Increased Compliance: A key to better patient outcomes
December 2003

Dear Colleague:

Noncompliance is a significant problem in veterinary medicine; the landmark AAHA Compliance Study found overall compliance to be between 20% and 30% for six common veterinary activities. These percentages do not account for pets that failed to visit veterinary practices within the previous year, further reducing actual compliance levels. According to the AAHA study, core vaccinations and heartworm testing have the highest compliance (about 80%) among the six areas studied; therapeutic nutrition had the worst (about 7%). Consequently, millions of dogs and cats in the United States do not receive the care their veterinarians fervently believe is best for these pets.

We are all aware of the medical consequences of noncompliance and poor compliance: recurring illnesses, hospitalization, the need for more expensive therapy with potentially more invasive procedures and more toxic drugs, poorer quality of life, premature death, loss of practice income, and the list goes on. Because everyone suffers from poor compliance, it is vital that veterinarians and their healthcare teams devise ways to improve compliance in their practices. Furthermore, the AAHA study found that the vast majority of clients want their veterinarian to recommend the best medical, surgical, and dietary care and are willing to pay for the best products and services.

This monograph is designed to provide ideas, tools, and suggestions for measuring and enhancing compliance in your practice. Improving compliance is everyone’s responsibility, every practice is capable of improving compliance, and every practice can improve patient care. Thank you for taking the time to review the information in this monograph.

Sincerely,

Karen Bowen Padgett, DVM
Director, Veterinary Business Channel
Hill’s Pet Nutrition, Inc.

John W. Albers, DVM
Executive Director
American Animal Hospital Association

Acknowledgments
Hill’s thanks the roundtable participants for their insights into this pressing clinical problem and the American Animal Hospital Association for its ongoing efforts to improve compliance. Hill’s is pleased to be part of the landmark AAHA Compliance Study and to support our colleagues in practice with many educational programs. Our goal, like yours, is to enrich and lengthen the special relationships between people and their pets.
Increased Compliance: A key to better patient outcomes

The Participants

**Fritz Wood, CPA, CFP**
Mr. Wood is a Certified Public Accountant and a Certified Financial Planner, who has been fully engaged in the veterinary industry for more than a decade. He is Personal Finance Editor and serves on the Editorial Advisory Board of Veterinary Economics. He has published many articles and presented at major veterinary conferences throughout the world. Mr. Wood's experience includes 10 years with a major management consulting firm.

Mr. Wood was treasurer and served on the Board of Directors of the American Veterinary Medical Foundation and on the Pricing Subcommittee of the National Commission on Veterinary Economic Issues (NCVEI). A graduate of the University of Kansas in accounting and business administration, Mr. Wood's professional affiliations include the American Institute of Certified Public Accountants (AICPA) and the Kansas Society of Certified Public Accountants (KSCPA).

**Robin Downing, DVM**
Dr. Downing graduated from the College of Veterinary Medicine at the University of Illinois in Champaign-Urbana in 1986. For the next five years, she was the first and only female veterinarian within a 100-mile radius of Worland, Wyo., where she brought sophisticated companion-animal medicine into the homes of pet lovers. In 1991, she purchased Windsor Veterinary Clinic, a stagnant practice in Colorado, and by 1994, the clinic had achieved AAHA status and received the Veterinary Economics Practice of Excellence award. Dr. Downing serves as a trustee for the Morris Animal Foundation, and she is an affiliate faculty member at Colorado State University's College of Veterinary Medicine. Dr. Downing is also an outspoken advocate of the family-pet bond. As a pain-management consultant, she lectures internationally on the importance of preemptive pain management in the compassionate care of companion animals.

**John W. Albers, DVM**
A 1967 graduate of Michigan State University, Dr. Albers served two years in the United States Army Veterinary Corps before entering private practice in Denver, Colo., in 1969. As a partner/owner of the Anderson Animal Hospital, he had primary management responsibility for this AAHA hospital. He has been active in organized veterinary medicine and held numerous positions in AAHA, including president. Since 1986, he has served AAHA as full-time executive director. He also serves as CEO of AAHA Services Corp., the association's for-profit subsidiary that operates AAHA MARKETLink.

Dr. Albers has been a member of the Joint Steering Committee, overseeing the AVMA/AAHA/AAVMC economic study and currently serves on the Board of Directors of the National Commission on Veterinary Economic Issues.

In 1990, Dr. Albers received the Distinguished Veterinary Alumnus Award from Michigan State University, and in 1996, he was named Veterinarian of the Year by the Colorado Veterinary Medical Association.

**Laurie J. Miller, RVT**
Ms. Miller is a 1993 graduate of the Columbus State Community College veterinary technician program. She has worked at Suburban Animal Clinic in Columbus, Ohio, since 1993 and is presently the hospital manager, overseeing client education and service. Suburban Animal Clinic is an accredited AAHA member and was awarded the Veterinary Economics Practice of Excellence in 2000. She is president of the Ohio Association of Veterinary Technicians and serves on the Ohio Veterinary Medical Association Practice Act Task Force. She was a speaker at the Midwest Veterinary Conference, AVMA annual convention, and Western Veterinary Conference.

**Mary Beth Leininger, DVM**
Dr. Leininger has been Director of Professional Affairs for Hill’s Pet Nutrition, Inc, since September 1999. Dr. Leininger received her veterinary medical degree from Purdue University and, for more than 30 years, co-owned an AAHA-accredited hospital in Plymouth, Mich., with her spouse, Dr. Steven Leininger. She has been received numerous awards, including an Honorary Doctor of Science degree from her alma mater and election as a Distinguished Practitioner in Veterinary Medicine in the National Academies of Practice.

Dr. Leininger is most widely recognized as the first woman elected to the office of president (1996-1997) of the AVMA in the 140-year history of the organization.

**Bruce Novotny, DVM**
A 1978 graduate of Kansas State University’s College of Veterinary Medicine, Manhattan, Kan., Dr. Novotny is the managing partner of Helios Communications LLC, a Shawnee, Kan., company specializing in communications for healthcare professionals. He has written or edited hundreds of articles as well as several books, monographs, and electronic case-based simulations for veterinary medical and animal science literature. Previously, he worked in private veterinary practice, industry, and publishing.

**Link Welborn, DVM, DABVP**
Dr. Welborn graduated from the University of Florida College of Veterinary Medicine in 1982. He is Diplomate of the American Board of Veterinary Practitioners with specialty certification in Canine and Feline Practice. He is co-owner and practice director of two general companion animal and one feline exclusive AAHA-accredited practices in Tampa, Fla. Dr. Welborn is president of AAHA and was a member of the AAHA Compliance Study Project Team. As chair of the Standards Enhancement Task Force, he coordinated the revisions and enhancements to the AAHA Standards of Accreditation. Dr. Welborn also chairs the Accreditation Program Task Force, the group enhancing and revising the AAHA accreditation standards for specialty practices.
Dr. Bruce Novotny: We’re here to discuss compliance—a topic that I think is the most significant in veterinary medicine today. Poor compliance may be as costly and dangerous as many diseases. Furthermore, improvement in compliance may be more important to pet owners and practitioners than the release of any blockbuster drug or food. After all, we can’t expect pets to live longer, healthier lives until owners better understand our instructions. Dr. Albers, the first question is for you. What is compliance?

Dr. John Albers: Very simply stated, compliance is when a pet that sees a veterinarian is actually receiving the care that the veterinarian and the profession believe is best for that pet.

Dr. Mary Beth Leininger: But some practitioners recommend different protocols. For example, there is controversy about vaccination schedules. How does compliance fit into differing recommendations?

Albers: I think compliance relates to what the veterinarian believes is good for a particular pet. So if a practice has adopted longer intervals between vaccinations and the animal was vaccinated two years ago, the owner is in compliance. But if that practice believes that the pet should be vaccinated annually, then the pet owner is not in compliance.

In some instances, the measure of compliance could be different from practice to practice.

Dr. Robin Downing: For decades our profession has looked at compliance in terms of clients behaving in a certain way. We’ve been dissatisfied when clients didn’t tow the line. It’s time to redefine our compliance model. Let’s not forget the saying, “Insanity is to do the same thing over and over and expect a different outcome.” If we do the same things we have always done, we are going to get the same results we’ve always gotten—client behavior that is not in alignment with our best medical recommendations for their pets. I think the most exciting thing about revisiting compliance is that it puts the onus on the veterinarian to be an advocate for the pet. We need to create a sense of urgency in the client’s mind. Until clients have that sense, they won’t care enough to take action.

Novotny: Dr. Albers, you were involved with the recent American Animal Hospital Association (AAHA) Compliance Study, which we will be referring to repeatedly in this discussion. Could you tell us a little bit about that study?

Albers: AAHA had some anecdotal data suggesting that compliance in veterinary medicine was a problem. This provided a huge opportunity to improve the healthcare we provide for pets. We did not have a wide-ranging, definitive study of the issue. Veterinarians like empirical evidence or a scientific study that can prove that there’s an opportunity to improve healthcare. So we had some conversations with pet food manufacturers and others in the animal health industry, particularly manufacturers of heartworm medication, who knew from their own studies that compliance was a problem. Hill’s Pet Nutrition encouraged us to develop a proposal for a wide-ranging study on the issue of compliance in important areas of companion-animal practice. We did that and then conducted the study over 15 to 18 months. In the study, we evaluated practice records and measured whether or not patients received the medical therapy that the doctor in that practice had recommended. It was each practice’s recommendations for good healthcare that were looked at in terms of compliance, not anyone else’s. (See “The AAHA Compliance Study,” p. 3)

Novotny: Physicians consistently overestimate compliance among their patients and their ability to detect or predict its occurrence. Having said that, is there a compliance problem in veterinary medicine today?

Ms. Laurie Miller: Absolutely. We think we are
doing a great job—we tell clients what they should be doing for their pets, but we don’t always write it down for them. Clients only have 15 to 30 minutes in the exam room to address a lot of problems, whether they are real or perceived, and they may not mention all their concerns. The whole staff needs to talk to clients about what is going on with their pets. We’re just not good at doing that.

**Albers:** Ms. Miller has raised a great point that was central to the early findings of the AAHA Compliance Study. We assume compliance is good. We confuse giving information with having the client act on that information. For example, we may casually mention that a pet is due for its heartworm test, but we don’t have the training and follow-up systems in place to make sure that the test is actually done.

