

# BEST PRACTICE BALANCED SCORECARDS FOR GOVERNANCE, ORGANIZATIONS & CEOs

By Ted Ball, Bruce Harber, Ken Moore & Liz Verlaan-Cole

**A**fter a decade of “lessons learned” in balanced scorecarding in the healthcare sector, we are coming to a much better understanding about “what works” and “what doesn’t work” in achieving strategic focus, organizational alignment and accountability for outcomes in healthcare organizations and local delivery systems. This essay is intended to provoke the thinking of Boards, managers and policy-makers on how some of these lessons and emerging best practices could be adapted to their unique circumstances.

What we do know is that there needs to be a *common language/common framework* that links the Board, the CEO, senior management and middle management to provide the strategic focus, alignment, synergy and implementation support that frontline service providers require to be successful at achieving the organization’s outcomes – the results that flow from their mission, their vision and their strategy.

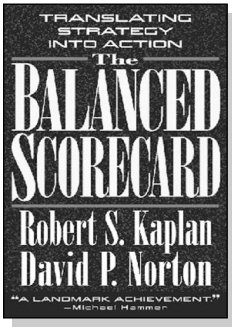
Emerging from the failures of re-engineering, restructuring and merger methodologies has come the art and science of Balanced Scorecarding – which has been tracked and evaluated by *Harvard’s Balanced Scorecard Collaborative* since 1990.

The bottom line: about 30% to 50% of organizations that practice balanced scorecarding experience improved performance on a balanced set of strategic indicators – including staff/customer satisfaction rates and financial performance.

However, similar to TQM/CQI and reengineering methodologies in the healthcare sector, 70% failure rates among organizations using a scorecard are common. This essay will provide you with some current insights into how the design and execution of BSC methodologies can put your organization among the 30% who are successful.

## Balanced Scorecarding

**A** Balanced Scorecard is a systems thinking-based tool/methodology/process that is deeply rooted in the failures of reengineering, downsizing, mergers and a plethora of “structural quick-fixes” that have been employed in the health sector over the past ten years.



In their book *The Balanced Scorecard*, by Kaplan and Norton state that “the Balanced Scorecard translates mission and strategy into outcomes and measures organized into four perspectives: *financial, customer, internal processes and learning and growth.*”

“The scorecard provides a framework, and a language to communicate mission and strategy; and it uses measurement to inform employees about the drivers of current and future success.”

“By articulating the outcomes the organization desires – and the drivers of those outcomes – senior executives can channel the energies, the abilities, and the specific knowledge of people throughout the organization towards achieving the long-term goals”.

In a best practice framework used in the healthcare sector, the scorecard contains the four strategic quadrants (*finance & customer outcomes, value-adding processes and the learning & growth enablers*) and traces their “relationship of effect” (follow the arrows in *Figure #1*).

These healthcare organizations start by determining the outcomes they will achieve for their customers, as well as the outcomes they will achieve in their financial quadrant.

They then determine what value-adding processes they need to design in order to achieve these outcomes; what skills their staff need, what learning & growth investments they need to make in order to enable the organization to design and implement the value-adding processes that will produce the results/outcomes listed in their customer and financial quadrants.

While there are examples of dramatic improvements in the corporate sector with the BSC, in recent years, numerous healthcare organizations in the United States, Canada and Europe have achieved breakthrough results as well.

Noorein Inamdar and Robert Kaplan in their essay “*Applying the Balanced Scorecard in Health Care Provider Organizations*” (*Journal of Healthcare Management*, May/June, 2002) noted that unlike the traditional, linear industrial-age management methodologies common to the healthcare sector, the BSC can provide the following benefits:

- A framework that will align the entire organization around the implementation of a more **customer-focused strategy**.
- Core principles and processes for **strategy implementation/execution**.
- A **communication and collaboration mechanism** that clearly assigns **accountability** to those responsible for carrying out the strategy – at all levels of the organization.
- A **measurement reporting system and monitoring** to assess the progress and success of the strategy.

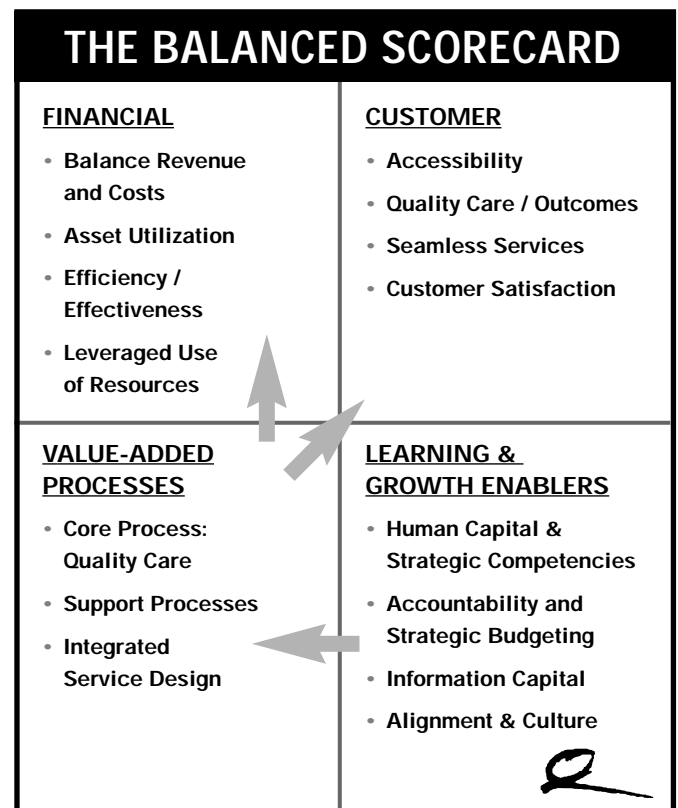


Figure #1

## WITHOUT PROCESS TO EXECUTE STRATEGY, YOU COULD BECOME A STATISTIC:

Most health care organizations do not have adequate processes to manage strategy. Consider the following:

- 95%** Of a typical workforce does not understand their organization's strategy
- 90%** Of organizations fail to execute their strategies successfully
- 86%** Of executive teams spend less than one hour per month discussing strategy
- 70%** Of organizations do not link middle management incentives to strategy
- 60%** Of organizations do not link strategy to budgeting

Balanced Scorecard Collaborative, Health Care Summit 2003

Figure #2

- Direction for allocating **resources** to achieve the strategy.
- A continual feedback and **learning process** that facilitates continuous adjustments to emerging realities.

The evidence suggests that most healthcare organizations do not currently have adequate processes to manage strategy. In *Figure #2* is the *Balanced Scorecard Collaborative's* data on organizations that employ traditional approaches to managing strategy.

Healthcare organizations need to ask themselves if their current practices reflects the overall performance of typical organizations.

## Execution

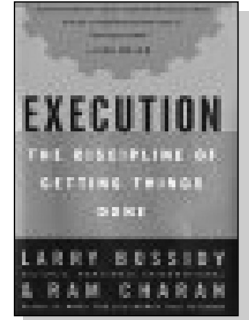
**W**hile the BSC holds open the possibility of changing these results dramatically, there are no guarantees.

Many healthcare organizations currently using a process that they call "a Balanced Scorecard", are actually only

using the BSC as a performance measurement tool – sometimes used to blame – rather than for the original purpose: *strategy implementation*.

Simply put, the BSC has been designed as a framework and a process that mobilizes people to achieve the outcomes and targets of their strategy. It is a tool/process for executing strategy.

Bossidy and Charan, in their book, *Execution: The Discipline of Getting Things Done* describes execution as "a systemic process of rigorously discussing hows and whats, questioning, tenaciously following through, and ensuring accountability."



"It includes making assumptions about the external environment, assessing the organization's capabilities, linking strategy to operations and the people who are going to implement the strategy, synchronizing those people with their various disciplines, and linking rewards to outcomes."

"It also includes mechanisms for changing assumptions as the environment changes, and for upgrading the organization's capabilities to meet the challenges of an ambitious strategy."

