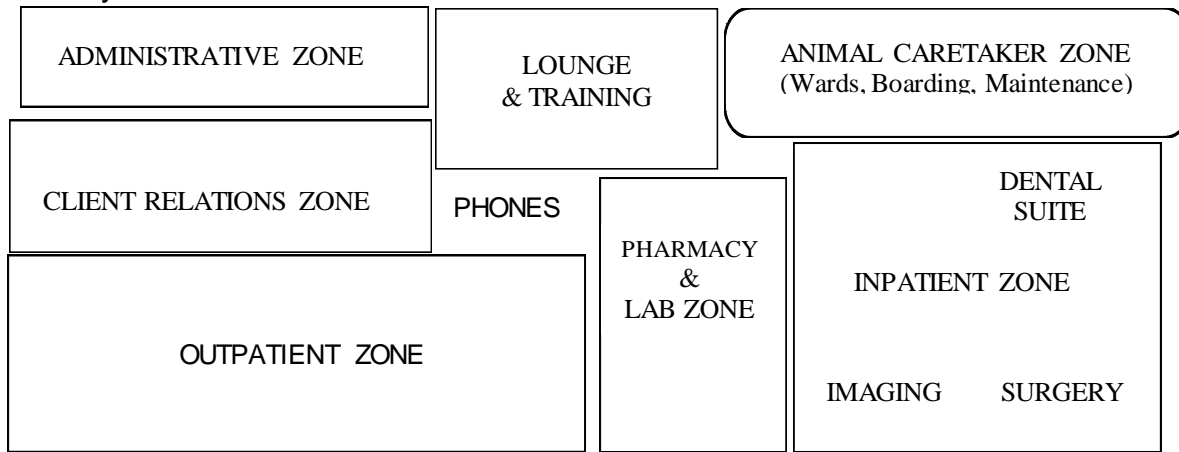


# ZONING A PRACTICE TUTORIAL

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Better utilization of the healthcare team:  
*"The best way to begin, is to begin."*

The change from a one doctor, one or two examination/consultation room system, to a two doctor system is usually minor; the owner just takes more time off. Usually we find that the two doctors just divide the longer one-doctor shift into two, continue to work in the traditional linear fashion, and never give it another thought. When a practice moves beyond two doctors, beyond 900 transactions a month, or when they expand into five or more consultation rooms (the need for an odd number of outpatient rooms becomes evident below), there are psychological, physical, and problematic issues to address in the basic operating premises. The practice style of two doctors working two or three consultation rooms concurrently, flowing erratically front to back, cannot be done in a practice that doubles in size. Zones must be established in a larger facility, to concentrate the doctor resources on the client needs; the nursing staff must concurrently accept veterinary extender roles.



## SAMPLE ZONING OF A VETERINARY FACILITY

The development of hospital zones (initially client relations, inpatient, and outpatient, and maybe later, resort and surgery) requires the client relations (reception) team AND nursing (technician) staff to accept accountability for zone operations, and see the doctors as visiting consultants (doctors work a specific zone for only a half day, then shift zones). Shift changes occur ONLY after/when all restocking and cleaning is completed, or the shortfalls are transferred in an overt and apologetic manner.

The problems associated with doctor-centered healthcare delivery (this is how most all veterinarians start their practices) can now be addressed by staff at shift change, from updated medical records and charge sheets (travel sheet), to restocking and cleaning; in short, the goal is for the staff to leave the hospital zone in better shape than they found it. The following are some general guidelines to use as starting point for discussion:

