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Designing and Implementing a Balanced Scorecard: Lessons Learned in Nonprofit Implementation

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The balanced scorecard has been referred to as the management innovation of the century, and extensive articles have been written using case studies of organizations that use this performance measurement system. This article addresses the key issues of design and implementation with a step-by-step guide to how to design a balanced scorecard and lessons to avoid implementation problems in government and nonprofit settings.

MANAGEMENT CHALLENGES

Today's managers are faced with competing demands and limited resources yet are challenged to perform in four major areas: increase efficiency, improve alignment and focus, enhance communication, and foster continuous quality improvement. To increase efficiency they must identify problem areas quickly and take appropriate corrective action, simplify decision-making based on readily available data that are actionable, and eliminate inefficient "*ad hoc*" reporting activity. Managers need live data that can be corrected to manage performance versus reported data after the fact that cannot be corrected. They are also challenged to improve alignment to company mission and goals and focus their employees on objectives that genuinely contribute to business success. They must align day-to-day activities with strategic objectives and inspire people to do the right things and provide timely feedback to course correct. Another challenge for managers is enhancing communication to convey clearly visible results in a non-confrontational performance reporting process. Finally, the ability to foster continuous quality improvement by identifying opportunities for improvement and having adequate data to support knowledge-based decision-making poses yet another major challenge.

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WHAT IS A BALANCED SCORECARD (BSC)?

A BSC can be used to address these management challenges. By definition, a BSC is a strategic measurement and management system capable of translating an organizations mission and strategy into a comprehensive set of performance measures. It can help the organization focus on issues before they become problems, transform data into actionable information, and manage performance for all strategic objectives, not just financial. The BSC takes the mission of the organization and the strategic initiatives for the year and translates those into objectives and measures in four traditional quadrants (1). The quadrants are: financial, innovation, customers, and people. The BSC is characterized as strategic, system designed, counterbalanced, and timely. It is visual, flexible (information can be rolled up and drilled down) and fosters accountability at all levels of the organization. Each measure is assigned an owner (individual or team) who is responsible for performance, data accuracy, and communication. In some instances, measures are counterbalanced and weighted to reflect the relative importance and priority of the measure. Measures can have zero weighting until data are available or until importance and timeliness are determined.

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In many instances, the BSC has changed the focus on what gets measured and receives managerial attention. Organizational strategy is expressed in measurable objectives that guide day-to-day employee activities to achieve stated corporate goals. Because of the information the BSC can provide, the nature of monthly financial meetings can change from a focus on the things a company does well to the things that need improvement, with an emphasis on an appropriate action plan. Increasingly mission driven organizations in health care have adopted the BSC to translate mission into measurable operating objectives. Health-care facilities facing financial pressures often react to pressure with an increased emphasis on financial metrics. Meaningful performance assessments include other dimensions such as quality, patient satisfaction, and staff retention in addition to revenues and operating costs. While retaining the financial measures, drivers of future financial success such as quality clinical outcomes, expert clinical care providers, satisfied patients, doctors and staff, and volume and market share growth are incorporated into the card. In a quality-driven organization like a health-care institution, BSC enables a focus on quality as a vehicle to improve performance.

Kaplan and Norton describe the BSC framework in terms of: translating the vision, communicating and linking, business planning, and finally feedback and learning (2). The BSC translates the vision by clarifying the vision and gaining consensus. Communication and linking occur as goals are set, objectives communicated, education in the use of the BSC is cascaded down the organization, and rewards are linked to performance. Business planning involves setting targets, aligning strategic initiatives, allocating resources, and establishing milestones. The final stage of the framework, feedback and learning, involves articulating the shared vision, supplying strategic feedback, and facilitating strategy review and learning.