While much has been written on *Organizational Balanced Scorecards* and their ability to mobilize an organization and to facilitate a better balance between empowerment and accountability, we are now seeing even greater levels of alignment and synergy in organizations that are developing three additional complementary scorecards: the *Balanced Governance Scorecard* and the *CEO/Chief-of-Staff Scorecard* – as well as *Managerial Accountability Agreements*.

## The Balanced Governance Scorecard

**T**he reality is that while the healthcare sector has undergone ten to fifteen years of unrelenting incremental changes, governance processes and methodologies have largely gone unchanged over that same period.

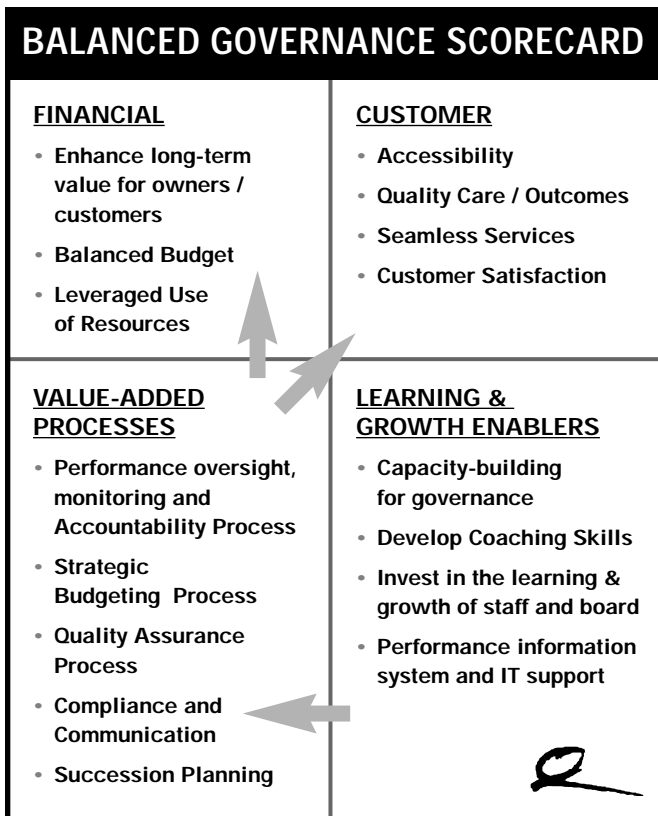


Figure #3

Even 15 years ago the healthcare sector was by far the most complex of organizational designs that humans have ever devised. Today, the complexities of hospitals and local delivery systems are staggering – when viewed through the lens of traditional industrial-age systems, structures, processes, and managerial styles.

Today, we have the benefit of learning from “what worked”, and “what didn’t work” in the *Carver Model* and the *Pointer/Orlikoff Model* of governance in the healthcare sector over the past ten years.

For Boards that have maintained their traditional governance model, and for Boards that have evolved their own unique approach to *Carver* or *Pointer/Orlikoff*, the Balanced Governance Scorecard could be the next iteration of their continuous improvement journey.

Balanced Governance Scorecarding is a methodology and a process that enables Boards to evaluate their own performance – as a group, and as individuals. It is designed to describe and manage the strategic responsibilities of the Board itself.

A recent study by *Governance Metrics* (August, 2003) clearly demonstrates that “good governance” makes a considerable difference to the operational performance

of an organization, and that “poor governance” contributes to sub-optimal performance at the operational level.

In his insightful book, *Deep Change: Discovering the Leader Within*, Robert E. Quinn states that “the most important lever for change is modelling the change process for other individuals. This requires that the people at the top themselves engage in a deep change process.”

Boards that are prepared to redesign themselves will therefore “model change” and “commitment to excellence” to the rest of the organization.

## The Board’s Responsibilities

**W**hat are the strategic responsibilities of Boards in a best practice healthcare governance model?

They are:

### 1. Approve Strategic Direction

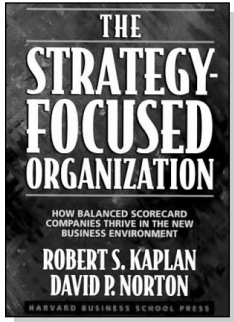
Boards of public hospitals and community service organizations represent the interests of the public in their mandate to set the strategic direction of their publicly-funded organizations. They represent the interests of the

## THE BOARD’S RESPONSIBILITIES

1. Approve Strategic Direction
2. Ensure leveraged use of resources
3. Coach the CEO/Chief-of-Staff and holding them accountable for results
4. Serve as the guardian for compliance and open communications
5. Select CEO/Chief-of-Staff, ensure continuous learning/improvements and succession planning

Figure #4

“owners” and “customers”: the citizens of the province/  
community.



However, it is the CEO’s job to develop strategy in conjunction with their senior and middle managers, and to implement/execute the strategic directions approved by the Board.

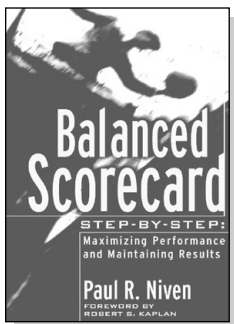
It is the CEO’s mandate to create, lead and manage a strategically-focused organization that has the

internal capacity to achieve the outcomes set by the Board.

A recent McKinsey survey in the corporate sector indicated that 44% of directors don’t fully understand the key drivers of value for the organization they govern. Given the complexities of hospitals and health systems, and given the dramatic changes that have occurred incrementally over the past ten years, there is little expectation that healthcare Boards can or should create strategy.

They hire a CEO for that. CEOs develop and implement strategies designed to achieve the Board’s “ends policies”. Boards approve or amend the high level strategies generated by the CEO and their Strategy Team: provide oversight; and, hold the CEO *accountable for outcomes*.

Boards of hospitals are also accountable for maintaining high quality-of-care standards in their organization. In some jurisdictions, Boards are required to have a Chief-of-Staff to whom they devolve their accountabilities for maintaining current quality-of-care standards at their hospital.



In the post-SARS world, and with recent evidence that 8,000 to 10,000 Canadians die annually because of preventable hospital and medical errors, quality-of-care issues are becoming critically important to the public – and therefore to the boards that represent their interests.

On behalf of the customers and the owners, Boards ensure that the organization’s systems, structures and processes are producing continuous improvements in the quality of care provided.

The Board’s job is to “add value” to the BSC development process – through their monitoring of the progress being made by the CEO, senior management and the Chief-of-Staff on the themes, perspectives, outcomes, measures and targets set out in an *Organizational Balanced Scorecard* that they have approved following extensive dialogues with the CEO and their strategy team.

The Board’s job is to “push the envelope” on behalf of the owners and customers by bringing a deep understanding of community values and a diverse set of perspectives/skills/ knowledge. They ask “wicked” and “probing questions” that stimulate and provoke everyone’s thinking about how best to serve the community – through the leveraged use of resources available.

Then they provide approval for the strategic directions (“ends”) that they believe reflect the public interest, and that they are convinced will achieve the organization’s mission and vision – within the resources that have been allocated by the provincial government.

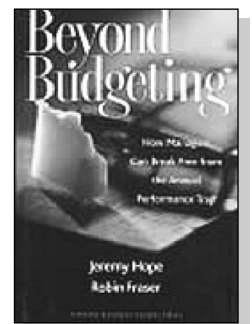
## 2. Ensure Leveraged Use of Resources

Boards must ensure that resources are used effectively and efficiently to achieve the strategy that they approve. They set fiscal policy, approve large capital expenditures and are accountable for ensuring a balanced budget.

While Boards can always attempt to convince the funders (provincial governments/the public) that they need more resources to fulfill their mission, their job is to ask probing/wicked questions of the CEO, senior managers and the Chief-of-Staff to ensure that the strategy they have approved has the resources required for success – and that the budget is balanced.

