

**Balanced Scorecard Awareness and the Factors of Adoption for Strategic Performance Reporting Systems in a Non-Profit Healthcare Organization: A Qualitative Study**

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CHRISTOPHER R. GIBBONS

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## Abstract

This qualitative interpretative descriptive study addressed the deficient adoption and integration of standardized performance reporting frameworks and systems, such as the Balanced Scorecard (BSC), within non-profit healthcare organizations. The purpose was to describe the levels of BSC awareness and comprehension, alongside the adoption criteria for such systems, among leadership and management at a multistate non-profit U.S. healthcare system. The research was guided by an integrated conceptual framework combining diffusion of innovations theory, institutional theory, and resource-based view theory. A qualitative interpretative descriptive methodology was employed, using a multiple data sources design to collect data from 36 healthcare leaders and managers via semi-structured interviews and open-ended questionnaires. Thematic analysis of the data revealed a significant gap in strategic management knowledge, with 58% of participants reporting unfamiliarity with the BSC framework. This lack of awareness was contrasted by the finding that 86% of participants had extensive experience with various alternative, often fragmented, strategic tools. BSC comprehension was highly stratified by organizational role; 75% of upper management demonstrated understanding, compared to only 7% of frontline managers, indicating a severe disconnect in knowledge transfer. Key adoption criteria identified by participants included user-friendliness, demonstrated value, alignment with organizational goals, and comprehensive training. The most significant barriers to implementation were resistance to change, insufficient time and resources, and the prevalence of hierarchical, top-down decision-making processes that exclude implementers. The study concludes that the underutilization of comprehensive strategic systems in the non-profit healthcare sector stems not from resistance to measurement itself, but from critical challenges in organizational knowledge dissemination, a lack of inclusive engagement in decision-making, and

inadequate implementation support. This research offers actionable recommendations for practice focused on education, leveraging existing tool usage, and fostering inclusive governance to improve the adoption and effective use of strategic performance reporting systems in healthcare.

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## Chapter 1: Introduction

The U.S. healthcare system is characterized by considerable complexity, which stems from a diverse mix of public and private stakeholders, various funding sources, and a wide range of regulatory structures (Dunn, 2016). Essential to the framework of the U.S. healthcare system, are private insurance companies, government programs, and occasionally individuals, collectively referred to as payers. Payers finance or reimburse the cost of health services and, through various mechanisms, negotiate, determine, and disburse payments for healthcare services (Gapenski & Reiter, 2016). Moreover, the healthcare regulatory landscape encompasses many federal, state, and local regulations, creating a challenging environment for healthcare organizations to meet compliance requirements (Knickman & Elbel, 2019). Additionally, the healthcare system includes an array of healthcare providers, including hospitals, clinics, and individual practitioners, each often operating within different payment models and regulatory environments (Wagner, 2020).

Adding to an already complex environment, healthcare organizations can be classified into three primary categories: for-profit, public-owned, and non-profit entities (Zelman, 2014). While for-profit organizations aim to generate revenue for their shareholders, non-profit organizations reinvest surplus funds into improving their services and fulfilling their mission (Young, 2018). Public-owned healthcare organizations are operated by government entities at federal, state, or local levels and are funded primarily through taxpayer dollars to serve the public interest (Zelman, 2014). The mix of for-profit, public, and non-profit organizations creates a fragmented healthcare system. This fragmentation leads to challenges with access, affordability, and quality of care for both patients and providers (Knickman & Elbel, 2019).

Consequently, the U.S. healthcare system faces ongoing scrutiny and debate surrounding its efficiency, equity, and effectiveness in delivering optimal health outcomes (Olden, 2019).

Healthcare is undergoing a period of relentless internal and external transformation, with many healthcare organizations struggling to keep pace with the rapid rate of change (Wagner, 2020). In addition to the complex and fragmented structure summarized above, numerous other challenges stem from a complicated combination of dynamically shifting forces, such as political healthcare reform, changing regulatory requirements, technological advancements, societal expectations, skilled workforce shortages, and evolving consumer preferences (Young, 2018). Given its societal significance, healthcare occupies a unique position between commercial business and social service (Oliver, 2018). Healthcare organizations must balance financial performance with patient care and safety. Consequently, integrating standard business processes and best practices into healthcare organizations to address operational and financial performance issues has proven challenging, considering the complex operating environment and the essential nature of the services provided (Forrestal, 2016). Nevertheless, healthcare leaders must provide effective stewardship and guide their organizations through this dynamic and complex environment to ensure their sustainability and their continued delivery of quality care to the communities they serve.

Strategic management is critical to effective stewardship within healthcare organizations. Stewardship involves the responsible management of resources, including financial and human capital, to ensure the organization achieves its goals and serves its stakeholders (Olden, 2019). As an established best practice applied across numerous industries and businesses, strategic management provides a framework for leaders to align the organization's resources with its goals and objectives, ultimately improving organizational performance and sustainability (Zuckerman,

2017). An essential component of strategic management is the application of concise, accurate, and up-to-date information (Olden, 2019). This information must be organized within strategic performance reporting frameworks that provide the conceptual structure and balanced perspectives for comprehensive performance measurement (Kaplan & Norton, 1996). These frameworks are then operationalized through strategic performance reporting systems (Mallon, 2019). Strategic performance reporting systems are valuable tools organizations use to monitor and report on their progress toward achieving strategic objectives (Harrison, 2016). Moreover, these systems provide decision-makers with timely and accurate data on organizational metrics, such as key performance indicators (KPIs), thereby supporting informed decision-making (Mallon, 2019).

Strategic performance reporting systems often utilize a dashboard or scorecard format to display KPIs and benchmarking data in a clear and concise layout (Ghazisaeidi et al., 2015). Dashboards and scorecards commonly include visual representations such as graphs or charts to provide a quick overview of organizational performance (Harrison, 2016). Strategic performance reporting systems may allow users to drill down into the data to explore performance metrics in more detail, providing a comprehensive view of organizational performance (Martin, 2018). There are several types of strategic performance reporting systems, including KPI Dashboards, Strategy Maps, Data Analytics Platforms, Business Intelligence Systems, and Balanced Scorecards (BSC) (Zuckerman, 2017). Most of these systems are singularly focused on reporting data; the BSC is unique in that it combines a strategic management framework in addition to a strategic performance reporting system (Ginter et al., 2013). This dual functionality has made the BSC particularly influential in strategic management, as it not only reports on performance but actively guides strategic decision-making and organizational alignment.

The BSC was first introduced in 1992 by Robert Kaplan and David Norton in the article titled “The Balanced Scorecard - Measures that Drive Performance” in the Harvard Business Review. The authors proposed that traditional financial measures alone were inadequate for assessing organizational performance and suggested a more comprehensive approach that included both financial and non-financial measures (Kaplan & Norton, 1992). The BSC quickly gained popularity and is now used by organizations across numerous industry classifications (Hoque, 2014). Compared to other strategic performance reporting systems, the BSC offers a unique strategic management framework that consists of four distinct perspectives that reflect diverse dimensions of organizational performance: financial, customer, internal processes, and learning and growth. The financial perspective, which measures financial performance, may include revenue growth, profitability, and return on investment (Jeronimo et al., 2022). On the other hand, the customer perspective measures non-financial metrics that may include customer satisfaction, loyalty, and retention. This perspective can also include measures related to market share, customer acquisition, and customer lifetime value (Quesado et al., 2018). The internal processes perspective measures the efficiency and effectiveness of operational activities critical to delivering value, including cycle times, quality metrics, productivity rates, and process innovation. Additionally, the internal processes perspective can focus on other areas such as product or service delivery, quality, and innovation. Lastly is the learning and growth perspective, which includes measures related to employee satisfaction, training and development, and organizational culture (Kaplan, 2010).

Overall, the BSC provides a holistic approach to measuring organizational performance that goes beyond traditional financial measures. By measuring performance across multiple perspectives, organizations can gain a comprehensive understanding of their performance and

identify areas for improvement (Kaplan & Norton, 2006). Moreover, the BSC assists managers with communicating organizational goals, strategic alignment of day-to-day actions, and prioritizing services, projects, and products. Through this comprehensive approach, the BSC enables organizations to align their activities with strategic objectives, improve decision-making, and achieve long-term sustainability (Kaplan, 2010).

According to the Harvard Business Review, the BSC has been recognized as one of the most significant management concepts in the last seventy-five years (Quesado et al., 2018). However, the application of the BSC in the healthcare sector is relatively unknown compared to other industries (Jeronimo et al., 2022). This study examined this knowledge gap by investigating BSC awareness, comprehension, and adoption criteria among healthcare leaders and managers in a healthcare organization.

### **Statement of the Problem**

The problem addressed in this study was the apparent deficiency in the adoption and integration of standardized performance reporting frameworks and systems, including the Balanced Scorecard methodology, among healthcare leaders and managers in non-profit healthcare organizations. This deficiency highlighted the need to explore mechanisms underlying BSC adoption to enhance knowledge on effective strategic planning and management in healthcare organizations (Gapenski & Reiter, 2016). Understanding perceptions and operational patterns associated with the BSC framework among healthcare professionals is critical for overcoming implementation barriers.

The closure of 51 hospitals in 2018 underscores the importance of effective strategic management practices in healthcare (Gujral & Basu, 2019). Hospital closures force patients to travel longer distances for care, resulting in devastating health effects. Research by Gujral and

Basu (2019) found that rural hospital closures increase average patient mortality by 5.9 percent due to reduced access to timely healthcare. While multiple factors contribute to closures, improved strategic and financial management could help organizations avoid this fate. The BSC is a strategic performance reporting framework that enables organizations to comprehensively assess performance, promote financial stability, and foster sustainable growth (Niven, 2014).

However, literature on BSC application in U.S. healthcare is limited compared to other sectors. While strategic management is widely utilized, BSC awareness and adoption levels in healthcare remain relatively unknown (Jeronimo et al., 2022). Although some literature indicates growing interest in the BSC, few case studies examine successful application, leaving it ambiguous whether organizations are implementing the framework or merely expressing interest. Factors contributing to BSC utilization within healthcare remain unclear (Amer et al., 2022; Reinaldy et al., 2023). This lack of research extends to adoption factors for strategic performance reporting systems within healthcare organizations. No studies have been identified that specifically address this subject, leaving a significant gap in understanding how these systems are perceived and implemented in the healthcare sector. This study sought to address these knowledge gaps and provide insights into BSC awareness and adoption in non-profit healthcare organizations.

### **Purpose of the Study**

The purpose of this qualitative interpretative descriptive study was to describe the levels of Balanced Scorecard awareness and comprehension, and the adoption criteria of strategic performance reporting systems for leadership and management at a multistate non-profit U.S. healthcare system operating in the Midwest and Mid-Atlantic regions. This research sought to contribute to the existing body of knowledge by offering insights into the levels of BSC

awareness and factors that influence the adoption and implementation of the BSC and related strategic performance reporting systems in the context of a non-profit healthcare organization. A qualitative methodology was deemed appropriate for this study, as the reasons behind BSC awareness and strategic performance reporting systems adoption factors within the non-profit healthcare sector had not been previously explored, thereby leaving the underlying causes largely unknown (Creswell & Poth, 2018). Furthermore, employing a qualitative approach enabled a more nuanced and in-depth examination of the complex dynamics and contextual aspects influencing the levels of BSC awareness and comprehension, as well as adoption factors of strategic performance reporting systems in healthcare organizations (Yin, 2015).

The recruitment of participants for this study took place within a non-profit U.S. healthcare system in the Midwest and Mid-Atlantic regions. Samples were selected from a population identified through organizational charts and email groups associated with leadership or management roles. The initial contact with potential participants was made via email, which invited them to participate through one of two data collection methods: completing an open-ended questionnaire via Qualtrics or participating in a semi-structured interview via Zoom. This dual-method approach allowed participants to select the format that best suited their preferences and availability while enabling the study to gather rich qualitative data through multiple channels.

To ensure consistency and rigor across both data collection methods, a structured set of questions needed to be developed that would serve both the interviews and the questionnaire. This process began with creating an interview guide based on the research questions and objectives, as well as the theoretical frameworks employed in the study. The development started with an extensive review of the existing literature on BSC awareness and adoption criteria. The

literature review served as the foundation for identifying key topics, themes, and constructs to be explored in the study (Creswell, 2013). Following the literature review, the interview guide was designed to follow a semi-structured format, allowing flexibility in exploring participants' perspectives and experiences. The development of the interview guide involved formulating open-ended questions that elicit rich and detailed responses, drawing on Patton's (2015) qualitative research methods for crafting effective questions. The questions were structured in a logical and sequential manner to ensure a coherent flow of the interview and to cover the identified topics comprehensively (Creswell, 2013).

To improve the effectiveness of the interview guide, a Delphi consensus review by a team of experts in qualitative research was used to gather feedback on the clarity, relevance, and comprehensiveness of the questions (Walle, 2015). Through an iterative Delphi consensus process, adjustments were made to the interview guide based on feedback received, with the goal of achieving consensus and ensuring alignment with the research questions (Yin, 2015). This development process supported the likelihood that the interview guide induced the desired information and facilitated an in-depth exploration of the research objectives.

