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Balanced Scorecard Development Using Nine Steps to Success™ at RSUD Jampangkulon

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ABSTRACT

This study seeks to develop a more workable and structured strategic performance framework for RSUD Jampangkulon by applying the Balanced Scorecard and using the Nine Steps to Success as an implementation path. This study seeks to develop a more workable and structured strategic performance framework for RSUD Jampangkulon by applying the Balanced Scorecard and using the Nine Steps to Success as an implementation path. The research follows an analytical case study approach. An initial screening phase is used to identify a small set of performance framework options through a structured literature-based shortlist, then Value Focused Thinking is applied to decide which option fits the hospital needs most closely. The main phase develops the scorecard in a full sequence, starting from a program launch to set working boundaries, followed by situation assessment, strategy formulation, objective setting, strategy mapping, selection of a lean set of core KPIs from an existing indicator bank, design of linked strategic initiatives, preparation of monitoring and performance analysis routines, tier based alignment through cascading with role clarity, and the definition of an evaluation and refresh cycle. The findings suggest that dispersed mandated indicators can be reshaped into a manageable core scorecard that supports routine control, supported by a strategy map treated as a working hypothesis, more stable KPI definitions, an initiative portfolio tied to measures, and a review rhythm that encourages follow up actions.

INTRODUCTION

Strategic performance management is usually expected to keep daily work connected to strategy, not just to produce periodic reports. It works better when it behaves like a control system that links objectives, measures, targets, and routine reviews that lead to follow up action, even if the learning cycle is not always neat in practice. Public hospitals feel this need more sharply because success is rarely one dimensional and financial signals alone do not explain service quality, patient experience, or operational reliability (Amer et al., 2022). Many hospitals still end up with indicator lists that look complete, yet the logic across indicators is unclear and the review process can drift into a compliance exercise (Bohm, 2021).

In *Badan Layanan Umum Daerah* (BLUD) or regional public service agency hospitals, the pressure is not only to deliver clinical outcomes but also to demonstrate accountability and

performance discipline through formal government evaluation mechanisms while at the same time the organization is pushed to strengthen internal alignment so performance can be traced from organizational priorities down to units and individuals (*Kementrian PANRB*, 2021). This combination can create a practical tension (Gde & Rasmen, 2019; Saputra, 2020; Yulitasari et al., 2025). Hospitals may collect many indicators because they are available or mandated, while managers still struggle to use them as a coherent strategy execution tool (Betto et al., 2022). In *Rumah Sakit Umum Daerah* (RSUD) Jampangkulon, a regional public hospital in Indonesia, early observations and discussions with leaders suggested that performance decisions often become reactive and incident driven, partly because unit indicators are not consistently tied to outcomes and the review rhythm is not yet anchored in a structured scorecard cycle (Singuru, 2026).

Research on the Balanced Scorecard in healthcare has grown, but many studies still emphasize measurement results rather than the design logic and governance routines that make a scorecard executable (Bohm, 2021). Evidence also suggests that implementation difficulty is less about choosing perspectives and more about translating strategy into objectives, initiatives, ownership, and review habits that survive day to day operational pressure (Amer et al., 2022). This leaves a practical gap for BLUD hospitals that need a lean and operable framework, not an academically impressive indicator catalogue (Afkarina et al., 2021; Harningrum & Aisyah, 2021; Setyawati & Riswan, 2024).

The novelty of this study is fivefold. First, it applies a systematic framework selection process combining PRISMA for literature screening and Value Focused Thinking (VFT) for criteria-based evaluation, ensuring BSC selection is traceable rather than preference-driven. Second, it fully documents all Nine Steps to Success™ sequentially from program launch through evaluation, providing a replicable template for other BLUD hospitals. Third, it uses the Diamond strategy framework to articulate strategy in terms of arenas, differentiators, vehicles, staging, and economic logic, avoiding vague strategic slogans. Fourth, it introduces FPCI (Fully cascade, Partial cascade, Contribute, Inform) role allocation for KPI ownership in public sector contexts, addressing accountability blur common in government hospitals. Fifth, it narrows 196 mandated indicators to a lean core set of 12 KPIs with clear definitions, targets, data sources, and review frequencies, demonstrating that existing indicator banks can be reshaped into executable scorecards.

This study addresses that gap by treating performance measurement as an execution system. It matters because it offers an implementable design package that clarifies strategic logic, narrows indicators into a core key performance indicator (KPI) set, links initiatives to objectives, and specifies cascading rules and a review cycle, which may reduce adoption friction in public hospital governance settings.

Therefore, the study aims to develop a strategic performance framework for RSUD Jampangkulon using the Balanced Scorecard as the core architecture. The development process is guided by the Nine Steps to Success™ sequence to keep the work structured from situational assessment through alignment and evaluation (Arumastuti & Setyaningrum, 2023). The expected contribution is a design level framework that is ready to run, including strategy logic, objectives, selected KPIs, initiative linkages, cascading structure, and a review cycle that can realistically be operated in a BLUD setting.

METHOD

This study used an analytical case study approach at RSUD Jampangkulon to build a practical performance management design that fits local constraints and governance requirements. Data were gathered through document review, semi structured interviews, and focused group discussions (FGD) with key stakeholders to capture both formal accountability needs and operational realities. Focus group discussion was used mainly to validate strategic logic and indicator choices.

The early phase was designed to keep the choice of framework evidence informed rather than preference driven. A systematic literature review was conducted to identify performance framework options that are commonly used for hospitals and relevant public sector settings, and the process was structured using Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) to maintain transparency in search, screening, and selection decisions (Page et al., 2021). The output of this phase was a shortlist of candidate frameworks that were plausible for RSUD Jampangkulon.

