Compliance: Taking Quality Care to the Next Level

AAHA
The Standard of Veterinary Excellence
Taking Quality Care to the Next Level

A Report of the 2009 AAHA Compliance Follow-Up Study
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Introduction

Wellness care services, such as vaccinations, parasite and heartworm testing and prevention, dental care, dietary recommendations, senior-care screening, and preanesthetic lab work, lead to longer and healthier lives for pets. Almost all practices provide high-quality services in these areas. But is providing these services good enough? If a minority of active patients in a practice actually receive the recommended care, is that practice really delivering high-quality care?

The landmark AAHA study on compliance, published in 2003 as *The Path to High-Quality Care* (AAHA Press), clearly demonstrated that, although most practices believed that a high percentage of their active clients were compliant with veterinary recommendations for good care, a much smaller percentage of their patients actually were in compliance. Table 1 summarizes compliance data from that study, based on chart reviews of 1,340 patients from more than 240 practices.

A number of key findings emerged from the veterinary practice component of that study:

- Practice teams assumed that giving information about services meant clients automatically accepted and followed through on the recommended services.
- Practice teams believed that if a client was not compliant, it was the client’s “failure,” and that if the client did not follow through on recommendations, it was due to the pet owner’s unwillingness to pay the cost.

Pet owners interviewed and surveyed as part of that study, however, told a much different story:
They expected and wanted the practice to recommend the best care for their pets.

Noncompliance was not about cost; it resulted from the practice’s failure to make a recommendation or to convey the value or importance of a recommended treatment.

Most pet owners who recalled receiving a recommendation reported that they would have followed through on it if they had been prompted to make an appointment or had received a reminder.

The 2003 study (undertaken in 2002 and completed in 2003) was funded by a generous educational grant from Hill’s Pet Nutrition. Following publication of *The Path to High-Quality Care*, compliance became a focus for much of the profession. Hill’s and AAHA sponsored and produced compliance workshops, and AAHA (with sponsorship from Hill’s, Pfizer, Merial, and Novartis) produced a traveling educational exhibit that toured the country, delivering a strong compliance message to both practice teams and pet owners. These companies and others launched additional initiatives to improve compliance.
The reaction from practice teams was strong, particularly among those that measured compliance and were surprised by the results. Many practices launched compliance-improvement initiatives. Some had more success than others. Some improved in specific areas but did not improve overall compliance. Some found the effort difficult to sustain. But all recognized that they needed to improve compliance before they could truly claim that they were providing high-quality care to their overall patient base.

As emphasis on compliance continues to grow, important questions remain:

- What measurable improvements, if any, have been achieved?
- What works to improve compliance and, conversely, what stands in its way?
- What level of investment is required for an effective and sustainable compliance-improvement effort? What is the return on the investment?

With these and other questions in mind, AAHA and Pfizer Animal Health joined in 2008 to find the answers. With a generous educational grant from Pfizer, AAHA engaged Fletcher Spaght Inc., the consulting firm that conducted the original compliance study in 2003. The results of the 2009 AAHA Compliance Follow-Up Study are detailed in the remainder of this publication. A companion document, *Six Steps to Higher Quality Care* (AAHA Press, 2009), details actions that practices can take to improve compliance, based on study results.
2009 AAHA Compliance Follow-Up Study

Goals and Objectives

Broadly, the goal of the follow-up study was to quantify improvement (if any) in practices that had taken some steps toward improving compliance. Had the profession moved the needle in terms of compliance? Further, we wanted to learn what were the “best practices” in terms of compliance improvement, what were the costs of these efforts, and whether there was an appropriate return on investment.

Finally, we wanted to examine an area not addressed in the initial study: pet owner adherence to recommendations and directions for dispensed or prescribed medications.

The 2009 study was divided into three modules:

I. benchmarking against medication adherence in human medicine, in an effort to identify strategies for improving adherence

II. pet owner research regarding adherence, to identify barriers and veterinary practice behaviors that impact adherence

III. investigation and analysis of efforts to improve compliance and adherence in veterinary practices, to identify effective measures that may be widely applied

The following definitions were used in the study:

Compliance: The percentage of pets receiving a treatment, screening, or procedure in accordance with accepted veterinary health-care recommendations.

Adherence: The extent to which clients administer medications prescribed, including filling and refilling the prescription, correct dose, correct use, correct timing, and completing the prescribed course.

Module I: Benchmarking Against Human Medicine

This module involved an extensive review of the medical literature dealing with adherence as well as in-depth interviews with fourteen experts in
Compliance: The percentage of pets receiving a treatment, screening, or procedure in accordance with accepted veterinary health-care recommendations.

Adherence in human medicine has been extensively studied, and the literature is rich. Many of the studies employed sophisticated monitoring systems to track adherence instead of relying on patient self-reporting. The reviewed studies cover a wide range of medical conditions. Although they report a broad range of adherence rates, few studies found rates greater than 80%, and many were lower. Examples of results from various studies include the following:

- The range of adherence was 48% to 90% for pediatric cancer patients.
- The average adherence in juvenile rheumatoid arthritis patients was 52%.
- Among adult glaucoma patients, adherence was less than 50%, and only 10% of patients persisted with treatment for one year.
- For antibiotics, the average adherence for all patients was 62%, and 28% of the patients in the study admitted to saving antibiotics for future use.

Not surprisingly, patients self-reported higher adherence than actually occurred. For hand dermatitis, patients estimated their compliance at 95%, although electronic monitoring showed actual adherence to be 42%. Hypertensive patients overestimated their compliance by 17%, as measured by pill counts.

It is important to note that studies in human medicine show
Adherence: The extent to which clients administer medications prescribed, including filling and refilling the prescription, correct dose, correct use, correct timing, and completing the prescribed course.

Patients self-reported higher adherence than actually occurred.

a clear benefit both in improved outcomes and lower costs for patients who have high adherence. Diabetics with low adherence rates have a 30% chance of needing hospitalization at some point, at an average cost of $16,500. Those with high adherence rates have a hospitalization risk of 13%, at a cost of $8,900. Pediatric asthma patients with low adherence miss 8.9 days of school over a 100-day period, compared to 5.4 days for highly adherent patients. The low-adherence group also had an 18.9% risk of hospitalization, as compared to 11% for those in the high-adherence group.

Why are adherence rates less than perfect? The following have been identified as the principal barriers to medication adherence in human medicine:

- patient psychological factors, including concerns about side effects, denial about need, forgetfulness, and asymptomatic conditions
- lack of patient understanding of or belief in the importance of taking the medications
- length of therapy, complicated regimens, and cost
- ineffective or incomplete communication between physician and patient

The good news is that a range of interventions have been shown to improve adherence in human medicine, and most of these are applicable to veterinary medicine. Such interventions can be grouped in three areas: technical, behavioral, and educational.

Technical: Simplifying the drug regimen is a major factor in improving adherence. Adherence rates for once-daily medication are much higher
The same actions that increase adherence among human patients can work for pets, too.

Compliance than for twice-a-day (or more frequent) dosing regimens. Clearly, replacing oral medication with a long-term injectable one is the optimal way to achieve 100% adherence. Combination pills and special packaging (blister packs and pill boxes) were also effective ways to increase adherence.

Behavioral: Providing rewards or incentives improves adherence in people; following medication with praise, play, or food could be an applicable corollary in pets. Refill reminders by mail, phone, or e-mail also improve adherence rates in human medicine.