HOW TO DESIGN AND IMPLEMENT A BALANCED SCORECARD

A BSC can be designed and implemented using specific process steps. Steps for defining your BSC are: select a measurement framework, determine key performance areas, select measures, and, finally, align measures to the framework for a fully defined scorecard. The first step of selecting a measurement framework is done at the strategic level of the organization by top management. Various frameworks exist in addition to Kaplan and Norton's BSC, such as the Malcolm Baldridge National Quality Award criteria, ISO 9000, Joint Commission for Accreditation of Healthcare Organizations (JCAHO), or you can design your own. The BSC examines four traditional areas:

1. Internal: What must we excel at to be successful?
2. Customer: How do our customers see us?
3. Innovation and learning: How can we continue to improve and create value?
4. Financial: How do our stakeholders view our success?

The Baldridge National Quality Award framework consists of seven areas: leadership, strategic planning, customer and market focus, information and analysis, human resource focus, process management, and business results. The Malcolm Baldrige Health Care Criteria are designed to help organizations use an integrated approach to measuring performance that results in improved organizational practices and results and facilitates the sharing of best practices among health-care organizations. The goals of the criteria are:

1. delivery of ever-improving value to patients and other customers, contributing to improved health-care quality
2. improvement of overall organizational effectiveness and capabilities as a health-care provider
3. organizational and personal learning (3).

The Health Care Criteria are built upon core values that reflect beliefs and behaviors found in high-performing organizations and can be used as a model for world-class health-care delivery. The core values and concepts that underpin the criteria are: visionary leadership, patient-focused excellence, organizational and personal learning, valuing staff and partners, agility, focus on the future, managing for innovation, management by fact, public responsibility and community health, focus on results and creating value, and a systems perspective. The criteria focus on organizational performance results in the following areas:

1. patient and other customer focus results
2. health-care results
3. financial and market results
4. staff and work system results
5. organizational effectiveness results, including operational and supplier performance
6. public responsibility and community health results (3).

The above areas are balanced among all stakeholders as well as balanced among short- and long-term goals. Another important aspect of the criteria is that they do not prescribe how the organization should be structured or managed. They do not prescribe procedures or tools and encourage flexibility and customization based on the type and size of the organization. Kaplan and Norton view the dimensions as a template and do not prescribe the four perspectives and encourage organizations to develop dimensions of performance for their industry. For example, some organizations have used dimensions such as research and development, environment, stakeholders, suppliers, leadership, or community (4). Some organizations include all external stakeholders within the customer group while others such as the Naval Undersea Warfare Center, Division Newport,

utilize a separate stakeholder perspective. In this example, the standard customer group was designated as paying customers, while the other customers such as tax payers and Congress are considered stakeholders (4). To comply with JCAHO standards, many health-care organizations have opted to create their own areas such as:

1. People: How are we developing, training, and motivating our employees?
2. Patients: How well are we satisfying our patient needs?
3. Research: How do we identify, design, and implement new processes?
4. Financial: How are we delivering adequate profitability and utilizing our assets efficiently?
5. Clinical: How are we improving our delivery systems, reducing errors, decreasing costs, and eliminating waste (5)?

The key question to ask in selecting a framework is: What are our key core values as reflected in the mission statement of the organization? These key elements or core values are extracted from the mission/vision statements and/or strategic plans in order to generate the framework. Bridgeport Hospital, a private community teaching hospital affiliated with Yale New Haven Health System named the BSC quadrants organizational health, financial health, process and quality improvement, and market share growth to customize the names to their industry (5). Other nonprofits in the health-care industry such as Dallas Family Access Network have named the BSC perspectives in a way that reflects their mission: health care perspective, social service perspective, operational perspective, consumer perspective, and financial perspective. Others designate their strategic priorities and make them the cornerstones of the BSC perspectives (6).