While the “owners” want accessible, high-quality services, as taxpayers, they also want to be confident that available resources are being spent wisely, for the highest return on investment for their community.

Organizations that use the balanced scorecard framework, language and process abandon the traditional budgeting process that can consume up to 30% of the time of senior executives, and a great deal of middle managers’ time – whose survival often depends on learning how to “game the numbers”.



In *Beyond Budgeting: How Managers can Break Free From the Annual Performance Trap* Jeremy Hope and Robin Fraser point out that “as long as budgeting – a vestige of the old command-and-control approach to management – remains in place – the newer tools designed to decentralize strategic decision-making will never achieve their full potential.”

The authors suggest five principles to ensure that there is a leveraged use of resources (see Figure #5).

Experience indicates that where organizations utilize a best practice balanced scorecarding methodology, and retain their traditional budgeting process, staff receive two conflicting messages: “we’re changing,” and, “we’re not changing”.

Where *strategic budgeting* has been used in conjunction with an *Organizational Balanced Scorecard*, the role of the Board is a key critical success factor.

## STRATEGIC BUDGETING PRINCIPLES

1. Provide a governance framework based on clear principles and boundaries.
2. Create a high-performance climate based on relative success.
3. Give people freedom to make decisions that are consistent with governance principles and the Board’s “ends policies”.
4. Place the responsibility for value creating decisions on front-line teams.
5. Support open and ethical information systems that provide “one truth” throughout the organization.

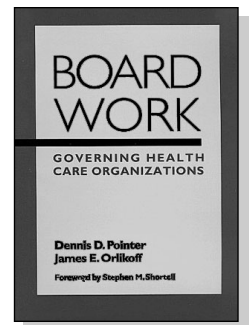
From: *Beyond Budgeting*

The Board needs to learn how to focus on the meaning of both the financial and non-financial data; ask probing questions on behalf of the “owners”; push for innovation, creativity, teamwork and collective intelligence – while holding their two employees accountable for the outcomes/results achieved within a best practice accountability framework and process.

### 3. Coach the CEO/Chief-of-Staff and Holding them Accountable for Results

The *Organizational BSC* monitoring process ensures that Board meetings are opportunities for board members to share their knowledge, discuss strategic tradeoffs, and lend decision support to the CEO, senior management team and Chief-of-Staff.

In their book, *Board Work: Governing Health Care Organizations*, Pointer and Orlikoff say “In today’s health care system, proposals and recommendations must wind their way through a governance labyrinth that significantly decreases an organization’s strategic and operational metabolic rate –at a time when decisiveness and agility are needed most.”



Pointer and Orlikoff point out that “Board meeting time is often spent passively listening to reports and receiving background information – from management, the medical staff and the Board’s own committees. Little time is left for the ‘red meat’ of governing: deliberating and debating decisions and policies that require Board input and action.”

The *Organizational Balanced Scorecard’s* performance measurement system provides the Board with a set of financial and non-financial measures and targets that shows past, current and anticipated performance using measures and targets that are meaningful and easy to understand.

With the best interests of the customers and owners in their hearts and minds, Boards use the BSC monitoring process of the CEO, Chief-of-Staff and senior management team to coach, guide, mentor and “add value” to their thinking – while “pushing the envelope” on behalf of the community they serve.

Figure #5

Because they want the CEO and Chief-of-Staff to succeed, Board members will want to find ways of “adding value” to their two employees – as they and their teams struggle with the actions required to close “the gap” between current performance, and the outcomes/results for which they are being held accountable by the Board.

Really excellent Boards are ones that master the skill and art of coaching. While there are many coaching models, Boards need to be intentional about how they will provide coaching and feedback to their employees.

In the healthcare sector, Boards that “add value” are those that create a safe environment where the CEO and senior management team can explore their best thinking on strategy with the Board, and, as a result, are able to enrich and leverage their thinking and their plans.

Apart from the monitoring of the progress being made on the *Organization’s Balanced Scorecard*, best practices suggests that CEOs and Chiefs-of-Staff should develop their own scorecards as a starting point for their *Accountability Agreements*. Their scorecards and the agreements should reflect how they personally will enable the organization to successfully achieve the organization’s BSC outcomes – as well as the “supports they require” to be successful, and the “consequences” of success and failure.

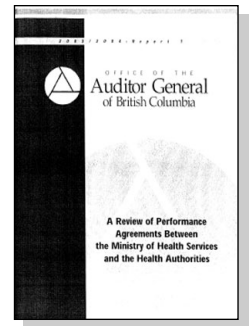
#### 4. Serve as Guardian for Compliance & Open Communication

Compliance includes legal, accounting and regulatory requirements – as well as oversight to ensure that the organization is adapting best practices for quality-of-care standards, human resource management, performance measurement and strategy implementation.

Increasingly, provincial governments are using *Performance Agreements* that set out high level agreed-upon outcomes that will be achieved, in return for public resources.

How these are designed is critically important. In *Beyond Budgeting*, Hope and Fraser point out that “fixed performance contracts cause managers to behave in dysfunctional ways”. They say “at best this results in ‘managing the numbers’, at worst, it results in outright misrepresentation and fraud.”

While some jurisdictions have designed the *Performance Agreement* (or *Business Planning Process*) to micro-manage the operations of healthcare organizations, this approach can create confused accountabilities for the CEO as to who their boss really is: their Board, or the public servants who are monitoring and inspecting them?



A recent *British Columbia Auditor’s Report* points to the models in New Zealand/Australia/Britain that are rooted in learning and continuous improvement, rather than in centralized bureaucratic control, as the “best practice” approach that needs to be developed.

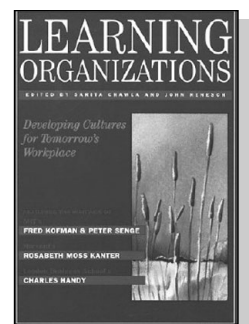
Whichever model is employed – best or worst practice – Boards are accountable for ensuring that their agreement with their funder is honoured.

Boards therefore need to ensure that, in addition to the outcomes that they are seeking to meet the unique needs of their community, they need to incorporate what they have agreed to in their *Performance Agreement*, in the *Accountability Agreements* with their two employees: the CEO/Chief-of-Staff.

Boards therefore devolve their accountabilities and monitor performance.

#### 5. Select the CEO/Chief-of-Staff, Ensure Continuous Learning and Succession Planning

Boards select their two employees and hold them accountable for achieving the outcomes listed in their *Organizational Balanced Scorecard* – where the outcomes are continuously adjusted to reflect emerging realities.

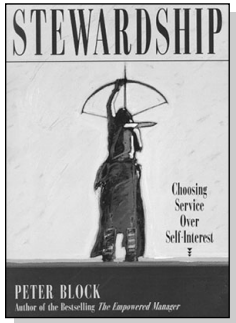


In the learning and continuous improvement model, Boards are not engaged in “gotcha” exercises; and, CEOs, senior managers are not engaged in “defensive routines”. Instead, the governance and managerial leadership participate in authentic learning dialogues to explore the “gaps” in performance, and to explore the possible leveraged actions that will close the gaps identified.

Boards are also responsible for ensuring that there is *succession planning* for all key executives, and that there are adequate resources for *learning and growth* – at least 1% to 5% of the payroll budget. Best practices suggests that these resources be initially devoted to ensuring that senior managers, middle managers and staff have the skills and capacity required to design and implement the processes that will achieve the organization's outcomes in the *customer and financial* quadrants of their BSC.

In their book, *A Balcony Perspective*, Broholm and Johnson describe a board member's role this way: "Board members have a critical role in the development of trust-worthy institutions. They build trust by understanding their role, and using their power wisely; by setting boundaries for staff which are creative, not oppressive; by serving as mentors to the organization, and by creating hospitable space for indepth reflection."

Participating in the development of the *Organizational Balanced Scorecard*, and developing their own *Governance Balanced Scorecard*, are two important ways for Boards to "model learning" for their organization. In doing so, they are functioning in stewardship to their community.