Educational: Handouts and instructions (that is, an Rx Plan) help adherence, as does patient counseling by a physician or pharmacist. Pictorial aids help in complex treatment regimens.

Module II: Pet Owner Research Regarding Adherence to Medication Use

This module consisted of in-depth interviews with 42 pet owners (16 in-person interviews and 26 telephone interviews), followed by an
online survey of pet owners that yielded 920 valid responses. Pet owners interviewed were diverse in terms of geography, age, and experience with pets. The online survey targeted pet owners who had received a prescription within the past 6 months (for acute conditions) or 12 months (for chronic conditions). Prescriptions for heartworm prevention were not included in the study.

Based on self-reporting, adherence to pet medications averaged 89%. This high figure is not surprising in light of the human health studies, in which patients significantly overestimated their own adherence rates. In Module III of this study, a veterinary practice chart review revealed average compliance for chronic medications was 76%.

Based on self-reporting by pet owners, there was no difference in adherence between chronic and acute conditions.

Table 2 summarizes several factors that strongly or slightly correlate with adherence. Note that the first three factors are largely out of the veterinary health-care team’s control. However, several other factors that both strongly and slightly correlate with adherence relate to practice team–pet owner communication, and all of these factors are within the practice team’s purview.

The most important finding related to communication is that there are significant gaps between those communication elements that would improve adherence (according to pet owners) and those that are actually delivered by veterinary practice teams. The six most important communication practices, and the related gaps, are described below.

Demonstration: Pet owners shown one or more ways to administer medication had a significantly higher rate of never having missed a dose (73%, versus 59% for those not shown). Further, those who had actually experienced a demonstration said they valued the demonstration more
Compliance

than those who had never experienced one. Unfortunately, only 43% of practices show owners how to administer medication, and only 40% explain administration. Only 8% of practices both show how to administer and have the owner demonstrate administration.

**Length of appointment:** Pet owner data indicate that adherence is high when appointments last more than 10 minutes; 70% of those whose appointments were more than 10 minutes long never missed a dose, whereas only 63% of those whose appointments were less than 10 minutes long never missed a dose. However, only 25% of pet owners indicated that their appointments lasted more than 10 minutes.

<table>
<thead>
<tr>
<th>Table 2. Factors Correlated with Adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factors Strongly Correlated with Adherence</strong></td>
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<tr>
<td>Species (dog owners reported higher adherence)</td>
</tr>
<tr>
<td>No young children at home</td>
</tr>
<tr>
<td>Experience of the pet owner</td>
</tr>
<tr>
<td>Communication (overall)</td>
</tr>
<tr>
<td>Written information</td>
</tr>
<tr>
<td>Frequency of visits to veterinarian</td>
</tr>
<tr>
<td>Veterinarian continuity</td>
</tr>
<tr>
<td>Communication-related</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Formulation of medication</td>
</tr>
</tbody>
</table>

*Some factors the practice cannot control (species, condition, etc.), but these can be kept in mind when discussing adherence to medications and care plans with pet owners.
Many veterinary practice teams fail to do the very things that are most likely to improve compliance.

Written information: Respondents who received written information had higher adherence and higher rates of never-missed-a-dose, and they found it easier to administer medications than did those who did not receive written information. Of those who received written information, 65% reported that they referred back to it. However, only 59% of pet owners reported having received written information; 72% said they would like to receive written information so they could refer back to it.

Follow-up calls: Pet owners who received a follow-up call achieved higher adherence and higher rates of never having missed a dose than those who did not receive a follow-up call. However, only 56% of pet owners reported having received a follow-up call.

Reminders for ongoing medication for chronic conditions: Pet owners whose pets were on chronic medications appreciated receiving reminders more than those who did not receive reminders (i.e., pet owners who did not receive reminders did not think they would value reminders). Those receiving reminders had higher rates of never having missed a dose. Unfortunately, only 30% of practices send reminders for refilling chronic medications.

Continuity with the veterinarian: Pet owners who reported seeing the same veterinarian at each visit reported both higher adherence and higher rates of never-missed-a-dose than pet owners who saw various veterinarians during office visits. However, approximately 50% of pet owners reported not always seeing the same doctor.
Adherence is more common when pet owners see the same veterinarian at each visit.

Cost is not a barrier to adherence. Pet owners are willing to pay a significant premium for medications that are easy to administer.

Clearly, all of these factors can be controlled by the practice team. By improving communication practices, teams can expect improvements in patient adherence to prescribed medications.

Cost and Adherence

Pet owner research explored cost as a possible barrier to adherence. We discovered (as noted in Table 2) that the cost of medication did not correlate with adherence. Indeed, in exploring cost as it related to administration of medications, this study found that pet owners were willing to pay a significant premium for ease of administration (such as less-frequent dosing schedules or an injection rather than a pill).

Specifically, when asked how much of a premium they would pay for medications that would pay for medications that required administration once per day rather than twice per day, or that required administration BID versus TID, or that were palatable, pet owners reported the following:

- Approximately 22% would pay a 50% premium.
- Approximately 18% would pay a 100% premium.
- Approximately 20% would pay a 200% premium.

Adherence Tips and Tricks

Pet owners described several techniques they use to administer medication. Their tips for remembering to give the medication included

- calendars and automated e-mail reminders (especially for less-frequently administered medications, such as monthly heartworm preventives);
What do successful practices do to improve compliance?

2009 AAHA Compliance Follow-Up Study

- giving the pet its medication at the same time the owner takes his or her medication;
- administering medications at mealtime (especially for those that require more than one dose per day);
- leaving the medication in a frequently visited site, such as the pet’s food dish.

Tips and tricks that pet owners use to administer medication included
- establishing a position of dominance;
- hiding the medication in food;
- using a towel to restrain a cat’s movements;
- providing rewards following administration.

Practices may help to improve adherence by sharing these tips and tricks with clients.

Module III: Efforts to Improve Compliance and Adherence

This module was structured to provide an in-depth analysis of compliance-improvement efforts made in veterinary practices since the release of the 2003 AAHA compliance study. Practices that had made at least some effort to improve compliance were targeted in an effort to determine whether their clients’ compliance rates had actually improved.

In addition, the research aimed to determine best practices for improving compliance and, to the extent possible, to determine the cost of various compliance initiatives and the return on the investment.

The research consisted of both in-depth qualitative interviews and an online survey. For the interviews, practices that were known to be making compliance-improvement efforts were selected, as were industry experts and practice management consultants working with practices to improve compliance. Eight practices were visited and interviewed (in California, Florida, and the Washington, D.C., area), and 35 additional interviews were conducted by telephone (27 practices and eight industry experts or consultants).
The online survey collected data from chart reviews of six to eight randomly selected patients per practice. Data were collected on 1,718 pets from 265 practices that completed the survey. The survey respondents were veterinarians (40%), practice managers (49%), and technicians or other staff (11%); 98% were AAHA members. Of the AAHA members, 71% were AAHA accredited, and 28% were not. Comparability to the 2003 study was sought.

Data were collected on recommendations and compliance for the following:

- Core vaccines
- Heartworm testing and preventives
- Dental disease grading and dental treatment
- Preanesthetic laboratory profiles
- Senior screening
- Chronic medication and associated diagnostic testing

As in the 2003 study, compliance rates were calculated by summing the total patients in compliance with a specific item, then dividing the sum by the number of patients eligible for that item. The calculation methodology was unchanged from the 2003 model, but two analytic modifications were made:

- Heartworm testing and preventive compliance were expanded from concerning only dogs in heartworm-endemic areas to all dogs as compared to each practice’s protocol, irrespective of geographic location or endemic status.