- An Outpatient Nurse (OPN) usually controls at least two consultation rooms (what used to be called exam rooms), one Outpatient Doctor, and shares one Pharmacy technical assistant float. The Inpatient Nurse (IPN) controls treatment, surgery, and imaging, one Inpatient Doctor, and one inpatient technical assistant float, as well as overseeing the animal caretaker staff (which may act as technical assistants when ward occupancy is low). The location of the laboratory determines who has operational control of that zone, and the potential staffing.
- Morning outpatient appointments are scheduled from 7:30 a.m. to 12:30, so the outpatient team (explained later) can leave the zone by 1:00 p.m.. The afternoon outpatient shift is from 12:30 to 5:00 p.m., and the evening outpatient shift (on practices with “late days”) is 4:30 to 8:00 p.m. (this evening doctor usually starts the shift with OHE and neuters from noon to 3 p.m., then has 3:30 to 4:30 p.m. for food and phone calls).
- Morning inpatient nursing rounds are before 8:00 a.m., which means all cases are prioritized on the treatment room white board BEFORE 8 a.m. by the inpatient nurse, and at 8 a.m., the doctor validates the plan with the morning inpatient nurse. The morning outpatient system stops at 12:30, and the afternoon inpatient rounds are at 1 p.m., that means there are 30 minutes to overtly transfer the shift to the next team. The afternoon inpatient priority changes are based on RTG (ready to go) times, so when the doctor reviews the cases which have been prioritized by the inpatient nurse, the promises made to the clients are foremost in their minds.
- Morning outpatient staff becomes afternoon inpatient team, so they can ensure their “day admits” are closed out as promised; the morning inpatient team becomes the afternoon outpatient team, so they can ensure they are available if there are questions at inpatient discharge. The p.m. doctor shift (noon to 8:30 p.m.) allows a larger practice the high density scheduling overlap for end-of-day rush times (common in bedroom communities and high dual income populations). In some locations, only Tuesday and Thursday are “evening hours”, based on community demographics and client access demands.
- The evening transfer of zones is assumed to be similar to the day exchange, and assessed by the morning shift, and may require greater calibration coordination, but the habits built on the midday shift change between zones will eventually carry over to EOD changes.
- The key elements to accept in this transition of thought include: 1) client relations schedules the hospital zones (no cherry picking) and resources (as provided by the nursing staff assessment), 2) no one leaves their zone during a shift (including doctors), except for the technical assistants who are moving animals, 3) the

nursing staff has the client/patient-centered schedule and keeps the doctors on schedule, 4) the doctors respect the schedules and the nurses, and 5) the hospital rooms and facilities are scheduled (not the doctors) with a client-centered commitment for the social contract of meeting the clients expectations in a timely manner.

The most effective scheduling is usually done by computer, and most of the newer computer programs (e.g., Avimark, Impromed, Cornerstone, RxWorks, ezyVet, etc.) have good clinical appointment capabilities, with variable boarding capabilities. Pre-booking requires three reminders (one e-mail at 30 days before, one text message at 1 week before, and one text message 24 in advance), and Cornerstone, RxWorks, and ezyVet report they have this capability on-line already. The doctors request appointments via the outpatient nurse to the client relations (reception) team; doctors do not touch/adjust the appointing system in any manner. The doctor's inpatient time, besides for telephone voice mail review, can also be a flexible healthcare delivery time, if no surgeries are scheduled (when the outpatient team is fully booked, the inpatient team handles walk-ins, emergencies, and drop-offs through an "odd" consultation room).

In the slow season, only one of the two consultation rooms assigned to an outpatient doctor needs to be scheduled, and walk-ins, drop-offs, and emergencies can then be used to fill the second room. This is the same system being used with Internet appointments; clients select their preferred time in one room, while the practice schedules clients on the "seams" in the other room (see "high density scheduling" in the Signature Series monograph *Zoned Systems and Schedules*, available from the VIN Bookstore, [www.VIN.com](http://www.VIN.com)). If the two rooms are totally booked for a doctor/OPN team, the IPN team will see the walk-ins, drop-offs, and emergencies through the "odd" room (assuming an odd number of consultation rooms, and two rooms dedicated per outpatient team), as well as be used to "catch-up" an outpatient doctor who has gotten off pace (coordinated by OPN and IPN through reception).

