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# Work Performance Follows Human Enhancement

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# Work Performance Follows Human Enhancement

*“You get what you measure.” “It’s not what we say, but what we do that counts.”*

Sound familiar? Both statements are all too true when it comes to performance and performance measures. What we advocate, encourage, applaud, validate, and otherwise reward will set the tone for risk taking, willingness to embrace betterment, as well as increase the level of cooperation and collaboration across departments. Despite their importance, most appraisal systems are at best unloved and in many cases despised.

This article describes concepts and tools that may already be familiar. However, unfortunately, even though known to many managers, performance implementation changes are desperately lagging, particularly in the healthcare environment.

## Measurement Genesis

Recently, a hospital approached us seeking help in changing their appraisal system. Their vision for performance measurement and enhancement included the following.

- a) Upgrading the dialog between appraisal reviewers and participants.
- b) Relying less on quantitative and more on qualitative elements.
- c) Improving employee skills and raising the quality of professional care.
- d) Meeting legal and accreditation requirements.
- e) Ease of system deployment, utilization and interpretation.

Many organizations want progress in these very same areas. But designing a system that fulfills all of them is tough. In fact, ease of use of most employee appraisal mechanisms may be in conflict with the other goals, since most tend to make the process more complex.

There are specific approaches for changing a performance measurement system. Today, with increasing costs of human resources and pressures for enhancing performance, putting off the task is less and less an option in this era of increasing competition and scarce human capital. Moreover, in order to achieve human work enhancement through performance refinements and evolution, it is no longer enough for management to merely request or demand more:

*Management must know specifically what “more” means.*

## Measurement Demise

A majority of executives, particularly from Human Resource (HR) departments, would say their appraisal systems fulfill most of the goals listed above. The reality is that most appraisals

do little more than complete a routine administrative task – one often fraught with emotion and concern. That is, to advance (or not advance) individuals in position and salary. They produce a “grade” annually, coincident with salary adjustments. Often both reviewers and participants despise the process. A common complaint is the lack of constructive guidance toward improvement.

Often, top management is also unhappy with the ritual. The measures don’t align with organization-wide goals -- goals arising from fast-changing shifts in the healthcare marketplace. Healthcare providers no longer can only focus on quality; they must be efficient and low cost as well. Most systems purport to assure that healthcare is good; few assure it’s fast and low cost. Implementing these changes can be essential to survival.

The non-profit hospital with which we spoke is not unlike others in its approach. The system produces recommendations for annual pay increases. Each participant receives a numeric score for performance of key activities. This score is multiplied by the percentage of time spent in that activity. This leads to a ranking on which pay raises are distributed. In the case of this hospital, these raises can cost in the range from 0 per cent to 5 per cent annually.

This system is at best weak or totally lacking in the following features:

- a. Specific advice regarding skill improvement.
- b. Linkages between the appraisals and strategic direction.
- c. Feedback from participants to reviewers and other supervisory staff.
- d. Group or process-oriented evaluations.
- e. Potential for recognition beyond the annual adjustments, including monetary and other forms of recognition.

## Performance Innovations

Current appraisal procedures are under-performing assets. That is, the time and expense required don’t produce the excellence in people needed to compete effectively. This has led to the search for innovation in performance appraisals. What follows are several innovations finding increasing validation and application in various settings.

### Up, Down and Around (360°) Reviews

This category expands the reviewer base beyond immediate supervision. Reviews can come from all around the participant – from above in the traditional way, from below by subordinates, from peers at the participant’s level, and even from customers. Such systems may also include a self-appraisal.

This approach is particularly appropriate in “hard-to-measure” groups where output is difficult to count. A version of the 360° review was applied to physicians in the Kaiser organization. Service quality wasn’t part of salary setting for physician-partners in the Permanente Medical Group. Only specialty and seniority counted.

The revamped appraisal relied on “panels” of physicians familiar with the participant’s skills. The chief of service and a self-appraisal also figured into the evaluation. A team, chosen by the physicians, decided what factors to measure.