- Dental compliance was expanded from “prophy done” to “prophy done and not done for a medical reason.” If dental disease was recorded but a prophy was not done because of an overriding medical problem, the patient was considered to be in compliance.

Only patients for which the practice indicated it was the primary care provider were included in the compliance calculations.

**Findings**

All areas except vaccinations showed significant improvement in compliance over 2003 levels (see Table 3).
Table 3. Comparison of Compliance Data, 2003 and 2009

<table>
<thead>
<tr>
<th>Area of Concern</th>
<th>Rate of Compliance (%)</th>
<th>2003</th>
<th>2009</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccines</td>
<td></td>
<td>87</td>
<td>83</td>
<td>-4</td>
</tr>
<tr>
<td>Heartworm tests*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>endemic only</td>
<td></td>
<td>83</td>
<td>87</td>
<td>4</td>
</tr>
<tr>
<td>overall regardless of endemic status</td>
<td></td>
<td>73</td>
<td>82</td>
<td>9</td>
</tr>
<tr>
<td>Heartworm preventive*</td>
<td></td>
<td>48</td>
<td>55</td>
<td>7</td>
</tr>
<tr>
<td>endemic only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>overall regardless of endemic status</td>
<td></td>
<td>45</td>
<td>51</td>
<td>6</td>
</tr>
<tr>
<td>Dentals†</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>needed and done</td>
<td></td>
<td>35</td>
<td>38</td>
<td>3</td>
</tr>
<tr>
<td>not done due to medical reasons (considered compliant)</td>
<td></td>
<td>53</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Preanesthetic blood work</td>
<td></td>
<td>69</td>
<td>88</td>
<td>19</td>
</tr>
<tr>
<td>Senior screenings</td>
<td></td>
<td>34</td>
<td>59</td>
<td>25</td>
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<tr>
<td>Chronic medication</td>
<td></td>
<td>76</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td>Testing associated with chronic medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall compliance</td>
<td></td>
<td>64</td>
<td>73</td>
<td>9</td>
</tr>
</tbody>
</table>


*Dogs only. In the 2003 study, overall compliance included endemic areas only. The 2009 study included all dogs versus the practices’ protocol, regardless of self-identified endemic status in determining overall compliance.

†For dentals, the 2003 survey did not include the options of no recommendation and/or cleaning due to a medical reason; compliance was defined as those animals with dental grade \( \geq 2 \) that received a dental cleaning. The 2009 study added the option of “not done for a medical reason” and expanded those considered in compliance to include prophys not done for a medical reason.
Core vaccines. The reasons for the decline in core vaccine compliance were not discovered by the study and therefore are only speculative. It is possible that changes to vaccine guidelines, which decreased the frequency of vaccine administration, may be partially responsible if practices have not converted patients to annual exams, or if past-due vaccines have slipped through the cracks. Although the average age of the patients in the 2009 study was two years greater than that of the 2003 population, and older patients typically receive vaccines less frequently, the reported decline appeared to be consistent in all age groups.

Heartworm testing and preventives. Compliance with heartworm testing and use of preventive medication improved, particularly in nonendemic and transitional geographic areas. We know that purchases of heartworm preventives from online and catalog companies have significantly increased; in this study all clients who were known to have purchased heartworm preventives—from the practice or from another source—were considered compliant. Preventive compliance increased even though many practices did not know or record whether an online or catalog purchase was made. Indeed, if all clients who had purchased from another source had been identified, actual total compliance would have been higher.

Most practices (84%) recommend 12 months of heartworm preventive. Almost all practices (96%) recommend heartworm testing and preventive for dogs. Only 38% make such recommendations for cats, and in these practices, only 12% of cats were in compliance.

Dental disease grading and treatment. The 2003 study reported that dental prophylaxis treatment would increase if the practice simply recommended it. In the 2009 study, recommendations had increased, as had the percentage of pets having a prophylaxis done when the recommendation was made. However, there is still a recommendation gap: for 15% of pets with a diagnosis of dental disease (grades 2–4), no recommendation was recorded.
**Preanesthetic lab work.** The percentage of patients having preanesthetic lab work increased dramatically, from 69% in 2003 to 88% in the current study. Much of the increase can be attributed to the finding that the fraction of practices now requiring preanesthetic lab work tripled, from 12% to 41%.

**Senior screening.** The 25% improvement in senior screening compliance can be attributed to three factors:

- The average age of the patients in the 2009 study increased by two years over the age of pets in the 2003 study, increasing the proportion that were seniors.
- There was a large increase in the number of senior pets for whom practices recommended screening.
- There was an increase in the percentage of pet owners who accepted the recommendation.

Although the percentage of senior patients receiving a recommendation increased, there remains a 28% recommendation gap.

**Chronic medication and associated diagnostic testing.** The practice survey showed 76% compliance in this area, whereas the pet owner survey indicated an adherence rate of 89%. It is important to note that practice-level compliance measures only the number of doses purchased versus the number prescribed. It does not measure owner adherence related to dosing and administration. Chronic medication compliance appears to increase somewhat with the age of the pet.

**Accredited practices performed better.** The AAHA-accredited practices that participated in the study had higher overall compliance than nonaccredited practices. (The number of nonmember participants, 2%, was too small to allow meaningful comparison.) The largest differences were in preanesthetic lab work (91% compliance among accredited versus 81% among nonaccredited practices) and senior screening (63% for accredited practices and 50% for nonaccredited practices). One reason
for the difference is that AAHA Standards of Accreditation address compliance for preanesthetic and senior screening.

**Best Practices**

In addition to measuring practices’ success in improving compliance, Module III also sought to identify measures and actions that yield higher compliance. The 2003 study identified the CRAFT formula:

Compliance = Recommendation + Acceptance + Follow Through

The 2009 study confirmed that CRAFT is the foundation for any compliance program and that the majority of the practices selected to participate in this study perform these basic tasks. In addition, monitoring, training and communication, and standard protocols were found to be essential to significantly improve compliance.

**Recording recommendations.** Recording recommendations significantly correlated with compliance. In this study, 52% of the participants always recorded recommendations, and another 35% did so at least 75% of the time. In addition, 90% of the practices reported recording client rejection of recommendations.

**Follow-up phone calls.** Making follow-up calls to unresponsive clients was almost universal among the practices in this study, with 25% making one call, 53% two calls, and 20% three or more calls. In the 2% of the practices that made no calls, compliance was significantly lower.

**Good habits.** Practices that have highly effective compliance programs have many good habits, including some or all of the following:

- frequent monitoring of compliance
- monitoring several areas of compliance
- attending compliance training workshops
- using multiple approaches to client education and communication
- conducting staff training exercises
- investing in compliance improvement
- developing and using written practice protocols

When practices employed four or more of these good habits, they achieved greater compliance.
Frequent monitoring of compliance was very significantly associated with higher compliance. This is clearly in keeping with the well-accepted management maxim, “what gets measured gets done.”

Regrettably, many practice management software (PMS) systems do not lend themselves to monitoring true compliance. As a result, some practices are not measuring actual compliance but rather are measuring numbers of procedures. For example, most PMS systems do not record a diagnosis; although they can report the number of dental procedures done in a given period of time, they cannot measure that against the number of patients with a diagnosis of dental disease. Nevertheless, merely measuring numbers of procedures was found to be helpful.

In contrast, measuring compliance with heartworm testing can be accomplished simply by dividing the number of tests performed by the number of active records in the system.