Other sources for background information in selecting your framework are annual reports, the strategic plan, project plans, various consulting studies or analyst reports, and benchmarking or competitive data (6). Once the framework is chosen, the next step is to define the key performance areas of the matrix. For example, if the four dimensions are defined as people, process innovation, customers, and financial, the people dimension might measure training hours, turnover rate, employee satisfaction, employee productivity, or timely completion of performance appraisals. The process innovation dimension might measure rework, product defects, on time delivery, cycle times, patient wait times, repeat tests or diagnostic procedures, or new services introduced. The customer dimension might measure patient complaints, patient satisfaction surveys, repeat customers, market share, annual sales per customer, customer profitability, or sales volume. The above three dimensions all contribute to the financial success of the enterprise and the final financial dimension can be measured with commonly used financial measures such as: return on investment, economic value added, cash flow, debt to equity ratio, profit as a percent of sales, net income, gross margin, or any of the measures of share price and market valuation. There is no ideal number of measures; however, many organizations measure a total of 25 to 30 performance indicators and balance the number of measures in each dimension.

The next step is selecting measures by defining a comprehensive list of measures and narrowing the list to key performance measures that truly measure business success. The larger list of measures can be derived from current management measures used at executive meetings, budgets, plans, board reports; by looking at key processes; by assessing what individual departments are using to measure their own performance; or by external benchmarks derived from seminars, articles, and books. This large list must be narrowed down to the critical few that are keys to performance. To select performance measures, it is important to link the measures to your strategy and overall goals of the organization. Certain diagnostic performance measures that are not strategic might also be included to maintain efficient functioning of the business (6). Measures should also be accessible, relevant, and easily understood. Measures should be balanced between leading and lagging indicators of performance and between short- and long-term goals. Another criteria for your BSC is to counterbalance the measures so no single measure outweighs others or is improved at the expense of another measure.

This comprehensive list of measures can be categorized into three groups: reject, future, and accept for inclusion in the BSC. In asking what should be measured, it is important to question current measures and why you use them. What should you measure, but are not currently measuring? What are the gaps? Criteria for rejecting measures include: measures may not have an owner, may be duplicated, impossible to get data on the measures, measures are trivial and do not contribute to the business. Future metrics might require further definition or data may not be currently available. The final narrow list should include measures from key performance areas and departments, measures for each strategic objective, a balance of financial and non-financial measures, process and outcome measures, and, finally, measures specific to high risk, high volume, problem prone, high cost, and other quality issues. The next step is to align measures to the framework to fully define the BSC.

A concluding step in identifying and defining measures is to set targets that are preferably quantitative to maximize objectivity. They should be realistic and challenging because of the public scrutiny most governments and health-care agencies receive. Targets communicate information, foster accountability, and give the public a vehicle to judge effectiveness of the agency and management effectiveness. For example, the Environmental Protection Agency had a target of reducing toxic waste levels by 50% over a 7-year

period. This stretch target provided a challenge that demanded a dramatic result, yet it was achieved. The target was critical to the success of the Environmental Protection Agency and was achievable because of the motivation and engagement of employees (4).

Targets can be obtained from customer and employee assessments, analyses of trends and industry averages, and benchmarking or stakeholder feedback. Feedback from employees and customers provides valuable information on meaningful targets and expectations of internal and external customers. Once targets are set, the organization has to prioritize the important initiatives that drive strategic results to gain maximum value from the BSC as a strategic management tool.

The implementation process can be divided into these major steps and activities:

1. Strategic Planning
   a. preparation and planning
   b. executive briefing
   c. strategic planning
2. Designing Framework
   a. senior manager briefing
   b. senior manager review
   c. BSC framework determined
   d. executive review and approval
3. Identifying and Defining Measures
   a. build framework
   b. brainstorm measures
   c. narrow measures
   d. identify gaps
   e. align measures
   f. set targets
4. Implement, Training, Ongoing Use
   a. roll-out plan
   b. executive review and approval
   c. education and training
   d. pilot
   e. project roll-out

A pilot area should be chosen where existing measures are well defined and widely recognized. The pilot area should ideally represent a wide variety of measures in multiple areas of the BSC that can be affected with accurate available data. Education and training provide communication and support for the achievement of targets. Many public agencies use dashboards as a reporting tool that enables performance data to be displayed in a clear and visual manner. Some use a traffic light reporting format that reflects targets achieved, close, or not reached by the colors green, yellow, or red. Ease of reporting and clear visual displays of results can drive management meetings, performance appraisal discussions, team meetings, and reports to the board. Computer software can provide a solution to displaying graphic results but are not a necessity. A dashboard with pictures depicting "How are we doing?" in a dimension of performance keeps the BSC front and center for all levels of the organization.