Value Focused Thinking (VFT) was then applied to evaluate the shortlist using criteria derived from stakeholder values and control needs, not just generic popularity. This approach helps translate what decision makers care about into explicit criteria so the final choice is traceable and less vulnerable to ad hoc bias (Françozo & Belderrain, 2022). The evaluation led to the selection of the Balanced Scorecard (BSC) as the primary framework because it supports multi perspective control and makes cause effect logic easier to communicate across units.

Balanced Scorecard development follows the Nine Steps to Success™ sequence so the work moves from strategic intent toward an executable control cycle (Balanced Scorecard Institute, 2023). Before starting the assessment step, a program launch is carried out to agree on scope, roles, decision rules, and the practical way of working. The scorecard scope is set at the hospital level and covers structural units, with *Indeks Kepuasan Masyarakat* (IKM) or community satisfaction index and *Indikator Nasional Mutu* (INM) or national quality indicators treated as the primary outcomes. Candidate KPIs are restricted to an indicator bank drawn from IKM, INM, *Standar Pelayanan Minimum* (SPM) or minimum service standards, and the draft BLUD performance measurement, while accreditation indicators are not used as the main source to keep the design lean and easier to run.

Below is a compact description of each nine steps stage, reflecting how it is implemented in the study, including the purpose, the method flow, and the tools that are actually used.

1. **Assessment:** Assessment focused on mapping internal and external conditions that shape execution feasibility. A Strength, Weakness, Opportunity, and Threat (SWOT) matrix was built from document evidence and stakeholder input to summarize strengths, weaknesses, opportunities, and threats in a way that supports strategy choice rather than just description (Astuti, 2024).
2. **Strategy:** Strategy translated assessment findings into a clearer strategic posture. The Diamond strategy framework was used to make strategy explicit in terms of arenas, differentiators, vehicles, and staging so the strategy was not reduced to slogans. The output is a concise strategy narrative and a small set of strategic themes that are ready to be translated into objectives.
3. **Strategy Objectives:** This step translates the strategy narrative into objectives that are specific enough to manage, while still coherent across the four Balanced Scorecard

perspectives. The flow starts by anchoring the top level outcomes, then identifying the process and capability drivers that plausibly influence those outcomes. Objectives are checked through discussion and light validation so each objective has a credible contribution path. The output is a focused list of strategic objectives with minimal overlap.

4. **Strategy Mapping:** The mapping stage turns the objective list into a cause and effect story so the strategy can be read as a logic chain rather than separate statements. The map is drafted, then sense checked through leadership input and feedback from the focus group discussion (FGD). Links between objectives are treated as testable assumptions rather than guaranteed causal claims, which keeps the map usable without overstating certainty. The output is a hospital level strategy map that becomes the reference for KPI selection and cascading.
5. **Performance Measures:** The intent is to define a small set of core KPIs with clear targets and ownership, instead of expanding the KPI list. KPIs are drawn from the indicator bank, mapped to objectives, and filtered through three checks. First is alignment to objectives. Second is a scoring rubric agreed in the FGD to make selection criteria explicit. Third is a practicality check using SMART (Specific, Measurable, Achievable, Relevant, and Time bound) principles, followed by leadership validation to confirm feasibility. A KPI dictionary is then written to lock definitions, formulas, data sources, frequency, and owners. The output is the core KPI set, initial targets, and operational definitions.
6. **Strategic Initiatives:** This stage connects measures to action, because measures alone do not improve performance. Initiative options are developed from the objective and KPI gaps, then discussed and selected in the FGD using simple prioritization logic that keeps decisions traceable. The value proposition view is used again when needed to test whether initiatives actually address user needs and service realities. The output is a shortlist of strategic initiatives that clearly point back to specific objectives and KPIs.
7. **Performance Analysis:** Performance analysis designed the review mechanics. Root cause analysis principles were applied to connect identified causes to corrective actions that can be audited in follow up meetings (Karkhanis & Thompson, 2021). A prototype executive dashboard concept was prepared to support routine monitoring and to reduce reliance on narrative updates that are hard to compare across periods. The output is a monitoring format, an executive dashboard concept, and a practical analysis guide for routine reviews.
8. **Alignment:** Alignment aims to make unit contribution visible so accountability does not stop at the top level. Cascading is developed from Tier 1 to Tier 2 and Tier 3 following the RSUD structure, while keeping consistency with government performance tiering logic under Indonesian regulation of *PermenPANRB* 89 of 2021. Each KPI is also classified as outcome, output, process, or input to keep the results chain readable for accountability. For cross function role distribution, this study uses FPCI, meaning Fully cascade, Partial cascade, Contribute, and Inform, because it tends to describe operational roles more directly than generic responsibility labels. The output is a tier based cascading map and an FPCI role allocation for each KPI.
9. **Evaluation:** The evaluation stage is intended to keep the system relevant and to support iterative improvement without constant redesign. The output is an evaluation cycle and governance recommendations that aim to keep implementation stable while still allowing learning-based updates.

RESULT AND DISCUSSION

This section reports the development results of a strategic performance framework for RSUD Jampangkulon using a Balanced Scorecard guided by the Nine Steps to Success™. The emphasis is on design outputs that appear workable for day to day use, ranging from strategy clarification to cascading logic and a review rhythm, rather than on long term impact evaluation. To keep the storyline easy to follow, the results are presented in the same sequence as the Nine Steps, and each step is supported by a table or figure that summarizes the key deliverable and briefly indicates the evidence base drawn from document review, interviews, and the FGD.

Before moving into the assessment work, a program launch is used as a practical way to set the ground rules for how the scorecard will be built. At this point the scope is fixed at the hospital level, the main outcome anchors are agreed, and roles plus working routines are outlined so the design does not shift too much midway through. The KPI candidate pool is also intentionally limited to an indicator bank already used for accountability, which helps keep the scorecard lean and arguably easier to operationalize. In effect, the program launch shapes what will be examined in the assessment stage, how data boundaries are treated, and how the subsequent strategy work is directed.