**Dr. Link Welborn:** There is a huge problem with compliance, but we tend to underestimate that problem because in most cases we have not been measuring it.

**Novotny:** If we polled ten practitioners and asked them what compliance was and what the level of compliance was in their practices, what do you think they would tell us?

**Downing:** They would convey what most of us have felt all along. Nobody gets up in the morning and says, “I’m going to go to work today and do as bad a job as I can. I’m not going to educate a single client.” We go to work to do the best job we can for our patients. Unfortunately, until now, we haven’t had an empirical measurement. I encountered a frightening statistic from two surveys by the American Heartworm Society in partnership with Merck (now Merial). In 1991, about 275,000 dogs were diagnosed with heartworm disease in the United States. A decade later, there were still about 250,000 cases diagnosed. Why is that? Do we not have appropriate tools? We now have more and better drugs to prevent heartworm disease. So is it because we don’t understand the disease? No. Much information is available about canine heartworm disease. That leaves only one missing piece. The dogs aren’t getting the preventives. That was a wake-up call for me as a veterinarian.

**Welborn:** I think part of the problem is complacency. We do not emphasize the importance of heartworm preventives as we did when heartworm disease was more prevalent and when new drugs and treatments were being introduced. I think that’s true in other areas as well.

---

**The AAHA Compliance Study**

Earlier this year, the American Animal Hospital Association (AAHA) released its in-depth study on “Compliance in Companion Animal Practices.” Sponsored by Hill’s Pet Nutrition, Inc., this study provides empirical evidence that confirms what many veterinarians already suspected—compliance rates in veterinary practices are low, with an overall average of 20% to 30%. The study examined compliance in six main practice areas: heartworm testing and preventives, dental prophylaxis, canine and feline core vaccines, preanesthetic testing, senior screening, and therapeutic diets.

Fortunately, noncompliance is one aspect of patient care that veterinarians can positively affect. In the study’s first module, Industry Analysis, the participating consultants and organizations identified the most common characteristics of practices with higher-than-average compliance. They include:

- well-managed, efficient practices that follow a business plan, track the use of tests and treatments on patients, and benchmark their performances against previous years and other practices.
- better systems and processes, including an efficient and effective reminder system and an entire staff who understands and implements discharge and follow-up protocols.
- veterinarians who present all alternatives to pet owners with confidence and provide a high level of client education.
- a higher technician-to-veterinarian ratio (3 to 1) along with a well-trained, well-paid staff who reinforces the doctors’ recommendations.

Other modules included in the study cover benchmarking, the attitudes and behaviors of veterinarians and practice managers, a pet owner survey, and the quantification of compliance based on gathered data. In all, the study

- surveyed over 1,000 pet owners
- reviewed the medical records of over 3,000 cats and dogs from almost 300 practices, and
- conducted in-depth interviews and visits with 51 small-animal practices.

AAHA members can view the complete results from the study, The Path to High-Quality Care: Practical Tips for Improving Compliance guide, and the compliance-measurement tool in the Members-Only section of www.aahanet.org. Members and nonmembers can purchase the guide and measurement tool on CD-ROM, or the CD-ROM alone, from the Web site. Call (800) 883-6301 for prices.

---

**Key Points**

- Compliance is when a pet that sees a veterinarian is actually receiving the care that the veterinarian and the profession believe is best for that pet.
- There is no reason why dogs that see veterinarians should be heartworm positive when we have safe and efficacious preventive medications.
- Practitioners consistently overestimate compliance among their patients.
Complacency is a big barrier to compliance. The AAHA study looked for practices that were doing a great job with compliance; they found none that had uniformly high compliance in all areas.

The AAHA study focused on the following six areas: heartworm testing and prevention, canine and feline core vaccines, preanesthetic testing, therapeutic diets, dentistry, and senior screening.

Downing: I agree. The AAHA study mentions compliance complacency and our need to kick ourselves out of that groove. If we do not perceive the problem, we won’t respond to it.

Albers: The American Heartworm Society test findings are important. Such statistics indicate the profession’s irresponsibility. There is no reason why 250,000 dogs—dogs that see veterinarians—should be heartworm positive when we have safe and efficacious preventive medications.

Novotny: There is a wide gap between what veterinarians recommend and what their clients actually do. What is the real level of compliance in a typical small-animal practice?

Leininger: What did the AAHA study tell us? Was there any kind of consistency among the participating practices?

Albers: Yes, there was consistency among practices: overall compliance was poor, somewhere between 20% and 30%. It’s interesting that even with the things that have been on the front burner the longest, such as vaccines and heartworm testing, compliance was in the 80% range. When you look at dentistry and senior screening, compliance drops into the 20% to 30% range. Compliance with therapeutic diets was the worst. For patients with medical conditions that could benefit from some form of therapeutic diet, compliance was only 7%.

Mr. Fritz Wood: And overall compliance is surely worse because the study only involved active clients—those who had seen a veterinarian during the past 12 months.

Novotny: Is the percentage higher in above-average practices?

Albers: When we started the study, one of the consultants’ goals was to find practices that we could put into a compliance hall of fame—practices that were doing a great job with compliance. We didn’t find a single practice that had uniformly high compliance in all areas.

We found some practices that had made a conscious effort to raise compliance in specific areas. Those practices showed that it can be done. A terrific example is a Des Moines, Iowa, veterinarian and staff who decided senior diagnostic screening was important and would benefit their patients. They measured compliance and found that only 20% of their senior patients had any diagnostic testing performed in a 12-month period, even though the staff thought they had educated clients. The whole staff worked hard to increase that level. Within six to eight months, 80% of their senior patients had some amount of diagnostic screening done. This practice demonstrated that it can be done. This also proves the adage: “What gets measured gets done.” However, that same practice told us that they thought their compliance in other areas probably was not very good, and they were right. Compliance in the areas of dentistry, heartworm prevention, and therapeutic diets was not much better than that of most other practices in the study. But this practice did demonstrate that when the whole staff paid attention to compliance, levels increased.

Leininger: What areas of medical activity were looked at in the study?

Albers: The six areas were heartworm testing and prevention, canine and feline core vaccines, preanesthetic testing, therapeutic diets, dentistry, and senior screening.

Downing: Like the Des Moines practice, we decided to focus on compliance in our practice in several key areas over a five-year period. One was preanesthetic bloodwork, and our compliance went from approximately 70% to 100%. A second was senior screening, and our compliance rose from approximately 50% to 85% to 90%. The third was heartworm prevention, and our compliance for year-round protection is now 75% to 80%, up from 35% to 40%.

When my practice participated in the AAHA study, we looked at the six areas studied. As much time and energy as we spent promoting therapeutic nutrition, our compliance was still only 15% to 20%. That is a huge area of interest in our practice, and we
thought we were doing a good job. We have such a long way to go, even though we are focusing on this compliance issue.

Leininger: It seems, then, that when a practice decides to look at compliance, that’s the first step in accomplishing better patient care in a particular area.

Albers: Another point about the study is that while we chose six specific areas to evaluate because they are fairly uniform as to their importance in wellness, we found no area where compliance was any better. We didn’t study whether pet owners are in compliance with recommendations for periodic testing of animals on long-term medication or for recheck visits, but we found nothing that suggested compliance in those areas was any better than compliance with therapeutic diets or dentistry or senior screenings.

Novotny: What, exactly, is high compliance?

Downing: Now that we recognize how low compliance rates are, any improvement translates into something huge. That is where our opportunity lies. We have no idea what achievements are possible in our practices. That is one of the most exciting aspects of having these data and the compliance tool (an on-line or CD-ROM tool for measuring compliance available with the AAHA compliance study package). We can apply that compliance tool to any area in our practice and get a handle on what is going on. As Dr. Leininger stated, that is the first step. Compliance starts to change as soon as we start paying attention, before we even develop a strategy.

Miller: The AAHA study was a wake-up call for my clinic. We had started measuring some compliance issues before the study results were released and thought we were doing great in heartworm prevention—we were selling more and doing much better. But then we divided the number of dogs in our practice by the number of months of heartworm preventive we had sold. We were only 25% compliant. So we made a conscious effort last year to talk to our clients about the importance of year-round prevention, and that the product is not just a heartworm preventive, but also an intestinal parasiticide.

Wood: Historically it has been easy to evaluate a practice financially. But now we’re talking about operation evaluation. Let’s say you have a clinic where business is good—it’s growing and the owner takes home about $200,000. That owner won’t be motivated to change. He’s doing better than many of his colleagues. But when the owner realizes that compliance in areas that directly impact pet care is one-third, one-fourth, or one-fifth of what it should be, he gets motivated. It’s not just the owner vs. his colleagues. It’s now the owner vs. his potential.

Leininger: It is health vs. disease and illness. The whole point of this is that we want pets to live longer and better and their families to enjoy them more. It goes back to the conviction of the recommendation, but what about the strength of conviction to even make a recommendation? That was one of the things that surprised me most in the AAHA study. It was not that compliance was poor, but how much
of that poor compliance was due to the recommendation lapse. In many cases, medical records indicated that a recommendation had not even been made. How can you expect your patient to benefit from a therapeutic diet when you do not recommend it to the owner? That is a huge shortcoming on our side.

Welborn: Nutrition is a perfect example of noncompliance in both human and animal health. A lot of people make poor nutritional decisions about their own diet, and they make poor nutritional decisions for their pets.

Wood: We should take a cue from the human dentistry field, perhaps orthodontia. Dentists know how to present a case. They know the power of before-and-after images and put them all over their offices. They show what they will do and give you the estimate. They have a formal way to ask clients for a gigantic amount of money. I don’t know their compliance rate, but they have a formal process in place.

In veterinary medicine, the average client visits twice a year for maybe 30 minutes per visit. And a third of that time the client sits unattended in the reception area. We are not getting information from clients, and they are not getting information from us, so 30% of the patient year is wasted in the reception area. I challenge practitioners to look carefully at the process, at each interaction between the client and the veterinary hospital, whether in the reception area or on the phone or during a recheck in the exam room. You see clients 60 minutes a year. Are you engaging them? How do you present your case for wellness? There is a lot to learn from dentistry.

Consequences of Poor Compliance

Novotny: How many pets are affected by noncompliance?

Miller: Every single one of them is affected.

Downing: There are an estimated 10.6 million dogs and 22.7 million cats in the U.S. that are never seen by a veterinarian in the first place; they are obviously not in compliance. But how many see a veterinarian?

Wood: Tens of millions of pets.

