

**DEVELOPING AND IMPLEMENTING  
A BALANCED SCORECARD  
IN A LONG TERM CARE ORGANIZATION**

**Final Report: CCHSE Fellowship**

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## Main Messages

- The balanced scorecard is an increasingly popular management tool, although research on its impact on the performance of organizations is scarce. This does not mean it is not effective and in fact opinions of executives who have implemented the tool are very positive. Research on its use in public sector organizations, and in particular healthcare, is needed. In particular, research focused on whether the scorecards actually achieve the end goal of being a strategic tool, and what organizational factors support this, would be very useful to those implementing balanced scorecards.
- Thinking about the balanced scorecard has evolved to focus on its value as a strategic management tool (i.e. as opposed to simply an operational performance monitoring system). In practice however most healthcare organizations report they have not reached this stage in their progression as users of a balanced scorecard. This may point to the lack of a strategic mindset in healthcare which is often focused on crisis management.
- When implemented in healthcare organizations, the four traditional perspectives identified by Kaplan and Norton need to be adapted to the organization's mission and vision. This takes time and a sometimes painful period of development. In particular, the financial dimension is often intentionally omitted when developing public sector scorecards. For public sector organizations, strategic financial indicators are difficult to develop and would likely mostly focus on efficiency measures (which may or may not be seen to be strategic).
- Implementing a balanced scorecard in an organization without a culture of using data to inform decision making, or an organization without a strategic mindset, is unlikely to be successful. At best it will result in a better ability to monitor operational processes, but the full impact of the balanced scorecard as a strategic tool will not be realized.
- Setting the objectives for the balanced scorecard in the organization is a critical first step. Again the focus on using it as a strategic tool needs to be articulated from the beginning. Likewise understanding the distinction between quality improvement and accountability is an important discussion so that the balanced scorecard is not seen as a way of measuring everything in the organization, for multiple purposes and multiple audiences.
- Long term care faces the same challenges as the rest of healthcare in implementing a balanced scorecard. In addition it faces a different (generally more stringent) regulatory environment, a competitive environment not generally experienced by acute care facilities in Canada, fewer resources (including information systems and staff with the expertise to analyze and interpret data), fewer professional staff, and a generally weaker culture of using evidence to inform decision making.
- Maintaining the attention of executives through the long period of development and implementation is very difficult, and crucial to the success of the scorecard.
- Cascading the scorecard from the corporate level to business units is essential to making the scorecard "real" to staff and managers in the organization.

## Executive Summary

This project examined the development and implementation of a balanced scorecard in a large, multisite long term care organization. The balanced scorecard (BSC), an approach to measuring the performance of an organization which links measurement to strategy, was developed in the early 1990s. It is a framework now used by over half of Fortune 1000 companies in North America. The BSC is starting to be used in some health care organizations although it is yet very rare in continuing care. Although the scorecard is touted as a strategic planning tool, the actual linkage to strategy often does not happen and it then remains an operational monitoring system.

*The CAPITAL CARE Group*, like most health care organizations, does not have readily accessible information on the performance of our organization in the key areas of our mission and strategic plan. We therefore do not have evidence available when needed to know where to focus our priorities, where we need to improve, whether our initiatives are having a positive impact, or what initiatives we might need to add to our remove from our strategic plan. It is not that we do not have data – on the contrary we collect all sorts of information. The question is whether it is useful and readily accessible in its current format for strategic planning purposes. Capital Care decided to develop a BSC to drive the strategic management processes of the organization. By demonstrating the value of using readily accessible data to see the impact of interventions and initiatives, it is also anticipated that the organizational culture will become more supportive of the use of evidence to support care and management decisions. Our specific objectives in implementing our BSC were to:

- keep the organization focused on its priorities by strengthening connections between strategies and human/financial resources,
- spur continuous improvement by establishing measurable targets,
- communicate the priorities of the organization to staff members and clarify how they can contribute to those priorities, and
- improve efforts to review and adapt strategies.

From the beginning of the process it was recognized that the development of the BSC, while a technical task that must be done well, was the easier part. The literature and our interviews with other healthcare organizations in Canada confirmed that the more difficult phase, and the part where many fail (some report up to 70%), was implementing the BSC, including linking the BSC to the organization's strategy, and cascading the BSC to other levels in the organization (i.e. beyond a corporate scorecard). Reasons for these failures include lack of executive management support at the beginning or inability to sustain that support through the length of time it takes for a BSC to become institutionalized, a lack of broad based staff involvement, irrelevant indicators or poor data, inadequate resourcing for data analysis and supporting the implementation process, lack of systems thinking in an organization, and inadequate attention to communicating the purpose of the BSC. Literature searches also turned up very little in terms of hard evidence of the effectiveness of BSCs, and in particular on how they have been linked to strategy in public/non profit organizations, although the anecdotal material is very positive. Only two articles were found on using BSCs in long term care and thus this project contributes to learning about BSC implementation in healthcare, and in particular within long term care.

There were two levels of intervention in this initiative. The first was at the corporate strategic level, with the development and implementation of a corporate BSC. The results are now being used quarterly to review progress with the executive team, and are used in the annual strategic planning process of the organization. It is anticipated that the use of a BSC will impact strategies selected and strategies to be dropped, and create a more evidence informed decision making culture. The second level of intervention is at the site level, with the development and implementation of care centre scorecards. The care centre BSCs have indicators in common that are compared across all of our sites. The centre scorecards will be more relevant to front line management and staff, and help them to see the value and use of a BSC for their own quality improvement work. This will help them to see how they directly contribute to the organization's strategy.

This project has implications for those implementing a BSC in a publicly funded (and in our case also publicly operated) healthcare organization. It identifies the challenges faced in developing a scorecard for a highly regulated, unionized environment in which both revenue and costs are heavily impacted by external forces. It raises the question of whether (and if so what) financial measures make sense as part of a BSC in this sector, which is opposite to BSCs in the private for profit world where the financial dimension is the most critical piece of the BSC. Further challenges are presented by the lack of integrated information systems in the long term care system, the paucity of benchmark data to use to compare performance, and few resources for data analysis and interpretation.

Healthcare organizations cannot simply take Kaplan and Norton's original BSC framework and apply it as is. They must invest considerable thought and effort in customizing it to their unique mission, vision and values. Many public sector organizations have struggled with the BSC because they have not adapted it adequately to meet their needs, or thought through what their purposes were in implementing it. Organizations often indulge in mimicry and adopt management tools without understanding what they actually mean for their organization. The BSC is fundamentally a strategic management tool, yet often does not advance beyond being an operational performance measurement system for the organization. This is particularly a challenge in public healthcare organizations which often do not have explicit strategic directions.

The true value of the BSC exists in its role as a strategic management system. Strategy interests itself with activities performed by the organization's executives that impact the sustainability and survival of their organization. A fundamental assumption of strategy is that executives perform the role of interpreting the environment and making choices for their organization. As time and attention of executives is in short supply, executives selectively attend only to some aspects. Using a BSC to selectively direct the attention of executives is where it is most effective as it determines what an organization does and just as importantly, chooses not to do. In the interviews of other healthcare organizations conducted as part of this project, it was found that most indicated they wanted to move to using their BSC for strategy development but that they had not yet gone there. Executive support is the key factor in determining the success or failure of a BSC implementation. The BSC requires systems thinking – the traditional thinking patterns of management need to change from a short term operational, reactive or tactical focus (favoured in today's healthcare system) to long term directional or strategic thinking.

Understanding the purpose of a BSC is critical to its successful implementation. If we try for both quality improvement and accountability in the same performance measurement system, we will achieve neither well. The purpose of the reporting system must be established up front – who needs what information? For what purpose? This will determine what indicators are chosen, how they are reported, and to whom. This is a critical discussion to have at the beginning of the process of development. Different levels of governance need different types of information for different purposes. The same BSC cannot be used by a provincial health department, regional health authority and care delivery organizations. Strategic BSC measures are different from regulatory and clinical reporting measures. The BSC is about long term strategy. Operational monitoring also needs to occur for continuous improvement purposes – but this operational monitoring is not part of the BSC.

Key learnings in this project included:

- The key dimensions and indicators of performance need to be driven from the organization's strategic plan. Simply adopting the original BSC framework developed for private for profit organizations (or for that matter adopting another organization's BSC without considering any differences in strategic directions/mission/vision) makes no sense for a public organization and misses the intent of a BSC.
- Taking the time to determine the objectives for the BSC, develop the BSC based on the organization's priorities, and using input from key stakeholders across the organization is more important than "getting it done" in a few months. This investment of time will help stakeholders understand the intent of the system and buy-in to actually using the results to influence what they do.
- The BSC, if developed well, can be a key driver to supporting a more evidence informed culture of decision making in an organization.
- The BSC must be integrated into the work processes, and in particular the strategic planning processes of the organization. Accountability for using the results of the BSC to make changes must be built into the organization's ways of doing business.
- The CEO and executive of an organization must be seen to be driving the development and implementation process. Without their support the BSC will drift to becoming one more report gathering dust on desks. This support is critical up front, and throughout the implementation process (i.e. it must be maintained). An executive lead is essential.
- Skills in formulating strategic hypotheses, data analysis and data management, and putting feedback and learning systems in place are critical to successful completion of BSC projects. Resources need to be assigned to support the BSC process, and those assignments need to be based on these skill sets.
- Cascading below the corporate level will engage a wider cross section of the organization, and be more likely to result in overall improvement in organizational performance.

## **Context**

*The CAPITAL CARE Group (TCCG)* is the largest public sector continuing care organization in Canada, with eleven care centres in the Edmonton region, serving 1700 clients in these centres and in the community. Like most health care organizations, TCCG does not have readily accessible information on the performance of our organization in the key areas of our mission and strategic plan. We therefore do not have evidence available when needed to know where to focus our priorities, where we need to improve, whether our initiatives are having a positive impact, or what initiatives we might need to add to or remove from our strategic plan.

The Balanced Scorecard (BSC), an approach to measuring the performance of an organization which links measurement to strategy, was developed by Kaplan and Norton in 1990<sup>1</sup>. It is a framework now used by over 50% of Fortune 1000 companies in North America and 40% in Europe<sup>2</sup>. Knowles<sup>3</sup> states that over 90% of business schools offer BSC courses although he acknowledges that the actual benefits of its use are very difficult to establish. Although the scorecard is touted as a strategic planning tool, the actual linkage to strategy is not always carried out. The BSC is starting to be used in some health care organizations although it is yet very rare in continuing care organizations. TCCG is implementing a BSC specific to the key dimensions of the organization's performance for the achievement of its mission, vision and strategic directions.