1. Assessment

   During the Assessment stage, the aim is to build a grounded picture of the situation so the Balanced Scorecard design does not end up relying on broad assumptions. Evidence is pulled from performance related documents and accountability requirements, then complemented with early conversations with leaders and key stakeholders, and finally condensed into a SWOT view that captures the internal and external factors most relevant to performance management. The table below summarizes the SWOT output and is used to surface priority issues and practical design needs before moving into the next step.

Table 1 - SWOT matrix

Strengths	Weaknesses
1. Clear positioning as a Type C referral hospital for the southern region with strategic location. 2. BLUD flexibility supports management innovation. 3. Large workforce capacity as a service delivery asset.	1. Organizational rigidity linked to Non-ASN recruitment issues and potential conflicts of interest tend to lower agility. 2. Decisions remain reactive (incident-driven), not consistently based on performance data. 3. Unit KPIs are not available / not aligned to outcomes; internal performance assessment tends to be formalistic and subjective.
Opportunities	**Threats**
1. Existing external indicator frameworks (IKM, INM, SPM) can be translated into BSC KPI candidates. 2. Draft of BLUD performance assessment aligns with BSC perspectives.	1. High service competition 2. Public sensitivity to service/cost/facilities and become Hospital reputational risk. 3. Policy pressure for BLUD financial independence through efficiency and sustainability.

3.	Stronger national quality-accountability direction pushes discipline in measurement and continuous improvement.

Thus, the SWOT suggests that RSUD Jampangkulon has a reasonable base for improvement, particularly through its service positioning and the room for innovation provided by BLUD flexibility, yet agility may still be constrained by organizational frictions, uneven use of performance data in decisions, and limited visibility of unit contribution to outcomes. Externally, the most actionable opportunity comes from existing mandated indicator frameworks that can be translated into KPI candidates, while competitive pressure, public sensitivity, and policy demands for BLUD efficiency add urgency to building a more structured performance system. These Assessment insights then inform the Strategy stage by sharpening the strategic choices and the strategic themes, so the scorecard direction stays responsive to internal gaps while remaining aligned with external dynamics.

2. Strategy

In the Strategy stage, the goal is to translate the Assessment insights into choices that are concrete enough to guide objectives, measures, and initiatives. Inputs are drawn from the SWOT summary, relevant performance mandate documents, and feedback from leadership interviews and a cross unit FGD, so the strategy stays close to implementation realities rather than ideal statements. The Diamond Framework is used to structure these choices and to keep the strategy from turning into a simple program list. The figure below summarizes the resulting strategy logic.

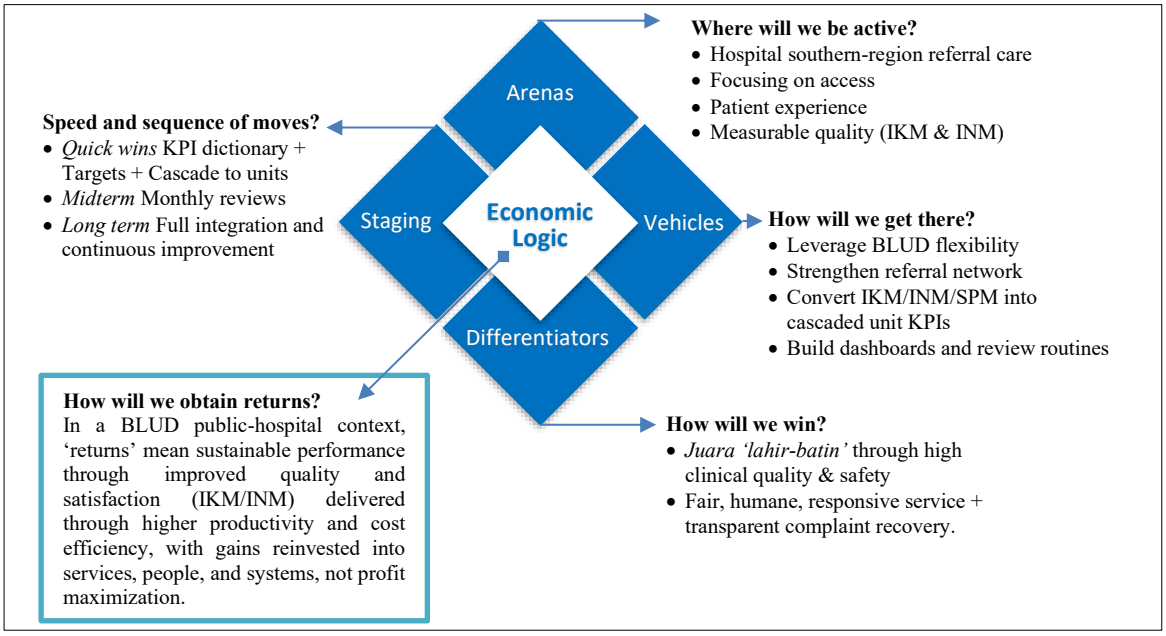

Figure 1 – Strategic Diamond Framework

In brief, the Diamond view positions the arena around strengthening the hospital role as a Type C referral provider for the southern area, while differentiators lean toward service quality, patient experience, smoother flow, and more disciplined performance governance. The vehicles emphasize process improvement, people capability, and data systems, and the

staging keeps the work phased because readiness is not uniform across units. Under the BLUD context, the economic logic is framed as sustaining service quality through productivity and efficiency, with gains expected to be reinvested into services and enabling systems.

To keep execution from drifting, the strategy is synthesized into three strategic themes derived from the hospital mission. **Service Excellence** focuses on consistent core clinical services, professionalism, and disciplined service recovery so patient experience and trust can improve. **Access and Flow** targets smoother journeys, shorter waiting time, clearer processes, and better cross unit coordination so access feels more predictable. **Performance Governance** moves the organization toward a more data guided routine, clearer ownership through cascading, and stronger accountability within the BLUD setting, while recognizing that behavior change may take time.

