


Fall 12-16-2016

Improving Employee Engagement through the Development of an Enterprise Performance Management System

Carlton D. Abner

University of San Francisco, carlton.abner@gmail.com

Follow this and additional works at: <https://repository.usfca.edu/dnp>

 Part of the [Health and Medical Administration Commons](#), [Nursing Administration Commons](#), [Performance Management Commons](#), and the [Strategic Management Policy Commons](#)

Recommended Citation

Abner, Carlton D., "Improving Employee Engagement through the Development of an Enterprise Performance Management System" (2016). *Doctor of Nursing Practice (DNP) Projects*. 83.
<https://repository.usfca.edu/dnp/83>

This Project is brought to you for free and open access by the Theses, Dissertations, Capstones and Projects at USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. It has been accepted for inclusion in Doctor of Nursing Practice (DNP) Projects by an authorized administrator of USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. For more information, please contact repository@usfca.edu.

Improving Employee Engagement through the Development of an
Enterprise Performance Management System

Carlton Abner DNP(c), MS, RN-BC

University of San Francisco

December 2016

Marjorie Barter, EdD, RN, CNL, CENP
Committee Chairperson

Robin Buccheri, PhD, RN, MHNP, FAAN
Committee Member

Acknowledgements

Stephen King once wrote, “We never know which lives we influence, or when, or why.” It is my sincere desire that the following people know exactly how they have been a substantial influence on me during my doctoral journey. The first person to ever tell me that they thought I possessed the aptitude and should most assuredly pursue a doctorate was Bruce Austin. We did it Dad. The first person I ever saw pursue their doctorate that was from my small, close-knit group of friends living in the lower middle-class neighborhood we grew up in was Candice Harrison. Dr. Harrison is now a Director of African American studies and an associate professor. I am so very grateful for your example. The first person to pursue college education in my immediate family was my sister, Marshel. She has also earned a graduate degree and authored several novels. Her perseverance has always been a light for me. My brother, James, has been an anchor and provided me with an example of how a man can provide for his family. During my childhood and early adult life, my mother committed herself to countless 16-hour days providing the financial support that made it possible for me to attend college. To this day, she is the best example of hard work and dedication that I have ever personally witnessed. To my classmates, I sincerely thank you for being “my people.” You have no idea how much I have enjoyed our time together. And to the faculty, particularly my faculty advisor, Dr. Marjorie Barter – I barely know what to say. Whatever success I enjoy from here on out will simply be the result of your investment in me. Finally, for my wife, Andrea, and son, Abram – there are no words. Your tolerance of all the stuff that kept me busy has been admirable. Andrea, whatever good that exists in me as a man is surely a reflection of the woman who has tirelessly stood by my side. I am grateful to you all.

Table of Contents

Section I. Title and Abstract

Title	1
Acknowledgments	2
Abstract	7

Section II. Introduction

Background Knowledge	8
Local Problem	10
Local Setting	11
Intended Improvement / Purpose of Change	14
Review of the Evidence	16
Thematic Review	17
Theoretical and Conceptual Framework	22
The Balance Scorecard as a Performance Management System	22
Anticipating a Significant Cultural Change	23
Accounting for Various Perspectives on Value	24

Section III. Methods

Ethical Issues	26
Setting	28
Planning the Intervention	32
Accounting for the Purpose, Process, and Activities within the Plan	32
Meeting the Leadership Need	34

Table of Contents (cont.)

Accounting for Costs and Benefits in the Planning	35
Implementation	36
Planning the Study of the Intervention	38
Methods of Evaluation	40
Project SWOT Analysis	43
Analysis	45
Section IV. Results	
Program Evaluation / Outcomes	47
Results of Composite Scores	47
Section V. Discussion	
Summary	50
Key Success	50
Additional Findings	50
Lessons Learned	52
Relation to Other Evidence	53
Organizational Culture	53
Barriers to Implementation / Limitations	57
Need for a Dedicated Resource	58
Data Quality	58
Interpretation	60
Conclusion	61

Table of Contents (cont.)

Section VI. Other Information

Funding 63

Section VII. References 64

Section VIII. Appendices

Appendix A. Initial Project Charter for the Value Creation Office, .
Letter of Support, USF Statement of Determination 75

Appendix B. Evidence Table 84

Appendix C. Kotter’s 8-Step Process 89

Appendix D. Bourdieu’s Theory of Field, Habitus, and Capital 86

Appendix E. The Nine Provisions of the American Nurses
Association’s Code of Ethics 92

Appendix F. Analytics Adoption Model 93

Appendix G. IT Project Justification and Costs 94

Appendix H. Fusion Database Search Tool..... 94

Appendix I. System Level Scorecard and Cascading Department
Metrics 95

Appendix J. Project Timeline and Gantt Chart..... 116

Appendix K. Pre- and Post-Implementation Questions 118

Appendix L. Project SWOT Analysis 120

Appendix M. Threat Matrix and Mitigation Strategies 121

Appendix N. Post- and Pre-Implementation Responses to Questions
Assessing Employee Engagement 123

Appendix O. Comparison of Post- and Pre-Implementation
Frequency Data 124

Table of Contents (cont.)

Appendix P. Comparison of Post- and Pre-Implementation
Composite Scores 122

Appendix Q. Correlations Observed with Engagement Questions.... 128

Appendix R. Project Request and Scope and Assessment Form 133

Appendix S. Missing Elements of Change 139

Abstract

There is ample evidence of our health care delivery system relying heavily on value-based outcomes. The increased focus on outcomes has required health care organizations to adjust how they approach data and how they successfully implement performance management systems. These performance management systems help the organization identify, measure, and report the organization's performance at an enterprise level using key performance indicators clearly linked to the organization's overall strategy. As one organization began implementing an enterprise performance management system, the goal of this project was to show how participating in projects with that level of strategic impact can lead to improved engagement scores.

Keywords: enterprise performance management, balanced scorecard, employee engagement, key performance indicators

Introduction

Background Knowledge

According to the Healthcare Financial Management Association (HFMA, 2011c), “Of all the transformations reshaping American health care, none is more profound than the shift toward value” (p. 1). The continued rise of health care expenditures has forced increased focus on outcomes that will require health care organizations to become skillful consumers of their own performance data (Behrouzi, Shaharoun, Ma’aram, 2014). According to Behrouzi et al. (2014), this sequence of events has illuminated the need for health care organizations to successfully implement performance management systems attuned to impactful outcomes data.

Care delivery geared towards medical and behavioral health conditions is responding to the need to move from silos of care to integrated, seamless services. For behavioral health care delivery, the focus on integrated care has led to consumer demand for the same feedback on outcomes in behavioral health care as that seen with care delivery for medical conditions (Lin & Durbin, 2008). For behavioral health care providers, this will require a move closer to their counterpoints in the physical health arena, whose use of metrics in care delivery is well-established. Identifying opportunities to improve care delivery across the continuum will depend heavily on the governance, organizational structure, people, process, and technology that organizations dedicate to their efforts geared towards performance measurement (Reichert & Furlong, 2014).

Health care organizations will need to collect, aggregate, and analyze a multitude of performance data, including clinical, financial, and operational metrics. Any deficiencies in their ability to do so should lead to an evaluation of whether the organization is capable of surviving independently (HFMA, 2011c). Establishing enterprise performance management (EPM)

systems is one way of meeting that capability need. An EPM provides a balanced approach to assessing performance, which will be a key to successfully navigating the industry's shift from volume to value (HFMA, 2011c). An effectively implemented EPM allows organizations to monitor how well they are performing on key initiatives. An EPM represents the integration of strategy development, financial planning, and performance monitoring. It leverages a broad assortment of key metrics, commonly referred to as key performance indicators (KPI), collectively providing feedback on financial performance, capital planning, operational budgets, and service delivery (El Mola, Parsaei, Leep, & Wong, 2004).

Keeping pace with the shift from a volume-based to a value-based payment model will require higher levels of collaboration, like that seen in interdisciplinary teams (HFMA, 2011c). Providing senior leaders with valuable performance data that clearly articulates progress towards strategic goals is dependent upon intimate collaboration between finance, operations, service line, and senior leaders. In most settings, these functions are poorly integrated (El Mola et al., 2004). As a result, only 20% of senior leaders report actively utilizing data to drive key decisions or actionable responses (HFMA, 2011c). Effectively established EPMs are integral to providing relevant information to key stakeholders accurately and efficiently (El Mola et al., 2004).

Central to any health care organization's response to a changing landscape is their workforce, particularly, the level of engagement of their workforce. High-performing organizations will separate themselves from underperforming organizations through their ability to holistically integrate strategy formulation, performance metrics used to assess their strategy, and the resources used to operationalize that strategy (Mehta, 2015). An engaged workforce, with a shared sense of commitment and accountability, will form the foundation to any value the organization will achieve (HFMA, 2011d).

Local Problem

On a macro level, this change in practice project is a result of the evolving health care landscape leading to the need for effective performance management data, coupled with the need for an aligned and engaged workforce monitoring and responding to that performance data. At the local level, operational silos and lack of interdisciplinary collaboration were making it difficult to respond to the changing landscape by capturing, integrating, and sharing valuable data. Additionally, the organization began looking for ways to participate in alternative payment models, such as full-risk contracts associated with the service delivered. These contracts would cap payments from business partners at an agreed upon level. Costs incurred outside of the established cap would be the responsibility of the organization. The movement to these risk contracts made for the ideal improvement opportunity, as there were no enterprise-wide mechanisms yet in place to collaboratively monitor performance and provide the early warning necessary to guide the day-to-day decisions made by those assigned to these contracts.

Responding to a changing health care landscape by maneuvering to participate in new payment models was a sound strategic endeavor necessary to retain clients and attract new business. Strategic responses, such as these, require the organization to adjust and/or implement the right processes and ensure that those processes are supported by the right people, with the right skill set, operating at an effective level of engagement (Lock, 2016). Seeing the results of effectively implementing the EPM for this organization was a part of the overall project plan; however, receiving that data would extend beyond the scope of this DNP project. Therefore, the design phase of the EPM development was used to show improvement in the co-occurring focal area mentioned above – providing an effectively engaged workforce needed to respond to a changing health care environment. To make effective use of the identified opportunity involving

the need for performance data, those involved in the development of the performance management system were targeted for assessment and improvement of their level of engagement.

Expanding into full-risk arrangements requires extensive analytical capabilities, including the ability to assess the level of risk assumed with each individual member (HFMA, 2011c). The project site had not yet achieved this level of sophistication. This is vital to pursuing this strategic path of business expansion, as the outcomes organizations are credited with achieving will establish their reputation in a competitive field (Hazelrigs, 2015). Designing and implementing the EPM system would be the first step in achieving more advanced levels of data analysis. Chief executive officers (CEO)s, senior leaders, and department vice presidents (VP) would first need to put in place the organizational approaches involved in establishing an EPM before moving on to other more advanced analytical approaches (Hazelrigs, 2015). Additionally, this first step would need to demonstrate an effective alignment of multidisciplinary teams bringing their collective skills and knowledge together to respond to performance data (Hazelrigs, 2015). Those multidisciplinary teams would be dependent on highly engaged participants making the pairing of engagement scores with the development of the EPM system a good match.

Local Setting

Through its partnerships with multiple employers and eight major insurance plans, a managed behavioral health organization (MBHO) served as the project site for this DNP project. The organization is hereafter referred to as XORG, a pseudonym honoring the organization's request for anonymity. The organization manages the behavioral health needs of over 12 million people in nearly every state. Established in 1995, XORG has partnered with multiple organizations to deliver two primary services: employee assistance programs and managed

behavioral health services. The organization has received national recognition for the services provided, and each year, its member satisfaction scores are consistently 90% and above, as measured by annually administered member surveys. Despite its successes, there is a general consensus among the staff and senior leaders within XORG for a more structured approach to identifying, measuring, and reporting performance metrics.

A charter was developed at the DNP project site to formally authorize the planning and implementation of a multidisciplinary group assembled as part of an organizational approach for identifying, measuring, and reporting on the value achieved by our stakeholders (see Appendix A). Along with the project charter, a statement of determination was completed and the executive sponsor of the project submitted his letter of support for the project (see Appendix A).

Collectively, the group was recognized as the Value Creation Office (VCO). The VCO was to act as a collaborative committee assembled to address the need for a structured, organization-wide approach to efficient distribution of data that illustrates how stakeholders are benefitting from their relationship with XORG. Senior leaders within the organization had metrics in place to monitor the services for which each individual department was responsible. Targets and desired outcomes were in place; however, those metrics and, in particular, the definition of those metrics, varied between each department and were connected to the priorities specific to each individual department versus being clearly tied to organizational goals. The cross-functional group making up the VCO was to be the first step in addressing the opportunity to instill a more unified approach to outcome measurement.

My role in the VCO was program manager, responsible for identifying and vetting the team members, drafting the charter, developing and following the communication plan, and developing and following the project plans for each of the projects that would result from its

formation. The program and, in particular, the projects that utilized performance data that led to measurable improvements would be leveraged for my DNP project.

While identifying how we provided value to our key stakeholders was a clear need, it became apparent that the organization had to establish a holistic and unified approach to performance measurement prior to addressing the more in-depth analytics involved in value provided. In order to leverage the data acquired at the local setting, an EPM approach had to be in place first. Data analysts at XORG had limited bandwidth for more in-depth analytics, as they were spending large amounts of time on manually extrapolating data from multiple sources. Once the data were gathered and aggregated in digestible formats, analysts would then spend their remaining time distributing those data to the multiple departments requesting it. In many cases, they were instructed to use multiple definitions for the same metric depending on how a specific department wanted to define that metric.

Issues with utilizing data is not a challenge unique to XORG. Organizations in today's health care environment are distinguishing themselves via their data use, as few are using the data they collect as the foundation of their movement to action (HFMA, 2011a). Additionally, health care organizations are quite used to the convergence around key metrics with the introduction of regulatory requirements associated with meaningful use, federally enforced quality initiatives, and accountable care organizations. Likewise, the data issues at XORG were not necessarily a knowledge deficit surrounding metrics. The most prominent opportunities involved identifying and defining key outcome measures; collecting and efficiently tracking them; efficiently distributing those outcomes to senior leaders, service line VPs, department directors, managers, and individual team members; and then collaboratively responding to those outcomes where and when appropriate.

History of performance management. Prior to beginning discussions on establishing the VCO at XORG, several attempts were made to unify efforts focused on capturing and tracking key measures. Beginning in 2010, senior leaders within the clinical operations department established their own version of a balanced scorecard, the progress of which will be discussed in later sections. Prominent market forces, such as client demand and the Affordable Care Act, would require adjusting the KPIs from that initial scorecard.

Responding to the demands of our plan partners, the evolution of scorecards included more customer-centric metrics. The new metrics were fairly well aligned with the goals of making prices more competitive, improving organizational efficiencies, upgrading capabilities, and controlling costs; however, they were not widely adopted.

Intended Improvement / Purpose of Change

The ultimate goal of this DNP project was to improve alignment around key strategic goals. According to a Harvard Business Review article on strategy execution, less than half of organizations are successful at executing their strategic aims (Sull, Homkes, & Sull, 2015). The most frequent reason attributed to the inability to successfully achieve a strategic aim is failure to align within the organization (Sull et al., 2015). Once the CEO identified the opportunity to improve the performance management approach, this DNP project would leverage that need and focus on establishing an EPM system within the organization. The EPM would be positioned as a tool that would help improve alignment behind monitoring and achieving strategic goals. The EPM would help the organization answer questions, such as (a) where are we headed as an organization; (b) what strategic aims do we need in place to get us there; (c) what key performance metrics do we need to monitor that will provide insight on our progress towards those strategic goals; and (d) what contingencies should we have in place?

A unified approach to performance management improves alignment behind strategic aims by providing the tools for organizations to monitor and respond to their key performance metrics as they relate to strategy. An additional avenue leading to improved alignment behind strategic aims is increasing employee engagement (Reid & Hubbell, 2005). These two approaches are critical considerations to this DNP project, because while implementing an EPM at XORG was a part of the overall project plan, receiving performance improvement data from it would not have occurred in a timely manner. Therefore, validating the organization was indeed more aligned behind its overall strategy would come by way of improvement in engagement scores.

The aim of this project was to show an increase in engagement scores of the target population involved in the development of the EPM system. For the purposes of this project, engagement was defined leveraging William Kahn's pioneering research on the topic, that defined engaged employees as those employees who are physically, cognitively, and emotionally attached to their defined work roles (Kahn, 1990).

Evidence of improved engagement would be demonstrated by an increase in overall scores from a pre- and post-engagement survey and/or improvement in one of the three focal areas addressed by the survey. Those three focal areas are aligned with the definition of engagement cited above and include (a) self-reflection on loyalty/intent to stay with the organization (retention), which represents their physical engagement; (b) self-assessment of the employee's personal disposition (personal satisfaction, pride in their work, sense of duty to serve the customer base), which represents their emotional engagement; and (c) key contributors impacting the employee's personal disposition (interface with the physical environment,

relationship with peers, and superiors, feedback/acknowledgement of quality work, feeling supported), which represents their cognitive engagement.

Review of the Evidence

To coincide with duality of both the development of an EPM and the engagement scores of those involved in that development, an iterative and thematic approach was taken during a comprehensive review the evidence. The review of applicable evidence was iterative in that, as mentioned previously, the initial focus of the project was on establishing a VCO. The VCO was to use a balanced scorecard approach to identify, monitor, and report on value achieved. Thus, the first iteration of the literature review focused on successfully implementing the balanced scorecard in a health care delivery setting. A literature search of databases included Joanna Briggs Institute of EBP (JBI), Cochrane Library, PubMed, and CINAHL. Keywords used during this search included *quality improvement*, *quality management*, *lean*, and *balanced scorecard*. Targeted articles were those utilizing the balanced scorecard with broad applicability within an organization (versus a focus on a specific unit or discipline) and also included international settings in similarly developed countries. Along with implementing the balanced scorecard, this first review of the evidence also included identifying success factors associated with change management.

PubMed yielded the most comprehensive initial results. The search terms *performance management system AND health** (truncated to narrow the search to healthcare or health care) yielded 187 articles. Two articles were chosen using the inclusion criteria discussed above. The search terms *balanced scorecard AND health* yielded 164 results, and 15 were included. Additionally, Google Scholar yielded three industry reports that provided excellent background

information for the need of establishing a structured performance management system in health care settings.

The second iteration of reviewing applicable evidence included a focus on strategy development and performance measurement, as well as how each may be linked to employee engagement. A literature search of databases included Joanna Briggs Institute of EBP (JBI), Cochrane Library, PubMed, and CINAHL. Articles were restricted to those occurring in a health care setting and those released within the last 15 years. Keywords used included *balanced scorecard*, *strategy development in health care*, *employee engagement*, *improving employee engagement*, *measuring employee engagement*, and *employee engagement survey*.

By this time, the new Fusion database search tool offered by the Gleeson Library at the University of San Francisco was implemented on the library's homepage. The Fusion research database is a search tool that allows users to query more than 200 multidisciplinary research databases by using keywords, titles, or authors. The database then allows users to refine those results through use of intuitive point-and-click tools that filter the initial keyword search results. Though it is not intended to replace subject-specific databases, the Fusion search tool is a great place to start. Utilizing the search terms *strategy development* and *health care* within the Fusion database search tool and limiting the source types to *Academic Journals*, there were over 40,000 results. Using Fusion's *Refine Results* tool (see Appendix H), those results were limited to the United States, English language, with topics that covered the health care industry, medical care, strategic planning, and personnel management. This narrowed the search to 71 articles. A similar approach was taken for *employee engagement*, *improving employee engagement*, *measuring employee engagement*, and *employee engagement survey*.

Thematic Review

The two iterations of reviewing applicable literature are represented thematically using the following themes: (a) the use of the balanced scorecard by health care organizations; (b) effectively orchestrating change; (c) the people, processes, and technology needed for successfully implementing an EPM; and (d) understanding the link, if any, between high-performing cultures, achieving strategic aims, and employee engagement. The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) Non-Research evidence appraisal tool (Dearholt & Dang, 2012) was used in evaluating the literature from each of themes mentioned below.

The balanced scorecard. Three primary themes emerged from articles on the balanced scorecard (BSC): (a) how the BSC was designed and implemented, (b) what impact the BSC had on the items being measured, and (c) the effective strategies or lessons learned during the implementation of the BSC. These emerging themes align well with addressing the ultimate practice question of whether the BSC could be an effective tool supporting strategy attainment in a health care setting.

The use of the BSC in health care was first documented in the late 1990s and has seen increased use in the last 10 years (Bisbe & Barrubés, 2012). The BSC has four categories, referred to as perspectives, which include financial, customer, process, and learning and growth (Kaplan & Norton, 1992). When applying the BSC to a health care setting, modification of the four traditional perspectives aids in its successful implementation (Bento, Bento, & White, 2013, Lupi et al., 2011). Regardless of the perspectives used, prior to implementing the BSC, organizations should outline enterprise-wide objectives, and each business unit should articulate unit-level strategies that contribute to the achievement of those organizational objectives (Kaplan & Norton, 2006). With the outlining of enterprise-wide objectives, it becomes clear how pairing those objectives with an EPM system, which monitors progress towards those objectives,

happens in tandem in high-performing cultures (HFMA, 2011c). Once in place, the BSC can positively impact on patient satisfaction scores, employee satisfaction, and financial metrics (Lorden, Coustasse, & Singh, 2008).

Effectively orchestrating change. Implementing an EPM relies on a multidisciplinary team functioning at a very high level, despite the EPM being a disruptive change. Utilizing a structured, evidence-based approach will increase the chances of success when dealing with changes such as this (Hughes, 2015; Kotter, 1996). Orchestrating an enterprise approach requires a change from the past performance management approaches, which centered on reviewing performance data in silos, which would never fully impact performance at a strategic level (Public Health Foundation, 2002). Sending a clear message that the reputation of our company in this evolving health care landscape would largely be determined by the outcomes we produced would help with the system-wide adoption of the change. Showing how these new approaches lead to better outcomes would also go a long way towards gaining adoption, as change frequently occurs when new methods produce superior results (Shirey, 2011).

The people, processes, and technology needed for successfully implementing an EPM. Leaders are required to expand their view over increasingly complex sets of data. Achieving a competitive advantage in today's health care environment requires people that are comfortable with information technology (Bijata & Piotrkowski, 2014). It is through this comfort with data that leaders are able to clearly articulate and unite their people around a common purpose (Thomas, 2009). When working with information technology (IT) projects, such as implementing an EPM, the most common contributor to failed projects is poorly defined business requirements (Lebedeva, 2015). Also key in a sound process for developing an EPM is ensuring that before any technology is considered for the project, metrics identified must

demonstrate a clear connection between what is being measured and the organizations overall strategy (HFMA, 2011c).

Understanding the link, if any, between high-performing cultures, achieving strategic aims, and employee engagement. Once the organization's strategy is laid out, consistently monitoring progress towards achieving the strategic aims within that strategy is key to successfully realizing the organization's overall strategic vision (HFMA, 2011a). High-performing organizations are focusing on engaging their workforce as a means of achieving their strategic aims (Sull et al., 2015). High-achieving organizations have also leveraged their workforce's IT skills and access to data to ensure that the work they are doing is meaningful. Allowing them to use their organization's data to come up with their own way of accomplishing tasks has helped improve their level of engagement, which has led to higher performance (Thomas, 2009).

Work that expands the breadth of an employee's typical duties can lead to improved employee engagement, particularly when it involves contributing in group work that will result in high levels of influence throughout the organization (Bonner, 2015; Mackay, Allen, & Landis, 2016; Parker, 1998; Ryan & Deci, 2000). Another approach leading to improved employee engagement scores is showing employees how their work is impacting progress towards achieving the organization's strategic goals (HFMA, 2011c). High performance work systems (defined as a collection of organizational policies and practices, including enterprise performance management) have a significantly positive effect on employee engagement (Oliveira & Silva, 2015). The tie between achieving strategic aims and high-performing cultures is clearly demonstrated in the Malcolm Baldrige National Quality Award given to organizations demonstrating quality and performance excellence. The award program uses a self-assessment

tool for evaluating business process and adopting best practices (American Society for Quality [ASQ], n.d.). Less than 10% of organizations applying for the award are considered, and those organizations that go on to win are more profitable than the companies making up the Standard & Poor's index of 500 leading U.S. companies by a factor of three to one (Public Health Foundation, 2002).

Gallup is widely recognized for raising awareness of the importance of employee engagement. It has advanced the consistent findings leveraged from 25 years of research on the subject, which have concluded that highly engaged employees help attract and retain talented human resources, and poorly engaged employees decrease productivity, stifle recruitment, and lower productivity (Harter, Asplund, & Fleming, 2004). Because it is a vital component through which outcomes are achieved, performance management systems are critical to an organization's effectiveness (Gruman & Saks, 2011). Typically, this connection would mean that thoughtful development of EPMs are given top priority. However, only a third of employees report that their organization's performance management processes are effectively geared towards assisting them improve their own performance (Gruman & Saks, 2011). Organizations looking to make the investment in implementing or improving their EPM system often deliberate on whether the focus of the EPM should be on improving performance or addressing engagement. According to a Gallup survey of over 8,000 employees, high-performing organizations focus on both (Mann & Darby, 2014). These high-performing organizations have honed their abilities to develop engaging relationships, while also instilling a sense of accountability, because they have realized that focusing on one while ignoring the other is an incomplete approach that risks limiting performance (Mone, Eisinger, Guggenheim, Price, & Stine, 2011).

Collectively, the above referenced articles, as well as the remaining articles, supported the approach of linking the design of an EPM system to employee engagement in four key areas: (a) the BSC can effectively be implemented in a health care setting; (b) the BSC is an effective tool to leverage in the development of strategy, implementation of strategy, and in the design of an EPM; (c) leveraging the BSC in an EPM with goals that cascade down to the individual employee is an effective way to improve employee engagement, as it shows each employee how their work is impacting progress towards achieving the organization's strategic goals; and (d) the disciplined utilization of an EPM is an effective way of tracking progress on strategic goals. A detailed review of the evidence utilizing the JHNEBP Non-Research evidence appraisal tool can be found in Appendix B.

Conceptual Framework

The conceptual framework that guided this project was comprised of Kotter's (1995) eight critical success factors for successful change management, Bourdieu's (1977) theory of practice to assist with understanding the contextual background of multiple key contributors, and the operating model commonly referred to as people, processes, and technology which use to help guide the implementation of the change in practice.

When attempting to introduce evidence into practice, there must be careful consideration of how behavior is influenced and how those behaviors are impacted by the environment, interpersonal relationships, and the evidence being introduced to practice. The key concepts and theories mentioned below formed the conceptual framework that guided this change of practice project. Collectively, they represent a logical and sequential explanation of the approach undertaken during the course of the project.

