The Balanced Scorecard: A Potent Tool for Energizing and Focusing Healthcare Organization Management

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EXECUTIVE SUMMARY

The current environment for healthcare organizations contains many forces demanding unprecedented levels of change. These forces include changing demographics, increased customer expectations, increased competition, and intensified governmental pressure. Meeting these challenges will require healthcare organizations to undergo fundamental changes and to continuously seek new ways to create future value.

This article provides explanation of a potent new management tool—the balanced scorecard—that can be used by healthcare organizations to meet these challenges. The article also presents the opinions of many high-level healthcare administrators that the balanced scorecard can be highly beneficial to healthcare organizations. It also summarizes these administrators' suggestions regarding the goals and measures that can make up an effective scorecard for a hospital as a whole, as well as for a specific subunit of a hospital. Interestingly, while no published report of balanced scorecard implementations in healthcare organizations exists, a number of administrators stated that they had fully implemented systems similar to the scorecard. These actions can be considered support for the scorecard's potential usefulness; at the same time, they suggest that some sharing of experiences will likely be available in the future.

As all administrators are well aware, moving from concept to practice is often difficult. While the article includes some suggestions for scorecard development and implementation, each organization must engage in the full range of activities, from defining its mission to the selection of goals and strategies, and develop its own unique scorecard to assist progress toward the selected goals. As a starting point, Table 3 provides a timeline of some general events that may be common to all organizations during this process.

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> In an effort that strikes at the heart of the managed-care industry, these employers (General Mills Inc., Honeywell Inc., Pillsbury Co., American Express Co. and Dayton Hudson Corp.) in January will begin purchasing medical services for 400,000 people directly from organized groups of doctors, hospitals and clinics—leaving the insurance companies out in the cold (Olmos 1996).

> Californians are looking closer than ever at the growing presence of HMOs as the predominant model of health care delivery in the state. . . . Against this backdrop, a new health plan—run by physicians—is emerging in our state, and has the potential of redefining the process by which health care is delivered. This plan, California Advantage, was launched by physicians (Kornreich 1996).

Healthcare organizations throughout the United States are under siege. Pressures from the public for cost control are coming in the form of initiatives for Medicare reform, while from the private sector, insurers are increasing their demands for higher quality at lower costs as they face similar demands from their customers. News of hospitals closing due to financial difficulties, or seeking mergers with stronger partners, abound. New and focused forms of healthcare delivery systems are also appearing, applying more competitive pressure on traditional healthcare organizations. All of these changes imply that continued viability of a healthcare organization will demand far more than just doing things a little better. Rather, fundamental changes are needed that can produce quantum leaps in both efficiency and quality of service (Deloitte & Touche et al. 1997).

Pressures like these are not new to companies in the for-profit sector, especially in the past decade of increased global competition. Many companies have successfully responded to this increasingly harsh competitive environment by scrutinizing how each product and process adds value to customers, and rethinking their entire strategies and operations. By now, terms such as "restructuring" and "reengineering" have become familiar parts of business vocabulary. What these terms signify is discarding the old "individual-based task-oriented" management concept, and replacing it with a "team-based process-oriented" management concept that views the entire organization holistically rather than as a number of disjointed pieces (Hammer and Champy 1993). Given the magnitude of the organizational changes, having performance measures that can both gauge progress toward the goals and provide feedback to focus efforts toward continuing improvement is crucial. Many for-profit firms have found the "balanced scorecard" an invaluable tool for focusing and sustaining their revitalization and continuous improvement efforts (Hoffecker and Goldenberg 1994; Kaplan 1994; Kaplan and Norton 1996a, 1996b; Maisel 1992). Our objective is to explore how a similar

approach can be used in the healthcare sector.

Our discussion of the balanced scorecard is in three sections. The first section outlines the nature of the balanced scorecard approach and illustrates some applications in other industries. In the second section we discuss what an effective balanced scorecard might look like for a healthcare organization, basing our discussion on findings obtained from two surveys: one of top-level hospital administrators, and one of hospital laboratory heads. In the third section, we discuss the process by which a healthcare organization can develop and implement the balanced scorecard.

THE BALANCED SCORECARD AND ITS APPLICATION IN OTHER SECTORS

The balanced scorecard is a customer-based planning and process improvement system aimed at focusing and driving an organization's change process. It is an integral part of the mission identification, strategy formulation, and execution processes, with a focus on translating strategy into an integrated set of financial and non-financial measures. As such, the balanced scorecard plays a major role in communicating the organizational strategy to the members and providing feedback to guide actions toward the attainment of objectives.