The open-ended questionnaire was developed to mirror the interview guide, using the same questions and logical sequencing that had been established through the interview guide development process. Since the interview guide and its questions had already undergone the Delphi review process by qualitative experts and been refined for clarity and alignment with the study's objectives, these questions were then adapted for both instruments - the semi-structured interviews and the self-administered questionnaire delivered via Qualtrics. This approach ensured consistency across both data collection methods while allowing participants to choose between written or verbal response formats. Both options were presented in a single email

invitation, enabling participants to select the format that best suited their preferences and availability. The use of identical questions across both instruments enabled methodological triangulation, enhancing the credibility and depth of the data collected while maintaining consistency across data sources (Lincoln & Guba, 1985).

For the collection of qualitative data, the multiple data source approach using both interviews and questionnaires was conducted within the operating footprint of the non-profit healthcare system under investigation. Data was collected over a 14-day period with 964 individuals invited to participate, resulting in 36 participants (34 questionnaire responses and 2 interviews). Moreover, the study used purposive sampling to select participants who met the minimum criteria for inclusion as managers (i.e., individuals who have direct reports), ensuring the relevance of participants to the study's objectives.

Although this 3.7% response rate (36 of 964 invitations) falls below the 60% threshold some studies recommend to avoid nonresponse bias in quantitative research, different standards apply to qualitative studies (Cummings et al., 2001). The literature indicates a lack of consensus on specific response rate thresholds for qualitative sampling targeting managers, as qualitative research prioritizes in-depth exploration over high response rates, making lower rates potentially acceptable (Yin, 2015). However, a low response rate may have limited participation from busier executives or those with less interest in strategic management topics, potentially affecting the comprehensiveness of perspectives captured. A subsequent section in this chapter provides a more comprehensive discussion on response rates. To ensure rigor and validity despite the limited sample size, several methodological strategies were employed. Member checking was conducted by sharing the findings with interviewed participants and seeking feedback and input to ensure the accuracy and validity of the results (Cassell et al., 2018). Triangulation was

employed by combining multiple sources of data, such as interviews and questionnaires, to provide a comprehensive understanding of the research problem (Edmonds & Kennedy, 2017). Content and thematic analysis were the chosen methods for analyzing the qualitative data collected from semi-structured interviews and questionnaires, utilizing both deductive and inductive coding approaches (Yin, 2015).

The study's results were analyzed using NVivo software, a widely recognized tool for qualitative data analysis (Elliott-Mainwaring, 2021). Additionally, Microsoft Excel was utilized to complement the NVivo analysis by facilitating further sorting and organization of coded units, enabling cross-tabulation and frequency analysis of themes across different participant demographics and organizational levels. This involved several key steps. Firstly, the qualitative data, including interview transcripts and questionnaire responses, were imported into NVivo to establish a centralized database for efficient organization and retrieval (Allsop et al., 2022). Coding was then applied to identify and label significant themes, concepts, and patterns within the data (Kuckartz, 2014). The coding process incorporated both deductive and inductive strategies. Deductive codes were derived from the study's conceptual framework and research questions, while inductive codes were generated from emergent patterns in the data.

The analysis proceeded through two distinct phases. Initial coding and theme identification were conducted in NVivo using its query and visualization tools to explore patterns and relationships in the data (Allsop et al., 2022). Following this initial coding phase, Microsoft Excel became the primary tool for deeper analytical work, manipulation of the coded units across multiple dimensions. Excel's functionality proved essential for cross-tabulating themes by organizational level and educational background, calculating frequency distributions, and identifying patterns that informed the final thematic structure. This iterative process of moving

between NVivo enabling systematic organization and for initial coding and Excel for analytical refinement aligned with established qualitative research principles and ensured comprehensive examination of the data (Durdella, 2019).

### **Introduction to Conceptual Framework**

The conceptual framework for this qualitative study on BSC awareness, comprehension, and adoption factors for strategic performance reporting systems in nonprofit healthcare organizations integrated three key organizational behavior theories: diffusion of innovations theory, institutional theory, and resource-based view theory (Johnson & Walston, 2022). This integrated conceptual framework provided a comprehensive approach to examining the awareness and adoption of a business process or innovation (Cassell et al., 2018). Each organizational behavior theory within this conceptual framework added unique and essential perspectives to the research. The integrated conceptual framework explored how new ideas or practices spread and are adopted within a social system. This also includes an exploration into the characteristics of the innovation (relative advantage, compatibility, complexity, trialability, and observability), the communication channels used to disseminate information about the innovation, the timing of adoption, and the social system in which the innovation is being introduced (Luthans, 2021). Furthermore, this framework examines how structures, norms, and rules in a social system influence the behavior of organizations and individuals within that system (Smith et al., 2012). The key social system aspects also include coercive, normative, and mimetic pressures, and how organizations conform to these pressures (Borkowski & Meese, 2022). Finally, the integrated conceptual framework highlights the importance of valuable, rare, unique, and non-substitutable resources in achieving a competitive advantage (Wagner & Hollenbeck, 2021). The significant perspectives within this facet of the framework include an

organization's resources, such as human capital, technology, financial assets, culture, and knowledge, and how these resources interact to influence the adoption and successful execution of an innovation (Borkowski & Meese, 2022).

Moreover, the integrated conceptual framework served as a guide for the development of the problem statement, purpose statement, and research questions by highlighting key factors, such as innovation characteristics, communication channels, institutional pressures, and organizational resources, that influence adoption decisions (Cassell et al., 2018). The problem statement was informed by the framework's focus on understanding the factors that influence the adoption of strategic performance reporting systems, such as the BSC, in the context of nonprofit healthcare organizations. The purpose statement was driven by the framework's goal of providing a comprehensive understanding of BSC awareness and adoption criteria for leadership and management. The research questions were informed by the framework's core concepts, such as the perceived characteristics of the BSC, the alignment of the BSC and strategic performance reporting systems with organizational norms and values, and the role of organizational resources and institutional pressures in adoption decisions. The integrated conceptual framework thus provided a systematic and coherent structure for examining the research problem, identifying research questions, and generating insights into the factors influencing the adoption of strategic performance reporting systems in nonprofit healthcare organizations (Creswell & Poth, 2018).

Figure 1 presents a visual representation of this integrated conceptual framework, illustrating how diffusion of innovations theory, institutional theory, and resource-based view theory converge to examine BSC awareness and adoption factors for strategic performance reporting systems within a non-profit healthcare organization. As shown in the figure, diffusion of innovations theory explains the spread of new tools and ideas, institutional theory examines

cultural and normative influences, and resource-based view theory analyzes resource impact on implementation. These three theories overlapped and integrated to form a comprehensive framework that enabled a deeper understanding of awareness, comprehension, and adoption processes. This conceptual framework provided a lens for understanding the factors of awareness and adoption surrounding the BSC and strategic performance reporting systems, enabling a deeper exploration of the challenges and opportunities leadership and management faced in implementing these systems in the non-profit healthcare context.

### **Introduction to Research Methodology and Design**

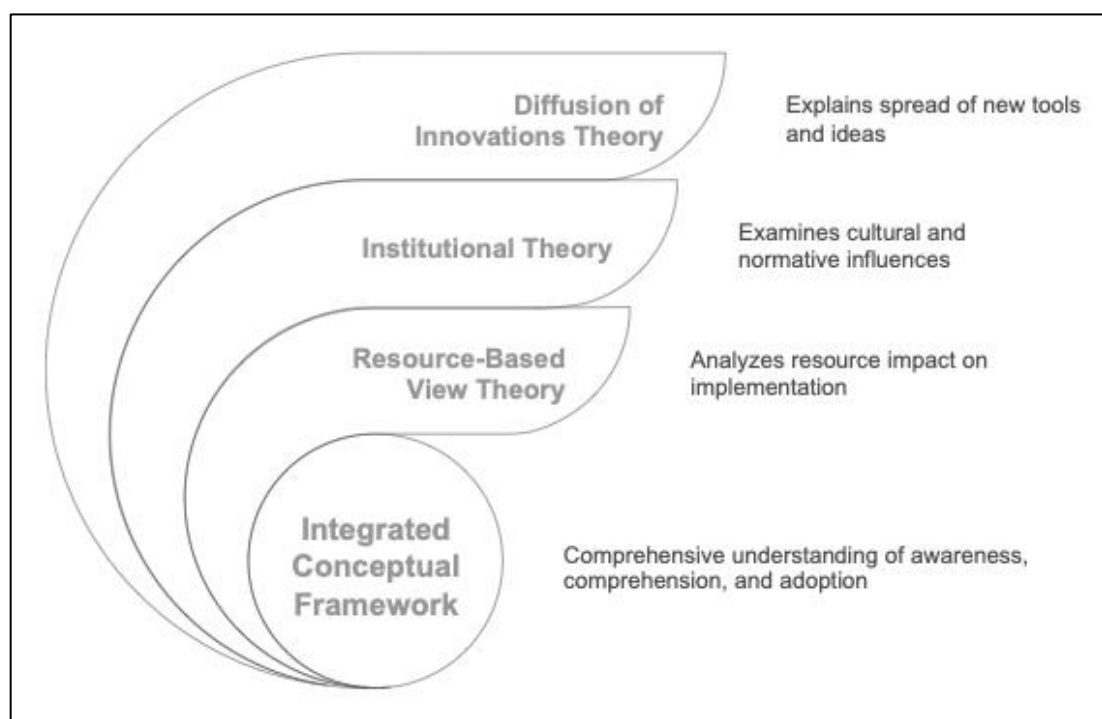
This qualitative interpretative descriptive study sought to describe the levels of BSC awareness and the adoption criteria of strategic performance reporting systems for leadership and management at a non-profit U.S. healthcare system. The research methodology selected was grounded in an interpretivist philosophical worldview, which emphasizes understanding and interpreting the social world and individuals' experiences within it (Yin, 2015). This worldview was particularly suitable for this study, as it recognizes the subjective nature of human experiences and the importance of context in understanding phenomena (Creswell & Poth, 2018).

Adopting the interpretivist approach enabled the research to investigate the complex and context-specific factors shaping BSC awareness and strategic performance reporting systems adoption criteria, promoting a deep understanding of the experiences, perspectives, and decision-making processes of healthcare managers and leaders (Walle, 2015). This worldview allowed the study to explore the nuanced and subjective nature of BSC awareness and adoption and generate rich, in-depth insights into the factors influencing the implementation of strategic performance reporting systems in non-profit healthcare organizations (Cassell et al., 2018). A fitting research

methodology for an interpretivist worldview is a qualitative research approach, which prioritizes the exploration of participants' perspectives, feelings, and experiences (Creswell & Creswell, 2018). By employing an interpretivist worldview and a qualitative research methodology, the study gained a deeper understanding of the underlying factors, motivations, and meanings that shape individuals' actions and experiences, providing rich insights into the phenomena (Yin, 2015).

### Figure 1

*Conceptual Framework for BSC Awareness and Adoption in Healthcare Organizations*



*Note.* This figure illustrates the convergence of three organizational behavior theories into an integrated framework for examining strategic performance reporting system awareness and adoption perspectives.

To operationalize this interpretivist qualitative approach, the study employed interpretative descriptive methodology, a specific framework designed to explore participants'

experiences, perceptions, and behaviors (Elliott & Timulak, 2021). Interpretative description is an approach that has gained recognition and significance in qualitative research. Several seminal works have contributed to the development and understanding of this methodology. Notably, the work of Thorne, Reimer-Kirkham, and O’Flynn-Magee (2004) introduced the concept of interpretative description as a research approach specifically designed to generate rich, contextualized descriptions of phenomena while incorporating interpretations and meanings. Their work emphasized the importance of capturing the complexity and depth of experiences and phenomena through a qualitative lens. Following these foundational works, Elliott and Timulak (2021) advanced interpretative description methodology through their examination of its practical applications and methodological refinements.

Distinct from other qualitative approaches like grounded theory, phenomenology, or case studies, an interpretative descriptive study (also known as generic) does not require adherence to a predetermined methodology or theoretical framework (Thorne et al., 2004; Yin, 2015). While researchers may choose to incorporate theoretical frameworks as analytical lenses, the approach itself is not bound by specific theoretical requirements. Instead, an interpretative descriptive methodology allows flexibility to investigate the research questions using various data collection methods and analytical techniques as deemed appropriate (Creswell & Creswell, 2018). The primary objective of this research approach is to achieve a deep, nuanced understanding of the subject matter, considering the subjective experiences and perspectives of the individuals involved (Yin, 2015). Interpretative descriptive studies typically rely on small sample sizes, emphasize the importance of context and seek to generate rich, detailed, and context-specific insights into the phenomenon under investigation (Edmonds & Kennedy, 2017). Moreover, an interpretative descriptive approach enabled the study to employ multiple data collection methods

(interviews and questionnaires) and analytical techniques (content and thematic analysis), strengthening the comprehensiveness of the findings (Creswell & Creswell, 2018; Elliott & Timulak, 2021). This adaptability enabled the exploration of complex research questions, yielding valuable insights that informed theory, practice, and policy (Elliott & Timulak, 2021).

To address the research questions, a multiple sources data collection was employed, incorporating semi-structured interviews and questionnaires to collect qualitative data from key stakeholders, including senior management, departmental leaders, and strategic practitioners. Questionnaires were designed using Qualtrics and disseminated through email, while synchronous interviews were conducted via Zoom using video teleconferencing capabilities. The recruitment of participants for the study was conducted in a non-profit healthcare system operating in the Midwest and Mid-Atlantic regions of the U.S. The selection of participants was based on a population identified through organizational charts and email groups affiliated with leadership or management positions. The initial outreach to potential participants was through email, inviting them to participate in the study. The use of semi-structured interviews and questionnaires provided a multiple data sources approach that allowed the study to triangulate data sources and strengthen the credibility and trustworthiness of the findings (Yin, 2015). In addition, the use of multiple data collection methods enhanced the study's ability to capture diverse perspectives and experiences, providing a richer and more holistic understanding of BSC awareness, comprehension, and adoption criteria for strategic performance reporting systems in the healthcare setting (Creswell & Poth, 2018).