The balanced scorecard as a performance management system. In its Value Project, the HFMA identified the need to move health care organizations “away from data-collecting organizations to data-driven organizations” (HFMA, 2011a, p. 2). The BSC provides a performance management system for organizations to make that transition. The BSC has been utilized as a performance management system since the early 1990s (Bisbe & Barrubés, 2012). It has increasingly been implemented in health care organizations over the last 10 years, with varying degrees of success (McDonald, 2012). Effectively implementing a BSC, coupled with a cultural focus on value, will be the approach used to turn a data gathering organization into one prominently placing outcomes and evidence at the foundation of all decisions surrounding organizational initiatives. The business case for developing such an approach is simple – employers, payers, government entities, and patients are all demanding to know what outcomes they can expect to receive and the cost they will have to pay for these outcomes (HFMA, 2011d).

Performance management systems are used to align organizations around defined processes and practices (Kaplan & Norton, 2007). The BSC is one such performance management system designed to offer flexibility in identifying strategic indicators to measure (Valenstein et al., 2004). It is made up of four categories, referred to as perspectives, which include financial, customer, process, and learning and growth. The BSC is designed to work in conjunction with organizational strategy maps that identify high-level organizational objectives (Naranjo-Gil, 2009). Once identified, those objectives are then paired with KPIs that are used to populate the BSC (Kaplan & Norton, 2007). Outcomes associated with implementing a BSC in a variety of health care delivery settings, as well as best practices in doing so, can be found in the table located in Appendix B.

Anticipating a significant cultural change. Implementing an EPM system that requires daily consumption of data in order to make more-informed, data-driven decisions will be a significant shift for the organization. These data-driven decisions will be key to improving performance, which would be enough if humans made decisions based entirely on a logical analysis of data. Unfortunately, this is not the case in every instance, and moving from the current state to the desired state does indeed rely on credible data confirming such a change is needed. Making significant changes in practice such as this typically only happens in the presence of an emotional connection coupled with actionable intelligence that aligns with the mission, vision, and strategies senior leaders have personally invested their time in developing (Radnor & Lovell, 2003). For this reason, the successful design and implementation of the EPM and the corresponding improvement in employee engagement will hinge on an evidence-based approach to change management.

Instituting change warrants the effective application of a structured, evidence-based approach geared towards making the implemented change successful and sustainable. Kotter's (1995) eight critical success factors will be used as a guideline for providing the best chance of successful adoption in this change of practice. Appendix C describes common pitfalls identified by Kotter leading to unsuccessful adoption of a change in practice, as well as the core concepts Kotter established to help organizations successfully navigate through change initiatives.

Accounting for various perspectives of value. Successful implementations usually have a foundational theory tightly linked to strategy that drives implementation approaches. This approach accounts for anticipated behavior, reasons attributed to that behavior, and supportive approaches for behavioral change that are applied to the implementation strategy. The EPM will depend largely on the effective collaboration of a multidisciplinary group. For this reason,

Bourdieu's 1977 theory of practice will be leveraged to help provide structure to the project (Bourdieu, 1977). Bourdieu's theory seeks to apply context to observed behavior, including how individual members approach the concept of value differently (in Webb, Schirato, & Danaher, 2002). This context involves the three tenets of Bourdieu's theory of practice, which include the field, habitus, and capital. We develop a better understanding of behavior through an appreciation of the field (social field or comfort zone), habitus (established social practices within a given field), and capital (rite of passage) that a member of a given field has expended to be accepted (Lynam, Browne, Kirkham, & Anderson, 2007) (see Appendix D). An example of applying this contextual expansion is understanding the different fields on which a senior clinician and chief financial officer (CFO) operate. When discussing the concept of achieving value with a senior clinician, you recognize that someone from his/her field might be more responsive to hearing how an EPM can help improve clinical outcomes, while the CFO might be more apt to respond to how the EPM will help deliver a measurable return on investment.

Finally, conceptualizing all of the above theoretical frameworks is the operating model commonly referred to as people, processes, and technology. The origins of this operating model are commonly attributed to ITIL (n.d.), which is the acronym used for what was formerly known as the Information Technology Infrastructure Library. As an operating model, it provides project leaders with a systematic approach to accounting for the people, skills, process updates, and technology needs associated with projects; it is frequently used in the information technology industry (Reichert & Furlong, 2014).

There are several variations of putting the approach in practice. For the purposes of this project, Gartner's robust guide on applying the people, processes, and technology operating model (Chandler, Hostmann, Rayner, & Herschel, 2011) will be used as the framework for

addressing critical EPM design components and integrated the EPM technology needed to support that design.

Methods

Ethical Issues

In a 2007 study of institutional review boards in the United States, nurses were identified to be more sensitive to ethical issues than their colleagues from other disciplines (Rothstein & Phuong, 2007). Ethical behavior makes up a critical component of practice for the professional registered nurse. Perhaps, it is that focus on ethical behavior that has led nurses to be ranked the most honest and ethical profession 15 of the last 16 years (Gallup, 2015). The Code of Ethics for Nurses is the framework that guides the ethical approach of the profession (American Nurses Association (ANA), 2015). The nine provisions within the code provide guidance to all nurses on applying their ethical obligation to their everyday practice. The most applicable provisions in the Code of Ethics to this change of practice project are provisions 1, 2, 4, 5, 7, 8, and 9 (see Appendix E for listing of all nine provisions). Collectively, these provisions remind the professional nurse that their primary commitment is to the patient and to treat every person with dignity. Additionally, the Code of Ethics provides guidance to nurses on using their authority, taking action, maintaining competence and integrity, and working collaboratively.

The first ethical issue encountered during the design of the EPM involved the validity of our data. Due to a combination of a lack of data governance and a failure to ensure that the people trusted to govern that data possessed the appropriate skills and competencies to do so, the quality of the data at XORG was known to be rather poor, as evidenced by several key leaders identifying quality issues in the data they were given, leading to many of them verbalizing their reluctance to use the data.

Data governance and steady progression through the analytics adoption model (see Appendix F) are vital ingredients to quality data analytics. As organizations move towards new

payment models, having an enterprise-wide approach that governs the formulation and use of data will help ensure data quality and integrity (Ramos Hegwer, 2015). The ethical dilemma in this scenario is whether or not you move the organization towards an EPM knowing the data that the EPM would depend on was going to be of poor quality. Even with less than perfect quality, the data could still provide valuable feedback and direction (HFMA, 2011c). Moving forward could indeed be accomplished, and overcoming this dilemma was significantly aided by assurances that the data quality issue could be sufficiently addressed via the development of an enterprise-wide data governance framework (Ramos Hegwer, 2015).

Another ethical issue encountered was the type of outcome measures targeted. A provision of the Code of Ethics speaks to the nurse's obligation to promote health. Currently in behavioral health care, outcome metrics are more process-oriented. These process-oriented measures, at best, display a loose association to true outcomes. This fixation on process-oriented metrics is most likely due to (a) payer focus on tracking the services that are paid for and ensuring those services were actually delivered and (b) contracts for managed care services that are too short to see real outcomes, such as those that would extend the life-expectancy of a member in a covered population (Essock, Olfson, & Hogan, 2015). Despite these identified shortcomings in process-oriented metrics, they still provide a good place to start, as they may drive performance in related metrics. For example, the connection between how soon a patient is seen by a behavioral health provider following an inpatient behavioral health admission can lead to reduction in readmission rates (Essock et al., 2015). With this in mind, and no viable alternative offered in the literature, the EPM would move forward with a significant amount of process-oriented metrics related to service delivery.

Lastly, to pay for the technology that would be used to aggregate and report on performance within the EPM, an innovative budget-neutral approach was offered to IT and senior leadership at the project site (see Appendix G). To get to a budget-neutral approach, several subscriptions to the current reporting tool would be eliminated. This could potentially place the jobs of those supporting that reporting tool at jeopardy. The chance of those individuals losing their jobs may have been remote, as they would have most likely been reassigned to other teams. Even if there were a significant chance that they could lose their jobs, from an ethical standpoint, it would still make sense to move forward with the approach. As mentioned in Provision 2 of the Code of Ethics, a nurse's primary commitment is to his/her patients. Along with the other provisions that speak to advancing health, it would make sense to move forward with implementing the EPM using the budget-neutral approach, as it offered the highest chance for project approval, which would ultimately lead to advancing health care and providing better care to the patients receiving our services.

Setting

The organization representing the change of practice project site was established in 1995 out of the recognized need to reduce behavioral health costs and improve the quality of services delivered. The organization ended its first year with \$10 million in revenue. By 2014, that number had jumped to over \$85 million. For more than 20 years, it has served its plan partners through the expert management of two primary services: employee assistance programs and managed behavior health (MBH). Through its partnerships with multiple employers and eight major insurance plans, the MBHO serving as the DNP project site manages the behavioral health needs of over 12 million people in nearly every state. The project site has received national

recognition for the services provided, and each year its member satisfaction scores are consistently 90% and above.

Despite rapid growth and financial success, there was a general consensus at XORG for a more structured approach to identifying, measuring, and reporting performance metrics.

Identifying opportunities to improve care deliver across the continuum will depend heavily on the governance, organizational structure, people, process, and technology organizations dedicate to their efforts geared towards performance measurement (Reichert & Furlong, 2014).

Responding to the need for a more structured approach to performance measurement would help the organization improve processes, leading to more accurate monitoring of patterns and improvement of behavioral health care delivery.

Beginning in 2010 at the DNP project setting, senior leaders within the clinical operations department established their own version of a balanced scorecard. The KPIs tracked on their scorecard at that time included a few financial metrics, as well as a few customer satisfaction measures. However, the majority of the metrics focused heavily on measuring the utilization of services, such as outpatient visits and inpatient days. Prominent market forces, such as client demand and the Affordable Care Act, would require adjusting the KPIs that the organization historically tracked. Additionally, the heavy focus on clinical/utilization metrics in the first scorecard warranted a more balanced approach to KPIs that included monitoring internal process and financial and quality metrics to compliment those utilization metrics.

In 2013, the board and senior leadership looked to Medicare, Medicaid, and full-risk contracts as targets for revenue growth. Senior leadership from the clinical department would once again attempt to get the organization to adopt a scorecard for tracking its performance on those new initiatives. Responding to the demands of our plan partners, the updated scorecard also

included a more customer-centric set of metrics that would help the organization keep pace with competitors. The new scorecard also offered a more balanced approach and included KPIs that tracked financial, clinical, and operational initiatives. The new metrics were fairly well aligned with the goals of making prices more competitive, improving organizational efficiencies, upgrading capabilities, and controlling costs. However, despite a more balanced approach, the scorecard was not widely adopted. This may have been due to the time-intensive work required to manually aggregate the data elements. It could have also been due to a general resistance to change endemic in the culture of the organization, which is discussed later in lessons learned.

As mentioned in the details about the local problem, the initial project focus was on the planning and implementation of a multidisciplinary group assembled as part of an organizational approach for identifying, measuring, and reporting on the value achieved by our stakeholders. Collectively, that group had been meeting as the VCO to address the need for a structured, organization-wide approach to reporting on how our stakeholders were benefitting from their relationship with the MBHO. Each department within the organization already had metrics in place monitoring services. However, those metrics, and in particular, the definition of those metrics, varied between each department and were connected to the priorities specific to each individual department, with no clear tie to organizational goals.

In 2015, recognizing Medicare and Medicaid as a growing market for managed behavioral health services, the CEO at XORG identified the need for a uniform approach to performance management, as this would be key to success in participating in these government programs (HFMA, 2011b). Participating in these programs without a unified approach represented an unacceptable risk. This assessment led to renewed efforts to identify KPIs critical

to monitoring the core functions of the organization and using those KPIs on a scorecard that would be widely adopted by the organization.

While identifying value provided was a clear need, it became apparent that the organization had to establish a holistic and unified approach to performance measurement prior to addressing the more in-depth analytics involved in value provided. In order to leverage the data acquired by XORG, an EPM approach had to be in place first. Data analysts had limited bandwidth for more in-depth analytics, as they were spending large amounts of time on data gathering from multiple sources. Once the data were extrapolated, they would then spend their remaining time distributing that data to the multiple departments requesting it and in many cases, using multiple different definitions for the same metric depending upon how a specific department wanted to define that metric.

Organizations in today's health care environment are distinguishing themselves via the ways in which they are leveraging their data. Few are using the data they collect as the basis by which their decisions and/or market responses are guided (HFMA, 2011a). Additionally, health care organizations are quite used to the convergence around key metrics with the introduction of regulatory requirements associated with meaningful use, federally enforced quality initiatives, and accountable care organizations. Likewise, at XORG, the issue was not necessarily a knowledge deficit surrounding metrics. The most prominent opportunities involved identifying and defining key outcome measures; collecting and efficiently tracking them; efficiently distributing those outcomes to senior leaders, service line VPs, department directors, managers, and individual team members; and then working collaboratively to respond to those outcomes where and when appropriate.

Planning the Intervention

Accounting for the purpose, process, and activities within the plan. Implementing an EPM improves alignment with strategic aims by providing the tools for employees to monitor key performance metrics as they relate to strategy. An additional avenue leading to improved alignment behind strategic aims is increasing employee engagement (Reid & Hubbell, 2005). Implementing the EPM and improving employee engagement scores are critical considerations to this DNP project, because while implementing an EPM at XORG was a part of the overall project plan, receiving performance improvement data from that EPM would not have occurred in a timely manner. Therefore, validating the organization was indeed more aligned behind its overall strategy would come by demonstrating an improvement in engagement scores.

The target population chosen to demonstrate this improvement was a key cohort of middle managers from various departments. This group of middle managers, who affectionately referred to themselves as the *coalition of the middle* (or COM), were members of a work group consisting of employees from multiple departments. They were chosen to provide feedback to identify KPIs that would collectively form the EPM. Targeting middle managers is of particular importance, as they are known to be key to successfully achieving and, conversely, failing to attain key strategic aims (Sull et al., 2015). The middle managers making up the COM would be used to demonstrate that using projects, such as the development of an EPM, will help them feel more engaged. Increases in their level of engagement, particularly their physical engagement, has been seen to significantly improve employee retention (Andrew & Sofian, 2012).

The relationship between performance metrics and engagement is a pivotal one, as few organizations are using data when making their most important decisions (HFMA, 2011a). High-performing organizations typically have more engaged employees who are tremendous

consumers of data, which helps them monitor their own performance. High-performing organizations will then use the data from the successes their more engaged employees were able to achieve in hopes of instilling their best practices throughout the organization (Reid & Hubbell, 2005).

Consistently reoccurring in the literature in high-performing organizations is the link between how effectively organizations are using their own performance data and high organizational performance, as well as the link between highly engaged employees leading to an organization's high performance (HFMA, 2011a, 2011c, 2011d, 2011e; Reid & Hubbell, 2005; Sopow, 2006; Sull et al., 2015). Organizations that effectively leverage performance management processes that address satiating their employee's physical, cognitive, and emotional needs see higher levels of engagement with an EPM approach (Gruman & Saks, 2011). As part of an ongoing and continuous process, high-performing organizations develop EPMs that incorporate personal performance agreements and facilitate engagement activities throughout the process, leading to enhanced job performance (Gruman & Saks, 2011).

For example, as a result of their efforts that focused on data-driven strategy and effectively engaging and aligning their staff around that strategy, Sharp Healthcare in San Diego, California saw a 35% decrease in costs with pilot participants. The University of Utah Health Care was able to reduce costs associated with joint replacements by 32%, total costs by 8%, and discharge delays by 50% by empowering their workforce during performance improvement projects and engaging them with innovative tools, such as their value summary dashboards (Phillips, 2015).

The ultimate goal of improving alignment around key strategic initiatives would have an approach that improved the data (implementing the EPM), as well as one that concurrently

addressed employee engagement (engagement scores of the COM). However, because engagement scores were the only outcome metrics that could be collected during the timeframe associated with this DNP project, the aim of this project was to show an increase in engagement scores of the target population involved in the development of an EPM system.

Meeting the leadership need. Intimate involvement in the design of the EPM would serve as the intervention that would raise engagement scores within the COM. Key to understanding the project's focus on employee engagement is understanding what impact engaged employees have on high-performing organizations. Senior leaders in high-performing organizations have learned that engaging and empowering their workforce leads to excellence in organizational performance (Spath, 2004). Likewise, senior leaders at XORG were keenly aware of the benefits that would come from digitally monitoring the organization's performance data. Similar to Sharp Healthcare and the University of Utah mentioned earlier, doing so should lead to improved accountability and engagement, as well as help the organization integrate strategic and IT objectives that would serve as a powerful catalyst to all efforts aimed at improving financial and operational outcomes (Kayyali, Kelly, & Pawar, 2016).

These accomplishments are admirable, and it is unlikely that they would have occurred without significant changes in how people are engaged when carrying out their day-to-day processes (Rock & Schwartz, 2007). Performance improvement outcomes are often achieved via efforts to empower and engage staff. North Shore University Hospital made remarkable strides in quality improvement, patient experience, and overall care delivery. The cornerstone of these gains was attributed to their focus on staff engagement (Scanlon & Woolforde, 2016). Similar approaches, such as those seen in the Magnet® Model, which promotes the importance of shared governance, and the American Nurses Credentialing Center's healthy work environment,

effective decision-making tenets have resulted in improved staff satisfaction, increased retention rates, and better patient outcomes (Bieber & Joachim, 2016). Engaged employees correlate to highly satisfied customers (Andrew & Sofian, 2012). Organizations like Zappos, Whole Foods, and Costco are widely known for their focus on developing a highly engaged staff, and that focus has led to exceptional achievement for these organizations, which have become luminaries in their respective industries (Thompson, Lemmon, & Walter, 2015). Thus, the focus on employee engagement is due to the demonstrated outcomes resulting from that focus enjoyed by many high-performing organizations.

The design of the EPM was the instrument used to get the target group more engaged. An enterprise approach to performance management is directly linked to improving engagement due to the EPM's ability to incorporate an organization's vision into a single program that summarizes the organization's performance in regards to its most important strategic goals. This tangible alignment of vision and strategic goals provides the foundation for aligning and engaging the people within an organization. These aligned and engaged people form the foundation of any value the organization plans to receive (HFMA, 2011d).

Accounting for costs and benefits in the planning. The technology associated with developing the EPM would, by far, account for the majority of any expense associated with the project. Adapting to the changing health care landscape more likely meant it was a matter of when and not if such an expense would occur, either with this project or a future one. While feeling the pressure from a combination of forces, health care organizations are discovering that succeeding in a value-based system means developing the ability to “collect, aggregate, and analyze clinical, financial, and operational data” (Ryan & Cohen, 2015, p. 6). Making these data

actionable would largely depend on the organization's ability to automate the data collection (HFMA, 2011a).

To pay for the technology that would be used to aggregate and automate performance reports within the EPM, an innovative budget-neutral approach was offered to the IT and senior leadership at the project site (see Appendix G). To get to a budget-neutral approach, several subscriptions to the current reporting tool would be eliminated. Depending on which vendor was selected, using the budgeted approach alone would save at least \$50,000 a year. It is hard to predict what would be gained in savings with the increased accountability, improved efficiencies, and increased staff engagement that literature shows would have accompanied the adoption of the digitized performance measurement system. However, this planning section has adequately demonstrated the potential benefits of implementing EPM.

Implementation

The *enterprise* in enterprise performance management systems alludes to the critical need for a systematic and uniform approach to performance management throughout the enterprise or organization (Mehta, 2015). This EPM approach focuses on four key components: performance standards, performance measures, reporting of progress, and quality improvement (Public Health Foundation, 2002). Guidelines for key performance metrics incorporated within the EPM advise that those metrics demonstrate a clear tie to strategy, provide relevant and timely feedback, are influenceable or provide some degree of control, are collected through automated processes requiring little to no manual intervention, and are transparent, as well as clearly defined (El Mola et al., 2004).

The design of the EPM was completed using measures that met the criteria outlined above. These metrics were collaboratively developed by a multidisciplinary workgroup

consisting of directors and VPs (see Appendix A for listing of members and titles). Once the workgroup finalized targets and definitions, the metrics were then approved in phases by senior leadership. The KPIs within the EPM leveraged the balanced scorecard approach, and the defining deliverable of this phase was a system level scorecard that would monitor progress on previously identified strategic aims established at XORG. The system level scorecard consisted of 15 measures providing insight on the organization's core strategic goals (see Appendix I). Internally, the project was referred to as the *KPI project*, and the agreed upon KPIs formed the foundation for goals that, in a later phase, would cascade down through each department all the way to each individual staff member at XORG. The cascading of KPIs in this fashion is a core tenet of the balanced scorecard (Kaplan & Norton, 2007). While these departmental KPIs can be found in Appendix I, the system level scorecard was the first phase of rolling out the KPI project, and the planning and implementation of that phase represents the work captured during this change of practice project. My role throughout this phased approach was to project manage the deliverables corresponding to each phase of the KPI project.

As the multidisciplinary workgroup of directors and VPs began their collaborative discussions around identifying and defining the metrics for the system level scorecard, an additional workgroup, referred to in earlier sections as the COM, was also established. My vision for this group was to receive their feedback on the identified KPIs that would collectively form the EPM. This group functioned as an early warning system, as their positions on the frontlines of service delivery would help ensure the identified performance metrics were sensible. They were also the target group that expected to show improvement in their employee engagement scores as a direct result of their involvement in developing the EPM. Prior to enlisting this group's involvement, they provided responses to a set of questions as part of a pre-assessment.

The pre-assessment questions were divided into two groups, which included (a) questions that assessed their perceptions of XORG's approach to performance management (prior to the KPI project) and (b) questions that assessed their level of engagement. These assessment questions will be discussed in detail in later sections.

Planning the Study of the Intervention

The EPM was developed in two main phases. The first phase was to develop the system level scorecard from which all other performance management metrics would flow. The second phase would then work with each department to develop the departmental metrics that link to the system level scorecard. Those department scorecards would then cascade down to individual performance goals.

The DNP project primarily covers the activities accomplished during the first phase. The timeline for this phase (see Appendix J) was divided into three milestones: (a) the red phase, which represented the majority of the pre-project planning; (b) the yellow phase, which represented most of the collaborative project work; and (c) the green phase, which represented the launch of digitized scorecards that would be used in the EPM. Of note, the activities outlined in the green phase relied upon the purchase of digitized EPM technology, the purchase of which was not approved by the organization. This is discussed in detail in the lessons learned section.

Assessing how effective the implementation of an EPM was on increasing the engagement scores of the target group would be demonstrated by comparing their pre-project assessment scores to their post-project assessment scores. For this group of middle managers, who otherwise had little to no involvement in organizational-wide projects, the expectation was that by involving them in a project with the breadth and depth of the EPM development, they would demonstrate improved internal motivation, which would lead to increased engagement

scores in their post-assessment survey responses (Ryan & Deci, 2000). Of the three areas of engagement addressed by the pre- and post-assessment questions (physical engagement, emotional engagement, and cognitive engagement), it was not possible to predict which area or areas would see improvement, as there was no mention in the literature of how developing an EPM would impact any specific engagement area. However, based on the literature, it was safe to predict that showing employees (via the use of the aforementioned scorecards) how their work impacted progress towards achieving the organization's strategic goals would show an improvement in their overall engagement scores (HFMA, 2011c). The evidence-based approach involving goal setting, monitoring those goals with the developed scorecards, and receiving coaching and feedback based on progress towards those established goals that would provide the anticipated outcomes of improving an employee's self-perception of their work, i.e., their level of engagement (Gruman & Saks, 2011). This formulaic approach was the foundation of the strategy that would lead to the intended improvement of increased engagement scores.

As mentioned in earlier discussion on the VCO, increasing the level of engagement was not the initial focus. As the VCO project was put on hold, so the organization could focus on developing an EPM that would lead to the more advanced analytics envisioned for the VCO, the DNP project focus would also pivot to measuring how developing that EPM would influence the organization. At the onset of this adjustment, the expected impact of implementing an EPM was not yet known. Using the research process outlined in the Review of Evidence section, trends involving performance management and employee engagement were recognized. Subsequent efforts in reviewing the literature would seek to understand this connection and try to harness evidence-based approaches that would exploit the connection and use it as an intended outcome. Fortunately, the workgroup consisting of directors and VPs involved in the initial discussions on

the VCO made a natural fit for tackling the work involved in officially developing the EPM. The only addition needed was finding a group that could demonstrate improved engagement scores as a result of their involvement in developing the EPM.

Using a group of middle managers made the most sense because of their typical lack of involvement in enterprise-wide projects, such as the EPM. Thus, having them work on developing the EPM would represent a significant change from their normal activities, which typically consists of working on projects that only impact their respective departments. This purposefully orchestrated dissonance involving doing work far separated from their typical projects would essentially confirm the effectiveness of the intervention by being a more substantial consideration compared to any other potentially confounding changes in the work environment. This group of middle managers also made good sense because of their predictable schedule. Many of the directors and VPs involved in the official workgroup had frequent travel engagements and competing considerations involving other high-priority organizational needs that would require their attention and frequently pull them away from the EPM workgroup. The COM had a steady and predictable work schedule that provided high assurances of their participation in both the pre- and post-assessment surveys.

Methods of Evaluation

The aim of this project was to show an increase in engagement scores. The workgroup of middle managers, who referred to themselves as the *coalition of the middle* (COM), would comprise the target population used to demonstrate the improved engagement scores. The COM's involvement in the development of the EPM system would be the intervention introduced to this target population that would lead to the improvement of engagement scores.

Evidence of improved engagement would be demonstrated by an increase in overall post-engagement survey scores compared to pre-engagement scores and/or improvement in one of the three focal areas addressed by the survey. Those three focal areas included (a) self-reflection on the employee's intent to stay with the organization, which represents their physical engagement (loyalty and retention); (b) self-assessment of the employee's personal disposition (personal satisfaction, pride in their work, sense of duty to serve the customer base), which represents their emotional engagement; and (c) key contributors impacting the employee's personal disposition (interface with the physical environment, relationship with peers, and superiors, feedback/acknowledgement of quality work, feeling supported), which represents their cognitive engagement. While the improvement of engagement scores via that chosen intervention was a prudent conclusion, no evidence was found that made it possible to predict which area or areas would show improvement by using the chosen intervention.

The assessment questions used in the pre- and post-project surveys consisted of 25 questions divided into two sections (see Appendix K). For each section of the survey, a 5-point Likert-type scale was used where 1 represented *strongly disagree* and 5 represented *strongly agree* with the statement. The first section evaluated perceptions of how effective XORG was in its performance management approach. The second section evaluated employee engagement.