### *Advantages*

*The 360° approach broadens input to the participant. This increases the participant's acceptance of the direction provided by these evaluations. Sometimes an employee with little faith in a supervisor's advice will lend more credence to peers and others.*

*For the patient-serving staff, a customer ranking will point to individuals who make the best impressions on patients. There are also "internal customers" for department services. These customers should also contribute to evaluations. An example of this is how radiology serves the OB/GYN department, and thus how the OB/GYN department can offer insight and input into performance issues.*

### *Disadvantages*

*The 360° approach requires more coordination and administration. So, it's not likely to be simpler in execution than current systems. The approach often upsets the hierarchies that characterize many healthcare organizations, and can be uncomfortable for reviewers and participants alike.*

## **Cross-over Skill Assessment**

This category includes both *deepening* skills within a position and *broadening* skills beyond a single position. Deepening skills means adding to one's portfolio of functional qualifications or increasing certification levels. In radiology, for example, is a radiologist or technologist able to cross over and work into other areas of the department, i.e., from ultrasound to nuclear medicine? Current recognition systems usually focus only on the technical skills associated with one's current position.

Seniority-based salary increases assume increasing levels of competency and proficiency with time. Unfortunately, such increases often become entitlements, automatically awarded just for staying in one job – without any real improvement.

## **The Focused Factory Concept**

Advisors to healthcare providers are pointing to industry paradigms to improve competitive posture. One of these is the focused factory. Industrial concerns have found that an operation focused on a few related products has better performance than one that tries to do everything. Hence, the notion of a *focused* factory.

The concept is moving to healthcare as providers in crowded markets focus on high profit segments. They then organize focused delivery services to compete more proficiently. Such a fight is underway in Los Angeles for heart transplants. Six facilities performed 183 transplants in 1997. The UCLA Medical Center was the leader with 102 of these, or 56 per cent of the market. The local business journal reported recently that Cedars-Sinai Medical Center, with a 13 per cent share, is opening an outpatient facility to treat critical cardiac patients.<sup>1</sup> Its hope is to expand its share.

This focused operation on delivery of cardiac services will demand deepened skills from the surgeons down to the support staff. Is a "bidding war" too far off for scarce skills? How can an organization in Cedars' position retain and recruit the team it needs to implement its strategy?

Does your appraisal system match plans for offering focused services? Maintaining or increasing a position in a competitive treatment area will require specialty skills.

## **Broader Can Be Better**

Broadening of skills is also growing in emphasis in industrial companies. Demand for cross-over skills fluctuates over seasonal, weekly, and daily cycles, often unpredictably. The

organization has choices of staffing for peak demand, hiring part time staff, or increasing the flexibility of the existing work force.

The motivation for skill broadening is the added flexibility provided by employees who do more things. Best practice in many industrial companies includes training each employee for positions upstream and downstream of their current positions. When volume drops or increases, managers can redirect resources when and where needed. Pay is based on the highest skilled position.

Airlines do this with their reservation services. In a peak period, the CEO's assistant may be taking your reservation. In a hospital, a receptionist might also work in admitting or other departments. The cross-trained staff moves easily to match staffing levels upon demand. The result is fewer employees (FTEs) to serve fluctuating needs.

### Goal Reality and Objectivity

Because forthright performance evaluation can easily become personal and confrontational, many managers find the process difficult and at times embarrassing. The result can therefore be a watered down version of what the performance discussion should and could have been. Perception of subjectivity is a reason for this conflict and for ineffectiveness of the process.

Greater objectivity can be brought to bear through a systematic process of goal setting. Goals can be institutional – relating specifically to the demands of a position, and personal – encouraging further development of skills and qualifications. The former is in a sense a condition of employment, the latter a measure of mobility within the organization.

Goal setting can also mitigate the bureaucratic perception of a performance review limited to the issue of compensation. Goals can be long range or short, and longer range goals can be broken down into smaller increments. This allows a more continuous dialogue between managers and subordinates based on results and deadlines that have been agreed to. This is more productive than an initial, general conversation about expectations, which is most often put aside and only resuscitated immediately before the evaluation interview.

#### *Advantages*

*Many employees will desire both broadening and deepening their skills and thus their value. Moving from job to job adds variety, even it doesn't lead to promotion. Better skills lead to better healthcare delivery. It also means better service for the same expense in the face of fluctuating workloads.*

#### *Disadvantages*

*A cross-training program requires time and dollars to implement. Other time requirements include designing the program. This involves new job descriptions and planning the development of employees in each position.*

*Sometimes contractual work rules are a barrier. These occur when job descriptions are narrowly defined, limiting flexibility. Joint employee-management participation in redesign addresses this risk.*

### Team Process Engineering

So far, the innovations in performance assessment have focused on individuals. However, most people work in groups. Most groups, in turn, are part of processes that include multiple departments. If an organization is going to improve cost and service, then it must address these cross-over department processes.