In determining the sample size for this qualitative interpretative descriptive study, it was important to consider the research questions, objectives, and the desired level of data saturation (Smith, 2021). Qualitative research often emphasizes smaller sample sizes compared to

quantitative research, as the objective is to obtain an in-depth and nuanced comprehension of the phenomena under examination (Cassell et al., 2018). For this study, a total of 964 individuals were invited to participate, resulting in 36 participants within a non-profit U.S. healthcare system, comprising 34 questionnaire responses and 2 interviews. For this study, samples were selected from a population identified through organizational charts and email groups associated with leadership or management roles. The minimum criteria for inclusion as management were individuals who have direct reports, ensuring the relevance of participants to the study's objectives. The sampling process continued over a 14-day data collection period, during which thematic saturation was achieved (Yin, 2015). The saturation pattern observed in this study is consistent with Guest, Bunce, and Johnson's (2006) empirical finding that saturation typically occurs within the first 12 interviews, though broader studies may require additional participants for comprehensive theme development. Moreover, Francis et al. (2010) proposed a method for determining adequate sample sizes for saturation, recommending initial analysis after 10-12 interviews, followed by incremental additions until no new themes emerge. In this study, thematic saturation for the primary themes was largely achieved after approximately 20 responses; however, the additional responses through the full sample of 36 participants provided valuable nuance and depth to the emerging themes.

The literature suggests that the response rate for questionnaires targeting managers can vary, and there is no consensus on a specific threshold. However, insights from various sources shed light on this matter. For instance, Cummings et al. (2001) recommend a desirable response rate of at least 60% for quantitative research targeting managers, as they found that rates below this threshold may introduce potential nonresponse bias. Similarly, Schriesheim et al. (1999) propose a response rate benchmark of 50% or higher as acceptable for quantitative studies

focusing on managers. Nevertheless, unlike quantitative research, where a high response rate is often desired, qualitative studies prioritize in-depth exploration of a smaller sample. Therefore, the focus in qualitative research is on the richness and depth of the responses rather than the number of participants. The goal is to gather detailed and insightful information from a diverse range of perspectives rather than striving for a specific response rate. It was important for the research to consider the quality and depth of the data obtained rather than solely focusing on achieving a particular response rate. This study's response rate of 3.7% (36 participants from 964 invitations) was below the quantitative benchmarks cited; however, consistent with qualitative research priorities, the focus remained on the depth and richness of responses, which successfully achieved thematic saturation for primary themes.

Data analysis followed Braun and Clarke's (2006) six-phase thematic analysis model: familiarization with the data, initial coding, searching for themes, reviewing themes, defining and naming themes, and producing the report. The study employed both deductive and inductive coding approaches to analyze the questionnaire responses and interview transcripts (Creswell & Poth, 2018). Deductive codes were developed from the study's conceptual framework and research questions, while inductive codes emerged organically from participant responses. Interview transcripts and questionnaire responses were analyzed separately before undergoing a triangulation phase to identify areas of convergence and divergence across data sources (Yin, 2015). NVivo software provided a systematic platform for organizing, coding, and interpreting the qualitative data, enabling consistent management of the large volume of textual responses (Elliott-Mainwaring, 2021). Microsoft Excel complemented the NVivo analysis by facilitating cross-tabulation and frequency analysis of themes across different participant demographics and organizational levels. The iterative analysis process involved multiple rounds of coding

refinement and theme development, with detailed memos documenting interpretive insights and analytical decisions throughout. The findings were presented through a narrative account that integrated participant quotations with thematic interpretation, providing a comprehensive understanding of BSC awareness and adoption criteria within the studied healthcare organization (Cassell et al., 2018).

### **Research Questions**

This study concentrated on two principal domains of inquiry: (1) the levels of BSC awareness and comprehension, and (2) the factors influencing the adoption of strategic performance reporting systems such as the BSC. To address these domains, the following research questions were developed, which served as the foundation for this study.

#### ***RQ1***

In what ways do leadership and management demonstrate awareness and comprehension of the BSC?

#### ***RQ2***

How do leadership and management perceive the adoption criteria for the BSC or other strategic performance reporting systems?

### **Significance of the Study**

Despite evidence of success in healthcare organizations, governmental backing, and widespread recognition as a best practice, the implementation and utilization of the BSC in healthcare remains unclear (Jeronimo et al., 2022). The existing literature provides a comprehensive understanding of the BSC's general aspects; however, most studies focus on industries other than healthcare. There is a notable gap in the literature exploring the crucial aspects of BSC awareness, comprehension, and the adoption considerations for strategic

performance reporting systems within the U.S. healthcare sector (Amer et al., 2021; Marques, 2022).

This study sought to enhance the understanding regarding the levels of awareness and comprehension of the BSC and what factors leadership and management consider when evaluating the adoption of a strategic performance reporting system. Gaining deeper insights into this area would not only clarify the BSC's role within healthcare but also serve as a basis for further explanatory research on attitudes, experiences, and perceptions related to the BSC and strategic performance reporting systems (Edmonds & Kennedy, 2017). An improved understanding of the BSC's application and adoption factors of strategic performance reporting systems could contribute to the development of strategies that encourage increased utilization of the BSC within healthcare organizations. Ultimately, the expanded use of the BSC in healthcare could enhance organizational effectiveness, leading to improved health service delivery and better health outcomes for the populations served (Health Resources and Services Administration, 2005).

## **Definitions of Key Terms**

### ***Adoption***

Adoption of a business practice or process refers to the decision and subsequent action taken by an organization to implement and integrate a new method, technique, or system into its existing operations. This process typically involves evaluating the potential benefits and compatibility of the new practice, training employees, and making necessary adjustments to ensure a smooth transition and successful integration, with the intent of enhancing organizational performance and efficiency (Gupta & Salter, 2018)

### ***Awareness***

Awareness of a business practice or process refers to the extent to which an organization's management and employees are informed about, understand, and recognize the existence, relevance, and potential benefits of a particular method, technique, or system.

Awareness is a crucial first step in the process of adoption and implementation, as it enables organizations to identify new opportunities, evaluate their suitability, and make informed decisions regarding their incorporation into existing operations (Jeronimo et al., 2022).

### ***Balanced Scorecard***

The Balanced Scorecard (BSC) is a strategic management methodology that helps organizations align their activities with their vision, mission, and goals. Developed by Robert Kaplan and David Norton in the early 1990s, it offers an inclusive framework and system to monitor performance across four perspectives: financial, customer, internal processes, and learning and growth (Kaplan, 2010). The BSC transforms an organization's strategic objectives into a set of quantifiable performance measures, facilitating continuous assessment and improvement. By providing a holistic view of organizational performance, the BSC enables managers to maintain a balance between short-term operational performance and long-term strategic objectives (Martin, 2018; Scherer, 2002).

### ***Benchmarking***

The process of analyzing and comparing similar processes across organizations and industries with the goal of identifying best practices, establishing improvement targets, and measuring progress. Benchmarking allows organizations to learn from others' successful approaches, gain insights into industry standards, and strive for continuous improvement by

implementing effective strategies and practices discovered through the benchmarking process (White & Griffith, 2019).

### ***Coercive Pressures***

Institutional forces that compel organizations to adopt certain practices through formal and informal pressures exerted by other organizations upon which they depend, as well as by regulatory bodies and cultural expectations in society (DiMaggio & Powell, 1983).

### ***Comprehension***

In the context of business research, comprehension refers to the ability to understand, interpret, and apply complex information or findings. It involves the cognitive process of assimilating information, transforming it into knowledge, and using that knowledge effectively (Walle, 2015).

### ***Customer Processes***

Kaplan and Norton (1992) describe customer processes as organizational practices and techniques focused on creating value and differentiation from the customer's perspective.

### ***Financial Processes***

According to Kaplan and Norton (1992), financial processes refer to the outcomes of organizational actions manifested in terms of budget enhancement and sustainability. For non-profit organizations, financial processes examine the most cost-effective ways to deliver customer benefits.

### ***Growth and Learning Processes***

Kaplan and Norton (1992) characterize the growth and learning processes as organizational practices and approaches that foster a culture encouraging innovation, organizational development, and growth.

### ***Internal Business Processes***

Kaplan and Norton (1992) define internal business processes as the organizational practices and techniques employed to meet customer and stakeholder expectations.

### ***Key Performance Indicators***

Key Performance Indicators (KPIs) are quantifiable metrics used to evaluate an organization's success in achieving specific objectives or goals. KPIs provide a clear and concise way to measure progress, helping organizations track their performance and identify areas for improvement (Martin, 2018).

### ***Lagging Indicator***

Lagging indicators are performance measures that reflect the outcomes or consequences of past actions. These indicators typically focus on results achieved at the end of a specific time period, providing an assessment of historical performance. An example of a lagging indicator is employee satisfaction, which measures the level of satisfaction based on past experiences. To create a well-rounded BSC, it is essential to include a combination of lag and lead indicators (Sharma, 2009).

### ***Leading Indicator***

Leading indicators are performance measures that act as the drivers or predictors of lagging indicators. They are indicators that provide insights into future performance and are believed to have a direct impact on the outcomes reflected by lagging indicators. The relationship between leading and lagging indicators suggests that positive changes in leading indicators can lead to improved performance in lagging indicators. By monitoring leading indicators, organizations can proactively identify areas for improvement and take strategic actions to drive favorable outcomes in lagging indicators (Sharma, 2009).

### ***Mimetic Pressures***

Institutional forces that lead organizations to imitate or model themselves after other organizations perceived as successful or legitimate, particularly when facing uncertainty about best practices or optimal strategies (DiMaggio & Powell, 1983).

### ***Normative Pressures***

Institutional forces stemming from professionalization, where members of occupational groups define the conditions and methods of their work and establish a cognitive base and legitimation for their occupational autonomy, often through professional networks and educational institutions (DiMaggio & Powell, 1983).

### ***Payer***

In the context of the U.S. healthcare system, a payer denotes an entity that finances or reimburses the cost of health services. Payers encompass a wide range of bodies, including private insurance companies, government programs (such as Medicare and Medicaid), and occasionally individuals themselves. These entities negotiate, establish, and distribute payments for the provision of healthcare services, playing a crucial role in the operation and management of the healthcare system (Wagner, 2020).

### ***Stakeholder***

An individual or group with a vested interest in the organization's success. In the context of public and nonprofit organizations, stakeholders may encompass employees, customers, clients, funders, elected officials, citizens, special-interest groups, suppliers, media, the financial community, and partners. It is crucial to consider all stakeholders when formulating the organization's mission, values, vision, strategy, and objectives, as well as developing measures for the BSC (Harrison & Thompson, 2015).

### ***Strategic Management***

Strategic management is the process of defining an organization's direction, making decisions on resource allocation, and implementing plans to achieve its long-term goals and objectives. It encompasses the continuous assessment and adaptation of strategies to respond to internal and external changes, ensuring sustained growth and competitive advantage (Harrison, 2016).

### ***Strategic Performance Reporting Frameworks***

A strategic performance reporting framework is a conceptual model or methodology that provides the underlying structure, principles, and theoretical foundation for how an organization conceptualizes, organizes, and balances its performance measurements across multiple dimensions (Kaplan & Norton, 1996). These frameworks establish the architectural blueprint that guides the development of reporting systems, defining the perspectives, relationships, and strategic linkages that ensure performance measurement aligns with organizational strategy (Ittner & Larcker, 2003).

### ***Strategic Performance Reporting System***

A strategic performance reporting system is a structured approach to collecting, analyzing, and presenting data related to an organization's strategic goals and objectives (Victor & Farooq, 2021). This system enables decision-makers to monitor progress, evaluate performance, and identify areas requiring adjustments or improvements (Ginter et al., 2013)

### **Summary**

The U.S. healthcare system is marked by its complexity due to diverse stakeholders, funding sources, and regulatory structures, which can result in challenges related to access, affordability, and quality of care (Wagner, 2020). To navigate this complex environment,

strategic management is essential for effective stewardship within healthcare organizations. The BSC, introduced by Kaplan and Norton in 1992, offers a comprehensive strategic management framework that measures performance across four perspectives: financial, customer, internal processes, and learning and growth (Niven, 2014). Despite its widespread adoption in other sectors, the BSC's application in the U.S. healthcare sector remains relatively unknown (Jeronimo et al., 2022).

The purpose of this qualitative interpretative descriptive study was to describe the levels of BSC awareness and comprehension, and the adoption criteria of strategic performance reporting systems for leadership and management at a multistate non-profit U.S. healthcare system operating in the Midwest and Mid-Atlantic regions. The study utilized a conceptual framework integrating diffusion of innovations, institutional theory, and resource-based view theory. Grounded in an interpretivist worldview, the study employed a qualitative interpretative descriptive methodology, utilizing multiple sources for data collection to provide rich insights into the research topic (Yin, 2015).