The first section querying attitudes on how effective XORG was with its performance management approach was used to provide anecdotal feedback that would either confirm or refute the perception that there was a need to implement an EPM. The questions from this section were developed using best practices identified during the research of how to effectively implement an EPM. For example, one best practice identified was that organizations should ensure their priorities and strategic objectives are widely disseminated to and clearly understood

by their employees (Reid & Hubbell, 2005). From that came the question, “I have a good understanding of XORG’s priorities and strategic goals.” With this face validity established, reviewing the responses to this section of the questionnaire led to an overwhelming confirmation of significant opportunities to improve the organization’s approach to enterprise performance management.

The second section, which addressed self-reported levels of personal engagement at work, used questions developed by Macey, Schneider, Barbera, and Young (2011a) on employee engagement. This work addressed best practices for developing engagement surveys, outlined the evidence-based approach that was used for the developing the survey questions (Macey et al., 2011a).

For confirmation that the developed questions were indeed well designed, they were compared to a widely used engagement survey, the Q12 developed by Gallup (Harter, Schmidt, Killham, & Asplund, 2012), and found to be very similar. This is significant in that Gallup’s survey tool has been used by approximately 25 million individuals and has demonstrated both reliability and validity in its ability to quantify employee engagement (Harter et al., 2004). The questions from Gallup’s employee engagement survey have also been found to be highly generalizable across industries (Harter et al., 2012).

Additionally, the survey questions for this DNP project that were developed using the employee engagement resource book (Macey, Schneider, Barbera, & Young, 2011) and the survey questions from the Gallup employee engagement survey (Harter et al., 2012) are nearly identical. However, this is a common finding with tools used to survey employee engagement, which often have nearly identical questions, as they are measuring commonly accepted concepts associated with employee engagement (Gruman & Saks, 2011). For example, Gallup’s Q12, the

Utrecht Work Engagement Scale (UWES), and the Job Involvement Survey (JIS) represent some of the most frequently used survey tools assessing employee engagement (Macey et al., 2011a). Many of the questions used in these survey tools are almost identical to one another. The UWES question, "I am enthusiastic about my job," is nearly identical to, "Most days I am enthusiastic about my work," from the JIS (Mackay et al., 2016).

The survey was administered during the first COM group meeting. Prior to going over the background leading up to the identified need for an EPM, COM attendees were given a bubble sheet with 25 responses. Each statement read to COM attendees corresponded to five bubbles representing the 5-point Likert-type scale. Instructions on what each bubble represented was at the top of the response sheet informing respondents that for each question, they were to use the following scale; 1 = strongly disagree, 2 = disagree, 3 = neither agree or disagree, 4 = agree, and 5 = strongly agree. Upon receiving the bubble sheets, which were exclusively for their responses, the respondents were instructed that they would see the question on the PowerPoint slide in front of them and it would be read once, repeated once, and then we would move on to the next question. This approach for relaying the questions to the group was done to ensure that respondents did not spend too much time evaluating each question and would instead provide a response more aligned to their initial instincts related to each question.

Project SWOT Analysis

The commonly used tool for assessing strengths, weaknesses, opportunities, and threats (SWOT) analysis was used at the conclusion of the project. The main strength associated with the project was its attempt to address a widely recognized need and doing so in an iterative fashion, reducing the chances that it would be overwhelming to the staff at XORG. This iterative approach would eventually lead to the advanced analytics on performance needed to keep pace

with market trends. The development of the EPM, which was synonymous with what was called the KPI project at the project site, also addressed a customer demand for performance data.

The key weakness of the project was failing to recognize the significant impact that the organization's culture could have on efficiently progressing through the project's milestones. Because the project was launched by XORG's CEO, there was a general assumption that this alone would be enough to ensure smooth transitions through the organization's multiple bureaucratic and restrictive project approval processes. The underestimation of the XORG's culture was so impactful, this one point comprises the majority of the lessons learned discussed later.

The most prominent opportunities resulting from the project involve seizing the momentum created first by discussions involving the VCO and then by this EPM project. There is little doubt that there was a definitive need to address the organization's approach to identifying, measuring, and reporting performance data. Now that these conversations and efforts are earnestly underway, it will be vital to XORG's ability to respond to market trends to seize the momentum created and continue to focus on these efforts as an organization.

Likewise, one of the biggest threats to successfully attaining the goals outlined by strategic initiatives is employee disengagement. The complicated data gathering approaches and significant changes to existing workflows can easily lead to a reversion back to the ingrained practices the employees were familiar with prior to the significant efforts expended during this project. Significant progress was made towards breaking down the silos that existed prior to this project, and disengagement most probably would lead to returning to the old habits that created them in the first place. To see a list of identified threats and the mitigation strategies identified during the project planning phase, see Appendix M.

Finally, as will be discussed in later sections, progress towards showing a demonstrable return on investment stalled when requests for the supporting technology that would aggregate, automate, and calculate the identified metrics was denied. The supporting technology was critical to providing on-demand access to the scorecards displaying the identified performance metrics. The purchase of the technology would be funded by concurrently reducing the number of descriptions XORG maintained for its current reporting tool. The reduction in these subscriptions would have had little impact on the people holding them, as there was less than 10% rate of subscribers who logged in at least once a week. Those subscribers would have had access to the new EPM tool, which would have provided access to the same metrics, but would have done so at yearly savings of \$50,000 for the organization. Not approving the technology piece of the project meant there was no alternative technology to offer subscribers of the current reporting tool, therefore, those subscriptions would not be eliminated, resulting in XORG failing to capitalize on the projected return on investment.

Analysis

Once the COM completed their post-project survey assessments, their responses were collected and entered into a Microsoft Excel spreadsheet, which served as the pre- and post-project response log. The first column of each response log recorded the number of respondents returning their responses. The top row was dedicated to each question, with the intersections of each row and column representing each respondent's Likert-type scale response to that question (see Appendix N for pre- and post-project responses).

Attendance at the COM's meetings fluctuated between 10 and 17 people during the project duration. The names of the 12 attendees who attended the first meeting, where the pre-project assessment was conducted, were recorded (not on their response sheets) to ensure that the

same members would be present and submit responses during the post-project assessment. The same 12 attendees were indeed present and submitted their responses during the post-project assessment. There were an additional four COM members who attended the post-project assessment. These additional four members were allowed to complete the assessment; however, their responses were not logged or included in the evaluation of data related to this project.

The use of Microsoft Excel to log the responses allowed for quick evaluation of the central tendency of the data set. Using the VPN provided by the University of San Francisco, these response logs were uploaded into SPSS, IBM's well-known software used for statistical analysis. This allowed for a more robust view of the mean, median, and mode (see Appendix O). Uploading the frequency data in SPSS, along with the intuitive data views provided by Microsoft Excel, would be used in combination to make it much easier to identify any changes in composite scores. This combination provided an at-a-glance view of all assessment items and, in particular, was very enlightening when comparing post-engagement composite means to pre-engagement composite means (see Appendix P). Per the Likert-type scale used on the questionnaire, any increase in mean scores would represent an increase in the respondent's level of agreement (1 = strongly disagree, 2 = disagree, 3 = neither agree or disagree, 4 = agree, and 5 = strongly agree). As all assessment items were worded in the positive, an increase in the respondent's level of agreement would signal a positive increase in the level of engagement.

The SPSS software was also leveraged to identify any possible correlations existing among the responses to all 25 assessment items. Using a combination of Spearman's rank correlation coefficient analysis tool in SPSS and the conditional logic offered in Microsoft Excel, any correlation coefficient higher than .6 was highlighted (see Appendix Q). As with the data used to assess attitudes towards the organization's performance management approach, any

correlations identified with this small number of participants were purely anecdotal. These correlations, if any, were intended only for generating conversation or for providing a starting point for conducting future research.

Results

Program Evaluations / Outcomes

Twelve members from the COM participated in the pre- and post-project assessment. The expected outcome from comparing the pre-project assessment scores to the post-project assessment scores was to see a demonstrable increase in engagement scores. Evidence of improved engagement would be demonstrated by an increase in overall post-engagement survey scores compared to pre-engagement scores and/or improvement in one of the three focal areas addressed by the survey (physical, cognitive, or emotional engagement).

Results of Composite Scores

Composite scores associated with the assessment items addressing engagement went from a mean of 59.0 to a mean of 64.8 (Appendix P). This represents a 10% increase in mean composite scores which is consistent with literature asserting that projects expanding the breadth of an employee's typical involvement at work can lead to an enriched experience where the employee feels greater self-efficacy (Parker, 1998). The purposeful enrichment of an employee's experience at work, particularly when it involves contributing to group work that will result in high levels of influence throughout the organization, has been shown to successfully improve the engagement scores of those involved (Bonner, 2015; Mackay et al., 2016; Parker, 1998; Ryan & Deci, 2000).

Impact on any specific area(s) of engagement (physical, cognitive, and/or emotional engagement). Of the questions assessing the respondent's level of engagement, there were five assessment items that showed a moderate increase in mean scores (see highlighted assessment items in Appendix P):

1. I can see myself working here a year from now.

2. I have what I need to get my work done.
3. I can see myself working here two years from now.
4. I feel like my opinion is valued.
5. I can see myself working here 5 years from now.

The most frequently occurring assessment items showing an increase in mean scores were those related to the respondent's intent to remain at the organization. These retention-related responses show that the area most impacted by the intervention (involvement in the design of an EPM) were those related to physical engagement.

Scarcity of additional results. As the project leader, my communication with the CEO from the onset of the KPI project included updates on progress. Consistently tied to those progress updates, and the very success of the project, was the need to purchase supporting technology that would provide business users with the ability to access these thoughtfully designed scorecards electronically. It was encouraging to have his emphatic agreement on and support for this augmentation to the scorecard development. My responsibilities as the project manager also included the assemblage and submission of the project scope and assessment documents (see Appendix R). These documents were submitted with a high degree of confidence, as they consisted of content leveraged from many of the evidence-based assignments submitted for this DNP practice project.

The requested documents were a required part of the IT project approval process known as Committee One and Committee Two. Committee One was the first step in providing the needed justification for a given IT request. This committee consisted of mid-level leaders at XORG from a variety of departments tasked with delivering judgment on the IT request. If approved, the project request would go to Committee Two, where the project's executive

sponsor project manager would work with leaders from the finance department to find appropriate means in which to fund the request. The documents submitted provided an abundance of substantiating data supporting the need for the requested technology and providing a budget-neutral way for purchasing it.

When the technology failed to gain the approval of Committee One and was subsequently denied, the CEO and executive sponsor of the project were demonstrably upset. Almost immediately, closed-door meetings between the CEO, the executive sponsor of the project, and the VP of Information Technology took place as a result of the denial. The outcome of those discussions led to the immediate formation of a workgroup charged with revamping the IT approval process. This workgroup began meeting in late August, and their internal investigation would lead to the eventual streamlining of this process. Unfortunately, those improvements came after the phase associated with this DNP project had concluded.

Providing insight on this project approval process and subsequent denial of a critical component to this DNP project was done in attempt to justify the lack of additional outcome data. While engagement scores were a measure targeted from the outset of the project, it was envisioned that the supporting EPM technology would also provide additional outcome data. Most prominent would have been the \$50,000 per year savings XORG would have enjoyed had the supporting technology and funding approach been approved. Additionally, it is highly likely that this particular technology would have made an immediate impact on XORG's ability to improve efficiency and reduce costs, which is discussed in the following section.

Discussion

Summary

Key success. The most significant outcomes achieved as a result of this change in practice project were the modest increases in mean composite scores related to individual employee engagement. The increased scores indicated that the 12 member workgroup involved in the intervention demonstrated the intended improvement. Given the significant difference in the breadth of the organization-wide EPM project compared to the type of work in which the COM members were usually involved, which was typically confined to intradepartmental projects, it is safe to assume the intervention (involvement in the EPM project) was the key contributor to the improved engagement scores. This expansion in the level of scope and impact of an employee's usual type of work, potentially leading to greater self-efficacy, confidence, and improved engagement (Bonner, 2015; Mackay et al., 2016; Parker, 1998; Ryan & Deci, 2000), was also noted prior to beginning the project during the review of literature.

Additional Findings

As mentioned earlier, the definition used for employee engagement contained three key elements: (a) self-reflection on the employee's intent to stay with the organization (loyalty and retention), which represents an employee's physical engagement; (b) self-assessment of the employee's personal disposition (personal satisfaction, pride in their work, sense of duty to serve the customer base), which represents an employee's emotional engagement; and (c) key contributors impacting the employee's personal disposition (interface with the physical environment, relationship with peers, and superiors, feedback/acknowledgement of quality work, feeling supported), which represents their cognitive engagement.

Impact on physical engagement. All three of the questions in the survey assessing the respondent's intent to remain at XORG showed moderate improvements in their mean scores. The mean score for whether a respondent could see themselves at XORG a year from now, two years from now and five years saw a 13% (4.0 to 4.5), two years from now saw a 24% increase (3.64 to 4.5), and five years from now saw a 29% increase (3.09 to 4.0). The increase in mean responses to these three questions in particular suggest the intervention of involving people in higher-level, organizational-wide projects they otherwise may not have been involved in can be an effective way to increase their levels of physical engagement. This finding is consistent with literature asserting that improvements in employee engagement has the potential to significantly affect an employee's loyalty and retention (physical engagement) (Andrew & Sofian, 2012; Harter et al., 2004; Mackay et al., 2016; Mann & Darby, 2014; Oliveira & Silva, 2015).

Impact on cognitive engagement. The one question showing an improvement in the area of cognitive engagement addressed the respondent's sense of having what they needed at work. While there was a modest 23% improvement in mean scores associated with this assessment item, it was a curious finding when compared to the mean scores of the assessment items addressing whether the respondent had the data they needed, nearly all of which showed a decrease in their mean scores. There is some evidence to suggest that despite the respondent's ability to recognize gaps in access to quality data to assist them in their jobs, the involvement in projects with the depth and breadth of the KPI project could still lead to improved engagement scores (Andrew & Sofian, 2012).

Impact on emotional engagement. The last item addressed by this project's working definition of engagement, emotional engagement, showed little movement in mean composite scores. When compared to the anecdotal assessment items addressing XORG's effectiveness

with performance management, this could actually be a positive finding. A significant setback occurred during this project when the supporting technology that would display the scorecards, which the project spent six months developing, was denied. As the project leader, it was impossible for me not to show my disappointment, as this technology was the cornerstone to using the scorecards that were so carefully developed.

Lessons Learned

The most important lesson learned, by far, was never to underestimate the impact of culture on a project's success. Before discussing this pivotal point further, it is first important to address one of the project's greatest strengths, which was the systematic, evidence-based approach used during the development of the EPM. When organizations seek to improve existing capabilities, they typically focus on three areas: (a) people, (b) processes, and (c) technology. The biggest contributor to the successful development of the EPM was leveraging the operating model commonly referred to as people, processes, and technology. This operating model provided the foundation for instilling a systematic approach to accounting for the people and skills, necessary updates to processes, and technology needs associated with the EPM design. As important as this operating model was to contributing to the project's success, it was missing the consideration of culture, leading to a valuable lesson learned. This omission was discovered during the post-project assessment, which incorporated the review of additional evidence to help explain the phenomena encountered. It is discussed more in depth as it relates to other evidence in the section below.

Relation to Other Evidence

Organizational Culture

The most significant link to other evidence was unfortunately discovered during the post-project assessment of lessons learned. Developing a deeper appreciation that interactions occurring in any health care organization are constrained by context (Sales, Smith, Curran, & Kochevar, 2006) was a lesson learned through experience versus accounted for in the planning stage. An organization known to be entrenched in its approaches, slow to change, and reticent to conclusively address data quality issues should not have been expected to instantly embrace enterprise projects meant to improve core business processes, no matter how academically sound. Playing into the overconfidence that acceptance was imminent was the combination that the KPI project (as it was internally referred to) was not only launched by the CEO but had large organizational support. This support was predominantly based in the middle and service line levels of the organization. While a prominent piece comprising the organization's culture, there were key senior leaders not yet on board.

While the operating model of people, processes, and technology provided a sound planning and implementation framework, it failed to account for what was later experienced, that is, culture enhances or prohibits the effective utilization of the people, processes, and technology approaches (Buttles-Valdez, Svolou, & Valdez, 2006). Without a deep appreciation for the organization's culture, project leaders risk losing a valuable piece of context. An organization's culture is where activities aimed at improving organizational capabilities gain context (Buttles-Valdez et al., 2006). Making sure the people needed to support data analytics and technology had the necessary skills to do so (Ramos Hegwer, 2015) was key in addressing the people perspective in the people, processes, and technology framework. The key consideration of ensuring that the EPM maintained a systematic tie to organizational strategy would help to ensure the project's success from a process standpoint (Sales et al., 2006). Thoughtfully developed and

collaboratively vetted business requirements for evaluating potential data vendors was core to a sound technology approach. While the above three considerations significantly contributed to a sound approach, they failed to address what the cognitive sciences have repeatedly shown – successful business initiatives are not possible without addressing the day-to-day behaviors of people within the organization (Rock & Schwartz, 2007).

At the foundation of understanding an organization's culture is the understanding of how culture is affected by patterns. Hard-wired patterns are resistant to change. It requires significantly less energy to function in routine operating patterns than what is needed to adapt to new patterns (Rock & Schwartz, 2007). The move away from routine patterns is a significant stressor, making it relatively common for people to resist change (Waldman, Balthazard, & Peterson, 2011). According to the Carnegie Mellon report on the holistic quadripartite framework, which incorporates people, processes, technology and culture, organizational culture is “the environment in which process, technology, and people interact” (Buttles-Valdez et al., 2006, p. 9). Impacting culture requires changing behavior. Changing behavior requires attention density, the act of focusing attention over an extended period of time (Waldman et al., 2011). This was the key consideration missing in terms of cultural considerations. It is not the backing of a CEO that will change behavior (though it might in the short term) nor is it any number of sound project documents or presentations given to a somewhat accepting audience. It is the time and attention given to the focal efforts that are geared toward changing behavior that is most responsible for the changed behavior (Rock & Schwartz, 2007). This was a significant omission. As pictured in Appendix S, whenever there is a failure to truly appreciate organizational culture, prepare for barriers to change.

The KPIs used in the EPM. As health care puts more emphasis on value, organizations are realizing that a key principal to impacting the most impactful outcomes, such as cost of care, is in shifting the primary focus of care delivery from the acute care setting to the outpatient setting (HFMA, 2011c). The system level scorecard established during this phase of the EPM development consists primarily of lagging measures (see Appendix I), none of which are reflective of this shift to a value mindset. This is by design, as the simplicity of this initial design of the system level scorecard seized upon the Kotter principles in gaining momentum through small wins. Most of the metrics on the system level scorecard were comprised of data that XORG already had access to and/or was data already familiar to XORG. This was meant to allow the establishment of the electronic scorecards related to these data elements a relatively simple task. As you look further at the other scorecards included that cascade beyond the system level scorecard, you see the beginnings of a more robust approach to data analytics and data more reflective of assessing value add. This iterative approach to a gradual escalation to more robust analytics is also in line with the behavioral health industry as a whole, which is lagging in its adoption of the more advance analytics seen in acute care facilities, most likely due to their use of electronic medical records (Essock et al., 2015).

What could have been. Enterprise-wide approaches to data management are the first steps needed to reduce the cost of service delivery (Ramos Hegwer, 2015). Decision makers are losing interest in process metrics and are looking for true outcomes (HFMA, 2012). During the discovery phase, which was used to evaluate potential vendors, two vendors were identified as finalists per their demonstrated ability to deliver value and meet the requirements outlined in Appendix R. A Forrester report featuring one of the finalists reported benefits based on customer interviews, where one company increased revenue by \$2.1 million, another decreased \$2 million

in expenses due to improved efficiencies, and yet another estimated a \$4.9 million savings due to improved productivity (Forrester, 2016). The report used interviews with four existing customers using the vendor finalist's technology. The composite net present value calculated from the organizational analysis amounted to more than \$5.5 million in savings from benefits received versus costs incurred (Forrester, 2016).

While there was no expectation to immediately see benefits such as those mentioned in the Forrester (2016) report, the project team was prepared to track and capture any benefits obtained once the technology was in place. Enterprise performance management platforms achieve their reported benefits in a number of ways. As mentioned in the Forrester report, most commonly reported benefits include:

- Leveraging real-time data to optimize efforts aimed at increasing revenue,
- Reducing operational costs through self-service and dramatically improved visibility, and
- Improving efficiencies through the use of automation decreasing the time that raw data is converted into actionable intelligence (Forrester, 2016).

This level of demonstrable achievement is only accomplished through extraordinary levels of collaboration leading to the destruction of previously entrenched organizational silos. The most effective approach used in this type of transformation involves bringing together multiple groups within the organization, including clinical teams, IT, sales and marketing, and leadership from other prominent service lines to collaborate on a frequent and ongoing basis (Kayyali et al., 2016). It is this level of collaboration that will be needed as health care organizations are being asked to assume more accountability for financial and clinical outcomes and are actively seeking ways to leverage their data to meet those demands (Ramos Hegwer,

2015). It is this ability to leverage data that has produced the savings reported by the University of Utah Health Care, which reduced costs associated with joint replacements by 32%, total costs by 8%, and discharge delays by 50%, all by leveraging their own data and improving the processes that turned that data into actionable intelligence (Phillips, 2015). Unfortunately, without a deeply ingrained organizational commitment to making the transition to a high-performing, data-driven culture, frequent setbacks will be encountered, no matter how well drafted and expertly-presented the project requests.

Barriers to Implementation / Limitations

The initial project plan associated with the KPI/EPM project evolved over time. As mentioned earlier, this project began with the intent to establish the VCO at XORG. The pivot made to a less extensive data management project is a pivot supported by the literature. The analytics involved in demonstrating value comprise a very complicated task when dealing with the multiple disparate data sources (claims, survey, quality, and financial) of 12 million members – the very definition of big data. When an organization is positioning to take on more advanced analytical processes such as this, it is not advisable to start with big data (Hazelrigs, 2015). While the organization recognized the need to leverage the volumes of data at their disposal, it was felt that the cultural ramifications of moving to a more data-driven organization also necessitated an incremental approach.

Having made a sound adjustment to the overall project and approach, the three most prominent barriers remaining were (a) lack of bandwidth to engage more frequently on the change initiative, (b) lack of confidence in the data required for the EPM, and (c) lack of support for the technology needed to support the EPM. The cultural considerations leading to the

technology needed to support the EPM being disapproved has been covered in the previous section.

Need for a dedicated resource. As the initial program manager and project leader, developing the organization's EPM was an additional duty for me. The responsibilities associated with my primary role within the organization competed for my time while working on the EPM project. The organization had established a new role, the Director of Decision Support, which was the ideal role to take on managing the EPM as a program; however, the director in that role showed little interest in the project. My primary role in managing proposals for the organization, supporting our business development needs, and assisting with the development of business development strategy would prevent me from providing the attention density needed to move the organization from its current siloed state to a more collaborative one. With the ability to dedicate all of my time to establishing the EPM, this area of attention density is where most of my additional bandwidth would have been focused.

Data quality. Senior leaders in the clinical operations and care management departments were often heard commenting on their lack of trust in the data they were provided. For members of my team in the Sales and Marketing Department, requests for the same data element, for example, the number of contracted providers in a given state, that were inadvertently responded to by two different analysts, would often produce two different results for the same data point. This was most likely due to the lack of data governance structure in place at the organization. An effective data governance approach would have enforced strict adherence to data definitions and a checklist approach to the activities involved in data analytics. For XORG, there were no structured approaches or checklists used in analytics. Nor were there widely accepted data definitions in place that provided clear guidance on what specific analysis was being requested.

While these are indeed imposing, potentially fatal omissions in practical approaches for organizations adjusting to a shifting health care landscape, efforts to address XORG's approach to data governance were beginning to occur. A new data governance approach, along with a redesigned enterprise data warehouse, was anticipated to be up and running around the same time of the EPM technology launch.

A potential limitation of note could be the survey questions used to assess employee engagement. While there are many different engagement surveys commercially available that would have eliminated this as a limitation, they were cost-prohibitive to this initial stage of EPM development. Though there was strong support for utilizing a commercially available survey tool assessing employee engagement at a later date, the first real opportunity to seriously consider the financial support needed to do so would not have occurred until the first quarter of 2017 – long after the project's completion. That being said, the survey questions used were developed using an evidence-based approach and, as mentioned in the Review of Evidence section that detailed this approach, wound up being remarkably similar to other validated survey tools.

There were no other major projects occurring during the time of this EPM project in which the COM members were involved. Additionally, given the significant difference in the breadth of the organization-wide EPM project compared to the type of work the COM members were usually involved, which was typically confined to intradepartmental projects, it is safe to assume their involvement in the project was the key contributor leading to their improved engagement scores.

Interpretation

This DNP project was able to meet its intended goal of increasing employee engagement scores for the members of the COM. This change was evidenced by a 10% improvement in their

mean composite post-implementation engagement scores. The intervention introduced to the COM members responsible for the increased engagement score was involving them in the development of key project at XORG, which was the establishment of an EPM system. Post-implementation engagement scores increased despite composite scores assessing impressions of XORG's approach to performance remaining flat and in some cases going down. Assessments of XORG's performance management practices were done only to provide more insight into organizational practices, the results of which were for information only. However, seeing those scores not change or decrease during the project timeframe, with no impact on engagement scores, may allude to significance of involving this group of middle managers in the upper-level strategy discussions that occurred during the EPM development. This level of work, which had far-reaching impact on the organization, provided an enhanced breadth of scope when compared to the type of work COM members typically are involved. Engagement scores improving in this type of setting is consistent with literature positing that purposeful enrichment of an employee's experience at work, particularly when it involves contributing in group work that will result in high levels of influence throughout the organization, has been shown to successfully improve the engagement scores of those involved (Bonner, 2015; Mackay et al., 2016; Parker, 1998; Ryan & Deci, 2000).

Throughout each phase of the EPM project, all parties involved had bought in with excitement to the understanding that XORG would move from manual data aggregation and spreadsheets to automated processes and on-demand access. Going from a push mentality, where senior leaders and department managers would wait for analysts to send them composite data, to a pull mentality, where these same individuals could access that data anytime from anywhere, was a welcome revolution. Denying the technology necessary for this revolutionary change was

a bitter setback. However, it was encouraging to see that despite that, the project was able to achieve its intended purpose. Yet, sustaining or improving upon the increased levels of engagement witnessed during this project will require the eventual implementation of the requested technology. This is due to the supporting EPM technology increasingly becoming more of a necessity for the organization, as it is the tool that will provide the on-demand access needed for data-driven decisions to become the norm at every level of the organization.