Behind these approaches is the belief that traditional stovepipe organizations and department budgeting are obsolete concepts. The principal customer-serving processes should be the basis for goal setting, budgeting, and appraisals.

This has spawned a movement endorsed by the JCAHO and other organizations. Common terms applied to these approaches include CQI (Continuous Quality Improvement), TQM (Total Quality Management), and BPR (Business Process Reengineering). Despite the various labels, all seek to improve the quality of the product or service while reducing its cost.

Many providers now sponsor efforts to improve processes. Features include process owners who oversee improvement efforts and process teams to design and implement process changes.

Complementing these efforts are new tools for measurement. Two are activity-based costing, also called activity based management, (ABC, ABM) and provider service models (PSM). (PSMs were described in an earlier Administrative Radiology article<sup>2</sup>. An update is available at [www.expert-market.com/CGR/](http://www.expert-market.com/CGR/).) These tools measure business outcomes – levels of service (the PSM) and cost (ABC) from a healthcare delivery process.

ABC came into being because the way financial data is organized obscures management visibility. Financial systems display costs by budgetary unit. Since processes cross departmental boundaries, managers have no visibility over the cost of that process. So, ABC changes the financial perspective from budgetary units to processes. Tracing a process across the organization also identifies non-value adding steps worthy of elimination.

A PSM locks in process improvements. The inputs for PSMs are desired service levels and forecasts of demand in terms of patient traffic or other indices of workload. The model contains a *staffing table* that defines the number of service providers needed to staff a process or step in a process. The PSM addresses oscillating workloads that are encountered daily.

Measurements (and the signals they send) are important to successful application of these tools. The Fairview Hospital and Health System in Minneapolis undertook a CQI program addressing the billing and collection function for its seven hospitals. The process extended from billing to cash collection.

Early recommendations reduced full time equivalent (FTE) staff by 12 – a fast return for the effort. In the process, the team concluded that the performance appraisal process was a disincentive to participate. The system was weighted toward rewarding competence in the one function, not eliminating waste or designing processes to put people out of work.

Since the Human Relations department had a team member, changes in appraisal metrics expanded to include recognition for improvement team contributions. This made the appraisal system more complex. The team chairperson and the facilitator, who frequently were not managers, made evaluations in addition to the regular reviewer.

Gainsharing programs can generate rewards for team members. Even modest amounts in the pay envelope speak volumes about management commitment. At the Saint Joseph Health Center in Kansas City, the CEO used operating savings to fund a gainsharing pool. Efforts were directed at both individual skill enhancement and group efforts to improve processes. Peer groups measured proficiency levels. Individuals advanced in terms of their abilities to carry out group roles such as leader, facilitator, and scribe. First year savings in the pool totaled \$6 million net of payments to participants.

However, such schemes may require persistence to implement. An effort in a staff model HMO failed for inability of the medical group, medical director, and board to agree on qualified savings. Many believed improving processes were “part of the job” and unsuitable for profit sharing. Others believed health plan members would view such efforts as corner-cutting to save money.

### *Advantages*

*Team approaches can produce the greatest improvement in service and cost. By their nature, cross-functional projects are not modest but are the best way to change a process. People working on the teams also find the efforts rewarding.*

*An effort in this area can generate its own reward pool. The outcome is likely to be increased market share and financial performance. This pool can fund gain-sharing among employees. It's important to assure that improvements are not achieved at the expense of patient care.*

### *Disadvantages*

*Traditional organization structures and accounting systems are barriers to team-based performance appraisal systems. Resistance may come because it's a cross-functional effort, and the teams will find it difficult to gather needed information and agree on ground rules for the effort.*

## **Balancing the Scorecard**

An article in the [Harvard Business Review](#)<sup>3</sup> introduced this approach. The insight is that many measurements have a backward looking financial basis. Evaluations that are only used for compensation purposes are in this category. The article calls for forward looking, “balanced” measures, including those with a customer perspective, an internal customer perspective, and an innovation and learning perspective. A recent article in [Administrative Radiology](#) urged the use of the balanced scorecard approach.<sup>4</sup>

With the balanced scorecard, goals for individuals and departments cascade down from broader organization goals. For example, a broad goal to increase market share in a hospital's service area could translate into faster processing in the Admissions Department. A one-hour current process could have a reduction goal to 15 minutes. Cedar Sinai in Los Angeles could use the approach to build its capability and market share in cardiac care, for example.