Peter Block defines *stewardship* as "the willingness to be accountable for the well-being of the broader community, by operating in service, rather than in control of those around us."

When Boards and CEOs have achieved a genuine partnership – a relationship of equality – even though the Board is the "partner-in-charge", (51% vs. 49%), then stewardship and partnership can become organizational realities.

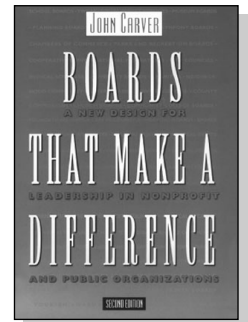
While it is the CEO's and Chief-of-Staff's responsibility to ensure that managers and medical chiefs are in alignment with the Board's strategic directions and "ends" policies, the Board provides "oversight" for the accountability processes that provide *the right balance of empowerment and accountability* for the organization's staff to succeed.

Finally, Boards are responsible for succession planning for all key executives.

## Governance/Management Roles

The Carver and Pointer/Orlikoff *Models* of governance provide clarity on the distinct roles of governance and management.

The CEO's responsibility to manage and lead the organization is distinct, but complementary, to the Board oversight responsibility.



The CEO's role is to lead and manage the senior team and middle managers to develop/facilitate/communicate the organization's strategy.

In a number of successful organizations, CEOs and their senior managers sought input from directors, managers and the wider system for their best thinking on the organization's BSC outcomes and measures – before returning to their Board.

To ensure that the outcomes for which the CEO and Chief-of-Staff are accountable are in fact achieved, the CEO's role is to ensure *organizational alignment* of the people, systems, structures, processes, culture and the skills that are required to succeed.

In the strategy implementation process CEOs and their senior management teams are as much *system designers* as they are strategists.

To ensure best practices in system and organizational design, balanced scorecarders use another systems thinking-based tool for complex system design: the *Strategic Alignment Model* – which helps system designers to discover how they can better align their structure, culture and skills to achieve their Balanced Scorecard outcomes (see alignment model, *Figure #6*).

In organizations where the Board is developing their own *Governance Balanced Scorecard* (while engaging in dialogues with the CEO/Chief-of-Staff and the senior management team on the initial few iterations of their *Organizational BSC*), the dialogues tend to be rich with mutual learning and empathy – rather than negative judgment, or blind acceptance.



<b>BOARD'S ROLE</b>	<b>CEO'S ROLE</b>
<b>VISION</b> <ul style="list-style-type: none"> <li>Continuously review, explore and refine the organization's vision</li> <li>Require highly participative processes for shared vision, strategy development and feedback</li> </ul>	<b>SHARED VISION</b> <ul style="list-style-type: none"> <li>Ensure teams and staff throughout the organization have ownership of the evolving vision and strategy</li> <li>Lead and manage transformation process</li> </ul>
<b>APPROVE STRATEGIC DIRECTIONS</b> <ul style="list-style-type: none"> <li>Long-term strategy and targets</li> <li>Partnerships and system integration</li> </ul>	<b>DEFINE &amp; COMMUNICATE STRATEGY</b> <ul style="list-style-type: none"> <li>Identify financial and non-financial drivers</li> <li>Capacity-building for BSC input through cascading process</li> <li>Partnership and system integration</li> </ul>
<b>OVERSEE FINANCIAL ACTIVITIES</b> <ul style="list-style-type: none"> <li>Performance review/monitoring process</li> <li>Fiscal policy/strategic budgeting</li> <li>Ensure leveraged use of resources</li> <li>Approve major capital expenditures</li> </ul>	<b>MANAGE FINANCIAL RESOURCES</b> <ul style="list-style-type: none"> <li>Fiscal policy/strategic budgeting</li> <li>Forecasting and strategic budgeting</li> <li>Propose major capital expenditures</li> <li>Balance the budget</li> </ul>
<b>COACH THE CEO/CHIEF-OF-STAFF &amp; PARTNER WITH SENIOR MANAGEMENT</b> <ul style="list-style-type: none"> <li>Decision support</li> <li>Performance feedback/advice</li> <li>Ask probing questions on behalf of the "owners" and "customers"</li> <li>Function as coach, guide, mentor</li> </ul>	<b>ORGANIZATIONAL &amp; PEOPLE ALIGNMENT</b> <ul style="list-style-type: none"> <li>Workforce acquisition/retention and performance management</li> <li>Alignment of processes, systems, structures, culture and skills to achieve the strategy</li> <li>Coach direct reports/model learning</li> <li>Provide the right balance of leadership/management and empowerment/accountability</li> </ul>
<b>SELECT &amp; MOTIVATE EXECUTIVES</b> <ul style="list-style-type: none"> <li>Executive performance and compensation</li> <li>Succession planning/executive development</li> <li>Invest in learning &amp; growth of board and staff</li> </ul>	<b>BUILD CAPACITY OF STAFF</b> <ul style="list-style-type: none"> <li>Invest in learning &amp; growth of staff</li> <li>Model learning</li> <li>Practice developmental facilitation and coaching</li> </ul>
<b>ENSURE COMPLIANCE</b> <ul style="list-style-type: none"> <li>Regulation requirements</li> <li>Quality care and risk management</li> <li>Stakeholder/funder communications</li> <li>Hold CEO/Chief-of-Staff accountable for outcomes</li> </ul>	<b>MANAGE EXECUTION</b> <ul style="list-style-type: none"> <li>Performance measurement/reporting/ review</li> <li>Partnership with Chief-of-Staff/senior team/Board</li> <li>Determine leveraged actions to close the performance gap</li> <li>Stewardship for success</li> </ul>

Ongoing monitoring dialogues, and retreats between the Board and the senior management team should be designed to achieve leadership alignment, common understanding, and, ultimately Board approval and support for achieving the outcomes listed in the *Organizational BSC*.

## The CEO's/Chief-of-Staff's Scorecards and Accountability Agreements

**B**est practices suggest that Chief Executive Officers are held accountable by their Boards for achieving the high level outcomes in the customer and financial quadrants listed in the Board-approved *Organizational BSC*.

While that continues to reflect best practices, in recent years CEOs have begun to develop their own scorecard – as part of their process for developing an *Accountability Agreement* with their Board. These agreements balance the “supports required” to successfully achieve the outcomes – as well as the “consequences” of success and failure.

In developing the *CEO Agreement*, the CEO reflects on the *Organizational BSC* and asks:

“What can I do, as CEO, to enable my organization to be successful? What will I do to ‘add value’ in each of the quadrants of the organizational and governance scorecards?” (see Figure #8)

By leading the organization through the BSC development process, CEOs will have a good understanding of the strengths and vulnerabilities of their organization – and how they can provide the right balance of leadership and management that will contribute to their organization’s success.

By engaging in *developmental coaching* with their direct reports, and working with each of them as they develop their own *Accountability Agreements*, and integrate them cross-functionally, the CEO will also have a good understanding of how they can support or remove barriers for senior and middle management, the Chief-of-Staff and the Board – so that they all successfully achieve their outcomes and targets.

When everyone is successful, the CEO is successful.