TCCG is growing in its commitment to evidence informed decision making. It has had a Research Unit since 1996 which is steadily increasing in its local, national and international reputation. Increasing numbers of staff are expressing an interest and becoming involved in research projects. In 2002 a Corporate Best Practice Committee was established at TCCG with the mandate to research and propose best practices. In 2003 a best practice desktop tool was developed to provide staff with access to online search engines and literature to investigate

research findings to support quality improvement in the organization. There are now 72 users of the desktop. In 2004 we received a three year knowledge brokering grant to bring together researchers, other partners and TCCG in using clinical data for quality improvement and research purposes. In 2005 at the Executive Management Committee's annual planning day, the organization established a strategic direction to "become the Western Canadian continuing care leader in practice based research, on site student training and evidence based practice". Taken together, these initiatives provide evidence of incremental but continuous progress in moving towards being a more evidence informed organization.

The development of a BSC is a natural next step for the organization in its maturing process with respect to the use of research informed evidence. In this case the evidence includes the development and implementation of a BSC itself, and the measures chosen as part of the BSC which wherever feasible are based on existing research or best practice evidence. Implementing the BSC and using it to drive the strategic management processes of the organization will enable TCCG to better use evidence, understand the value of using evidence, and to identify and then monitor strategic priorities.

The timing of this initiative is particularly appropriate. In 2005 Alberta's Auditor General conducted a review of continuing care in the province and found that one third of facilities were not meeting basic legislated standards. His report generated a lot of media attention and recognition that funding levels for continuing care were too low (as a result a slight increase in funding was implemented January, 2006 and a second increase in April, 2006) and that the standards need to be updated. New standards are expected in the spring of 2006. Implementing a BSC is one mechanism for demonstrating TCCG's commitment to quality improvement at a strategic level.

From the beginning of the process it was recognized that the development phase of the BSC was the easier part. While it is critical that the selection of measures be done well, involving key stakeholders and selecting valid indicators, this is really a technical task. The literature and our subsequent interviews with other healthcare organizations made it clear that the more difficult phase was implementing the BSC, including linking the BSC to the organization's strategy, and cascading the BSC to other levels in the organization (i.e. beyond a corporate scorecard). The literature speaks of BSCs as strategic management tools, but it is clear that they often do not progress beyond corporate level monitoring tools (also an important function). Thus this paper focuses on the implementation of a BSC, rather than describing in depth the development process, in the context of supporting a more evidence informed approach to decision making.

Literature searches turned up very little in terms of hard evidence of the effectiveness of BSCs, and in particular how they have been linked to strategy in public/non profit organizations, although the anecdotal material is very positive. While there are books written on the topic these are more "how to" or theoretical in nature rather than research based, and are seldom targeted at the public/non profit sectors. Only two articles were found on using BSCs in long term care<sup>4,5</sup> and thus this project contributes to learning about BSC implementation in healthcare, and in particular within long term care.

TCCG's objectives in implementing a BSC are to:

- keep the organization focused on its priorities by strengthening connections between strategies and human/financial resources,
- spur continuous improvement by establishing measurable targets,
- communicate the priorities of the organization to staff members and clarify how they can contribute to those priorities, and
- improve efforts to review and adapt strategies.



By demonstrating the value of using readily accessible data to see the impact of interventions and initiatives, and benchmarking against targets established in the research literature and best practice in other jurisdictions, it is anticipated that the organization's culture will become more supportive of the use of evidence to support care and management decisions.

## **Implications**

There are two levels of intervention in this initiative. The objectives outlined above were intended to apply to both levels. The first is at the corporate strategic level, with the development and implementation of a corporate BSC. The results from the corporate scorecard will be reviewed regularly by the executive team to monitor progress. They will also be used in the annual strategic planning process of the organization. Having a BSC will change the nature of executive team meetings, and the organization's strategic planning process. It is anticipated that the use of a BSC will impact strategies selected and strategies to be dropped, and create a more evidence informed decision making culture with a more data literate management team once the value of having timely data linked to strategic priorities is demonstrated.

The second level of intervention is at the site level, with the development and implementation of care centre scorecards. The centre BSCs have indicators in common that can be compared across all of our sites. These indicators were identified by groups from the centres (e.g. Customer Service Committee, Volunteer Coordinators, Administrators, Best Practice Committee) to ensure they are relevant. Centres may also choose to add some indicators specific to programs at their sites. The centre scorecards will be more relevant to front line staff and management, and help them to see the value of a BSC for their own quality improvement work, and how they directly contribute to the organization's strategy.

This project has implications for those implementing a BSC in a publicly funded (and in our case also publicly operated) healthcare organization. It identifies the challenges faced in developing a scorecard for a highly regulated, unionized environment in which both revenue and costs are heavily impacted by external forces. It raises the question of whether (and if so what) financial measures make sense as part of a BSC in this sector, which is opposite to BSCs in the private for profit world where the financial dimension is the most critical piece of the BSC. Further challenges are presented by the lack of integrated information systems in the long term care system, the paucity of benchmark data to use to compare performance (although this is changing with the implementation of the RAI-2.0 or Resident Assessment Instrument on a national level), and few resources for data analysis and interpretation.

Healthcare organizations cannot simply take Kaplan and Norton's framework and apply it as is. They must invest considerable thought and effort in customizing it to their unique mission, vision and values. The BSC is fundamentally a strategic management tool, yet often does not advance beyond being used as an operational performance measurement system. This is particularly a challenge in public healthcare organizations which often do not have explicit strategic directions.

## **Approach**

### Literature Review

Over the last decade and a half, we have seen implementation of the BSC across for profit business and more recently not for profit/public sector organizations alike. Kaplan and Norton<sup>1</sup> argue that the BSC directs the attention of executives towards important activities that impact the performance of an organization. These include directing attention of executives towards "financial" measures such as profits, growth, and earnings; and "operational" measures such as

customer satisfaction, internal processes, and innovation. Kaplan and Norton<sup>1</sup> advocate the monitoring and measurement of “operational” indicators of performance, as these “are the drivers of future financial performance” (p.71). That is, a balanced approach to measuring performance is one that takes into consideration both tangible short-term financial indicators and more intangible operational indicators with long-term consequences.

In their subsequent works, Kaplan and Norton<sup>6,7</sup> propose that the true value of the BSC exists in its role as a strategic management system. Strategy is the domain of the organization’s executives. It interests itself with substantial activities performed by these executives that impact the sustainability and survival of their organizations. A fundamental assumption of strategy is that executives perform the role of interpreting the environment and making choices for their organization. As time and attention of executives is in short supply, executives selectively attend only to some aspects.<sup>8,9,10,11,12,13,14</sup> As a strategic management system, the BSC selectively directs the attention of executives. McAdam and Walker<sup>15</sup> found in their study of four local UK government authorities that it was at the strategic management level that the BSC is most effective. Directing attention of executives is an important activity, as it should inevitably determine what an organization does<sup>10,13</sup> and just as importantly, chooses not to do.

The verdict on whether the BSC is a great management discovery or alternatively a management fad remains much discussed in the literature.<sup>16</sup> In fact, evaluating the success of a management system is not quite so simple and obvious. First, inevitable errors such as attribution and self-reporting bias are likely to occur in organizations.<sup>17</sup> So, organizations sometimes pretend that management tools actually work in order to be seen as desirable entities.<sup>18</sup> And second, as the BSC is relatively new, and as it is supposed to impact the long-term success of an organization, it is still quite early to evaluate its impact.

Cases cited in the business literature tend to report on exceptional cases of BSC implementation rather than the failures which might actually be more prevalent. Voelker, Rakich, and French<sup>19</sup> report that 70% of scorecards developed do not ever get implemented. Reasons for these failures include lack of executive management support at the beginning or inability to sustain that support through the length of time it takes for a BSC to become institutionalized, a lack of broad based staff involvement, irrelevant indicators or poor data, inadequate resourcing for data analysis and supporting the implementation process, lack of systems thinking in an organization, and inadequate attention to communicating the purpose of the BSC.

#### *Use of the BSC in public sector organizations*

Public sector organizations differ quite substantially from for profit business firms in three major respects. First, they operate in a highly politicized environment and under strong institutional pressures from government. Second, the criteria for evaluating their performance differ quite fundamentally from private firms – in the public sector success is measured against the service mission of the organization whereas the success of a private sector organization is ultimately judged by the profit it returns to shareholders. Third, they operate in a protected environment and face lesser pressures for survival. Despite these fundamental differences between public and private sector organizations, new public management practices including an increased emphasis on accountability and the rising influence of market forces have compelled public sector organizations to operate differently than in the past. Long term care in particular needs to be competitive with the private sector since it is not covered by the Canada Health Act, and public organizations are funded the same as private organizations in provinces such as Alberta. One such way in which public sector organizations are conforming to market

expectations (or perhaps borrowing from the private sector) is by adopting management tools such as the BSC.

The BSC has been adopted by public sector organizations across various industries in a number of countries including the United States, Canada, United Kingdom, and New Zealand.<sup>20,21,22,23,24</sup> There is a recently emerging, albeit still limited field of literature on the adoption of the BSC in healthcare.<sup>19,20,23,24,25,26,27,28,29,30,31</sup> In 2001 Voelker et al.<sup>19</sup> stated that “Healthcare has been slower than most industries to adopt the BSC” (p.21). Zelman et al.<sup>31</sup> stated somewhat more optimistically two years later: “As with any innovation, the balanced scorecard can be expected to go through a product life cycle: introduction, growth, maturity, and decline. In health care, the balanced scorecard is well into its growth phase” (p.1). For example, Pink et al.<sup>24</sup> studied how 89 hospitals in Ontario developed a BSC. They found that the Financial Advisory Panel of these hospitals was open to establishing non-financial indicators of performance but the availability and quality of data was a concern.