The progress on metrics is widely available with information and BSC presentations on the internal shared computer drive for easy access. Managers access the information to use in staff meetings and to prepare their budget requests during the capital budget process. The capital budget request process mandates a description of how the item requested impacts the BSC dimensions.

Organizations with a sophisticated intranet can utilize it for providing information on the BSC. The U.S. Army Medical Department uses the intranet to communicate their implementation plan, communications plan, reporting, training, strategy map of objectives, answers to commonly asked questions, and educational links (4). Other organizations market their BSC using newsletters, management meetings, board reports, e-mails, and other written or multimedia vehicles. Using the BSC as a framework for meeting agendas at the senior, middle management, departmental, and team levels has helped all employees at Bridgeport Hospital speak a common BSC language.

BALANCED SCORECARD AND THE GOVERNMENT AND NONPROFIT SECTOR

The BSC has been successfully implemented in the nonprofit and government sectors that are mission driven as opposed to financially focused. The BSC enables an organization to take the mission and align it to the goals and objectives for employees. Performance measurement techniques allow the public sector to clearly articulate and demonstrate results to their constituency and to measure program results. The BSC encourages a balance of internal quality and efficiency metrics with externally focused customer measures.

The unique feature of a BSC in the nonprofit sector is the role of the mission in driving strategy such as who the organization serves and how constituency requirements are met. Determining who is served by the agency is not an easy task since multiple payers and benefactors exist for most public and nonprofit agencies. Financial measures are often seen as a constraint in the government sector and not a measure of success. Financial measures achieved in the public sector indicate results attained in a cost-effective manner with accountability. The employee learning and growth dimension can be seen as an enabler for achievement of the other dimensions of performance. Niven articulates the following issues unique to the public sector BSC and how to overcome these potential problems to implementation in the public arena (4).

UNIQUE GOVERNMENT AND NONPROFIT CHALLENGES

Public sector managers have historically argued that what they produce (positive outcomes and goals of the

government or improved health status of the patient) is difficult to measure. Although outcomes can be intangible, outputs of the agency can be tracked that denote progress toward meeting social or health goals. Some governmental agencies have a culture of punishing poor performance, and a BSC will publicize results and hold employees accountable. A cultural change to view problems as opportunities is a long and difficult process that can be introduced using a BSC. Another dilemma facing government use of the BSC is the concern that the public and/or media will misconstrue results, particularly negative ones. Because our legislation requires freedom of information, the benefits of the BSC must be weighed against the potential pitfalls of disclosure to proceed with a BSC.

Programs typically evolve and change as administrations are elected; however, performance measurement is mandated by the Government Performance Results Act of 1993 and tools such as the BSC are needed to measure results demanded by constituents. The act mandates that all federal agencies must have a strategic planning process that identifies objectives and measures performance. It also states that measures must be reported in the agency budget. Despite these mandates, most federal managers do not link performance information to their resource allocation. The BSC enables an organization to align capital investment and resource allocation decisions with strategic imperatives. Bridgeport Hospital, a subsidiary of the Yale New Haven Health System, links their capital budgeting process to the BSC initiatives by a matrix that allocated weights and points to capital projects. The Defense Logistics Agency aligns the budget using the BSC to eliminate turf battles and encourage debate and discussion of proposed expenditures. An open discussion fosters collaboration and synergy across various plans (4).

Although agencies have constraints in technology and staff skills, and have a culture of mistrust of the business sector, the BSC can help to demonstrate value to taxpayers and keep agencies viable. Public sector managers can also benefit from the intrinsic rewards of the BSC such as increased knowledge, learning, employee satisfaction, and possible increases to budget (4). A BSC can encourage focus on the mission, accountability for results, and alignment of resources to meet goals of the agency. Despite the unique challenges posed by government use of a BSC, the advantages outweigh the disadvantages as public sector use of the BSC continues to expand.