3. Strategy objectives

In the Strategy Objectives step, the intent is to turn the strategy narrative into a set of objectives that are specific enough to manage, yet still connected across the Balanced Scorecard perspectives. The objectives are derived from the Strategy stage and refined through stakeholder discussion so they do not read like a program list, but instead point to directions that can later be translated into measures and initiatives. The table below presents the objectives matrix and summarizes how the objectives are grouped by perspective as the working input for the strategy map.

Table 2 – Objectives Matrix

Code	Objectives	Perspective
Tier 1 – Strategic Objectives (Outcomes)		
T1-C1	Improve IKM	Customer
T1-C2	Achieve the INM target	Customer
Tier 2 – Tactical Objectives		
T2-C1	Strengthen service recovery and customer experience	Customer
T2-P1	Improve standardised, safe services with more predictable patient flow	Internal Process
T2-L1	Build staff capability and data literacy for performance based management	Learning & Growth
T2-F1	Maintain BLUD sustainability through efficiency and cost and logistics discipline	Financial
Tier 3 – Operational Objectives		
T3-C1a	Follow the complaint handling SOP consistently	Customer
T3-P1a	Control outpatient flow to reduce waiting time	Internal Process
T3-P1b	Improve compliance with clinical pathway implementation by case or unit	Internal Process
T3-P1c	Complete medical records within 24 hours after service	Internal Process
T3-P1d	Ensure patient identification compliance before procedures	Internal Process
T3-L1a	Deliver competency-based training	Learning & Growth
T3-L1b	Use SIMRS as a management tool	Learning & Growth
T3-L1c	Maintain BLUD performance reporting discipline for routine review	Learning & Growth
T3-F1a	Control the cost recovery rate	Financial
T3-F1b	Control inventory levels and stock turnover	Financial

The objectives matrix suggests a structure where the main outcomes sit at the top, while objectives in internal process, learning and growth, and financial sustainability act as nearer term drivers that the organization can influence more directly. This arrangement supports a practical logic, namely that outcome improvement is unlikely to be stable without process discipline, stronger people and data capability, and more consistent resource governance. These objectives are then linked into a cause and effect storyline in the Strategy Mapping step, which helps create a clearer strategic path before the core KPIs are finalized.

4. Strategy mapping

In the Strategy Mapping stage, the aim is to turn the objective list into a strategy storyline that can be read as a plausible cause and effect chain. The map is drafted from the objective's matrix, then refined through leadership interviews and feedback from the cross unit FGD, so the links are not only conceptually neat but also within what the organization can reasonably influence. The figure below presents the strategy map, placing the main outcomes at the end point while highlighting the process and capability drivers that are expected to matter most.

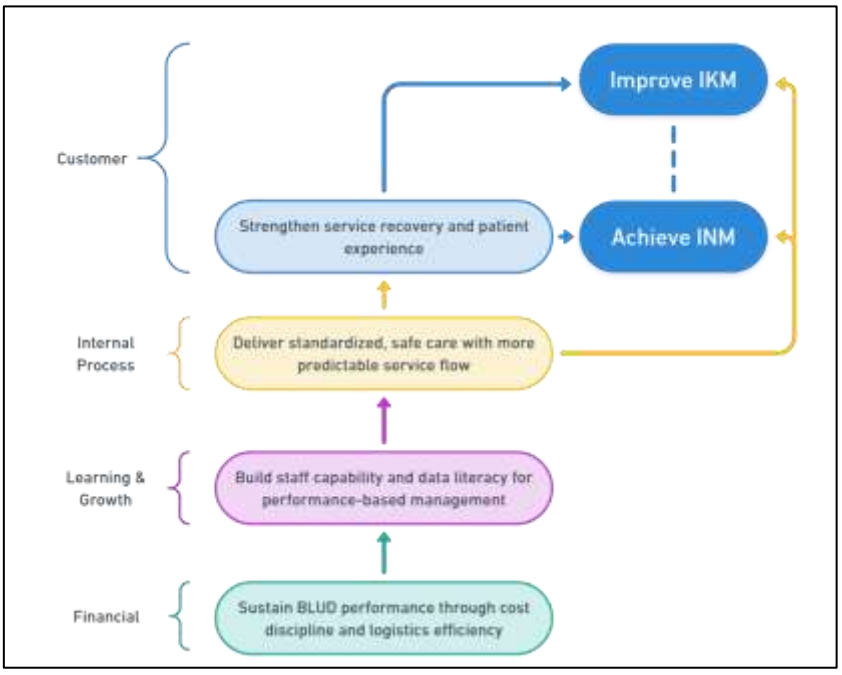

Figure 2 – Strategy Map

The map suggests a logic that starts with capability building and more disciplined governance, moves into improvements in service processes that are closer to daily operations, and eventually points toward better results at the outcome level. Outcomes are kept at the top to prevent the discussion from drifting into activity claims, while objectives in internal process, learning and growth, and resource sustainability are positioned as levers that are easier to manage directly. The links in the map are treated as working hypotheses, which means they provide a structured way to discuss why KPI trends move up or down, rather than serving as untouchable causal statements. This map then becomes the reference for the next step, where core KPIs and initial targets are selected so the measures reflect the agreed strategic path.

5. Performance measures

In the Performance Measures stage, the aim is to agree on a small set of core KPIs that reflect the strategic path while remaining feasible for routine tracking. KPI candidates are first gathered from the indicator bank already used for RSUD accountability consists of 196 indicators drawn from four sources, IKM, INM, SPM, and the draft BLUD performance measurement guideline, with an additional INM fulfilment rate used to summarize overall compliance then mapped back to objectives and the strategy map so each measure has a clear strategic rationale. Selection is carried out through discussion and a cross unit FGD using a simple scoring rubric that considers objective linkage, measurability, and practical data readiness, then it is tightened further through operational definitions and initial target agreement. The table below presents the selected core KPIs along with targets, linked objectives that will later shape the monitoring routine.