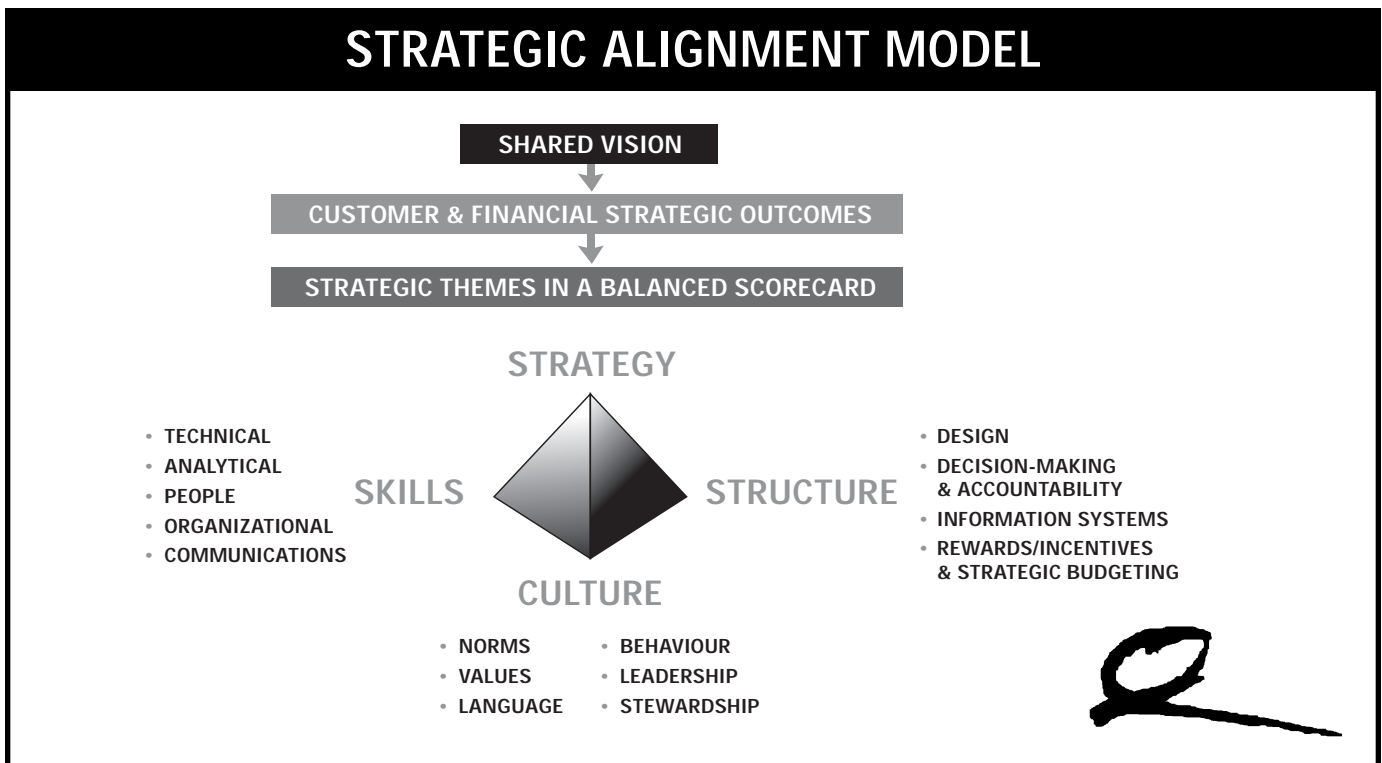


Figure #6

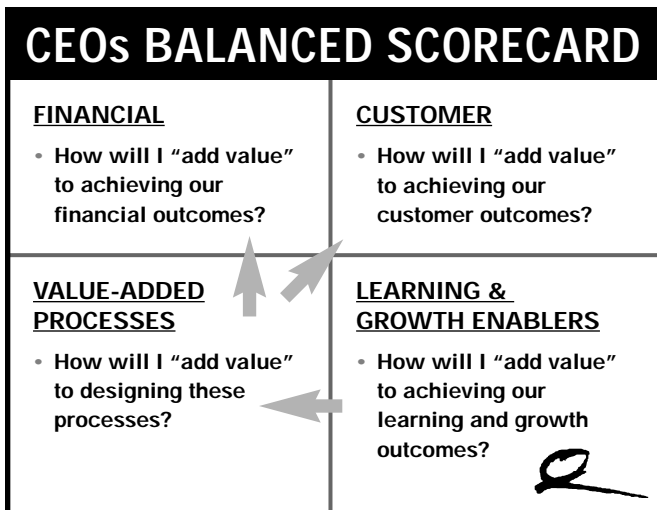


Figure #8

While the Board has two employees (CEO/Chief-of-Staff), the Chief-of-Staff is a member of the CEO's senior management team. The CEO is the one accountable for the overall strategy and the results produced. There can also be “shared accountabilities” that require partnership and collaboration between the Board's two employees to ensure that the organization is successful.

While there are some examples of organizations that have successfully engaged physicians in the *Organizational Balanced Scorecard Process*, the evidence would suggest that there is significant room for improvement.

That's why the process for developing the *Chief-of-Staff's BSC* and *Accountability Agreement* is so critically important to hospitals. Current wisdom suggests: “slow down, in order to speed up”, and, “plan to plan, or plan to fail”.

Medical Chiefs and Medical Advisory Committees need to see how the accountability process and the BSC are used to mobilize the “supports” they need to successfully achieve the quality-of-care outcomes for which they are accountable.

Can this process address the long-held criticism of the lack of meaningful physician engagement in decision-making and strategy?

Yes. When physicians experience this process as a systematic method for holding the Chief-of-Staff, CEO, senior managers and the Board accountable for providing the agreed-upon “supports required” to achieve their outcomes, the BSC will become a meaningful and important tool for the hospital's physician leadership group.

Physicians, through the Medical Chiefs, and through the Chief-of-Staff, can be full participants in on-going decision-making and strategy development with this model.

However, where the BSC is seen as yet another “management fad”, and where physicians may have become demoralized and cynical about ever experiencing improvements, it could take two or three years before active cooperation occurs.

For the best results, there needs to be a renewed commitment – on the part of the hospitals and their physician leadership – for cooperation, collaboration, trust-building and respect.

In organizations where hospital/physician relationships require a period of trust-building, the Chief-of-Staff can provide the medical perspective on the first few iterations of the BSC in their work with the other members of the CEO's strategy team.

Once there is an environment of trust, respect and partnership, the Chief-of-Staff can then facilitate the best thinking of the Medical Chiefs and the hospital's quality-of-care committee – and fully engage the medical perspective in the BSC process before seeking the Board's approval on the *Organizational BSC*.

When there is alignment on the medical perspective, on the part of the physician leadership, the Chief-of-Staff can then work with the Medical Chiefs to develop *Accountability Agreements* with them that clearly set out the “supports required” for them to be successful.

In this design, physicians can achieve the *balance of empowerment and accountability* that holds the prospect for significantly improving hospital/physician relations – and ultimately, organizational performance.

This approach acknowledges that our existing systems, structures and processes that define hospital/physician relationships have been unintentionally designed to create conflict and dysfunctionality.

While traditional hospital/physician relationship designs may have ingrained personal conflict between management/physicians/Board/CEO, people must be ready to “let go” of past conflicts, forgive, and be ready to move on and collaborate to achieve the organization's *shared vision*.

Among the handful of hospitals that have successfully integrated the physician's perspective into their BSC in the early stages of development is **Duke Children's Hospital** – named to the Balanced Scorecard Collaborative's *Hall of Fame* in 2000.

## Managerial Accountability Agreements

**B**ecause CEOs are accountable for all of the outcomes in the organization's evolving BSC, they need systems, structures and processes that will ensure that their accountabilities to the Board are linked and integrated into the accountability process for all managers.

An *Accountability Agreement* is a tool for people to mobilize the support they need to successfully achieve the outcomes for which they are accountable (see *"Redefining Accountability in the Healthcare Sector"*, *Managing Change*, Spring, 2003).

*Accountability Agreements* need to be designed as a "fair business bargain". They are a personal promise to achieve measurable results within a guarantee that *"you can't be accountable for anything over which you have no control."*

When vice-presidents, directors, and managers and medical chiefs integrate their *Accountability Agreements* cross-functionally, they are able to reach agreements on how they will work together to align the systems, structures and processes that will enable them – individually and collectively – to achieve the outcomes in their *Organizational BSC*.

The *Accountability Agreement* is the manager's best friend, not their worst enemy! It is designed to reflect the right balance of empowerment and accountability.

## Synergy & Alignment

**S**o, how does the **Balanced Scorecard, Accountability Agreement** and **Performance Agreement** work together to create alignment and synergy at the organization level?