Inamdar and Kaplan<sup>23</sup> have also argued that the BSC is applicable and relevant for healthcare organizations. They found in their study of nine early adopter healthcare organizations that the BSC helped in strategy implementation by for instance forcing them to clarify and gain consensus on their strategy and bring strategy down to the front line workers through cascading the scorecards, and that it has a broader and more strategic perspective than other measurement systems more commonly used in healthcare. Their study found that these organizations were not yet using the scorecard for strategy development although they anticipated moving to this step as they progressed in their implementation. This finding is consistent with TCCG’s interviews of Canadian healthcare organizations – one of the most consistent themes is that organizations would like to use it for strategy development but have not yet gone there.

Use of the BSC in long term care organizations is still extremely rare. Only two published articles were found on this sector, both focusing on the developmental process in their organizations. Macdonald<sup>4</sup> described the process used by Sisters of Charity of Ottawa Health Service (SCOHS), noting their need to adapt Kaplan and Norton's framework from the four original dimensions to five dimensions that fit the SCOHS strategic direction. As is often the case for public or non profit organizations, finances were not one of the five dimensions chosen. They noted the lack of existing measures when they first started out, and the lack of accessible data to use for benchmarking.

Potthoff et al.<sup>5</sup>, writing about a multisite non profit U.S. long term care organization (Ebenezer Social Ministries in Minnesota), noted the stringent regulatory environment that U.S. long term care facilities operate under and the negative repercussions this has for quality assurance because of its focus on a reactive rather than a positive quality improvement approach. They also recognized that 80 to 90 percent of care in these facilities is provided by nursing assistants and thus it is their behaviour that has the greatest impact on quality of life. Their organization selected six dimensions of performance for their performance measurement. In the U.S. example, financial viability was one of the six dimensions chosen. Both articles emphasized the importance of driving the measurement system out of the organization's mission, vision and values, and that unique issues arise from measurement in long term care.

Overall, there is sufficient evidence in the literature that BSC has caught the attention of public sector and healthcare organizations. There is also evidence that the BSC has been employed as a strategic management tool to monitor key performance indicators that impact the long-term sustainability of an organization. However, the actual evidence on when and how it might positively impact organizational performance remains fragmented and speculative at best.

*Barriers to BSC adoption in public sector organizations*

Literature suggests that public sector organizations face unique barriers in adopting the BSC. The three most salient barriers to success faced by public sector organizations in general, and public healthcare organizations in specific, are (1) needs for customization, (2) conflicting performance evaluation criteria, and (3) implementation barriers.

The key challenge faced by public sector organizations is their struggle with customizing the BSC to meet their specific needs. Organizations need to alter the broad BSC framework to suit their specific needs. The BSC as developed by Kaplan and Norton needs to be contextualized to meet the specific requirements of these public sector organizations. As the criteria for evaluating the performance of public sector organizations – and even more so in a complex arena such as healthcare – are hard to identify and measure, these organizations need to adapt the BSC quite significantly.<sup>4,5,19,26,31,32</sup>

Kaplan and Norton's framework which places the financial dimension at the top (i.e. all other dimensions drive the ultimate goal of financial profit) does not fit for non profit or public sector organizations, which generally give it a lower placing in the framework or delete this dimension<sup>19</sup> (i.e. finances are seen as a means to an end, not the end itself). Chan's<sup>21</sup> study of municipal governments found that one in five municipalities using a BSC had not developed measures from the financial performance perspective. Pink et al.<sup>24</sup> noted that the Ontario Hospital Report chose measures of financial viability rather than profitability in their balanced scorecard since this better fit the publicly funded, not for profit hospital system predominant in Canada. Customers or clients generally are at the top of a public sector BSC framework. Many public sector organizations have struggled with the BSC because they have not adapted it adequately.

The second barrier to BSC adoption is conflicting performance evaluation criteria. Different stakeholder groups have different expectations and gauge the performance of an organization in

light of their own interests and values. A public sector organization has multiple stakeholders with diverse expectations. Voelker et al.<sup>19</sup> note that the many different stakeholder groups that need to be considered make applying the BSC in healthcare uniquely challenging.

The criteria for evaluating a public healthcare system are multi-faceted and may include for instance dimensions related to quality of care and safety, client satisfaction, fiscal efficiency, and quality of research and innovation. While clients as a stakeholder group are primarily concerned about the quality, timeliness and quantum of care they receive, government as a stakeholder exercises pressures for fiscal prudence as well as the requirement to meet regulatory mandates, and professional administrators as the stakeholder would like to see evidence of quality, research, and innovation. These diverse expectations from the various stakeholders may work at cross-purposes with each other.

The BSC literature is rife with lists of implementation barriers, and particularly within healthcare settings – not surprising perhaps given the amount of change it brings to an organization. This list is summarized in Table 1 below.

Table 1  
Balanced Scorecard Implementation Barriers

- Obtaining executive approval – i.e. selling the initial concept<sup>23,46</sup>
- Obtaining executive time and commitment<sup>19,23,27,33</sup>
- Lack of a clear mission or strategy<sup>4,16,46</sup>
- Determining appropriate measures – for instance developing the “value proposition” for the customer perspective<sup>23,30,46</sup>
- Deploying throughout the organization<sup>23</sup>
- Gaining and maintaining commitment to implement<sup>19,23,46</sup>
- Obtaining and interpreting timely data in a cost effective manner<sup>16,19,23,27,46</sup>
- Lack of data for desired indicators<sup>24,33</sup>
- Data quality issues<sup>24</sup>
- Time/resource implications to developing and maintaining the BSC<sup>19,20</sup>
- Keeping the BSC simple and using it for learning<sup>23</sup>
- Changing traditional ways of thinking to systems thinking<sup>19</sup>
- Fear of use of the results for punishment<sup>46</sup>



The BSC needs sustained executive commitment, time, and attention in order to be successfully adopted by an organization. This is the most frequently cited barrier/facilitator to successful implementation of a BSC<sup>2,23,27,33</sup> and was confirmed in the interviews carried out by TCCG. While the BSC directs attention of executives towards issues that impact long-term performance, such attention needs to be sincere and sustained over a long period of time. However, as most executives have limited time and feel obliged to attend to competing pressures from the environment, they are more inclined to focus on temporally urgent issues of immediate threatening consequence than on long-term strategic issues and opportunities.<sup>34</sup>

Executive attention is inadequate in itself.<sup>23</sup> It needs to be tightly coupled with other communication channels within an organization in order to be effective.<sup>35</sup> There is a need for linkages between governance mechanisms such as executive meetings, annual reports and business plans; and operational communication channels such as work policies and processes so that these strategic indicators are routinized into a simple framework that can be understood, measured, and evaluated at the working level. Radnor and Lovell<sup>20</sup> also speak to the importance of linking the BSC to an existing planning or performance measurement process such as business planning to reduce time and costs.

Another barrier is that not all public sector organizations have an explicit strategy. This is the central theme of a provocative paper by Inkpen and Choudhury<sup>36</sup> entitled “The seeking of strategy where it is not: Towards a theory of strategy absence”. In the absence of strategy, there will be a temptation to measure operational indicators or to try to make the BSC the only performance monitoring tool for the organization rather than focusing it on strategic indicators. Macdonald<sup>4</sup> notes that “without clear strategic direction, implementation of the balanced scorecard as a strategic management tool becomes an exercise in futility” (p.34).

There is also much empirical evidence in the management literature that organizations indulge in mimicry and adopt management tools without understanding what they actually mean. Adopting myths provides legitimacy which is an important resource for survival. Pressures to adopt these myths might be **coercive** (e.g. government wants us to do it – this is one of the reasons cited by Radnor and Lovell<sup>20</sup> as an incentive to adopt the BSC), **normative** (e.g. all good healthcare organizations adopt it), or **mimetic** (e.g. everyone else seems to be doing it – again cited as a reason for adopting the BSC by Radnor and Lovell<sup>20</sup>). Institutional theory predicts that early adopters of a management practice (e.g. Total Quality Management, Balanced Scorecard) do so for efficiency/effectiveness reasons while the late adopters do so for ceremonial conformity<sup>37</sup>.

One of the biggest implementation barriers is a lack of corporate culture in continuing care valuing the use of data to monitor progress/make decisions, due largely to the lack of information systems beyond financial systems. Kizer<sup>38</sup> states that “Managing large amounts of information is integral to providing health care, and the success of any healthcare organization today is highly dependent on its ability to manage information” (p.92). Inamdar and Kaplan<sup>23</sup> also found skills in formulating strategic hypotheses, data analysis and data management to be critical to successful completion of BSC projects. Their study found the greatest need for improvement was in putting feedback and learning processes in place. Long term care organizations tend to have fewer staff with graduate degrees with the skill set of looking critically at data to interpret what it means. Zelman et al.<sup>31</sup> note that health care organizations have poor data warehousing and non integrated information systems which makes it difficult to access information when it is needed. TCCG’s Corporate Best Practice Committee is beginning to get more confident in the use of quality indicator reports which is a positive direction that should facilitate usage of the BSC reports.

Other evidence informed initiatives in the organization such as those described earlier will also support the move to actually using the BSC to make changes.

### *Making the BSC happen*

The two key challenges that most influence the success of the BSC are managing executive attention and translating this attention into action. The “attention-based view” (ABV) of the firm addresses this predicament.<sup>13,35,39</sup> The ABV argues that an organization’s behaviour is the result of the ways in which it distributes and regulates the attention of its executives such as the CEO and Board members.<sup>12,40,41</sup>

As attention and time available to executives is scarce, they must choose among a given set of alternatives. Simon<sup>42</sup> refers to this process as “selection” and explains that “if an individual follows one particular course of action, there are other courses of action that he thereby forgets” (p.3). Human beings have a limited cognitive capacity to deal with a multitude of problems and events. Executive attention implies salience, or the privileging of a particular event or problem over others,<sup>13,34,43,44</sup> also defined as strategic choice.<sup>9,45</sup> For example, Dutton and Jackson<sup>34</sup> propose that “decision makers selectively attend to some emerging developments while ignoring others” (p.77). That is, as top managerial time and attention is a scarce resource, they must be very selective about what they focus on. This highlights the important role played by attention to BSC indicators.

Ocasio and Joseph<sup>35</sup> studied General Electric to see when and how exactly does executive attention to strategic issues lead to implementation. They found that selective retention of executive attention occurs only when immediate steps are taken to make strategic directions easily understandable, measurable, and relevant particularly at the operational level. If we are to

apply their findings to the BSC, the strategic management tool in itself is inadequate. Rather, the tool must be imbibed into the various daily routines and structures of the organization.

