Performance Appraisal: A Tool for Practice Improvement

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Do these statements describe your practice?

- Within 30 days, physicians we recruit know specific changes they should make to succeed with our practice.
- Employees have specific performance improvement plans.
- Accountability for job performance is clear to each employee and is consistently applied.
- The partners in the practice regularly identify their own strengths and areas to improve.

If not, you may be among the many oncology practices that do not have appropriate performance review systems in place. Data do not exist, as far as we know, about the percentage of oncology practices that systematically review performance of employees or physicians. But we do know that some practices have no evaluation system at all, and many have a system that is cumbersome, ineffective, or both. Regarding physician appraisals, one consultant reported, “In my experience most groups either don’t do it or don’t do it well.”

Why Bother?

“The payoff is improved job performance—it’s as simple as that,” says Robert J. Solomon, PhD, a professor in organizational behavior at William & Mary’s Mason School of Business (Williamsburg, VA) and author of *The Physician Manager’s Handbook*. “The performance appraisal is the mediator between what you want done and motivating the employee to do it. The extent to which you can tie performance to compensation makes the appraisal much more powerful. It gives you the basis to say ‘your job performance just doesn’t merit an increase.’”

Not having an effective evaluation system increases the risk of inefficiency, poor office morale, and high turnover rates. Employees may not receive training that can help them improve, and they are likely to distrust the fairness of workload distribution, salaries, and bonuses. High-performing employees can be demoralized by feeling that their work goes unnoticed or by seeing lower performers receive the same treatment and compensation that they receive.

A good appraisal system also aids management, giving practice leaders the information needed for management decisions such as staff development, job structuring and promotions, workload distribution, and compensation. Well-documented performance appraisals also provide a sound basis for disciplinary actions and termination decisions and provide back-up if such actions are challenged. Consistently applied appraisals are also important if an employee alleges wrongful discharge or violation of Equal Employment Opportunity laws.

Elements of an Effective Performance Appraisal System

To be effective—and by that we mean contributing to improved performance, achieving practice goals, and supporting individual development—the performance appraisal should be a systematic, year-round approach that links performance to objectives and to consequences. Although the appraisal process for physicians will differ from that of staff, the essential characteristics of effective evaluation listed here apply to both groups:

Job-Specific Criteria

Create an appraisal tool on the basis of an individual’s job description (Data Supplement 1). If your practice does not have position descriptions, or they are out of date, *start there*. Written job duties are essential for hiring the right people and establishing expectations. Evaluate the nurse practitioner on the specific responsibilities he or she has, and do the same for the receptionist and the insurance reimbursement specialist. Conversely, do not include activities unrelated to an individual’s job responsibilities.

Schedule and Schedule Adherence

Set a schedule for written evaluations and review to be performed at least annually. Some practices do all appraisal reviews at the same time each year; others schedule them to occur within 30 days of the anniversary of hire or follow another approach. No single way is best; use a schedule that works well for your practice. Managers often procrastinate in conducting reviews, so create an oversight system to ensure that the deadline is met. Ignoring overdue evaluations makes the employee feel devalued and can contribute to poor morale. Meeting appraisal deadlines should be a criterion in each supervisor’s job description.

Alignment With Strategic Practice Objectives

This element may seem like a “no-brainer,” but take time to review evaluation criteria for all staff physicians, in light of your group’s strategic objectives. Given your marketing objectives, should physicians have a responsibility to participate in a hospital committee or to meet personally with referring physicians? What is an achievable improvement goal for the collection rate or for receivables that are more than 120 days old?

Use of Both Quantitative and Qualitative Criteria

Include measurable factors in evaluation. For the receptionist, examples of quantitative criteria are collecting the pa-

tient's copayment 90% of the time and registering patients with an error rate of less than 2%. Examples of physician quantitative criteria are making two patient education presentations a year, achieving a certain patient satisfaction rate (if patient surveys are conducted), and dictating 90% of patient records within 48 hours. Examples of qualitative criteria for evaluating the receptionist are "seeks innovative solutions" and "maintains composure and performs well in stressful situations." For physicians, "stays abreast of clinical advances" and "maintains good relationships with referring physicians" are examples.

Ongoing and Immediate Feedback

"Immediate feedback is the most critical element and the most effective performance appraisal procedure" says Solomon. "If the performance is good, it's more motivational to comment right then and there. On the other hand, if a problem occurs or performance needs improvement, you will immediately begin to modify the substandard behavior." If you do not give employees immediate feedback when there is a performance lapse, they can fairly assume their performance is satisfactory, leading to unmet practice goals and a missed coaching moment. Solomon clarifies that "immediate" does not mean commenting in front of others, nor does it mean commenting two weeks later. Talking to the employee privately, in the next few hours or within a day or two, is appropriate. If you are not the direct supervisor, it may be appropriate to comment to the employee's manager rather than directly to the individual, so as not to circumvent the manager's authority. Finally, providing immediate feedback throughout the year ensures that the regularly scheduled review contains no surprises—a tenet of effective performance appraisal.