Miller: And all of them are affected by noncompliance. For example, even though a pet is taking heartworm preventive, it still may be exposed to heartworms because the pet next door is not taking a preventive. It is a trickle-down effect.

Albers: Or they may be in compliance with heartworm recommendations for testing and prevention, but they may not be in compliance with a dental recommendation. I doubt there are many animals that are 100% compliant in every area.

Novotny: What are the consequences of noncompliance?

Leininger: One is the quarter-million heartworm cases we see every year when we have absolutely safe and effective prevention available.

Miller: Early death from a manageable disease, such as kidney disease.


Downing: Does the veterinarian lose? Absolutely.

Welborn: And the pet also has a diminished quality of life, so there’s not just shortened longevity but diminished quality.

Novotny: Randomized, controlled, double-blind studies have proved that compliance increases longevity and quality of life in cases of cancer and kidney disease. Another consequence of noncompliance is drug resistance. If you don’t give an antibiotic long enough, the patient may end up with a more serious infection.

Downing: Poorly managed or unmanaged chronic disease is one area where we have a tremendous medical opportunity. As Dr. Welborn has said, noncompliance results in not just a shorter life span, but a poorer quality of life. It’s our moral imperative to ensure that our patients are living not only longer lives, but better ones.

Novotny: So everyone agrees that poor health outcomes and premature death result from noncompliance. What about increased healthcare costs, when you try to save clients money and they don’t have all the preventive services done that they should?

Downing: Part of our goal is to change veterinarians’ thinking so they understand that, in the long-term, they save clients money by doing the lower-dollar interventions now. Instead of coming up with $1,500 or $2,000 for a health crisis, the client spends much less money by doing some preventive things along the way.

Albers: John Fletcher, head of the firm that did most of the AAHA study, asked me a provocative question. We were talking about the fact that veterinarians readily admit that they
do not always recommend the best thing for a patient, but instead recommend what they think the client wants to spend or can afford to spend. He asked, “Isn’t that unethical? Why don’t the principles of veterinary ethics state that it is unethical to recommend anything less than the best?” If you went to a physician and he thought you should have a colonoscopy but wasn’t sure you could afford it, so he sent you home with an occult blood test, wouldn’t you be outraged?

Miller: But that is happening in human medicine.

Albers: Just because it’s happening doesn’t make it right.

Downing: No, it doesn’t make it right at all. If we take our ethical obligations seriously, it is unethical for us not to recommend what is best for the pet. The legal ramifications of that are coming.

Miller: It is already happening in California courts. A client sued for medical negligence because a veterinarian never mentioned that the pet should lose weight. There was no documentation that the veterinarian had ever mentioned that to the client.

Downing: Much of low compliance can be set squarely on the shoulders of the veterinarian who declines to recommend the very best. The recommendation gap goes along with the compliance gap. A lack of a recommendation translates to withholding information. And withholding information probably does have legal, as well as monetary, consequences for our profession.

Responsibility for Compliance

Novotny: Let’s switch gears now. Isn’t compliance really the client’s responsibility?

Albers: If the veterinarian and the practice staff have done a good job of educating a client and making a recommendation in a way that clearly explains the benefit and value of the recommendation, and if they have done everything they can to follow up and help the client accept that recommendation, and if there is then a refusal or failure to comply, then it is the client’s responsibility. We learned from the AAHA study that most veterinarians assumed their part was already done. Now we know that it only becomes the client’s responsibility if we have done everything we can.

Welborn: It is a shared responsibility. We should not defer responsibility to the client. We should accept our portion of that responsibility. That is really where having the conviction to make forceful recommendations on behalf of the welfare of the pet comes into play.

Novotny: What is the single biggest barrier to compliance?

Downing: The veterinarian. Dr. Welborn mentioned that complacency is a real problem. We lack conviction. Veterinarians like to be liked, and we don’t want to be rejected. So we withhold our recommendations, and we don’t spend the time to educate and communicate with clients. And we don’t ensure that our whole practice team is educated in our procedures so that the client gets a consistent message throughout his visit.

Wood: The AAHA study measured compliance against what the veterinarian in a practice recommends. That is all well and good when you talk to the other doctors. However, I suspect that if you talk to 18 employees in a clinic, you would not get the same answer 18 times. Clinics don’t have protocols: this is what we do with every kitten; this is what we do with every adult dog. I’ve seen a lack of standard operating procedures even in successful, high-performing clinics. Clinics need to deliver a consistent message. Clients are not sure what they need, so the staff member holds up four different products to see if they recognize the one they want or have used before. That sends the message: “If we are this confused up front, just imagine what is happening back in surgery.” There is no protocol.

Albers: My view isn’t as negative. Many practices do have protocols. The problem is that not everyone in the practice is uniformly behind the protocols or educated about them. Maybe the whole team knew about them at some point, but that was three years ago. Or if there is a protocol, the responsibility for communicating it falls on the doctor. The message isn’t consistent with everybody at every point of contact. Every associate veterinarian, technician, and client relations specialist can undermine a protocol if they do not buy into it.

Leininger: They can subtly sabotage it. Dr. Downing, your practice has a process in which you educate pet owners about nutrition in a very repetitive way.

Downing: All of the members of our healthcare team have been through mandatory and specific training, clarifying our position on the use of nutrition for wellness and longevity. They have had uniform training through a Hill’s program called Veterinary Nutritional Advocate. Then we reiterate the key messages in each of those modules during
The AAHA standards are focused on quality of care, and compliance is a quality of care issue.

Every associate veterinarian, technician, and receptionist can undermine a protocol if they do not buy into it.

Every member of the staff needs to convey the same message and understand the same protocols if compliance is to be increased.

Our own staff meetings. We don’t talk about nutrition at every weekly staff meeting, but we talk about it several times a year and focus on a particular issue that we think needs attention. My receptionist, nurse, and all doctors who encounter clients have heard the same messages. My receptionist is not going to go into detail about a nutritional recommendation that I make, but she will lay the groundwork when the client comes in. She might say, “Today I know that the nurse and Dr. Robin are going to talk to you about the best food for your pet.” So the client has already heard about diet when she sees the doctor. Then it is the doctor’s job to make the recommendation. The nurse explains the details.

With this kind of continuity, where every team member understands the basics of nutritional management (whether we are managing an illness or wellness), everyone can answer last-minute questions that occur to the client as she is leaving. Or, if a client says, “I know that my dog eats a special food, but I cannot remember which one,” my receptionists are trained to look at the patient’s medical record—we write the dietary recommendation and portion on the front. The protocol is spread among the entire team.

We are now struggling to identify all the areas in which we need to create that same kind of depth. Fortunately, Hill’s has given us the Veterinary Nutritional Advocate program that has been so critical to our success with therapeutic nutritional management.

Welborn: In March, the new AAHA Standards of Accreditation were introduced. Some of the standards involve protocols because AAHA recognizes that establishing protocols for the use of the entire practice team is an important component of high-quality care. Those protocols include those related to wellness care, management of common diseases, and nutritional guidelines both for wellness and medical problems.

Furthermore, the protocols need to be consistent among the veterinarians in the group. Sometimes the owner decides what the practice is going to do without achieving buy-in from other practice team members. Particularly when dealing with healthcare protocols, all veterinarians need to be involved so that they are all committed to the same things. Then the entire practice team needs to be involved in determining the most effective methods to achieve compliance with each protocol.

Leininger: Do the new AAHA standards mention compliance?

Welborn: Yes, there are specific standards that address compliance and the need to measure it, and how to implement a program to improve compliance within the practice. Those
standards are focused on quality of care, and compliance is a quality of care issue.

**Novotny:** What are other barriers to compliance?

**Miller:** Time. When you have 15 to 30 minutes to address everything, it is hard. One area we fall down in is talking to clients over the phone. We are adding that into one of our protocols. We just don’t have enough time when clients are only at the clinic for 15 to 30 minutes, so we are thinking of hiring people to call clients and talk to them about the food or medication that we sent home.

**Albers:** There is a lot of information to convey in a short time. If you have an animal come in for an annual physical exam, you have to talk about vaccinations, heartworm prevention, senior screening, dentistry, and diet, all in a relatively short period. That underscores why it is so important that everybody on the healthcare team be aware of and participate in your practice protocols. I think Ms. Miller’s point about follow-up is important, too. A lot of compliance can be addressed through proper follow-up, by calling people afterward and sending reminders. We don’t maximize use of our practice management software systems. We send reminders for heartworm tests and vaccinations, but they could be used to send reminders for just about everything. In the AAHA study, a lot of veterinarians told us their clients did not want them to call and bother them, but we found that clients said just the opposite. They want to be reminded and don’t mind telephone calls. Clients perceive such reminders as an indication that the veterinarian must care enough to make sure they get the recommendation.

**Leininger:** When I go to my dentist, he does not try to fix everything in one visit. If a problem is found during a routine cleaning and exam, I’m asked to return for the next procedure. And do I object to that? No, because I know it needs to be done. Where did we get the idea that we had to cover 10 topics and the ear flush and the nail trim all at one time? Maybe veterinarians should start thinking that they do not have to cover 100% of the problems in one visit.

**Downing:** I think Dr. Leininger is right. Why do we have this idea that we have to do every single piece of business in one visit? We’ve lost sight of how important it is to recheck, reschedule, remind, and recall. These steps are part of our continuum of care, part of our continuum of compliance. When we schedule certain patients to be in touch with our healthcare team on a regular basis, we increase the number of opportunities to help the client identify if something is not right. The more contact we have with that client, the more opportunities there are for my receptionist to ask if everything is okay. She can ask if there is anything the client needs to talk to us about. We know there are clients who will tell the receptionist things that they will not tell the doctor. Maybe they think it’s too much bother, or they don’t want us to think they’re asking a dumb question, or they don’t want to be perceived as a bad pet owner. They aren’t going to ask these questions unless they have an opportunity to do so. How is that going to happen? By enticing them back into our practices through rechecks, rescheduling, reminders, and recalls.

**Wood:** KPMG, the consulting firm that performed the Mega Study for the American Veterinary Medical Association (AVMA), AAHA, and the Association of American Veterinary Medical Colleges, showed indisputably that people who buy pet food from a veterinary hospital visit the hospital much more frequently. More frequent visits result in greater sales of veterinary services and products and better pet healthcare.