### BSC Development at TCCG

A small work group appointed by the organization's Executive Management Committee (EMC) and led by a member of the executive team began by carrying out a review of the key literature on the BSC. On the basis of that work, EMC accepted the recommendation to develop and implement a BSC at TCCG. It was important in that initial literature review to determine whether the BSC had advanced beyond a management fad to become mainstream, particularly in health care. The evidence supported this as a normative shift that had lasting power. Our work group also reviewed the literature on implementation strategies for the BSC. The literature emphasized the importance of establishing the organization's objectives in implementing a BSC. Thus part of the recommendation to EMC was a set of objectives (see Context section above).

A Steering Committee of nine representatives from across the organization was then appointed to lead the initiative (chaired by an executive lead). Steering Committee members were selected to represent key areas within the organization in order to ensure various perspectives were all addressed in the scorecard (e.g. finance, human resources, strategic planning, clinical, middle and executive level operations management, executive management). The executive lead for the BSC also holds responsibility for leading the organization's strategic planning process, so has the ability to integrate the BSC with that process. Niven<sup>46</sup> emphasizes the importance of assigning an executive sponsor. A manager from the Corporate Planning Department who reports to the Committee Chair was assigned as the project manager. A portion of his time is dedicated to this initiative.

A consultant was engaged to facilitate a two day process with EMC and the Steering Committee. The consultant was selected because she had published one of the two articles we found on developing a BSC in long term care – and she was Canadian based and from a non profit organization so understood our context. This helped move us forward in developing a framework (the customization of balanced scorecard dimensions and critical success factors, also often called strategic objectives) based on the organization’s mission and vision. In those two days approximately 120 potential indicators were identified by the approximately 20 workshop participants. Those 120 indicators were eventually reduced down to 29. We used methodologies described in courses, textbooks and literature reviews including:

- presenting the draft indicators and overall framework and getting feedback from various groups across the organization that was used to refine the indicators and framework;
- identifying lead champions for each indicator and asking them to define the numerator and denominator (using research evidence, existing databases, and provincial/regional benchmark definitions if available) and propose targets – these individuals also hold accountability for leading initiatives to help meet those targets;
- having the Steering Committee rate the indicators using criteria such as ease of access to data, relevance to our strategic plan, availability of benchmarking data, and validity and reliability of the data;
- obtaining historical data where available, designing and trialing new data collection tools where required, and then reviewing the results with the Steering Committee to determine the usefulness of the indicators; and
- obtaining EMC approval at critical steps in the process, including approval for the actual indicators chosen, targets and implementation plan.

TCCG's BSC project has been proceeding based on evidence (where available) and advice received from those who have implemented BSCs in their organizations, whether successfully or unsuccessfully (the latter are rarely reported in the literature so this is a key question asked of other organizations). This information has been obtained from attending courses, speaking with consultants, reading textbooks, literature reviews, and interviewing other healthcare organizations. Our Steering Committee debates the pros and cons of new ideas as they arise and vets these against what we have already learned from other sources, and our knowledge of the culture of our organization. This contextualization process is cited in the literature as critical to the successful implementation of a BSC.

The interviews with other organizations focused on Canadian healthcare organizations since they have generally not published their work. Contacts were obtained mostly through word of mouth referrals, as well as identifying organizations through the literature review work. Ten organizations were formally interviewed and notes were typed up at the end of each interview (see Appendix 1 for interview questions). Some of the key themes emerging from these interviews were:

- most organizations interviewed acknowledge that they have not linked their BSC to strategy but would like to move it beyond a monitoring tool;
- dedicated resources are critical to the success of a BSC implementation;
- the BSC must be customized to the organization's mission and goals;
- the BSC should be a living tool – it needs to change over time;
- CEO and senior management leadership is key to the survival of the BSC;
- keep it simple and manageable – just get it out there and start using it; and
- keeping it a strategic vs. an operational level tool is a constant challenge.

Since the methodology used was derived from the expertise of others who had developed balanced scorecards, another long term care organization would likely want to use the same basic steps, again assessing these against the context of their organizational culture. A smaller organization for instance might be able to collapse several steps in one since it would not have as many groups to consult with, shortening the developmental period. Bringing in an external consultant was very helpful because at that point in time, TCCG had no internal expertise in developing a BSC. The danger of doing it all in house would be losing the evidence based approach unless the organization was able to invest a significant amount of up front training in an internal lead, and had someone with the skill set and mindset (i.e. strategic thinking abilities) to learn how to lead such an initiative.

#### Communication and External Dissemination

Kaplan and Norton<sup>47</sup> quote Southern Gardens Citrus Processing VP Tristan Chapman as saying “You need to spend as much time communicating the scorecard as you do developing it”. They cite the Hilton hotel chain and Mobil for their best practice in BSC implementation and note some of their communication vehicles such as painting scorecard measures on the walls of employee-only corridors, frequent references by the company president, posters, paycheck stuffers, site visits from members of the leadership team to explain their strategy and the BSC, newsletter articles, town meetings, etc. – the point being that a multi-faceted approach to communication is the key.

At TCCG a communication strategy has been developed with the assistance of the organization’s Manager of Communications (questions addressed in the communication plan are outlined in Appendix 2). TCCG’s CEO has indicated her willingness to incorporate messages about the BSC in any and all appropriate venues as she speaks to various groups within and

external to the organization. Throughout the development process, and once the scorecards were developed, updates on the BSC were presented at forums such as EMC meetings, Senior Staff Forums (all management staff, approximately 110 people, in the organization), Corporate Best Practice Committee meetings, the organization's Management Advisory Committee (a group of senior regional health authority staff which in effect serve as the organization's oversight body in the absence of a formal governance board), Medical Advisory Committee, and our foundation board. The corporate BSC report was also posted on the intranet for all staff to access.

External dissemination has not been a priority at this early stage of development but to date two class lectures for business courses at the University of Alberta in January, 2005 were given focusing on Capital Care's experience in developing a BSC. An invited presentation on knowledge brokering at TCCG was given to Alberta's Knowledge Transfer Network in May, 2005 and included mention of the BSC project as an example of evidence informed decision making. A February, 2006 presentation at the annual provincial CCHSE conference, focusing on TCCG's structures for evidence informed decision making, included mention of the BSC as one of the supporting vehicles for the organization's overall maturation in using evidence, and the CEO is including the BSC as an example in many of her presentations about the organization now.

### **Results to Date**

The initial corporate BSC has 29 indicators (including definitions/formulas for all indicators and targets for those indicators that have existing data), within five key dimensions of performance identified as critical to the achievement of TCCG's mission, vision and strategic directions (see Appendix 3 for the overall BSC framework developed for TCCG and Appendix 4 for a diagram of how it relates to the overall strategic planning process). Similar to the



experience of other public sector organizations, finances were not chosen as a key **strategic** dimension of the organization. In fact it was challenging to come up with financial indicators that were truly strategic (as opposed to operational indicators which are already monitored and are no less important, but just not strategic in an environment where government and the regional health authority primarily determine revenue levels, and costs are primarily driven by union agreements). In the end two financial indicators were identified for the initial corporate scorecard (building sustainability and cost per resident day), but one might question whether financial indicators make sense to include for a public sector long term care organization since indicators need to be selected for the ability to influence results through strategic initiatives. A third financial indicator (overtime hours) was added in April 2006 after the first year review of the scorecard. (See Appendix 5 for the corporate balanced scorecard summary page.)

A standard BSC was also developed for the organization's six campuses, focused on the strategic priorities of centre management. These centre scorecards include 23 indicators which are common across all sites. The indicators were identified by the Corporate Best Practice Committee and campus Administrators. Some of these are also included on the corporate scorecard so they are not all distinct indicators. The centre scorecards use the same five key dimensions of performance as the corporate scorecard. Centres have identified their indicator targets (based on their campus specific results – so the targets vary by campus), and have submitted their campus specific list of priority indicators to work on improving based on their first year results. In addition, the Human Resources Department took the initiative on their own to develop an HR Department BSC, again following the same five key dimensions of performance. (See Appendix 6 for the centre BSC summary page.)

As described earlier, the development of a scorecard is a technically complex stage of work, but from a change management perspective implementation is the more difficult phase, and one

that often does not get completed. The work involved is often underestimated by the organization, as is the importance of ongoing communication about the purpose of the scorecard. Capital Care's involvement of a wide range of staff in the development work should assist with buy-in and thus pave the way for a more successful implementation process.

Inamdar and Kaplan<sup>23</sup> found obtaining initial approval as well as buy-in for the lengthy development and implementation process to be one of the key barriers identified by health care organizations who were early adopters of the BSC. Capital Care's executive team identified the key dimensions of performance and brainstormed potential indicators, so there was initial ownership from that group. This is an important factor in favour of its successful implementation.

The project is at the stage of moving from development to implementation in the organization and so that executive team support is now critical to the successful **use** of the scorecard as a strategic management tool. An implementation plan, including a corporate BSC policy, was approved by EMC in 2006 and is now being rolled out. During the development phase, a meeting with EMC to discuss this project generated a list of barriers they anticipated within our organization (see Appendix7). These implementation barriers are similar to those cited in the literature with respect to BSCs, as noted earlier in Table 1. The Steering Committee is aware of these and will address them as it communicates about the project.

One barrier will be communicating the purpose of the scorecard. Questions that have arisen include how does this relate to the regional health authority's community care scorecard (developed around the same time as TCCG's), and how does the BSC relate to TCCG's existing quality indicators report. These are issues that need to be addressed through ongoing consistent communication to a variety of groups within the organization, and by thinking through how the various monitoring and accountability mechanisms fit together (i.e. the different purposes and

audiences for each). The regional continuing care BSC lists six areas that their BSC supports (i.e. its objectives). Strategic planning/strategy development is not listed among these and so is a key area of difference in purposes – TCCG’s BSC addresses its own organizational strategic directions. The indicators chosen for the regional BSC are more operationally focused (e.g. screening rates, immunization rates, outbreaks) and those of concern at a regional oversight/accountability level (in addition to those above, there are for instance access indicators such as days beds are vacant before admissions, and complaints reported to the region). TCCG’s preexisting quality indicators report was developed in the absence of an overall performance monitoring framework, using what information was available as a first step towards more formalized quality monitoring. It focuses on clinical quality indicators (e.g. several ways of measuring falls and pressure ulcers) rather than all dimensions of performance, including monitoring indicators required for reporting to the regional health authority. Its focus is on quality of care monitoring in selected areas. So each of the three reports focuses on different measures, selected for different purposes.