The scorecard can be used at different levels: throughout the total organization, in a subunit, or even at the individual employee level as a "personal scorecard." For each level, the balanced scorecard approach involves identifying the key components of operations, setting goals for them, and then finding ways to measure progress toward achieving these goals. Taken together, the measures provide a holistic view of what is happening both inside and outside that organization or level, thus allowing each constituent of the organization to see how their activities contribute to attainment of the organization's overall mission. As Richard Quinn, vice president of quality at Sears, has observed, "You simply can't manage anything you can't measure" (Lingle and Schiemann 1996).

This trend toward seeking better measurement systems is well documented. Birchard (1995) discovered that 80 percent of large American companies are seeking improvements in the performance measurement area. Kurtzman (1997) reported that 64 percent of U.S. companies are experimenting with a performance measurement system. The shared concern of these companies is that measurement systems that focus on the wrong aspects of performance can actually undermine the organization's strategic mission by perpetuating short-sighted business practices (Hoffecker and Goldenberg 1944). The medical facilities of the University of California-San Diego is a specific example of a healthcare organization hurt by the lack of attention to organizational goals. According to a private consultant's report, one of the major reasons for the facilities' $25 million loss in fiscal 1995–1996 was "conflicting objectives and competition for both

control and resources. Enterprise-wide goals are often subordinate to those of departments or divisions" (Acello 1996).

Because the balanced scorecard is directly linked to mission and strategy, the relevant components and measures will vary across organizations depending on their specific goals and circumstances. At a general or conceptual level, however, some agree that a typical balanced scorecard would include at least the following four components:

(1) Customer perspective: How do customers see us?

(2) Internal business perspective: At what must we excel?

(3) Innovation and learning perspective: Can we continue to improve and create value for customers?

(4) Financial perspective: How do we look to providers of financial resources?

Figure 1 illustrates how these perspectives, or components, interact to provide an integrated view of how the organization is progressing.

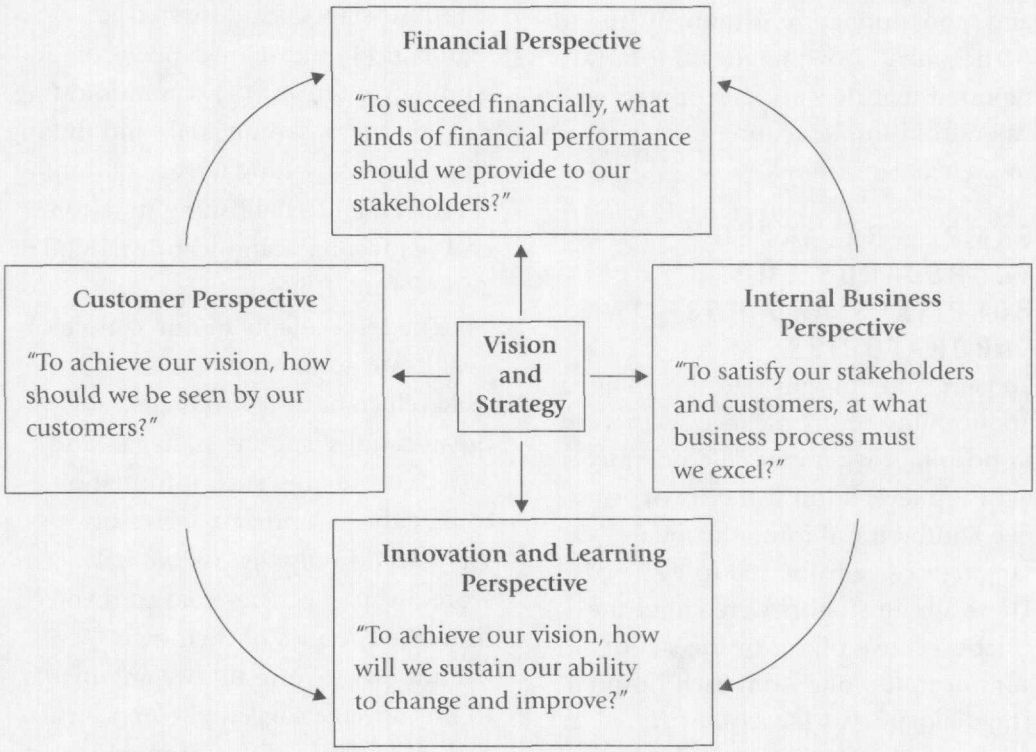
While the balanced scorecard concept implies that all components are important to organizational success, many companies today consider customer satisfaction to be the overriding concern (Horngren, Foster, and Datar 1997). The customer perspective measures how well the organization is meeting the current demands and needs of its customers, and anticipates what customers may require in the future. The focus of the internal business perspective is on the ability of the internal processes to satisfy current and future customer expectations. In the innovation and learning component, the focus is on improving the organization's ability to meet customer expectations. The financial perspective keeps tabs on how well the operational results are being translated into financial well-being, which is vital to the organization's continued viability.