**Leininger:** Veterinarians also think cost is a barrier to compliance, but the AAHA study proves otherwise. While veterinarians are notorious for making decisions based on what we think the client will actually say yes to or be able to afford, clients want us to recommend the absolute best for their pet, regardless of the cost.

**Novotny:** What percentage of clients felt that way?

**Leininger:** It was high, somewhere around 90%. Clients want to hear about what is possible.

**Novotny:** What percentage of clients, when offered the best medical or surgical therapy, said they did not want that?

**Downing:** The study measured what percentage of clients declined specific services based on cost in three categories—it was fewer than 10% in every case.

**Albers:** It was 7% for dental, 4% for therapeutic diets, and 5% for senior screening. Veterinarians tell me that some people lie about the reason they refuse the recommended care. So perhaps instead of 4%, it is really 8% who refused therapeutic nutrition because of cost. But the numbers are still low. Even if it was 20% who refuse because of cost, that still leaves 80% of clients who would be happy to pay our fee for the service.
Key Points

- The need for a recommended procedure—or the benefit of it—is often not explained well enough to clients.
- The AAHA compliance study showed that clients want veterinarians to recommend what is best for their pet, regardless of cost.
- It is clear that money is not the prime motivator in the client’s decision-making process.

Leininger: We think the biggest obstacle for pet owners is cost, and in reality, that is the smallest obstacle.

Albers: Veterinarians told us in interviews that they are sometimes reluctant to make recommendations that they know are important because they are concerned that the pet owner will think they are just trying to sell their services and make more money. But 75% of pet owners agreed that their veterinarian made recommendations because the recommendations were in the best interest of the pet. Only 10% agreed that the veterinarian’s recommendations were motivated by the desire to generate more money. Again, there’s a complete contrast between what veterinarians and clients think.

Downing: How many times do veterinarians have to hear this message? And in how many different ways? This has come up in survey after survey of pet owners. It is clear that money is not the prime motivator in the client’s decision-making process.

Leininger: Why do you think that is such a difficult message for veterinarians to get?

Welborn: I think it’s because of the profession’s large-animal background.

Wood: Dr. Jack Stephens, the founder and CEO of Veterinary Pet Insurance, has said we need to remember that we are only about 30 years removed from when dogs and cats were largely disposable. As practice management consultant Dr. Marty Becker always says, this migration from the backyard to the bedroom is a relatively recent phenomenon.

Welborn: We all want to be liked, and we have a fear of rejection. We’ll have 200 clients say “yes” to everything we recommend. But when one client says “no” and implies that it’s not worth it for his pet, it will wash away all 200 positive responses in our mind. This negative interaction between a veterinarian and an individual client overshadows all of the studies that are consistent on this issue. The reality is we have to change our mental response to that interaction.

Wood: There is an area of psychology called behavioral finance. We know people project their own financial situation. If I am an assistant and not making ends meet, or an underpaid receptionist or technician, or a doctor making the national average of $70,000, I project my economic situation onto my client. If I can’t figure out where my rent check is coming from, then I probably would not have a $1,000 workup done. So I make economic decisions for clients based on my financial situation. It is almost self-fulfilling. From the veterinarian to the kennel assistant, too many are guilty of this phenomenon.

Albers: I’ve also talked to veterinarians who just don’t believe the data confirming that pet owners don’t consider cost when making decisions. The way I think about costs is that if I go out to a nice restaurant, I might look at the menu and think to myself, “Wow, that’s pricey.” But I’ll order what I want anyway because I want that experience. Or I’ll go on the Web and see that a room at the Four Seasons is $400 per night, and I’ll think, “Wow, $400 per night.” But if I want that experience, I’ll pay for it. When a veterinarian recommends dentistry and preanesthetic lab work and tells the client it will be $225, the client may very well say, “Wow, that’s expensive!” The client, however, may agree to do it, even if he verbalizes that it is expensive. The message that veterinarians seem to take away from that sort of conversation is that people really do not want to spend money.

Downing: When instead our response should be, “Yes. That is a lot of money.”

Leininger: But it’s a great investment in your pet’s health.

Albers: But for many veterinarians, the typical reaction as soon as a client says, “Wow, that’s expensive,” is “maybe we could skip the lab work.”

Downing: I think it comes back to your example about the Four Seasons. They say, “Wow, that is expensive. But I am going to spend that.”

Novotny: What factors lead to good compliance?

Miller: Repetition of the recommendation is important. The client comes in and the receptionist says, “We see Fluffy needs a heartworm test.” He may say, “I don’t want a heartworm test today,” but at least he’s heard the recommendation once. Then when he goes to the exam room, the technician reiterates that Fluffy needs a heartworm test. He may tell the technician he doesn’t want a heartworm test. Then the doctor comes in and says, “Fluffy needs a heartworm test.” Now he has heard the recommendation three times, and he finally realizes Fluffy must need a heartworm test. So he is more likely to agree to the test.

Downing: Part of what contributes to compliance is clear
A KEY TO BETTER PATIENT OUTCOMES

and specific instructions that are written as well as verbal. Clients cannot process the volume of information that we try to impart in the exam room. They won’t remember a majority of what they hear. They will remember more of what they read. If what we say is complemented by written instructions, then we know they are going to walk away with a much clearer message.

Also, the words we choose when speaking with clients can strengthen our message, and the conviction behind our recommendations influences the client to make the right decision. Saying “need” vs. “should.” Saying “we could do this or that” is not as persuasive as saying, “It is in Fluffy’s best interest for us to do A, B, and C.”

We had a dog come into our clinic with end-stage glaucoma. It had been to an ophthalmologist, and the diagnosis was clear. The receptionist mentioned the ophthalmologist’s recommendation that the eye be removed. The clients said, “No, you are not taking our dog’s eye out.” The veterinary nurse did her preliminary examination and again mentioned the ophthalmologist’s recommendation. The clients said, “No, we can’t take her eye out.” I walked into the exam room and said, “We need to take her eye out.” The clients said, “All right. When will we do that?” It happens over and over again. The point is repetition, repetition, repetition. Human nature being what it is, we need to hear a message at least three times. Marketing people know this.

Novotny: And you need to check for understanding. I know what I said, but I am not sure what you heard.

Albers: Another barrier to compliance that clients mentioned in the AAHA study is that the need for a recommended procedure—or the benefit of it—is not explained well enough. It is not enough to just say, “We should get Fluffy back in to clean her teeth,” or “Rover is 8 years old. We should draw some blood.” You need to explain why, what the benefit is, and what will happen if we do not do it. Back to a point mentioned earlier—in the AAHA report, a significant number of clients indicated they wanted instructions both verbally and in writing.

Wood: A study done in 1996 supports that. People remember 20% of what they hear, 40% of what they see, and 70% of what they see and hear. A 1973 study found that patients remember half of what the clinician says. Of the half they remember, half of that is wrong. The best case scenario is that they get 25% of the stuff right. So your recommendations and instructions have to be spoken and written down; images and illustrations are also helpful.

Downing: To remember what contributes to good compliance, we can use the acronym CRAFT (Compliance equals Recommendation plus Acceptance plus Follow-Through). Actually, I think we ought to make it CRAFTA because we have the recommendation and the initial acceptance, which is the client’s willingness to hear what we have to say to begin the process. Then we have the follow-through. But then there’s another level of acceptance, and that is the client’s continued participation in the process of managing the pet.

Albers: The formula was really meant to be that compliance equals the sum of those three components. They can occur in a different sequence, but they all have to happen to achieve compliance.

Leininger: There is the “Yes, we will get the dental work done.” And then there is the “Yes, we will continue with home care and a dental diet after the dental work is done.”

Albers: Even if a client tells the doctor in the exam room, “Okay. I’ll have my dog’s teeth cleaned,” but no appointment is set or follow-up call is made,
INCREASED COMPLIANCE:

then there is no compliance. Even though there may have been a recommendation and an acceptance, there is no compliance because there was no follow-through. Again, the three parts can happen, in any sequence.

**Leininger:** We need to look at how we talk to clients when making a recommendation. We may have to keep packaging what we say in a different way until they finally get it. Maybe we should demonstrate how damaging something will be to the overall health of the pet if the client doesn’t follow through. Maybe that will be a message that will resonate.

**Novotny:** Is part of the problem that we see many clients only once or twice a year? Instead of getting them to come back, like a dentist would, we try to do everything in one day and think the rest can wait until we see the patient in a year. Instead we should be saying, “Your pet has these problems and we need to schedule a time to talk about them. This is what your pet needs. Let’s do these things.”

**Albers:** Your point is great. I need to be able to say, “Fluffy is 8 years old. We should run some lab tests just to check things out. Then let’s schedule you to come back in a week and we’ll talk about the lab results and catch up with the routine vaccinations.” I think the dental model is something we can learn from. Dentists never say let’s block off four hours next Monday morning to fix everything at once.

**Downing:** We are talking about pet ecosystem management. It works great in our context. One problem I face every day in my practice, being a practice of second and third opinions, is the myopia that occurs in veterinary exam rooms. A pet is brought in because of a fractured toenail, so we fix the fractured toenail and send the pet on its way, leaving its renal disease undiagnosed. Or its horrible dental disease undiagnosed. All because it came in for a broken toenail. When that happens, we are not managing that pet’s ecosystem. We are not practicing holistic medicine. We need to manage the whole patient within the context of its family, its lifestyle, its activity. As a profession, we have to correct the myopia and start managing the patient in the context of its entire living situation.

**Leininger:** I agree with Dr. Downing about the importance of looking at the whole animal. I think we are the last health profession that looks at an entire creature. In the human medical profession, they focus on organs or systems and they almost never look at the entire being. My dad is 89 years old and he sees a geriatric psychiatrist, a cardiologist, and a gastroenterologist. And these physicians do not talk with one another. We as a health profession are among the last to actually spend some time looking at this entire creature and not only the creature, but who it connects with, its family. And some of us are willing to give that away. We are going to say we will only look at the toenail.

**Novotny:** I want to revisit information and recommendations for a little bit. If you give clients information and send them out the door, is that a recommendation?

**Wood:** It’s a good start but, there is no follow-through, which is an integral part of the CRAFT equation.

**Downing:** We talk about a problem we have identified in a patient, and we think we have delivered a recommendation. We expect the client to make the jump from information to action. The AAHA study demonstrates that this does not happen. Delivery of information is not adequate to compel the client to take action. We need to specifically state our recommendation and make sure the recommendation is given in writing as well as verbally. In our practice, we try to schedule a follow-up appointment while the client is in the exam room. We try to capture that next contact.