The client relations triad, reception, telephone, and discharge staff members, must also have a midday shift, so no one MUST work the telephone for more than 5 hours at a time. The **Recovered Pet** and **Recovered Client** programs, as described in another of the Signature Series® Monographs, *Client Relations Zone*, will easily fund the additional staff needed for these zones and transitions.

The issues impacting most expanding veterinary hospitals include: new floor plan revisions have often separated admission from discharge, enlarged or opened up a VERY large treatment area, and has increased the circulating space and distance. In an expanding hospital staff without an expanded facility, the increase in traffic, and front to back "everywhere" doctor habits, cause the staff to wait and hover, hoping to be told where to be or what to do so they do not get yelled at by the doctor(s).

- The five (or other larger odd number) consultation rooms allow two doctors to work outpatient (each has two rooms scheduled) while the center room is the overflow, emergency, and inpatient admission room to help keep things on track.
- I have designed facilities with two A&D rooms for surgery staff use in early morning (Admissions) and late afternoon (Discharges); mid-day they are dedicated to emergency (usually handled by inpatient staff if the outpatient schedule is full), walk-ins and/or visiting specialists.
- The new habits are much easier to learn than forgetting/unlearning the old linear habits which made the doctor follow their case front-to-back, sucking staff behind as they moved.
- The hardest change for most practices is to shift from doctor-centered healthcare delivery to client-centered service with full facility utilization scheduling (empty consultation rooms make no money, but are common in a doctor-centered practice).
- In the new format, when the doctor(s) moves between zones, they enter a new staff zone that is controlled and prioritized by the nursing staff, just like in human healthcare wards. They check-in with the nursing staff BEFORE they start to see the patients.

### **The Key Players:**

- **The Hospital Administrator/Manager** - this person will vary with the ownership format. In a multi-owner practice, a Board-form of policy and precedent reference must be established (see the 2000 ISUP text, "*Veterinary Management in Transition: Preparing for the 21<sup>st</sup> Century*"). The minimum credentials for this person should be a Certified Veterinary Practice Manager (CVPM), as provided by the Veterinary Hospital Managers Association (VHMA), [www.vhma.org](http://www.vhma.org), and in the larger veterinary complex situations, may in fact be an administrative team.
- **The Client Relations Coordinator** - this person is the coordinator of the front staff, including receiving and discharge of clients/patients, telephone/fax/e-mail communications, medical record surveillance, resources are maintained and positioned, zone goals are kept current, and client outreach/mailing functions, including reminders, newsletters, health alerts, text messages and news releases.
- **The Outpatient Coordinator** - this person ensures the Outpatient Nurses (OPNs) and outpatient technical assistants are trained, resources are maintained and positioned, zone goals are kept current, and is the contact point when there is a change in protocol or operational formats. This person acts as the coordinator for the outpatient zone and attending staff members, although they may functionally be in the total hospital duty site rotation.
- **The Inpatient Coordinator** - this person ensures the Inpatient Nurses (IPNs) and inpatient technical assistants are trained, resources are maintained and positioned, zone goals are kept current, and is the contact point when there is a change in protocol or operational formats. This person acts as the coordinator

for the inpatient zone and attending staff members, although they may functionally be in the total hospital duty site rotation.