The research sought to enhance understanding of BSC awareness and factors influencing the adoption of strategic performance reporting systems, addressing a significant literature gap and informing future research, practice, and policy development. By supporting the development of strategies to encourage BSC utilization, the study ultimately aimed to enhance organizational effectiveness and improve health outcomes for served populations. Chapter 2 provides an examination of the literature on the BSC and strategic performance reporting systems, focusing on their relevance to the research problem while identifying gaps in the existing literature that this study sought to address. The chapter also presents the conceptual framework, detailing how

diffusion of innovations theory, institutional theory, and resource-based view theory inform the study's approach.

## Chapter 2: Literature Review

The problem addressed in this study was the apparent deficiency in the adoption and integration of standardized strategic performance reporting frameworks and systems, including the Balanced Scorecard (BSC) methodology, among healthcare leaders and managers in non-profit organizations. Despite widespread recognition of the BSC as a leading strategic management tool, this deficiency highlights the need to explore the mechanisms underlying the adoption of such frameworks to enhance knowledge on effective planning and management in healthcare settings. Gaining deeper insight into perceptions and patterns associated with the BSC and related frameworks is critical to progress in overcoming barriers to strategic performance reporting system implementation in healthcare.

The purpose of this qualitative study was to describe the levels of BSC awareness and comprehension, and the adoption criteria of strategic performance reporting frameworks for leadership and management within a non-profit U.S. healthcare system. This research explored the depth of understanding and application of the BSC among healthcare professionals, focusing on the criteria for its adoption and integration into existing performance systems. It investigated implementation challenges, including organizational and cultural barriers, with the goal of providing insights for optimizing BSC use in strategic management. By offering perspectives on BSC awareness and factors influencing its adoption in a non-profit healthcare context, this study sought to contribute to both academic literature and practical healthcare management.

The literature review presented in this chapter provides an exploration of the BSC as a strategic management tool, with a particular focus on its application in healthcare organizations. The review begins by discussing the literature search strategy, including the keywords, Boolean phrases, and sources used to identify relevant scholarly works. It then introduces the conceptual

framework, which integrates diffusion of innovations theory, institutional theory, and resource-based view theory to guide the investigation of BSC awareness, comprehension, and adoption considerations in healthcare contexts. The review proceeds to examine the origins, theoretical foundations, components, and structure of the BSC, as well as its application, implementation, impact, and effectiveness across various sectors. Criticisms and limitations of the BSC are also addressed, providing a balanced perspective on this strategic management tool. The review then narrows its focus to the BSC in healthcare, exploring awareness, adoption, application, impact, and outcomes specific to this sector. Research gaps are identified, justifying this study and its methodology. Following the identification of research gaps, the chapter provides a rationale for employing a qualitative interpretative descriptive methodology, drawing on patterns and precedents evident in prior literature. The chapter concludes with a summary of key findings from the literature review.

### **Literature Search Strategy**

This literature review encompassed scholarly peer-reviewed articles, doctoral dissertations, seminal books, and carefully vetted gray literature reports found in the EBSCO, ProQuest, Emerald Insight, and Sage Journals databases, accessed through the National University library portal. The review focused on journal articles published from 2014 to 2024 to capture current research, while also selectively including seminal pre-2014 articles that provided foundational theoretical perspectives on awareness, assimilation, the BSC, and other relevant frameworks. Additionally, the Mercy College of Ohio library database and Google Scholar search engine were also utilized to expand article retrieval. The search strategy employed multiple Boolean operators and various combinations of search terms to ensure comprehensive coverage of the literature. Key search terms included: “balanced scorecard”, “strategic

performance measurement system”, “adoption”, “healthcare”, “awareness,” and “qualitative interpretative descriptive,” among numerous other related terms and synonyms. As the dissertation examined awareness, comprehension, and adoption considerations surrounding the BSC and strategic performance reporting systems among healthcare managers, these primary keywords, combined through various Boolean strategies and supplemented with additional search refinements, helped isolate articles concentrating directly on these central concepts.

### ***Keywords and Boolean Phrases***

The keywords “balanced scorecard” and “strategic performance measurement system” filtered specifically for literature focused on strategic measurement tools and methodologies, rather than unrelated clinical systems or general organizational topics. Including “adoption” retrieved articles emphasizing assimilation factors and processes involved with implementing management innovations like scorecards. The word “healthcare” yielded context-specific works tailored to medical environments rather than more generic business or technology fields. Incorporating “awareness” focused on perceptions, familiarity, and comprehension-based dimensions of BSC usage. Adding “qualitative interpretative descriptive” captured studies focused on revealing complex social dynamics through descriptive investigations similar to this study. Together, these Boolean search parameters streamlined identification of academic works intersecting healthcare organizations, strategic measurement instruments, implementation phenomena, and qualitative approaches.

Additionally, targeted search terms and Boolean phrases like “diffusion of innovations” AND “healthcare”, “institutional theory” AND “balanced scorecard”, and “resource-based view” AND “strategic planning” were leveraged to pinpoint scholarly literature central to the three conceptual framework theories. These tailored keywords and search strings enabled efficient

identification and screening of academic works with direct relevance to diffusion of innovations, institutional theory, and resource-based view theory in context of adoption and assimilation dynamics, thus supporting an evidence-base for the integrated conceptual framework applied to this study. In sum, the application of select key words, search terms, and Boolean search parameters supported the identification of literature directly aligning with the numerous aspects of this study.

### ***Literature Sources***

The identified literature focused on dissertations, seminal books, and carefully screened gray works that supplemented a core emphasis on peer-reviewed journals. Regarding journals, parameters emphasized works published within the last 10 years to represent contemporary advancements. However, legacy merit was incorporated by retaining particular pre-2014 articles deemed noteworthy contributions providing fundamental theoretical grounding of awareness, assimilation, BSC and other frameworks germane to this study. Books, textbooks, and book chapters considered influential pillars providing foundational support relevant to the study were included to provide proper conceptual framing. While not peer-reviewed, these works shape academic discourse within the management, healthcare administration, economics, and sociology fields.

While the literature selection prioritized recent and relevant works, it is important to acknowledge the decline in publication frequency on the BSC within healthcare since 2015. Research activity between 2000 and 2015 was comparatively more evident than in subsequent years, though still modest relative to activity in other sectors. After 2015, publications continued through 2024, albeit at a diminished rate. This trajectory reflects a limited adoption cycle within healthcare practice, which has correspondingly constrained scholarly engagement, leaving

several theoretical and practical questions open for further examination. The diminished volume of healthcare-focused publications since 2015 further justified incorporating complementary academic sources.

The inclusion of doctoral dissertations represented academic works that offer contemporary insights and robust methodological models, making them well-suited for this literature review. Though not peer-reviewed, dissertations contain insightful research on precise aspects of phenomena like BSC adoption and assimilation dynamics. They utilize stringent qualitative, quantitative, and mixed methodologies concentrated explicitly within pertinent strategic planning and healthcare administration spheres. Therefore, doctoral dissertations provided targeted evidence supporting the examination of this study's problem statement, purpose, and questions. For example, Wisniewski's (2021) phenomenology supplies firsthand descriptions of balanced scorecard impacts on nurses, while Tlili's (2018) case study offers a multifaceted analysis of adoption barriers through interviews with 36 executives. Such discoveries helped guide this study's qualitative interpretative descriptive orientation to prompt nuanced explanations from leaders themselves. Furthermore, Aguenza's (2020) methods helped shape the questionnaire and semi-structured interview process used in this study. Consequently, the incorporation of doctoral dissertations furnished contemporary, field-specific insights to enhance contextual grounding and methodological models for investigating awareness and assimilation determinants.

While prioritizing peer-reviewed evidence, it is essential to acknowledge the practical insights offered by gray literature, which complements academic research by providing applied findings relevant to policy and practice. Governmental reports were instrumental in providing up-to-date guidelines and implementation strategies. A notable example is the guide from the

U.S. Department of Health and Human Services that advises on the BSC's application within rural hospitals (Department of Health and Human Services, 2017). These governmental documents are products of comprehensive research efforts, including a synthesis of academic literature, interviews, focus groups, surveys, and field studies, that yield practical guidelines to directly inform strategic planning and decision-making processes in healthcare. Such insights from gray literature serve to bridge the gap between academic research and the pragmatic needs of healthcare management, ensuring a well-rounded understanding of the BSC's implementation in the healthcare context, thus supporting the selective inclusion of gray sources in this literature review.

### **Conceptual Framework**

This study integrated three key organizational behavior theories (diffusion of innovations theory, institutional theory, and resource-based view theory) to facilitate a comprehensive investigation of awareness, comprehension, and adoption considerations related to the BSC and similar strategic performance reporting systems in healthcare contexts. Diffusion of innovations theory explains how new tools and ideas spread within an organization (Rogers, 1962). Institutional theory examines how organizational culture and norms influence adoption of innovations (DiMaggio & Powell, 1983). Resource-based view theory analyzes how access to resources impacts capacity to implement strategic changes (Barney, 1991). Together, these three perspectives provided a framework for understanding the personal, cultural, and systemic dynamics that shape assimilation of new systems in healthcare settings (Johnson & Walston, 2022). The integrated conceptual framework enabled a multifaceted investigation that yielded key insights into existing barriers and potential opportunities related to BSC implementation. This section assesses the selected theories for their ability to contribute to understanding and

adopting strategic performance reporting systems, such as the BSC. It also evaluates each theory's applicability in the healthcare sector and for management innovations, while addressing the criticisms and limitations and discussing the theory's contribution to the integrated conceptual framework.

### ***Diffusion of Innovations Theory***

A central theoretical pillar incorporated into the integrated conceptual framework for this study was Rogers' (1962) diffusion of innovations theory. This theory seeks to explain how new innovations and ideas propagate through communication channels over time within a social system (Dearing & Cox, 2018). The foundations of diffusion of innovations theory emerged through rural sociology research in the mid-20th century examining how agricultural innovations spread amongst farming communities (Valente & Rogers, 1995). Ryan and Gross's (1943) seminal study of hybrid seed corn adoption across Iowa farmers provided empirical evidence for patterns of social influence that early sociologists like Gabriel Tarde (1903) had theorized, documenting an S-shaped curve of gradual then accelerating adoption rates. However, the prominent diffusion of innovations theory widely applied today in disciplines ranging from communications to marketing to healthcare is credited to Rogers, starting with the publication of his book *Diffusion of Innovations* in 1962 (Rogers, 1962). This landmark work formally advanced a model synthesizing interdisciplinary research on diffusion dynamics related to attributes, adopters, communication channels and consequences. Rogers' model was designed to provide a generalizable, integrated framework for understanding qualities impacting adoption of new innovations and practices across diverse contexts (Berwick, 2003). According to Rogers (1962), diffusion transpires through various communication channels in a social system,

resulting in participants progressing through stages from initial knowledge of the innovation through adoption and confirmation.

Rogers (2003) explains that the diffusion of innovations progresses through a multi-stage sequence consisting of knowledge, persuasion, decision, implementation, and confirmation phases. At the initial knowledge stage, members of a social system gain exposure to and an understanding of the innovation's existence along with its potential applications (Rogers, 2003). Scholars emphasize how this early awareness knowledge constitutes a prerequisite foundation preceding adoption decisions (Kaminski, 2011). Next, the persuasion phase involves participants cultivating favorable or skeptical perceptions concerning the innovation's qualities based on its perceived characteristics, advantages, complexity, compatibility, and other attributes (Rogers, 2003). Dearing and Cox (2018) discuss how emotional and cognitive processing during the persuasion phase of the innovation-decision process shapes an individual's progress towards adoption or rejection. They suggest that both affective responses and rational evaluation of the innovation's characteristics, potential outcomes, and alignment with personal and organizational needs influence the formation of attitudes and the subsequent decision to adopt or reject the innovation (Dearing & Cox, 2018). The decision stage culminates the information gathering and appraisal process as individuals determine whether to fully adopt or reject the new technology or practice (Berwick, 2003). Committing to adoption leads to the implementation phase where the innovation gets operationalized within existing workflows; however, this commonly reveals unforeseen barriers and adaptation necessities associated with innovation execution (Rogers, 2003). Finally, the confirmation phase is marked by individuals affirming the innovation-decision by seeking endorsements supporting their adoption choice amid initial usage of the innovation (Kaminski, 2011).

In the decades since its inception, diffusion of innovations theory has undergone continual assessment and evolution regarding its core constructs and propositions (Dearing & Cox, 2018). Key developments include Moore and Benbasat's (1991) reconceptualization emphasizing perceptions rather than objective innovation attributes. Moreover, several significant concepts have emerged from continued diffusion research, including the innovation-decision process, adopter categorizations, attributes of innovations, and factors that influence the spread of new ideas (Rogers, 2003). Furthermore, contemporary research continues to validate Rogers' framework, with studies like Kaminski (2011) confirming that these original innovation attributes remain strong predictors of adoption rates.

**Diffusion of Innovations Theory for Management Innovations.** Diffusion of innovations theory is useful for investigating the adoption and integration of management innovations across sectors (Wisdom et al., 2014). Within the strategic management literature, concepts from diffusion research have been employed to trace adoption patterns surrounding performance measurement systems. For example, Northcott & France (2005) leveraged diffusion of innovations theory principles in their examination of leadership attitudes and BSC usage rates across 19 healthcare organizations. Their findings revealed crucial insights into how executive perceptions of performance management innovations, specifically regarding dimensions of relative advantage, compatibility, complexity, adaptability, and effectiveness, shaped an organization's readiness to adopt new strategic tools such as the BSC. Additionally, Van Grembergen and Saull (2001) demonstrated the applicability of diffusion theory for understanding internal organizational dynamics that impact management innovation adoption. Their research highlighted how awareness communication flows and influence patterns across diverse stakeholder groups affected an organization's speed of BSC adoption and internal

diffusion paths. Such applications of key diffusion concepts to assess adoption patterns surrounding measurement-focused management innovations demonstrate the framework's versatility within strategic management domains.