Conclusion

The analytics adoption model is a well-established progression organizations hoping to leverage more robust analytical function should move through (see Appendix F). While senior leaders referred to XORG as a data-driven organization, there was no evidence that the organization had made any progression beyond that of the first stage of that model, which is level 0 – fragmented point solutions (Sanders, 2012). Conflicting messages are created when organizations consistently fail to demonstrate the values and attributes they are communicating, both internally and externally. This misalignment creates a functional dissonance at all levels of the organization that, if not addressed, will impact every level of the organization and stifle progress (Buttles-Valdez et al., 2006). With the EPM being key to the organization's future growth and with it having the full support of the CEO led to my false assumption that systemic buy-in was a certainty. It was not.

Despite an obvious setback, the project achieved its intended outcome. A consideration for further improvement is to better understand why engagement scores increased despite the obvious set back. There seems to be a connection to resiliency that could be explored. Are there ways to improve resiliency at an organization level? What cultural elements of an organization

impact resiliency, and how can those be leveraged to improve engagement scores if a bidirectional relationship between resiliency and engagement exists?

While this project was not intended to make an immediate impact on patient care, the improved performance resulting from more efficient data management practices that would have occurred with the digitized EPM eventually would have led to such practices. It would have been interesting to share the improved engagement scores with senior leaders to spur discussions on how those improved scores resulted from team members' participation in work that offered a larger scope than what they usually experienced. Perhaps, that would have led to more efforts aimed at this type of employee engagement. Such efforts could have had an appreciable impact on retention, succession planning, and continued increases in employee engagement scores. Without a dedicated resource to lead such efforts, there is little confidence that this type of sustained focus is possible.

The key take away for me and my future DNP practice is to always approach change with the same reverence for an evidence-based foundation that was displayed in this project. However, that future practice and evidence collection will include an overabundance of organizational cultural considerations. The mantra going forward will be prepare yourself with the evidence needed to support change and then over-prepare for the culture that will be impacted by that change.

Funding

There were no external sources of funding for this change of practice project. All project supplies, supporting materials, handouts, and presentations were done in conjunction with an organization-wide project conducted at XORG. The project plan was heavily dependent upon supporting technology, the purchase of which would have been made possible by eliminating infrequently used software licenses. All other resources were already in place, requiring no additional funds.

References

- American Nurses Association (ANA). (2015). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD.
- American Society for Quality. (n.d.). *Malcolm Baldrige National Quality Award*. Retrieved from <http://asq.org/learn-about-quality/malcolm-baldrige-award/overview/overview.html>
- Andrew, O., & Sofian, S. (2012). Individual factors and work outcomes of employee engagement. *Procedia - Social and Behavioral Sciences*, 40, 498–508. doi:10.1016/j.sbspro.2012.03.222
- Behrouzi, F., Shaharoun, A. M., & Ma'aram, A. (2014). Applications of the balanced scorecard for strategic management and performance measurement in the health sector. *Australian Health Review*, 38(2), 208–217. doi:10.1071/AH13170
- Bento, A., Bento, R., & White, L. F. (2013). Validating cause-and-effect relationships in the balanced scorecard. *Academy of Accounting & Financial Studies Journal*, 17(3), 45–55.
- Bieber, P., & Joachim, H. (2016). Shared governance: A success story. *Nurse Leader*, 14(1), 62–66. doi:10.1016/j.mnl.2015.09.011
- Bijata, M., & Piotrkowski, K. (2014). Enterprise architecture as a tool to support the strategic management processes in an organization. *Hyperion International Journal of Econophysics & New Economy*, 7(1), 177–189. Retrieved from <http://connection.ebscohost.com/c/articles/97769546/enterprise-architecture-as-tool-support-strategic-management-processes-organization>
- Bisbe, J., & Barrubés, J. (2012). The balanced scorecard as a management tool for assessing and monitoring strategy implementation in health care organizations. *Revista Española De Cardiología (English Ed.)*, 65(10), 919–927. doi:10.1016/j.recesp.2012.05.014

- Bonner, L. (2015). A survey of work engagement and psychological capital levels. *British Journal of Nursing*, 25(15), 865–871. doi:10.12968/bjon.2016.25.15.865
- Bourdieu, P. (1977). *Outline of a theory of practice*. Cambridge, New York: Cambridge University Press, 1977.
- Buttles-Valdez, P., Svolou, A., & Valdez, F. (2006). *A holistic approach to process improvement using the People CMM and the CMMI-DEV: Technology process, people, & culture, the holistic approach*. Retrieved from <http://www.sei.cmu.edu/library/assets/Valdez08.pdf>
- Chandler, N., Hostmann, B., Rayner, N., & Herschel, G. (2011). *Gartner's business analytics framework*. Retrieved from http://www.gartner.com/imagesrv/summits/docs/na/business-intelligence/gartners_business_analytics__219420.pdf
- Dearholt, S. L., & Dang, D. (2012). Evidence appraisal: Non-research. *Johns Hopkins Nursing Evidence-Based Practice: Model and Guidelines* (2nd ed., pp. 125–141). Indianapolis, IN: Sigma Theta Tau International.
- El Mola, K. M. G., Parsaei, H. R., Leep, H. R., & Wong, J. P. (2004). Design of an effective manufacturing performance measurement system. *IIE Annual Conference. Proceedings*, 1–6.
- Essock, S. M., Olfson, M., & Hogan, M. F. (2015). Current practices for measuring mental health outcomes in the USA: International overview of routine outcome measures in mental health. *International Review of Psychiatry*, 27(4), 1–10.
doi:10.3109/09540261.2015.1014314
- Forrester. (2016). *The total economic impact of domo*. Retrieved from <https://www.domo.com/learn/forrester-case-study-the-total-economic-impact-of-domo>

Gallup. (2015). *Gallup survey on honesty and ethical standards of people in different fields.*

Retrieved from http://www.gallup.com/file/poll/187892/Honesty_Ethics_15121.pdf

Gruman, J. A., & Saks, A. M. (2011). Performance management and employee engagement. *New Developments in Performance Management*, 21(2), 123–136.

doi:10.1016/j.hrmmr.2010.09.004

Harter, J., Asplund, J., & Fleming, J. (2004). *HumanSigma: A meta-analysis.* Retrieved from

<http://www.gallup.com/businessjournal/101956/HumanSigma-MetaAnalysis-Relationship-Between-Employee-Engag.aspx>

Harter, J., Schmidt, F., Killham, E., & Asplund, J. (2012). *Q12 meta-analysis.* Retrieved from

https://strengths.gallup.com/private/resources/q12meta-analysis_flyer_gen_08%2008_bp.pdf

Hazelrigs, J. (2015). Data rich insight strong. *RISKMATTERS, Spring 2015*, 36–37. Retrieved

from <https://campaign.optum.com/riskmatters/spring-2015/data-rich-insight-poor.html>

Healthcare Financial Management Association. (2011a). *Building value-driving capabilities: Business intelligence* (Healthcare Financial Management Association's Value Project).

Retrieved from <http://www.hfma.org/busint/>

Healthcare Financial Management Association. (2011b). *Building value-driving capabilities:*

Contract and risk management (Healthcare Financial Management Association's Value Project). Retrieved from <http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=5214>

Healthcare Financial Management Association. (2011c). *Building value-driving*

capabilities: Current state and future directions (Healthcare Financial Management Association's Value Project). Retrieved from <https://www.hfma.org/ValueProject/Phase1/>

- Healthcare Financial Management Association. (2011d). *Building value-driving capabilities: People and culture* (Healthcare Financial Management Association's Value Project). Retrieved from <http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=5219>
- Healthcare Financial Management Association. (2011e). *Building value-driving capabilities: Performance improvement* (Healthcare Financial Management Association's Value Project). Retrieved from <http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=5217>
- Healthcare Financial Management Association. (2012). *Defining and delivering value* (Healthcare Financial Management Association's Value Project: Phase 2). Retrieved from <http://www.hfma.org/ValueProject/Phase2/>
- Hughes, M. (2015). Leading changes: Why transformation explanations fail. *Leadership, 12*(4), 449–469. doi:10.1177/1742715015571393
- ITIL. (n.d.). In *Wikipedia online*. Retrieved from <https://en.wikipedia.org/w/index.php?title=ITIL&oldid=743876297>
- John Hopkins Nursing Evidence-Based Practice. Retrieved from http://www.hopkinsmedicine.org/evidence-based-practice/_docs/appendix_f_nonresearch_evidence_appraisal_tool.pdf
- Kahn, W. A. (1990). Psychological conditions of personal engagement and disengagement at work. *The Academy of Management Journal, 33*(4), 692–724.
- Kaplan, R. S., & Norton, D. P. (1992). The balanced scorecard – measures that drive performance. *Harvard Business Review, 70*(1), 71–79. doi:10.2307/256287
- Kaplan, R. S., & Norton, D. P. (2007). Using the balanced scorecard as a strategic management system. *Harvard Business Review, 85*(7/8), 150–161.

Kayyali, B., Kelly, S., & Pawar, M. (2016). *Why digital transformation should be a strategic priority for health insurers*. Retrieved from

<http://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/why-digital-transformation-should-be-a-strategic-priority-for-health-insurers#0>

Kotter, J. P. (1995). Leading change: Why transformation efforts fail. *Harvard Business Review*, 73(2), 59–67.

Kotter, J. P. (1996). *Leading change*. Boston, MA: Harvard Business School Press.

Lebedeva, A. (2015). Five essential project management skills for RM and IG professionals. *Information Management Journal*, 49(5), 28–34.

Lin, E., & Durbin, J. (2008). Adapting the balanced scorecard for mental health and addictions: An inpatient example. *Healthcare Policy = Politiques De Santé*, 3(4), e160–e174.
doi:10.12927/hcpol.2008.19898

Lock, M. (2016). *Putting tax dollars to work with data-driven insight* (No. 11666). Aberdeen Group.

Lorden A, Coustasse A, & Singh KP. (2008). The balanced scorecard framework-a case study of patient and employee satisfaction: what happens when it does not work as planned? *Health Care Management Review*, 33(2), 145–155.

Lupi, S., Verzola, A., Carandina, G., Salani, M., Antonioli, P., & Gregorio, P. (2011). Multidimensional evaluation of performance with experimental application of balanced scorecard: A two year experience. *Cost Effectiveness and Resource Allocation: C/E*, 9(1), 7. doi:10.1186/1478-7547-9-7

Lynam, M., Browne, A., Kirkham, S., & Anderson, J. (2007). Re-thinking the complexities of “culture”: what might we learn from Bourdieu? *Nursing Inquiry*, *14*(1), 23–34.

doi:10.1111/j.1440-1800.2007.00348.x

Macey, W. H., Schneider, B., Barbera, K. M., & Young, S. A. (2011a). Phase 1 of creating and executing an engagement campaign: Diagnostics and the engagement survey. In *Employee engagement: Tools for analysis, practice, and competitive advantage* (pp. 69–88). West Sussex, England: John Wiley & Sons.

Macey, W. H., Schneider, B., Barbera, K. M., & Young, S. A. (2011b). Phase 2 of creating and executing an engagement campaign: Action planning and intervention. In *Employee engagement: Tools for analysis, practice, and competitive advantage* (pp. 89–111). West Sussex, England: John Wiley & Sons.

Mackay, M. M., Allen, J. A., & Landis, R. S. (2016). Investigating the incremental validity of employee engagement in the prediction of employee effectiveness: A meta-analytic path analysis. *Human Resource Management Review*. doi:10.1016/j.hrmmr.2016.03.002

Mann, A., & Darby, R. (2014, August 5). Should managers focus on performance or engagement? *Gallup Business Journal*. Retrieved from <http://www.gallup.com/businessjournal/174197/managers-focus-performance-engagement.aspx>

McDonald, B. (2012). *A review of the use of the balanced scorecard in healthcare*. Retrieved from http://www.bmcdconsulting.com/index_htm_files/Review%20of%20the%20Use%20of%20the%20Balanced%20Scorecard%20in%20Healthcare%20BMcD.pdf

- Mehta, R. (2015). *Enterprise performance management in hospitals: White paper*. Retrieved from <https://www.pwc.in/assets/pdfs/publications/2015/enterprise-performance-management-in-hospitals.pdf>
- Mone, E., Eisinger, C., Guggenheim, K., Price, B., & Stine, C. (2011). Performance management at the wheel: Driving employee engagement in organizations. *Journal of Business and Psychology*, 26(2), 205–212. doi:10.1007/s10869-011-9222-9
- Naranjo-Gil, D. (2009). Strategic performance in hospitals: the use of the balanced scorecard by nurse managers. *Health Care Management Review*, 34(2), 161–170. <https://doi.org/10.1097/HMR.0b013e31819e8fd0>
- Oliveira, L. d., & Silva, F. d (2015). The effects of high performance work systems and leader-member exchange quality on employee engagement: Evidence from a Brazilian non-profit organization. *Procedia Computer Science*, 55, 1023–1030. doi:10.1016/j.procs.2015.07.092
- Parker, S. K. (1998). Enhancing role breadth self-efficacy: The roles of job enrichment and other organizational intervention. *Journal of Applied Psychology*, 83(6), 835–852. doi:10.1037//0021-9010.83.6.835
- Phillips, L. (2015). A value toolkit: How University of Utah Health Care is creating and measuring value. *Strategic Financial Planning*. Retrieved from <https://www.hfma.org/Content.aspx?id=40460&pagesid=1>
- Public Health Foundation. (2002). *From silos to systems: Using performance management to improve the public's health*. Retrieved from <http://www.phf.org/resourcestools/Documents/silossystems.pdf>

- Radnor, Z., & Lovell, B. (2003). Success factors for implementation of the balanced scorecard in a NHS multi-agency setting. *International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services*, 16(2–3), 99–108.
doi:10.1108/09536860310465618
- Ramos Hegwer, L. (2015, November 2). Making good on the promise of big data in health care. *Leadership*. Retrieved from
http://www.hfma.org/Leadership/Archives/2015/Fall/Making_Good_on_the_Promise_of_Big_Data_in_Health_Care/
- Reichert, J., & Furlong, G. (2014). Five key pillars of an analytics center of excellence, which are required to manage populations and transform organizations into the next era of health care. *Nursing Administration Quarterly*, 38(2), 159–165.
<https://doi.org/10.1097/NAQ.0000000000000023>
- Reid, J., & Hubbell, V. (2005, March/April). Creating a performance culture. *Ivey Business Journal*, 69(4), 1–7. Retrieved from <http://iveybusinessjournal.com/publication/creating-a-performance-culture/>
- Rock, D., & Schwartz, J. (2007). The neuroscience of leadership. *Reclaiming Children & Youth*, 16(3), 10–17.
- Rothstein, W. G., & Phuong, L. H. (2007). Ethical attitudes of nurse, physician, and unaffiliated members of institutional review boards. *Journal of Nursing Scholarship*, 39(1), 75–81.
doi:10.1111/j.1547-5069.2007.00147.x
- Ryan, D., & Cohen, A. (2015). Getting to the essentials in evaluating value/risk contracts. *Strategic Financial Planning, Summer*. Retrieved from
<http://www.hfma.org/Content.aspx?id=31150>

- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *The American Psychologist*, *55*(1), 68–78. doi:10.1037//0003-066x.55.1.68
- Sales, A., Smith, J., Curran, G., & Kochevar, L. (2006). Models, strategies, and tools: Theory in implementing evidence-based findings into health care practice. *Journal of General Internal Medicine*, *21*(s2), s43-s49. doi:10.1007/s11606-006-0274-x
- Sanders, D. (2012). *Healthcare analytics adoption model: A framework and roadmap (White Paper)*. Retrieved from <https://www.healthcatalyst.com/white-paper/healthcare-analytics-adoption-model/2/>
- Scanlon, K. A., & Woolforde, L. (2016). Igniting change through an empowered frontline: A unique improvement approach centered on staff engagement, empowerment, and professional development. *Nurse Leader*, *14*(1), 38–46. doi:10.1016/j.mnl.2015.11.007
- Shirey, M. R. (2011). Establishing a sense of urgency for leading transformational change. *The Journal of Nursing Administration*, *41*(4), 145–148.
<https://doi.org/10.1097/NNA.0b013e3182118550>
- Sopow, E. (2006). The impact of culture and climate on change programs. *Strategic Communication Management*, *10*(6), 14–17.
- Spath, P. (2004). *Leading your healthcare organization to excellence: A guide to using the Baldrige criteria*. Chicago, Ill. : Health Administration Press
- Sull, D., Homkes, R., & Sull, C. (2015). Why strategy execution unravels, and what to do about it. *Harvard Business Review*. Retrieved from <https://hbr.org/2015/03/why-strategy-execution-unravelsand-what-to-do-about-it>

- Thomas, K. W. (2009). The four intrinsic rewards that drive employee engagement. *Ivey Business Journal Reprints*. Retrieved from <http://iveybusinessjournal.com/publication/the-four-intrinsic-rewards-that-drive-employee-engagement/>
- Thompson, K. R., Lemmon, G., & Walter, T. J. (2015). Employee engagement and positive psychological capital. *Organizational Dynamics*, 44(3), 185–195.
doi:10.1016/j.orgdyn.2015.05.004
- Valenstein, M., Mitchinson, A., Ronis, D. L., Alexander, J. A., Duffy, S. A., Craig, T. J., & Barry, K. L. (2004). Quality indicators and monitoring of mental health services: what do frontline providers think? *The American Journal of Psychiatry*, 161(1), 146–153.
- Waldman, D. A., Balthazard, P. A., & Peterson, S. J. (2011). Leadership and neuroscience: Can we revolutionize the way that inspirational leaders are identified and developed? *Academy of Management Perspectives*, 25(1), 60–74. doi:10.5465/AMP.2011.59198450
- Webb, J., Schirato, T., & Danaher, G. (2002). *Understanding Bourdieu*. London, GBR: SAGE Publications Ltd. Retrieved from <http://site.ebrary.com/lib/alltitles/docDetail.action?docID=10468633>

Appendices

Appendix A

Initial Project Charter for the Value Creation Office, Statement of Determination, and Letter of Support



**ESTABLISHING THE
VALUE CREATION OFFICE**

PROJECT CHARTER

**DOCTOR OF NURSING PRACTICE
PROJECT SITE**

OCTOBER 1, 2015

Introduction

According to the Healthcare Financial Management Association (HFMA), “of all the transformations reshaping American health care, none is more profound than the shift toward value.” In response to the growing focus on value, there is increasing pressure to effectively demonstrate how we are delivering value to its key stakeholders. Typically, the evidence validating an organization’s value proposition is captured via a well-established and system-wide performance measurement system. As a result of feedback from several contributors on current processes in comparison to evidence-based best practices associated with performance measurement systems, the following opportunities have been identified:

1. Many analytical reports, projects, and outcomes are the result of individual requests. This approach secludes key performance data in silos, illuminating the need for a unified organizational approach to identifying, measuring, and reporting key performance data.
2. Often, the need for data that validates the value of a proposed or provided service springs from unplanned and unpredictable requests. This has highlighted the need for quick, easily accessible metrics associated with the performance of services provided.
3. Organizational approaches appear to be on target in response to industry needs. However, the performance of organizational initiatives is not uniformly measured or widely distributed, presenting an opportunity to improve reliable and transparent organizational performance feedback.
4. Adjustments to current business practices routinely occur absent goal-driven and achievable targets or associated metrics and practices in place to monitor progress. This presents the opportunity for researching and implementing an organizational approach to performance measurement. Such an approach would include a proven framework and the needed structure for regularly instituting organizational initiatives with identifiable targets, associated metrics, and a routine approach to assessing progress.
5. Once in place, the aforementioned performance measurement system must be directly related to the organization’s overall strategy and should stimulate a uniform approach to monitoring and provide the opportunity for responding and improving, as well.

Objective

Establish a uniform approach to identifying, measuring, and reporting value achieved.

Associated Goals

The objective of this project is the implementation and adoption of a uniform approach to performance measurement. Successfully reaching this objective will be evidenced by achieving the following goals:

1. 100% of organizational initiatives will have associated performance targets.
2. 100% of measures tracked by the established performance measurement system will be directly linked to the organization's overall strategy.
3. Employees frequently in need of performance data (sales representatives, account managers, and senior client facing leaders) will report improved satisfaction with the new performance measurement system, as evidenced by pre- and post-implementation surveys utilizing a yet to be determined valid measurement tool.
4. Readily available and effective performance data will have a measurable impact on key performance indices, as evidenced by improvements in win rate, customer satisfaction, and overall revenue.

Authorization

This Charter formally authorizes the planning and implementation of a multidisciplinary group that will meet every other week to discuss an organizational approach to identifying, measuring, and reporting on value achieved by our stakeholders. Collectively, the group will be recognized as the Value Creation Office (VCO). The VCO will act as a collaborative committee assembled to address the need for a structured, organizational-wide approach to efficient distribution of how stakeholders are benefitting from their relationship with our organization. A project plan will be developed and submitted to the Project Sponsor for approval. The project plan will include: scope statement, schedule, cost estimate, targeted resources, communication plan, quality framework, targeted performance perspectives, targeted metrics, and risk identification and mitigation strategy.

Project Scope

Research and identify best practices associated with performance measurement systems instituted in health care delivery. Collaboratively select, customize, and implement a performance measurement system that specifically addresses the opportunities and goals listed above.

Dependencies

- Senior Leadership embracement of a system-wide approach to measuring value achieved
- Established organizational strategies linked to measurable goals
- IT / Analytics endorsement and provision of dedicated resources to respond to a more predictable analytical work stream
- Collaborative contribution that accounts for the multiple perspectives associated with value

Assumptions

- Senior leaders are in support of the proposed solution to the opportunities identified and are willing to become vocal champions of this project.
- Sales representatives, account managers, and customer facing leaders agree with the need for this project and will enthusiastically support and participate in it.
- The VCO will not impact current reporting structures or hold any formal authority.
- Progress towards established goals will be driven by the recognized need for demonstrable proof of value achieved, as this will further the impact and reach.
- Outside of minor adjustments, the majority of technology and human capital needed for successful completion of this project are already in place.

Risks

- Disengagement due to the timeframe necessary for successful implementation
- Inability to limit the number of metrics tracked, overwhelming limited resources
- IT / technical barriers that prevent the acquisition of identified metrics
- Low executive / senior leadership support
- New / unfamiliar project type for the project lead
- Failure to include metrics linked to the organization's overall strategy
- Setting of ambiguous goals

Timeline

Phased Approach

Red Phase Milestones

- Current state assessment
- Research on best practices
- Identification of gaps
- Charter development

Yellow Phase Milestones

- Finalize VCO team
- Establish framework
- Finalization of metrics
- Sponsor and SLT sign-off

Green Phase Milestones

- Subcommittee work
- Collect data on selected metrics
- External / internal distribution
- Annual relationship review

Strategy

- Implementing a phased approach piloting 1-2 metrics at a time
- Leveraging IHI model for improvement
- Targeting implementation of balanced scorecard as framework for tracking metrics
- Application of Bourdieu's Theory of Practice to account for multidisciplinary group and how each member will approach the concept of value differently (see attachment C)

- Application of Kotter's eight critical success factors (Kotter, 1995) as a guideline for providing the best chance of successful adoption of a change in practice (see attachment D)

Resource Roles and Responsibilities

Project Sponsor: Griff Docking SVP, Chief Marketing Officer

Academic Committee Representative: Deb Happ, Ph.D., SVP, Clinical Operations **Project Lead:** Carlton Abner MS, RN-BC

VCO Members (who later became the KPI workgroup)

Robin J.: VP, CAO	Link between financial spend and value produced
Paula M.: Reg. VP, Clinical Operations	Provide insight on the capabilities of our clinical operations and
Adam P.: Director, Clinical Operations	feedback on planned process improvement initiatives
Shelley B.: VP, Quality Improvement	Provide insight on improving clinical outcomes
Sesha M.: VP, IT, Analytics & Claims	Assist with technical barriers associated with reporting value
Bob W.: Corp VP, Account Management	Represent the needs of our current clients and the effectiveness of
Karen P.: VP, Account Management	our responses to those needs
Darryl D.: VP, Network Operations	Offer insight on existing network and plans improvement
Fred G.: VP, Analytics and Reporting	Represents the operational arm of the VCO as most outputs on value
Moises M.: Director, Analytics	will be delivered through reporting and analytics
Dr. Steve S.: Medical Director	Offer provider insight on outcomes and planned responses
Peter H.: Director, Business Dev.	Contribute to delivering VCO outputs to prospective clients
Sarah M.: Dir., Value Based Programs	Provide input on major program initiatives and progress towards
Jeylinne E.: Comm. Resource Analyst	anticipated value associated with those programs
Molly N.: Manager, Marketing	Provide guidance on messaging the value our clients are achieving
Megan C.: Marketing Manager	and help ensure that message is legally defensible
Chris G.: Quantitative Analyst	Assist with gathering data and populating scorecard
Aaron B.: Manager, PMO	Offer insight on planned projects related to the VCO

SPONSOR ACCEPTANCE

Approved by the Project Sponsor:

Griff D.
Senior Vice President & Chief Marketing Officer

Date: _____



DNP Project Approval Form: Statement of Determination

Student Name: Carlton D Abner

Title of Project:

Establishment of the Value Creation Office

Brief Description of Project:

The Value Creation Office (VCO) will help my organization with uniformly applied performance measurement system that utilizes the balanced scorecard to identify, measure and report on the value that our stakeholders (members we cover, providers we contract with and health plans we contract with) have achieved as a result of their relationship with us.

A) Aim Statement:

By January of 2016, the VCO will develop a scorecard that will include 4-5 metrics per performance perspective. The VCO's scorecard will be based on the balanced scorecard framework and will be tied to the organization's overall strategy via its system level scorecard. It will be developed by January, 2016 via a collaborative, multidisciplinary team that will provide input on what metrics will be used. Following its development, the VCO's scorecard will be used for 6 months and an evaluation of its effectiveness will be completed by September of 2016. The VCO's scorecard, will help guide the organization towards a uniform approach to identifying, measuring and reporting on the value our client achieve as a result of their relationship with New Directions.

B) Description of Intervention:

The VCO will be a committee that provides the organization with a more structured approach to measuring value. The approach utilizes a multidisciplinary team which will break down silos used in the current approach to measuring performance. The VCO will not impact current reporting structures and will have no formal authority. Our senior leadership, from the CEO down, has recognized the need for uniform, collaborative approach to meet the increasing demand from our stakeholders to show how our services are making a difference. Our CEO as agreed to sit in on meetings occasionally and offer input. Our account executives, who are responsible for managing the relationships with our key stakeholders, will be the primary customers of the VCO's scorecard and will leverage it in conversations and quarterly meetings with their clients. Each perspective has a co-facilitator who is a VP, senior manager or director of a department closely aligned with that perspective. The VP of finance is the co-facilitator of the financial perspective. The VP of quality is the co-facilitator of the clinical quality and outcomes perspective. The director of clinical value will be cofacilitating the process



perspective and our marketing manager is the co-facilitator of the testimonial/qualitative value perspective. In lieu of formal authority, these cofacilitators will drive work groups that will further develop and respond to metrics within their respective perspectives.