Several recent articles and books have discussed the advantages of the balanced scorecard and its application in other sectors (e.g., Hoffecker and Goldenberg 1994; Kaplan and Norton 1992, 1993, 1996a, 1996b, 1996c; Kurtzman 1997; Maisel 1992; Mifliorato, Natan, and Norton 1996; Newing 1994, 1995). Among the numerous successful users of the balanced scorecard are AM&R division of Mobil Oil; Tenneco, Brown and Root; AT&T; Intel; 3Com; and Elf Atochem. Adopters in the service sector include the international accounting firms Ernst & Young (Vitale, Mavrinac, and Hauler 1994) and KPMG Peat Marwick (Irvine 1993).

The banking industry also reports good results. For example, in late 1989, the Bank of Montreal's "corporate performance was heading downhill fast" (Birchard 1995). Senior management, deciding that "a successful turnaround strategy had to include a new approach to performance measurement," developed and implemented a balanced scorecard. "By the end of 1993, employees had

helped cut roughly $350 million in costs, and productivity was back in line with industry average." In the insurance industry, Allstate Corp. developed a balanced set of measures that has helped it to achieve higher levels of customer satisfaction, employee effectiveness, process effectiveness, and innovation, thus significantly improving corporate cash flows (Birchard 1995). In Cigna Insurance's Property and Casualty division, bonuses are tied to balanced scorecard results (McWilliams 1996). Active Tools, a manufacturer of automobile parts, has successfully used the balanced scorecard approach at the hourly employee level. Active Tools' director of quality, Glenn Miller, explains how the balanced scorecard has helped his firm: "It has empowered our workers to improve performance and given upper management the means to focus its efforts. Our continuous improvement efforts have accelerated greatly over the last several years because we are finally driven by the right data" (Hoffecker and Goldenberg 1994).

FIGURE 1
A Sample Balanced Scorecard with Four Components



Source: Adapted from R. Kaplan and D. Norton, "Using the Balanced Scorecard as a Strategic Management System," *Harvard Business Review*, January–February, 1996, 76.

DESIGNING A BALANCED SCORECARD FOR A HEALTHCARE ORGANIZATION

An extensive literature search did not reveal a reported application of the balanced scorecard in the healthcare sector. Nevertheless, three factors make us believe that this management tool can contribute substantial value to healthcare organizations. First is the many instances of successful application in service organizations. Second, the approach of developing an integrated set of performance measures is conceptually appealing and would seem to be consistent with the thrust of viewing organizations in a holistic fashion. Third, both top-level healthcare administrators and laboratory administrators who participated in our survey uniformly reported that they see great potential value from implementing this approach in their organizations.

SAMPLE BALANCED SCORECARDS FOR HOSPITALS AND HOSPITAL LABORATORIES

To gain some insight into the potential applicability of the balanced scorecard in hospitals, we undertook a dialogue with top-level administrators of five Southern California hospitals ranging in size from 300 to 425 beds. These administrators were either the chief executive officer or the senior administrator, one from each hospital. The dialogue was loosely structured in the form of a question and response survey asking to what extent the hospital had considered developing a system like the balanced scorecard. Each administrator was asked to identify up to five major components, along with the goals and associated measures, that might form the basis for an effective balanced scorecard for his or her hospital.

Prior to considering these administrators' responses, we must reiterate that the first step in designing a balanced scorecard is not identifying the measures themselves, but agreeing upon the organization's overall mission. Following this sequence is important because to be effective, the scorecard measures must support attainment of a common mission. After this crucial first step, the design and implementation process can be divided into four stages, as illustrated in Figure 2: (1) translating the vision and gaining consensus; (2) communicating the objectives, setting goals and linking strategies; (3) setting targets, allocating resources, and establishing milestones; and (4) feedback and learning (Kaplan and Norton 1996b).