**Diffusion of Innovations Theory in Healthcare Contexts.** Various scholars have worked to contextualize the model for specific fields and innovations (Wisdom et al., 2014). For example, Berwick's (2003) research explicitly integrated several core diffusion of innovations concepts including innovation attributes, communication channels, time dimensions, and social systems within a proposed framework for understanding uptake and acceleration of medical innovations in healthcare contexts. More recently, Wisdom et al. (2014) also emphasized that diffusion of innovations theory is highly applicable for investigating the adoption and integration process of various administrative, technological, and delivery model innovations within healthcare service organizations. Moreover, Northcott & France (2005) study used Rogers' diffusion of innovations theory to provide a relevant framework for understanding the communication and social system dynamics that influence healthcare practitioner adoption perspectives regarding the BSC. Specifically, Northcott & France (2005) applied diffusion of innovations theory concepts to examine physicians' orientations toward BSC systems and trace how perceptions of relative advantage and complexity shaped adoption readiness. Berwick (2003), Wisdom et al. (2014), and Northcott & France (2005) demonstrate how diffusion of innovations theory helps investigate multiple levels of integration surrounding innovations like the BSC within healthcare's complex social system, supporting the theory's inclusion in the conceptual framework.

**Criticisms and Limitations of Diffusion of Innovations Theory.** Diffusion of innovations theory, despite its extensive application in various fields, has faced several criticisms

and limitations. One notable criticism is the theory's assumption of a linear and sequential process of innovation adoption, which may oversimplify the complex and iterative nature of diffusion in real-world contexts (Lyytinen & Damsgaard, 2001). Lyytinen and Damsgaard (2001) argue that the theory's stage-based model may not adequately capture the dynamic interactions and feedback loops that shape innovation adoption processes. Furthermore, the theory has been criticized for its pro-innovation bias, which assumes that all innovations are inherently beneficial and should be widely adopted (Abrahamson, 1991). Abrahamson (1991) argues that this bias overlooks the potential negative consequences and unintended outcomes of innovation adoption, such as increased costs, disruptions to existing routines, or unequal distribution of benefits.

Moreover, diffusion of innovations theory has been critiqued for its limited attention to the broader social, political, and cultural contexts that influence innovation diffusion (Wejnert, 2002). Wejnert (2002) argues that the theory often focuses on individual adopters and their characteristics, while giving less emphasis to the role of structural factors, power relations, and societal norms in shaping diffusion patterns. This limitation may limit the theory's ability to fully explain the complexities of innovation adoption in diverse organizational and institutional settings.

Nevertheless, despite these criticisms, diffusion of innovations theory remains a valuable framework for understanding the spread of new ideas and practices. Researchers can address these limitations by complementing the theory with other perspectives, such as institutional theory or resource-based view theory, which offer insights into the contextual factors and organizational dynamics that shape innovation adoption (Johnson & Walston, 2022). Additionally, scholars can adapt and extend the theory to better account for the complex and

varied nature of diffusion processes. Greenhalgh et al.'s (2004) comprehensive review revealed that successful innovation adoption in healthcare depends not only on innovation attributes but also on organizational context and system readiness, demonstrating the value of supplementing diffusion theory with additional theoretical perspectives.

**Conceptual Framework Application.** Diffusion of innovations provided a relevant framework for examining how innovations progress from awareness through adoption and implementation within a social context. Evaluating diffusion of innovations dynamics related to communication channels and innovation attributes revealed crucial perspectives regarding BSC adoption considerations in healthcare settings. The theory's emphasis on the innovation-decision process, from knowledge through persuasion to implementation, offered essential structure for investigating why strategic frameworks may fail to penetrate healthcare organizations despite their proven benefits in other sectors. Furthermore, Rogers' (2003) identification of innovation attributes such as complexity, relative advantage, and compatibility provided specific constructs for understanding what healthcare leaders seek when evaluating strategic performance systems. Integrating this lens into the study's conceptual framework enabled a thorough exploration of complex integration processes.

### ***Institutional Theory***

In addition to diffusion of innovations theory, institutional theory formed another critical pillar of the conceptual framework used in this study. Whereas diffusion of innovations concentrates on how innovations spread, institutional theory focuses more on organizational dynamics that determine adoption readiness at a systemic level (Wisdom et al., 2014). Institutional theory is a widely recognized perspective in the fields of organizational studies and sociology; however, it does not have a single creator. Instead, it emerged from the collective

contributions of several scholars over time (DiMaggio & Powell, 1983). At its core, institutional theory proposes that organizational decisions and actions are significantly shaped by the norms, rules, beliefs, and expectations imposed on them by their internal and external environments (Scott, 1987). This diverges from earlier theories that portrayed organizations as single actors freely optimizing decisions based solely on rational calculations of efficiency or performance (DiMaggio & Powell, 1983).

**Institutional Theory for Management Innovations.** Institutional theory provides a valuable lens for understanding the adoption and integration of management innovations like the BSC within organizations. As DiMaggio and Powell (1983) explain, institutional theory suggests that organizations are deeply influenced by the norms, rules, and expectations prevalent in their environments, leading to conformity pressures and the tendency for organizations to become more similar over time. This isomorphic pressure can take the form of coercive mechanisms, such as regulatory requirements or resource dependencies; mimetic processes, where organizations imitate successful peers to navigate uncertainty; and normative influences, often stemming from professionalization and shared educational backgrounds (DiMaggio & Powell, 1983). Through these complex mechanisms, organizational decisions and configurations become shaped by institutional factors rather than just market competition or resource needs alone (Suddaby, 2010). Consequently, these institutional forces play a significant role in shaping organizational behavior and decision-making processes, including the adoption and implementation of management innovations such as the BSC.

Institutional theory has been applied extensively in research on management innovation adoption and implementation. For instance, Wisdom et al. (2014) conducted a comprehensive review of innovation adoption theories and constructs, highlighting the relevance of institutional

theory in understanding the complex dynamics that influence the uptake of new practices and tools within organizations. They found that institutional pressures, such as regulatory mandates, industry norms, and the desire for legitimacy, play a significant role in driving the adoption of management innovations. Similarly, Van Grembergen and Saull (2001) used institutional theory to investigate the adoption of the BSC in IT service organizations. Their study revealed how coercive, mimetic, and normative pressures influenced the awareness, acceptance, and implementation of the BSC, demonstrating the importance of considering institutional factors when examining management innovation adoption.

Moreover, institutional theory provides insights into the challenges and barriers organizations face when adopting management innovations like the BSC. As Suddaby (2010) notes, the institutional environment can create resistance to change, as deeply embedded norms and practices may hinder the acceptance of new approaches. Greenhalgh et al. (2004) echo this point, emphasizing that the successful adoption of innovations often requires overcoming institutional barriers and aligning the innovation with existing organizational culture and values. In the context of the BSC, institutional theory can help explain why some organizations may struggle to fully embrace and integrate the framework, despite its potential benefits. By recognizing the institutional forces at play, researchers and practitioners can develop strategies to navigate these challenges and support successful adoption and integration of management innovations like the BSC.

**Institutional Theory in Healthcare Contexts.** Institutional theory has significant relevance in understanding the adoption and assimilation of management innovations, such as the BSC, within healthcare contexts. As Wisdom et al. (2014) note, healthcare organizations are subject to various institutional pressures that shape their readiness to embrace new practices and

tools. Wisdom et al. (2014) further explain that these pressures can include regulatory requirements, industry standards, accreditation guidelines, and the influence of professional networks and associations. Healthcare leaders' decision-making processes regarding the adoption of innovations like the BSC are often influenced by these institutional factors, alongside rational considerations of efficiency and effectiveness (Wisdom et al., 2014).

Several studies have specifically examined the role of institutional forces in shaping BSC adoption and implementation within healthcare settings. For example, Kollberg and Elg (2011) investigated the practice of the BSC in Swedish healthcare services, revealing how the framework's adoption was driven by a combination of coercive pressures from government mandates and mimetic influences as organizations sought to emulate successful peers. Similarly, Oliveira et al. (2020) applied institutional theory to explore the factors influencing BSC implementation in Portuguese healthcare organizations. Their findings highlighted the importance of normative pressures, such as shared professional values and training, in facilitating the acceptance and use of the BSC among healthcare practitioners.

Moreover, institutional theory provides a lens for understanding the challenges healthcare organizations may encounter when adopting management innovations like the BSC. As Ax and Bjornenak (2005) discuss, deeply ingrained institutional norms and practices within healthcare settings can create resistance to change and hinder the successful assimilation of new approaches. Healthcare organizations often have complex hierarchies, professional silos, and well-established routines that may not easily align with the cross-functional collaboration and data-driven decision-making promoted by the BSC (Ax & Bjornenak, 2005). While these institutional barriers present significant challenges, Kollberg and Elg's (2011) study of Swedish healthcare organizations revealed that successful BSC adoption occurred when organizations

prioritized change management, secured buy-in through stakeholder engagement, and modified the BSC to complement rather than conflict with established organizational culture.

**Criticisms and Limitations of Institutional Theory.** Institutional theory has made significant contributions to understanding the influence of norms, rules, and expectations on organizational behavior and decision-making. However, the theory has also faced criticisms and limitations. One criticism is the theory's emphasis on the homogeneity and stability of organizational fields, which may underestimate the role of agency, conflict, and change in shaping institutional dynamics (Dacin et al., 2002). Dacin et al. (2002) argue that institutional theory often portrays organizations as passive recipients of institutional pressures, neglecting their capacity to actively resist, negotiate, or transform institutional arrangements.

Moreover, institutional theory has been criticized for its limited attention to the micro-level processes and individual actions that contribute to institutional change (Powell & Colyvas, 2008). Powell and Colyvas (2008) contend that the theory often focuses on macro-level influences, such as societal norms or regulatory frameworks, while overlooking the role of individual actors, their interpretations, and their everyday practices in reproducing or challenging institutional structures. This limitation means institutional theory cannot fully explain why some healthcare organizations successfully adopt innovations like the BSC while others in similar environments do not.

Another criticism of institutional theory is its insufficient consideration of power, interests, and resources in shaping institutional pressures and organizational responses (Suddaby, 2010). Suddaby (2010) argues that the theory often treats institutions as given and uncontested, while underplaying the political and strategic dimensions of institutional processes. This limitation may obscure the ways in which powerful actors leverage their resources and influence

to shape institutional arrangements in their favor or resist institutional pressures that threaten their interests.

Despite these limitations, institutional theory remains a valuable lens for examining the adoption and assimilation of management innovations, such as the BSC, in healthcare contexts. Researchers can address these criticisms by integrating institutional theory with other perspectives, such as diffusion of innovations theory or resource-based view theory, which offer complementary insights into the role of agency, resources, and micro-level processes in shaping institutional dynamics (Johnson & Walston, 2022). Lawrence et al.'s (2009) work on institutional entrepreneurship revealed that actors within organizations can strategically influence institutional change, challenging the theory's traditional emphasis on conformity and compliance. This recognition of agency within institutional constraints, particularly when combined with other theoretical perspectives, enhances our understanding of innovation adoption in healthcare.

**Conceptual Framework Application.** The integration of institutional theory into the study's conceptual framework was crucial for investigating the adoption and assimilation of the BSC in non-profit healthcare organizations. This theory provided a robust foundation for understanding how institutional pressures, including government regulations, accreditation standards, professional norms, and industry best practices, significantly influence healthcare leaders' decision-making processes regarding the adoption of management innovations like the BSC. By incorporating institutional theory, the study explored the complex dynamics that shape the acceptance and use of the BSC within healthcare settings, considering the coercive, mimetic, and normative pressures that drive organizational change. Moreover, institutional theory offered valuable insights into the challenges healthcare organizations may encounter when implementing

management innovations, such as deeply entrenched hierarchies, siloed departments, and resistance to change, which may hinder the successful assimilation of new approaches (DiMaggio & Powell, 1983). The inclusion of institutional theory in the conceptual framework enabled a comprehensive exploration of the institutional factors that facilitate or impede the adoption of the BSC, providing a solid foundation for understanding the unique context of non-profit healthcare organizations.

### ***Resource-Based View Theory***

Resource-based view theory, initially promoted by Barney (1991), is a prominent framework in strategic management that analyzes how an organization's resources impact its competitive positioning and strategic outcomes. The theory stipulates that organizations can derive sustained competitive advantages from valuable, rare, inimitable, and non-substitutable strategic assets and organizational capabilities (Barney, 1991). Resources encompass both tangible and intangible assets, such as financial capital, processes, systems, culture, knowledge, and intellectual property, that are controlled by the organization (Wernerfelt, 1984). Furthermore, Barney et al. (2011) assert that the uniqueness and value of an organization's resources dictate its capacity to effectively implement strategies and innovations that support institutional goals and organizational adaptation.

The roots of resource-based view theory can be traced back to the work of Penrose (1959), who conceptualized firms as bundles of productive resources. However, the theory gained prominence in the 1980s as a counterpoint to the dominant industry structure view, which emphasized external market factors as the primary determinants of competitive advantage (Wernerfelt, 1984; Barney, 1991). Resource-based view theory shifted the focus to the internal

resources and capabilities of organizations, arguing that these factors were the key drivers of sustained competitive advantage and superior performance (Barney, 1991).