In *Figure #9* we have created a Venn diagram that outlines the various pieces of the governance/management puzzle that we have dealt with in this essay.

The centerpiece of this architecture is the *Organizational Balanced Scorecard* which, when approved by the Board, becomes the "ends policies" and the official strategy of the organization – subject to continuous improvements that are driven by the emerging internal and external realities that the organization must manage.

**"Accountability Agreements are designed to reflect the right balance of empowerment and accountability."**

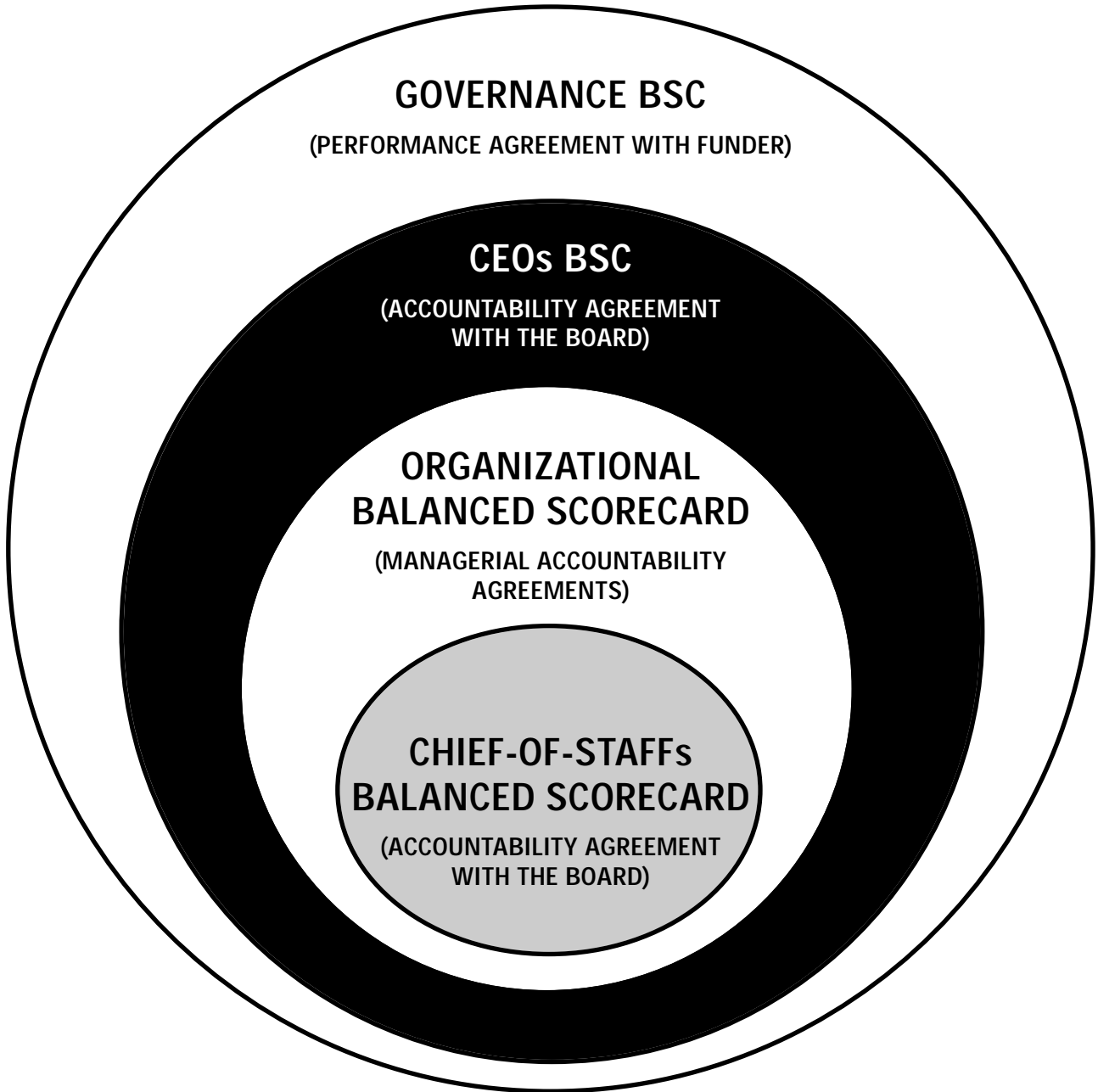
While the CEO is accountable for the outcomes listed in the financial and customer quadrants of the *Organizational BSC*, they develop a personal BSC, and an *Accountability Agreement* with their Board that reflects the "supports required" to succeed, as well as the "consequences" of success and failure.

In healthcare systems, where legislation requires the Chief-of-Staff to be accountable to the Board directly, a Chief-of-Staff creates a scorecard and an accountability agreement with the Board that is reflected in both the *Organizational BSC* and the *CEO's Accountability Agreement*.

To ensure their own success, CEOs require their direct reports to develop *Accountability Agreements* that incorporate the outcomes in the *Organizational BSC* that they are accountable for achieving.

In turn, vice-presidents have *Accountability Agreements* with directors, and managers have agreements with their directors – thereby linking everyone in management with the Board's directions. This is how an organization can achieve alignment of "people, systems, structures and processes".

# ALIGNING BALANCED SCORECARDS AND ACCOUNTABILITY AGREEMENTS



The Board is accountable for everything. The CEO's scorecard reflects the Organizational BSC and the Chief-of-Staff's. The Organizational BSC incorporates the Chief-of-Staff's BSC.



Figure #9

Finally, encompassing everything is the Board's own Balanced Scorecard – what we have called the *Balanced Governance Scorecard* – which provides the Board and individual board members with a methodology for measuring their own performance.

Instead of dealing with each of the components of governance, management, quality and financial performance as separate silos that have nothing or little to do with each other, this suggested architecture aligns each of these pieces into a single integrated approach that will produce synergy, collaboration, alignment, and, strategic focus.

However, for this system to work, managers – particularly the top managers – need to be deeply and fully committed to change.

In the *Strategy-Focused Organization* Kaplan and Norton point out that experience has repeatedly shown that “the single most important condition for success is the ownership and active involvement of the executive team.”

These authors remind us that “strategy requires change from virtually every part of the organization. Strategy requires teamwork to coordinate these changes. And strategy implementation requires continual attention and focus on the change initiatives and performance against targeted

outcomes. If those at the top are not energetic leaders of the process, change will not take place, strategy will not be implemented, and the opportunity for breakthrough performance will be missed.”

## Local Delivery System Integration

**W**hile Balanced Scorecards can create alignment and synergy within an organization, they can also be utilized within a local delivery system to achieve enhanced integration and coordination of services at the patient/customer contact points across the continuum of care within a community.

Healthcare delivery organizations are often trapped in senseless silo competitions between institutions and community agencies. They are engaged in relational dynamics that systems thinking scholars call a “*system archetype*” – a repeating pattern of behaviours/thinking that always fails in the end.

The archetype in this case is called “*The Tragedy of the Commons*” (see *Figure #10*) where the end result is: everybody loses.

**“The single most important condition for success is the ownership and active involvement of the executive team.”**

## THE TRAGEDY OF THE COMMONS

This *systems thinking archetype* illustrates one of the common mistakes in designing complex systems: combining perverse incentives for individuals or silos in systems where – ultimately – survival requires cooperation and coordination of effort and resources.

Named after an essay by ecologist Garrett Hardin (1968), the tragedy occurs over the use of a “common pasture” where the villagers of a community graze their livestock and where the incentive structure is designed to reward everyone for increasing the size of their livestock herds.

In time, the common pasture is bare dirt, all the livestock die, and the villagers starve. What is missing from the commons system are appropriate incentives, governance and decision-making processes that ensure that the size of the herds grow to the level where it matches the growth rate of the grass.

As an illustration for the healthcare sector, Hardin's story reveals why it is essential that individual silos see the larger picture and develop incentives and decision-making processes that will enable a community to collaborate and coordinate in their individual and collective self-interests.