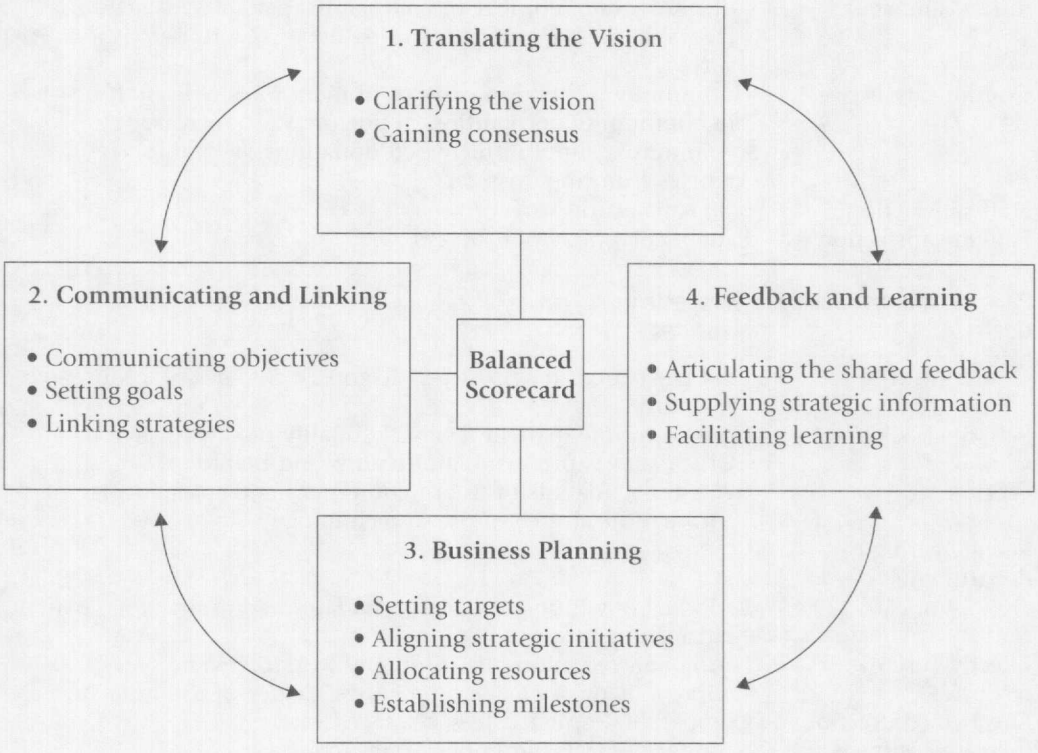
The respondents in our sample of healthcare administrators, however, were reluctant to reveal their organizations' specific strategies and goals, considering such information to be either proprietary or sensitive. They would only discuss the balanced scorecard in a general context divorced from the specifics of their own institutions. As a result, we are unable to link specific suggested components and measures to different missions and strategies. Hence, our findings are best viewed as an illustration of the possible breadth and depth in scorecard design,

rather than as potential models for adoption.

The collective set of goals and measures suggested by the top-level administrators is presented in Table 1. In compiling this exhibit, some rewording was undertaken to group items with similar content. Another objective of our study was to illustrate how the balanced scorecard may be applied to a hospital subunit. Toward this end, we also engaged in a similar dialogue with laboratory administrators at five hospitals (different from those for the top-level administrators, due to accessibility). Two of these hospitals were non-profit and three were for profit, and their sizes ranged from 200 to 800 beds. The balanced scorecard suggested by these laboratory administrators is presented in Table 2.

Although the literature search did not reveal reported applications of the balanced scorecard in the healthcare sector, we suspected that some hospital administrators may

FIGURE 2
The Four Stages of Balanced Scorecard Design and Implementation



Source: Adapted from R. Kaplan and D. Norton, "Using the Balanced Scorecard as a Strategic Management System," *Harvard Business Review*, January–February, 1997, 76.

TABLE 1

An Illustrative Balanced Scorecard Based on Hospital Administrators' Suggestions

Panel A: Customer Perspective Goals	Measures
Prompt service	Patient satisfaction surveys; emergency room and admission times; scheduling flexibility
High quality care	Patient evaluations; patient referrals; number of patients admitted; accurate diagnosis rate; external ratings; favorable press coverage; market share; repeat patients
Prompt emergency room response	Time to respond; patient satisfaction surveys
Staff attitude and friendliness	Patient satisfaction surveys; community perception of staff; market share; repeat patients
Good food	Complaint rate; patient satisfaction survey
Quality nursing care	Patient surveys; number of complaints
HMO's satisfaction	Number of contracts; number of new contracts per period; number of contracts renewed
Doctors' satisfaction	Number of contracts with key physicians/groups; doctors' ability to participate in decision making that affects them; doctor satisfaction surveys; retention rate of good doctors
Competent doctors, nurses, and staff	Reputation; number of referrals; number of contracts; accurate diagnosis rate; number of complaints; patient satisfaction; favorable press coverage featuring doctors/staff; perception surveys
Community image	Community perception surveys; number of doctors/staff involved in community; recognition of doctors/staff; increased community support; increased donations; favorable news articles featuring hospital
Staff satisfaction	Staff satisfaction surveys
Patient satisfaction	Patient surveys; HMO surveys