The study clearly showed that frequency of monitoring was related to higher compliance. The practices that monitored compliance weekly had significantly higher compliance rates than those that monitored monthly, and monthly monitoring produced greater compliance than “occasional” monitoring.

Monitoring several areas of compliance improves compliance rates as well. The study found a straight-line relationship between the number of areas monitored and compliance rates: The more items were monitored, the more overall compliance improved. Practices that monitored
Frequent monitoring, of a variety of areas, improves compliance rates.

Six equals success: Practices using six or more forms of communication achieved significantly higher compliance.

one to two items had an overall compliance rate of approximately 70%, whereas those that monitored seven to ten items had overall rates of approximately 80%.

Attending compliance training workshops significantly increased compliance, and attending two or more workshops increased compliance over attending one workshop. Sources of training most commonly mentioned were the AAHA Compliance Workshops and AAHA audio conferences and webinars.

Using multiple approaches to client education and communication increases compliance. Practices in this study named eight forms of client education and communication they use to improve compliance:

- providing written care plans
- providing printed educational material
- scheduling an appointment before the client leaves the practice
- making telephone follow-up calls if no appointment is scheduled
- sending reminders if no appointment is scheduled
- mailing educational material for follow-up
- printing a recommendation on the bottom of the invoice
- reviewing issues covered during the visit, by a client relations specialist or other staff member

Practices employing six or more client education/communication approaches achieved significantly higher compliance than those using fewer approaches.

Conducting staff training exercises at the practice impacts compliance, and using more than one type of training (such as discussions, role playing, and reviewing results) was found to be significantly associated with better compliance.
Investing in compliance improvement correlated with higher compliance; as with other factors, investment in multiple areas resulted in higher overall compliance. In most cases, however, the investments made were relatively modest in relationship to overall spending. The most frequently mentioned investments included

- books, materials, printing, mailings;
- training and continuing education;
- practice coaching and consulting;
- outside services (e.g., Vetstreet);
- software or system upgrades.

Developing and using written practice protocols results in achieving higher compliance. Three out of four practices in the study reported using written protocols always or almost always, and these practices achieved significantly higher compliance than practices that did not use protocols.

Other Findings

Respondents agreed that monitoring and working to improve compliance is good medicine and provides economic value. There was 91%
agreement with the statement, “Compliance monitoring is important to help us focus on good medicine,” and 93% agreement with the statement, “Compliance monitoring is important because it has a positive economic impact on our practice.”

It is apparent that today there is much greater awareness of compliance, particularly as a driver of quality care, than there was prior to publication of *The Path to High-Quality Care*. In the practices studied, thinking has shifted toward offering high-quality care consistently, without prejudging clients’ ability or willingness to pay.

Practices are now accepting greater responsibility for compliance. In the 2003 study, interviewees indicated that compliance was 60% client responsibility; thinking has shifted to the point that interviewees in this study indicated that compliance is 60% *practice* responsibility. There is much less belief that the practice has little influence on compliance.

**Improving Compliance in Your Practice**

This study uncovered a wealth of practical steps for improving compliance and identified barriers to success. Those findings have been used to produce a companion volume, *Six Steps to Higher-Quality Patient Care*, which contains instruction and tools that any practice can use to take quality care to a higher level through improved compliance.
Six Steps to Higher-Quality Patient Care
Six Steps to Higher-Quality Patient Care
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Introduction

The landmark 2003 AAHA compliance study, funded by an educational grant from Hill’s Pet Nutrition and published as *The Path to High-Quality Care* (2003), established that there were huge opportunities to improve the level of care in virtually all practices by improving compliance with recommendations made by the professional staff for optimal pet health.

The 2009 AAHA Compliance Follow-Up Study, funded by an educational grant from Pfizer Animal Health and published as *Compliance: Taking Quality Care to the Next Level* (2009), clearly demonstrated that compliance can be significantly improved when compliance programs are implemented in practices. We learned that compliance programs

- do result in improving the care that your patients receive;
- are relatively straightforward to establish and implement;
- do require the commitment and the support of the practice leadership;
- do require the entire staff to buy in and participate;
- do not require significant financial investment.

Moreover, the study identified the key steps that drive the best compliance programs (see Textbox 1). By following the six steps identified in this guide, we believe that any practice can implement a successful compliance program. As a result, you can ensure that your patients receive the care that your practice team believes is in the best interest of the pets whose care has been entrusted to you.

Once implemented, the program will be sustainable and will become a part of your practice routine.
Six Steps Drive the Best Compliance Programs

1. Set the strategic direction.
2. Gain staff buy-in and align the organization.
3. Prepare for the client visit.
4. Educate and communicate with clients.
5. Follow up with clients.
6. Sustain the initiative.
Before You Begin: Measure Compliance to Set a Baseline

If you have not already done so, we strongly recommend that you measure your current compliance levels. There are two reasons that this is important:

• You should have a baseline so that you can periodically measure your progress and, where needed, make adjustments.

• Most practices that participated in the 2003 study believed that their compliance was high, but every practice in the study overestimated actual compliance (many by 50% or more). For these practices, and for practices that have since measured compliance, the results have proven to be a wake-up call and a motivator for the practice team.

Step 6 discusses the importance of assessing results through ongoing compliance monitoring. The experience of performing the initial measurement will make ongoing monitoring easier.
How to Measure Compliance

Accurate compliance measurement involves two numbers: the number of patients that actually received a specific procedure, and the number of patients actually eligible to receive the procedure. The second number includes all active patients for whom the given procedure was actually recommended or for whom such a recommendation was consistent with practice protocols.

In the compliance calculation, the first number is the numerator, and the second the denominator:

\[
\% \text{ compliance} = \frac{\text{(number of patients who actually received a procedure)}}{\text{(number of active patients eligible for the procedure)}}
\]

For example, consider a practice that has 1,800 active canine patients and recommends annual heartworm testing for all of them. If the practice determines that it has conducted 1,116 canine heartworm tests in the last 12-month period, then compliance with its heartworm-testing protocol is 62%.

\[
62\% = \frac{1,116}{1,800}
\]

Although this example is relatively straightforward, other areas are more difficult to monitor and track.

For example, if this same practice performed 360 canine dental prophylaxis treatments in a 12-month period, compliance is better than 20% (360/1,800), because certainly not all canine patients actually needed the treatment. Some of the dogs would be puppies or young adults, with no visible tartar or periodontal disease. Others would be older adults whose owners practice regular oral home care and feed a tartar-reducing diet. Still others would have periodontal disease but also would have a serious medical problem that precludes anesthesia and dental treatment.

Optimally, your protocol for calculating compliance should include determinations about how to count animals in each category (for example, count as eligible all patients with a dental grade of 2 or higher, but count as compliant those that have a medical reason not to have a prophy as well as those that received the service). However, we recognize that few practices use their patient management software (PMS) systems in a way that allows automatic calculation of compliance in a case like this.
Simply tracking the number of procedures done is not an accurate means of compliance tracking. Similarly, revenue is not an accurate measure of compliance, because it fails to take into account fee increases and growth in number of active patients.

Constraints on Accurate Measurement

Unfortunately, measuring (and subsequently monitoring) compliance can be a challenge. Practice management software (PMS) systems typically do not lend themselves to easy and accurate compliance measurement. One of AAHA’s strategic goals is to work collaboratively with PMS vendors to improve on the ability of PMS systems to track compliance, but until that occurs, practices will have to accommodate reality.