Table 3 – Selected KPI

No	Indicator	Target	Objectives Code
1	IKM	*88 point*	T1-C1
2	INM	*76,9%*	T1-C2
3	Complaint Response Timeliness	≥80%	T2-C1
4	Medical Record Completion Within 24 Hours After Service	90%	T2-P1`
5	Patient Identification Compliance	100%	T2-P1
6	Outpatient Waiting Time	≥80%	T2-P1
7	Clinical Pathway Compliance	≥80%	T2-P1
8	Average Training Hours per Staff	>80%	T2-L1
9	Hospital Management Information System (SIMRS) Development	100%	T2-L1
10	Completeness of BLUD Performance Reporting	100%	T2-L1
11	Cost Recovery Rate	≥65%	T2-F1
12	Inventory Turnover	30–35 days	T2-F1

The core KPI set suggests that outcome measures are kept as anchors to prevent the system from drifting into activity reporting, while measures in internal process, learning and growth, and resource governance act as closer levers that units can influence more directly. This structure is intended to reduce the risk of a compliance style scorecard, since each KPI is tied back to objectives and has a contribution path that can at least be traced in practice. With the core measures in place, the next step focuses on identifying strategic initiatives that are most relevant for moving priority KPIs, especially in areas that are expected to have the strongest pull on the outcomes.

6. Strategic initiatives

In the Strategic Initiatives stage, the goal is to define a focused set of initiatives that can realistically move the core KPIs, rather than expanding into a long activity list. Initiative options are compiled from internal discussions and document review, then refined through leadership interviews and prioritized in a cross unit FGD so the choices reflect both expected impact and implementation feasibility. Each initiative is explicitly linked to one or more strategic objectives to keep execution aligned with the strategy map. The table below summarizes the selected initiatives and their linked objectives as the main execution package for the scorecard.

Table 4 – Selected Initiatives

Linked objectives code	Initiative
T2-C1 (T3-C1a)	Complaint & Service Recovery System (SOP, channels, root-cause review)
T2-C1	Service Experience Improvement Program (communication standards, hospitality, navigation)
T2-P1 (T3-P1c, T3-L1b)	Implement Electronic Medical Record (EMR) (paperless clinical documentation & integration)
T2-L1 (T3-L1a)	Competency-Based Training Plan (clinical + service coaching)
T2-L1 (T3-L1b)	SIMRS Optimization & KPI Dashboard (data dictionary, dashboards)
T2-F1	Cost Efficiency & Resource Utilization Program (cost control, asset utilization, waste reduction)

The selected initiatives indicate a practical emphasis on improving patient experience and complaint handling, stabilizing service flow and waiting time management, strengthening clinical documentation through electronic medical records, building staff capability through competency-based training, improving performance visibility through SIMRS and KPI dashboards, and supporting BLUD sustainability through cost efficiency and better resource utilization. Taken together, these initiatives are meant to act as the main levers that connect strategic intent to day to day change, although their pace may still depend on data readiness and cross unit coordination. With the initiative package defined, the next step turns to Performance Analysis, which sets the monitoring routine, reporting format, and basic analysis flow used to track progress and decide follow up actions.

The Balanced Scorecard graphic below is included to pull the whole design into one view, linking strategic objectives, selected KPIs, targets, and initiatives. It is not presented as a claim of perfect causality, but as a shared reference for implementation discussions before the monitoring, cascading, and evaluation steps are applied.

Table 5 - Balanced scorecard graphic

	A leading hospital in holistic *(lahir-batin)* healthcare through excellent, fair, innovative, and collaborative services.		
Mission	1. Build a competent, values-driven workforce to deliver excellent and professional care. 2. Improve eco-friendly facilities and infrastructure through continuous innovation to strengthen access to care. 3. Boost productivity and competitiveness through technology and collaboration to achieve effective and efficient governance.		
Strategic Themes	**Service Excellence** *Pelayanan Kesehatan Juara*	**Access & Flow** *Akses Pelayanan Juara*	**Performance Governance** *Tata Kelola RS Juara*
Strategic Results	Patients consistently receive safe and high-quality care	Access becomes faster and more predictable through smoother service flow and digital queue/registration, reducing waiting and improving patient experience	The hospital runs in a performance-driven and efficient way, using data, EMR, and cost discipline to sustain service improvements

Strategic Objectives and Strategic Map	Measures	Targets	Initiatives
Customer	• IKM • INM • Complaint Response Timeliness	88 Point 76,9 %	• Complaint & Service Recovery System

				• Service Experience Improvement Program
Internal Process		• Medical Record Completion Within 24 Hours After Service • Patient Identification Compliance • Outpatient Waiting Time • Clinical Pathway Compliance	90% 100% ≥80% ≥80%	• Implement Electronic Medical Record (EMR)
Learning & Growth		• Average Training Hours per Staff • Hospital Management Information System (SIMRS) Development • Completeness of BLUD Performance Reporting	>80% 100% 100%	• Competency-Based Training Plan • SIMRS Optimization & KPI Dashboard
Financial		• Cost Recovery Rate • Inventory Turnover	≥65% 30-35 days	• Cost Efficiency & Resource Utilization Program
Hospital core value "SIGAP": *Semangat, Inovative, Gesit, Amanah, Profesional*				

7. Performance analysis

Once the KPIs are locked, performance analysis turns the scorecard into a routine management loop. The focus is on defining how each KPI will be monitored, who provides the data, how often it is reviewed, and how the results are presented so follow up decisions can be made consistently. The first table below presents the scorecard monitoring plan, which specifies the data source, review frequency, and PIC for each KPI, serving as the operational backbone for routine tracking. The second table provides a prototype of the BSC executive dashboard, designed as a one-page summary to support leadership review meetings and to keep discussions anchored on targets, trends, and action items.