A 2003 article by Zelman, Pink and Matthias<sup>31</sup> is one of the best we have found at providing an overview of the use of the BSC in health care and in delineating the differences between a regional (or health system) scorecard versus an organizational scorecard. This is critical in our context, as TCCG began its work on its scorecard before the regional health authority did, and questions arise from time to time as to why there would need to be two different scorecards. Zelman et al. do a good job of explaining the different audiences, purposes, etc. for the two levels within a health care system, and thus why their scorecards **must** be different. This article has proven to be useful in communicating the differences and it has been shared with the regional health authority as well.

If we try for both quality improvement and accountability in the same performance measurement system (e.g. a report card or a balanced scorecard), we will achieve neither well although the same information may contribute to different systems. The purpose of the reporting system must be established up front – who needs what information? For what purpose? This will determine what indicators are chosen, how they are reported, and to whom.

“If the need to demonstrate accountability is overemphasized . . . institutions will be so busy complying with external requirements they will not have time to devote to bringing about improvements. Getting the balance right between accountability and improvement is the most difficult challenge. . . .”<sup>48</sup>

This conceptualization about the differences between levels of governance and their need for information has continued to evolve in discussions with the regional health authority and the provincial health department, facilitated by the “Knowledge Brokering Group” (affectionately known as the KBG) grant held by TCCG, funded by CHSRF as one of six national demonstration projects on knowledge brokering.

There are countless management and measurement frameworks used by organizations (e.g. ISO 9000, TQM, Key Performance Indicators, etc.) – the difference that needs to be communicated regarding the BSC is its value as a strategic management, as opposed to simply a performance measurement, tool. In Inamdar and Kaplan’s<sup>23</sup> study of healthcare organizations, they found that the participants understood that the strategic BSC measures needed to be different from regulatory and clinical reporting measures. The BSC is about long term strategy.

The BSC has been developed and communicated at TCCG as a strategic tool that supports a culture of evidence informed decision making. Its existence signals the organization’s commitment to strategic planning. The results have been used as part of the 2005 and 2006 annual executive team strategic planning sessions as input to updating the three year business plan of the organization. One factor in the organization’s favour as we move into the

implementation of the BSC is that at the executive team's 2005 planning day, four long term strategic directions were identified for the organization. This had not been done before – in the past we had focused only on more immediate projects rather than broad strategic directions (the lack of strategy was cited earlier in the literature review section as a barrier to BSC implementation in healthcare). Thus implementing a tool to support these strategies is timely.

Operational indicator monitoring also needs to happen so that there is continuous data for improvement of processes in an organization. This operational monitoring though is not part of the BSC. For example it might be **important** to monitor resident and staff flu immunization rates (and we do), but for TCCG this would not be a **strategic** indicator. On the other hand, given TCCG's strategic direction to be a leader in student training, our indicator on the number of students doing placements within TCCG is strategic for us (but may not be for another organization).

“Indicator creep” is a constant theme in the literature on the BSC – adding more and more indicators, thus losing the focus on the strategic<sup>23</sup>, and was confirmed as an issue in our interviews with other organizations. The BSC must focus on the critical indicators that will drive strategic performance breakthroughs over the long term. It requires systems thinking – the traditional thinking patterns of management need to change from a short term operational or tactical focus to long term directional or strategic thinking. This will be a challenge for the organization as there will be a desire to have one performance monitoring system do it all. Radnor and Lovell<sup>20</sup> note that organizations cannot be successful with just one performance measurement system.

TCCG took almost three years to develop our corporate scorecard and produce the first corporate BSC report. Literature indicates that a BSC can be developed in 6-12 months with outside help, or up to 4-5 years if the work is done internally without dedicated resources. The

centre BSC reports (i.e. cascading it to the first level down in the organization) were produced six months later. Even if resources permitted it, developing and implementing the BSC in 6-12 months would not have been advisable for TCCG. Change initiatives need to be implemented gradually in the organization, with time for consultation and input, and learning about the goals of the intervention. This is the nature of our organizational culture and helps achieve enough buy-in to maintain momentum. In Inamdar and Kaplan's<sup>23</sup> study healthcare executives emphasized the importance of using a lot of teaching, discussion and consensus building to ensure a successful implementation. Our interviews with other healthcare organizations indicated that cascading often did not occur until four years into the process.

This gradual approach to implementation is even more important in an organization with limited resources for data analysis and interpretation, and which is just developing a culture of using evidence informed information for decision making. In addition, the goal of automating the collection and reporting of indicators depends on information systems capable of doing so. Procurement requires the financial resources to acquire the systems (funding has not kept up with the increased costs of technology) and the availability of the systems themselves. These systems are only beginning to emerge and the scope and breadth of the indicators they currently produce is limited. TCCG (and other long term care organizations in the province) is just now in the process of acquiring a clinical information system for use across the organization.

Accountability for meeting targets has been assigned to indicator leads. For the corporate scorecard, these are members of the EMC. For the centre scorecards these are often a designated position at the centres (e.g. Volunteer Coordinator). Champions have also been identified at each site to facilitate the BSC implementation process within their campuses. The use of champions has worked successfully in the past for the organization as a means of supporting change management initiatives (e.g. Customer Service, Occupational Health & Safety, and our no

manual lift policy implementation). The key is finding people who are interested and enthusiastic about the potential of the initiative who can then communicate that enthusiasm to their peers.

The program leaders need to take responsibility. This was confirmed in the interviews with other healthcare organizations - the successful implementers had been able to get the program heads to take accountability; the unsuccessful ones had frustrated Planning Department people who could not get program leads/executive members interested. Olve et al.<sup>16</sup> also identify the importance of identifying roles early on in the introduction of a BSC.

### *Next Steps*

A communication plan is being implemented to support the BSC rollout, including training for site champions (the initial session was held in April 2006). A toolkit was developed through the BSC Steering Committee to assist with this. A champions' group has been established as a means of sharing ideas and learning from each other as they roll out the BSC at each of their campuses. "Buddies" from the Steering Committee have been assigned to support the centre champions. The implementation plan approved by EMC included the annual reporting and data collection schedule for BSC indicators, including the identification of who is responsible for delivering which data, by what dates.

As identified in the literature review, the initiative will survive best if integrated into regular organizational processes and reporting systems. In this coming year the BSC results will become a routine part of EMC meetings. We will start with quarterly reports on the results that are available quarterly (e.g. sick time, injuries, falls, turnover), to keep the attention on the BSC, in addition to an annual review of all the results. Once the clinical information system is implemented, a great deal more information will be available whenever required (monthly/quarterly – however often determined appropriate for reporting). And the BSC will be

a major contributor to the annual strategic planning sessions of EMC and Centre Operations Committees. By including it in these annual sessions that focus on strategic directions, the tool's strategic nature is reinforced. As identified in the interviews with other organizations, the challenge will always be to keep the scorecard at a strategic level. Integrating it with the regular strategic planning processes of the organization will help with this. When the indicators are updated, it will be up to the Steering Committee and EMC to revisit this objective before revising the indicators so as to not get caught in the trap of moving to a focus on operating indicators.

Seeing is believing – once the BSC results are routinely reported and discussed at various management forums it will eventually become a natural way of doing business in the organization, and participants will see its value to their work. The CEO has also committed to reviewing individual centre balanced scorecard results with the respective administrators to ensure action is being taken on initiatives to improve performance, thus reinforcing their accountability for using the results.

The momentum needs to be sustained though, and organizational resources assigned on an ongoing basis to support the production and analysis of reports, as confirmed through the interviews undertaken with other organizations. A Performance Measurement Coordinator position has been created (through restructuring an existing position) to support this work and other quality improvement initiatives within the organization. Assigning these resources is an indicator of the organization's support for and belief in this performance system, as the lack of dedicated resources was one of the barriers identified in the literature (summarized in Table 1 previously). This requires ongoing attention to keep the goal before EMC and the rest of the organization. The EMC lead continues to have responsibility for overseeing the production of the BSC reports, with the Performance Measurement Coordinator reporting to that position. Without a portion of the Coordinator's time dedicated to supporting the production of BSC reports, the



BSC would not be sustainable. The intent is to have the corporate scorecard discussed quarterly at EMC meetings, including identifying actions that may need to be taken or incorporated into the next year's planning cycle. Likewise the quarterly site scorecards are to be discussed at the site operations team meetings (it is anticipated some administrators will be more diligent about this than others) and the CEO has committed to reviewing these one on one with the administrators and holding them accountable for actions required based on results that might indicate a need for a change in direction/new initiatives. At this point in time there is not an intent to have the Planning Department do any additional analysis/recommendations other than flagging which items are below target, which is easy to see at a glance from the one page BSC summary pages.

In April, 2006 the Balanced Scorecard Steering Committee was renamed the Balanced Scorecard Implementation Steering Committee, and the terms of reference were changed to reflect the change in role (see Appendix 8). In its purpose statement, one of the two key functions of this committee was identified as "Ensure the BSC continues to reflect and inform strategic priorities of the organization". Thus this committee too has been tasked with remaining vigilant to ensure the BSC continues to operate as a strategic management tool.

Organizations are complex entities – introducing a BSC will never be the only factor impacting performance in a given time period and coming up with agreement on valid measures of "success" attributable to a BSC is challenging to say the least. Measuring the impact of a BSC in a public sector organization is far more complex than looking for instance at changes in profitability in the private sector. The literature generally reports just on the perceptions of executives (who perhaps not surprisingly are positive in their reports, given that they have invested a great deal of time and effort implementing the system in their organizations). At TCCG potential indicators of impact will be identified and discussed by the BSC Implementation Steering Committee (see Appendix 9 for initial ideas). As a first step, several items have been

added to the 2006 staff survey that ask staff about whether they get and whether they use information to make improvements. The results on these items will be tracked over time. Bilkhu-Thompson<sup>49</sup> notes that despite the popularity of the BSC, the effectiveness of a BSC process in health care has not been evaluated.