C) How will this intervention change practice?

Our current process for measuring performance is fragmented and, at best, loosely attached to organizational strategy. The VCO will use enterprise-wide strategy to form the foundation of key performance indicators that will populate widely disseminated scorecards. These KPIs will not focus on any individual performance, rather will look at how certain services, processes and workflows are contributing to improved care for the members we support. Examples include how making sure 7 day follow up after an admission is scheduled (a process measure) and how doing well in that process might impact the prevention of 30 day readmissions (a quality/outcome measure) **D) Outcome measurements:**

Specific measurements are as yet to be determined but will include measurements from the financial, process, clinical/quality, and customer perspectives. Measurements for each performance perspective will be vetted by the VCO in an effort to gain their buyin in populating and using the balanced scorecard approach foundational to the VCO.

Clinical performance measures will have the most impact and will include HEDIS 7 day follow up and 30 day readmission rates. Once metrics are determined and the reporting requirements are landed, the VCO will evaluate those clinical metrics and begin to collaborate on ways to improve them.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:

<http://answers.hhs.gov/ohrp/categories/1569>

This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED PRACTICE



CHANGE OF PROJECT CHECKLIST

*

Instructions: Answer YES or NO to each of the following statements:

Project Title:	YES	NO
The aim of the project is to improve the process or delivery of care with established/accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	x	
The specific aim is to improve performance on a specific service or program and is a part of usual care . ALL participants will receive standard of care.	x	
The project is NOT designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does NOT follow a protocol that overrides clinical decision-making.	x	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does NOT develop paradigms or untested methods or new untested standards.	x	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience.	x	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	x	
The project has NO funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	x	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., not a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	x	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: <i>“This project was undertaken as an Evidencebased change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board.”</i>	x	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.



STUDENT NAME (Please print):

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print):

Signature of Supervising Faculty Member (Chair):

DATE 8/3/2015

Dr. Marjorie Barter
DNP Committee Chair
University of San Francisco

Dear Dr. Barter,

The purpose of this letter is to inform you, as the Committee Chair, of our awareness of and support for Carlton Abner's Doctor of Nursing Practice (DNP) doctoral implementation project here at XORG. At this time, we have declined to provide permission to use our organization's name or likeness in any future publications or the DNP Comprehensive Project paper.

If you have any questions, please feel free to contact me directly or relay your questions or comments through Carlton.

Sincerely,

G.D.
Senior Vice President and Chief Marketing Officer

(NOTE: this letter of support was recreated to honor the wishes of the organization to remain anonymous in any publications involving the change of practice DNP project work at the project site. The original document was received, reviewed and approved by the Committee Chair.)

Appendix B

Evidence Table

Articles on the Balanced Scorecard				
Author/year	Design	Sample / Setting	Outcome	Evidence Strength/ Quality
Behrouzi et al., 2014	Review of literature that includes 29 articles published since 2002. Identified 87 articles searching Science Direct, Springer, Emerald, and Scopus; 29 included BSC implementations in the health sector and were included in the review.	29 articles published since 2002 featuring health care delivery organizations utilizing the BSC.	69% of articles in the review used the BSC only as a performance measurement tool (1st Generation) versus 21% used it as a cause and effect tool (2nd generation). 45% of the articles in this review used four perspectives in their BSC, with a range of 3-6. 17% of the articles lacked a customer/patient-based measurement, suggesting a lack of a patient focus. All 29 articles utilized some form of internal business processes in their BSC. 41% of articles exceeded the recommended 5 KPIs per BSC perspective, with a range of 8-49 KPIs.	IV / A
Bento et al., 2013	Non-experimental study utilizing data from a subsample of the performance measurement practices. Survey conducted by the American Institute of Public Accountants (AICPA).	332 firms that reported using the BSC out of the 1,990 business that responded to the AICPA survey.	Validated that the learning and growth, internal and customer perspectives within the BSC have a direct impact on the financial perspective. The interrelatedness of all of the BSC perspectives highlights the importance of understanding the linkages and not delegating different parts of the BSC to separate units within the organization. Effectively implementing BSC will rely heavily on senior leaders understanding that leaders at all levels and within all units, financial or non-financial, directly influence the overall financial performance of the organization.	IV / A
Lorden et al., 2008	Non-experimental / longitudinal embedded case study on the impact of the implementation of the BSC on patient satisfaction and financial outcomes.	150 bed, not-for-profit teaching hospital in Texas.	Inpatient satisfaction scores improved from 79.6 to 82.3 out of 100 but was not statistically significant. Outpatient scores increased from 71 – 89 and were statistically significant. Employee satisfaction showed a statistically significant decrease ($p < .05$). Margin and net revenue also decreased and the facility eventually closed prior to the full implementation of the program.	IV / B
Naranjo-Gill, 2009	Non-experimental survey assessing demographics (age, educational level) and utilization patterns of nurse managers who	281 nurse managers in Spain sent surveys, 114 returned,	Younger nurses were more likely to use the BSC in a collaborative/ interactive manner. Older, more administratively focused nurse managers were more likely to use the BSC in a diagnostic manner. BSC is more successful when	IV / B

	implemented the BSC in their departments.	responses (52%).	used in an interactive manner that stimulates dialogue and agreement among the staff.	
Valenstein et al., 2004	Non-experimental survey evaluating satisfaction with quality indicators by mental health providers.	1,094 randomized mental health providers sent surveys, with 684 returned.	76% reported having great deal of autonomy in treatment decisions. 65% believed in the value of the indicators, but only 38% felt able to influence performance and only 13% were willing to accept incentives coupled with risks.	IV / A
Articles on change management				
Author/year	Design	Sample / Setting	Outcome	Evidence Strength/ Quality
Hughes, 2015	Critical analysis Kotter's Change Model published in an original peer-reviewed research journal on leadership.	Review of 94 publication on change management proceeding and following Kotter's work.	The author concluded through the review of the reference material as well as through his own personal practice, the effectiveness of leveraging Kotter's Change Model in change management.	V / B
Public Health Foundation, 2002	Resource guide.	Developed by consortium of 32 individual experts representing 14 organizations widely recognized in the fields of Performance Management and Public Health.	Clearly articulates the link between a system-wide performance management approach and health care delivery outcomes, particularly in public health.	V / B
Shirey, 2011	Non-experimental / case study on executing organizational change.	No specific setting; author represented as an expert provided knowledge gained through life experience.	Provides successful approaches to facilitating organizational change. Validates using Kotter's 8 step framework.	V / C
Successfully designing and implementing an EPM				
Author/year	Design	Sample / Setting	Outcome	Evidence Strength/ Quality
HFMA, 2011a	Non-experimental survey evaluating the current state and future direction of healthcare.	Developed by the Healthcare Financial Management Association fielded responses from 31 healthcare	Establishes the business case for quantifying and prioritizing expected clinical outcomes. Guides organizations on how to develop a business intelligence strategy focused on converting financial and clinical data into actionable, accessible information.	IV / A

		delivery organizations in the U.S.		
HFMA, 2011b	Non-experimental survey evaluating the people and culture of high-performing organizations.	Developed by the Healthcare Financial Management Association fielded responses from 31 healthcare delivery.	Defines process reengineering within the hospital and then across the continuum of care. Guides on effectively implementing evidence-based best practices for mitigating risk and contracting for clinical care delivery.	IV / A
HFMA, 2011c	Non-experimental survey evaluating the business intelligence involved in healthcare delivery.	Developed by the Healthcare Financial Management Association fielded responses from 31 healthcare delivery.	Defines the meaning of value in health care, provides an overview of the current state of value in the healthcare industry, and maps out future directions for value-oriented providers.	IV / A
HFMA, 2011d	Non-experimental survey evaluating performance improvement best practices.	Developed by the Healthcare Financial Management Association fielded responses from 31 healthcare delivery.	Defines a strategic vision for value and speaks to building multidisciplinary teams focused on achieving value. Also provides guidance on rewarding employees and improving engagement.	IV / A
HFMA, 2011e	Non-experimental survey evaluating performance improvement best practices.	Developed by the Healthcare Financial Management Association fielded responses from 31 healthcare delivery.	Presents effective strategies for converting financial and clinical data into actionable, accessible information to drive decision making Develop businesses cases that prioritize and reliably quantify the impacts of value improvement projects.	
Sull et al., 2015	Non-experimental survey.	Cover story of the Harvard Business Review featuring survey data from 8,000 managers in more than 250 companies about strategy execution.	Successful implementation of corporate strategy relies less on alignment or adhering to plan, and more on coordination across divisions and fostering ability to adapt to varying market conditions. Other cautions include the assumption that communication means comprehension.	V / B
Research on Employee Engagement				

Author/year	Design	Sample / Setting	Outcome	Evidence Strength/ Quality
Kahn, 1990	Non-experimental, qualitative field study.	Observation, documentation, analysis, and in-depth interviews of 31 participants in two different settings.	Defined engaged employees as those who are physically, cognitively and emotionally connected with their work roles.	V, A
Oliveira & Silva, 2015	Non-experimental, multiple regression analysis of 189 survey respondents.	Electronic survey data collected from 669 employees at a large Brazilian nonprofit organization.	High performance work systems (defined as a collection of organizational policies and practices, including enterprise performance management) have a significantly positive effect on employee engagement. Employee engagement is defined as a positive and rewarding psychological work related state, characterized by vigor, dedication, and absorption.	IV, B
Gruman & Saks, 2011	Non-experimental review of research on the development of employee engagement and its link to elements of the performance management process.	Review of 134 journal articles used to develop a model of engagement management that builds on research conducted on performance management.	Enhancing performance may be best achieved by orienting performance management systems to promote employee engagement. One important way to enhance the performance management process is to focus on fostering employee engagement as a driver of increased performance.	IV, A
Mone et al., 2011)	Non-experimental, direct observation and incorporation of other research.	Study conducted at a large corporation and 43 journal articles on performance management and employee engagement.	Certain performance management practices can lead to higher levels of engagement Five major components of performance management are then outlined with actions that can drive engagement in their teams and organizations. The five major components include: 1. Setting performance and development goals 2. Providing ongoing feedback and recognition 3. Managing employee development 4. Conducting mid-year and year-end appraisals 5. Building a climate of trust and empowerment	V, C (poor quality only due to lack of a clear description of the setting in which the direct observation occurred)





Mann & Darby, 2014	Non-experimental survey addressing performance management approaches and employee engagement.	Survey of over 8,000 employees.	High-performing organizations have implemented EPMS that incorporate a focus on improving performance as well as employee engagement.	V, B
--------------------	---	---------------------------------	---	------





Appendix C

Kotter's 8-Step Process

As depicted in the picture to the right, Kotter's has developed an 8-Step Process for leading change. They include; creat a sense of urgency, build a guiding coalition, form a strategic vision and initiatives, enlist a volunteer army, enable action by removing barriers, generate short-term wins, sustain acceleration, institute change. A brief account of each one of these strategies is listed in the table below.



 <p>Step 1 Create a sense of urgency</p>	<p>This is crucial first step. It will provide the background that addresses the need for change and seizes an opportunity as a means for getting people excited about the need for change. The current health care landscape has provided that opportunity as we are in the middle of an appreciable shift to value. In order to continue to compete, we must be prepared to show our key stakeholders (plans we partner with, providers, and members we cover) how we are providing value through the services we deliver.</p>
 <p>Step 2 Build a guiding coalition</p>	<p>As mentioned above, the VCO is made up of a multidisciplinary team in which the initial stages of development will be spent on gaining buy-in on the need for a uniform approach. We'll also use this initial stage to gain buy-in on what is measured based on the group's impression of what is valuable to our key stakeholders.</p>
 <p>Step 3 Form a strategic Vision</p>	<p>Initial meetings have been dedicated to ensuring that there is an agreed upon need for change. Once that was established, the group is collaboratively developing the vision and strategy that will address the need for change.</p>
 <p>Step 4 Enlist a volunteer army</p>	<p>The VCO will have no formal authority. It will operate as a group of volunteers contributing to a collective need.</p>

 <p>Step 5 Enable action by removing barriers</p>	<p>My role as the program manager will be facilitating discussions and removing the identified barriers that we encounter during our march towards acquiring the data we need to demonstrate the value we produce. This will be most important once we have established the metrics that we have agreed upon and work to acquire the data. Anticipated barriers include the need to coordinate reporting requirements with the reporting team; acquiring claims data from our plan partners, including up to 2 years of previous claims data, to help with establishing baselines; and working with plans to make sure they feel safe providing that data.</p>
 <p>Step 6 Generate short-term wins</p>	<p>I have advised the group that we start simple and begin collecting data on our “low hanging fruit” before we move on to more complicated data sets. Examples on data that we can quickly gather and analyze includes cost of care trends that we can pull from claims data and show our behavioral health care costs are bucking trends compared to plans that are not managing their behavioral health populations. More complex analysis that we might pursue as the group matures will include looking at the impact on specific populations. For example, measuring our ability to keep those with severe and persistent mental illnesses out of emergency departments.</p>
 <p>Step 7 Sustain Acceleration</p>	<p>The group has agreed to meet every two weeks to make sure that we continue to keep our momentum and quickly begin to populate our dashboard.</p>
 <p>Step 8 Institute Change</p>	<p>We are in the initial planning stages now, but there is definitely a sense that this group can have a huge impact on our organization.</p>

Appendix D

Bourdieu’s Theory of Field, Habitus, and Capital

Concept	Considerations
Field	<p>Definition: Socially structured space with unique principles that distinguish it from other groups – “sites of cultural practice” (Webb, Schirato, & Danaher, 2002).</p> <ul style="list-style-type: none"> • When groups or individuals are operating within their familiar social fields, i.e., within their “comfort zone,” it requires very little conscious effort to do so. • When change is introduced, individuals and groups will respond to that change based on how they have come to understand the world from their own unique situational perspective. • Having an understanding of the field of the individuals and groups that will have to endure the impending change will help adopt strategies that can increase the likelihood of the actors upon that field, embracing the change (Lynam, Browne, Kirkham, & Anderson, 2007).
Habitus	<p>Definition: Within each field, the individual actors perceive and respond to the social practices of those they are surrounded by – like the cultural and historical expectations one would apply to someone identifying themselves as an artist (Webb, Schirato, & Danaher, 2002).</p> <ul style="list-style-type: none"> • Understanding this concept is crucial in change management • Working with a cross-functional group consisting of multiple vocational backgrounds, one must recognize that the individuals comprising the group are from different fields (Lynam, Browne, Kirkham, & Anderson, 2007) • Adoption and buy-in will require adapting your message to be attractive to people from the vantage point of their particular field.
Capital	<p>Definition: Capital is the resource drawn upon to gain entry and achieve increasing status in a field. In education, cultural capital would include one’s academic degree (Webb, Schirato, & Danaher, 2002).</p> <ul style="list-style-type: none"> • Fields are structured in classes and are somewhat hierarchical. • The vehicle for navigating through the classes is capital. Bourdieu identifies four different forms of capital (Sieger, Fritz, & Them, 2012) <ol style="list-style-type: none"> 1. Economic capital – which is what we are familiar with as money or wealth 2. Social capital – the effort we spend on meeting the social obligations and obligations inherent in maintaining relationships within or respective fields 3. Symbolic capital – which alludes to the pride or esteem we get from our status in the field and the possession of all forms of capital 4. Cultural capital – which involves the educational process and effort spent on gaining the intellectual qualifications necessary for acceptance by members of the selected field.

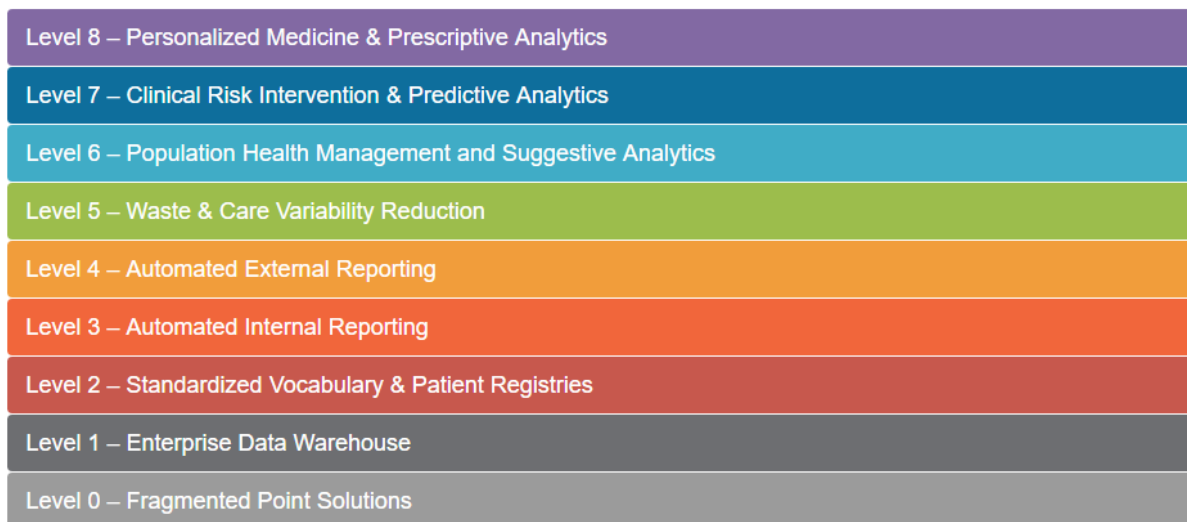
Appendix E

The Nine Provisions of the American Nurses Association's Code of Ethics

- Provision 1:** *The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person*
- Provision 2:** *The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population.*
- Provision 3:** *The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.*
- Provision 4:** *The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care.*
- Provision 5:** *The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.*
- Provision 6:** *The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.*
- Provision 7:** *The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.*
- Provision 8:** *The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.*
- Provision 9:** *The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain integrity of the profession, and integrate principles of social justice into nursing and health policy.*

Appendix F

Analytics Adoption Model



Source: Sanders, D. (2012). Healthcare Analytics Adoption Model White Paper (Analytics in Healthcare). Health Catalyst. Retrieved from <https://www.healthcatalyst.com/white-paper/healthcare-analytics-adoption-model/2/>

Appendix G

IT Project Justification and Costs

Tangible Benefits:

- Provides program owners with real-time performance data
- Automates updating performance data
- Allows business users to dive in to data without any additional support from reporting
- Will function as the one stop shop for performance saving time looking for data in multiple places
- Provides broad visibility of performance data allowing teams, departments and senior leaders opportunity to collaborate
- Helps to get performance data out of silos and enhance collaboration
- Will enhance accountability and help leaders to identify opportunities and work to remove barriers
- Instrumental for managing risk-based contracts
- Will enhance product/program development by providing insights on high-achieving plans where practices can be replicated to improve performance in other plans
- Will provide the technology support needed for move to a more data-driven culture

Total Project Cost =

- Subscription fees for 50 users with pricing from two vendors

Vendor A List Pricing (Domo)			
Item	Count	Yrly subscription rate	Yearly Total
General License Users			
General user license fee	20	\$750.00	\$15,000.00
Super-Users			
Super-User license fee	30	\$1,500.00	\$45,000.00
View-Only Subscription		unlimited/included	\$0.00
		Platform/Implementation fee	\$35,000.00

Total subscription fees for general users, super-user and view only licenses and platform fee:	\$95,000.00
With additional 15% markup for unplanned cost overruns and/or maintenance.	
	\$110,000.00

Vendor B List Pricing			
Item	Count	Yrly subscription rate	Yearly Total
General License Users			
General user license fee	50	\$1,800.00	\$90,000.00
Super-Users			
Super-User license fee	0	N/A	\$0.00
View-Only Subscription	30	\$300.00	\$9,000.00
Total subscription fees for general users, super-user and view only licenses:			\$99,000.00
With additional 15% markup for unplanned cost overruns and/or maintenance.			
With additional 15% markup for unplanned cost overruns and/or maintenance.			\$115,000.00

Measurable Savings

Depending on which vendor is selected, projecting at least a **\$50,000 yearly savings** with the adoption of the digitized performance measurement system and reduction of Tableau licenses.

Off-setting by reducing number of current Tableau users

Current Price of Tableau Subscriptions			
Item	Count	Yrly subscription rate	Yearly Total
General License Users			
Tableau general user license	160	\$800.00	\$128,000.00
Tableau general user license maintenance fee	160	\$77.00	\$12,320.00
Desktop/Super-Users			
Tableau desktop (super-user) license	33	\$1,599.00	\$52,767.00
Tableau desktop (super-user) license maintenance fee	33	\$400.00	\$13,200.00
Number of current Tableau user licenses	193		
Total current Tableau licensing fees:			~ \$206,287.00
Proposed Future State with Reduction of Tableau Subscriptions			
Item	Count	Yrly subscription rate	Yearly Total
General License Users			
Tableau general user license	40	\$800.00	\$32,000.00
Tableau general user license maintenance fee	40	\$77.00	\$3,080.00
Tableau desktop (super-user) license	10	\$1,599.00	\$15,990.00
Tableau desktop (super-user) license maintenance fee	10	\$400.00	\$4,000.00
Number of future Tableau user licenses	50		
Total for future Tableau subscription fees:			\$55,070.00

<u>Net Savings from reduced user licenses:</u>			<u>\$151,217.00</u>
Vendor A List Pricing (Domo)			
Item	Count	Yearly subscription rate	Yearly Total
General License Users			
General user license fee	20	\$750.00	\$15,000.00
Super-Users			
Super-User license fee	30	\$1,500.00	\$45,000.00
View-Only Subscription		unlimited/included	\$0.00
		Platform/Implementation fee	\$35,000.00
Total subscription fees for general users, super-user and view only licenses and platform fee:			\$95,000.00
<u>Future Cost Tableau licensing fees:</u>			<u>\$55,070.00</u>
<u>Combined cost of retained Tableau licenses and Vendor A Licenses</u>			<u>\$150,070.00</u>
<u>Net Savings from current subscriptions fees with Vendor A and retained Tableau subscriptions</u>			<u>\$56,217.00</u>
Vendor B List Pricing			
Item	Count	Yearly subscription rate	Yearly Total
General License Users			
General user license fee	50	\$1,800.00	\$90,000.00

Super-Users			
Super-User license fee	0	N/A	\$0.00
View-Only Subscription	30	\$300.00	\$9,000.00
Total subscription fees for general users, super-user and view only licenses:			\$99,000.00
<u>Future Cost Tableau licensing fees:</u>			\$55,070.00
<u>Combined cost of Tableau and Vendor B Licenses:</u>			<u>\$154,070.00</u>
<u>Net Savings from current subscriptions fees with Vendor B and retained Tableau subscriptions</u>			<u>\$52,217.00</u>

Net Project Cost (1 Year)

Depending on which vendor is selected, projecting at least a **\$50,000 yearly savings** with the adoption of the digitized performance measurement system and reduction of Tableau licenses.

Appendix H

Fusion Database Search Tool

The screenshot displays the Fusion Database Search Tool interface. At the top, a search bar contains the keyword "strategy development" in healthcare. Below the search bar, the search results are listed, including titles like "Health care transformation: from service lines to programs" and "Using vectors to minimize the mystery of IT strategy development".

On the left side, there is a "Refine Results" sidebar. A blue arrow points from the "Refine Results" header to the sidebar. The sidebar is divided into several sections:

- Current Search:** Shows the search terms: "strategy development" in healthcare.
- Expanders:** Includes options like "Apply related words", "Also search within the full text of the articles", and "Apply equivalent subjects".
- Limiters:** Includes filters for "Available in Library Collection", "Published Date: 20010101-20161231", "Source Types", "Geography", "Language", and "Subject".

The "Subject" section is particularly detailed, listing various categories such as "health care industry", "medical care", "nonprofit organizations", "strategic planning", "company personnel managem...", "health care industry -- o...", and "health care industry -- s...". Each filter has a small 'x' icon to indicate it is active.