GOVERNMENT AND NONPROFIT AGENCY CASE EXAMPLES

The City of Charlotte, North Carolina was one of the first to adopt a BSC approach to performance measurement and have reaped many positive results from the implementation of a BSC. The city adopted the traditional quadrants to fit their culture and emphasize the customer perspective rather than the financial as a public-sector organization. The city uses the BSC to articulate strategy and cascades objectives, measures, targets, and initiatives from their strategy. They have simplified the number of measures over the years and delineate four types of measures: activity, input, output, and outcome (4). These are tracked across a corporate BSC as well as key business unit scorecards. For example, the city level scorecard may have a customer objective to provide public transportation and measure users of public transportation. The key business unit scorecard for the transportation department might measure detail such as available modes of transport, repair time, frequency of on time arrivals, and other measures of customer satisfaction with public transportation. The city links the BSC to budgeting to allocate resources to strategic initiatives.

The County of San Diego, California, instituted a BSC in the Health and Human Services Agency to measure how they serve their customers. Each program area developed a scorecard demonstrating successful customer service. To communicate with more than 5,000 employees, the county held "validation sessions" to get feedback from employees and educate staff on the importance of performance measurement. BSC software demonstrations allowed employees to see the outcomes measured. Employees gave input into the process of determining measures and were exposed to all program areas to compare how other groups were measuring outcomes. The chief executive got input from all employees on how to measure the organizations' wellness by focusing on BSC metrics in a weekly email message. The objective is: "To create a safe and healthy environment that supports balance in people's lives." Employees replied with their ideas for measuring organizational wellness (4).

Bridgeport Hospital in Bridgeport, CT is a 425-bed, community teaching hospital that is part of the Yale New Haven Health System. With fully capitated, managed care risk arrangements, the hospital had been experiencing operating losses. All management groups, including clinical leadership, came together for the process of mapping the course to attain strategic goals that would put the hospital in a financially healthy position. The leadership of the hospital, the Board of Directors, and the medical staff worked in parallel with administrative staff to craft a scenario for a successful future. Community physicians were selected to participate in refining and establishing clinical priorities.

To reach the strategic goals, a plan was created based upon the four strategic dimensions considered most critical to driving change. These dimensions became the basis of the BSC, drove the critical success factors, supported the hospital's objectives and translated into measures on the card.

Bridgeport Hospital established the following targets in their BSC. Metrics used to measure organizational health are employee survey action plans, vacancy rates, and turnover rates. In this quadrant, results reported were employee survey action plans implemented, leadership group development plans in place, an interdepartmental survey conducted, and RN and overall turnover rates were lower than targets. Metrics used to measure quality are: patient satisfaction survey scores, patient safety, establishment of a minimally invasive surgery program, and JCAHO accreditation. Results achieved in 2001 include increases in patient satisfaction and customer preference scores. Additional clinical pathways were also established and a patient safety plan was put in place. Process improvement was defined as optimizing cycle and turnaround times, eliminating unnecessary work, streamlining processes, and maximizing technology to enhance efficiency. Metrics are operating room turnaround time and the number of physicians connected to hospital clinical information systems. Results achieved in this quadrant were a decrease in ED to admission time, hours on ED diversion below target, medical/surgical RN to patient ratio target exceeded, and 50 physicians.linked to hospital clinical information systems. Volume and market share growth were measured by expanded clinical services, coordinated clinical care centers, and increased ambulatory volume. Metrics in this quadrant are medical/surgical volume, urgent care visits, primary care visits, and home care visits. Results for 2001 were overall volume and market share at goal, and cardiovascular surgery and diagnostic cardiac catheterizations above goal. Visiting Nurse Association private duty volume and hospice volume were also reported above goal. Goals for financial health are increased coordination with Yale New Haven Health System (YNHHS) to achieve economies of scale, program development funds, and revenue enhancement strategies. Metrics to measure financial health include group purchasing, funded programs, managed care price increases, and cost per discharge. Results obtained in 2001 were managed care price increases achieved, number of full-time equivalent employees were below budget, costs per case for visiting nurse association were below goals, supply chain savings were achieved in excess of $750,000, and the hospital was fully participating in the YNHHS legislative initiatives.