The BSC has been a contributor to TCCG's journey as an evidence informed decision making organization. While it is one of the most far reaching initiatives in terms of potential impact on the organization, it is only one contributor. Other initiatives were identified at the beginning of this paper, and regardless of the success of the BSC, those will continue – they are not contingent upon the BSC. It is anticipated that the BSC will take the organization further down the road of being a **strategically** evidence informed organization. Only time will tell whether this outcome is realized – that will be up to the organization.

## **Further Research**

It was clear from the literature review that research evidence on the BSC is lacking. Research is needed on the implementation of a BSC in different types of healthcare settings (in our case specifically long term care) to determine what is needed in a setting with few resources (including information systems and persons with expertise to develop and produce reports, and interpret the information for front line staff and managers). This needs to include how the BSC is linked to strategy development, and what organizational factors support/hinder moving from performance monitoring to use in developing strategy. This paper focused on the process of developing and implementing a BSC because of the stage the organization is at in its BSC work, which is also the focus of most published literature on BSCs. Research and even a systematic literature review including grey literature is particularly needed on the actual impact of BSC implementations in healthcare.

## References and Bibliography

- <sup>1</sup> Kaplan, R. S., & Norton, D. P. (1992). The balanced scorecard - measures that drive performance. *Harvard Business Review* (January-February), 71-79.
- <sup>2</sup> Kaplan, R. S., & Norton, D. P. (June 2001). Transforming the balanced scorecard from performance measurement to strategic management: Part II. *Accounting Horizons*, 15(2), 147-160.
- <sup>3</sup> Knowles, B. (May 2004). Lessons learned from the public sector. *Performance Measurement and Management*, 4(5), 1-11.
- <sup>4</sup> Macdonald, M. (1999). Using the balanced scorecard to align strategy and performance in long term care. *Healthcare Management Forum*, 11(8), 33-38.
- <sup>5</sup> Potthoff, S., Olson, D., Thompson, N., & Kissner, M. (1999). Long-term care management: A balanced performance measurement system. *Journal of Strategic Performance Measurement* (February/March), 16-22.
- <sup>6</sup> Kaplan, R. S., & Norton, D. P. (1996). Using the balanced scorecard as a strategic management system. *Harvard Business Review* (January-February), 75-85.
- <sup>7</sup> Kaplan, R. S., & Norton, D. P. (2004). Measuring the strategic readiness of intangible assets. *Harvard Business Review*, 82(2), 52-63, 121.
- <sup>8</sup> Barnard, C. I. (1938). *The functions of the executive*. Cambridge, MA: Harvard University Press.
- <sup>9</sup> Child, J. (1972). Organizational structure, environment and performance: The role of strategic choice. *Sociology*, 6(1), 1-22.
- <sup>10</sup> Cyert, R. M., & March, J. G. (1963). *A behavioral theory of the firm*. Englewood Cliffs, NJ: Prentice-Hall.
- <sup>11</sup> Daft, L. R., & Weick, E. K. (1984). Toward a model of organizations as interpretation systems. *Academy of Management Review*, 9(2), 284-295.
- <sup>12</sup> Hambrick, D. C., & Mason, P. A. (April 1984). Upper echelons: The organization as a reflection of its top managers. *Academy of Management Review*, 9(2), 193-206.
- <sup>13</sup> Ocasio, W. (1997). Towards an attention-based view of the firm. *Strategic Management Journal*, 18 (Summer Special Issue), 187-206.
- <sup>14</sup> Simon, H. A. (1947). *Administrative behavior*. New York: Free Press.
- <sup>15</sup> McAdam, R., & Walker, T. (2003). An inquiry into balanced scorecards within best value implementation in UK local government. *Public Administration*, 81(4), 873-892.
- <sup>16</sup> Olve, N., Petri, C., Roy, J., & Roy, S. (2004). Twelve years later: Understanding and realizing the value of balanced scorecards. *Ivey Business Journal*, (May-June), 1-7.
- <sup>17</sup> Fiol, C. M. (1995). Corporate communications: Comparing executives' private and public statements. *Academy of Management Journal*, 38(2), 522-536.
- <sup>18</sup> Meyer, J., & Rowan, B. (1977). Institutional organizations: Formal structure as myth and ceremony. *American Journal of Sociology*, 83, 340-363.
- <sup>19</sup> Voelker, K. E., Rakich, J. S., & French, G. R. (2001 Summer). The balanced scorecard in healthcare organizations: A performance measurement and strategic planning methodology. *HOSPITAL TOPICS: Research and Perspectives on Healthcare*, 79(3), 13-24.
- <sup>20</sup> Radnor, Z., & Lovell, B. (2003). Defining, justifying and implementing the balanced scorecard in the national health service. *International Journal of Medical Marketing*, 3(3), 174-188.
- <sup>21</sup> Chan, Y.L. (2004). Performance measurement and adoption of balanced scorecards: A survey of municipal governments in the USA and Canada. *The International Journal of Public Sector Management*, 17(2 and 3), 204-221.
- <sup>22</sup> Griffiths, J. (December 2003). Balanced scorecard use in New Zealand government departments and crown entities. *Australian Journal of Public Administration*, 62(4), 70-79.
- <sup>23</sup> Inamdar, N., Kaplan, R. S., & Bower, M. (2002). Applying the balanced scorecard in healthcare provider organizations. *Journal of Healthcare Management*, 47(3), 179-195.
- <sup>24</sup> Pink, G. H., McKillop, I., Schraa, E. G., Preyra, C., Montgomery, C., & Baker, G. R. (Spring 2001). Creating a balanced scorecard for a hospital system. *Journal of Health Care Finance*, 27(3), 1-20.
- <sup>25</sup> Baker, G. R., & Pink, G. H. (1995). A balanced scorecard for Canadian hospitals. *Healthcare Management Forum*, 8(4), 7-13.
- <sup>26</sup> Chow, C. W., Ganulin, D., Haddad, K., & Williamson, J. (May/June 1998). The balanced scorecard: A potent tool for energizing and focusing healthcare organization management. *Journal of Healthcare Management*, 43(3), 263-280.

- <sup>27</sup> Gumbus, A., Bellhouse, D. E., & Lyons, B. (2004). A three year journey to organizational and financial health using the balanced scorecard: A case study at a Yale New Haven health system hospital. *Journal of Business & Economic Studies*, 9(2), 54-64.
- <sup>28</sup> Oliveira, J. (2001 May). The balanced scorecard: An integrative approach to performance evaluation. *Healthcare Financial Management*, 55(5), 42-46.
- <sup>29</sup> Pineno, C. J. (2002). The balanced scorecard: An incremental approach model to health care management. *Journal of Health Care Finance*, 28(4), 69-80.
- <sup>30</sup> Zelman, W. N., Blazer, D., Gower, J. M., Owens Bumgarner, P., & Miller Cancilla, L. (December 1999). Issues for academic health centers to consider before implementing a balanced-scorecard effort. *Academic Medicine*, 74(12).
- <sup>31</sup> Zelman, W. N., Pink, G. H., & Matthias, C. B. (2003). Use of the balanced scorecard in health care. *Journal of Health Care Finance*, 29(4), 1-16.
- <sup>32</sup> Ellingson, D. A., & Wambsganss, J. R. (Spring 2001). Modifying the approach to planning and evaluation in governmental entities: A "balanced scorecard" approach. *Journal of Public Budgeting, Accounting & Financial Management*, 13(1), 103-120.
- <sup>33</sup> Curtright, J. W., Stolp-Smith, S. C., & Edell, E. S. (2000 Jan-Feb). Strategic performance management: Development of a performance measurement system at the Mayo Clinic. *Journal of Healthcare Management*, 45(1), 58-68.
- <sup>34</sup> Dutton, J. E., & Jackson, S. E. (1987). Categorizing strategic issues: Links to organizational action. *Academy of Management Review*, 12(1), 76-90.
- <sup>35</sup> Ocasio, W., & Joseph, J. An attention based theory of strategy formulation: Linking decision making and guided evolution in strategy processes. *Advances in Strategic Management* (Forthcoming).
- <sup>36</sup> Inkpen, A., & Choudhury, N. (1995). The seeking of strategy where it is not: Towards a theory of strategy absence. *Strategic Management Journal*, 16, 313-323.
- <sup>37</sup> Westphal, J. D., Gulati, R., & Shortell, S. M. (1997). Customization or conformity? An institutional and network perspective on the content and consequences of TQM adoption. *Administrative Science Quarterly*, 42, 366-394.
- <sup>38</sup> Kizer, K. (2000). Reengineering the Veterans healthcare system. In: Ramsaroop, P., Ball, M.J., Beaulieu, D., & Douglas, J.V., Eds. *Advancing Federal Sector Healthcare*. New York, NY: Springer-Verlag.
- <sup>39</sup> Hoffman, A., & Ocasio, W. (2001). Not all events are attended equally: Toward a middle-range theory of industry attention. *Organization Science*, 12(4), 414-434.
- <sup>40</sup> Finkelstein, S., & Hambrick, D. C. (1990). Top management team tenure and organizational outcomes: The moderating role of managerial discretion. *Administrative Science Quarterly*, 35(3), 484-503.
- <sup>41</sup> Henderson, R., & Mitchell, W. (1997). The interactions of organizational and competitive influences on strategy and performance. *Strategic Management Journal*, 18(6), 5-14.
- <sup>42</sup> Simon, H. A. (1951). *Administrative behaviour* (2nd ed.). New York: Free Press.
- <sup>43</sup> Jackson, S.E., & Dutton, J.E. (1988). Discerning threats and opportunities. *Administrative Science Quarterly*, 33(3), 370-387.
- <sup>44</sup> Mitchell, R., Agle, B., & Wood, D. (1997). Toward a theory of stakeholder identification and salience: Defining the principle of who and what really counts. *Academy of Management Review*, 22(4), 853-886.
- <sup>45</sup> Cohen, M. D., March, J. G., & Olsen, J. P. (1972). A garbage can model of strategic choice. *Administrative Science Quarterly*, 17(1), 1-25.
- <sup>46</sup> Niven, P. (2002). *Balanced scorecard: Step by step*. NY: John Wiley & Sons, Inc.
- <sup>47</sup> Kaplan, R.S., & Norton, D.P. (2000). Celebrating best practices in strategy-focused management. *Balanced Scorecard Report Insight, Experience & Ideas for Strategy-Focused Organizations*. (Special Hall of Fame 2000 Issue), 1-16.
- <sup>48</sup> Webstock, D. (2000). Shipwrecked on Scylla? Renavigating between accountability and quality improvement. *Aambeeld*, 28(1) cited in Vroeijenstijn, A.I. (1992). Improvement and Accountability: Navigating between Scylla and Charybdis. *Guide for External Quality Assessment in Higher Education*. London: Jessica Kingsley.
- <sup>49</sup> Bilkhu-Thompson, M. K. (2003). A process evaluation of a health care balanced scorecard. *Journal of Health Care Finance*, 30(2), 37-64.