Appendix I
System Level Scorecard (SLS) and Cascading Department Metrics

System Level Scorecard						
	Financial	Target	Definition	Green	Yellow	Red
1	Budgeted Revenue	\$16,055,206	The income that the organization expects to receive during the indicated budget (quarterly) period	The targeted revenue	Amount between G & R	R = target - 10%
2	Net Margin (year-to-date)	\$11,711,580	Percentage of revenue remaining after all operating expenses in the indicated budget (quarterly) period	The targeted margin	Amount between G & R	Target - 10%
3	Variance from budgeted administrative expenses	(+/-) 3%	The total amount of variance from budgeted administrative expenses (excluding salaries, including travel, printing, consulting, equipment, software, supplies, postage, etc.)	0-3% variance	Amount between G & R	Greater than a 10% variance
	Growth	Target	Definition	Green	Yellow	Red
4	MBH Pipeline	\$25,000,000	Projected amount of sales revenue for target opportunities where 1) the probability of closing the deal is greater than 25% and, 2) Active communications are ongoing with a senior member at the target opportunity (Pipeline Target = forecasted revenue x 4)	The targeted pipeline	Amount between G & R	Target - 25%
5	EAP Pipeline	\$6,400,000	Projected amount of sales revenue for target opportunities where 1) the probability of closing the deal is greater than 25% and, 2) Active communications are ongoing with a senior member at the target opportunity (Pipeline Target = forecasted revenue x 4)	The targeted pipeline	Amount between G & R	Target - 25%
6	MBH Membership target	2.5 M	Membership growth target during surge planning. Current target is 2017 growth target and current qtr. numbers reflect membership associated with pipeline opportunities	The membership targeted	Amount between G & R	Target - 25%
	Organizational Effectiveness	Target	Definition	Green	Yellow	Red
7	Turnover rate	<10%	Percentage of employees in a workforce that leave during a certain period of time	6-10%	Amount between G & R	0-5% or 15% or greater
8	Employee Engagement	TBD	TBD - will either be currently used engagement questions or quarterly survey using Q12)	TBD	TBD	TBD
9	IT Roadmap	On time/On budget indication in reference to key IT Roadmap projects Schedule	Green/On	90% of projects achieve qrtly milestones	Amount between G & R	Less than half of projects achieve qrtly milestones
10	Strategic initiatives	On time/On budget indication in reference to strategic initiatives	Green/On Schedule	90% of projects achieve qrtly milestones	Amount between G & R	Less than half of projects achieve qrtly milestones
	Customer Experience	Target	Definition	Green	Yellow	Red

11	EAP/MBH Member Sat	90%	Response to EAP and MBH quarterly member satisfaction surveys	At or above target	Amount between G & R	80 percent or less
12	MBH Client Satisfaction	90%	Response to quarterly MBH client satisfaction surveys	At or above target	Amount between G & R	80 percent or less
13	EAP Client Satisfaction	90%	Response to quarterly EAP client satisfaction surveys	At or above target	Amount between G & R	80 percent or less
14	Provider Satisfaction	85%	Response to quarterly Provider satisfaction surveys	80-85%	Above 85% or between G & R	80 percent or less
15	Cost of Care	2/2	TBD	95% of plans hitting cost target	Amount between G & R	Less than 80% of plans hitting cost targets
Finance Department KPIs						
	Finance Department KPIs	Target	Definition	Green	Yellow	Red
1	Engagement	TBD	TBD - will either be currently used engagement questions or quarterly survey using Q12)	TBD	TBD	TBD
2	Variance of Finance Dept budgeted & administrative expenses	(+/-) 3%	The total amount of variance from budgeted administrative expenses (excluding salaries, including travel, printing, consulting, equipment, software, supplies, postage, etc.)	0-3% variance	Amount between G & R	Greater than a 10% variance
3	PMPM Administrative costs by plan	For Information Only	(Total direct staffing costs (by role) + general and administrative costs / total membership) / 12.	For information only at this time	Will explore setting target for 2018	N/A
4	Direct Admin expense by department (total) +/- 3%	+/- 3%	The total amount of variance from budgeted administrative expenses (excluding salaries, including travel, printing, consulting, equipment, software, supplies, postage, etc.)	0-3% variance	Amount between G & R	Greater than a 10% variance
5	Cost per FTE	For Information Only	Proportion of costs to FTE on cost center or cost center group level Total Costs (all the associated expenses with an FTE - admin etc.) / Total Number of FTEs	For information only at this time	Will explore setting target for 2018	N/A
6	PGs by plan		95% of total PGs performing at or above target Tracking total number of PGs and identifying PGs that are underperforming	95% of all PGs performing at or above target	Amount between G & R	Any PG greater than \$100,000 at risk, or any time 10% of total PGs are under

						performing
7	Revenue Growth Rate	For Information Only	calculated by comparing the current revenue (from a quarter or other time period) to that of the previous equivalent time period	For information only at this time	Will explore setting target for 2018	N/A
	New Revenue Activity by	Target	Definition	Green	Yellow	Red
	Segment EAP					
8	New Revenue to date (compared to forecast)	Total revenue of all opps.	Target is total revenue compared to forecasted revenue	At or above total same period last year	Amount between G & R	10% less than this time last year
9	New Revenue to date (compared to same time last year)	Total revenue of all opps.	Target is total revenue from same period last year	At or above total same period last year	Amount between G & R	10% less than this time last year
10	Revenue growth to date		Total amount of revenue growth from either rate increase or upsell activity	95% of target	Amount between G & R	90% or less of target
11	From Rate increase	\$250,000	Total amount of revenue growth rate increase	95% of target	Amount between G & R	90% or less of target
12	From Upsell	\$250,000	Total amount of revenue growth from upsell activity	95% of target	Amount between G & R	90% or less of target
13	Forecast accuracy	95% of forecast	Accuracy of sales forecast absolute error = actual-forecast accuracy=1-(absolute error)/max(actual;forecast)	95% of target	Amount between G & R	90% or less of target
	MBH					
14	New Revenue to date (compared to forecast)	\$33,000,000	Total revenue of all opps. Target is total revenue compared to forecasted revenue	At or above new growth initiative	Amount between G & R	10% less than this time last year
15	New Revenue to date (compared to same time last year)		Total revenue of all opps. Target is total revenue from same period last year	At or above total same period last year	Amount between G & R	10% less than this time last year
16	MBH Upsell	\$1,300,000	Total amount of revenue growth from upsell activity	95% of target	Amount between G & R	90% or less of target
17	Sales Forecast accuracy	\$8,403,750	Accuracy of sales forecast absolute error = actual-forecast accuracy=1-(absolute error)/max(actual;forecast)	95% of target	Amount between G & R	90% or less of target
	Organizational Effectiveness					
	Engagement Scores by Department	Target	Definition	Green	Yellow	Red
1	Finance and Project Management	TBD	TBD - will either be currently used engagement questions or quarterly survey using Q12)	TBD	TBD	TBD
2	Claims Admin	TBD	TBD - will either be currently used engagement questions or quarterly survey using Q12)	TBD	TBD	TBD
3	IT, Analytics and Reporting	TBD	TBD - will either be currently used engagement questions or quarterly survey using Q12)	TBD	TBD	TBD

4	and Appeals	TBD	TBD - will either be currently used engagement questions or quarterly survey using Q12)	TBD	TBD	TBD
5	Sales and Marketing	TBD	TBD - will either be currently used engagement questions or quarterly survey using Q12)	TBD	TBD	TBD
6	Clinical Operations	TBD	TBD - will either be currently used engagement questions or quarterly survey using Q12)	TBD	TBD	TBD
	Turnover Rate by Department	Target	Definition	Green	Yellow	Red
7	Finance and Project Management	<10%	Percentage of employees in a workforce that leave during a certain period of time	6-10%	Amount between G & R	0-5% or 15% or greater
8	Claims Admin	<10%	Percentage of employees in a workforce that leave during a certain period of time	6-10%	Amount between G & R	0-5% or 15% or greater
9	IT, Analytics and Reporting	<10%	Percentage of employees in a workforce that leave during a certain period of time	6-10%	Amount between G & R	0-5% or 15% or greater
10	Quality Management, Accreditation and Appeals	<10%	Percentage of employees in a workforce that leave during a certain period of time	6-10%	Amount between G & R	0-5% or 15% or greater
11	Sales and Marketing	<10%	Percentage of employees in a workforce that leave during a certain period of time	6-10%	Amount between G & R	0-5% or 15% or greater
12	Clinical Operations	<10%	Percentage of employees in a workforce that leave during a certain period of time	6-10%	Amount between G & R	0-5% or 15% or greater
Sales and Marketing						
	Operations	Target	Definitions	Green	Yellow	Red
1	Engagement	TBD	TBD - will either be currently used engagement questions or quarterly survey using Q12)			
2	Variance from budgeted administrative expenses	(+/-) 3%	The total amount of variance from budgeted administrative expenses (excluding salaries, including travel, printing, consulting, equipment, software, supplies, postage, etc.)	0-3% variance	Amount between G & R	Greater than a 10% variance
3	Organizational support	90% on schedule	Project managing strategic planning and other projects outside of sales and marketing	90% of projects achieve qrtly milestones	Amount between G & R	Less than half of projects achieve qrtly milestones
4	Participate in a visit with current or prospective client	90% participation	Percentage of staff who have not participated in sales call/visit	90% of staff participation	Amount between G & R	Less than half of staff participating
	EAP Activity	Target	Definitions	Green	Yellow	Red
5	Pending EAP proposals/quotes	309	Number of EAP proposals pending in the tracking period	At or above same time last year	Amount between G & R	10% less than this time last year
6	Opportunities created/opened in last 30 days	14	Opportunities created in the last 30 days.	Target is same time period last year	Amount between G & R	10% less than this time last year
7	Net revenue	\$63,175	Total revenue of all opps. Target is total revenue from same period last year	At or above total same period last year	Amount between G & R	10% less than this time last year

8	Average proposal size	For Information Only	Number of current proposals divided by net revenue	For information only at this time	Will explore setting target for 2018	N/A
9	EAP sales	TBD	Revenue from opportunities marked closed/won	Target for quarter	Amount between G & R	Less than 90% of sales
10	EAP close rate	For Information Only	Proposals marked closed won as a percentage of the total number of proposals closed in the quarter	For information only at this time	Will explore setting target for 2018	N/A
11	EAP pipeline	\$6,400,000	Projected amount of sales revenue for target opportunities where 1) the probability of closing the deal is greater than 25% and, 2) Active communications are ongoing with a senior member at the target opportunity (Pipeline Target = forecasted revenue x 4)	The targeted pipeline	Amount between G & R	Target - 25%
12	EAP forecast 2016	For Information Only	Forecasted sales total broken down by quarter with quarters weighted to represent the amount of sales historically occurring in the given quarter	Target for quarter	Amount between G & R	Less than 90% of sales
	MBH Activity	Target	Definitions	Green	Yellow	Red
13	Active MBH proposals	2	Proposals that are or were being worked on during the quarter	Target	Amount between G & R	50% or less of target
14	MBH activity target	TBD	target vs achieved (2 per Quarter?)	Target	Amount between G & R	50% or less of target
15	MBH pipeline	\$25,000,000	Projected amount of sales revenue for target opportunities where 1) the probability of closing the deal is greater than 25% and, 2) Active communications are ongoing with a senior member at the target opportunity (Pipeline Target = forecasted revenue x 4)	The targeted pipeline	Amount between G & R	Target - 25%
16	MBH forecast 2017	\$8,302,500	Total forecasted 1st year revenue of all pipeline activity expected to close in 2017	Target for quarter	Amount between G & R	Less than 90% of sales
17	MBH forecast 2018	\$76,211,940	Total forecasted 1st year revenue of all pipeline activity expected to close in 2018	Target for quarter	Amount between G & R	Less than 90% of sales
18	MBH Sales	TBD	Revenue from opportunities marked closed/won	Target for quarter	Amount between G & R	Less than 90% of sales
19	MBH close rate	For Information Only	Proposals marked closed won as a percentage of the total number of proposals closed in the quarter	For information only at this time	Will explore setting target for 2018	N/A
	Marketing Activity	Target	Definitions	Green	Yellow	Red
20	Execution of marketing plan	90% on schedule	Measured quarterly, beginning Q3, - Reporting on track R, Y, G	90% of projects achieve qrtly milestones	Amount between G & R	Less than half of projects achieve qrtly milestones
21	Number of website visits (ndbh.com)	For Information Only	associated with development of Phase 2 and 3 of website development (source Google analytics)	For information only at this time	Will explore setting	N/A

					target for 2018	
22	Collateral development (Wave 1)	Wave 1 completed by June 2016	100% on schedule	All documents complete	Amount between G & R	Less than 90% of documents complete
23	Collateral development (Wave 2)	Wave 2 completed in End of Q3	100% on schedule	All documents complete	Amount between G & R	Less than 90% of documents complete
24	Contribution to overall growth	TBD	Place holder to capture in subsequent meetings	TBD	TBD	TBD
25	Impact of co-branded EAP marketing materials	For Information Only	Survey of internal sales execs and Blue Sales reps as well as increase of sales beginning in June. Will use 2016 and 2017 to establish foundation (amount of sales and sales cycle)	For information only at this time	Will explore setting target for 2018	N/A
26	Testimonials	2 per year	Member, provider or plan exec testimonial added to testimonial repository	2 per year	1	0
27	Monthly EAP news letter open rate	For Information Only	Tracking viewership of EAP news letters. Would like to eventually measure the impact on acct retention and upsell (source Constant Contact or Marketing Cloud)	For information only at this time	Will explore setting target for 2018	N/A
	Communications Activity	Target	Definitions	Green	Yellow	Red
	External communications					
28	Survey of internal stakeholders involved in requesting external	90% sat	Satisfaction survey sent twice yearly to department VPs Target and RYG will depend upon the rating system used	90% satisfaction or above	Amount between G & R	Below 80%
	Awards and Recognition					
29	Submit 2 company award	2 per year	2 award submission for company and/or individual recognition to well recognized trade	Submission of 2 packets	1 packet	No packets
	Internal communications					
30	Internal survey satisfaction	90% sat	Satisfaction survey sent twice yearly to staff on our internal communication activities Target and RYG will depend upon the rating system used	90% satisfaction or above	Amount between G & R	Below 80%
31	All-staff employee engagement events	90% sat	Satisfaction survey sent twice yearly to staff on our All-staff events Target and RYG will depend upon the rating system used	90% satisfaction or above	Amount between G & R	Below 80%
	Public Relations					
32	Press releases	For Information Only	Views reported per release compared to target	For information only at this time	Will explore setting target for 2018	
33	News coverage	For Information Only	Placement per pitch	For information only at this time	Will explore setting target for 2018	
	Product Development	Target	Definitions	Green	Yellow	Red
34	Introduction of new products (actual vs planned)	For Information Only	consider adding revenue or cost per sale metric	For information only at this time	Will explore setting	

					target for 2018	
35	Revenues derived from new products	For Information Only	% of revenue or number of sales	For information only at this time	Will explore setting target for 2018	
Clinical Operations						
	UM Measures	Target	Definitions	Green	Yellow	Red
1	Average reviews per day work	18	Average number of cases handled each word day for each case manager	95% or greater of target	Amount between G & R	85% of target or below
2	% of reviews sent to peer review	10%	Incident-based reviews that are conducted using evidence-based guidelines, when available, or practice parameters developed by national medical specialty societies	10-11%	Amount between G & R	15% or higher
3	Concordance rate with IRO	80%	MD Reviewer agreement with the utilization management team member's decision	80% or higher	Amount between G & R	75% or below
4	7-day readmission rate	7%	The rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 7 days after discharge	7-8%	Amount between G & R	15% or higher
5	30-day readmission rate	12%	The rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge	At or below target	Amount between G & R	15
	CM Measures	Target	Definitions	Green	Yellow	Red
	% enrolled from referrals	50%	Voluntary participation in CM program as a result of a referral	TBD	TBD	TBD
	% engaged	30%	Members actively participating in their care plans as evidence by bi-directional feedback during scheduled follow up appointments	TBD	TBD	TBD
	Average daily number of cases	60	Number of cases each case manager is overseeing each work day	TBD	TBD	TBD
	# of cases open > 90 days	TBD	Number of cases in an active status after 90 days	TBD	TBD	TBD
	% engaged members closed with at least on goal met	85%	Members in engaging in their case management plan that complete at least one of the goals identified	TBD	TBD	TBD
	% of cases closed - lost to follow-up	<15%	Number of cases closed due to lack of patient engagement/patient not responding to attempts to follow up	TBD	TBD	TBD
	# of Active Co-CM Cases	For Information	Number of cases involving case managers involved in managing medical conditions as well as behavioral conditions	TBD	TBD	TBD
Account Management						
	All Accounts	Target	Definitions	Green	Yellow	Red
1	Admits / 1000	5.2	Number of total inpatient days per 1000 members (number of admissions divided by number of covered members) X 1000	At or below target	Amount between G & R	6.5 or greater
2	Days / 1000	24	A measure used to evaluate inpatient utilization management performance (Total number of inpatient days divided by the number of covered members) X 1000	At or below target	Amount between G & R	28 or higher

3	Average Length of stay	4.5	A measure used to evaluate inpatient utilization management performance calculated by dividing the sum of inpatient days by the number of patients admissions	At or below target	Amount between G & R	6.0 or greater
4	7-day follow-up appointments scheduled	75%	% of patients with a follow up appointment following discharged scheduled	At or above target	Amount between G & R	65% or less
5	7-day follow-up appointments kept	60%	% of patients with a follow up appointment following discharged kept	At or above target	Amount between G & R	50 percent or less
6	30-day readmission rate	9%	The rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge	At or below target	Amount between G & R	15
7	Per Member per month claims cost		Specifically applies to the costs incurred for each enrolled member each month	At or below target	Amount between G & R	
8	Annual encounter with a PCP	70%	Members engaged in case management or care transitions program will have an encounter with a PCP within 12 months	70% or higher	Amount between G & R	60% or lower
9	Stand Alone ER Visits per K	For Information Only	The utilization of the emergency department (ED) by the adult population (age 18 or older, excluding exchange population) where a behavioral health or substance use diagnosis was the primary reason for visit will be lower than the regional benchmark	For information only at this time	Will explore setting target for 2018	
10	Average speed to answer	20 sec	Average speed to answer member/provider calls in call center	At or below target	Amount between G & R	25 seconds or greater
11	Call center abandonment rate	3%	Percentage of callers who hang up before speaking to representative	At or below target	Amount between G & R	3.5% or greater
12	% of First Call Resolution	For Information Only	Percentage of issues resolved during first contact with call center	For information only at this time	Will explore setting target for 2018	
13	Member Satisfaction Survey	90%	Response to EAP and MBH quarterly member satisfaction surveys	At or above target	Amount between G & R	80 percent or less
14	Provider Satisfaction Survey	85%	Response to quarterly Provider satisfaction surveys	80-85%	Above G & R	80 percent or less
15	Client Satisfaction Survey	90%	Response to quarterly MBH client satisfaction surveys	At or above target	Amount between G & R	80 percent or less
16	Revenue from upsell	\$250,000/yr.	Revenue for upsell of new or existing product	At or above target	Amount between G & R	75 percent or less of target
Alabama		Target	Definitions	Green	Yellow	Red
1	Admits / 1000	5.2	Number of total inpatient days per 1000 members (number of admissions divided by number of covered members) X 1000	At or below target	Amount between G & R	6.5 or greater
2	Days / 1000	24	A measure used to evaluate inpatient utilization management performance	At or below target	Amount between G & R	28 or higher

			(Total number of inpatient days divided by the number of covered members) X 1000			
3	Average Length of stay	4.5	A measure used to evaluate inpatient utilization management performance calculated by dividing the sum of inpatient days by the number of patients admissions	At or below target	Amount between G & R	6.0 or greater
4	7-day follow-up appointments scheduled	75%	% of patients with a follow up appointment following discharged scheduled	At or above target	Amount between G & R	65% or less
5	7-day follow-up appointments kept	60%	% of patients with a follow up appointment following discharged kept	At or above target	Amount between G & R	50 percent or less
6	30-day readmission rate	9%	The rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge	At or below target	Amount between G & R	15
7	Per Member per month claims cost	\$7.52	Specifically applies to the costs incurred for each enrolled member each month	At or below target	Amount between G & R	\$8.27 or more
8	Annual encounter with a PCP	70%	Members engaged in case management or care transitions program will have an encounter with a PCP within 12 months	70% or higher	Amount between G & R	60% or lower
9	Stand Alone ER Visits per K	For Information Only	The utilization of the emergency department (ED) by the adult population (age 18 or older, excluding exchange population) where a behavioral health or substance use diagnosis was the primary reason for visit will be lower than the regional benchmark	For information only at this time	Will explore setting target for 2018	N/A
10	Average speed to answer	20 sec	Average speed to answer member/provider calls in call center	At or below target	Amount between G & R	25 seconds or greater
11	Call center abandonment rate	3%	Percentage of callers who hang up before speaking to representative	At or below target	Amount between G & R	3.5% or greater
12	% of First Call Resolution	For Information Only	Percentage of issues resolved during first contact with call center	For information only at this time	Will explore setting target for 2018	N/A
13	Member Satisfaction Survey	90%	Response to EAP and MBH quarterly member satisfaction surveys	At or above target	Amount between G & R	80 percent or less
14	Provider Satisfaction Survey	85%	Response to quarterly Provider satisfaction surveys	80-85%	Above G & R	80 percent or less
15	Client Satisfaction Survey	90%	Response to quarterly MBH client satisfaction surveys	At or above target	Amount between G & R	80 percent or less
16	Revenue from upsell		Revenue for upsell of new or existing product	At or above target	Amount between G & R	75 percent or less of target
	Arkansas	Target	Definitions	Green	Yellow	Red
1	Admits / 1000	5.2	Number of total inpatient days per 1000 members (number of admissions divided by number of covered members) X 1000	At or below target	Amount between G & R	6.5 or greater

2	Days / 1000	24	A measure used to evaluate inpatient utilization management performance (Total number of inpatient days divided by the number of covered members) X 1000	At or below target	Amount	28 or higher G & R
3	Average Length of stay	4.5	A measure used to evaluate inpatient utilization management performance calculated by dividing the sum of inpatient days by the number of patients admissions	At or below target	Amount	6.0 or greater G & R
4	7-day follow-up appointments scheduled	75%	% of patients with a follow up appointment following discharged scheduled	At or above target	Amount	65% or less G & R
5	7-day follow-up appointments kept	60%	% of patients with a follow up appointment following discharged kept	At or above target	Amount	50 percent or less G & R
6	30-day readmission rate	9%	The rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge	At or below target	Amount	15 between G & R
7	Per Member per month claims cost	TBD	Specifically applies to the costs incurred for each enrolled member each month	At or below target	Amount	TBD between G & R
8	Annual encounter with a PCP	70%	Members engaged in case management or care transitions program will have an encounter with a PCP within 12 months	70% or higher	Amount	60% or between lower G & R

9	Stand Alone ER Visits per K	For Information Only	The utilization of the emergency department (ED) by the adult population (age 18 or older, excluding exchange population) where a behavioral health or substance use diagnosis was the primary reason for visit will be lower than the regional benchmark	For information only at this time	Will explore setting target for 2018	N/A
10	Average speed to answer	30 sec	Average speed to answer member/provider calls in call center	At or below target	Amount	35 seconds or greater G & R
11	Call center abandonment rate	5%	Percentage of callers who hang up before speaking to representative	At or below target	Amount	6% between G & R
12	% of First Call Resolution	For Information Only	Percentage of issues resolved during first contact with call center	For information only at this time	Will explore setting target for 2018	N/A
13	Member Satisfaction Survey	90%	Response to EAP and MBH quarterly member satisfaction surveys	At or above target	Amount	80 percent or less G & R
14	Provider Satisfaction Survey	85%	Response to quarterly Provider satisfaction surveys	80-85%	Above 85% G & R	80 percent or less G & R
15	Client Satisfaction Survey	90%	Response to quarterly MBH client satisfaction surveys	At or above target	Amount	80 percent or less G & R
16	Revenue from upsell	\$250,000/yr.	Revenue for upsell of new or existing product	At or above target	Amount	75 percent or less of target G & R
	Florida	Target	Definitions	Green	Yellow	Red
1	Admits / 1000	5.2	Number of total inpatient days per 1000 members (number of admissions divided by number of covered members) X 1000	At or below target	Amount	6.5 or greater G & R

2	Days / 1000	24	A measure used to evaluate inpatient utilization management performance (Total number of inpatient days divided by the number of covered members) X 1000	At or below target	Amount between G & R	28 or higher
3	Average Length of stay	4.5	A measure used to evaluate inpatient utilization management performance calculated by dividing the sum of inpatient days by the number of patients admissions	At or below target	Amount between G & R	6.0 or greater
4	7-day follow-up appointments scheduled	75%	% of patients with a follow up appointment following discharged scheduled	At or above target	Amount between G & R	65% or less
5	7-day follow-up appointments kept	60%	% of patients with a follow up appointment following discharged kept	At or above target	Amount between G & R	50 percent or less
6	30-day readmission rate	9%	The rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge	At or below target	Amount between G & R	15
7	Per Member per month claims cost	\$6.05	Specifically applies to the costs incurred for each enrolled member each month	At or below target	Amount between G & R	\$6.65
8	Annual encounter with a PCP	70%	Members engaged in case management or care transitions program will have an encounter with a PCP within 12 months	70% or higher	Amount between G & R	60% or lower
9	Stand Alone ER Visits per K	For Information Only	The utilization of the emergency department (ED) by the adult population (age 18 or older, excluding exchange population) where a behavioral health or substance use diagnosis was the primary reason for visit will be lower than the regional benchmark	For information only at this time	Will explore setting target for 2018	N/A
10	Average speed to answer	30 sec	Average speed to answer member/provider calls in call center	At or below target	Amount between G & R	35 seconds or greater
11	Call center abandonment rate	5%	Percentage of callers who hang up before speaking to representative	At or below target	Amount between G & R	6%
12	% of First Call Resolution	For Information Only	Percentage of issues resolved during first contact with call center	For information only at this time	Will explore setting target for 2018	N/A
13	Member Satisfaction Survey	90%	Response to EAP and MBH quarterly member satisfaction surveys	At or above target	Amount between G & R	80 percent or less
14	Provider Satisfaction Survey	85%	Response to quarterly Provider satisfaction surveys	80-85%	Above 85% or between G & R	80 percent or less
15	Client Satisfaction Survey	90%	Response to quarterly MBH client satisfaction surveys	At or above target	Amount between G & R	80 percent or less
16	Revenue from upsell	\$250,000/yr.	Revenue for upsell of new or existing product	At or above target	Amount between G & R	75 percent or less of target
	Kansas City	Target	Definitions	Green	Yellow	Red
1	Admits / 1000	5.2	Number of total inpatient days per 1000 members (number of admissions divided by number of covered members) X 1000	At or below target	Amount between G & R	6.5 or greater

2	Days / 1000	24	A measure used to evaluate inpatient utilization management performance (Total number of inpatient days divided by the number of covered members) X 1000	At or below target	Amount between G & R	28 or higher
3	Average Length of stay	4.5	A measure used to evaluate inpatient utilization management performance calculated by dividing the sum of inpatient days by the number of patients admissions	At or below target	Amount between G & R	6.0 or greater
4	7-day follow-up appointments scheduled	75%	% of patients with a follow up appointment following discharged scheduled	At or above target	Amount between G & R	65% or less
5	7-day follow-up appointments kept	60%	% of patients with a follow up appointment following discharged kept	At or above target	Amount between G & R	50 percent or less
6	30-day readmission rate	9%	The rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge	At or below target	Amount between G & R	15
7	Per Member per month claims cost	\$7.64	Specifically applies to the costs incurred for each enrolled member each month	At or below target	Amount between G & R	\$8.40
8	Annual encounter with a PCP	70%	Members engaged in case management or care transitions program will have an encounter with a PCP within 12 months	70% or higher	Amount between G & R	60% or lower
9	Stand Alone ER Visits per K	For Information Only	The utilization of the emergency department (ED) by the adult population (age 18 or older, excluding exchange population) where a behavioral health or substance use diagnosis was the primary reason for visit will be lower than the regional benchmark	For information only at this time	Will explore setting target for 2018	N/A
10	Average speed to answer	30 sec	Average speed to answer member/provider calls in call center	At or below target	Amount between G & R	35 seconds or greater
11	Call center abandonment rate	5%	Percentage of callers who hang up before speaking to representative	At or below target	Amount between G & R	6%
12	% of First Call Resolution	For Information Only	Percentage of issues resolved during first contact with call center	For information only at this time	Will explore setting target for 2018	N/A
13	Member Satisfaction Survey	90%	Response to EAP and MBH quarterly member satisfaction surveys	At or above target	Amount between G & R	80 percent or less
14	Provider Satisfaction Survey	85%	Response to quarterly Provider satisfaction surveys	80-85%	Above 85% or between G & R	80 percent or less
15	Client Satisfaction Survey	90%	Response to quarterly MBH client satisfaction surveys	At or above target	Amount between G & R	80 percent or less
16	Revenue from upsell	\$250,000/yr.	Revenue for upsell of new or existing product	At or above target	Amount between G & R	75 percent or less of target
	Kansas	Target	Definitions	Green	Yellow	Red
1	Admits / 1000	5.2	Number of total inpatient days per 1000 members (number of admissions divided by number of covered members) X 1000	At or below target	Amount between G & R	6.5 or greater