Until diagnoses are consistently entered into patient records in the PMS system, accurate compliance will be difficult to calculate accurately and automatically. Although AAHA has developed common diagnostic terms and procedural terms and is encouraging PMS system vendors to incorporate them in their systems, it will likely be some time before the terms are in widespread use.

Given the limitations of the PMS systems and the difficulty in accurately assessing compliance in all areas, here are some recommendations for measuring compliance:

- Determine the areas of compliance (for example, heartworm testing and preventive, dentals, or senior screening) to track.
- Meet with your customer service representative or your PMS system vendor and explain what you are trying to measure on a periodic basis.
- Ask the PMS representative to help you understand what information is readily available in your database and how you can best enter patient information to facilitate compliance tracking.
- Based on what information is available, develop protocols for determining compliance for each area being tracked. Keep in mind that
data from other sources in the practice, including manual counts, might be needed to supplement the data available from the PMS system.

• If necessary, ask the PMS representative to help you write queries to create the reports you need.

You may need to make some compromises and acknowledge that you may not be measuring and tracking true compliance, given the constraints of your PMS system. However, if you consistently use the same methodology to determine compliance, you will be able to track changes and trends over time.

For example, if you cannot accurately arrive at the number of patients diagnosed with periodontal disease and therefore in need of dental prophylaxis, you might assume that every dog and cat over five years of age (for example) is a likely candidate for annual dental cleaning. Then you can divide the number of procedures by the active client base over age five to get a number for compliance tracking—even though you will not be accounting for patients that either do not need a dental or should be excluded from the count for medical reasons. Again, the important element is that you use the same methodology every time.

**Six Steps to Higher-Quality Patient Care**

**Step 1: Set the Strategic Direction**

After you review patient records to establish a baseline compliance level, share the results with practice leadership. This generally includes the practice owner(s), practice administrator, and, if appropriate, senior staff. The results for your practice can be compared to national results reported in the 2009 AAHA Compliance Follow-Up Study (see Table 1). Full results
The leadership decides whether the practice’s compliance level warrants efforts to improve patient care through improving compliance. Unless the practice already achieves 80% to 90% compliance for all recommendations, health care for the practice’s patients would be improved with a compliance initiative.

Assuming that the answer is “yes, compliance can be improved,” the leadership must agree to support the commitment to improve compliance.

Table 1. National Compliance Rates for Key Elements of Care (2009)

<table>
<thead>
<tr>
<th>Area of Concern</th>
<th>Rate of Compliance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccines</td>
<td>83</td>
</tr>
<tr>
<td>Heartworm tests*</td>
<td></td>
</tr>
<tr>
<td>endemic only</td>
<td>87</td>
</tr>
<tr>
<td>overall, regardless of endemic status</td>
<td>82</td>
</tr>
<tr>
<td>Heartworm preventive</td>
<td></td>
</tr>
<tr>
<td>endemic only</td>
<td>55</td>
</tr>
<tr>
<td>overall, regardless of endemic status</td>
<td>51</td>
</tr>
<tr>
<td>Dentals</td>
<td></td>
</tr>
<tr>
<td>needed and done</td>
<td>38</td>
</tr>
<tr>
<td>not done due to medical reasons (considered compliant)</td>
<td>53</td>
</tr>
<tr>
<td>Preanesthetic blood work</td>
<td>88</td>
</tr>
<tr>
<td>Senior screenings</td>
<td>59</td>
</tr>
<tr>
<td>Chronic medication</td>
<td>76</td>
</tr>
<tr>
<td>Testing associated with chronic medication</td>
<td>89</td>
</tr>
<tr>
<td>Overall compliance</td>
<td>73</td>
</tr>
</tbody>
</table>

*Dogs only. The overall compliance rate considers all dogs as compared to the practices’ protocol, regardless of self-identified endemic status.


of the 2009 study are available in a companion report, Compliance: Taking Quality Care to the Next Level (2009).
Add compliance responsibilities to the job description of each team member. Improving compliance is a shared responsibility. All team members are accountable for results.

Practice owners, administrators, and senior staff must commit to support and participate in the compliance-improvement effort, or it will fail.

Although a major capital equipment investment is not required, and most practices can implement an improvement program without adding staff, a successful program does involve a significant amount of staff time and training.

Moreover, a good compliance-improvement program requires the participation of the entire staff team; this is not something that is only, or even chiefly, the responsibility of the doctors, the technicians, or the client service staff. In effect, compliance responsibilities will be added to the job description of every team member. This means that the practice leadership must be committed to the effort and must agree to support and to participate in the program.

Practice leadership must also commit to providing team members with access to continuing education that specifically targets compliance, whether it takes the form of seminars, workshops, audio conferences, webinars, online courses, or lunch-and-learns.

Compliance Advocate

The leadership designates a member of the team to be the practice’s Compliance Advocate. This person will become the team champion for compliance, providing help in organizing people and processes, scheduling and providing training, monitoring results, reporting results to the practice team, and ensuring participation at all levels. The person selected for this role should be passionate about improving patient care through compliance.
It is very important that the person selected as Compliance Advocate have the full support of the practice leaders.

**Step 2: Gain Staff Buy-in and Align the Organization**

Achieving staff buy-in is critical; the 2009 AAHA study found that lack of staff buy-in can easily have a negative effect on compliance.

To build staff commitment, involve the team in setting the strategic direction. To do this, practice leaders present the findings from the initial compliance assessment, emphasizing issues related to quality of patient care.

The 2009 AAHA compliance study found that practice teams generally responded to the quality-of-care message that is intrinsic to compliance programs. Focusing on the improved care that results from better compliance is generally the most effective means of leading all members of the practice team to agree that efforts need to be made to improve compliance.

The immediate goal of this step is to lead everyone on the practice team to agree to support and participate in a practicewide compliance-improvement program. It is very important at this stage that practice team members see and understand that the practice leadership is committed to the program and will fully participate in it. Make clear that improving compliance will be a shared responsibility and that all team members will be accountable for results.

Many leadership books and seminars offer insights and ideas for bringing staff together around a common goal. A selection of these resources is included in the appendix of resources at the end of this guide.
Build Staff Commitment; Make It Personal

A few practices in the 2009 compliance study encouraged practice team members to review their own pets’ medical records to ensure that they were in compliance with the practice’s recommendations and protocols.

Staff members whose pets were not up-to-date with all recommendations could take advantage of a special opportunity to become fully compliant at no cost or at a deeply discounted cost.

These practices indicated that staff buy-in increased as a result, and it was helpful when team members could assure clients that their own pets received the same care that the practice recommended.

Gain Consensus about Guidelines and Protocols

Ensure that the entire practice team shares a common understanding and agreement about all aspects of recommended patient care. If, for example, one doctor believes that dogs should be on a heartworm preventive for 12 months of the year and another believes that 6 to 8 months is adequate, they need to come to an agreement about which recommendation the practice will adopt. Otherwise, team members will be confused about which doctor’s recommendation to support. This will spark conflict. Worse, clients will hear conflicting messages. Ultimately, not only compliance but the practice’s credibility will suffer. Establishing medical protocols and requiring that doctors conform to them will prevent chaos.