Table 6 – Scorecard monitoring plan

KPI	Target	Frequency	Data sources
PIC: Director			
IKM	*88 point*	Monthly	IKM Survey
INM	*76,9%*	Monthly	Quality and Patient Safety Unit (PMKP)
PIC: Head of Administration and General Affairs Department			
Complaint Response Timeliness	≥80%	Monthly	Complaint Handling Unit, Complaint Log, Digital Channels
Completeness of BLUD Performance Reporting	100%	Quarterly	BLUD Performance Report Documents
Cost Recovery Rate	≥65%	Monthly	Financial Reports
Inventory Turnover **Partially Cascade*	30–35 days	Monthly	Warehouse, Stock Cards
PIC: Head of Clinical Services Department			
Outpatient Waiting Time	≥80%	Monthly	Queue System, Registration Counter, Outpatient Clinics
Clinical Pathway Compliance	≥80%	Monthly	Clinical Pathway Audit, EMR, Medical Committee
Patient Identification Compliance	100%	Monthly	Patient Safety Audit, Medical Record Sampling
PIC: PIC Head of Supporting Services Department			

Inventory Turnover **Partially Cascade*	30–35 days	Monthly	Pharmacy Warehouse, Stock Cards, SIMRS
PIC: PIC Head of Quality and Accreditation Department			
Average Training Hours per Staff	>80%	Quarterly	Training Reports
Hospital Management Information System (SIMRS) Development	>100%	Quarterly	Roadmap SIMRS, Module Progress Tracking
Medical Record Completion Within 24 Hours After Service	90%	Monthly	Electronic Medical Records (EMR), SIMRS, Completion Audit

Table 7 – BSC executive dashboard

No	KPI	Target	Actual	R A G	Risk Highlights	Action Plan
1	IKM	*88 point*				
2	INM	*76,9%*				
3	Complaint Response Timeliness	≥80%				
4	Medical Record Completion Within 24 Hours After Service	90%				
5	Patient Identification Compliance	100%				
6	Outpatient Waiting Time	≥80%				
7	Clinical Pathway Compliance	≥80%				
8	Average Training Hours per Staff	>80%				
9	Hospital Management Information System (SIMRS) Development	100%				
10	Completeness of BLUD Performance Reporting	100%				
11	Cost Recovery Rate	≥65%				
12	Inventory Turnover	30–35 days				

Taken together, the monitoring plan and the dashboard prototype suggest an intentional move toward consistency in performance discussions. By clarifying data sources, timing, and responsibility, the design reduces the risk of repeated debates over definitions and late reporting, which often turns performance review into a procedural exercise. The dashboard format also encourages a shift from describing numbers to interpreting trends and agreeing on follow up actions. Since data readiness and analytical capacity can vary across units, the study proposes a practical analysis guide that stays lightweight yet still points the discussion toward likely drivers and actionable fixes. The table below summarizes the priority KPI groups, the practical questions to ask, the suggested analysis methods, the drill down lenses, and the expected outputs that will support decisions and follow up.

Table 8 - Practical analysis guide

KPI group	Practical question	Method	Drill down lens	Expected output
IKM	Which elements pull the score down	trend and gap review, Pareto	unit, service element, complaint theme	top drivers and small service fixes
INM	Which indicators fail most often	Pareto and monthly trend	the 13 indicators, unit, shift	2 or 3 priority indicators and CAPA plan

KPI group	Practical question	Method	Drill down lens	Expected output
Documentation	Where records are late	compliance ranking, short RCA	unit, DPJP, shift	priority list and coaching or audit action
Patient safety compliance	Why compliance drops	audit trend, short RCA	unit, profession, shift	cause signals and practical enforcement plan
Service flow	Where the bottleneck is	timestamp and flow analysis	registration, clinic, pharmacy, lab	bottleneck map and revised flow actions
Financial sustainability	Which cost or revenue driver shifts	variance and cost driver Pareto	unit, service type, spend category	cost control actions and revenue cycle fixes
Inventory	Which items move slowly	ageing stock and Pareto	item group, unit consumption	reorder rule adjustments and waste reduction

Overall, the table works as a quick analysis menu that turns KPI signals into a structured diagnosis flow. The methods are kept deliberately simple, such as trend and gap checks, Pareto, audit trend review, short RCA, and timestamp-based flow analysis, so teams can identify main drivers and agree on small but realistic actions. The expected outputs are also framed to be operational, including priority lists, CAPA plans, coaching or audit actions, flow improvements, and cost or revenue cycle adjustments, so the analysis can move naturally into the next Nine Steps stage, Alignment, through clearer ownership and unit level follow up. With the monitoring and reporting routine outlined, the next step is Alignment, where objectives and KPIs are cascaded to tiers and roles are clarified so unit level contribution becomes visible.

8. Alignment

At the Alignment stage, the point is to make the scorecard usable beyond the hospital level by showing where departments and units actually contribute to outcomes. The work therefore focuses on cascading objectives and KPIs across tiers and making roles explicit, since unclear ownership is often where a scorecard becomes hard to run in practice. The tables below are arranged to reflect the sequence used in this study, starting with role language, moving into tier linkage, then breaking down objectives, and finally distributing KPIs to departments and their units.

Before cascading begins, a shared role vocabulary is set so KPI ownership does not blur when indicators cut across functions. Table 9 introduces the cascading role categories used in this study, distinguishing units that fully cascade a KPI, those that partially cascade it, those that contribute to the result, and those that mainly need visibility for coordination. This simple structure is not perfect, but it tends to prevent early disputes because responsibilities are stated in plain terms.