2	Days / 1000	24	A measure used to evaluate inpatient utilization management performance (Total number of inpatient days divided by the number of covered members) X 1000	At or below target	Amount between G & R	28 or higher
3	Average Length of stay	4.5	A measure used to evaluate inpatient utilization management performance calculated by dividing the sum of inpatient days by the number of patients admissions	At or below target	Amount between G & R	6.0 or greater
4	7-day follow-up appointments scheduled	75%	% of patients with a follow up appointment following discharged scheduled	At or above target	Amount between G & R	65% or less
5	7-day follow-up appointments kept	60%	% of patients with a follow up appointment following discharged kept	At or above target	Amount between G & R	50 percent or less
6	30-day readmission rate	9%	The rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge	At or below target	Amount between G & R	15
7	Per Member per month claims cost	\$5.86	Specifically applies to the costs incurred for each enrolled member each month	At or below target	Amount between G & R	\$6.45
8	Annual encounter with a PCP	70%	Members engaged in case management or care transitions program will have an encounter with a PCP within 12 months	70% or higher	Amount between G & R	60% or lower
9	Stand Alone ER Visits per K	For Information Only	The utilization of the emergency department (ED) by the adult population (age 18 or older, excluding exchange population) where a behavioral health or substance use diagnosis was the primary reason for visit will be lower than the regional benchmark	For information only at this time	Will explore setting target for 2018	N/A
10	Average speed to answer	30 sec	Average speed to answer member/provider calls in call center	At or below target	Amount between G & R	35 seconds or greater
11	Call center abandonment rate	5%	Percentage of callers who hang up before speaking to representative	At or below target	Amount between G & R	6%
12	% of First Call Resolution	For Information Only	Percentage of issues resolved during first contact with call center	For information only at this time	Will explore setting target for 2018	N/A
13	Member Satisfaction Survey	90%	Response to EAP and MBH quarterly member satisfaction surveys	At or above target	Amount between G & R	80 percent or less
14	Provider Satisfaction Survey	85%	Response to quarterly Provider satisfaction surveys	80-85%	Above 85% or between G & R	80 percent or less
15	Client Satisfaction Survey	90%	Response to quarterly MBH client satisfaction surveys	At or above target	Amount between G & R	80 percent or less
16	Revenue from upsell	\$250,000/yr.	Revenue for upsell of new or existing product	At or above target	Amount between G & R	75 percent or less of target
	Louisiana	Target	Definitions	Green	Yellow	Red
1	Admits / 1000	5.2	Number of total inpatient days per 1000 members (number of admissions divided by number of covered members) X 1000	At or below target	Amount between G & R	6.5 or greater

2	Days / 1000	24	A measure used to evaluate inpatient utilization management performance (Total number of inpatient days divided by the number of covered members) X 1000	At or below target	Amount between G & R	28 or higher
3	Average Length of stay	4.5	A measure used to evaluate inpatient utilization management performance calculated by dividing the sum of inpatient days by the number of patients admissions	At or below target	Amount between G & R	6.0 or greater
4	7-day follow-up appointments scheduled	75%	% of patients with a follow up appointment following discharged scheduled	At or above target	Amount between G & R	65% or less
5	7-day follow-up appointments kept	2% increase	% of patients with a follow up appointment following discharged kept	2% increase over 2016	Amount between G & R	No improvement or decrease from 2016
6	30-day readmission rate	10%	The rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge	At or below target	Amount between G & R	15
7	Per Member per month claims cost	\$5.85	Specifically applies to the costs incurred for each enrolled member each month	At or below target	Amount between G & R	\$6.45
8	Annual encounter with a PCP	70%	Members engaged in case management or care transitions program will have an encounter with a PCP within 12 months	70% or higher	Amount between G & R	60% or lower
9	Stand Alone ER Visits per K	2% improvement every 6 months	The utilization of the emergency department (ED) by the adult population (age 18 or older, excluding exchange population) where a behavioral health or substance use diagnosis was the primary reason for visit will be lower than the regional benchmark	2% improvement every 6 months	Amount between G & R	No improvement or decrease from 2016
10	Average speed to answer	30 sec	Average speed to answer member/provider calls in call center	At or below target	Amount between G & R	35 seconds or greater
11	Call center abandonment rate	5%	Percentage of callers who hang up before speaking to representative	At or below target	Amount between G & R	6%

12	% of First Call Resolution	For Information Only	Percentage of issues resolved during first contact with call center	For information only at this time	Will explore setting target for 2018	N/A
13	Member Satisfaction Survey	90%	Response to EAP and MBH quarterly member satisfaction surveys	At or above target	Amount between G & R	80 percent or less
14	Provider Satisfaction Survey	85%	Response to quarterly Provider satisfaction surveys	80-85%	Above 85% or between G & R	80 percent or less
15	Client Satisfaction Survey	90%	Response to quarterly MBH client satisfaction surveys	At or above target	Amount between G & R	80 percent or less
16	Revenue from upsell	\$250,000/yr.	Revenue for upsell of new or existing product	At or above target	Amount between G & R	75 percent or less of target
	Michigan	Target	Definitions	Green	Yellow	Red

1	Admits / 1000	5.2	Number of total inpatient days per 1000 members (number of admissions divided by number of covered members) X 1000	At or below target	Amount between G & R	6.5 or greater
2	Days / 1000	24	A measure used to evaluate inpatient utilization management performance (Total number of inpatient days divided by the number of covered members) X 1000	At or below target	Amount between G & R	28 or higher
3	Average Length of stay	4.5	A measure used to evaluate inpatient utilization management performance calculated by dividing the sum of inpatient days by the number of patients admissions	At or below target	Amount between G & R	6.0 or greater
4	7-day follow-up appointments scheduled	75%	% of patients with a follow up appointment following discharged scheduled	At or above target	Amount between G & R	65% or less
5	7-day follow-up appointments kept	60%	% of patients with a follow up appointment following discharged kept	At or above target	Amount between G & R	50 percent or less
6	30-day readmission rate	9%	The rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge	At or below target	Amount between G & R	15
7	Per Member per month claims cost	\$5.85	Specifically applies to the costs incurred for each enrolled member each month	At or below target	Amount between G & R	\$6.45
8	Annual encounter with a PCP	70%	Members engaged in case management or care transitions program will have an encounter with a PCP within 12 months	70% or higher	Amount between G & R	60% or lower
9	Stand Alone ER Visits per K	For Information Only	The utilization of the emergency department (ED) by the adult population (age 18 or older, excluding exchange population) where a behavioral health or substance use diagnosis was the primary reason for visit will be lower than the regional benchmark	For information only at this time	Will explore setting target for 2018	N/A
10	Average speed to answer	30 sec	Average speed to answer member/provider calls in call center	At or below target	Amount between G & R	35 seconds or greater
11	Call center abandonment rate	5%	Percentage of callers who hang up before speaking to representative	At or below target	Amount between G & R	6%
12	% of First Call Resolution	For Information Only	Percentage of issues resolved during first contact with call center	For information only at this time	Will explore setting target for 2018	N/A
13	Member Satisfaction Survey	90%	Response to EAP and MBH quarterly member satisfaction surveys	At or above target	Amount between G & R	80 percent or less
14	Provider Satisfaction Survey	85%	Response to quarterly Provider satisfaction surveys	80-85%	Above 85% or between G & R	80 percent or less
15	Client Satisfaction Survey	90%	Response to quarterly MBH client satisfaction surveys	At or above target	Amount between G & R	80 percent or less
16	Revenue from upsell	\$250,000/yr.	Revenue for upsell of new or existing product	At or above target	Amount between G & R	75 percent or less of target
	Walmart	Target	Definitions	Green	Yellow	Red

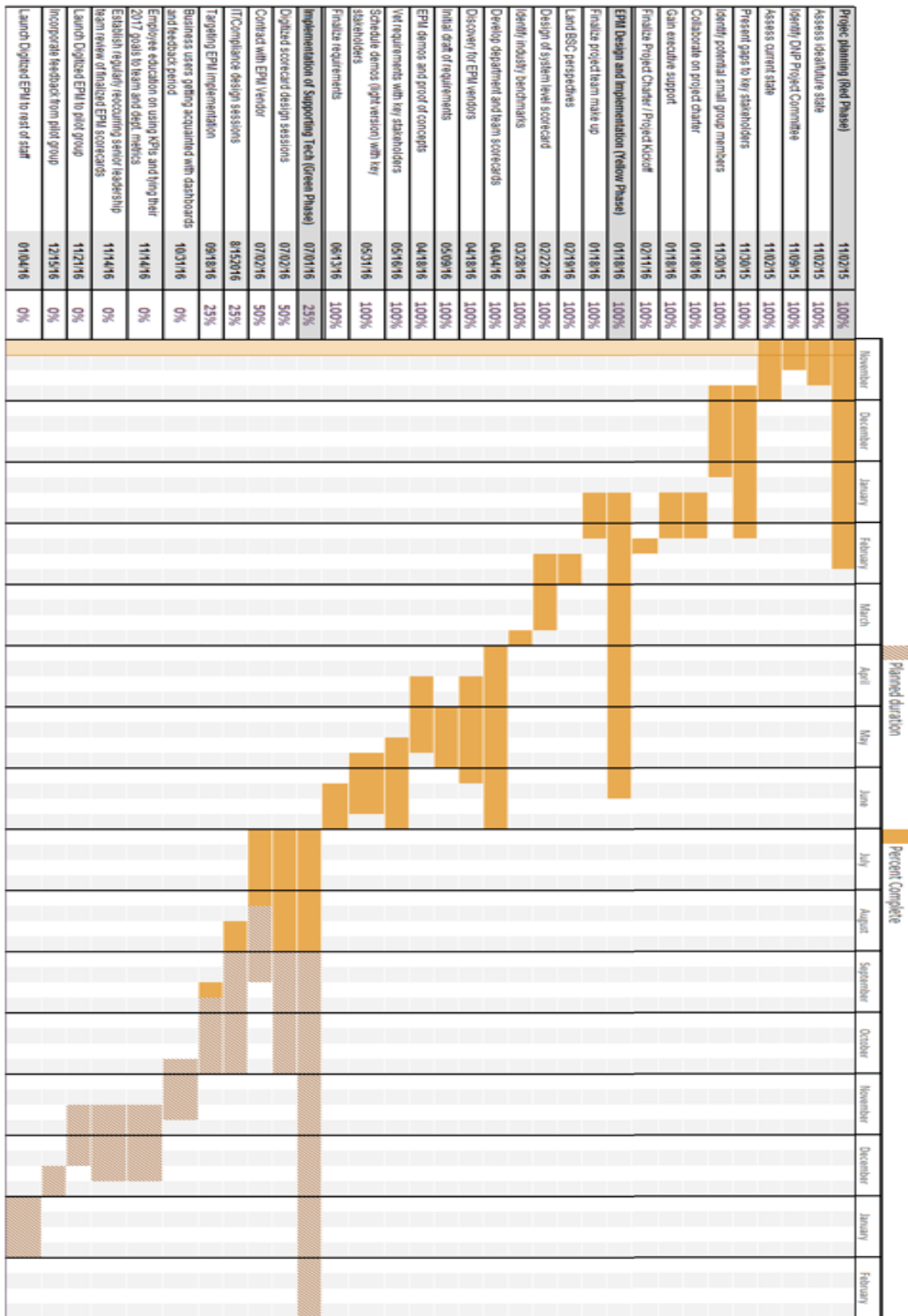
1	Admits / 1000	5.2	Number of total inpatient days per 1000 members (number of admissions divided by number of covered members) X 1000	At or below target	Amount between G & R	6.5 or greater
2	Days / 1000	24	A measure used to evaluate inpatient utilization management performance (Total number of inpatient days divided by the number of covered members) X 1000	At or below target	Amount between G & R	28 or higher
3	Average Length of stay	4.5	A measure used to evaluate inpatient utilization management performance calculated by dividing the sum of inpatient days by the number of patients admissions	At or below target	Amount between G & R	6.0 or greater
4	7-day follow-up appointments scheduled	75%	% of patients with a follow up appointment following discharged scheduled	At or above target	Amount between G & R	65% or less
5	7-day follow-up appointments kept	60%	% of patients with a follow up appointment following discharged kept	At or above target	Amount between G & R	50 percent or less
6	30-day readmission rate	9%	The rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge	At or below target	Amount between G & R	15
7	Per Member per month claims cost	\$5.85	Specifically applies to the costs incurred for each enrolled member each month	At or below target	Amount between G & R	\$6.45
8	Annual encounter with a PCP	70%	Members engaged in case management or care transitions program will have an encounter with a PCP within 12 months	70% or higher	Amount between G & R	60% or lower
9	Stand Alone ER Visits per K	For Information Only	The utilization of the emergency department (ED) by the adult population (age 18 or older, excluding exchange population) where a behavioral health or substance use diagnosis was the primary reason for visit will be lower than the regional benchmark	For information only at this time	Will explore setting target for 2018	N/A
10	Average speed to answer	30 sec	Average speed to answer member/provider calls in call center	At or below target	Amount between G & R	35 seconds or greater
11	Call center abandonment rate	5%	Percentage of callers who hang up before speaking to representative	At or below target	Amount between G & R	6%
12	% of First Call Resolution	For Information Only	Percentage of issues resolved during first contact with call center	For information only at this time	Will explore setting target for 2018	N/A
13	Member Satisfaction Survey	90%	Response to EAP and MBH quarterly member satisfaction surveys	At or above target	Amount between G & R	80 percent or less
14	Provider Satisfaction Survey	85%	Response to quarterly Provider satisfaction surveys	80-85% Above 85% or	Amount between G & R	80 percent or less
15	Client Satisfaction Survey	90%	Response to quarterly MBH client satisfaction surveys	At or above target	Amount between G & R	80 percent or less
16	Revenue from upsell	\$250,000/yr.	Revenue for upsell of new or existing product	At or above target	Amount between G & R	75 percent or less of target

Appendix J

Project Timeline and Gantt Chart

Task Name	Start Date	End Date	% Complete	Duration	Predecessors
Red Phase	11/02/15	02/18/16	100%	79d	
Assess ideal/future state	11/02/15	11/20/15	100%	15d	
Identify DNP Project Committee	11/09/15	11/20/15	100%	10d	
Assess current state	11/02/15	11/27/15	100%	20d	
Present gaps to key stakeholders	11/30/15	02/10/16	100%	53d	4
Identify potential small group members	11/30/15	01/15/16	100%	35d	4
Collaborate on project charter	01/18/16	02/05/16	100%	15d	6
Gain executive support	01/18/16	02/09/16	100%	17d	6
Finalize Project Charter / Project Kickoff	02/11/16	02/18/16	100%	6d	5
Yellow Phase	01/18/16	06/17/16	68%	110d	
Finalize project team make up	01/18/16	02/05/16	100%	15d	
Land BSC perspectives	02/19/16	03/03/16	100%	10d	9
Design of system level scorecard	02/22/16	03/31/16	100%	29d	
Identify industry benchmarks	03/28/16	04/01/16	100%	5d	
Develop department and team scorecards	04/04/16	06/17/16	100%	55d	
Discovery for EPM vendors	04/18/16	05/20/16	100%	25d	
Initial draft of requirements	05/09/16	05/20/16	100%	10d	
EPM demos and proof of concepts	04/18/16	05/06/16	100%	15d	
Vet requirements with key stakeholders	05/16/16	05/27/16	100%	10d	
Schedule demos (light version) with key stakeholders	05/31/16	06/10/16	100%	9d	
Finalize requirements	06/13/16	06/28/16	100%	25d	
Green Phase	07/02/16	02/28/16	25%	202	
Digitized scorecard design sessions	07/02/16	09/02/16	50%	25d	21,22
Contract with EPM Vendor	07/02/16	08/19/16	50%	15d	24
IT/Compliance design sessions	09/05/16	10/14/16	25%	30d	24
Targeting EPM implementation	09/18/16	10/28/16	25%	10d	
Business users getting acquainted with dashboards and feedback period	10/31/16	11/25/16	25%	20d	
Employee education on using KPIs and tying their 2017 goals to team and dept. metrics	11/14/16	12/16/16	0%	25d	
Establish regularly reoccurring senior leadership team review of finalized EPM	11/14/16	12/19/16	0%	26d	
Launch Digitized EPM to pilot group	11/21/16	12/12/16	0%	18d	
Incorporate feedback from pilot group	12/15/16	12/29/16	0%	10d	
Launch Digitized EPM to rest of staff	01/04/16	01/30/16	0%	22d	

Project Gantt Chart



Appendix K

Pre- and Post-Implementation Questions

Section 1 – Attitudes on Performance Management

1. I have a good understanding of XORG's priorities and strategic goals.
2. I feel like there is a uniform approach to identifying and reporting organizational performance here at XORG.
3. Having performance data that provides an indication of how my group, team or department is performing against established objectives is important to me.
4. I find it relatively easy to view data related to how my department is performing and contributing to XORG's strategic goals.
5. I participate in regular discussions within my department, group or team where we review data linked to how we are performing against established objectives.
6. I find it relatively easy to obtain performance data on how my group, team or department is performing against established objectives.
7. I am frequently informed on how my group, team or department is contributing to XORG's strategic goals.
8. Our organization does a good job of establishing quantifiable goals that are clearly linked to XORG's overall strategy.
9. As an organization, we do a good job with establishing dashboards and / scorecards at all levels of the organization that are easily accessible or displayed publicly.

Section 2 – Assessment of individual level of engagement

10. I am satisfied with working at XORG.
11. I can see myself working here a year from now.
12. Expectations here at XORG are clearly communicated and I know what is expected of me.
13. I have what I need to get my work done.
14. XORG provides an environment that allows me to operate at the best of my abilities.
15. I can see myself working here two years from now.
16. Within the last week, I have received praise or recognition for doing good work.
17. I clearly get a sense that my immediate supervisor, manager or leaders within my department care for me on a personal level.
18. I frequently engage with someone here at XORG that encourages my continued professional growth and development.
19. I feel like my opinion is valued.
20. XORG's mission makes me feel like I am contributing to something important.
21. There is an established culture here at XORG of performing at our best and doing quality work.
22. I have close friends here at XORG.

- 23.** I have discussed my future goals, growth and/or progress with someone here at XORG within the last six months.
- 24.** In the last year, I feel like I was provided with opportunities to grow.
- 25.** I can see myself working here 5 years from now.

Appendix L

Project SWOT Analysis

S	Strengths	W	Weakness
	<ul style="list-style-type: none"> ▪ Responsive to widely (internally) recognized need to improve approach to performance management ▪ Responsive to industry trends and customer demand for performance metrics ▪ Project launched and supported by the CEO ▪ Strong support from senior leadership ▪ Strong buy-in from frontline staff ▪ Enthusiastic stakeholder support and desire to contribute ▪ Academic rigor provided by DNP project approach ▪ Clear communication of background and purpose of project which elicited excitement from staff members involved in the work as well as those who were not ▪ Adaptability to frequently changing directives 		<ul style="list-style-type: none"> ▪ Failure to recognize the significance of the organizational culture and its ability to impact project deliverables ▪ Very little research-related (cohort studies, RCTs, evidence summaries) articles as the subject matter did not yield literature of this type ▪ Limited outcome data due to time constraints ▪ Inability to engage key personnel needed for effectively rolling out the KPIs and scorecards ▪ Unable to demonstrate a return on investment
O	Opportunities	T	Threats
	<ul style="list-style-type: none"> ▪ Build upon KPI project to reengage in the work started by the VCO ▪ Leverage momentum from KPI project to address the growing need to use performance data in assessing new market opportunities associated with Medicare and Medicaid contracts ▪ Leverage the project’s momentum for using performance data in performance and quality improvement initiatives ▪ Leverage the elevated awareness for the need for data governance and ensuring data analysts possess the necessary skill needed for higher order analytics ▪ Use momentum to strengthen efforts around instilling a high-performance culture built off the accountability that an EPM provides 		<ul style="list-style-type: none"> ▪ Failure to link metrics to overall org strategy ▪ Diverse range and potential competing focal points of key stakeholders ▪ Disengagement ▪ Measure creep ▪ Lack of resources ▪ Overcoming technical barriers ▪ Conflicting measuring methods ▪ Competitor MBHOs demonstrating more advance analytical capabilities ▪ Increasing internal and external demands for performance data

Appendix M

Threat Matrix and Mitigation Strategies

Threat	Level of Risk	Mitigation Strategy
Disengagement	Moderate	<ul style="list-style-type: none"> ▪ Frequent meeting (q two weeks) to keep momentum ▪ Frequent feedback on progress made to celebrate small wins an incremental successes
Measure creep	Moderate	<ul style="list-style-type: none"> ▪ Identifying 1 – 2 initial measures per perspective and building up ▪ Cascading down from a system level scorecard down to the individual will help ensure that organizational priorities are the focus at each level ▪ Set unambiguous goals that have a clear tie to the organization’s overall strategy
Lack of resources	Severe	<ul style="list-style-type: none"> ▪ Team approach / sub-committee ▪ Finance involved (CAO) in workgroup to get first-hand view of the impact of resources and quality improvement ▪ Strategy that clearly identifies priority areas for allocation ▪ Consider implementing Office of Strategy Management as part of sustainment efforts
Overcoming technical barriers	Severe	<ul style="list-style-type: none"> ▪ IT engagement, onsite visits with partner plans to discuss importance of having access to data ▪ Initial implementation will highlight the need for quality data and its critical association with informed decision making. ▪ Will require some IT investment; will demonstrate need and target priority needs in coordination with CAO
Low exec support	Severe	<ul style="list-style-type: none"> ▪ Communication plan includes frequent updates (at least monthly) updates
Unfamiliar to PL	Mild	<ul style="list-style-type: none"> ▪ Academic rigor provided by DNP project approach ▪ Addition of internal resource (Dr. Happ) to DNP committee
Ambiguous goals	Moderate	<ul style="list-style-type: none"> ▪ Utilize IHI’s Aim approach; establish current state, future state goal and time frame and ensure goal is measurable
Conflicting measuring methods	Moderate	<ul style="list-style-type: none"> ▪ Multidisciplinary approach will agree to what is being measured and how it is being measured ▪ Position KPI project as the organizational focal point for how the organization uniform all efforts related to identifying, measuring and reporting on performance metrics ▪ Consistent use of the same approach and definitions throughout the organization

<p>Failure to disseminate</p>	<p>Moderate</p>	<ul style="list-style-type: none"> ▪ This point is continually reinforced with the senior leaders involved with the KPI project ▪ Once metrics that will be monitored have been established, internal and external-facing collateral to broadcast those metrics and PI projects utilizing those metrics will be developed.
<p>Failure to link metrics to overall org strategy</p>	<p>Severe</p>	<ul style="list-style-type: none"> ▪ Will be priority point of reference when discussing potential KPIs ▪ All potential metrics must demonstrate a tie to the system level BSC and/or the organization’s overall strategy ▪ This will be a checkpoint item with the projects executive sponsor and senior leadership team
<p>Diverse range and potential competing focal points of key stakeholders</p>	<p>Severe</p>	<ul style="list-style-type: none"> ▪ Early involvement of key stakeholders in the development of the BSC ▪ Clear communication of organizational priorities using tools such as one page strategy maps so that key stakeholders have a clear understand of how they can contribute to the overall strategy of the organization ▪ Create subcommittees that focus on themes that align with initiatives and objectives of key stakeholders. These subcommittees can further the impact of responding to key indicators through the formation of small groups capable of rapidly presenting solutions to identified opportunities. ▪ Make BSC performance reports broadly available and easily accessible

Appendix N

Post and Pre-implementation Responses to Questions Assessing Employee Engagement

<p>I am satisfied with working at XORG</p> <p>I can see myself working here a year from now</p> <p>Expectations here are clearly communicated and I know what is expected of me</p> <p>I have what I need to get my work done</p> <p>My working environment allows me to operate at the best of my abilities</p> <p>I can see myself working here two years from now</p> <p>Within the last week, I have received praise or recognition for doing good work</p> <p>I clearly get a sense that my immediate supervisor, manager or leaders within my department care for me on a personal level</p> <p>I frequently engage with someone here that encourages my continued professional growth and development</p> <p>I feel like my opinion is valued</p> <p>Our company's mission makes me feel like I am contributing to something important</p> <p>There is an established culture here of performing at our best and doing quality work</p> <p>I have close friends here</p> <p>I have discussed my future goals, growth and/or progress with someone here at work within the last six months</p> <p>In the last year, I feel like I was provided with opportunities to grow</p> <p>I can see myself working here 5 years from now</p>																	
Post implementation																	
	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Composite
	4	4	4	4	2	4	4	4	4	4	4	3	4	4	4	3	60
	4	5	3	4	4	5	5	5	5	5	3	3	3	5	4	4	67
	5	5	4	5	5	5	4	4	4	4	4	4	4	4	4	5	70
	4	4	5	1	2	4	4	5	5	5	3	1	4	4	4	4	59
	4	4	5	3	3	4	5	5	4	5	5	3	4	5	4	4	67
	5	5	4	4	5	5	5	5	5	5	4	4	5	5	4	5	75
	5	5	3	2	3	5	2	5	3	4	4	4	3	2	3	4	57
	4	4	3	3	4	4	5	5	4	5	3	2	5	5	5	3	64
	4	4	3	4	2	4	5	5	5	4	4	2	4	3	5	4	62
	4	4	4	4	2	4	4	4	4	4	4	3	4	4	4	3	60
	4	5	3	4	4	5	5	5	5	5	3	3	3	5	4	4	67
	5	5	4	5	5	5	4	4	4	4	4	4	4	4	4	5	70
Pre-implementation																	
	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Composite
	5	5	3	2	4	4	4	5	5	5	4	3	2	2	4	3	60
	5	4	4	4	5	4	5	5	4	4	4	4	4	5	4	4	69
	4	4	4	3	2	4	4	4	2	4	5	4	4	4	4	3	59
	4	5	5	2	2	4	4	5	5	4	3	2	4	5	5	4	63
	3	4	3	3	3	4	5	5	5	4	3	3	4	4	5	3	61
	5	5	4	4	4	4	5	5	5	4	4	3	4	5	5	4	70
	2	2	1	1	2	2	4	3	2	1	1	1	3	1	1	2	29
	3	2	3	3	2	2	4	3	2	4	3	2	2	2	2	1	40
	5	5	4	4	2	4	5	5	4	5	4	4	5	4	5	4	69
	3	4	4	3	3	4	5	5	5	4	4	3	4	5	3	3	62
	4	4	4	3	4	4	5	5	5	5	4	3	4	4	5	3	66
	4	4	4	3	2	4	4	5	4	4	4	3	4	4	4	3	60