## Appendix 1

### TCCG Interviews with Canadian Healthcare Organizations

The interviews used open ended questions, with questions building on the responses received to the previous question. General question prompts to start off included:

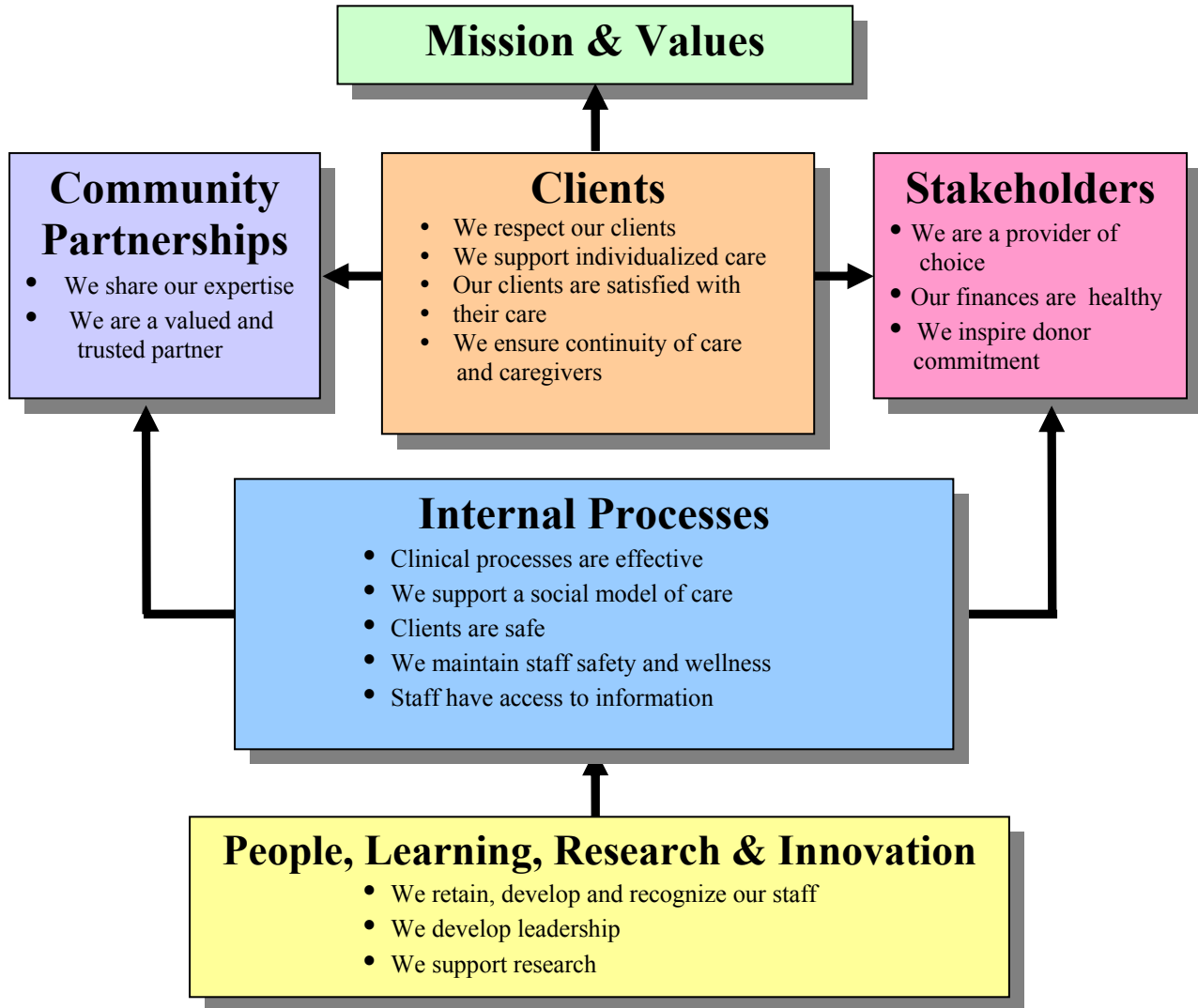
- How long has the BSC been used in your organization?
  - How are the scorecard results used?
- What was the implementation process for the BSC? What worked? What didn't work?
  - Were targets set for all indicators at the beginning of implementation – and if so were these stretch targets?
  - If BSC training was done is it ongoing as new people come into the organization? What did it include?
- Who are the BSC results communicated to?
- How far is the BSC cascaded in the organization?
  - What was the process for developing and implementing the cascading process?
  - How much support was provided in this process?
  - Which areas were chosen to cascade to and why?
- How is the BSC linked to strategic planning?
  - Has a strategy map been created for the BSC?
  - Has the scorecard explicitly been used to drive the development of corporate strategies?
- What are the key successes/lessons learned? What would you do differently?
  - What impact has the scorecard had?

## Appendix 2

### Communications Plan Questions Addressed

- Which groups to target and how. Not everyone needs to be targeted, at least not to the same degree, as there are diminishing returns for the effort involved. For instance, how relevant is the BSC to front line unregulated workers such as personal care attendants? Should efforts include them at all, and if yes should the focus be on a limited number of indicators that are most relevant to their day to day work, as opposed to the whole framework? One organization interviewed for instance sends only one BSC dimension's results to their Board (patient quality) rather than the whole BSC.
- Who needs to be on board – use champions from within those groups in providing the messaging.
- Messages tailored to the levels in the organization – what's in it for them? As an example, clinicians will respond to excellence in care.
- Who needs to communicate to which audiences? This cannot be seen to be just a Planning Department initiative. Middle managers and the site administrators are particularly critical in communicating the message.
- What is the essence of the scorecard – we need to make it easy to understand and provide the overall context before getting into all the details of the results.
- Reframe what the organization is already doing – a framework to help interpret things better – this is not rocket science. Similarly, tie the BSC into other initiatives – how it fits/supports them (e.g. resident safety, RAI quality indicators implementation, customer service, OH&S, new strategic initiatives, QA framework)
- Questions anticipated – a Q&A has been developed and will be added to over time based on what we have learned from other organizations, and knowing the culture of our organization.
- Communication vehicles – we will use those that are natural for the organization (e.g. corporate newsletter, presentations to existing groups, pay stub attachments, intranet).
- What, if any, information about results should be communicated externally. (Pink et al.<sup>24</sup> note in their discussion of the Ontario Hospital Report Card that information is political and can be interpreted and used incorrectly.)

Appendix 3





## Appendix 4

### MISSION AND CORE VALUES

**Mission:** *Delivering quality continuing care in partnership with our community*

**Values:**

**VISION** - We are guided by a vision of the future

**CUSTOMER** - We regard our residents as our central focus

**QUALITY** - We are committed to quality and excellence

**ETHICS** - We strive to do what is right

**TRUST & TEAMWORK** - We work as a team

**COMMUNICATION** - We communicate honestly and openly

**LEADERSHIP** - We achieve our mission through leaders who inspire, support and provide guidance

**TRAINING & DEVELOPMENT** - We improve our staff through effective recruitment, development and retention

**TECHNOLOGY & INNOVATION** - We improve our methods, systems and equipment

#### VISION

*We are leaders in innovative continuing care, recognized for enhancing quality of life for those we serve*

#### STRATEGY (Key Outcome Areas)

- Programs & Services respond to the needs of clients and the community
- *The CAPITAL CARE Group* retains and develops its staff
- *The CAPITAL CARE Group* uses information, research & evaluation to guide decisions, innovations and continuous improvement in care & quality of life for those we serve
- Infrastructures support the organization in achieving its mission and goal

#### OBJECTIVES (Critical Success Factors)

Clients	Stakeholders	Community Partnerships	Internal Processes	People, Learning, Research and Innovation
<ul style="list-style-type: none"> <li>• Respect</li> <li>• Individuality</li> <li>• Satisfaction</li> <li>• Continuity of care</li> </ul>	<ul style="list-style-type: none"> <li>• Provider of choice</li> <li>• Healthy finances</li> <li>• Donor commitment</li> </ul>	<ul style="list-style-type: none"> <li>• Shared expertise</li> <li>• Valued &amp; trusted partner</li> </ul>	<ul style="list-style-type: none"> <li>• Effective clinical processes</li> <li>• Social model of care</li> <li>• Client safety</li> <li>• Staff safety /wellness</li> <li>• Information access</li> </ul>	<ul style="list-style-type: none"> <li>• Retention, development &amp; recognition of staff</li> <li>• Leadership development</li> <li>• Research</li> </ul>

#### MEASURES (Indicators)

Clients	Stakeholders	Community Partnerships	Internal Processes	People, Learning, Research And Innovation
<ul style="list-style-type: none"> <li>• Respectful treatment</li> <li>• Choice about what matters</li> <li>• Individual treatment</li> <li>• Satisfaction with help received</li> <li>• Client knows caregivers</li> <li>• Family knows caregivers</li> </ul>	<ul style="list-style-type: none"> <li>• Families recommend TCCG</li> <li>• Sustainability</li> <li>• Cost/resident day</li> <li>• Staff overtime hours</li> <li>• Donor 3+ years</li> </ul>	<ul style="list-style-type: none"> <li>• Publications</li> <li>• External Presentations</li> <li>• No. of students</li> <li>• No. of staff with joint appointments</li> </ul>	<ul style="list-style-type: none"> <li>• % restraints</li> <li>• Dementia education %</li> <li>• Injurious falls</li> <li>• Sick time</li> <li>• Lost time injuries-frequency</li> <li>• Lost time injuries-severity</li> <li>• No. of BP desktop users</li> </ul>	<ul style="list-style-type: none"> <li>• Staff turnover</li> <li>• Education days per permanent FTE</li> <li>• Staff appreciation of each other</li> <li>• Staff satisfaction with career opportunities</li> <li>• Management turnover</li> <li>• No. of new research projects approved by RRC</li> <li>• No. of research projects underway</li> </ul>