- **The Inventory Manager** - this person coordinates the inventory team, which includes the stocking, restocking, and computer maintenance of the inventory pricing and tracking systems. Although vendor stocking is becoming a preferred economy of scale service, there must be someone who monitors the vendors when they have committed to provide this service. Like the coordinators, program managers like inventory should functionally be in the total hospital duty site rotation.
- **The Resort Manager** - this person coordinates the Pet Resort (boarding operations), which includes occupancy levels, animal caretaker staff, and guest cleanliness and comfort. Unlike the coordinators and other practice program managers, the resort manager has their own business separate from the practice, so their zone should be functionally separate from the hospital duty site rotation. In some low occupancy periods, the Resort Manager may coordinate with the Inpatient and Outpatient Coordinators to provide their animal caretakers cross-training as technical assistants within the practice's healthcare delivery zones.
- **The Hiring Team** (explained in detail in the Wiley text, *Building the Successful Veterinary Practice: Innovation & Creativity*, Volume 3) - this group is developed initially as the Client Relations Coordinator, Inpatient Coordinator, and Outpatient Coordinator (+/- practice manager), and they interview and select all candidates for employment, and become the training team for orientation and training (see the Signature Series monograph for *Orientation and Training* for checklists and systems). As the practice staff accepts accountability for outcomes, the Client Relations Coordinator, Inpatient Coordinator, and/or Outpatient Coordinator, may select developing staff members to take their place on the hiring team. A diversified hiring team often is all that is needed to prevent a "them-us" environment from developing, and better, never makes the doctor, owner, or hospital manager the focal point for new staff failures.
- **The Safety Team** - one person from each zone is identified by the respective coordinators and meets with the hospital administrator/manager at least monthly to address safety and comfort issues (OSHA concerns included). *The Veterinary Safety & Health Digest*, from The Veterinary Safety & Health Digest, 1550 Athens Road, Calhoun, TN, 37309-3035, should be their subscription to review and implement with each issue. The Safety Team members are accountable for safety, comfort, and maintenance issues within their respective zone, and have a direct link to the facility Board via the hospital administrator manager.
- **The "L" Team** - in many veterinary hospitals with which we consult, the coordinators evolve into the Leadership Team (L Team), and assume a role in budget surveillance, program management, and client outreach. They conduct the quarterly budget review with the ownership and administrator/manager, review the program delivery successes and shortfalls, and set the zone commitments for the coming quarter. The coordinators should assume the staff scheduling role within a quarter of being selected, scheduling staff based on

doctor schedules, which were based on client demands and hospital capabilities. This allows the zone coordinators to discuss cross-training and inter-relationship support missions on a regular basis, which is practice leadership in action!

### **Needed Scheduling Actions:**

#### **Zone the hospital staffing plan**

- Outpatient schedules have two columns (rooms) per shift doctor
- Outpatient doctor and Outpatient Nurse work two consultation rooms
- OPN escorts all clients/patients from receiving to consultation room
- There is a Pharmacy/Laboratory technical assistant float
- The OPN and OP doctor NEVER leave front during shift
- The OPN keeps the doctor “on schedule” for the entire shift
- There should be a day drop-off bank of cages close to front
- Client Relations schedules inpatient care regardless of doctor
- Inpatient doctor and Inpatient Nurse (RVT) work treatment/surgery
- The IPN and IP doctor NEVER leave back during shift
- There is always a treatment/surgery technical assistant float

#### **Shifts are half day, changing the doctor’s role (+/- CVT/RVT/LVT/nurse)**

- Morning outpatient doctor becomes afternoon inpatient doctor, thereby following a “day admits” that were done to ensure continuity of care
- Morning inpatient doctor becomes afternoon outpatient doctor, thereby being able to discharge the morning drop-offs and surgeries
- Morning dental prophylaxis (DG1+ and DG2+) are staff functions, and may require an additional nurse if booking rates are as expected (85% of adult animals deserve some form of dental care) – dental imaging starts at DG2+!
- Noon doctor (on three doctor days, this is the noon to 8 evening shift) starts with spays, neuters, and oral surgeries (DG3+ and DG4+) (noon-3 p.m.), has an hour for phone/food, then does evening outpatient (4-8 p.m.)
- IPN & doctor conducts rounds at 8 a.m. and 1 p.m., and then the IPN keeps the doctor on schedule
- ONLY the technical assistants (floats) move between zones, moving patients and support each other

Details of doctor scheduling are discussed in the High Density Scheduling section of the *Zoned Systems and Schedules* monograph. The samples need to be adjusted for the midday shift change and number of outpatient or inpatient teams, but that is internal to the individual practices. Evening hours is a consideration for increasing client access in some communities, after the population is surveyed with an appropriate new client “WELCOME” form (see Signature Series Monograph, *Medical Records for Continuity of Care and Profit*). The doctor schedules need to be done six weeks in advance so all other staff schedules can be done 30 days in advance by the coordinators.