### *Advantages*

*The balanced scorecard methodology brings alignment between higher order organization and lower level department goals. It complements efforts in team-oriented process improvement. If the organization already has teams in place, it can check that those efforts are directed at strategic projects. It can serve a similar role in skill building, by providing direction regarding priorities for skill enhancement.*

### *Disadvantages*

*To succeed, such an effort requires formal strategic plans. Not every organization has one. The consulting industry now actively supports this approach with methodology and software tools. Some “solutions” may be over-designed to the needs of the organization and quite expensive to implement.*

## **A Team That Gets the Job Done**

Changing performance measures is a serious undertaking. We find a team approach works best. The structure we recommend has three teams:

- a. **The Steering committee (SC):** includes department heads reporting to the business unit leader. Reviews progress. Meets every two or three weeks.

- b. **The Design Team (DT):** appointed by the SC. Meets weekly. Responsible for evaluation the existing system and designing a new one.
- c. **Front Line Team (FLT):** aids in pilot implementation of solutions. Comments on “workability” of new procedures.

The teams follow a process that leads from setting requirements to conceptual design to detail design and pilot implementation. The team also serves as an “introspection” process, which takes the organization from an existing system performing below expectations to an improved vision reflecting the organization’s ability to absorb and adapt to change. The following paragraphs describe the process steps.

#### Describe the “as-is” appraisal system

This step produces a detail description of *how* appraisals are currently performed. This includes all forms, the way appraisals are assigned, and the decisions based on appraisals – including compensation and other recognition mechanisms. Frequently, a client will survey current participants to gather their opinions. The documentation should also include analysis of position descriptions, patterns of advancement, and relative success in obtaining and retaining staff skills.

#### Assess “as-is” strengths and weaknesses.

This step evaluates the existing system, characterizing *how well* the procedures work. Inputs can include the staff surveys and benchmarking of other healthcare and non-healthcare appraisal systems. At the end of the process, the DT prepares a specification for a new more appropriate appraisal system. The specification includes the features the DT believes are needed in a successful process.

#### Develop a vision of ideals.

We use the specifications to develop a new, “straw man” appraisal system. An internal team without a consultant’s assistance could use benchmarking to generate ideas for ways to meet its specifications. This will be an “ideal” system to achieve overall success, such as one the organization would implement if it were starting from scratch.

This tool for recommendation development should produce “stretch” targets, avoiding excessive compromise with existing practices. The recommendations would draw from the techniques described here as well as traditional approaches.

#### Develop the to-be process.

In the next step, the DT should select the features of the ideal approach it wishes to implement. At this point, they should compromise and incorporate necessary trade-offs that may retain current features while implementing attractive recommendations.

#### Design and perform the pilot.

This step takes the program from conceptual design to implementation on a trial basis. It’s an important step in testing the procedures and getting “buy-in” from the organization to fully implement the to-be.

## Conclusion

Performance is not a “sometime thing.” Peak performance is a staff and management activity that must be realized and measured consistently. To achieve peak performance, it is up to management to know, see and be able to articulate what success looks like. Unfortunately, too many organizations are leaving performance to chance, and allowing mediocre performance to prevail.

Changing performance means acknowledging the efficacy of appraisal systems and mechanisms. True performance appraisal systems do more than assess who gets a raise. In healthcare, a viable system of performance appraisal is management’s stethoscope of how the organization is functioning and what may be needed for optimal health. It’s also a check-up of sorts, in order to be proactive about the organization’s diagnosis and vigilant of a prospectively disastrous prognosis.

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*Larry Benson, Mark Marcussen, and Larry Friedman contributed to this article. The group offers expertise in strategy development and process improvement to the healthcare and other industries.*

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<sup>1</sup>Toledano, Jessica, “The Battle for Heart Transplants,” Los Angeles Business Journal, September 7, 1998, page 3.

<sup>2</sup> Ayers, James B., “Provider Models: The Key to an Operations Strategy,” Administrative Radiology Journal, March 1989, pp. 38-42.

<sup>3</sup> Kaplan, Robert S. and Norton, David P., “The Balanced Scorecard – Measures that Drive Performance,” Harvard Business Review, January-February 1992, pp. 71-79.

<sup>4</sup> Ginsberg, Caryn and Essig, Sherry, “Performance Management,” Administrative Radiology Journal, July 1998, pp. 15-19.