Panel B: Internal Business Perspective Goals	Measures
Cost control	Cost per patient day; cost per diagnosis; cost per procedure; per case cost
Service excellence	Complaint rate; patient feedback; quality of care; degree to which staff is professional, friendly, and helpful
Efficiency	Cycle time; analysis of use of equipment and space; degree of automation; degree of use of technology
Reengineering of departments	Cost reduction
Quality of care	Periodic evaluations of doctors, staff, and administrators; patient satisfaction surveys
Effective use of resources	Hiring and retention rate of quality workforce; rate of improvement of business processes; degree of use of technology
Effective contracting	Comparable capitated fees; managed care
Increase contracts	Number of HMOs; number of new contracts
Doctors' satisfaction	Contracts with key physicians/groups
Friendly and helpful staff	Patient surveys
Selected specialization	Cancer; heart, etc. (provide value for the cost)

continued

TABLE 1
continued

Panel C: Innovation and Learning Perspective Goals	Measures
Collaboration with medical groups	Physician referrals; cost/benefit analysis
Continuous innovation	Number and quality of new services offered in past five years; number of new programs; market response to initiatives
State-of-the-art technology	Degree of use of technology; degree of automation; expenditures on hardware and software; benefits versus costs; patient capitation; rate of increase of outpatients; fiber optics network, doctor links
Doctor research and creativity	Number of professional presentations and publications by doctors; number of new procedures; degree of usage of state-of-the-art equipment; quality of care; number of ongoing instructional development programs
Partnerships with research institutions and other agencies	Number of joint activities; number of institutions/agencies participating in joint activities
Relationship with physicians	Benefit/cost analysis

Panel D: Financial Perspective Goals	Measures
Increase MediCal capitation contracts	Number of contracts received; percentage of contracts relative to competition; dollars generated from new contracts
Reduce emergency room use	Percent unnecessary usage; analysis of emergency room use
Expand community philanthropy/ fund-raising	Dollars raised; number and dollars of corporate gifts; donor support for special projects; level of fund-raising activity for the hospital; number and dollars of external grants
Increase contracts	Contracts with HMOs, MediCal, Medicare
Increase regular insurance contracts	Market share
Partner with other medical groups	Referrals and use

already have undertaken similar, if not identical, initiatives. We therefore asked the administrators to what extent their hospital had already implemented a monitoring system similar to the balanced scorecard, and how beneficial they thought such a system could be. All but one of the top-level administrators said they had totally implemented such a system and all of them thought such a system would be extremely beneficial to their hospitals, indicating a score of 10 on a scale of 1 to 10 (where 1 = not at all beneficial and 10 = extremely beneficial). In contrast, none of the laboratory administrators reported that their unit had totally implemented a system similar to the balanced scorecard, with their implementation status ranging from 2 to 4 on a scale of 1 (not at all) to 10 (totally). The laboratory

administrators were consistent with the top-level administrators in saying that such a system would be extremely beneficial, with the lowest score being 8 on a scale of 1 (not at all beneficial) to 10 (extremely beneficial).

Because the top-level and laboratory administrators came from different hospitals, the divergence in their reported levels of scorecard implementation could reflect genuine differences in their institutions' current conditions. The laboratory administrators' hospitals may have also implemented the balanced scorecard, but not yet pushed implementation to the laboratory level. Another possible explanation might be that top administrators have a tendency to say—and perhaps believe—what they wish the state of affairs to be, rather than what the state of affairs actually is. Both interpretations suggest that the set of hospitals in the sample can expand the scope (e.g., down to subunit or individual levels) of their scorecard development and implementation. To the extent that the top-level administrators were accurate in their perceptions of current scorecard implementation, this offers the promise that with time, their experiences may be available to help other administrators to improve their organizations. Such sharing would be beneficial in view of the uniformly positive assessment of the scorecard's potential benefits.

Customer Perspective

Top-Level Administrators' Suggestions for the Hospital as a Whole. Panel A of Table 1 shows that these administrators consider patient satisfaction to be of primary importance. This emphasis on patient satisfaction encompasses not only an emphasis on quality of medical care and prompt service, but also focuses on details such as satisfaction with the food served. The chief measures suggested for assessing patient satisfaction are patient satisfaction surveys. Hospital administrators, however, also saw value in such tractable measures as emergency room and admission times, patient referrals, market share, and repeat patients.

Other suggested goals related to quality of staff and community image, reflecting a perceived need for increased community support. This community support comes from both financial contributions and favorable news coverage. Suggested measures for assessing the degree of goal achievement include: retention rate of good doctors, accurate diagnosis rate, favorable press coverage, community perception surveys, and increased donations.

Laboratory Administrators' Suggestions for Their Units. Panel A of Table 2 shows that laboratory administrators believe quality is very important. This emphasis on quality encompasses the tests performed and the services rendered, including being friendly, helpful, and timely. Another goal of laboratory administrators, naturally, is fast turnaround; this achievement can be evaluated by such measures as number of tests delivered on time, cycle time, and degree of automation.