**Welborn:** A real-world example might be how we deal with an obese pet. We should tell the client that obesity results in health problems, but some veterinarians make this statement and leave it at that. Some go on to state that the pet needs to lose some weight. Though true, we need to provide guidance about how that should take place. Then there is the next step of recommending that the pet be switched to a food such as Prescription Diet Canine r/d, Feline r/d, or Feline m/d (Hill’s Pet Nutrition). But even that is not enough unless you follow through and make sure the client actually accepts the recommendations. An appropriate recommendation provides information about the importance of the problem and then provides the action steps that need to take place to deal with the problem.
into a clinic, we need to tell the owners about the health risks associated with obesity and give them materials to read at home, literature about problems that can result from obesity—cancer, diabetes mellitus, cardiovascular disease, liver disorders, and joint problems. I cannot tell you how much osteoarthritis I have cured with “hypogroceriosis.” It’s not enough to tell a client that his pet is overweight; we have to tell him what we are going to do about it. In my clinic, we first make sure there’s not a metabolic disease, like hypothyroidism, interfering with the pet’s ability to be active and lose the weight that it needs to lose. After that, we make a specific nutritional recommendation and show the client how to measure the portions. Then we schedule a free weigh-in for two weeks later. If there’s no progress in the two weeks, something in the equation is not working, and we try something different. It’s difficult for the client to turn down this recommended plan.

Wood: If we did a survey, I bet we’d find that 95% of veterinary practices don’t send a card or make a call reminding clients to purchase the next bag or case of food. And that is why too many pets don’t stay on therapeutically appropriate foods the rest of their lives. In the case of obesity, not only is quality of life compromised, the case of obesity, not only is food the rest of their lives. In

Novotny: Do you think clients would be more compliant if veterinarians and their healthcare teams made more, and better, recommendations?

Leininger: Absolutely. A couple of the practices involved in the AAHA study focused on one service and were able to increase the percentage of pets that did receive the recommended care. Compliance can be improved. We can make a difference.

Welborn: In the AAHA study, the overall compliance rate for senior screening was 33%. However, of the pet owners who actually received a recommendation for senior screenings, 72% of them accepted that recommendation.

Albers: All the veterinarian had to do was make a recommendation to the client.

Downing: Also, 23% of owners of pets with dental disease never got a recommendation, or what they perceived as a recommendation, although they may have had the information delivered to them.

Novotny: Can you spot non-compliant clients when they come into your office?

Leininger: Absolutely not. They don’t look any different from other clients.

Wood: Aside from pulling their medical records and seeing that their pets are behind in vaccinations, I don’t think you could identify them.

Novotny: I asked that question because a Louisiana State University study recently examined compliance among breast cancer patients, and the researchers found no association between compliance and age, race, stage of cancer, economic status, or education level.

How do you respond to someone who says, “The AAHA study results are fine, but my clients are different—they won’t pay for quality care.”?

Downing: We have empirical evidence showing that it is not true that clients won’t pay for quality. It comes back to Dr. Welborn’s example of the 200 clients who say yes to everything and the one who says no. That is the one we remember. It colors our perception.

Albers: If veterinarians say clients won’t pay for quality care, I ask them why they think that. These surveys cross all economic spectrums. They are balanced, relative to the U.S. census population in terms of socioeconomic class and income, race, and gender. “What is it that makes your practice different?” I ask the practitioner, who says, “Well, I just have this client...” Then I ask her to think about what her colleagues are doing down the street. If it’s true in one practice, is it true of all the practices in that area? When I hear practitioners make a statement that clients won’t go for a necessary procedure, I know it is going to be tough to change the mindset in that practice.

Leininger: A number of years ago, a Canadian veterinary medical association did a study on raising fees. Included in the study were some tiny, blue-collar towns in the northern provinces. Two practices in one town had demographically the same kind of clients, but one practice bought into the change in fees that the medical association recommended and implemented substantially higher fees. The
other practice did not. The clients said yes in the first practice; clients at the other practice were never asked because the doctor said it would not work. Dr. Albers is right. There are some things we cannot change. There will be some practices that won’t thrive.

Welborn: I don’t think we can give up on these practices. As a profession, we haven’t done a good enough job educating them. Hopefully the AAHA study will open a few eyes. There will be some noncompliant practices that will change into compliant practices. And there will be some that you can’t do anything about.

COMPLIANCE AND PATIENT OUTCOMES

Novotny: What is the relationship between compliance and better patient outcomes?

Albers: The relationship is directly proportional. Improved compliance is associated with improved outcomes.

Welborn: We have to assume that is the case, and it’s a reasonable assumption, but I don’t think we have true measures of patient outcomes.

Downing: Sometimes we do know the patient outcomes, if we have compliance with recommendations. Renal disease is a good example. Hyperthyroidism in cats is another. It’s easy to extrapolate from the data we have that the probability is high that compliance leads to better outcomes. Ideally, this begins to feed upon itself. We have compliance breeding compliance.

Wood: If you don’t believe it’s true, then all your recommendations are based on economic motivation. This is not a case of AAHA dictating guidelines, but practitioners saying these are their guidelines. Consequently, practitioners presumably would not recommend them if they were not in the best interest of their patients.

Welborn: And once aware, you need to begin measuring compliance.

Miller: And find out where the weaknesses are.

Leininger: The first step is to give every practice access to the tool that AAHA has developed. It explains where the holes are. AAHA has prepared materials to start the process, and you can measure where you are starting from. But even before this AAHA tool can be used, practitioners have to decide what they believe is important in their practices. They have to look at their protocols—what they believe relative to vaccination frequency, what diseases they vaccinate against and under what circumstances, and so on. It has to be a consensus opinion—the veterinarians and the technicians. Once that’s established, then practitioners can measure what compliance is in their practices.

Downing: The AAHA measurement tool helps quantify compliance, and it is not until we quantify it that we can set meaningful goals—10%, 15%, 25% improvement. Then it’s train, train, train, and track, track, track.

ROLE OF THE HEALTHCARE TEAM

Novotny: Which brings us to the veterinary healthcare team. What are their roles in improving compliance?

Downing: They are pivotal roles. Every member of the team has the opportunity to help improve compliance. In some situations, the veterinary nurse or the receptionist has more influence in sustaining compliance than the veterinarian has. Why is that? Because they are the ones who have
more frequent, ongoing contact with clients.

I like thinking about compliance in terms of a continuum. The care that leads to compliance begins with the client’s first exposure in the reception area. How do we manage that encounter? When the client goes into the exam room with the veterinary nurse, how is that encounter managed? Then the doctor meets the client in the examination room. How does the doctor manage that contact? There are steps along that compliance continuum to reinforce the foundation that was laid at Steps 1 and 2. Then how do we close the deal? How do we manage a client’s encounter as he leaves the clinic? Does he leave with a strong, specific set of recommendations that clients understand better. We tend to talk doctor-ese. Instead of talking about renal disease, our staff might talk about kidneys, or instead of lymphoma, they talk about cancer.

Wood: Practice management consultant Don Dooley has said to forget the doctor and spend the time training the healthcare team. We need to get them on board in terms of protocols and processes to improve compliance. Train them and give clear direction about what the protocols are in your practice. Then get out of their way.

Novotny: In the AAHA study, was compliance affected by the ratio of technicians to veterinarians in the practice?

Downing: Oh, yes. A 3:1 ratio—three support staff to one doctor—created better, though not optimal, compliance.

Novotny: So it is more of a dental model?

Downing: Yes.

Leiminger: It may be that a higher number of support staff per veterinarian indicates those veterinarians are willing to delegate and let the support staff actually do what they can do. Dr. Downing mentioned that the veterinarian makes the core recommendation, and the veterinary nurse gives the supporting documentation—the explanation why this patient needs to be on a reducing diet or a renal diet. Then the receptionist handles the small questions. The doctor should do only what doctors do and should delegate the rest.

Also, the support staff may talk in a way that clients understand better. We tend to talk doctor-ese. Instead of talking about renal disease, our staff might talk about kidneys, or instead of lymphoma, they talk about cancer.

Wood: As has been shown in human medicine, if you don’t have the white coat, you are more likely to get the questions.

Dr. Taffi Tippit, a practitioner in Houston, is convinced that when her receptionists or technicians present a recommendation to a client, they do it in a different way, so that fewer clients think it is economically motivated than when the doctor makes the same recommendation. The client thinks, “What does the receptionist have to gain by recommending this annual wellness screen?” Clearly, the data suggest a strong correlation between improved compliance and greater involvement by the healthcare team.

Albers: The AAHA study included an interesting chart that showed which staff members were most involved with compliance according to the veterinarians queried—the veterinarian mostly, the veterinarian and staff equally, or mostly staff. The results were: The veterinarian only, 48%; the veterinarian mostly, 49%; the veterinarian and staff equally, 65%; and mostly staff, 75%.

Novotny: Do we compliment clients enough when they do something right?

Leiminger: Veterinarians are trained to look for the negative. When a client follows a weight-loss protocol that we set up, and a goal is reached, we should celebrate that. We don’t always do that.

Downing: Complimenting clients has been key to some of our success with therapeutic nutritional management. The idea actually came from my receptionist. She said we need to remember to say something nice to owners whose pets are on a reducing diet, even if we have to stretch it, for example, “I think I see a waistline emerging.”

With our renal patients, we do follow-up bloodwork once we make a nutritional change to Prescription Diet k/d. If there is enough renal function left, and we make that nutritional intervention, we should see noticeable improvement, such as decreased BUN concentration. I recently examined a cat that was azotemic, with a BUN of 42 mg/dl and a creatinine of 2.4 mg/dl. After nutritional intervention, the follow-up bloodwork showed a BUN of 22 and creatinine of 2.2. It may be a small change, but it is a big step in reinforcing the client’s commitment to stay compliant with our recommendations.

Novotny: The World Health Organization calls that supporting and not blaming the client. How important is it to set

Key Points

• The first step in improving compliance is to give every practice access to the tool that AAHA has developed. It explains where the holes are.

• The AAHA study included a chart that showed which staff members were most involved with compliance according to the veterinarians queried—the veterinarian only, 48%; the veterinarian mostly, 49%; the veterinarian and staff equally, 65%; and mostly staff, 75%.
Dr. Leininger’s point is well made that we have to resist the temptation of setting our goals too high, or we set ourselves up for failure. We shouldn’t say we are going to have 100% compliance—that’s not achievable in many areas.