Figure #10

So, how do you get organizations to shift their historical silo-behaviours and competitive dynamics to achieve vertical and horizontal integration of customer services within a delivery system?

At his June, 2003 dialogue workshop with Board leaders and senior managers in eastern Ontario's Champlain District, Dr. Dennis Pointer, the foremost authority on best practice healthcare governance, advised that "Boards are the best stimulants, facilitators and vehicles for greater inter-organizational cooperation."

But Boards have to consciously choose to change from: **"representing the interests of their silo"; to "representing the interests of their common 'owners' and 'customers': the citizens of the province, and the community they serve."**

While the health sector's addiction to "structural quick-fixes" will compel many to believe that *Regional Health Authorities*, more mergers or more rules and requirements for hospital networks are the solution to consumer demands for a "seamless system of services", experience with system integration issues does not support their beliefs that change happens when you simply change the structure.

From the former North Shore Health Region in British Columbia, and from a number of American integrated health systems, we see compelling examples where having a *common language/common framework* for problem-solving and decision-making that the BSC strategy implementation process provides, enables everyone – cross-functionally within organizations, and at the hand-off points across the delivery system – to integrate at the service delivery level.

The paradoxical lesson learned: organizations within a local delivery system can be independent and interdependent at the same time – when they share a common language/common framework for strategy implementation.

When a critical mass of healthcare organizations within a local delivery system have included "seamless services"

as a customer outcome; and "integrated service design" as a value-adding process in their BSC – for which the Board is holding the CEO accountable – there will be measurable improvements in system integration.

While it is possible to retain the benefits of independent governance and management and achieve the efficiency and effectiveness goals of integrated services at the customer delivery level – progress will be slow and painful, until and unless the system abandons its silo-orientation.

Boards can and should play a key role in creating this shift in the thinking and behaviour at the community level.

**"Organizations within a local delivery system can be independent and interdependent at the same time – when they share a common language/common framework for strategy implementation."**

When a critical mass of Boards within a local delivery system realize that they are all representing the same "owners" and "customers", decision-making and strategy development within an organization will shift from the traditional silo-focus, to a customer-focus and community-focus.

Service integration from a customer perspective will only actually occur when a critical mass of CEOs and Executive Directors across a local delivery system are being held accountable for measurable improvements in system integration by their respective Boards.

When this occurs, collaboration, coordination and cooperation can be transformed from "buzz-words", to meaningful changes that will produce the results that consumers want and need.

Governments can and should play a key role in this shift as well. Instead of merely the rhetoric supporting integration, Ministries of Health need to align their core systems, structures, processes and incentives to support integration at the customer service level.

If provincial governments want the healthcare organizations that they fund to be accessible and seamless for the citizens they serve, then they must integrate their own internal departmental silos.

## Is Failure an Option?

Evidence from the *Balanced Scorecard Collaborative* tells us that only 10% of organizations ever successfully implement their strategy.

Common reasons for failure are located in the four barriers: *vision, people, management* and *resource allocation*, as set out in *Figure #11*.

Balanced scorecarding methodology is rooted in the lessons learned from our “best mistakes” from the past. The traditional “quick-fixes” for healthcare have historically been: increased funding, and structural change – sometimes described as “tinkering on the edges, and playing on the margins”.

The question is: have we really learned from our “best mistakes” of the past, or, are we doomed to repeat them a few more times before we change? Will we continue to call for “more money” or another “structural quick-fix” as the solution?

Today, we are experiencing the ultimate paradox: increasing spending on the healthcare system will result in a society that would in fact be less healthy – because the resources for quality education, clean water, safe food and secure electrical power would be diverted to hospitals.

So, if the solutions aren’t more money, or a reorganization of power and control structures, where are the solutions? The answer is: within the organization itself.

*Learning Organizations* are organizations that deeply understand that the solutions to their most perplexing problems are within their organization – in the hearts and minds of the people who work there.

Learning organizations align their systems, structures and processes to tap into the collective intelligence of their organization. In the healthcare sector, organizational culture has now become the “burning platform” for change.

While nurses and other health professionals have self-selected to be in the “caring business”, their employers have not historically demonstrated much care, concern or respect for front-line workers. To discover why customer satisfaction and public confidence rates are slipping, one need only look at staff satisfaction rates.

Even with billions of dollars in increased spending, a decade of incremental “quick-fixes” has produced one of “the most toxic work environments in the country” – with the healthcare sector ranking dead last among fifteen employment categories – according to the *CPRN-Ekos Employment Relationship Survey, Canada, 2000*.

**“While nurses and other health professionals have self-selected to be in the caring business, their employers have not historically demonstrated much care, concern or respect for front-line workers.”**

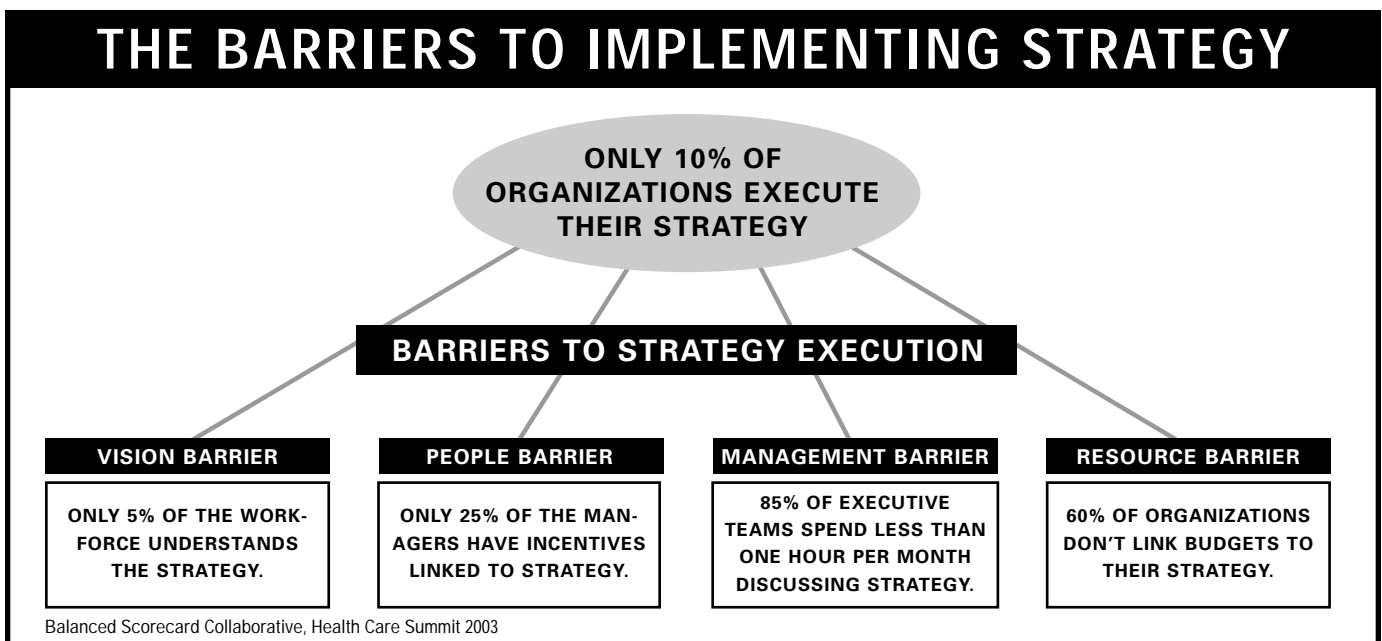


Figure #11



The reality is that our healthcare system is making healthcare workers sick. The health sector currently experiences absenteeism rates that are more than twice the national average (see essay, “Best Practice Balanced Scorecards: A Powerful Tool for Mobilizing Human Effort”, *Managing Change*, Winter, 2002).

Traditionally, health system politics has led to an endless series of measures intended to create an “illusion” of movement forward, or an “illusion” that there is accountability for the outcomes being achieved with the resources provided.