TABLE 2

An Illustrative Balanced Scorecard Based on Hospital Laboratory Administrators' Suggestions

Panel A: Customer Perspective Goals	Measures
Quality testing	Number and quality of tests; number of referrals; number of repeated tests (2); increased business; accuracy level
Fast turnaround	Number of tests delivered on time; cycle time; increased business; turnaround time; degree of automation
Effective reports	Complaints from clients/lack of delivery of reports to office; on-site printing of reports
Quality service	Follow-up from MDs; time in/out; extent to which staff is friendly and helpful
Panel B: Internal Business Perspective **Goals**	**Measures**
Quality of tests	Number of tests repeated; satisfaction surveys; complaint rate
Speed/turnaround	Turnaround time; time studies; doctor satisfaction
Service excellence	Complaint rate; satisfaction surveys; periodic review; increased automation
Competent staff	Accurate testing rate; periodic evaluations
Broad test menu	Actual versus competition; number of newer testing measures
State-of-the-art testing facilities	Quality and currency of testing equipment; efficiency and effectiveness of equipment; degree of automation; percent of budget allocated to hardware/software
Efficiency	Point correct cards; cycle time; yield; cost per test
Panel C: Innovation and Learning Perspective **Goals**	**Measures**
Employee development	Range of knowledge of tests; expenditures for employee development; attendance at seminars, conferences and workshops; degree to which continuing education is encouraged
Client education	Technical bulletins/newsletters distributed to clients
Improved technology	Speed of introducing/adopting technology; degree of automation; employee satisfaction
More testing capability	Number of employees in training; number learning new instrumentation; number learning new test methods; number of new tests per year
Continuous innovation	CEU classes; number of new tests offered per period; time to deliver new products; customer/doctor comments
Adequate physical facilities	Adequacy of equipment for providing a broad and current test menu; employee satisfaction surveys
Panel D: Financial Perspective **Goals**	**Measures**
Survival	Adequacy of budget; bed vacancy level; cash flow; expenditures relative to budget
Cut cost	Degree of increased automation, less labor; cost per test; rate of repeat testing
Increase automation	Rate of decrease in turnaround time
Expansion of test menu	Dollars coming in; number of new contracts; number of referrals
Prudent use of supply	Inventory level
Qualified staff	Customer/doctor comments
Increase patients/contracts	Number of new patients/contracts; rate of growth in cash inflows; rate of increase in federal/state insurance contracts

One commonly suggested measure of how well the laboratory is meeting its goals is the extent to which business has increased.

Internal Business Perspective

Top-Level Administrators' Suggestions. Because of the current financial climate, we were not surprised that hospital administrators' number-one goal from the internal business perspective is cost control. Panel B of Table 1 shows that suggested measures for tracking cost control performance were primarily items that could be compared with industry benchmarks (e.g., cost per patient day, per diagnosis, and per procedure). Other goals were related to the need for improving the organization's financial structure (e.g., effective use of resources, effective contracting, and increasing contracting). Suggested measures for gauging progress toward these goals were: the degree to which technology is used, comparable capitated fees, the number of new contracts, and the ratio of value provided to cost.

Some of the suggested measures for the internal business perspective also are included in the customer perspective and others. This overlap suggests that one measurement can relate to multiple goals and illustrates the flexibility with which the various components of the scorecard can be constructed.

Laboratory Administrators' Suggestions. Relating to internal processes, the hospital laboratory administrators suggested that maintaining a competent staff, a broad test menu, and state-of-the-art testing facilities are important goals (Table 2, Panel B). Excellence of service and efficiency, along with test quality and turnaround time, were also suggested as important goals.

Suggested measures for tracking the extent to which these goals are being achieved include doctor satisfaction, other satisfaction surveys, and complaint rates. Cycle time and turnaround time also were stressed, along with cost per test (as a measure of efficiency).

Innovation and Learning Perspective

Top-Level Administrators' Suggestions. Top-level administrators suggested working more closely with medical groups as a goal, progress toward which was seen to be reflected in reduced physician referrals and cost/benefit analysis (Table 1, Panel C). Three other suggested goals were concerned with state-of-the-art technology, continuous improvement, and amount of doctor research activities. Suggested measures for gauging progress in these areas were the number and quality of new services and programs offered in recent years, and the market response to these initiatives. Measures of progress in technology included the amount expended, and the degree of utilization of technology. An indirect measure of such progress was suggested to be the increase in treatment on an outpatient basis.

Relating to research productivity, suggested measures were: number of professional presentations and publications, number of new

procedures, and number of ongoing instructional development programs. Perhaps due to the enormous cost of some programs, a stated goal was to increase partnership projects with research institutions and other agencies. Progress in this area was measured by the amount of participation in such joint activities.

Laboratory Administrators' Suggestions. Employee development, continuous innovation, and improved technology were stressed as goals for the innovation and learning perspective (Table 2, Panel C). Laboratory administrators also demonstrated an interest in achieving adequate physical facilities and testing capabilities.