The 2009 AAHA study found that practices that established clear guidelines and written protocols achieved the greatest compliance-improvement results. The best protocols are clear and very specific, representative of widely accepted guidelines, and understood and accepted by everyone on the team as representing optimal health care.
There are two similar ways to approach the development of guidelines and written protocols, depending on the size of the practice. For smaller practice teams, the entire team can gather to develop compliance protocols. Addressing one area at a time (dental care, preanesthetic testing, and so on), invite everyone in the group to answer the question, “What do we believe every pet that comes to us for care should have or receive to maintain optimal health?” Designate one person to take notes during the discussions and to draft the resulting protocols. Distribute the written protocols to staff, then schedule another meeting to resolve differences of opinion and finalize the protocols.

For larger practices, the team can be divided into groups assigned to develop draft protocols for specific areas (vaccinations, heartworm testing and prevention, senior screening, and the like). As in small practices, each group meets to answer the question, “What do we believe…,” drafts a protocol based on the discussion, distributes the draft to group members, and meets again to resolve disagreements and create a Review Draft.

Then—and this is key to winning across-the-board support for the protocols—circulate each group’s Review Draft protocol among all members of the practice team for discussion and amendment. This ensures that the final product will reflect input from all and will be supported by all.

Several tools can help your team develop compliance protocols. Authoritative guidelines have been developed for various components of care (such as vaccinations) by AAHA and the American Association of Feline Practitioners (AAFP). Although these existing guidelines are excellent resources, each practice must ensure that the protocols it establishes have the support of the practice team. For a list of AAHA and AAFP guidelines, see the appendix of resources at the end of this guide.

Protocols, of course, must reflect your practice’s approach to patient care. Figure 1 offers a partial list of questions to guide your team’s thinking about what to include in protocols.
Protocol Quick Start: Questions to Spark and Guide Development of Patient Care Protocols

Use these lists to stimulate your thinking about compliance protocols; don’t be limited by the topics if there are other elements of wellness care that the practice team deems important.

**Periodic Wellness Exams**

How often should your patients routinely receive an examination? Is the frequency the same for all species? Does it change with the pet’s age or environment (e.g., inside or outside)?

**Vaccinations**

- What is the protocol for puppy and kitten vaccines?
- What is the frequency for core vaccines (DHLPP and FVRCP) for adult pets?
- Which noncore vaccines should be given, and with what frequency?
- How do these protocols vary with age, environment, number of pets in the household, or exposure?

**Parasite Testing and Prevention**

- What is the recommended frequency for testing fecal samples? Does the protocol change with species or environment?
- What is the recommended frequency for heartworm tests? Are heartworm tests recommended for all dogs and cats, or only for those that travel?
- For how many months of the year is heartworm preventive recommended? Are additional medications recommended for specific parasites?
- When is the flea season in your area? When and for how long should flea products be used?
- Are ticks a problem in your area? What is their season? When and for how long should tick products be used?

**Dental Care**

- At what age should regular dental examinations begin (with radiographs)? At what ages or stage of periodontal disease is a dental cleaning recommended? Are dental sealants recommended following dental cleanings?
- What home care options are discussed with clients? When is brushing the pet’s teeth recommended, and with what specific products, methods, and frequencies? Are dietary or chew recommendations made for tartar control?
FIGURE 1

Protocol Quick Start: Questions to Spark and Guide Development of Patient Care Protocols

Baseline Laboratory Screening/Minimum Database

• At what age should cats and dogs have their initial baseline laboratory screening?

Senior Screening

• At what age are your patients considered “senior” and candidates for screening? Is the age the same for both dogs and cats? Is the age the same for both small- and large-breed dogs?
• What tests are included in the basic senior screen? Do the tests that are recommended change with age or species? How frequently should tests be repeated?

Preanesthetic Lab Work

• Does the practice require preanesthetic lab work for all patients, only high-risk patients, or no patients?
• If tests are required for high-risk patients only, list some criteria used to establish risk.
• Which tests are included for all patients, and which for high-risk patients?

Nutritional Recommendations

• What are the practice protocols for discussing nutrition? Is nutrition discussed with every patient? Is it discussed with every patient for whom a therapeutic diet might be indicated?
• Are patients weighed, and is the weight recorded at every visit?
• Does the practice have a weight-management program for overweight pets?

Microchips

• What is the practice recommendation regarding pet identification? Does it vary by species or environment?
• Are pets with a microchip scanned at every visit to verify placement and function?
• Are other means of identification (e.g., tags) also recommended?

Both the initial 2003 AAHA study and the 2009 follow-up study showed a clear relationship between making a recommendation and achieving compliance. Often, low compliance can be attributed to the doctor’s or staff’s failure to make a clear recommendation. Although the “recommendation gap” (that is, the shortfall between 100% and the percentage of eligible patients to whom recommendations are actually made) was smaller in 2009 than in 2003, it still exists.

Therefore, AAHA strongly recommends that a recommendation be entered in every medical record for every visit, even if it is for something as straightforward as the time of the next visit.

Setting Goals for the Compliance Program

Setting a practice team goal can help your compliance-improvement program succeed by creating a clear measure of success and common understanding about expectations. An achievable yet challenging goal will inspire staff members as they track group efforts to meet—or exceed—expectations.

To motivate staff, set a reasonable goal. For example, let’s say the rate of compliance with dental treatments is 35%. According to the 2009 compliance study, the average rate of compliance for dentals is 38%. Perhaps 45% compliance would give the team an exciting goal.

You can set a goal for one particular service or for overall compliance. It is also useful to assign a time frame, for example, one or two years.
When your practice achieves the goal, be sure to take time to celebrate as a team, perhaps with a pizza lunch or an afternoon ice-cream break. At that point, think about establishing a new, somewhat higher goal.

**Step 3: Prepare for the Client Visit**

In the 2009 AAHA study, one tool emerged as among the most important aids to practices with successful compliance-improvement programs. The tool? A compliance checklist. Figure 2 is a sample checklist; you can use it as is or modify it to match your practice’s protocols.

To make the best use of the checklist, put it to work *before* the client arrives. Most practices using a checklist pull the records of patients the evening before their scheduled appointments. Someone, usually a technician or a client service specialist, reviews the patient record to see whether the patient is in compliance with all of the practice’s compliance protocols and/or all recommendations that were previously recorded in the medical record.

Items that are not in compliance or that are due at this visit are checked off, and the completed list is attached to the front of the patient record folder.

When the client arrives, the prepared checklist guides the practice team as the list accompanies the client through the appointment. Every member of the practice team refers to the checklist to promote compliance:

- **The client service specialist**, upon the client’s arrival, mentions the items that are due or have been recommended and suggests appropriate action.

- **The veterinary technician**, when putting the client in an exam room or prior to the doctor’s arrival, offers to begin the recommended service (for example, drawing blood) before the doctor sees the patient.
### Compliance Checklist

**Prearrival Checklist:** Check YES if patient is IN compliance with protocol, NO if patient is NOT in compliance with protocol.

Client/Patient Name: ____________________________________________________________

Date: _______________________________________________________________________

#### Wellness Exam

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Current

#### Vaccinations

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Core

Noncore (specify) __________________________________________

#### Parasite Testing and Prevention

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fecal

Heartworm

Flea/tick prevention

Heartworm/intestinal parasite prevention

#### Dental

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recommendation for prophy

---

*From: Six Steps to Higher-Quality Patient Care. Copyright © 2009 by AAHA Press (www.aahanet.org).*
### Compliance Checklist

**Prearrival Checklist:** Check YES if patient is IN compliance with protocol, NO if patient is NOT in compliance with protocol.