Over time, resource-based view theory has evolved and expanded to incorporate dynamic capabilities, knowledge-based views, and the concept of resource orchestration (Teece et al., 1997; Sirmon et al., 2011). Teece et al. (1997) conceptualized dynamic capabilities as an organization's ability to integrate, build, and reconfigure internal and external competencies to address rapidly changing environments. Grant (1996) extended resource-based view theory through the knowledge-based view, which emphasizes the role of knowledge as a strategic resource and the importance of knowledge creation, integration, and application in driving competitive advantage. Sirmon et al. (2011) introduced the concept of resource orchestration, which focuses on the managerial actions involved in structuring, bundling, and leveraging resources to create value and drive organizational performance. These extensions of resource-based view theory have broadened its scope and applicability in understanding how organizations can effectively manage and deploy their resources to achieve strategic objectives and adapt to changing contexts.

**Resource-Based View for Management Innovations.** Resource-based view theory offers pertinent perspectives for investigating complex phenomena like the adoption of management innovations, such as the BSC. The very strategic initiatives meant to support organizational effectiveness depend substantially on existing resources supporting essential capabilities (Lin & Wu, 2014). Kraaijenbrink et al. (2009) explain that with resource configurations shaping capacity, strategic change inherently builds upon operational and cultural resource foundations. Wang and Ahmed (2007) also contend that resource-based view theory

offers explanatory power when investigating slow-moving strategic innovation adoption and change failures in contexts like healthcare.

Several studies have applied resource-based view theory to understand the adoption and implementation of management innovations. For example, Zigan et al. (2007) explored the role of intangible resources in the successful adoption of the BSC in German hospitals. Their findings highlighted the importance of human capital, organizational culture, and knowledge management capabilities in facilitating the effective implementation of the BSC. Similarly, Lin and Wu (2014) investigated the impact of dynamic capabilities on the relationship between the BSC and organizational performance in Taiwanese firms. They found that dynamic capabilities, such as sensing, seizing, and transforming, significantly influenced the successful adoption and utilization of the BSC, ultimately leading to improved organizational outcomes.

Moreover, resource-based view theory provides insights into the challenges organizations may face when attempting to adopt management innovations like the BSC. As Barney (2001) notes, the successful implementation of new management practices often requires the reconfiguration and alignment of existing resources and capabilities. Organizations with limited or misaligned resources may struggle to effectively adopt and integrate management innovations, despite their potential benefits (Kraaijenbrink et al., 2009). By recognizing the role of resources in shaping an organization's capacity for change, resource-based view theory can help researchers and practitioners identify the key resource-related barriers and enablers influencing the adoption and assimilation of management innovations like the BSC.

**Resource-Based View in Healthcare Contexts.** In healthcare contexts, resource-based view theory has been increasingly applied to understand the adoption and implementation of management innovations, including frameworks and systems like the BSC. Building on this

theoretical perspective, Gunasekaran et al. (2022) argue that healthcare organizations' unique resource configurations can significantly influence their ability to effectively adopt and utilize new management practices. These resources include tangible assets, such as medical equipment, health IT infrastructure, and care delivery facilities, as well as intangible assets, like clinical expertise, creative talent, leadership ability, reputations for excellence, and patient-centered cultures (Barney, 2001).

Several studies have specifically examined the application of resource-based view theory in understanding adoption and implementation within healthcare settings. For instance, Yu et al. (2023) investigated the role of resource orchestration in facilitating innovation adoption in healthcare organizations. The findings highlighted the importance of effectively structuring, bundling, and leveraging resources to support the successful implementation of management innovations like the BSC. Similarly, El-Garaihy et al. (2022) applied resource-based view theory to explore the critical success factors for healthy workplace programs in healthcare organizations. Their study emphasized the significance of aligning resources, such as leadership support, employee engagement, and organizational culture, in driving the effective adoption and sustainability of these programs. Together, these studies demonstrate that successful implementation of management innovations in healthcare depends not merely on resource availability, but on how effectively organizations align and orchestrate their unique resource configurations.

Moreover, resource-based view theory provides a lens for understanding the challenges healthcare organizations may encounter when adopting management innovations like the BSC. Amer et al. (2022) applied resource-based view theory to analyze barriers to innovation adoption in healthcare and identified that organizations often face resource constraints, such as limited

financial resources, inadequate health IT infrastructure, and a lack of skilled personnel, which can hinder their ability to effectively adopt and integrate new management practices.

Overcoming these resource-related barriers requires careful attention to resource allocation, capacity building, and the alignment of management innovations with existing organizational resources and capabilities (Gunasekaran et al., 2022). Resource-based view theory helps healthcare leaders understand how their organizations' resources influence readiness for change, enabling them to develop more effective strategies for implementing the BSC and other management innovations.

**Criticisms and Limitations of Resource-Based View Theory.** Resource-based view theory has made significant contributions to understanding the role of firm-level resources and capabilities in shaping competitive advantage and organizational performance. However, the theory has also encountered several criticisms and limitations. One notable criticism is the theory's focus on internal resources and capabilities, which may neglect the importance of industry-level factors and external market conditions in shaping competitive dynamics (Priem & Butler, 2001). Priem and Butler (2001) argue that resource-based view theory often assumes that valuable, rare, inimitable, and non-substitutable resources are sufficient for achieving sustained competitive advantage, while underestimating the influence of industry structure, competitive pressures, and technological change on firm performance.

Moreover, resource-based view theory has been criticized for its static view of resources, which may overlook the dynamic nature of resource acquisition, development, and deployment over time (Kraaijenbrink et al., 2010). Kraaijenbrink et al. (2010) contend that the theory often treats resources as given and fixed, while underemphasizing the processes of resource accumulation, reconfiguration, and adaptation in response to changing environments. This

limitation may obstruct the theory's ability to explain how firms can sustain their competitive advantage in the face of rapidly evolving technologies, customer preferences, or regulatory landscapes. Another criticism of resource-based view theory is its limited applicability in highly dynamic and uncertain environments, where the value and relevance of resources may quickly erode (Eisenhardt & Martin, 2000). Eisenhardt and Martin (2000) argue that in such contexts, the sustainability of competitive advantage may depend more on the firm's dynamic capabilities, such as its ability to rapidly sense and seize new opportunities, reconfigure its resource base, and adapt to changing conditions. This limitation may require extending resource-based view theory to incorporate more dynamic and adaptive perspectives on resource management and organizational change.

Notwithstanding these criticisms, resource-based view theory remains a valuable framework for understanding the adoption and assimilation of management innovations, such as the BSC, in healthcare contexts. Researchers can address these limitations by complementing resource-based view theory with other perspectives, such as diffusion of innovations theory or institutional theory, which offer insights into the external factors and institutional pressures that shape resource allocation and innovation adoption (Johnson & Walston, 2022). Additionally, scholars can extend resource-based view theory by explicitly incorporating dynamic capabilities, learning processes, and strategic adaptation into their analyses, as demonstrated by studies on resource orchestration and strategic agility (Sirmon et al., 2011). Such an integrated approach provides a more comprehensive understanding of how healthcare organizations can successfully navigate the complex process of adopting and sustaining management innovations like the BSC.

**Conceptual Framework Application.** The integration of resource-based view theory into the study's conceptual framework was essential for investigating the adoption and

assimilation of the BSC in non-profit healthcare organizations. Resource-based view theory provided a solid foundation for understanding how an organization's unique resource configurations, including tangible and intangible assets, significantly influence its ability to effectively adopt and utilize management innovations like the BSC. By incorporating resource-based view theory, the study explored the complex resource-related dynamics that shape the capacity for change within healthcare organizations, considering the role of resources in facilitating or hindering the successful implementation of the BSC. Moreover, resource-based view theory offered valuable insights into the challenges healthcare organizations may encounter when adopting management innovations, such as resource constraints, inadequate infrastructure, and misaligned capabilities, which may impede the effective assimilation of new practices. The inclusion of resource-based view theory in the conceptual framework enabled a comprehensive exploration of the resource-related factors that support or constrain the adoption of the BSC, providing a solid foundation for understanding the unique resource context of non-profit healthcare organizations.

### ***Framework Integration***

The integration of diffusion of innovations theory, institutional theory, and resource-based view theory provided a comprehensive framework for investigating BSC adoption in healthcare organizations. While each theory offers valuable individual insights, their combination addresses the multifaceted nature of innovation adoption that no single theory could fully capture. Diffusion of innovations theory illuminates the innovation-decision process and communication patterns, institutional theory reveals the organizational and environmental pressures shaping adoption decisions, and resource-based view theory explains how organizational capabilities enable or constrain implementation. This integrated approach aligns

with Wisdom et al.'s (2014) argument that understanding management innovation adoption requires examining the interplay between innovation characteristics, institutional contexts, and organizational resources.

The value of this multi-theoretical approach has been demonstrated in similar healthcare innovation studies. Johnson and Walston (2022) successfully employed this same theoretical combination to examine electronic health record adoption, revealing how innovation attributes, institutional pressures, and resource configurations interact to shape implementation outcomes. Their findings confirmed that adoption failures often result from addressing only one dimension while neglecting others, for instance, focusing on technology features without considering institutional resistance or resource limitations. Similarly, Moullin et al. (2015) demonstrated that integrated frameworks capture the complex realities of management innovation adoption in public sector organizations, where technical, institutional, and resource factors simultaneously influence outcomes.

In addition to the selected theories of diffusion of innovations, institutional theory, and resource-based view, two other theories were considered for the conceptual framework: the technology acceptance model and the knowledge-based view. The technology acceptance model, developed by Davis (1989), focuses on factors influencing an individual's adoption and use of new technologies. While the BSC is not a hard technology, the technology acceptance model could have provided insights into how perceived usefulness and ease of use shape attitudes and intentions towards adopting new management tools. However, the technology acceptance model was deemed too narrowly focused on individual-level adoption decisions and did not adequately capture the broader organizational and environmental factors that influence the adoption of strategic performance reporting systems like the BSC in healthcare settings.

On the other hand, the knowledge-based view, an extension of the resource-based view, emphasizes the role of knowledge as a strategic resource and source of competitive advantage (Grant, 1996). The knowledge-based view could have offered a lens for examining how an organization's knowledge assets and learning capabilities influence its ability to effectively adopt and utilize the BSC. However, it was determined that the knowledge-based view's focus on knowledge and learning was already sufficiently captured by the "learning and growth" perspective within the BSC framework itself. Moreover, the resource-based view provided a more comprehensive understanding of the various types of resources and capabilities that shape an organization's capacity for adopting and implementing new management practices.

Ultimately, the decision was made to integrate diffusion of innovations theory, institutional theory, and resource-based view theory because they collectively provided a more robust and multifaceted framework for understanding the complex interplay of innovation characteristics, institutional pressures, and organizational resources in shaping BSC adoption and assimilation processes in healthcare organizations. The combination of these three theories was deemed most suitable for addressing the research questions and objectives of this study, as they offer complementary perspectives on the various factors influencing the awareness, comprehension, and adoption of the BSC and similar strategic performance reporting systems in the healthcare context.

In sum, the integration of these three theories enabled a comprehensive investigation of BSC adoption that addressed the study's research questions from multiple perspectives. This multi-theoretical approach provided the analytical depth necessary to understand why strategic performance frameworks like the BSC face unique adoption challenges in healthcare settings, where innovation characteristics, institutional dynamics, and resource constraints intersect in

complex ways. The framework thus filled a critical gap in the literature by moving beyond single-theory explanations to capture the full complexity of strategic management innovation adoption in healthcare organizations.

### **The Balanced Scorecard**

The concept of the Balanced Scorecard (BSC) originated in the early 1990s from Robert Kaplan and David Norton as a new approach to performance measurement (Kaplan & Norton, 1992). Recognizing that reliance solely on financial metrics failed to provide a holistic and strategic view of organizational success, Kaplan and Norton devised a balanced framework assessing performance across financial and non-financial dimensions (Niven, 2014). Formally introduced via a 1992 Harvard Business Review article titled “The Balanced Scorecard -- Measures That Drive Performance,” the BSC method aimed to align leading and lagging indicators with corporate strategy (Kaplan & Norton, 1992).

In subsequent years, Kaplan and Norton continued advancing the method, realizing BSC’s utility for enabling strategy execution beyond just measurement (Niven, 2014). Through additional scholarly publications and business collaborations, the BSC evolved from a tactical metric system into an integrated strategic planning and management tool (Hoque, 2014). This expansion built on the initial multi-dimensional performance measurement concept by adding capabilities for mapping strategic objectives, articulating desired outcomes, and monitoring progress toward goals through embedded analytics (Marr & Schiuma, 2003). With these additions, the BSC became a dynamic framework supporting ongoing strategy assessment, calibration, and improvements grounded in holistic data-driven analysis rather than siloed reports (Kaplan & Norton, 1996).

The inception and ongoing enhancements of the BSC framework sparked widespread business interest. Kaplan and Norton's 1993 best-selling book on BSC deployment solidified the method's popularity across many industries (Niven, 2014). By the early 2000s, the BSC had been adopted by over 50% of large U.S. firms and numerous public sector agencies globally (Silk, 2004). Hood and Margetts (2007) notes the BSC's significance as one of few private sector management innovations governmental entities proactively embraced. Furthermore, various BSC adaptations emerged for specific industries like healthcare, education and more (Abu Jaber & Nashwan, 2022). Ultimately the BSC progressed over three decades from a performance measurement conceptualization to an indispensable strategy execution system utilized widely across sectors (Marr & Schiuma, 2003). The tool's enduring relevance demonstrates that Kaplan and Norton successfully developed a strategic management framework that continues to provide value across diverse organizational contexts.