Self-Evaluation

"The process of writing a self-evaluation causes the employee to consider his or her job performance as a supervisor would, and to begin thinking about changes for the future," Solomon says. Kenneth T. Hertz, FACMPA, principal with the Medical Group Management Association Health Care Consulting Group (Englewood, CO), agrees, and outlines the following process: A week or more ahead of their review, give employees a copy of their own evaluation instrument and job description (Data Supplement 2). Ask them to identify aspects of the job that warrant changes in the job description; evaluate themselves; and come prepared to talk about their performance, strengths and weaknesses, and the goals they would like to set for professional and personal development.

Written Evaluation Report and In-Person Meeting

Your evaluation should always be put in writing. Evaluate the employee separately on each factor in the job description. Be specific and direct, using concise and unambiguous language. Include examples to explain and support your report. Evaluate behavior, performance, and output, not the employee's personality. At an appointed meeting with the employee, give the employee a copy of your written analysis and

outline the ways you reached your assessment, such as direct observation, review of the employee's work, and observations by others. Solicit the employee's comments on every factor in the evaluation. Discuss whether the job description should be changed. At the end of the discussion of performance, identify goals for improvement.

Performance Plan

The performance appraisal should not be simply a report card. As Hertz states, "If you miss setting goals for development, it becomes a hollow process." Using the results of the performance appraisal, identify, with the employee, very specific goals and timelines for achieving them. The goals might address improvement areas or development in an aspect of the job that the person finds interesting. Discuss with the employee possible reasons for poor performance and ways to improve. For instance, if the evaluation shows that the employee is not meeting expectations for data entry, is training needed on software updates that have been issued? Is attendance or punctuality poor? Have other assignments kept him or her from the task? After agreeing on the reason(s), set a goal for improvement and create a specific plan, including a timeline, to achieve it. In some cases, assign creation of the initial plan to the employee, but make certain to review it and revise if necessary. In the example about data entry, if the employee needs training, offer suggestions he or she might want to consider as first steps in the performance plan, such as setting aside time to use the software tutorial or user manual, identifying training available from the vendor, setting up training sessions with a senior colleague, or paying a consultant or staff member from another practice to work with the employee after hours.

Physician Performance Evaluations

If your practice has never engaged in a formal physician evaluation process, now would be a great time to start. As consultant Hertz puts it, "Unless you've been off the planet for the last year or two, you've heard about accountable care. The savvy practice will begin to do its own internal evaluation and performance appraisal of physicians and outcomes, using protocols or clinical pathways to measure physician performance against standards." That said, Hertz acknowledges that the group must have a culture that supports evaluation of individuals. Solomon echoes this perspective. "Physicians are not used to this. But the demand for demonstrating outcomes is increasing. Physicians aren't going to be able to do what they want however they want."

How to begin? Always keep in mind, and stress to others, that performance evaluation is about achieving strategic practice goals, improving care, and improving patient satisfaction—it is not about being intrusive or criticizing anyone's practice. People typically resist change, so start slowly. Engage the group in a discussion about achieving goals and improving

performance, both clinical and behavioral. If your practice has done strategic planning, use those goals.

An effective performance appraisal system for physicians will have the same elements as those listed above. Physicians typically do not have job descriptions, so start with listing the responsibilities of each physician, both clinically and behaviorally, in achieving the practice goals (Data Supplements 3 and 4). Performance in areas of timeliness for appointments, efficient use of the electronic medical record system, marketing, participation in tumor boards, community outreach, clinical care, and effective interaction with other providers are all areas of performance that might be considered important by the group.

Feedback to Newly Hired Individuals

Whether or not your group has a performance appraisal system in place for all physicians, Hertz emphasizes that feedback to new physicians is absolutely critical for recruitment and retention. “The process should be structured, with assignments and a schedule for providing feedback,” he advises. “In the first three months the administrator and the president of the group or an assigned physician should meet with the new doctor every month, maybe every two weeks. Someone needs to take time to review charts and obtain feedback from the other clinical staff. Talk to the physician about how he or she is doing in patient care, documentation, coding, interactions with nurses and patients. Be specific about whether expectations are being met.”

If improvement is needed, jointly develop a performance plan. Hertz cautions that a new recruit who doesn’t know how he is doing is likely to leave. “The group just paid maybe \$15,000 to move the family. Maybe a sign-on bonus was paid. The time and effort needed to provide feedback is worth the investment.”