Appendix O

Comparison of Post and Pre-implementation Frequency Data

Post-implementation Responses to Questions Assessing Level of Engagement

Assessment Item	10	11	12	13	14	15	16
	I am satisfied with working at XORG.	I can see myself working here a year from now.	Expectations here are clearly communicated and I know what is expected of me.	I have what I need to get my work done.	My working environment allows me to operate at the best of my abilities.	I can see myself working here two years from now.	Within the last week, I have received praise or recognition for doing good work.
Valid	12	12	12	12	12	12	12
Missing	0	0	0	0	0	0	0
Mean	4.33	4.50	3.75	3.58	3.42	4.50	4.33
Median	4.00	4.50	4.00	4.00	3.50	4.50	4.50
Mode	4	4 ^a	3 ^a	4	2	4 ^a	5
Std. Deviation	.492	.522	.754	1.165	1.240	.522	.888
Variance	.242	.273	.568	1.356	1.538	.273	.788
Range	1	1	2	4	3	1	3

17	18	19	20	21	22	23	24	25
I clearly get a sense that my immediate supervisor, manger or leaders within my department care for me on a personal level.	I frequently engage with someone here that encourages my continued professional growth and development.	I feel like my opinion is valued.	Our company's mission makes me feel like I am contributing to something important.	There is an established culture here of performing at our best and doing quality work.	I have close friends here.	I have discussed my future goals, growth and/or progress with someone here at work within the last six months.	In the last year, I feel like I was provided with opportunities to grow.	I can see myself working here 5 years from now.
12	12	12	12	12	12	12	12	12
0	0	0	0	0	0	0	0	0
4.67	4.33	4.50	3.75	3.00	3.92	4.17	4.08	4.00
5.00	4.00	4.50	4.00	3.00	4.00	4.00	4.00	4.00
5	4	4 ^a	4	3	4	4 ^a	4	4
.492	.651	.522	.622	.953	.669	.937	.515	.739
.242	.424	.273	.386	.909	.447	.879	.265	.545
1	2	1	2	3	2	3	2	2

Pre-implementation Responses to Questions Assessing Level of Engagement

Assessment Item	10	11	12	13	14	15	16
	I am satisfied with working at XORG.	I can see myself working here a year from now.	Expectations here are clearly communicated and I know what is expected of me.	I have what I need to get my work done.	My working environment allows me to operate at the best of my abilities.	I can see myself working here two years from now.	Within the last week, I have received praise or recognition for doing good work.
Valid	12	12	12	12	12	12	12
Missing	0	0	0	0	0	0	0
Mean	3.91	4.00	3.55	2.91	3.00	3.64	4.55
Median	4.00	4.00	4.00	3.00	3.00	4.00	5.00
Mode	5	4	4	3	2	4	5
Variance	1.091	1.200	1.073	.891	1.200	.655	.273

17	18	19	20	21	22	23	24	25
I clearly get a sense that my immediate supervisor, manger or leaders within my department care for me on a personal level.	I frequently engage with someone here that encourages my continued professional growth and development.	I feel like my opinion is valued.	Our company's mission makes me feel like I am contributing to something important.	There is an established culture here of performing at our best and doing quality work.	I have close friends here.	I have discussed my future goals, growth and/or progress with someone here at work within the last six months.	In the last year, I feel like I was provided with opportunities to grow.	I can see myself working here 5 years from now.
12	12	12	12	12	12	12	12	12
0	0	0	0	0	0	0	0	0
4.55	4.00	4.00	3.55	2.91	3.64	3.73	3.91	3.09
5.00	5.00	4.00	4.00	3.00	4.00	4.00	4.00	3.00
5	5	4	4	3	4	4a	5	3
.673	1.800	1.200	1.073	.891	.855	2.018	1.891	.891

Appendix P

Comparison of Post-implementation Composite Scores to Pre-implementation Composite Scores

Composite Engagement Scores

	<p><i>I am satisfied with working at XORG</i></p> <p><i>I can see myself working here a year from now</i></p> <p><i>Expectations here are clearly communicated and I know what is expected of me</i></p> <p><i>I have what I need to get my work done</i></p> <p><i>My working environment allows me to operate at the best of my abilities</i></p> <p><i>Within the last week, I have received praise or recognition for doing good work</i></p> <p><i>I clearly get a sense that my immediate supervisor, manager or leaders within my department care for me on a personal level</i></p> <p><i>I frequently engage with someone here that encourages my continued professional growth and development</i></p> <p><i>I feel like my opinion is valued</i></p> <p><i>Our company's mission is valued</i></p> <p><i>There is an established culture here of performing at our best and doing quality work</i></p> <p><i>I have close friends here</i></p> <p><i>I have discussed my future goals, growth and/or progress with someone here at work within the last six months</i></p> <p><i>In the last year, I feel like I was provided with opportunities to grow</i></p> <p><i>I can see myself working here 5 years from now</i></p>																
	Post-Implementation scores																Composite
Mean:	4.33	4.50	3.75	3.58	3.42	4.50	4.33	4.67	4.33	4.50	3.75	3.00	3.92	4.17	4.08	4.00	64.8
Median:	4	4	4	4	3	4	5	5	4	5	4	3	4	4	4	4	65.5
Mode:	4	4	3	4	2	4	5	5	4	5	4	3	4	5	4	4	67.0
	Pre-implementation scores																
Mean:	3.91	4.00	3.55	2.91	3.00	3.64	4.55	4.55	4.00	4.00	3.55	2.91	3.64	3.73	3.91	3.09	59.0
Median:	4	4	4	3	3	4	5	5	5	4	4	3	4	4	4	3	61.5
Mode:	5	4	4	3	2	4	5	5	5	4	4	3	4	5	5	3	60.0
	Delta from preimplementation scores																
Mean:	0.42	0.50	0.20	0.67	0.42	0.86	-0.21	0.12	0.33	0.50	0.20	0.09	0.28	0.44	0.17	0.91	
Median:	0.00	0.00	0.00	1	0.00	0	0.00	0.00	-1	1	0.00	0.00	0.00	0.00	0.00	1	
Mode:	-1.00	0.00	-1.00	1	0.00	0	0.00	0.00	-1	1	0.00	0.00	0.00	0.00	-1.00	1	

← **Post-Implementation Mean**

Compared to

← **Pre-Implementation Mean**

A 10% Improvement

Post and Pre-implementation Composite Scores Assessing Attitudes towards XORG’s
Performance Management Approach

(For information only)

	<i>I have a good understanding of our organizational priorities and strategic goals</i>	<i>I feel like there is a uniform approach to identifying and reporting organizational performance</i>	<i>Having performance data that provides an indication of how my group, team or department is performing against established objectives is important to me</i>	<i>I find it relatively easy to view data related to how my department is performing and contributing to organizational goals</i>	<i>I participate in regular discussions within my department, group or team where we review data linked to how we are performing against established objectives</i>	<i>I find it relatively easy to obtain performance data on how my group, team or department is performing against established objectives</i>	<i>Our organization is frequently informed on how my group, team or department is contributing to overall strategy of the organization</i>	<i>As an organization, we do a good job of establishing quantifiable goals that are clearly linked to the organization that are easily accessible or displayed publicly</i>	<i>Scorecards at all levels</i>						
	Post-Implementatoin scores									Composite					
Mean	3.50	1.75	4.75	1.67	2.58	1.75	2.92	1.83	1.67	22.4					
Median	4	2	5	1	3	2	4	2	1	23.0					
Mode	4	2	5	1	1	2	4	2	1	23.0					
	Pre-implementation scores														
Mean	3.55	1.73	4.73	1.82	2.82	2.00	2.91	1.82	1.27	22.7					
Median	4	2	5	2	3	2	3	2	1	23.5					
Mode	4	2	5	2	2	2	3	2	1	21.0					
	Delta from preimplementation scores														
Mean	-0.05	0.02	0.02	-0.15	-0.23	-0.25	0.01	0.02	0.39						
Median	0.00	0.00	0.00	-1.00	0.00	0.00	1.00	0.00	0.00						
Mode	0.00	0.00	0.00	-1.00	-1.00	0.00	1.00	0.00	0.00						

Of Note – no significant changes in composite scores

Appendix Q

Correlations Observed with Engagement Questions (For Information Only)

Engagement Question	Survey questions demonstrating a correlation					
	Question 1	Question 11	Question 14	Question 15	Question 21	Question 25
I am satisfied with working at XORG.	I have a good understanding of our organizational priorities and strategic goals.	I can see myself working here a year from now.	My working environment allows me to operate at the best of my abilities.	I can see myself working here two years from now.	There is an established culture here of performing at our best and doing quality.	I can see myself working here 5 years from now.
Correlation Coefficient	-.645*	.707*	.662*	.707*	.868**	.750**
Sig. (2-tailed)	.024	.010	.019	.010	.000	.005

Engagement Question	Survey questions demonstrating a correlation					
	Question 1	Question 7	Question 10	Question 14	Question 21	Question 25
I can see myself working here a year from now.	I have a good understanding of our organizational priorities and strategic goals.	I am frequently informed on how my group, team or department is contributing to established organizational initiatives.	I am satisfied with working at XORG.	My working environment allows me to operate at the best of my abilities.	There is an established culture here of performing at our best and doing quality work.	I can see myself working here 5 years from now.
Correlation Coefficient	-.810**	-.758**	.707*	.775**	.767**	.707*
Sig. (2-tailed)	.001	.004	.010	.003	.004	.010

Engagement Question	Survey questions demonstrating a correlation					
	Question 1	Question 7	Question 10	Question 14	Question 21	Question 25
I can see myself working here two years from now.	I have a good understanding of our organizational priorities and strategic goals.	I am frequently informed on how my group, team or department is contributing to established organizational initiatives.	I am satisfied with working at XORG.	My working environment allows me to operate at the best of my abilities.	There is an established culture here of performing at our best and doing quality work.	I can see myself working here 5 years from now.
Correlation Coefficient	-.810**	-.758**	.707*	.775**	.767**	.707*
Sig. (2-tailed)	.001	.004	.010	.003	.004	.010

Engagement Question	Survey questions demonstrating a correlation				
	Question 10	Question 11	Question 14	Question 15	Question 21
I can see myself working here 5 years from now.	I am satisfied with working at XORG.	I can see myself working here a year from now.	My working environment allows me to operate at the best of my abilities.	I can see myself working here two years from now.	There is an established culture here of performing at our best and doing quality work.
Correlation Coefficient	.750**	.707*	.707*	.707*	.615*
Sig. (2-tailed)	.005	.010	.010	.010	.033

Engagement Question	Survey questions demonstrating a correlation			
	Question 10	Question 11	Question 15	Question 25
My working environment allows me to operate at the best of my abilities.	I am satisfied with working at XORG.	I see myself working here a year from now.	I see myself working here two years from now.	I can see myself working here 5 years from now.
Correlation Coefficient	.662*	.775**	.775**	.707*
Sig. (2-tailed)	.019	.003	.003	.010

Engagement Question	Survey questions demonstrating a correlation			
	Question 18	Question 19	Question 23	Question 24
Within the last week, I have received praise or recognition for doing good work.	I frequently engage with someone here that encourages my continued professional growth and development.	I feel like my opinion is Valued.	I have discussed my future goals, growth and/or progress with someone here at work within the last six months.	In the last year, I feel like I was provided with opportunities to grow.
Correlation Coefficient	.619*	.672*	.738**	.620*
Sig. (2-tailed)	.032	.017	.006	.032

Engagement Question	Survey questions demonstrating a correlation		
	Question 16	Question 17	Question 23
I feel like my opinion is valued.	Within the last week, I have received praise or recognition for doing good work.	I clearly get a sense that my immediate supervisor, manager or leaders within my department care for me on a personal level.	I have discussed my future goals, growth and/or progress with someone here at work within the last six months.

Correlation Coefficient	.672*	.707*	.833**
Sig. (2-tailed)	.017	.010	.001

Engagement Question	Survey questions demonstrating a correlation		
	Question 1	Question 7	Question 24
There is an established culture here of performing at our best and doing quality work.	I have a good understanding of our organizational priorities and strategic goals.	I am frequently informed on how my group, team or department is contributing to established organizational initiatives.	In the last year, I feel like I was provided with opportunities to grow.
Correlation Coefficient	-.654*	-.698*	-.624*
Sig. (2-tailed)	.021	.012	.030

Engagement Question	Survey questions demonstrating a correlation		
	Question 2	Question 4	Question 8
I have close friends here.	I feel like there is a uniform approach to identifying and reporting organizational performance.	I find it relatively easy to view data related to how my department is performing and contributing to organizational goals.	Our organization does a good job of establishing quantifiable goals that are clearly linked to the overall strategy of the organization.
Correlation Coefficient	.849**	.652*	.656*
Sig. (2-tailed)	.000	.022	.020

Engagement Question	Survey questions demonstrating a correlation		
	Question 4	Question 16	Question 19
I have discussed my future goals, growth and/or progress with someone here at work within the last six months.	I find it relatively easy to view data related to how my department is performing and contributing to organizational goals.	Within the last week, I have received praise or recognition for doing good work.	I feel like my opinion is valued.
Correlation Coefficient	.624*	.738**	.833**
Sig. (2-tailed)	.030	.006	.001

Engagement Question	Survey questions demonstrating a correlation		
	Question 7	Question 16	Question 21
In the last year, I feel like I was provided with opportunities to grow.	I am frequently informed on how my group, team or department is contributing to established organizational initiatives.	Within the last week, I have received praise or recognition for doing good work.	There is an established culture here of performing at our best and doing quality work.
Correlation Coefficient	.641*	.620*	-.624*
Sig. (2-tailed)	.025	.032	.030

Engagement Question	Survey questions demonstrating a correlation		
	Question 2	Question 3	Question 9
Expectations here are clearly communicated and I know what is expected of me.	I feel like there is a uniform approach to identifying and reporting organizational performance.	Having performance data that provides an indication of how my group, team or department is performing against established objectives is important to me.	As an organization, we do a good job with establishing dashboards and / scorecards at all levels of the organization that are easily accessible or displayed.
Correlation Coefficient	.632*	.632*	.829**
Sig. (2-tailed)	.027	.027	.001

Engagement Question	Survey questions demonstrating a correlation	
	Question 13	Question 19
I clearly get a sense that my immediate supervisor, manger or leaders within my department care for me on a personal level	I have what I need to get my work done.	I feel like my opinion is valued.
Correlation Coefficient	-.659*	.707*
Sig. (2-tailed)	.020	.010

Engagement Question	Survey questions demonstrating a correlation	
	Question 3	Question 16

<p>I frequently engage with someone here that encourages my continued professional growth and development.</p>	<p>Having performance data that provides an indication of how my group, team or department is performing against established objectives is important to me.</p>	<p>Within the last week, I have received praise or recognition for doing good work.</p>
<p>Correlation Coefficient</p>	<p>-.651*</p>	<p>.619*</p>
<p>Sig. (2-tailed)</p>	<p>.022</p>	<p>.032</p>

Appendix R

Project Request and Scope and Assessment Form

Classification	<input checked="" type="checkbox"/> Strategic	<input type="checkbox"/> Operational	<input type="checkbox"/> Compliance	<input type="checkbox"/> Infrastructure
Requested Delivery Date		Review Date	May 17, 2016	
Outcome	<input type="checkbox"/> Approved <input checked="" type="checkbox"/> Not Approved			

Project Name: Organizational KPIs

Business Justification

The effort to align every department behind organizational key performance indicators (KPI) is a senior leadership team (SLT) initiative and an effort launched at the request of our CEO. Their expectation for supporting this initiative is to have the supporting technology described in this project request form in place by 1/1/2017 so that our associates can link their individual goals to that of their team or department's scorecard and that manager/leaders can begin tracking progress on those goals.

Currently, operational and clinical data comes from multiple disparate sources which relegates it to spreadsheets for compilation. The static nature of spreadsheets forces key leaders to sit and wait for data to be pushed to them. High-performing organizations have moved to technological adjuncts that allow for on-demand and real-time consumption of data aggregated from multiple disparate sources.

This project brief will substantiate the purchase and implementation of a digitized enterprise performance management system. The selected business intelligence tool will function as a self-service integrated platform that offers on-demand access to real-time performance data aggregated from multiple sources. Business users including board members (view only), members from the SLT, finance, IT, Sales, Marketing, Operations and other supporting services will be able to improve performance and save time by becoming consumers of data from multiple disparate sources residing in one intuitive platform with that is (primarily) updated automatically.

Qualify Need for the project

Impact - what benefits or difference your capability will make for Customer and/or XORG

Per the request of the CEO, the organization has launched a KPI project. In order for that project to be successful, one person would have to be 100% dedicated to compiling data from multiple sources, updating it on a daily, weekly or monthly basis (depending on the KPI) and then distributing that data to business users. Without offering business users some way of logging in and viewing performance data aggregated from multiple disparate sources, they would lose interest in keeping up with KPIs, crippling any hope an organizational KPI project would have for gaining adoption. Additionally, this digitized tool answers a long-standing customer request from our health plans for the ability to view performance data. These digitized

BI tools come with role-based security settings that would allow for people outside the organization to view performance data associated with the serves we deliver at little or no additional cost.

Productivity - what gains in time and resources, losses in time and resources?

With technology in place that automates data collection and displays that data in intuitive formats, leaders in the highest performing organizations spend double the amount of time analyzing their data. This allows them to quickly move to collaborative communication with decision makers and other members of the leadership team to respond to the analysis. This is exactly the intent of implementing a BI tool such as this. Improve visibility and communication of performance data while dramatically decreasing the amount of time it takes to get that data.

Proof - what evidence substantiates your impact?

Digital enterprise performance management technologies have demonstrated the ability to markedly enhance an organization's profitability and viability. The expectation is that the investment in this technology will improve service delivery. High performing data-driven organizations are 89 percent less likely to delivery critical information to business users late, 56 percent more likely to have multiple disparate data sources integrated using real-time connections and are 2.5 times more likely to collaborate across departments. The improved service delivery outcomes would then be used in proposals and presentations to help grow the business.

This investment will ultimately be substantiated through increased revenue from new business. Prior to that, business users will report improved access to meaningful data, higher levers of cross-functional collaboration and an improved awareness of and connection to the overall organizational strategic aims.

Internal and External Customer Expectations

What functionality have you promised the customer?

Driving this is the demand from business users for quicker, more efficient access to impactful data. Pushing data and reports to business users is a practice that assures mediocrity. When business users pull data, work with the data, identify what's working and what's not on their own this approach fuels a responsive environment that drives growth and customer satisfaction.

A core workgroup comprised of senior leaders from multiple departments have affirmed the need for on-demand access to meaningful data. They have verbalized the need for intuitive, dynamic and interactive features like clicking on metrics and taking a deeper dive. And they want both operational and clinical data in real-time.

Internal and External Mandated Dates/Customer Requested Dates

What dates have you promised the customer or are mandated by law?

In keeping up with the CEOs request to have a KPI project in place prior to his retirement, this project calls for digital KPI scorecards in place by 1/1/2017. In order to get business users familiar with the tool, ideally, this technology should be in place by October of 2016.

Risks if project if not completed

What are the risks from a business perspective of not completing the project and/or not getting the project completed on time?

As mentioned above, the KPI projected started by the CEO will not be effective without this technology in place. More importantly, there is a significant risk to forecasted revenue. The 2017 – 2019 revenue forecasts includes revenue from capitated contracts in addition to our current administrative fee only (ASO) contracts. Managing capitated contracts will require business users to closely monitor, trend and respond to data – in most cases – on a daily basis. In risk arrangements, an organization's financial performance will hinge on its ability to identify and manage at-risk members known for consuming large quantities of resources through their high utilization of services. Our organization has projected over \$34 million in revenue from these risk arrangements in 2017, \$104 million in 2018 and \$130 million in 2019. Effectively managing these capitated payment models and maintaining margins will hinge upon how efficiently we get actionable data to our clinical operations team members.

Risks of what could happen if we do provide this

What are the possible risks from a business perspective of what could happen if we do provide this project?

There is always the risk of data breach when relying on vendors to help with data needs. Vendors will be vetted for their ability to mitigate this risk. Discussions with the current vendors have been very fruitful in terms of mitigating this risk even with a cloud-based solution, there is substantial evidence that the vendors being consider now can protect that data more effectively in the cloud than we could via an on-site solution.

PLEASE MAKE SURE THE BELOW QUESTIONS ARE ANSWERED IN THIS PROJECT REQUEST:**1. How is the task being performed today? (The exact steps so that we can estimate the amount of time spent)**

Currently, there are multiple reports in Tableau on our clinical performance. The reports load slowly, are static offering no ability to drill down and, due to the volume of reports, it is very difficult to find meaningful data. For operational data, members of our finance team send out spreadsheets monthly or quarterly. In both cases, the data is not compared to performance targets in terms of providing an at-a-glance view of how we are performing compared to established goals.

2. Why is that process no longer working?

Our senior leaders, including the CEO, have expressed growing concern over the lack of a systematic process in place to measure and monitor the quality and outcomes of the services we provide. The most frequently identified opportunities associated with the need for an EPM include:

- Lack of coordination leading to duplicative efforts
- Siloed reporting requests leading to limited opportunities for cross-functional discussions
- Ad hoc performance reporting has led to the creation 227 Tableau workbooks with over 1000 different reports making finding key metrics time-intensive
- Performance of services delivered is not uniformly measured or widely distributed
- Program development/adjustment occurs without goals/targets and associated metrics

- Metrics obtained are often done so absent established and clearly understood definitions

3. How many hours per week/month does it take one FTE to complete this task?

Aggregating data from the multiple sources involved in the KPI project would require an FTE be fully dedicated to the task

4. How many FTEs are performing the tasks now?

N/A – there currently is no one dedicated to compiling enterprise-wide performance data for the purposes of viewing it in one location.

5. If the enhancement is approved, specifically, how will it save time/money?

Addressed above

6. What is the desired deadline for this project?

Addressed above

7. How will utilization be tracked for the implementation of this feature, how will it prove the return on investment (ROI)?

Utilization can be tracked with built in reports. However, the best way to quantify utilization will be through the collaborative discussions that will take place at every level of the organization on the KPIs.

A budget-neutral approach to purchasing the technology is provided in the scope and assessment document. ROI will be achieved via the reduction of project slippage due to poor visibility/accountability on core projects and increased revenue driven by improved program outcomes.

Requirements

The following business requirements have been identified by key stakeholders associated with the KPI project.

	Need or Feature	Must or Nice to have	Need Assumptions Dependencies
	<i>{This will be list of the needs and features that are requested. Each need will always start out with the heading “The system shall provide the ability to” }</i>		<i>These are the assumptions and dependencies that are directly related to</i>
	The system will be able to aggregate data from multiple disparate sources	<i>Must have</i>	
	The system must provide a flexible management dashboard that reports key management information. Must have the ability to look at organizational performance as well as user or department-wide performance for purposes of managing workflow / productivity	<i>Must have</i>	
	The system must have role-based security build that controls access to restricted info.	<i>Must have</i>	
	The system shall provide the ability to allow a defined role or specific user to determine default scorecard/landing page	<i>Must have</i>	

	The system shall provide the ability to include default/prebuilt organizational scorecards as part of the initial implementation	<i>Nice to have</i>	
	The system shall provide the ability to hover or link to a summary of the meaning of the measure	<i>Nice to have</i>	
	The system automatically generates real-time, rules-based alerts when an event threshold is reached or a trend is identified	<i>Must have</i>	
	The system shall provide the ability to set alerts users can set that signal performance has gradually shifted or that an abnormal event has occurred	<i>Nice to have</i>	
	The system shall provide the ability to click and drill down to the drivers of performance data	<i>Must have</i>	
	The system shall provide a key that displays the meaning of colors or symbols used on the scorecard	<i>Must have</i>	
	The system shall provide the ability to automate updating of scorecards (for the most part) with no manual intervention	<i>Must have</i>	
	The system shall provide the ability to upload spreadsheets which automatically populates the corresponding scorecards	<i>Must have</i>	
	Software updates completed with little to no impact on default scorecards or scorecards created by business users	<i>Nice to have</i>	
	Updating the system require little to no intervention for internal IT resources	<i>Nice to have</i>	
	Following implementation/build, no additional coding is required to utilize the disparate data sources for creating scorecards	<i>Nice to have</i>	
	The system shall provide the ability to do real-time threshold and trend reporting	<i>Nice to have</i>	
	The system shall provide the ability for each user to create multiple user-defined reports and display them on a personal dashboard.	<i>Must have</i>	
	The system shall provide the ability for each user to create multiple personal dashboards, each with an independent set of reports, which the user can easily switch between	<i>Must have</i>	
	The system shall provide the ability to create department and team scorecards	<i>Must have</i>	
	The system shall provide the ability to communicate within their teams on their scorecard	<i>Nice to have</i>	
	The system shall provide the ability to allow dashboards to be assigned to individual users or to groups of users using security group rules	<i>Nice to have</i>	
	The system shall provide the ability for a system administrator to select the users who will receive an automatic warning alert e-mail notification when a specific threshold is reached or a pre-defined trend is identified	<i>Nice to have</i>	
	The system shall provide the ability for an inexpensive and secure way to share scorecards with people outside of the organization	<i>Must have</i>	
	The system shall provide the ability to lock down any drill-down function on scorecards shared outside of the organization	<i>Must have</i>	

Project Scope and Assessment

Project Name: KPI Project
Department: Sales and Marketing
Executive Sponsor: Griff D
Project Requestor: Carlton Abner
Project Manager/Business Analyst: PM/BA involved
Date: 5/24/2016
Projected Due Date: TBD

Problem Statement

Currently, operational and clinical data comes from multiple disparate sources which relegates it to spreadsheets for compilation. The static nature of spreadsheets forces key leaders to sit and wait for data to be pushed to them.

Project Scope

Purchase and implementation of a digitized enterprise performance management system/business intelligence tool that will function as a self-service integrated platform providing the ability for on-demand access to real-time performance data aggregated from multiple sources.

Scope of Technical Changes:

Current Workflow

There is no current workflow associated with one tool providing on-demand access to data from multiple disparate sources of data. Data is currently pushed to business users who submit an analytics ticket. If the business user has additional data needs associated with the ticket, they can work with the analysts assigned to their original ticket or may have to submit another ticket.

Proposed Workflow

A digitized performance reporting tool will offer on-demand access to real-time data. The technology will also offer point and click capabilities that allow business users to take deeper dives making future workflows variable and impossible to map out. However, the dynamic capability of this new technology has been a long-standing request from the program owners it is intended to support.

Appendix S

Missing Elements of Change (Buttles-Valdez, Svolou, & Valdez, 2006, p. 13)