### ***Theoretical Frameworks of the Balanced Scorecard***

The BSC represents a noteworthy synthesis of several key strategic management theories, integrating multiple disciplines to create a holistic system for organizational monitoring and control (Madsen & Stenheim, 2014). At its core, the BSC builds upon cybernetic controls theory, organizational performance measurement scholarship, and research on strategic performance systems in its underlying framework (Hansen & Schaltegger, 2016). By unifying these three central theoretical streams, Kaplan and Norton conceived an integrated approach encompassing critical strategy facets including clarity of objectives, balanced diagnostics, and closed-loop controls to enable the coordinated implementation and adaptation required for competitive organizations (Cross & Lynch, 1992).

Cybernetics theory, originally developed in mathematics and engineering, examines self-regulating systems that utilize continuous feedback to maintain desired states (Ashby, 1956). Beer (1966) applied these cybernetic principles to management, arguing that comprehensive oversight requires integration of financial and nonfinancial performance measures. He proposed that sole reliance on backward-looking financial metrics hindered the requisite variety needed for dynamic strategic control. The BSC framework builds directly on these cybernetic management principles, enabling strategy calibration through clarifying objectives, assessing multidimensional performance, and determining corrective actions, which represents the essence of cybernetic control (Cross & Lynch, 1992).

In parallel with BSC development, scholarship in organizational performance measurement investigated frameworks interlinking operational statistics and financial outcomes (Lynch & Cross, 1991). This research supports the BSC's methodology balancing lagging indicators of historical success with leading diagnostics pinpointing drivers. Specifically, performance management theory established that certain measures predict future financial and growth trajectories based on responsiveness to strategic changes (Campbell et al., 2002). By incorporating nonfinancial metrics aligned to strategy as leading indicators, the BSC taps performance management concepts that support long-term competitiveness (Kaplan & Norton, 1996).

Though cybernetics and performance measurement established foundations, the BSC also encompassed strategy perspectives. Strategic performance measurement systems research recognized that performance cannot be managed without linking to specific strategic objectives (Cross & Lynch, 1992). Kaplan and Norton advanced knowledge by formalizing strategy mapping methodologies for objective setting as precursors of balanced multidimensional

measurement (Kaplan & Norton, 1996). The BSC's combination of strategic clarity and feedback-driven performance controls explains its significant impact and widespread adoption.

In sum, by synthesizing key research streams in cybernetics management, organizational performance measurement, and strategy-linked metrics, the BSC is an integrated framework for strategic guidance and execution coordination (Niven, 2014). Specifically, the BSC's foundational theoretical frameworks encompass self-regulating systems that utilize continuous performance data to guide adjustments, frameworks interlinking operational data to financial outcomes, and strategy mapping techniques clarifying objectives tied to measurements (Campbell et al., 2002). The widespread and persisting BSC adoption over three decades affirms Kaplan and Norton's contribution in unifying diverse theoretical frameworks and strategic management concepts into a holistic organizational control methodology that continues to benefit many organizations (Niven, 2014).

### ***Components and Structure of the Balanced Scorecard***

The BSC core framework encompasses four key perspectives for enterprise assessment: financial, customer, internal business processes, and learning and growth (Kaplan & Norton, 1996). As Kaplan (2010) notes, the financial dimension focuses on profitability, revenue growth and cost efficiency outcomes signaling fiscal health. Sainaghi et al. (2019) discuss how customer indicators measure satisfaction, loyalty, retention, market share and other facets representing service delivery effectiveness from clients' vantage points. According to Niven (2014), the internal business process perspective concentrates on operational statistics tied to innovation, quality, integration, and value chain competencies that enable customer and financial goals. Finally, learning and growth gauges employee capabilities, information systems, and

organizational climates driving sustainable execution required across the financial, customer, and internal business processes as outlined by Kaplan (2010).

These specific four perspectives were strategically selected by Kaplan and Norton (1996) to provide a comprehensive and balanced performance view aligned to strategy. As Kaplan (2010) details, the financial and customer lenses offer concrete outcome measures on the ultimate goals of fiscal viability and audience impact. Meanwhile, the internal and growth dimensions provide diagnostic assessments on organizational capacities predicting and driving the external success markers that matter most according to Niven's (2014) analysis. This balance between short and long-term outlooks, desired ends, and means enables a dynamic interlinked measurement system rather than just siloed static reports (Sainaghi et al., 2019). Furthermore, each dimension offers macro insights into overall enterprise strategy execution for addressing broad challenges versus micro functions according to Sainaghi et al. (2019). This interconnected structure of perspectives ensures that organizations measure not only their current performance outcomes but also the underlying capabilities that drive future success.

### ***Application and Implementation of the Balanced Scorecard***

Since its inception, the BSC strategic performance methodology has been extensively deployed across various sectors as organizations recognized potential benefits from its multidimensional framework linking indicators to strategy (Tawse & Vera, 2023). Hoque (2014) traces widespread adoption across most industries including financial services, technology, hospitality, retail, and energy. Public and social sector organizations in government, defense, and education have also implemented the BSC to enhance accountability, improve resource allocation, and demonstrate value to stakeholders (Niven, 2014).

Examining case studies provides insights into organizational approaches and challenges experienced when implementing BSC systems. De Geuser et al. (2009) analyzed a financial services firm's scorecard effort, revealing difficulties in aligning metrics to intangible assets and facilitating necessary cultural changes. Across industries, common barriers include data deficiencies, inadequate IT infrastructure, limited strategic focus, and weak linkages between metrics and strategy (Tawse & Vera, 2023). Organizations that successfully implemented the BSC addressed these barriers through robust IT support, extensive stakeholder involvement, careful metric selection, and sustained commitment to organizational learning (De Geuser et al., 2009).

Technology plays a critical role in supporting BSC implementation through automated data integration, analytics, and reporting capabilities essential for maintaining multidimensional performance systems (Tawse & Vera, 2023). Software solutions have been developed to enable various scorecard functionalities ranging from strategy mapping to predictive modeling (Delen et al., 2018). When effectively integrated, information systems amplify the BSC's capabilities and organizational impact. Stefanescu et al. (2012) found that integrating BSC technology with business intelligence practices accelerated performance management benefits across Romanian companies, while Delen et al. (2018) documented similar correlations between mature IT-scorecard integration and improved financial and operational outcomes. These implementation experiences across sectors demonstrate that successful BSC adoption requires both technological infrastructure and organizational commitment to strategic alignment and continuous improvement.

### ***Impact and Effectiveness of the Balanced Scorecard***

Substantial research across sectors has examined the impact of BSC adoption on organizational performance, with comprehensive meta-analyses demonstrating consistent positive gains despite some variation in magnitude across different contexts (Hoque, 2022; Ismail, 2022). These positive gains, as Prenestini et al. (2024) document, span both financial and non-financial dimensions, including improved customer outcomes, innovation capacity, and operational efficiency, demonstrating the BSC's value beyond traditional financial metrics. Importantly, these positive outcomes persist even when researchers control for organizational factors like industry, size, age, and prior performance, providing strong evidence that BSC adoption itself generates organizational benefits (Grigoroudis et al., 2012).

According to Weterings (2021), BSC researchers emphasize evaluating performance influences across all four scorecard perspectives rather than solely financial gains which take longer to manifest. This multi-perspective approach reveals important non-financial benefits; Kaplan and Norton (2001) found that BSC systems generate measurable improvements in customer satisfaction and retention well before financial impacts become apparent. While financial returns emerge more slowly than operational improvements, studies of Nordic and Indian bank BSC initiatives revealed adopters achieve significantly higher long-term returns on assets plus lower expenses compared to non-adopters (Sharma et al., 2018; Rautenbach & Sutherland, 2021). Furthermore, these non-financial measurement perspectives strengthen innovation capacity and organizational survival during turbulent periods, as tracking all four dimensions enables evidence-based strategy reorientation before financial metrics signal distress (Bento et al., 2017).

As Braam and Nijssen (2011) and Hoque (2022) discuss, because the BSC involves substantial modifications of systems, priorities and culture, researchers underscore effectiveness depends substantially on implementation process factors beyond mere tool adoption. Notable conditions shown to matter include securing top leadership commitment, customizing to integrate with pre-existing measures avoiding redundant data burdens, strengthening linkages with budgeting and rewards processes, and ensuring balanced use of all four perspectives according to Prenestini et al. (2022). Evidence further indicates BSC effectiveness strengthens progressively over iterations as causal data usage, analytical capabilities, and lead-lag measure alignment mature as documented by Sharma et al. (2018).

### ***Criticisms and Limitations of the Balanced Scorecard***

Despite widespread adoption, scholarly critics identify inherent limitations and biases within Kaplan and Norton's BSC framework that may restrict effectiveness (Norreklit et al., 2016). Common themes include insufficient integration of environmental sustainability, employee welfare, and societal outcome facets vital for responsible management beyond primarily profitability measurements (Hubbard, 2009; Moxham & Boaden, 2007). As Bieker (2021) contends, critics argue the BSC foundation overly centers financial returns without adequately capturing extended stakeholder interests and social costs. Proposed scorecard adaptations attempt to address perceived imbalances through additional metrics such as carbon emissions, community health impacts, and workplace injuries (Hubbard, 2009).

Further criticism from Norreklit et al. (2016) questions the purported causal linkages across BSC perspectives that presupposing generalized performance drivers apply uniformly without acknowledging contextual complexities. Challengers also debate assumptions regarding line-of-sight dependencies from learning and development expenditures to eventual financial

returns, as detailed by Madsen and Slatten (2015), who found training investments exhibit nonlinear, context-dependent influence. Findings like these fuel arguments to tailor scorecard causal linkages based on strategy-specific theories of change rather than standardized models (Norreklit et al., 2012).

Despite these criticisms, scholars have developed modifications that address perceived limitations while retaining the BSC's core structure. As Elg et al. (2012) and Poister et al. (2013) demonstrate, enhanced societal outcome measures for public health and community partnerships prove particularly valuable in social sectors like healthcare and education. Research indicates that successful adaptations typically retain Kaplan and Norton's foundational quartet of perspectives while inserting sector-specific supplementary lenses rather than abandoning the framework entirely (Elg & Kollberg, 2009). This suggests the original BSC structure remains versatile enough for widespread applicability while allowing context-relevant customizations that address stakeholder and sustainability concerns (Poister et al., 2013).

Beyond inherent design limitations are BSC implementation challenges involving inadequate data systems, narrow applications divorced from budgets, and lack of employee engagement with performance metrics, as Braam and Nijssen (2004) highlight. Critics emphasize failed, suspended, or abandoned BSC initiatives resulting from poor change management execution, questioning the framework's practical utility without proper deployment support. Such evidence keeps expectations realistic about the depth of transformation achievable through any tool alone without conscientious leadership and supporting conditions.

These critiques and implementation challenges take on particular significance in healthcare delivery contexts, where the complexity of clinical operations, regulatory requirements, and multiple stakeholder interests create additional layers of difficulty for BSC

adoption. Healthcare organizations must navigate not only the general limitations of the BSC framework but also sector-specific barriers including professional hierarchies, patient safety priorities, and the challenge of quantifying health outcomes. The following section examines how healthcare organizations have attempted to adapt and implement the BSC within these unique contextual constraints, exploring both the promise and pitfalls of applying this business-oriented framework to healthcare delivery.

### **The Balanced Scorecard in Healthcare**

The application of the BSC in healthcare has garnered significant attention as organizations strive to navigate the complex landscape of healthcare delivery and improve overall performance. The BSC, originally developed by Kaplan and Norton (1992) for the business sector, has been adapted to address the unique challenges and priorities of healthcare organizations, offering a comprehensive framework for strategic management and performance measurement (Zelman et al., 2003). This section of the literature review explores the awareness, adoption, application, impact, and criticisms of the BSC in healthcare, synthesizing findings from various studies to provide a comprehensive understanding of the BSC's role in driving organizational success and patient care improvements.

**Awareness of the Balanced Scorecard in Healthcare.** Although awareness of the BSC in healthcare showed some growth in its first two decades, driven by organizations' recognition of the need for comprehensive performance measurement tools (Gurd & Gao, 2008), actual understanding and implementation have lagged behind other sectors. Moreover, Zelman et al. (2003) noted that during this same period, the BSC had gained some attention in healthcare as a means to align organizational strategy with performance metrics, moving beyond solely financial measures to include customer, internal process, and learning and growth perspectives. As

Inamdar et al. (2002) observed, the BSC's multidimensional approach to performance measurement has resonated with a segment of healthcare leaders seeking to balance the competing demands of quality care, patient satisfaction, operational efficiency, and financial sustainability.

However, the early awareness gains have not translated into widespread understanding or adoption, with significant gaps emerging over the past two decades as implementation varied dramatically across organizations and regions (Behrouzi et al., 2014). Niven (2008) notes that the adoption of the BSC as a strategic management tool varies among healthcare organizations; while some have fully embraced its concepts and potential applications, others may have a limited or superficial understanding of its benefits and implementation. This variation in awareness and comprehension can be attributed to factors such as the complexity of the healthcare industry, the diversity of organizational structures and cultures, and the limited dissemination of BSC knowledge and best practices within the sector (Rabbani et al., 2011).