Table 9 - Cascading role categories

Code	Category	What it means in practice
F	Fully cascade	One primary owner is expected to carry the KPI and manage follow up
P	Partially cascade	Ownership is shared across more than one unit because a single owner would be unrealistic
C	Contribute	The unit supports performance through related processes but is not the main owner

I	Informed	The unit needs visibility for coordination but does not translate it into its own KPI

Once roles are defined, the next task is to confirm that tier one outcomes and strategic objectives have a clear contribution path at the next tier. Rather than copying KPIs downward, the mapping clarifies how higher-level objectives translate into department level focus areas that are closer to operational control. Table 10 presents the tier one to tier two objectives mapping and provides a practical line of sight between top level outcomes and departmental priorities, which becomes the base for further decomposition.

Table 10 - Objectives tier 1 to tier 2 mapping

Tier 1	Tier 2 strategic objective key driver / tactical objectives
Improve IKM	Strengthen service recovery and customer experience
Achieve INM and improve IKM	Improve standardized and safe services with more predictable flow
	Build staff capability and data literacy for performance based management
	Maintain BLUD sustainability through efficiency and disciplined cost and logistics

Because some tier two objectives still sit at a fairly conceptual level, they are then translated into more specific operational objectives. The intent is not to multiply objectives, but to make them clear enough to be measured and managed by the units closest to day to day processes. Table 11 summarizes this decomposition from tactical objectives to operational objectives, showing how the strategic direction is retained while the control points become more concrete.

Table 11 - cascading tactical objectives to operational objectives

Tier 2 tactical objective	Tier 3 operational objective
Strengthen service recovery and customer experience	Run the complaint SOP consistently
Improve standardized and safe services with more predictable flow	Manage outpatient flow to reduce waiting time
	Enforce clinical pathway compliance by case or unit
	Ensure medical records are complete within 24 hours
	Ensure patient identification before procedures
Build staff capability and data literacy for performance-based management	Deliver competency-based training
	Use SIMRS as a management tool
	Maintain disciplined BLUD performance reporting for routine review
Maintain BLUD sustainability through efficiency and disciplined cost and logistics	Control Cost Recovery Rate
	Control inventory and stock turnover

With the objective structure in place, cascading is then applied at department level so contributions do not remain abstract. The mapping begins with the administration and general affairs department because it often anchors governance support, people management, and system strengthening that affect data stability and review routines. Table 12 shows how departmental KPIs are distributed to the underlying units using the agreed cascading roles, so governance related indicators do not stay as department targets without operational support.

Table 12 - Mapping administration and general affairs department KPIs to its units

Operational Objectives	KPI	PU	KU	PP	Cross department notes
Run the complaint SOP consistently	Complaint Response Timeliness	F	I	C	Clinical services department contributes for closure and follow up
Maintain disciplined BLUD performance reporting for routine review	Completeness of BLUD Performance Reporting	I	C	F	Other units contribute as data providers
Control Cost Recovery Rate	Cost Recovery Rate	I	F	C	Clinical services and supporting services department contribute through service and cost drivers
Control inventory and stock turnover	Inventory turnover	I	P	I	Supporting services department shares ownership due to stock process control

*Notes PU : Human Resources and General Affairs unit
KU : Finance and Assets unit
PP : Planning and Reporting unit

The next mapping focuses on the clinical services department because it is usually the closest driver of outcomes and patient experience. Table 13 outlines how service related KPIs are shared across implementing units, recognizing that many service indicators are cross unit by nature and may not be realistic if assigned to a single owner. Role clarity here helps balance execution work and data responsibility.

Table 13 - Mapping clinical services department KPIs to its units

Operation Objectives	KPI	PM	PK	Cross department notes
Manage outpatient flow to reduce waiting time	Outpatient Waiting Time	C	F	Administration and general affairs department contributes through front office coordination and information channels
Enforce clinical pathway compliance by case or unit	Clinical Pathway Compliance	F	C	Quality and accreditation department contributes through audit and follow up
Ensure patient identification before procedures	Patient Identification Compliance	C	F	Quality and accreditation department contributes through compliance audit
Ensure medical records are complete within 24 hours	Medical Record Completion Within 24 Hours After Service	C	C	SIMRS and medical records unit is treated as F for control and monitoring

*Notes PM : Medical services unit
PK : Nursing services unit

The mapping shifts to supporting services department, since bottlenecks in support functions can quietly shape flow and quality. Table 14 distributes supporting service KPIs to relevant units to make their contribution explicit and to position support not as a passive

function but as part of the performance chain that influences outcomes. It also clarifies support roles in data provision and process compliance.

Table 14 - Mapping supporting services department KPI to its unit

Operation Objectives	KPI	PJM	SP	Cross department notes
Control inventory and stock turnover	Inventory turnover	P	I	Finance and Assets unit shares ownership for financial control and recording discipline

Notes PJM : Medical support services unit
SP : Facilities and Infrastructure unit

The final mapping covers the Quality and Accreditation function, which often sits at the center of standards, audits, and improvement activity, yet can be hard to connect to operational KPIs without a clear translation. Table 15 links departmental KPIs to the relevant units and highlights that several quality indicators remain cross functional, which is precisely why the cascading role categories are useful for avoiding duplication and ownership confusion. This mapping also makes it easier to integrate audit and improvement cycles into routine performance reviews.

Table 15 - Mapping Quality and accreditation department KPI to its units

Operation Objectives	KPI	AKR	SIMRS	Cross department notes
Deliver competency-based training	Average Training Hours per Staff	F	I	All units contribute through attendance and practice adoption
Use SIMRS as a management tool	SIMRS development	I	F	Administration and general affairs department contributes through administrative and budget support
Ensure medical records are complete within 24 hours	Medical Record Completion Within 24 Hours After Service	I	F	Clinical services department contributes through daily documentation input

Notes AKR : Accreditation unit
SIMRS : SIMRS and medical records unit

To close the alignment section, a KPI Tree is provided as a visual summary of indicator hierarchy from outcomes down to nearer term drivers. Figure 3 illustrates how indicators are structured and how contribution paths can be traced more quickly, including which measures operate as outcomes, which behave more like outputs or processes, and which reflect inputs or capacity. This visual is helpful because it reduces the risk of the scorecard being seen as a standalone list of numbers, even though the relationships should still be treated as working assumptions .

