# Driving Organizational Transformation: Metrics and Incentives

Balanced scorecards and thoughtful use of financial and non financial incentives are key elements of a comprehensive strategy for achieving enterprise transformation.


## Executive Summary

Hospitals and health systems are fundamentally changing their approach to care delivery in order to reliably deliver safe, high-quality, patient-centered care to the populations they serve.

As described in Press Ganey's 2018 Strategic Insights report, *A Strategic Blueprint for Transformational Change,*[1] successful transformation requires a true commitment to understanding and meeting patients' needs, leadership convergence around this goal, and a clearly articulated vision for achieving it.

Metrics and incentives are key elements of a comprehensive transformation strategy. Performance metrics provide the necessary guidance for achieving and sustaining improvement across domains, and the thoughtful use of incentives can help drive workforce engagement in the improvement vision. This report provides specific, actionable recommendations for the following:

- Building balanced scorecards that incorporate the measures that board members and senior leaders need to monitor performance and progress across critical areas
- Using financial and nonfinancial incentives to drive engagement in efforts to achieve the overarching goal of safe, high-quality care that meets patients' needs

Derived from feedback from Press Ganey's extensive national client base and discussions with industry and academic experts, the recommendations support the development of an organizational culture in which leaders and managers share a collective sense of accountability for key dimensions of performance and are committed to continuous improvement.

The journey to enterprise transformation requires deliberate progression beyond incremental initiatives and domain-level improvement to a model that aligns the domains of clinical excellence, safety, patient experience and workforce engagement, bridging operational silos. The concept of collective leadership in which all personnel embrace key goals and draw satisfaction from improvement is a true competitive differentiator among health care organizations.

## Balanced Scorecards as a Tool for Strategic Management

A balanced scorecard is more than an efficient way to summarize data. It is a critical tool for the development of collective accountability, which helps leaders focus on both short- and long-term organizational goals.

The concept of the balanced scorecard was introduced in 1992 during a time of transformation for business that is analogous to what health care organizations are experiencing today. Companies were becoming more complex, in both the services and products they were delivering and the markets in which they were competing. They were adapting to new organizational structures resulting from mergers and acquisitions, and their ability to manage intangible assets (loyalty, brand recognition, information infrastructure) and create cultures that valued teamwork and innovation became critical success factors.

In this context, the balanced scorecard enabled leadership to track not just their financial results, but also the capabilities that determined their ability to grow and execute their strategies. If the core of strategy is how organizations create value for their customers, the balanced scorecard enabled organizations to track their progress in this regard by managing performance relative to short-term objectives (e.g., financial performance) and long-term goals (e.g., value creation and competitive differentiation).

Today, health care providers face similar challenges, and many may already use balanced scorecards. To support true enterprise transformation, however, the measures reported on the scorecards must include *all* types of data that are critical to integrating care around meeting patients' needs and competing in the new health care marketplace.

To identify the metrics that best fulfill this requirement, Press Ganey collected input from 139 CEOs, presidents and other senior leaders of health care organizations via an email pulse survey.[2] Respondents were asked to rate potential metrics for a Board Quality Report Card as "Very Important," "Important," "Somewhat Important" or "Not Important." Their ratings were given point scores of 100, 75, 50 and 0, respectively.

Candidate measures were identified for the following categories:

1. Patient safety (e.g., occurrence of central-line associated blood stream infections [CLABSIs])
2. Communication with patients and among employees (e.g., patient-reported assessment of nursing communication during hospitalizations)
3. Teamwork (e.g., patient-reported assessment of whether "Staff worked together to help you")
4. Loyalty (e.g., patient-reported "Likelihood to recommend" a hospital)
5. Employee engagement (e.g., employee-reported assessment of "I am proud to tell people I work for this organization")
6. Value-based purchasing (e.g., Value-Based Purchasing total score metric)
7. Outcomes (e.g., Hospital-wide All-Cause 30-Day Mortality [Observed/Expected])

[1] *A Strategic Blueprint for Transformational Change*. 2018 Strategic Insights report. Press Ganey Associates, Inc.
[2] "A Proposed Quality Report Card for Boards." 2016 white paper. Press Ganey Associates, Inc.

The results of that survey and the ratings calculated for candidate metrics were then considered by a group of 25 CEOs and other C-suite leaders. Based on this work and subsequent discussions with industry leaders, Press Ganey recommends the adoption of balanced scorecards for boards (Figure 1) and senior management (Figure 2). The focus in these prototypes is on acute care, but the combinations of measures can be tailored to the type of organization and care setting.

The recommended measures have been organized according to the four major components associated with enterprise transformation. Note that the data come from different sources (e.g., patients, employees) and that organizations must develop measurement plans for each metric. Each measure is sufficiently important that it requires consistent, frequent measurement, and long lags between data collection compromise ability to improve. The recommended frequency of data reporting is described in the fourth column of each table, with more frequent reporting for senior management than boards.