Properly practiced, balanced scorecarding and learning organization processes for high-performance teams can shift the traditional political culture of healthcare organizations to one which focuses everyone on the strategy – and their personal role in strategy execution.

But the fact is that balanced scorecarding can be an illusion as well. Instead of a CEO-led, highly participative strategy implementation process, scorecarding can simply become a *performance measurement system* that pinpoints “who to blame”, rather than “what to fix”, and “who needs support”, when there is little or no progress.

Unless an organization is determined to be in the 30% success group, balanced scorecarding can in fact become counter-productive – producing an entrenched command-and-control mindset; increasing cynicism, fear and anxiety; further contributing to declining staff morale; and ultimately, adversely effecting customer satisfaction and public confidence rates.

## Successful Scorecarding

**W**hat are some of the critical success factors for balanced scorecarding?

In *Figure #12* we have listed eight. Of these, we believe that the most leveraged are the first and the last.

That is, scorecarding needs to be the CEO’s *strategy implementation process* – conducted in an atmosphere of a true *learning organization* – where there is a balance of empowerment and accountability, strategic-focus and continuous capacity-building for learning, growth and change.

Peter Senge, author of the *Fifth Discipline: The Art & Practice of the Learning Organization* says “a learning organization is a place where people continually expand

their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective action is set free, and where people are continually learning how to learn together.”

Without such an enlightened managerial philosophy and practice, BSCs will continue to experience 70% failure rates – or at least sub-optimal performance outcomes.

Today, it is estimated that 86% of executive teams spend less than one hour per month on strategy. Clearly, providing strategic direction to the organization as a whole isn’t an important priority within intense work weeks that are often 70 hours – 90 hours long for many healthcare executives.

Highly urgent, and ultimately unimportant matters, regularly hijack the attention and talent of our senior managers.

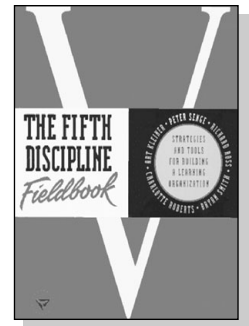
Governance – at the Board level, and at the provincial level, need to ask themselves the extent to which they contribute to this problem – and how they can play a key role in providing the time, space and motivation for managers to become successful scorecarders.

Where “crisis management” has become an ingrained habit, the medium and long-term targets of a Balanced Scorecard can easily become a pipe dream.

If politics – internally and externally – is still the key driving force within an organization, the Balanced Scorecard will simply become a new methodology for “doing politics”.

Until and unless the Board, the CEO, the Chief-of-Staff, the senior management team and the organization’s middle managers are aligned on a *shared vision* and a coherent strategy – and have developed the internal capacity to actually execute the strategy – balanced scorecarding will not produce the results that an organization needs to achieve.

The results achieved with the Balanced Scorecard are also highly dependent on shifting the role of middle managers from command-and-control and a silo-orientation, to developmental facilitation/coaching and cross-functional integration.



# CRITICAL SUCCESS FACTORS FOR BALANCED SCORECARDING

1. Used as a tool/process by the CEO to develop and implement strategies that achieve the outcomes for which they are held accountable by their Board.
2. The traditional senior management team, composed of silo-heads, is transformed into the *CEO's Strategy Implementation Team* whose role is to lead and manage the transformation of the whole organization – through “just-in-time” developmental facilitation and coaching.
3. Organizations invest in the skills of their people and build the capacity of senior and middle managers through the BSC cascading process – in which people “learn-by-doing” in highly participative processes. Middle managers integrate cross-functionally and provide facilitation and coaching.
4. Boards redesign their traditional governance processes by adapting best practice healthcare governance to their unique circumstances – using a *Balanced Governance Scorecard*. They model change, learning & growth and stewardship.
5. Organizations utilize best practice *Accountability Agreements*, linked to their *Organizational BSC*, for everyone in management – so they can be aligned with the Board, integrated cross-functionally, and achieve the right balance of empowerment and accountability to ensure their success.
6. CEOs and Chiefs-of-Staff develop individual scorecards as part of their *Accountability Agreement* process with their Boards. Their agreements change as reality changes.
7. The organization aligns its structures, systems, processes, cultures and skills to achieve the outcomes in their *Organizational BSC*. The CEO and senior management are responsible for organizational alignment.
8. The organization practices as a true *learning organization*.

The most successful organizations are those that utilize the balanced scorecard development process as an opportunity for developing the internal capacity of middle managers to lead and manage change. Middle managers “learn-by-doing”, “just-in-time” within safe and supportive environments that provide them with the supports they require to be successful.

Clearly, balanced scorecarding requires an enormous effort. Is it worth it? The answer is: only if you are unrelenting in your determination to succeed!

## It's About People

**F**or those organizations that are unhappy with their current processes for governance, management and accountability, the best practice Balanced Scorecard process holds the possibility of addressing many of the issues that are the cause of sub-optimal performance today.

While the pressure for public accountability can be expected to escalate friction between Boards/CEOs and senior managers, the Balanced Scorecard offers a best practice framework for guiding the development of strategy; providing a methodology for strategy execution; a measurement and monitoring process; a system for balancing empowerment and accountability; and, a process for building collaboration, synergy and partnerships throughout the organization – and between the organizations within a local delivery system.

However, it is our collective view – rooted in the diverse experiences of our authors team – that scorecarding should only be undertaken by those organizations that are aligned at the Board/Senior Management level, and are deeply committed to successfully transforming their organization into a true learning organization.

It is our collective judgment that, while the *Organizational Balanced Scorecard* should be the central tool for strategy implementation, it won't achieve the gains that are possible unless it is combined with several of the other systems thinking-based tools, and team learning practices of learning organizations.

In our view, strategy development and strategy implementation are not really about the tools – they are about people, and about how to best support people who are undergoing change.

While the tools and processes of learning organizations provide the essential *common language/common framework* for talking about, planning for and implementing change, the truth is, there will be no change, until and unless there is change at the top: from non-strategic, crisis-oriented, command-and-control mindsets and processes to highly strategic, fully aligned governance and managerial leaders.

*Governance Scorecards, Organizational Balanced Scorecards and CEO/Chiefs-of-Staff Scorecards and Managerial Accountability Agreements* are a proven set of tools and processes for achieving leadership alignment – the essential first step in achieving real and positive change within the healthcare system.

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**“The most important lever for change is modelling the change process for other individuals.**

**This requires that people at the top themselves engage in the deep change process.”**

**Robert E. Quinn**

**“Deep Change: Discovering the Leader Within.”**

**Redefining  
Accountability  
In The  
Healthcare Sector**

By  
Bruce Harber & Ted Ball

**A**ccountability is a word that is loaded with meanings that strike fear in the heart and soul of our health care system. That's because it has come to mean: "Who is to blame?" And, "how should they be punished?" So why are we surprised when the outcome of this approach is blame-avoidance, blame-shifting, cover-ups, in-fighting, defensive behaviors, anti-learning dynamics and the cause of even further dysfunction in a health system that has already been diagnosed as being among "the least healthy work environments in the country".

Our bottom line message in this essay is: the concept, and the process of accountability needs to be fundamentally redefined within the public sector - from top to bottom.

Our First Ministers chose to make Roy Romanow's recommendations to improve accountability within the health system mean: "Who is in charge?"

Within the traditional political dynamics of our federal system, the issue has become: who gets to blame who - when funds earmarked for diagnostic equipment are used to buy a lawn-mower?

Some of the key issues that arise when the issues are framed this way are: How can the federal government punish the province that allowed such a mistake to occur? How can the province punish the offending hospital? How can the hospital board punish its CEO? And, how can the CEO punish the person who actually made the mistake?

We already know the unintended consequences of these types of systems, structures and processes. The whole focus is on blame and blame avoidance - rather than on accountability for achieving measurable outcomes that may be perfectly reasonable and very desirable.

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## **ACCOUNTABILITY**

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