Overall, the Alignment outputs suggest that strategic objectives and core KPIs can be translated into department and unit level contribution through tier mapping, objective decomposition, and explicit cascading roles. This makes the scorecard feel more operational because ownership, data pathways, and contribution lines become easier to trace, although it still depends on discipline in review and follow up. The final step is Evaluation, where the review rhythm, learning rules, and refresh mechanism for KPIs, targets, and initiatives are set so the system remains relevant instead of becoming another static document.

9. Evaluation

In the Evaluation stage, the goal is to keep the scorecard relevant and usable over time, rather than letting it become a one-off design document. The evaluation logic is set as a learning cycle, where strategy links in the map are treated as working assumptions that need to be checked against KPI trends and operational realities (Busco & Quattrone, 2015; Nielsen & Nielsen, 2015). As an output, the study proposes a structured review cadence. Monthly reviews focus on red KPIs, data timeliness, and short corrective actions. Quarterly reviews are used to look for recurring patterns and cross unit issues that cannot be solved through isolated fixes (Hristov et al., 2024). Annual reviews are intended for refreshing targets, reprioritizing initiatives, and adjusting cascading roles when the organizational context or data readiness changes. This evaluation arrangement is designed to support continuous improvement while keeping governance lightweight, so the Balanced Scorecard can function as an ongoing performance management system rather than another static reporting format.

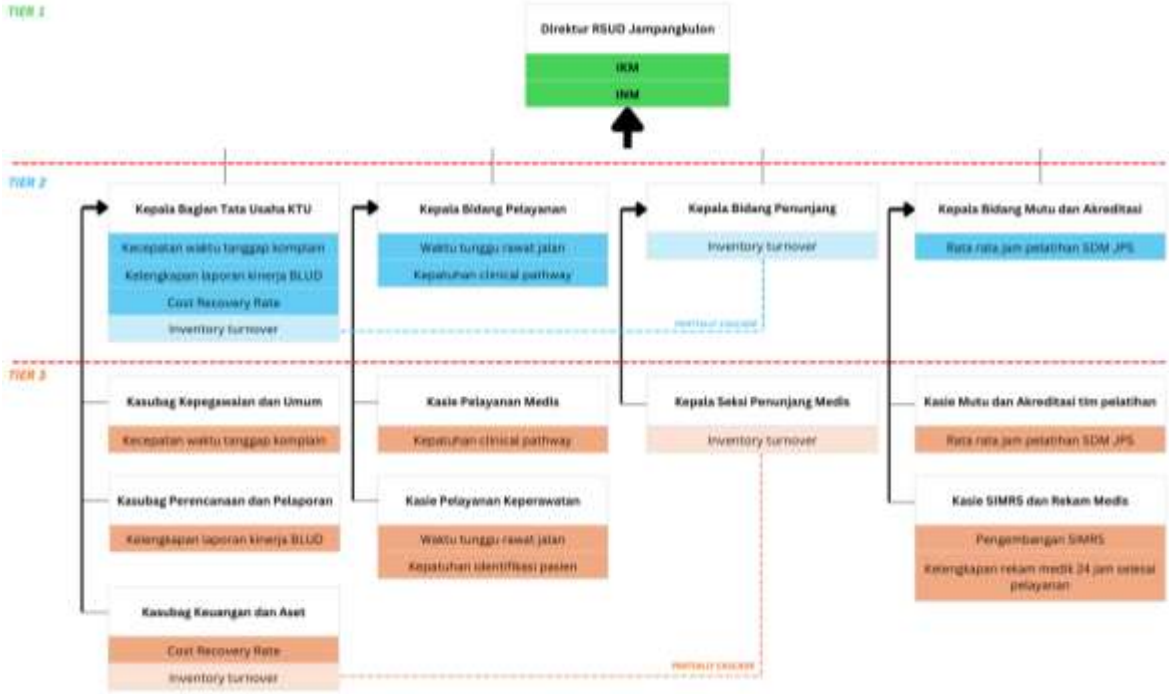

Figure 3 - KPI tree

This study indicates that RSUD Jampangkulon's issue is less about missing indicators and more about missing a workable performance system. Mandated measures exist, but without a clear strategy logic, stable KPI definitions, and a consistent review rhythm, they can stay as reporting routines rather than decision inputs. Using the Nine Steps sequence helps make the Balanced Scorecard executable because it links strategy, objectives, measures, initiatives, monitoring, and evaluation into one management cycle. The study also suggests that an existing indicator bank is useful only when narrowed into a lean core KPI set that can realistically be reviewed and acted on, especially when data readiness differs across units. Finally, cascading across tiers and clarifying roles through FPCI appears to reduce accountability blur by making contribution paths easier to trace. The main limitation is that impact is not yet observed, so the design still needs to be tested through at least one full review cycle.

CONCLUSION

The study concludes that the objective of developing a more workable strategic performance framework at RSUD Jampangkulon can be addressed through a Balanced Scorecard built with the Nine Steps to Success approach. A key insight is that having many existing indicators does not automatically create a performance management system, so a structured sequence is needed to lock in the strategy logic, objectives, a lean set of core measures, and a review cadence that turns metrics into decision support. By using the existing indicator bank as raw material, narrowing it into core KPIs, linking those KPIs to the strategy map, and clarifying unit contribution through cascading and role allocation, the scorecard design becomes easier to run and its accountability lines become more visible within a BLUD context. Future work should test the design through at least one full review cycle to observe implementation discipline, follow up quality, and how priority KPI trends respond in practice.

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