#### INITIATIVES TO ACHIEVE TARGETS

Appendix 5

**The CAPITAL CARE Group Corporate Balanced Scorecard Summary Page\***

Perspective	Critical Success Factor	#	Indicators (Δ - def. has changed over time)	Results			Targets	Corporate Lead
				2003	2004	2005	2005	
Clients	Respect	1	Client survey "I am treated with respect by staff"					Chair, Cust. Service Comm
	Individuality	2	Client survey "I have choices about things that matter ..."					Chair, Cust. Service Comm
		3	Client survey "I am treated as an individual"					Chair, Cust. Service Comm
	Satisfaction with Care	4	Client survey "Overall, I am satisfied ..."					Chair, Best Practice Comm
	Continuity of Care	5	Client survey "I know my caregivers"					Director, HR
		6	Family survey "I know my relative's caregivers" (LTC)					Director, HR
6		Family survey "I know my relative's caregivers" (non-LTC)					Director, HR	
Stakeholders	Provider of Choice	7	Family survey "I would recommend Capital Care ..." (LTC)					Chair, Cust. Service Comm
		7	Family survey "I would recommend Capital Care ..." (non-LTC)					Chair, Cust. Service Comm
	Healthy Finances	8	Sustainability: [building costs - depreciation] / amort.					Director, Finance
		9	Total cost per resident day (long term care only)					Director, Finance
		10	Staff overtime hours					Director, Finance
Donor Commitment	11	# of donors contributing annually for the past 3 years					Director, Fund Development	
Community Partnerships	Shared Expertise	12	# of publications					Exec Associate
		13	# of external presentations					Exec Associate
	Valued & Trusted Partner	14	# of students doing placements within TCCG					EMC lead for Educators
		15	# of staff with joint educational institutions appointments					Exec Associate
Internal Processes	Effective Clin. Processes	16	% of cog. impaired residents with mech. restraints Δ					Chair, Best Practice Comm
	Social Model of Care	17	% of staff educated in dementia care					Chair, Best Practice Comm
	Client Safety	18	Major injury rate from falls (per 100 resident days)					Clinical Specialist
	Staff Safety & Wellness	19	Sick time (sick hours over total hours)					Director, HR
		20	Staff lost time injuries: frequency					Director, HR
		21	Staff lost time injuries: severity					Director, HR
Access to Information	22	Number of Best Practice Desktop users					Director, Plan & Rsch	
People, Learning and Research	Retention, Development and Recognition of Staff	23	Voluntary turnover rate of permanent staff					Director, HR
		24	Education days per permanent FTE					EMC lead for Educators
		25	Staff survey "[staff] appreciate each other ..."					Chair, Cust. Service Comm
	Leadership Development	26	Staff survey "... adequate opportunity to move [jobs]"					Director, HR
		27	Voluntary turnover of permanent management staff					Director, HR
	Research	28	Number of new research projects approved by RRC					Director, Plan & Rsch
29	Number of research projects underway						Director, Plan & Rsch	

\* Results and target numbers deleted

Appendix 6

**Centre Balanced Scorecard: Traditional Centres in 2005 or FY 04/05\***

Perspective	Critical Success Factor	#	Indicators	Results in 2005 or FY 04/05						Are differences across centres important?
				CCG	CCD	KCV	CCN	CCS	CCL	
Clients	Respect	1	Client survey "I am treated with respect by staff" (%)							Yes – stat. sig.
	Individuality	2	Client survey "I have choices about things ..." (%)							No
	Satisfaction with Care	3	Client survey "Overall, I am satisfied ..." (%)							Yes – stat. sig.
		4	Client survey "I enjoy mealtimes" (%)							Yes – stat. sig.
	Continuity of Care	5	Client survey "I know my caregivers" (%)							No
		6	Family survey "I know my relative's caregivers" (%)							No
Stakeholders	Provider of Choice	7	Family survey "I would recommend Capital Care ..." (%)							No
	Healthy Finances	8	Total Cost per day LTC (\$)							No
		9	Drug Costs per day LTC (\$)							No
		10	Occupancy (%)							No
	Donor Commitment	11	Total Donations to sites (excluding corporate campaigns) (#)							No
Community Partnerships	Valued & Trusted Partner	12	Average hours / per volunteer per year (#)							No
		13	Number of active volunteers (#)							No
Internal Processes	Effective Clin. Processes	14	% of residents with mechanical restraints (%)							Yes
		15	Worked hours (%)							No
	Social Model of Care	16	Family survey: "There is a homelike atmosphere." (%)							Yes – stat. sig.
	Client Safety	17	Major injury rate from falls (injuries / resident days * 100)							Yes
	Staff Safety & Wellness	18	Sick time - sick hours over total hours (%)							Yes
		19	Staff lost time injuries: frequency (injuries / wrkd hrs * 200,000)							Yes
20		Staff lost time injuries: severity (hrs injured / wrkd hrs * 200,000)							Yes	
Access to Information	21	Access to computers (%)							Yes	
People, Learning, Research and Innovation	Retention, Development and Recognition of Staff	22	Voluntary turnover rate of permanent staff (%)							No
	Leadership Development	23	Staff survey: "... adequate opportunity to move [jobs]" (%)							Yes – stat. sig.

\*Results deleted

## Appendix 7

### **Implementation Barriers Identified by Capital Care's Executive Team**

- Turnover in the organization – we have new members on the executive team, and quite a few new managers in the organization who were not around when the project was initiated so do not have the same history/buy-in
- Ensuring the data used are accurate
- Are the things being measured by the scorecard the most meaningful
- We are often asked for data by the region or other parties and this diverts us in a new direction of collecting information that is labour intensive and confuses efforts to streamline data collected to fewer key measures
- This will result in new information presented in different ways which will initially be seen as one more imposition on staff time (i.e. yet another report to have to read)
- The lack of reliable benchmark information to provide context to the numbers we come up with
- Limited information system capacity in our organization
- The organization is very lean (fewer managers, fewer professional staff) compared to acute care hospitals – people will feel they have no time to study and use the numbers

## Appendix 8

### ***The CAPITAL CARE Group***

#### **BALANCED SCORECARD IMPLEMENTATION STEERING COMMITTEE**

#### **TERMS OF REFERENCE**

##### **PURPOSE:**

The mandate of this Committee is to oversee implementation of *The CAPITAL CARE Group's* Balanced Scorecard (BSC). Implementation of the BSC has the following key goals:

- Ensure the BSC indicators reflect and inform strategic priorities for the organization.
- Help the organization achieve maximum improvement in corporate and centre BSC indicator results – i.e. to be as successful as possible with the BSC.

##### **ROLES:**

1. Data collection:
  - Assisting efforts to obtain / collect the data needed to calculate BSC results.
  - Conduct environmental scanning to obtain indicator results from comparable organizations for benchmarking purposes.
2. Report generation:
  - Provide input into the centre and corporate BSC reports and other documents that include the BSC results.
  - Support efforts to meet the reporting schedule outlined in the BSC policy.
3. Reviewing results:
  - Review centre and corporate BSC results in light of past performance, targets, internal benchmarks and organizational efforts to make improvements.
  - Review regional BSC indicator results in light of past performance, targets, external benchmarks and organizational efforts to make improvements.
4. Organizational alignment:
  - Continue efforts to reduce non-strategic initiatives and processes across the organization.
  - Continue efforts to increase the connection between organizational initiatives and BSC indicators; i.e. ideally so that all initiatives can be measured for progress and that all BSC indicators are supported by initiatives to improve results.
  - Continue to consolidate performance measurement processes and activities within a centralized annual Balanced Scorecard cycle.

5. Taking action:
  - Foster a proactive approach towards the BSC, e.g. by collecting action plans from the centres on an annual basis, by focusing on systems rather than people, and by considering rewards and incentive systems.
  - Support efforts to share successful strategies, select appropriately challenging targets, translate strategic goals into specific actions that staff can perform.
  - Help answer staff questions about how they can contribute to the BSC.
  
6. Communicating results:
  - Assist EMC and BSC Champions in communicating results to their managers and front line staff.
  - Assist in the production of communication materials / templates for use across the organization.
  - Help answer staff questions about BSC results.
  
7. Adapting the BSC
 

Ensure the BSCs continue to reflect organizational priorities by revising them in conjunction with changes to organizational mission, vision, values and strategies.

Review new performance indicators that become available (e.g. through benchmarking with other organizations, regional indicators, RAI) to determine their suitability for inclusion in the organizational BSCs.

Continue to evaluate and improve BSC indicators so that they are maximally effective at yielding progress. E.g. in terms of strategic importance, data quality, cost of collection, ease of understanding, ability to report in a timely fashion, balance with other indicators, strength of connection to the success factor / strategic objective, external benchmarking potential.

**MEMBERSHIP:**

Regular Members

- Director, Corporate Planning
- Director, Human Resources
- Director, Finance
- Administrator
- Clinical Specialist, Rehabilitation
- Two managers from the centres
- Manager, Information Planning
- Best Practice Leader

**OFFICERS:**

Chair: Director, Corporate Planning  
 Project Coordinator: Manager, Information Planning

**TERM OF OFFICE:**

May 2007

**ACCOUNTABLE TO:**

Executive Management Committee

**MEETING SCHEDULE:**

Quarterly or at the call of the chair

**CIRCULATION OF MINUTES:**

Committee Members, EMC

## Appendix 9

### **Potential Indicators of BSC Impact at TCCG**

- Feedback from executive team members focusing on how they use the BSC
- Feedback from BSC Steering Committee members/Corporate Best Practice Committee members asking how they have used the BSC in their centres/departments
- Feedback from organizational managers through a survey for instance
- Adding some items to our biannual staff survey (which will be carried out next in 2006) with respect to the organization's strategy/communication of performance
- Process measures such as frequency of meetings where the BSC results are discussed
- Impact on performance measurement in the organization (e.g. changes in reporting systems, streamlining of quality indicator processes)
- Changes to the organization's strategic plan resulting from the BSC
- Number of cascaded scorecards developed
- Number of indicators centres add that are specific to their own campus scorecards (i.e. taking ownership of their centre BSC)