**Albers:** I’ll take the opposing position. Rather than focusing on one area, I’d prefer an increase in compliance across the board, even if it is only a few percentage points. I see compliance as a process, and the process is the same whether we are trying to improve compliance with therapeutic diets or senior screening. I think if I had a practice, I would try to work on staff training and talk about how to improve compliance, whatever the issue is. If a dog needs dental care, but my practice happens to be focusing on senior care, I am not going to ignore the dental problem. I will apply the same principles to try to get compliance with the dental procedure.

If you could move the needle just 3% in all areas of compliance, you would have tremendous growth.

**Welborn:** We have chosen in our practice to focus on several things at one time. There is so much overlap. It is hard to say that we are going to focus on senior screening for this particular pet, but not talk about dental disease or dietary management. It doesn’t make sense to focus on just one area.

**Albers:** I don’t disagree that there is a lot of overlap. You can’t talk about advanced periodontal disease and not talk about senior care, because who gets periodontal disease? It tends to be the older pet. And we can’t talk about older pets without talking about renal disease. On the other hand, we know there are practices that remain skeptical. To create momentum for those practices, it may take a narrow focus to prove that you can improve compliance.

**Wood:** In some clinics, if there are too many compliance areas that need attention, it’s easier to do nothing. If you only have 15 minutes and you know it’s impossible to get everything done in that time, it becomes easier to overlook the obesity or the lab tests or avoid the five-minute conversation about dental disease. It’s too overwhelming to the client. That is my concern if we say compliance is dismal in all six of these areas. It’s too much for some practices.

**Novotny:** Does this happen? You decide you are going to work hard on one area, and you do for three months and have good results. But next month you get busy doing something else, and you let the other area slide. What message does that send? It was important last month, but it is not important this month. Does that happen?

**Miller:** That is why we stopped celebrating dental health month and senior pet care month. We focus on dental care, senior pet screens, and heartworm testing year-round. We don’t have a specific month just to do heartworm tests.

**Downing:** Our mindset has to be that these are long-term commitments. It needs to become habitual in our practice culture that certain things happen.

**Welborn:** If you have healthcare protocols that you believe in, they should be consistent.

**Tracking Compliance**

**Novotny:** What is the best way to track compliance?
**Albers**: That is a huge problem. Even though most good systems will accommodate diagnostic codes, almost no one uses them. When we visited veterinarians for the AAHA study, the consultants assumed that they would be able to extract a lot of compliance data from the practice management software systems, but they could not. In fact, they found that the only reliable data on compliance came from a hand search of medical records. The problem is that we track procedures, but knowing that we did 20 more dental procedures this month than last month doesn't tell us anything about compliance. That's because we have no idea how many patients should have had a dental procedure this month. So, until we get more uniform recording of diagnostic codes, it will be hard to get compliance data in a simple way. Consequently, we can compare practices because they all use the same tracking system. It may take AAHA or the AVMA to set the codes for measuring compliance from one practice to another.

**Wood**: The only way short of looking at medical records is purchasing volumes. Let's say that in Kansas City, Missouri, you believe that dogs need to be on year-round heartworm prevention. If I know the number of dogs you saw last year and make a phone call to your distributor, it is easy to do the math and see that enough heartworm preventive was bought to cover just 40% of the dogs, or cover only 40% of the recommended time period.

The good news is that the software providers are acknowledging the importance of compliance and are willing to facilitate that process. If practices ask software vendors to incorporate compliance tracking into their products, then it will happen.

**Leininger**: Because of AAHA, we have a uniform chart of accounts that is used by almost every veterinary practice. Consequently, we can compare practices because they all use the same tracking system. It may take AAHA or the AVMA to set the codes for measuring compliance from one practice to another.

**Albers**: AAHA plans to do that by developing a common set of diagnostic codes as well. We can develop a common set of diagnostic codes. The biggest challenge will be getting veterinarians to see the value in entering those codes.

**Leininger**: Because it will be one more step.

**Albers**: It is not only the “one more step” problem. I think we are reluctant as a profession to commit ourselves to a diagnosis before we have the necropsy report. We could be wrong.

**Wood**: While most of the systems today can handle diagnostic codes, I can count on one hand the number of practices utilizing them.
**Key Points**

- Explain to staff members that they are not selling products; they are educating clients on proper pet nutrition and proper pet ownership.
- Veterinarians need to stop thinking about just annual wellness exams and start thinking about what each individual pet needs. Senior pets, for example, may need more frequent checkups.
- Tell the client your recommendation, then go over the written instructions to reinforce compliance.

**Increased Compliance:**

**Welborn:** If people embrace the idea of improving compliance, they will recognize that diagnostic codes are necessary to measure it. Ultimately, we will use diagnostic codes.

**Downing:** I think you’re right. Compliance will be the hook. Veterinarians are going to recognize the need to track compliance, then we will try to and realize we don’t have a way to do it.

**Communicating with Clients**

**Novotny:** Let’s talk more about effective communication. In 1999, the journal *Medical Care* published an article in which investigators audiotaped conversations between patients taking long-term medications and their primary care doctors. The average conversation lasted less than four minutes. We don’t have comparable information in veterinary medicine, but we have our typical 15- to 30-minute appointments. How can a client absorb all the information? How can you impart all the necessary information during that brief interval?

**Leininger:** You can’t.

**Downing:** No, but there are steps you can take. Probably one of the most important things is to be prepared. Medical charts need to be pulled before the client arrives. Someone on the team needs to identify and flag the areas in which this patient is not receiving the best care. Those areas then receive attention during the client interaction. Secondly, it’s important to prepare written materials you can give the client.

**Leininger:** Pet owners need to hear and see the information.

**Downing:** The written materials used to reinforce the verbal message have to be easily retrievable. It doesn’t matter how great the written materials are if they are not easily retrievable by every member of the healthcare team.

**Wood:** But even if you have all that, you may find those pieces of paper in the parking lot.

**Downing:** Exactly. Which brings me to the third piece: the follow-up phone call. If we are going to maximize our 15 to 30 minutes with a client, that experience needs to be an integrated one. We impart a verbal and written message, and then we follow up. So that 30-minute appointment is not really a 30-minute appointment. It is 30 minutes plus the time we are on the phone with them a week or three weeks from now because we have scheduled another call back.

**Leininger:** But it is not just the doctor’s contact that will inform the pet owner. It is the healthcare team member who calls back in three days and asks how the transition to a new food is going. And two weeks later, the client brings the pet back for the weight check. And three months later, we repeat the laboratory tests. It becomes a continuum of information that goes beyond that one time in the office with the doctor. It is the whole team’s communication over time.

**Downing:** One of the statistics in the AAHA survey that astounded me was that only 10% of clients did not want their veterinarian to call them.

**Welborn:** Another interesting fact was that 80% of clients wanted both verbal and written instructions. Sometimes the veterinary practice team thinks we are forcing information on the clients, but all we are doing is giving them what they want.

**Miller:** In our staff training, we say we are not selling a product. We are educating clients on proper pet ownership. That is a key to getting the staff to buy into it.

**Leininger:** We have to stop thinking about a one-time annual wellness exam. That may not work for an older pet. The interval for appointments should be what that particular pet needs. Tailoring a schedule for repeated health evaluations to a pet’s medical condition is no different than tailoring a vaccine protocol to a pet’s infection risk.

**Novotny:** Maybe one way to maximize the time that you spend with clients is to verbalize instructions, and then go over the written instructions with them. People will remember two or three concepts on a good day, and you should prioritize what you tell them.

The American Academy of Family Physicians did a study in 1996 that suggested as many as 90 million Americans struggle to understand health information. So when you give handouts and tell clients to read them and call if they have questions, it may not work. If these numbers are correct, 20% to 40% of the clients in a typical practice may not know what you’re talking about. Sometimes our instructions are written at too high of a level. Some people suggest that materials be as low as a fourth-grade reading level.

**Downing:** We use a patient report card to help with written instructions. You can design your own or use someone else’s template. It helps us maximize our time with the client. Most report cards have an area for writing recommendations and...
comments, and we will fill that in and review it with the client. As Dr. Novotny suggested, we tell them what we are going to tell them, and then we review it in a written form before they leave the room. So the client leaves with something in writing, and we place a copy of the patient report card in the medical records so that other members of the healthcare team can look at it and know that three weeks ago a certain recommendation was made.

Welborn: There is a bit of a conflict between the desire to communicate with clients at their level and our desire to show that we possess medical knowledge.

Leininger: The goal is better patient care and, to reach that goal, the client has to understand not only what better care is, but why it is in the pet’s best interest. It shouldn’t make any difference how you get there.

Wood: Using audiovisuals is an effective way to explain bodily functions and conditions. Studies have repeatedly shown that even highly literate patients recall a physician’s instructions much better when diagrams or pictures are used to illustrate a point.

Novotny: You should use materials suited to the literacy level of each client.

CELEBRATING SUCCESS
Novotny: Tell me, if you are improving compliance in a practice, when and how should you celebrate success?

Miller: I was just planning that this morning—we are having a team appreciation day. We’re closing the clinic for half a day, going out to lunch, and having some team competitions at a restaurant that has great game machines. We had set goals for year-round heartworm prevention and far exceeded them.

Leininger: How did you get there?

Miller: Training. We had in-house seminars and shared the numbers with the staff—the number of dogs in the practice and the number of heartworm pills being sold. They were astounded because they thought we had many more on year-round prevention. We let them establish a realistic goal. One of the heartworm prevention companies also came in to help us set that goal. Our goal was an increase of 40%. We actually increased compliance by 70%.

Leininger: Did you change your process and recommendations to the client?

Miller: We took all the six-pack packages from the front desk, leaving only 12-pack packages there. Because the receptionists had to leave the front desk to get a six-pack, they were more apt to recommend the 12-pack. Also, we kept telling clients their pets needed to be on year-round prevention and why. All of our team members were brought up to speed for the reason behind that need. So it created a sense of urgency.