<table>
<thead>
<tr>
<th>Client/Patient Name: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: ________________________________</td>
</tr>
</tbody>
</table>

- [ ] Home care

#### Senior Screening

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] [ ] Standard protocol</td>
<td></td>
</tr>
<tr>
<td>[ ] [ ] Specific test or recommendation (specify) ___________________</td>
<td></td>
</tr>
</tbody>
</table>

#### Preanesthetic Lab Work

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] [ ] (If appropriate for today’s visit)</td>
<td></td>
</tr>
</tbody>
</table>

#### Nutrition

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] [ ] Current on therapeutic drug recommendation</td>
<td></td>
</tr>
<tr>
<td>[ ] [ ] Appropriate weight for age and breed</td>
<td></td>
</tr>
<tr>
<td>[ ] [ ] Weight-loss program recommended</td>
<td></td>
</tr>
</tbody>
</table>

#### Microchip

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] [ ] Chip implanted</td>
<td></td>
</tr>
<tr>
<td>[ ] [ ] Scanned for proper functioning</td>
<td></td>
</tr>
</tbody>
</table>

#### Chronic Medications

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] [ ] Current on refills</td>
<td></td>
</tr>
<tr>
<td>[ ] [ ] Periodic testing for monitoring purposes</td>
<td></td>
</tr>
</tbody>
</table>

---

*From: Six Steps to Higher-Quality Patient Care. Copyright © 2009 by AAHA Press (www.aahanet.org).*
• **The doctor**, if the client has not accepted the recommendation, reinforces the recommendation by discussing with the client the need for the service and how the patient will benefit from it.

• **The doctor and/or veterinary technician** offers educational material or resources to support all recommendations.

• **The client service specialist**, upon discharge, follows up with recommendations, schedules an appointment for a recommended procedure or the next visit, and enters appropriate reminders into the PMS system.

  Staff training and preparation, including role playing, for these client interactions is beyond the scope of this book; resources for such training are listed in the appendix.

The use of a checklist, along with the appropriate actions by each member of the practice team, can return huge dividends in compliance improvement.

**Step 4: Educate and Communicate with Clients**

One of the most significant findings from the 2003 AAHA Compliance Study (*Path to High-Quality Care, 2003*) was that practice teams greatly overestimated client compliance in their own practices, largely because team members believed that they *told* clients what was needed. Doctors and staff alike confused *telling* clients what to do with having the client accept the recommendation and follow through on it.

Similarly, the pet owner research component of the 2003 AAHA Compliance Study revealed that communication failures and a lack of understanding of the need for or benefit of a recommendation was responsible for a large amount of noncompliance.

For compliance to succeed, medical and support staff alike must understand the difference between telling and gaining agreement—and act on their understanding.
To persuade clients, understand the difference between telling and gaining agreement—and act accordingly.

Practice Teams Share Responsibility for Communication Failures

Rarely are communication failures the sole responsibility of one party, the speaker or the listener. However, a veterinary practice team’s responsibilities as advocates for excellent pet health care require every team member to be certain that he or she helps clients to understand their pets’ needs for wellness care and that recommendations are clearly communicated.

The difference between telling and communicating was obvious in a series of videotapes of practice team–pet owner interaction, which were created in actual practices as part of the 2003 AAHA Compliance Study.

In one practice, the doctor finishes his exam of a significantly overweight pug. The clients (a middle-aged couple) put the dog on the floor and proceed to chase it around the exam room, attempting to attach
the leash to the collar. While the circus on the floor plays out, the doctor launches into a discussion of the pug’s weight and recommends diet and exercise. The doctor’s recommendation is clear. From the clients’ reaction, it is also clear that what they heard was, “Blah, blah, blah, blah, blah.” The doctor’s conclusion following the visit was that the owners had no interest in addressing their pet’s weight problem.

Another veterinarian participating in the 2003 study was interviewed regarding his thoughts about recommendations and compliance. He stated, “I give them [clients] my ‘spiel’ and then it’s up to them to accept the recommendation or not.” In many cases, giving the same spiel to every client guarantees poor compliance.

**Communicating the Need for and Value of Recommended Care**

In the 2003 AAHA study, the researcher observed a veterinarian examining a dog and then recommending a dental prophylaxis treatment. She spent the next five to six minutes explaining the process to the pet owner, emphasizing the safety of the anesthetic and the like. After the pet owner left the practice, the researcher asked the veterinarian how she thought the interaction went and whether she thought the pet owner “got it” and would schedule the prophy. Based on the lack of questions from the pet owner, the veterinarian was confident that the owner would comply. A check with the client relations specialist indicated that the pet owner declined the opportunity to schedule the procedure. Clearly the doctor had failed to communicate the need for and the benefit of performing the service.

In contrast, in the 2009 study, one practice was found to have doubled its rate of dental compliance. This team reported that they had changed
To enlist client support, spend less time explaining how a medical process is performed and more time on its benefits.

What versus Why

Features are services rendered and their effects; for example, dental prophys result in clean teeth.

Benefits are the good that accrues from the effects. Benefits of dental prophys include healthier gums, better breath, less tooth pain, and the avoided risk of heart disease.

Features are the what of compliance. Benefits are the why. To enlist client support, focus on the why.

from saying, “I recommend a dental cleaning,” to “We need to get these teeth cleaned.”

The team emphasized that the “need” statement was followed by a clear explanation of the reasons why cleaning was needed, the benefits of cleaning the teeth, and the risks that would be avoided by following through on the recommendation.

Simply stated, the practice team must be certain that pet owners understand not just the recommendation itself but the value and benefit it delivers.

The Importance of Multiple Touch Points

“Multiple touch points” means that more than one person “touches” the client with education and recommendations to encourage compliance.

For many people, hearing a recommendation once is not sufficient. And some pet owners may be reluctant to ask questions of the doctor. Such clients may be more comfortable discussing a recommendation with the veterinary technician.
Compliance improves as clients become better educated about pet health.

The benefit of the client checklist, discussed previously, is that it allows multiple team members to discuss recommendations with the pet owner. This provides multiple repetitions as well as the opportunity to talk with or ask questions of whomever the client feels most comfortable with.

Of course, multiple touch points can only work when all team members are conversant with the basic value and benefits of following practice protocols—and all voice a consistent message at many points throughout the client visit.

**Communication Training**

Instruction in communication is beyond the scope of this guide. However, all practices must acknowledge the importance of clear communication and are urged to thoughtfully assess the skills of practice team members. Where skills are lacking or need improvement, seek and use appropriate training programs. Some useful training programs and tools are listed in the appendix at the end of this guide.

Communications training is provided at many veterinary conferences and is generally available through local resources, such as community colleges. As of this writing, Pfizer Animal Health offers an excellent client communication workshop through its Frank initiative.

**Client Education**

It is accepted in human health care that a patient who is well educated about health needs is a better patient in terms of compliance and good health. The 2009 AAHA Compliance Follow-Up Study demonstrated that the same is true in veterinary medicine: Compliance improved as exposure to pet owner education increased.
Just like their pets, not all pet owners learn in the same way. Although sometimes a verbal explanation or recommendation may be sufficient, for many pet owners, verbal communication reinforced with other educational materials is best for ensuring compliance. Educational materials that can be presented to pet owners include (but are not limited to) those discussed below.

**Custom handouts.** Some practices like to present information in their own way, and they take the time to prepare handouts on a variety of topics. If your practice uses custom handouts, it is a good idea, when possible, to cite an authoritative resource for the material you include or to refer to other sources of corroborating information.

**Brochures.** Practices can develop their own client information brochures. However, brochures are available on almost any topic from pharmaceutical firms, pet food companies, and organizations like AAHA and AVMA.