**Figure 1**

BALANCED SCORECARD FOR BOARDS

| | | Source | Recommended Frequency |
|---|---|---|---|
| Safety | • SSER (Serious Safety Event Rate)<br>• Employee survey rating: I would feel safe being treated as a patient here | • Safety reporting<br>• Engagement data | 3 months<br>Annual Survey with Monthly/ Quarterly Pulse Surveys |
| Patient Experience | • Likelihood to recommend:<br>- HCAHPS/Inpatient survey rating<br>- CGCAHPS/Medical Practice survey rating<br>• Nurse communication<br>• Doctor communication<br>• Staff worked together to care for you | • Patient surveys | 3 months |
| Workforce & Engagement | • Employee survey ratings:<br>- I would recommend this organization to family and friends who need care<br>- Loyalty: I would recommend this organization as a good place to work | • Engagement data | Annual Survey with Monthly/ Quarterly Pulse Surveys |
| Clinical Excellence | • Hospital-wide all-cause 30-day rates (Observed/Expected):<br>- Mortality<br>- Readmissions | • Publicly reported | 6 months |

**Figure 2**

BALANCED SCORECARD FOR SENIOR MANAGEMENT

| | | Source | Recommended Frequency |
|---|---|---|---|
| Safety | • SSER<br>• CAUTI performance score<br>• CLABSI performance score<br>• PSI-90 performance score<br>• Employee injury rate | • Safety reporting | Quarterly |
| Patient Experience | • Likelihood to recommend:<br>- HCAHPS/Inpatient survey rating<br>- CGCAHPS/Medical Practice survey rating<br>- Press Ganey Emergency Department survey rating<br>• Nurse communication—Inpatient<br>• Doctor communication—Inpatient<br>• Staff worked together to care for you—Inpatient | • Patient surveys | Monthly |
| Workforce & Engagement | • Employee survey ratings:<br>- Safety: I would feel safe being treated as a patient here<br>- Safety culture: Organizational culture encourages patient safety<br>- Loyalty: I would recommend this organization to family and friends who need care<br>- Loyalty: I am proud to tell people I work for this organization<br>- Communication: Different levels of this organization communicate effectively with each other<br>- Teamwork: Physicians and staff work well together<br>- Teamwork: Different units work well together in this organization<br>• RN turnover | • Engagement data | Annual Survey with Monthly/ Quarterly Pulse Surveys |
| Clinical Excellence | • Hospital-wide all-cause 30-day rates (Observed/Expected):<br>- Mortality<br>- Readmissions<br>• Value-Based Purchasing total score metric | • Publicly reported data | 3 months |

The key to the effective use of such balanced scorecards is to convey to boards and senior management that all the metrics matter, and that therefore, mediocre or declining experience on any one of them must be addressed. Further, board members and senior management should expect that it will be difficult to improve any of the measures in isolation, as previous cross-domain analyses indicate.

## Use of Incentives

Balanced scorecards can describe current performance for key metrics, but translating these data into improvement requires accountability and innovation. Thoughtful use of financial and nonfinancial incentives is essential for sharing that accountability and drive for improvement.

Detailed observations of the financial and nonfinancial incentive systems for hundreds of organizations have shown the following.

- One size does not fit all. There is no ideal incentive system that is appropriate for every organization. Organizations with long histories and "tight cultures" can use nonfinancial incentives such as peer pressure with great effectiveness, while organizations that are earlier in their journey might need financial incentives for simple goals such as getting physicians to attend meetings.
- Incentive systems should be understood by all—including the clinicians and other personnel who are their focus—to be a means to an end, where the "end" is driving improvement in care. Previous cross-domain analyses have demonstrated that an engaged workforce is essential for safe, patient-centered, clinically excellent care.[3] Therefore, to improve care the organization needs to steadily increase workforce engagement. As that engagement occurs, the ways in which financial incentives are used can evolve, or even be replaced by nonfinancial incentives.

Accordingly, effective leaders need to be able to convey context, humility and flexibility. In terms of context, data and incentives are being used for improvement, not judgment. They should always be viewed and communicated as part of an effort to improve care for patients. One way leaders and senior managers can promote clarity about the goal of the incentive program is by sharing actual patient stories that put the data in context.

Leadership humility is an essential component of an effective incentive strategy, because no measure defines ideal care in every situation, no dataset is ever complete, and risk adjustment is never perfect. Thus, the implications of data can always be questioned by skeptics. But if the imperative to improve is sufficiently compelling to an organization and its personnel, then the willingness to use reasonable data that are available to guide improvement should be the social norm.

Finally, flexibility is a key requirement, because neither the data nor the incentive structures will ever be perfect. Leadership should be open to revising the incentive program annually, after receiving input from personnel affected by the programs.