Similarly, with new administrative or clinical staff, help them start off right by providing frequent feedback, using the job description as a guide to cover each area of accountability. Assign a mentor to orient the individual and answer day-to-day questions. A 90-day probationary period is common, but don’t wait that long to discuss performance. A 30-day initial review coupled with performance planning to build on strengths and address areas for improvement can be valuable at this stage.

Multisource Feedback: The 360 Review

Tools that give credible assessments from others can be beneficial in performance appraisal. The 360 review, also referred to as multisource feedback, is such a tool. In a 360 review, performance evaluation is solicited from people who interact with the individual being appraised, including peers, subordinates, and managers (Data Supplement 5). Ideally, information from patients would also be used.

Both Solomon and Hertz say that a 360 review can be a valuable tool but can easily be misused or used incompetently. Solomon notes, “It should focus on problem identification and resolution—how did that person’s performance affect me and my performance?” Hertz advises using professional consultation, “A 360 review needs to be professionally administered,

Further Information

Leading Physicians Through Change: How to Achieve and Sustain Results, by Jack Silversin and Mary Jane Kornacki. Tampa, FL: American College of Physician Executives, 2000 (available at www.acpe.org/publications)

Partner Performance Counseling, Chapter 22 in *Managing the Professional Service Firm*, by David Maister. New York: The Free Press, 1993 (available at www.davidmaister.com)

Performance Appraisal Source Book, by Mike Deblieux. Alexandria, VA: Society for Human Resource Management, 2003 (available at www.shrm.org)

The Physician Manager’s Handbook: Essential Business Skills for Succeeding in Health Care, 2nd ed., by Robert J. Solomon. Sudbury, MA: Jones and Bartlett Publishers, 2008 (available at www.jblearning.com)

with appropriate development of survey instruments, assurance of anonymity, and protection of individuals from retribution. It should be done in a culture that embraces change.” Corroborating this perspective, Dubinsky et al¹ report that implementing multisource feedback as part of the performance appraisal process involves a culture change and should be approached as a change management project, with extensive communication and training for all involved.

Summary

Performance appraisal is a process, not a form. Accordingly, beware of adopting a template or using a form from another practice. To be meaningful to both the individual and the practice, the appraisal must be correlated with specific responsibilities and must be used to develop performance improvement goals.

Solomon comments that the best way to think about performance appraisal is as one of a number of tools to make a practice more effective. “The appraisal is the sum total of what has already occurred, including hiring and managing. You can’t take these processes in isolation. If you’re doing a bad job in the selection process, then performance appraisal becomes more difficult, because now you’re trying to clean up a mess that should never have been there to begin with. You can’t say ‘we’re going to fix all of our front-office problems by putting in a performance appraisal system.’ You need a selection process that works effectively, a performance appraisal system that works effectively, and managers who understand how to lead and motivate people.”

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Reference

1. Dubinsky I, Jennings K, Greengarten M, et al: 360-degree physician performance assessment. *Healthc Q* 13:71-76, 2010

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The September 2010 article by Towle and Barr, entitled, “National Practice Benchmark: 2010 Report on 2009 Data” (*J Oncol Pract* 6:228-231, 2010), contained errors.

In the Results section, under Level 1 Quantitative Benchmarks, the fourth and fifth paragraphs referred to total revenue and total practice expense, whereas it should have been total medical revenue and total operating expense, respectively, as follows:

“Total **medical revenue** and total **operating expense** are among the most important data that oncology practices monitor on a regular basis. Figure 5 shows 3-year trends for these important metrics as well as the COGPF. Total **medical revenue** is defined as all **revenue** collected **in the period** for the **provision of medical goods and services. This does not include nonmedical revenue, which is defined as revenue earned for services other than the provision of medical care.** Total **operating expense** is defined as all cash expenses for the period **except for W-2 physician compensation.** COGPF is defined as the total of all money paid for drugs in the period less rebates or other cash reductions received in the same period. Each of these data elements is reported as the average per FTE HemOnc.”

“It is interesting to note that total **medical revenue** and total **operating expense** **track one another through the three years, but the cost of goods paid for increases in each year. The decrease in total operating expense that we see between 2008 and 2009 was achieved even with a continued rise in drug costs.** We believe this indicates an overall lowering of the cost of practice operations even as the cost of drugs continues to rise, consistent with the slight increase in the number of new patients per FTE HemOnc. These three measures indicate an overall increase in service delivery efficiency.”

In Figure 5, data were given for total revenue and total practice expense, whereas data should have been given for total medical revenue and total operating expense. In addition, incorrect data were given for the cost of goods paid for (COGPF). The corrected figure is reprinted below in its entirety.

Figure 5. Three-year trend in total **medical revenue**, total **operating expense**, and cost of goods paid for (COGPF). Percentages represent change from one year to the next.

The online version has been corrected in departure from the print. The authors apologize to the readers for the mistakes.

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