IMPLEMENTATION KEY MOVES AND LESSONS LEARNED

The widespread use of the BSC by over 60% of organizations around the world does not guarantee that the benefits of the BSC will be realized. Many organizations fail to make strategy execution a core competency and fall prey to the following pitfalls that can be the BSC program at risk (7).

- Members of the senior team are not committed to the BSC program.
- Executives are not held accountable for implementing the BSC.
- The BSC is treated as a planning event and not a long-term program.

As in any widespread implementation, there exist key moves that can help to guarantee success of the project. Timing for implementing a BSC is critical. It may be the right move at the wrong time in the organization's culture. Financial issues and struggles may have priority, or the senior leadership may not be committed to the change. A key move is to assess the organizational culture and timing to assure the commitment of leadership and staff. Another key move is to keep it simple and start with the critical few measures that are available and reliable. Data must be displayed in formats that are easily understood and visual. Many organizations use a traffic light reporting system or other visual indication of whether targets are met, off track or on track.

Exploiting existing as well as surrogate data when available: Many organizations have difficulty with data support and are challenged with the ability to collect data, display data, analyze, and communicate data in real time. Computerized software exists but can be costly. Data are most useful if it is real time and not after the fact. With live data, the BSC can be utilized as a tool to manage performance, not just report it.

Another key move is to find champions in the organization to facilitate support for the BSC. The creation of the card is a consensus building exercise that enables leaders to work toward agreement on priority measures. To avoid the flavor-of-the-month syndrome, it is important to assign accountability and ownership of the measures to a team or individual. Senior leaders should review the performance data frequently and can ideally use the data in monthly management meetings with the board and managers of the company. Finally, recognizing and celebrating along the way are important to keep the process active and visible.

The BSC can be analyzed using a SWOT analysis that looks at the strengths, weaknesses, opportunities, and threats to the organization when implementing the BSC. One strength of the BSC is that it fosters well-designed measures that are driven by strategy and helps managers articulate strategy more effectively. However, there is a weakness inherent in the process: implementation requires the input and participation of every involved in strategy or it can become a source of controversy as opposed to unification. Too many measures can lead to resistance and the focus on accountability adds risk to the organizational climate. The BSC affords the opportunity to link employees to the enterprise by promoting best practices and sharing results. It fosters collaboration, problem solving, and

knowledge management. When the BSC is linked to the performance appraisal process and compensation of employees, it can be perceived as threatening to the status quo (8).

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LESSONS LEARNED IN THE IMPLEMENTATION PROCESS

Lessons learned in this implementation process include:

- Timing and culture must be right.
- Active and visible commitment by executive leadership is critical.
- Establish buy-in from measurement owners.
- Mine the data–who owns the data? Where does it reside? Will they give it up?
- Be sure the data have integrity.
- Use familiar terminology and data display mechanisms.
- Determine who should review the data and who should take action.
- Don't strive for perfection.
- BSC is a long process to develop and roll out; it takes time and patience.
- Resource allocations are needed: time, staff, and equipment.

SUMMARY

The balanced scorecard is used by more than 60% of the Fortune 500 companies to measure their performance and align goals to strategy. In this article, we reviewed common management challenges and how the implementation of a BSC can help to overcome these challenges and foster continuous improvement in government and nonprofit organizations. Major steps and activities in the implementation process were presented along with lessons learned from successful implementations. Implementing a BSC can result in the alignment of the organization's mission, vision, and strategic plan to key measures that define success for the organization. Other results of using a BSC are the creation of a management tool to identify opportunities for improvement and a tool to support knowledge-based decision-making. Organizations using the BSC report improved accountability and follow-up as well as streamlined communication of performance measures. ★

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