The basic key to “system success” is to start to schedule the hospital rather than the doctors, assign the staff primary patient healthcare duties (led by a shift doctor), and respect the social appointment and care contract given to clients as they access the hospital (as explained in Chapter 2, *Building the Successful Veterinary Practice: Programs & Procedures* (Volume 2), published by Iowa State University Press in 1998).

The **OPERATIONAL ZONES** for the new systems and schedules would usually include the following areas of staff accountability:

**Client Relations Zone:**

- Receiving/Greeting
- Telephone
- Discharge
- veterinary software operations
- sending newsletter and health alerts
- Pre-booking with timely reminders
- Client access area maintenance and cleanliness
- Recovered pet and recovered client programs (*Signature Series* monograph)

**Outpatient Zone:**

- Pharmacy-Lab forward to reception
- Client/patient outpatient movement
- Outpatient client education
- Behavior management assistance to clients
- Nutritional advise and monitoring
- Parasite Prevention & Control Assistance
- Supervision of pharmacy/lab technical assistant float
- Laboratory operations (*in larger practices, there may be a lab tech*)
- Client recalls for outpatient follow-up
- Inventory management
- Outpatient zone maintenance and cleanliness
- Title 16, CFR
- FEAR FREE monitoring

**Inpatient Zone:**

- Supervision of technical assistant float
- Wards and Rounds (8 a.m. and 1 p.m.)
- Treatment Room
- Dental Suite Operations
- Imaging (*in larger practices, there may be an imaging tech*)

- Surgery (*in larger practices, there may be a surgery tech*)
- Pack Prep
- Inpatient White board
- Inpatient zone maintenance and cleanliness
- Title 21, CFR

**Resort (boarding) Zone:**

- Bathing
- Grooming
- Animal Caretakers
- Outdoor maintenance and cleanliness
- Chapter 1, Sub-chapter A, Title 9, CFR

The **FUNCTIONAL ZONING** of the hospital allows the respective coordinators to become accountable for the new systems and schedules. They are accountable for staff competency (training) and productivity (effectiveness within the zone) within their training role. Each coordinator and staff member must have a client/patient advocate, whether they are “in their zone” or scheduled to work elsewhere. Once a practice starts to schedule the facility based on client and patient demands, and empowers the staff to be advocates for the client and patient, the linear thinking of a doctor centered practice will start to disappear, and the productivity will become enhanced.

There is a 500 page text (with 18 appendices) in the VIN Library, available for free download, or at the following link:

**THE PRACTICE SUCCESS PRESCRIPTION:  
TEAM-BASED VETERINARY HEALTHCARE DELIVERY**

<http://www.vin.com/Proceedings/Proceedings.plx?CID=TomCat2007&O=Generic>

There is a 250 page, staff friendly, companion piece in the VIN Library, available for free download, or at the following link:

**PROMOTING THE HUMAN-ANIMAL BOND IN VETERINARY PRACTICE  
or  
BONDING THE CLIENT TO YOUR PRACTICE FOR FUN AND PROFIT  
(2nd EDITION)**

<http://www.vin.com/Proceedings/Proceedings.plx?CID=TOMCAT2&O=Generic>

If the above two references seem daunting, or just plain confusing, please remember, I am available for on-site consulting (this system usually requires a full-year consult, which includes an initial 4-day on-site and two subsequent quarterly 2-day visits). We have averaged 11-38% growth in the first year (dependent on where the practice is at with Core Values, written SOC, and staff empowerment).