**Newsletters.** Client newsletters are useful for providing periodic information that reinforces recommendations. Newsletters might feature a case or discuss a common topic, such as dentistry. Like handouts and brochures, newsletters can be written and developed by the practice, but there are other sources of excellent newsletters, such as AAHA’s PetsMatter Web site (aahanet.org/petsmatter/petsmatter.htm).
**Posters, charts, and models.** A variety of wall charts, posters, and anatomical models are available through manufacturers and pet food companies. Speak with your sales representatives about what might be available.

**The Internet.** In 2007, more than 100 million Americans were e-consumers of health-related information or services for themselves or their families. If clients are going to the Internet for their own health-care information, you can be sure they are seeking similar information about their pets’ health.

AAHA recommends that practices embrace the Internet, in the belief that well-educated veterinary health-care consumers are the best clients. However, it is imperative that you direct your clients to sites that contain authoritative information, such as AAHA’s www.healthypet.com. AAHA recommends you search for sites that provide information that meets your criteria; steer your clients to those sites through links on your own Web site and in client handouts or brochures.
Practices that employ six or more touch points have significantly higher compliance rates.

As in verbal communication, multiple touch points boost success in client education. The more you say to your clients, and the more different ways you reinforce your message, the more likely they are to hear and understand it. The 2009 AAHA study showed that practices that employed six or more forms of communication and/or client education had significantly higher compliance rates than practices that used fewer forms.

A variety of client education resources are listed in the appendix.

**Step 5: Follow Up with Clients**

Following up on recommendations is critical to improved compliance. The pet owner research component of the 2003 AAHA study showed that many more pet owners would have complied with recommendations made by the practice if the practice had followed up.

**Before the Client Leaves**

The single most important and the best opportunity for following up on recommendations occurs before the client leaves the practice. In the 2003 study, researchers saw many instances in which the doctor, for example, strongly encouraged a dental cleaning, but when the client got to the exit and paid the bill, no one asked if she would like to schedule the procedure. Here are some examples of following up before the client leaves the practice:

**Vetstreet.** AAHA endorses the Pet Portal™ product from Vetstreet because of its demonstrated effectiveness as a client education and communication tool. Pet owners who establish a Pet Portal through their practice’s Web site tend to be more active and more compliant with recommendations.

Vetstreet.
• The doctor recommends senior screening. Before the client leaves the exam room, the doctor or the technician says, “If you like, we can draw the lab samples while you are here and phone you tomorrow with the results.”

• The doctor and/or technician recommends that a newly adopted dog be started on heartworm medication. The client service specialist has the prescription filled and ready to go as the client leaves the practice.

• The doctor has pointed out the need for a dental cleaning. At the exit, the client service specialist says, “I see that Dr. Martin wants to get Jasper’s teeth cleaned. We have an opening next Tuesday. Would that work for you?”

After the Client Leaves
After the client leaves the practice, follow-up remains critical. To be effective, the practice needs a good system for tracking recommendations and scheduling reminders and follow-up.

Making a phone call to remind clients of recommendations was the most successful follow-up tactic. The calls should clearly express concern
A phone call to the client is the most successful follow-up strategy.

for the pet’s well-being without being intrusive or pushy. A call might be scripted like this:

(After greeting and identifying yourself) I noticed that the last time you were here, Dr. Martin felt it was important that Jasper have his teeth cleaned to reverse that periodontal disease. Dr. Martin wanted me to follow up with you to see if you had any questions for her, or whether we could go ahead and schedule that for you.

Reminder cards are also effective, whether sent via postal service or electronically. In fact, the 2003 AAHA study showed that reminders were still effective after up to five attempts. Because of the success of follow-up phone calls, however, we suggest that practices start with a phone call and then follow up with reminder cards if needed.
Pursue compliance every chance you get: before, during, and after the client visit.

Before the Next Visit

Every client visit presents an important opportunity to follow up on earlier recommendations. Using the compliance checklist and reviewing the patient record before the client arrives for a subsequent visit make it easy to take advantage of these opportunities. Consistently repeating a recommendation over time increases your credibility as well. If a recommendation was made during a previous visit, and the client has not complied, then if the recommendation is not repeated at subsequent visits, the client will surely question the importance of the recommendation.

Step 6: Sustain the Initiative

A compliance-improvement program should never be seen as the program du jour. Raising the level of care for one month, six months, or one year
and then letting it falter and stop is not a success; compliance efforts must be sustained. Improving dental compliance during Pet Dental Health Month in February should not be the goal; improving dental compliance every month is a much better goal. Sustainability depends on three critical components:

- ongoing and frequent staff training
- monitoring and reporting results
- continuing commitment on the part of the practice leadership

**Ongoing and Frequent Staff Training**

Ongoing and frequent staff training keeps compliance top of mind. There is a natural tendency for enthusiasm to wane over time unless the importance of the program is continuously reinforced. In addition, it is easy to assume that new staff will quickly adapt to your practice’s compliance program, but the reality is that team turnover demands ongoing training and support.
Six Steps to Higher-Quality Patient Care

Team training should include, at a minimum,

- reviewing and reinforcing practice protocols, including the rationale for the protocols as they relate to quality care;
- updating and modifying the program as team members attend workshops or other continuing education programs and acquire new ideas and skills;
- descriptions by team members of approaches they have taken or words they have used that have succeeded (or failed) with pet owners;
- role playing by various team members demonstrating how they approach various scenarios;
- reviewing results through ongoing monitoring and reporting, with transparency regarding both successes and failures.

Monitoring Compliance

The 2009 AAHA study showed a clear relationship between monitoring compliance and improvement in compliance. In fact, compliance improved significantly as monitoring was done more frequently. Further, compliance improved significantly in a straight-line relationship as the number of areas or services that were monitored increased.

After a practice has established its baseline compliance measurement (as detailed on page 2), the same protocols should be used to monitor and track changes in compliance over time. As stated previously, what and how you monitor compliance may be limited by the real-world constraints of PMS system design. That should not deter you, however. The key to monitoring compliance is to use the same method repeatedly over time, so that trends can be tracked.

It is strongly recommended that the monitoring results be made available for all members of the practice team to review. Posting a chart using a colorful bar graph or a thermometer to show changes makes it easy for the team to review its progress. Use the results as a starting point for discussion at staff meetings and to congratulate the team on passing important milestones.
Remember that it is important to celebrate the gains in compliance. Likewise, when discussed in a neutral context, negative results can provide a valuable opportunity for team discussion about why compliance declined and what the team can do in response.

**Continuing Commitment**

If the practice leadership does not maintain its level of support and participation in the compliance effort, team engagement will drop off rapidly. That’s not to say that other initiatives cannot be introduced; there is always room for continuous improvement. However, because of the critical relationship between compliance and the quality of care received by patients, leadership should never waver from its commitment to compliance.
Appendix

Resources for Building a Successful Compliance-Improvement Initiative in Your Practice

Client Education


Communication


Compliance


**Guidelines**


- AAHA/AAFP Pain Management Guidelines for Dogs and Cats (PDF file).
- 2006 AAHA Canine Vaccine Guidelines Revised.
- AAHA Dental Care Guidelines for Dogs and Cats.
- AAHA Senior Care Guidelines for Dogs and Cats.


- 2008 Feline Retrovirus Management.
- 2003 Zoonoses Guidelines.
- 1998 Feline Senior Care Guidelines.


**Leadership**


Staff Training (www.aahanet.org > AAHA Store > Books and Products)