Downing: Back in 2000 we had dismal compliance with seasonal heartworm protection. In 2001, the heartworm survey pushed us to go to year-round protection. We saw a smaller than expected increase in the number of doses sold for dogs in our practice. Then we participated in the AAHA compliance survey and realized we were not doing what we could be. We found that we got to the end of the 12-month period, and clients who had been sold a 12-pack of Heartgard (Merial) still had three doses left. So we set up a courtesy call program. I ask my clients if they want to participate—I don’t want to call if it is inconvenient for them. Then two days before to two days after the first of the month, we call clients on the list to remind them to administer the heartworm preventive to their dogs. I’m on my own courtesy call list. Even I have a hard time remembering that next dose. We put a sticker on the front of the records that says, “Heartgard courtesy call.” Every time that record is touched by a healthcare team member, they know they don’t have to ask about the call list because the client is already on it. Our clients think this service is great, and they thank us.

Wood: To a pet owner, there is an enormous difference between the word “recommend” and the word “need.” If you recommend something to me, it’s not urgent, critical, or time sensitive. It’s just nice to have. If you say I need something, that’s a whole different ball game.

Downing: What do you say to a client when he asks if it’s necessary for him to do what you’re recommending?

Leininger: If you don’t say “Yes,” you’re crazy.

Downing: And then you just be quiet. I think we forget how important it is to be silent and get out of the client’s way. If the client tells us it is expensive, we say, “Yes, it is.” And then zip it.

Welborn: Will Rogers said that we should never miss a good chance to shut up.

FOLLOW-UP PROTOCOLS AND COMPLIANCE
Novotny: Which follow-up
We can learn a lot from human dentistry. Dentists are good business people. Rarely does anybody leave a dental office without another appointment.

Reminder calls are appropriate and effective for a variety of things, including:
- heartworm checks
- vaccinations
- missed medication refills
- missed food repurchase
- wellness exams
- missed appointments

protocols positively affect compliance? We talked about reminders and phone calls. Does anyone have anything else that you want to discuss?

**Leininger:** I think we can learn a lot from the human dental model. They are doing something right. Oral health in this country is better than it has ever been. These dentists are very good business people. They have good incomes. They have a life. They have well-compensated support staff. So something is going right. Rarely does anybody leave a dental office without another appointment. Also, they stage their visits. They don’t do everything all at once.

**Novotny:** How does your dentist contact you before an appointment?

**Leininger:** With a phone call two days before the appointment—every time.

**Novotny:** And if you miss your appointment?

**Leininger:** I get a phone call asking when we can reschedule.

**Miller:** We contact clients for missed appointments.

**Leininger:** If it is important that a patient be on a certain medication and the client is behind in refilling the prescription, then why wouldn’t we call the client and remind him?

**Miller:** That is something we need to track better.

**Leininger:** In our practice, we generated a call list for patients that needed more food. We don’t have much storage space, so we needed to get the product in and out of the clinic in the same week. We calculated when clients would need the next bag of food, and we’d call them to say we were getting a shipment. If we had to leave a message, we’d tell them to call by a certain date so we could order the product for them. If they didn’t call back by that date, they were still on the list showing that they needed more food. One of the surprising things from the AAHA study was how often clients wanted to be reminded before they tired of it—five times. We think one or two reminders are enough, but we forget that our clients are as busy as we are. A veterinary visit may not be a priority this week. So they need the repeated contacts.

**Downing:** When clients buy products from us, it’s a great opportunity to keep them in compliance in other areas. When a client buys a refill of food, Heartgard, or CET chews (Virbac), my receptionists pull that animal’s chart even though the client is there to buy a specific product. The receptionists do a quick spot check of the areas that we consider reminder services. They look for anything asking when we can reschedule.

**Miller:** I get a reminder card a month before my appointment. Then I get the phone call, both at home and at work.

**Welborn:** Some people making the phone calls in veterinary hospitals are relieved to get an answering machine so they can leave their message. They think they have done their job instead of working to actually speak directly to the client.

**Wood:** It’s unusual to have a receptionist at a dental office whose compensation is not directly tied to how full those chairs are every day. That is why you get those phone calls ahead of time.

**Novotny:** We do pretty well with reminders for vaccinations and heartworm checks. We’ve learned that 80% of clients want reminders. How many practices contact clients when they miss an appointment? Miss a medication refill? Miss a food repurchase? Does that happen?
that is out-of-date. It gives them
the opportunity to tell the client
that we need to get back on
track. They can say, “I see that
Maggie is due for her vaccina-
tions. Would you like to sched-
ule that appointment while you are
here today?” Or they can say, “As long as you are here,
could we take a minute to look
ahead?” The client has not had
an interaction with the doctor or
nurse, so there is really no level
of intimidation. Yet the client
may be receptive since it was
important enough for the recep-
tionist to bring it up.

Albers: That is a great point. I
agree that every patient record
that is pulled for whatever rea-
son should undergo a compli-
ance review by the receptionist.
She shouldn’t mention that we
sent them six reminders and
they didn’t pay any attention to
them. But now that they are
standing in your clinic, some-
thing can be done.

Downing: When clients come
in for medication refills, my
receptionists say, “It has been
six months since we have run
blood work. If we are going to
renew this prescription, we
need to schedule it. Do you
have time later this week or
next so we can do that?” I
won’t give medications if I
don’t have current lab work on
a pet. In 18 years of practice,
I have only had two clients tell
me they were switching to a
veterinarian who does not
require that. And that’s fine
with me—I don’t want a
patient to die of hepatitis and
leave me wondering whether
I induced it because I didn’t
bother to do the right thing.

Welborn: Dr. Albers used an
interesting term—compliance
review. That’s what the practice
team should be doing when
they look at medical records.

Wood: In the AAHA study,
core vaccines and heartworm
tests had good compliance. It
dropped off dramatically in
other areas, with therapeutic
diets at the bottom. So you
have two areas in the 80%
range, and then it drops to sin-
gle digits. Why is that?

You could argue that some
core vaccines are required by
law, but heartworm testing is
not. I think the compliance is
higher in those areas because
we send out reminders for
them, but not for senior test-
ing, therapeutic diet follow-up,
 flea and tick follow-up, or
heartworm prevention follow-
up. Do clients need reminders
for these other products and
services?

Novotny: We have protocols
for vaccination and parasitic
testing.

Welborn: And one facet of
that protocol is a reminder.
We’ve done that effectively with
senior testing in our practice.
We don’t ask if clients want it.
We tell them it’s part of our
annual health exam protocol for
older pets.

Leininger: You commented on
the single-digit compliance for
therapeutic nutrition. The scary
thing is that the biggest oppor-
tunity we have to impact the
health of most pets is by feeding
them the right food. We know
that there are so many pets that
could benefit from therapeutic
rations. Think of all the disease
processes or health risks for
which therapeutic nutrition is
beneficial, but only 7% of
patients are getting it. An
unconscionable number of
patients’ health problems could
be improved if veterinarians
recommended a nutritional
product and then followed up
to make sure the product was
fed as directed.

Downing: From a wellness
perspective, there are three key
elements that influence health
and longevity—genetics, envi-
ronment, and nutrition. We
have no control over genetics,
even if we are involved with
clients who breed dogs and
cats. We have a bit more con-
trol over environment because
we can help clients create a
healthy environment for their
pets. Nutrition is where we have
an unbelievable opportunity to
lay an appropriate foundation
from the very beginning of the
pet’s life. Why then are we so
reluctant to say this is the right
nutritional product for you to
feed your pet? A nutritional rec-
commendation is no different
than a surgeon recommending
the best surgical technique for
treating a particular condition.
That is a specific decision that
you make. Why are our nutri-
tional recommendations not
equally specific?

Welborn: The consequences
of failing to make appropriate
recommendations in nutrition
and dentistry are insidious.
People can eat poorly every day
for a long time before their
arteries are clogged. The conse-
quences are definitely negative
for both people and pets, but
they are insidious.

Downing: And human nature
being what it is, we have a hard
time responding to a potential
negative outcome that might
not rear its ugly head until years
from now.

ECONOMIC IMPACT OF
IMPROVED COMPLIANCE
Novotny: Improved care and
patient outcomes will likely lead

Key Points

• Every medical record
  that is pulled for any
  reason should undergo
  a compliance review by
  the receptionist.

• In the area of nutri-
  tion, veterinarians
  have an opportunity to
  lay an appropriate
  foundation for a pet’s
  entire life.

• The scary thing is
  that the biggest oppor-
  tunity we have to
  impact the health of
  most pets is by feeding
  them the right food.

A KEY TO BETTER PATIENT OUTCOMES
Key Points

- Improved compliance will likely lead to improved care, and this will lead to increased practice revenue.
- There is a direct correlation between revenues generated in a veterinary practice and the quality of care that is possible in that practice.
- We improve our recommendations with better client education, leading to better compliance, greater use of services, and more opportunities to uncover additional patient needs.

INCREASED COMPLIANCE:

Albers: The National Commission on Veterinary Economic Issues (NCVEI) states that there is a direct correlation between revenues generated in a veterinary practice and the quality of care that is possible in that practice. It is impossible for an economically unsuccessful practice to deliver high-quality care. You have to generate revenue if you are going to have adequate facilities, equipment, staff, training, and continuing education. There are people who say we just want to increase compliance to make more money. Sure, better compliance is going to generate more money, but then we can plow that money right back into the practice and improve the quality of care even more.

Downing: It becomes a self-perpetuating cycle. We improve our recommendations with better client education, leading to better compliance, greater use of services, and even more opportunities to uncover additional patient needs. It is a constantly increasing quality of care.

Wood: AAHA created a model that estimated the additional number of pets that could receive better care and the additional revenue that could be generated through even modest increases in compliance. A 10% increase in compliance for the seven areas studied means that an average practice provides 1,287 more treatments and earns $132,535 in additional revenue. A 25% increase in compliance means an average practice provides 2,674 more treatments and earns $308,423 in additional revenue.

Downing: That amount of increase in compliance, 10% to 25%, does not force me to hire additional people or expand my facility. I can do that with the resources I have and my current team. Saying you don’t want to increase compliance is like saying you don’t want to earn any more money because you don’t want to pay any more taxes. With an increase from 10% to 25%, I could increase my earnings, but not have to increase my staff. This means I am not increasing my overhead, which translates to a much healthier bottom line for reinvestment and much healthier patients.

Wood: From a crass, strictly business perspective, if you keep a pet alive for two additional years through better compliance, its lifetime value might increase by 40%. For example, if it dies at age 14 instead of age 12, over its lifetime that pet was not worth $10,000, but $14,000. So the pet wins, the pet owner wins, and everybody in the practice wins. If you believe that increased compliance leads to increased longevity, then that directly correlates to increased spending. The owners of aged pets spend more.

