAR NOTE: Having used the attached *Alignment of Accountabilities* concept in many practices, most have eventually added programs as well as shelving those programs where there is NO PASSION in getting the program started. With a "passion", the program naturally becomes more sustainable.

- For the **WELLNESS SURVEILLANCE SYSTEMS**, break into three-person teams, and with full consensus of the triad, have them use the NEED column to mark YES or NO, with the following decision tree:
  - If the client may need to know it sometime – mark YES
  - If the patient may need it some time – mark YES.
  - If neither of the above apply, mark NO

  When the triads have completed the task, come together and compare answers. Then ask if one vet, with one visit a year, could do all the things NEEDED? Then ask, can team members do many of these items? Then ask, What do we need to do to make that happen?

- For the **Problem Solver vs Problem Preventer** survey sheet, use triad teams to discuss the "Clinical Outcome" focus they perceive as their practice's usual operational approach, or maybe leadership expectations would be a better term, to the client-centered patient advocacy and team-based veterinary healthcare delivery modalities. Ask the following for each clinical outcome focus:
    - Which column would make clients perceive a preferred approach?
    - Which ones would end up at the grocery store line as a "gee whiz" discussion with friends?
    - Which perspectives are more likely to get neighbor referrals?
    - Which approaches would give you MORE pride in performance?

ALIGNMENT OF ACCOUNTABILITIES

Zone Coordinators are developed as coordinators of outcomes and people, by functional areas of the practice (see VCI *Signature Series* monograph, *Zoned Systems & Schedules*). These people work regular shifts, and are in the trenches; usual coordinator positions include:

Coordinator of Coordinators: _____
Client Relations Coordinator: _____
Outpatient Coordinator: _____
Inpatient Coordinator: _____
Surgery Coord: _____
Laboratory Coord: _____
Imaging Coordinator: _____
__
Animal Care Coordinator: _____
Training Coordinator: _____
+/- Spa/Resort Manager: _____

Program managers are developed as managers of programs (often medical or surgical services) or operational facility functions (e.g., see VCI *Signature Series* monograph, *Inventory & Maintenance*). These people work regular shifts, and are in the trenches; commonly, manager positions may include:

Inventory Manager: _____
Controlled Substance Mgr: _____
Nutritional Mgr: _____
Boutique Mgr: _____
Dental Hygiene Manager: _____
Behavior Counselor: _____
Fear Free Advisor: _____
2x4L* Manager: _____
Golden Years Mgr: _____
Genetic Predisposition Mgr: _____
Safety Manager: _____
Cl. Outreach/Newsletter Mgr: _____
Social Media Mgr: _____
Pet Parent Awareness Training Mgr: _____

**2x4L = two times for life (visitation rate: one dog year = 5-7 people years)*

Client:	Patient:			I.D.:		Sex:	DOB:
Date:	Nurse:	T	P	R	BP	Wt	BCS*

codes: N = need now (❑), X = do it, A = appointment made, D = deferred until, W = waived, + = positive, - = negative,

Wellness Surveillance System	Needed	X (by who)	A	For When	W or D	Until When
Insurance						
Care Credit/Other Lender						
Life Cycle Consultation						
Progress Note 12-system Physical Exam						
Dental Score						
Pre-emptive Pain Score						
Lead II ECG						
Ton-o-pen/globe pressure/STT						
Imaging (age/breed dependent)						
Kidney Screen (ERD - urine)						
Blood Chemistry (age/breed dependent)						
Heartworm Screen (SNAP - 3dx)						
FeLV Combo (SNAP)						
Fecal (sample + SNAP) - 6 mo						
Deworm						
Heartworm Preventative						
Flea & Tick Preventative						
Rabies (traveling with your pet)						
DA2P (K-9 Distemper series)						
Lepto						
Parvo Booster						
Lyme						
Giardia						
FVRCP (feline multi-valent)						
FIV						
FeLV						
Fluoride - 6 mo						
Bartonella						
Day Admit						
RTG - Discharge Plan						
* Nutritional Plan						

PROBLEM SOLVER APPROACH	CLINICAL OUTCOMES	PROBLEM PREVENTER APPROACH
State-of-the-Art Medicine & Surgery	Practice Focus	HAB – Client-centered Patient Advocacy to Extend & Enhance the Duration and Quality of an Animal's Life
High-quality care for disease treatment & injury – plus - Preventive healthcare limited to vaccination & parasite prevent per client's request	Primary Clinical Goal	Disease prevention and wellness advice to maintain long-term health and well-being of patient & strong owner-pet-practice relationship
As needed usage, resulting in downward visitation trends	Utilization of Services	Regular, semi-annual consultations, informed usage, resulting in upward trend
Internal to practice - variable based on background of providers and staff	Compliance	Relatively high due to clear a written standards of care (SOC) with emphasis on client education
Client's response is left to self-motivation and understanding of pet owner – seldom a medical record closure for continuity of care	Adherence	Client response is monitored by staff to ensure medical record closure, continuity of care, and patient welfare, as well as client's ***Peace of Mind!***
Variable due to focus on acute care	Patient Health	Surveillance programs increased Optimal due to minimizing incidence of chronic or degenerative disease
Increased prevalence of chronic preventable disease	Epidemiology	Low prevalence of preventable disease
Relatively limited verbal dialog Seldom uses informational handouts Focuses on patient's immediate condition or client's concern Minimal outreach follow-up; client expected to return on their own Principally involves the veterinarian	Client Communications	High level of verbal dialog and written information/instructions Broad discussion of wellcare topics after addressing client concerns Emphasis on client partnerships and education as animal steward Involves all healthcare team members Focuses on data gathering and patient family history Seeks to establish an empathetic practice-client relationship Seeks to understand depth of human-animal bond within family
Lack of understanding of preventive healthcare benefits 'Estimate' use draws client attention to right hand column Focus is on cost rather than value Skepticism of need for service Price resistance, comparison shopping Loyalty is not developed to practice	Client Response	Values relationship with practice team 'Healthcare Plan' use draws client attention to left hand column of needs Assigns emotional value to low incidence preventable disease, encourages use of staff access for appropriate pricing of service Awareness of enhanced pet quality of life and extending the long term Human-animal bond relationship Loyalty to practice increases
Primary emphasis is on technical skills Belonging is not encouraged Focuses on job description skills and adherence to standard operating procedures and protocols Fear of errors overrides innovation or creativity in practice functions	Healthcare Team Response	Finds personal satisfaction in building strong client relationships Unified preventive healthcare vision fosters strong sense of teamwork Values "learning organization" culture Organizational behavior allows self-healing of conflicts

Adapted from AAHA Information Sheet, 2013