Interestingly, while the number of employees attending educational and training seminars, conferences, and workshops was seen as a measure of how well the goals of the innovation and learning perspective were being achieved, the laboratory administrators also expressed an interest in surveys of employee satisfaction. This perhaps reflects the view of employees as internal customers, and the assumption that employees have a desire to maintain their skills through innovation and learning. The laboratory administrators also suggested that a measure for the innovation and learning perspective is feedback from doctors and customers.

Financial Perspective

Top-Level Administrators' Suggestions. The administrators' suggested financial goals indicated a perceived need to increase reliance on MediCal capitation contracts (reflecting the fact that they were from California hospitals), and community philanthropy and fund-raising (Table 1, Panel D). These goals were linked to such measures as dollars generated from new contracts and percentage of contracts relative to competitors. The administrators suggested the increase in dollars from fund-raising activities as a gauge for progress in obtaining community support. At the same time the hospital administrators wanted to increase contracts and other services, they suggested that achieving a stated goal of reducing emergency room use would enhance the financial perspective. The view that the emergency room was unnecessarily costly was supported by the suggested measure of percent of unnecessary usage. The administrators also suggested that an analysis of emergency room use could help to gauge progress toward this goal. Other suggested measures for financial goal attainment included market share, referrals, and number of increased contracts with (HMOs), MediCal, and Medicare.

Laboratory Administrators' Suggestions. Perhaps reflecting the current financial pressures on healthcare organizations, the laboratory administrators' number-one goal appears to be survival (Table 2, Panel D). All the suggested measures relating to this goal are very cost and revenue oriented. Administrators placed emphasis on bed vacancy levels, cash flows, and budget considerations. Indeed, cutting cost is viewed to be so important that it is suggested as a goal itself. Increasing

business is another important goal, with suggested measures including the number of new patients or contracts. Emphasis also was placed on the rate of increase in federal and state insurance contracts. Another measure was the rate of growth in cash inflows.

DEVELOPING AND IMPLEMENTING A BALANCED SCORECARD IN A HEALTHCARE ORGANIZATION

The preceding summary of suggestions by hospital administrators and their expressed opinions about the potential benefits from implementing a balanced scorecard system strongly supports the potential value of this approach to healthcare organizations. For healthcare administrators interested in adopting this management tool, a major question is how to successfully engage in the implementation process. Administrators are well aware that translating general concepts into concrete action is one of the most challenging aspects of management. For example, legitimate questions remain about how the measures suggested by our sample of administrators can be operationalized. In considering the suggested use of patient surveys, who should be surveyed and how often, what they would be asked, how would non-responses be dealt with, and how would the results be portrayed are just a subset of the questions that must be addressed in the implementation process. A detailed account and analysis of the implementation process and experience in even one hospital can shed valuable light onto these important questions.

As we reported earlier, however, our sample of administrators was reluctant to reveal what they considered to be proprietary information. We hope that in time, their willingness to share this experience increases. For the purposes of the current discussion, we felt that despite admitted differences within the healthcare sector (i.e., mix of profit versus service focus, relative power of administrators versus specialists, contractual arrangements between the hospital and suppliers [e.g., doctor groups]), the experiences from other sectors still can be a useful point of reference for healthcare administrators interested in scorecard application. The reports from these sectors indicate that two years or more are needed for an organization to design and implement its own balanced scorecard, with major component steps as illustrated in the hypothetical practitioner application in Table 3.

Table 3 reiterates the point that designing the performance measures should be an integral part of the entire strategic planning process. Well-designed measures aid in communicating the organization's goals and strategies for obtaining those goals, motivate actions congruent with these goals and strategies, and give feedback and guidance about progress toward these goals. To get the full benefits from the balanced scorecard approach, therefore, a healthcare organization needs to first determine its total mission, decide on its most important objectives, and

TABLE 3
A Hypothetical Practitioner Application: A Sample Schedule for the Development and Implementation of a Balanced Scorecard for a Hospital

Months 1–2	A strategic planning retreat involving everyone in the hospital is held to identify strategic issues and to discuss possible solutions. The purpose of this meeting is to form consensus regarding the vision and strategic goals and objectives. A second retreat meeting is held if necessary.
Months 3–4	A strategic planning committee (preferably including the administrator) is formed with the charge to identify objectives for each perspective in the hospital's balanced scorecard.
Months 5–6	Using the balanced scorecard as a communication tool, the strategic planning committee seeks comments on, and acceptance of, the hospital's balanced scorecard from hospital members (departments, labs, and individuals).
Month 7	Based on comments from hospital members, the strategic planning committee revises the balanced scorecard.
Months 8–9	The revised balanced scorecard is communicated to the hospital members. Each member is required to develop an individual balanced scorecard that supports the hospital-wide goals and objectives.
Months 10–11	The strategic planning committee reviews individual and departmental balanced scorecards and suggests possible revisions.
Month 12	Based on finalized balanced scorecards, the hospital formulates a five-year strategic plan. The first-year plan is expanded into the annual operating plan for the coming year.
Months 13–24	Both departmental progress and hospital progress are reviewed quarterly to identify areas that require attention and additional effort.
Months 25–26	Based on the individual balanced scorecards, the hospital evaluation committee evaluates each member's performance for the last year and makes recommendations relating to retention, promotion, salary increases, and other rewards.
	The strategic planning committee revises the hospital's balanced scorecard and the five-year strategic plan based on internal and external scanning of the hospital's conditions and changes in the environment. In helping to revise the strategic objectives on the balanced scorecard, the strategic planning committee identifies as many strategic issues as possible and for each of these issues, considers possible solutions that can be employed by the hospital.