Albers: Thank you for reminding us that the pet owner wins, too. Every study done in the past decade shows that 75% to 80% of pet owners regard their pet as a member of the family. They want that pet to live as long as possible and have as high a quality of life as possible. Why not improve compliance? Nobody loses in this deal. Why would we not make an effort to improve compliance?

Novotny: What should practices do with the additional income?

Leininger: I think it needs to be reinvested in our staff. In most veterinary hospitals, staff members have borne the brunt of our lack of profitability. We don’t pay them well. We don’t give them time off or opportunities to get better at what they want to do. Because of that, they leave us. That perpetuates the cycle of poorly trained people who can’t talk to clients, resulting in low compliance.

Welborn: The other impact on the staff is that if they earn more, their quality of life improves. As a result, they are better able to appreciate the financial investment in taking care of their own pets.

STAFF TRAINING

Novotny: What are the best training programs available for veterinary hospital staff and what do they teach?

Leininger: Hill’s has a great program called Veterinary Nutritional Advocate (VNA).

Miller: Yes—we are requiring all our staff to go through the VNA program.

Downing: VNA is an excellent training program for staff. Some of its advantages are:

- It delivers credible messages in an easily understood and sequential systematic format;
- Everyone on the team hears the same message;
- It delivers a consistent, recurring message about quality medicine and quality practice;
- It’s a self-paced program so each team member can experi-
ence the program in a way that is meaningful to him or her;
• It is Web-based, which means employees can access it at home or at work;
• All team members can and do benefit from going through the program;
• And it’s free.

In our practice all team members and doctors who contact clients are required to go through the VNA modules.

Two other training programs come to mind—Animal Care Training and the Lifelearn series. Like VNA, they provide consistent exposure to key messages. These are programs on CDs and DVDs that can be used in the clinic and are cost-effective. They can be viewed multiple times and used as refresher courses. Practice leaders buy these training tools once, but they can be used over and over, so the actual cost per single delivery is very low.

The most important element of these training programs is the consistency of the message—every team member hears the same set of key messages.

**Albers:** AAHA’s Training and Orientation for Practice Staff (TOPS) program is a CD-ROM and Internet-based program. Staff members can use it at home and have 30 days to complete each of the four modules. Testing is administered through Cedar Valley College (CVC) in Dallas.

Another program is CVC and AAHA’s Distance Education Veterinary Technology Program (DEVTP). This is a college-degree program in which veterinary assistants and other support staff have an opportunity to earn an associate’s degree in veterinary technology.

**Welborn:** AAHA’s Pathways to Compliance Workshop, conducted by Karyn Gavzer, is another training program worth mentioning (see http://wwwaa hanet.org/web/Compliance_programdetails.html for more information).

**Albers:** That AAHA compliance training program is a series of one-day hands-on workshops for practice teams, held in different locations around the country through May of 2004. Team members learn about the compliance issue and how to improve it in the practice and acquire tools to take back to their hospitals.

**Wood:** VetMedTeam also offers online training opportunities and participants can earn continuing education credits.

**Downing:** Many of the national meetings, including the AAHA annual meeting, Central Veterinary Conference, and the Western Veterinary Conference offer both technical and practice management training for support staff. That trend has even trickled down to both regional and state veterinary medical associations.

**Leininger:** When conference organizers ask me what seminars they should be offering, I always answer, “Front office stuff.” Start talking to that underserved population who make the difference in whether we are successful or not.

**Welborn:** We shouldn’t forget the opportunity to utilize corporate representatives who will come into the practice.

**Miller:** When we did a pain management seminar, we had manufacturer representatives conduct an in-clinic seminar for us. We included the front desk personnel, so now they understand the importance of pain management in our practice.

**Novotny:** We have had several examples of compliance success. Does anyone have anything to add?

**Albers:** I visited a practice in North Carolina that hired someone to do a medical records audit. They initially hired this person to find lost charges. The value this person has added is that she reviews every medical record and files a reminder for everything that was done into the computer system. She makes sure that if a fecal exam was run that the results are in the record. Or if the fecal exam was positive, she makes sure that the client is called and asked to come in and pick up the appropriate medication. Each day she also creates a computer list of reminders that were sent out 30 days earlier with no response, and she calls all those people. Interestingly this practice is not tracking what the results of this have been, but they have seen a dramatic increase in revenues. They hired a full-time medical records auditor, but she is really a compliance czar. She’s making sure that there is constant follow-up. If clients don’t respond to a first reminder, they get a phone call. I have no doubt that this person has more than paid for her salary and benefits. But it’s a foreign concept to veterinarians to hire somebody just to do that, even though we can demonstrate that those kinds of investments will more than pay for themselves. Again, as we’ve cited, a 10% improvement in compliance in the six areas studied generates $132,535 a year in the average practice.

**Conclusion Novotny:** Does anyone else have other tips to improve compliance and patient outcomes?
We could double the number of dental procedures just by making a recommendation 100% of the time.

Albers: In the AAHA study, only 50% of the owners of pets that probably needed dentistry (that is, their pets were over 5 years old) recalled receiving a recommendation. But 50% of the people who received a recommendation did it. So we could double the number of dental procedures just by making a recommendation 100% of the time.

Welborn: In our practice, we had difficulty getting veterinarians to recommend dental procedures until we all agreed on the definitions for various stages of periodontal disease. Now all the veterinarian is expected to do is grade the stage of disease and highlight that on the patient visit slip. That tells the practice team what to do from there. The grade actually becomes an invoice item, so the computer puts an explanation of the problem on the invoice and automatically sets up a reminder. We effectively limit our dependency on the veterinarians because now all they are asked to do is grade the disease. The team takes over from there.

Leininger: It is like getting veterinarians away from the cash register.

Miller: Or away from the computer.

Downing: We have talked about the fact that we have to train, train, and train. Then when we are done training, we have to train some more. Then and only then can we focus on training the client and creating expectations in clients.

We also have to deliver specific messages to the owner of a pet that has specific needs. The more specific we are in our recommendations, the more likely our clients will agree with our recommendations. We need to change our vocabulary away from “recommend” or “should” or “could” to “need.” That alone is a potent motivator.

Novotny: In summary, then, we’ve agreed that veterinarians and their healthcare teams tend to overestimate the compliance levels in their practices. Noncompliance and poor compliance are significant problems in veterinary medicine, as shown in the AAHA Compliance Study. Selected negative outcomes associated with poor compliance include premature death, poorer quality of life, and loss of practice income.

Conversely, improved compliance is associated with improved patient outcomes. Compliance means that the pets in your practice are receiving the care you believe is best for them.

We’ve seen that clients are not solely to blame for poor compliance; compliance is everyone’s responsibility, and practitioners need to make recommendations based on what an individual pet needs. These recommendations should be reinforced by everyone on the healthcare team. Because pets, their owners, and the practice all benefit from improved compliance, someone on the healthcare team should review every record, pulled for any reason, for compliance.

And one of the most important outcomes of this discussion is this: Every practice is capable of improving compliance and, thus, patient outcomes.

---

**Key Points**

- We could double the number of dental procedures just by making a recommendation 100% of the time.
- Every practice is capable of improving compliance and, thus, patient outcomes.

---

**Contact Information for Staff Training Programs**

<table>
<thead>
<tr>
<th>Name of program</th>
<th>Web site</th>
<th>Phone number or e-mail</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hill’s Veterinary Nutritional Advocate (VNA)</td>
<td><a href="http://www.hillsvet.com">www.hillsvet.com</a></td>
<td>(877) 883-5251</td>
<td>Free</td>
</tr>
<tr>
<td>Animal Care Training (ACT)</td>
<td><a href="http://www.4act.com">www.4act.com</a></td>
<td>(800) 357-3182</td>
<td>$1,495 for complete series</td>
</tr>
<tr>
<td>Lifelearn staff training series</td>
<td><a href="http://www.lifelearn.com">www.lifelearn.com</a></td>
<td>(800) 375-7994</td>
<td>$79 per CD-ROM</td>
</tr>
<tr>
<td>AAHA’s Training and Orientation for Practice Staff (TOPS)</td>
<td><a href="http://www.aahanet.org">www.aahanet.org</a></td>
<td>(800) 883-6301</td>
<td>$99 per module</td>
</tr>
<tr>
<td>CVC/AAHA’s Distance Education Veterinary Technology Program (DEVTP)</td>
<td><a href="http://www.aahanet.org">www.aahanet.org</a></td>
<td>(800) 883-6301</td>
<td>AAHA members: $319 per course</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nonmembers: $389 per course</td>
</tr>
<tr>
<td>AAHA’s Pathway to Compliance Workshop</td>
<td><a href="http://www.aahanet.org">www.aahanet.org</a></td>
<td>(800) 883-6301</td>
<td>AAHA members: $289. Team price (3 from same practice): $549</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nonmembers: $329. Team price (3 from same practice): $639</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.vetmedteam.com">www.vetmedteam.com</a></td>
<td><a href="mailto:info@vetmedteam.com">info@vetmedteam.com</a></td>
<td>Varies</td>
</tr>
</tbody>
</table>
HILL’S INVITES YOU TO ATTEND A SYMPOSIUM ON
“The Compliance Continuum: A Quality-of-Care Issue”

Veterinarians who believe their clients are following their recommendations may be in for a big surprise. A recent study by the American Animal Hospital Association (AAHA) reveals the barriers to compliance, and not all of them are related to clients. This symposium will review the findings of the AAHA Compliance Study that was underwritten by a generous grant from Hill’s Pet Nutrition, Inc. By attending, you’ll discover both the barriers to compliance and the opportunities for improvement.

As the sponsor of this symposium, Hill’s invites you to learn:
■ What’s Our Responsibility? What’s Our Opportunity?
■ Quality of Life, Quality of Care: A View from the Trenches
■ Better Compliance...Better Medicine...Better Business
■ How to Use the “CRAFT” Formula in Practice

Make plans now to attend this important symposium at these four national conventions:

The North American Veterinary Conference
Sunday, January 18, 2004 · 2PM – 5PM

American Animal Hospital Association
Sunday, March 21, 2004 · 10:15AM – 2:45PM

Western Veterinary Conference
Monday, February 16, 2004 · 1PM – 5PM

American Veterinary Medical Association
Sunday, July 25, 2004 · Time to be determined

Presented by Dr. John Albers, Dr. Robin Downing, Mr. Fritz Wood and Ms. Karyn Gavzer.
Speakers will vary by conference.