## Pitfalls in the Use of Financial Incentives

Financial incentives are useful for focusing attention on specific issues for which improvement is an organizational priority. Most health care organizations in the United States use financial incentives for physicians and selected other personnel to encourage productivity under the fee-for-service systems. These organizations vary in the proportion of compensation for clinicians and administrative personnel that is tied to quality and other performance dimensions. Further, many organizations have incentives aligned to the outcomes they value across their leadership team, and often down to the level of front-line management.

[3] *Achieving Excellence: The Convergence of Safety, Quality, Experience and Caregiver Engagement*. 2017 Strategic Insights Report. Press Ganey Associates, Inc.

While financial incentives are effective for focusing attention on issues, there are several potential pitfalls that should be considered. For example, financial incentives are limited in their ability to encourage innovation and major improvement. Because financial incentives are either received or not received, agreement must be reached on the threshold for awarding them. That means defining a level of performance that is "good enough" to merit payment of the incentive, which means defining a floor for performance. The natural tendency of personnel subject to the incentive is to try to negotiate that floor down to an easily attainable target, which conflicts with the objective of optimizing performance improvement.

In addition, problems with sample size and risk adjustment may arise in the development of financial incentives at the individual physician level, because so much of health care delivery today is a group/team activity. Sometimes physicians are not part of any identifiable group that is working together, and there is no option for a group performance incentive. An important tactic for dealing with this challenge is to cultivate a sense of group accountability for performance (e.g., among hospitalists, or among emergency department personnel) and award financial incentives based on how the group performs.

Other possible drawbacks include the following.

- A misplaced focus on metrics that are easily measured, but not meaningful. Organizations often gravitate toward easy-to-measure performance metrics, even though the behaviors and outcomes they wish to cultivate are relatively complex. Metrics should provide useful, actionable information that influences organizational progress toward the overarching goal.
- Failure to use appropriate benchmarks. The performance of a given unit should be compared with that of like units. Similarly, physicians should be compared against those in their specialty rather than the entire physician population.
- Goal setting that is aspirational, but not realistic.
- Diminished focus on issues that are not tied to financial incentives.

## Use of Nonfinancial Incentives

Nonfinancial incentives can be powerful drivers of performance improvement in patient experience and other dimensions of quality. The use of nonfinancial incentives is intertwined with the goal of enhancing engagement of the workforce. Ideally, personnel believe in the organization's goals, take pride in them, and as improvement is achieved, are less likely to experience burnout and more likely to be resilient in the face of stress.

Accordingly, tactics for reducing burnout and enhancing resilience are integral to the use of nonfinancial incentives. Several key tools are available to enhance the nonfinancial rewards for individuals and groups associated with improvement. These tools include the following.

- Appreciative inquiry—Group exercises in which various types of personnel discuss cases in which the care made them proud can help identify the features of care that "capture us at our best." Examples might be cases in which the care was extremely empathic, well-coordinated or timely. This sets the stage for acceptance of social norms and the creation of systems that ensure that those features happen reliably, not just occasionally. The theory behind appreciative inquiry is that if an organization can make its strengths happen reliably, its weaknesses become less important.

- Use of stories/comments—Internal sharing of data on performance is valuable, but stories and comments are emotionally engaging in ways that data alone cannot be. Listening to stories told by personnel is an important function of leaders, as is repeating those stories to show that they were really heard.
- Transparency—Internal and public transparency have their greatest impact on the personnel who are being transparent. Transparency creates the context in which personnel try to be at their best with every patient.
- Teams—Having a group of peers who work closely together in the care of patients brings peer pressure to life. Within a well-functioning team, personnel value their colleagues' respect and would never want to disappoint them.
- Patient involvement on committees—Having patients on committees exerts a powerful influence on health care providers and payers. Their presence motivates all to be at their best.

## Conclusion

Health care organizations are under intense pressure to remodel care delivery in ways that enhance value for patients, and to do so as efficiently as possible. As these pressures to improve performance have intensified, the first phase of responses has been to develop an array of targeted initiatives aimed at specific problems/imperatives in specific parts of the care delivery system. These specific initiatives have accomplished considerable improvement, but not enough to meet the intensifying needs of patients, the marketplace or the care workforce.

For that reason, organizations seeking to improve care delivery, to compete successfully on value and to retain their best personnel should move toward the strategic solutions that drive enterprise transformation. Balanced scorecards and thoughtful use of incentives as described in this white paper can hasten progress in that direction. Future versions of balanced scorecards can be expected to include data related to the organization's response to consumerism measures and improvement of outcomes across the continuum of care. But organizations can set a positive tone now by presenting the different types of data cited in this report via balanced scorecards to their boards and senior management teams and by using incentives to drive improvement.

Press Ganey is a leading provider of patient experience measurement, performance analytics and strategic advisory solutions for health care organizations across the continuum of care. With more than 30 years of experience, Press Ganey is recognized as a pioneer and thought leader in patient experience measurement and performance improvement solutions.

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