formulate strategies to accomplish the objectives. Because each organization has a unique set of circumstances that makes it different from any other organization, its mission, objectives, and strategies should be developed with these unique circumstances taken into consideration. While another organization's balanced scorecard or the illustrative one provided in this article can be useful references, each organization must develop its own scorecard. This is especially so because effective implementation of strategies will require coordinated efforts by all members of the

organization. By broadly involving members and constituents in the scorecard development process, the organization can ensure full and open communication of needs, concerns, and ideas, increased understanding of needed actions, as well as acceptance and dedication to a shared set of goals.

Returning to the time schedule (Table 3) and getting organization members away from their short-term day-to-day concerns and tasks during the early part of the development stage can sharpen their focus when identifying the long-term issues of mission, objectives, and strategies. A useful way to accomplish this may be a one- or two-day retreat. Having developed a generally accepted mission statement, a set of objectives, and strategies for obtaining them, a committee consisting of representatives from all major interest groups can then be formed. These interest groups would consist of those internal to the organization (i.e., physicians, nurses, administration, staff, etc.) and those external to the organization (i.e., local community leaders, insurance providers, etc.). This committee's task is to identify more specific goals under each of the major perspectives agreed to by the organization's constituency in the more broadly defined mission statement. (These perspectives can be the four components in our illustrative scorecard, a subset of these components, or all these components plus others.) Frequent and open communication between the committee and the other constituents is the most necessary, to ensure agreement with, and acceptance of, the final product.

The next task is selecting performance measures for each specific goal. Because these measures have a direct impact on each member of the organization, soliciting an even wider participation in this step is extremely important. This can be accomplished by forming a committee for each perspective. Kaplan and Norton (1996b) provide three guidelines to help such committees select the appropriate measures:

Guideline I: The performance measures(s) selected should be positively related to degree of attainment of the related goal; as the latter increases, the former also should increase.

Guideline II: Not all the performance measures should be focused on outcomes. Outcome measures tend to be prepared only periodically, and often are not sufficiently timely to alert remedial action. Performance drivers also need to be included to serve as leading indicators of outcomes. To illustrate, the ability to meet its budget can be an outcome measure for a healthcare organization. The number of patient admittances can be a performance driver, however, because it will affect both the organization's budget allocation and expenditures.

Guideline III: The number of performance measures should be kept low so as not to diffuse attention and create confusion. Many instances of performance measure proliferation are due to people confusing the diagnostic as opposed to strategic purposes of such measures. For example, a healthcare organization's cash reserves can be a diagnostic measure, because it can indicate potential cash flow difficulties. Having adequate cash flows provides no indication whether the organization is attaining its more fundamental, or strategic goals, however (e.g., increased quality of patient care).

As can be seen from the discussion above and the illustrative schedule in Table 3, the development and implementation of the balanced scorecard can be a complex and lengthy process. Because of the volume of current demand for change, improvement, and reform, healthcare organizations will be well served by initiating the process that will implement the balanced scorecard or a similar approach to stimulate and support changes leading to improvement.

SUMMARY

The current environment for healthcare organizations contains many forces demanding unprecedented levels of change. These forces include changing demographics, increased customer expectations, and intensified governmental pressure. Because healthcare is naturally more costly for older people, the aging of our population is of great concern to those who must pay for healthcare. The number of people over 75 in the United States is expected to grow to more than 25 million by the year 2025, compared to approximately 15 million in 1997. Meeting these challenges while faced with constrained resources will require healthcare organizations to undergo fundamental changes and to continuously seek new ways to create future value. This article has provided an explanation of a potent new management tool that can potentially be used by healthcare organizations. Many high-level healthcare administrators are of the opinion that this new tool—the balanced scorecard—can be highly beneficial to healthcare organizations. It summarizes these administrators' suggestions regarding the goals and measures that can comprise an effective scorecard for a hospital as a whole, as well as for a specific subunit. This article also offers suggestions on how a healthcare organization can effectively undertake a scorecard development and implementation process.

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