While scholars have identified strategies to enhance awareness and understanding of the BSC in healthcare, emphasizing the importance of research, education, training, and knowledge sharing (Bisbe & Barrubés, 2012), these recommendations have not translated into widespread practitioner awareness. Nippak et al. (2014) identified the role of leadership engagement, stakeholder involvement, and clear communication as critical for promoting BSC awareness and buy-in within healthcare organizations, though implementation of these strategies remains limited. Although the development of healthcare specific BSC frameworks, case studies, and implementation guidelines has contributed to the academic body of BSC knowledge, actual dissemination to healthcare practitioners appears insufficient, as many healthcare leaders remain unfamiliar with these resources (Rabbani et al., 2011).

**Adoption of the Balanced Scorecard in Healthcare.** While various factors could theoretically drive BSC adoption in healthcare, including the need for strategic alignment, performance improvement, and accountability in an increasingly complex and competitive healthcare landscape (Trotta et al., 2013), actual adoption remains limited. Although Kocakulah et al. (2018) noted that some healthcare organizations have sought to adopt the BSC as a means to translate their mission, vision, and strategy into actionable objectives and measures, enabling them to monitor and improve performance across multiple dimensions, widespread implementation has not occurred. The BSC's emphasis on linking financial and non-financial metrics would be particularly relevant for healthcare organizations, as they strive to balance the imperatives of cost containment, quality improvement, and patient-centered care (Hwa et al., 2013), yet many organizations remain unaware of this potential.

Critically, the adoption rates of the BSC in U.S. healthcare organizations remain largely unknown, with limited empirical data available to provide a comprehensive understanding of its prevalence and usage patterns (Trotta et al., 2013). While some studies have attempted to estimate BSC adoption rates in healthcare settings, the results vary widely and are often based on small, non-representative samples or anecdotal evidence (Gurd & Gao, 2008). For instance, Zelman et al. (2003) surveyed a sample of U.S. healthcare organizations and reported that approximately 60% of respondents claimed to use the BSC or a similar performance measurement system; however, this finding appears inflated compared to more recent assessments and may reflect confusion about what constitutes true BSC implementation. As Behrouzi et al. (2014) noted, the study's small sample size and potential self-selection bias limit the generalizability of these findings to the broader U.S. healthcare landscape. Moreover, the lack of a standardized definition of what constitutes BSC usage further complicates efforts to

accurately assess adoption rates, as organizations may claim to use the BSC while only implementing select components or modified versions of the framework (Behrouzi et al., 2014). This inconsistency in defining and measuring BSC usage makes it challenging to compare adoption rates across studies and draw definitive conclusions about the extent of BSC implementation in U.S. healthcare organizations. These measurement challenges suggest that actual BSC awareness and adoption may be considerably lower than reported figures indicate.

The limited institutional adoption of the BSC in healthcare faces significant challenges. Grigoroudis et al. (2012) identify several barriers to BSC adoption, including the lack of resources, the complexity of the healthcare system, the resistance to change, and the difficulty in defining and measuring meaningful performance indicators. Additionally, the unique characteristics of the healthcare industry, such as the presence of multiple stakeholders, the emphasis on clinical outcomes, and the regulatory environment, complicate BSC implementation to the point where many organizations may choose to abandon or avoid the framework (Speckbacher, 2003). These combined barriers help explain why BSC adoption remains limited despite its theoretical benefits.

While scholars have identified potential enablers, such as evidence of its potential benefits, the availability of healthcare specific BSC templates and tools, and theoretical support from professional organizations and accreditation bodies (Lin et al., 2014), these facilitators have not translated into widespread adoption. Zelman et al. (2003) also identified the role of leadership commitment, stakeholder engagement, and a culture of continuous improvement as necessary for successful BSC adoption in healthcare organizations, though these conditions appear uncommon in practice. Despite early optimism about BSC growth in healthcare, evidence

suggests that awareness and adoption have plateaued, with many healthcare organizations remaining unfamiliar with the framework or its potential applications (Rabbani et al., 2011).

**Application of the Balanced Scorecard in Healthcare.** In the limited instances where BSC has been implemented, healthcare organizations have attempted to adapt the framework to address the unique challenges and priorities of the sector. While the original four perspectives of the BSC (financial, customer, internal process, and learning and growth) remain theoretically relevant, the few healthcare organizations that have adopted BSC have expanded the framework to better align with their specific needs and objectives (Gurd & Gao, 2008). For example, some documented healthcare BSC implementations have incorporated additional perspectives, such as quality of care, patient safety, and community health, to emphasize the importance of clinical outcomes and population health (Chen et al., 2006), though these remain exceptional cases rather than standard practice.

Among organizations that attempt BSC implementation, one reported application is the development of cascading scorecards that theoretically align strategic objectives and measures across different levels of the organization (Nippak et al., 2014). This approach involves creating linked scorecards for individual departments, units, or teams, with the intention of ensuring their performance goals and initiatives contribute to the overall organizational strategy (Rabbani et al., 2011). In theory, cascading the BSC could foster a sense of ownership and accountability among frontline staff and managers, while promoting collaboration and communication across the organization (Bisbe & Barrubés, 2012), though actual implementation of cascading scorecards appears rare given limited BSC awareness at operational levels.

Another potential application of the BSC in healthcare would be the integration of clinical and operational metrics to drive evidence-based decision-making and continuous quality

improvement (Trotta et al., 2013). By incorporating key performance indicators related to patient outcomes, process efficiency, and resource utilization, healthcare organizations could theoretically use the BSC to monitor and improve the quality and cost-effectiveness of care delivery (Grigoroudis et al., 2012). Furthermore, the BSC could potentially serve as a platform for benchmarking and sharing best practices within and across healthcare organizations, advancing a culture of learning and innovation (Rabbani et al., 2011), though limited awareness and adoption prevent most organizations from realizing these benefits.

**Impact and Outcomes of the Balanced Scorecard in Healthcare.** While limited BSC implementations make comprehensive impact assessment difficult, the few documented cases have become subjects of research interest. In the minority of healthcare organizations that have implemented BSC, studies have reported positive effects on various aspects of organizational performance, including financial results, patient satisfaction, clinical quality, and employee engagement (Behrouzi et al., 2014). For example, Inamdar et al. (2002) found that select healthcare organizations implementing the BSC experienced improvements in financial performance, patient satisfaction, and market share, as well as enhanced strategic focus and alignment, though these organizations may not be representative of the broader healthcare sector.

However, the evidence on the impact of BSC in healthcare is inconsistent, with many studies reporting mixed or limited effects (Grigoroudis et al., 2012). This variability in outcomes can be attributed to factors such as the quality of BSC design and implementation, the organizational context and readiness, and the measurement and evaluation methodologies employed (Trotta et al., 2013). Furthermore, the long-term sustainability and effectiveness of BSC initiatives in healthcare may depend on the ongoing commitment, resources, and

adaptability of the organizations involved (Rabbani et al., 2011), factors that appear uncommon given the limited awareness and understanding of BSC among healthcare leaders.

Despite the challenges in measuring the impact of BSC in healthcare and the limited number of implementations, scholarly recognition of its theoretical potential to drive meaningful improvements in organizational performance and patient care persists (Gurd & Gao, 2008). Lin et al. (2014) argue that the BSC could theoretically serve as a powerful tool for aligning strategic objectives, promoting accountability, and fostering a culture of continuous improvement in healthcare organizations, if awareness and proper implementation could be achieved. However, without increased awareness and adoption among healthcare leaders, the evidence base on BSC impact in healthcare will likely remain limited, preventing organizations from understanding its true potential value (Rabbani et al., 2011).

**Criticisms of the Balanced Scorecard in Healthcare.** Despite limited adoption in healthcare, the BSC has faced theoretical and practical criticisms that may contribute to its low awareness and implementation rates. One frequently cited concern is the complexity and resource-intensive nature of BSC implementation in healthcare organizations (Grigoroudis et al., 2012). Developing and maintaining a robust BSC system requires significant investments in time, personnel, and infrastructure, which would strain the already limited resources of many healthcare organizations (Rabbani et al., 2011). This perceived complexity may deter organizations from even considering BSC adoption and creates difficulties in ensuring alignment and buy-in from all stakeholders, particularly in large and diverse healthcare systems (Behrouzi et al., 2014).

Another theoretical criticism of the BSC in healthcare concerns the potential for an overemphasis on quantitative metrics and a neglect of qualitative and contextual factors that

influence organizational performance (Trotta et al., 2013). Some scholars argue that the BSC's focus on measurable indicators could lead to a narrow and mechanistic view of healthcare performance, potentially overlooking important dimensions such as patient experience, professional autonomy, and ethical considerations (Gurd & Gao, 2008). This concern may contribute to healthcare leaders' reluctance to adopt BSC, as it highlights their perception that BSC requires a rigid framework incompatible with healthcare's complexity, despite scholars advocating for flexibility in addressing the specific needs and values of healthcare organizations (Bisbe & Barrubés, 2012).

A third criticism of the BSC in healthcare relates to the limited evidence on its long-term effectiveness and sustainability, particularly problematic given the few implementations available for study (Inamdar et al., 2002). While the small number of studies on BSC implementations have reported positive short-term effects, there is a lack of research on the long-term impact and viability of these initiatives in healthcare organizations (Trotta et al., 2013). This absence of longitudinal evidence prevents healthcare leaders from assessing whether BSC investments would yield sustained benefits, potentially explaining the limited interest in adoption and raising questions about whether healthcare organizations could maintain momentum and benefits over time, particularly given changing priorities, leadership turnover, and resource constraints (Rabbani et al., 2011). Without more widespread implementation to study, these concerns remain largely theoretical, creating a cycle where limited adoption prevents the research needed to address criticisms that may be deterring adoption (Lin et al., 2014).

The limited adoption cycle described in these criticisms appears reflected in the BSC healthcare literature itself. While appreciable BSC healthcare research emerged between 2000 and 2015, publication frequency has notably declined since then, with only sporadic studies

appearing through 2024. This pattern suggests that as widespread adoption failed to materialize, both practitioner interest and scholarly investigation diminished, leaving many theoretical concerns unresolved and practical questions unanswered.

### **Application of a Qualitative Methodology**

Previous qualitative studies examining the BSC in healthcare have demonstrated the value of interpretative approaches for understanding complex adoption phenomena. Kollberg and Elg (2011) employed semi-structured interviews with healthcare professionals to explore BSC implementation challenges in Swedish healthcare, revealing insights about organizational resistance and adaptation that quantitative measures alone could not capture. Similarly, Rabbani et al. (2011) utilized qualitative case study methodology to examine BSC adoption patterns, finding that in-depth interviews uncovered critical contextual factors influencing implementation success that were not apparent in survey data.

The study employed a qualitative interpretative descriptive methodology, which was well-suited for exploring the complex and multifaceted nature of BSC awareness, comprehension, and adoption criteria in healthcare organizations. Qualitative research designs are particularly useful for investigating phenomena in their natural context, capturing the perspectives and experiences of individuals, and generating rich, detailed data (Creswell & Poth, 2018). The literature demonstrates that qualitative approaches have been especially effective in BSC healthcare research when exploring early-stage adoption factors. For instance, Inamdar et al. (2002) combined interviews with document analysis to understand how healthcare organizations initially approached BSC implementation, while Bisbe and Barrubés (2012) used qualitative methods to explore knowledge-sharing mechanisms that facilitated BSC understanding among healthcare teams. In the context of this study, a qualitative approach

allowed for an in-depth examination of the factors influencing BSC awareness, comprehension, adoption criteria, challenges and barriers perceived by managers and leaders, and the implementation considerations in a non-profit healthcare setting.

The interpretative descriptive methodology, specifically, is designed to generate knowledge relevant to clinical practice and healthcare decision-making (Thorne et al., 2004). This approach focuses on understanding the experiential knowledge of individuals and groups, and interpreting these subjective experiences to inform practice improvements and policy development (Thorne, 2016). While case studies have dominated qualitative BSC research in healthcare (Grigoroudis et al., 2012), the interpretative descriptive approach offered unique advantages for exploring practitioner perspectives that had been underrepresented in the literature. In this study, an interpretative descriptive methodology enabled the research to explore the unique perspectives and insights of healthcare leaders and managers regarding BSC awareness, comprehension, and adoption criteria, and to translate these findings into actionable recommendations for enhancing the effective utilization of this strategic management tool in healthcare organizations.

Moreover, the multiple data sources approach employed in this study, combining semi-structured interviews and open-ended questionnaires, aligned with the principles of qualitative research and the interpretative descriptive methodology (Creswell & Poth, 2018). This approach built upon successful precedents in the BSC healthcare literature, where researchers like Nippak et al. (2014) demonstrated that combining multiple qualitative data sources provided richer insights into BSC awareness and engagement than single-method approaches. The use of multiple data sources allowed for the triangulation of findings, enhancing the credibility and trustworthiness of the study results (Tracy, 2010). The semi-structured interviews provided an

opportunity for in-depth exploration of participants' experiences and perspectives, while the open-ended questionnaires allowed for a broader capture of insights from a larger sample of healthcare leaders and managers (Trotta et al., 2013). This multiple data sources approach ensured a comprehensive understanding of the factors influencing BSC awareness and adoption criteria in the selected non-profit healthcare system, strengthening the validity and relevance of the study findings for informing practice and policy decisions (Gurd & Gao, 2008). While these qualitative approaches provided valuable insights into BSC implementation in healthcare, the decline in BSC research after 2015 and the persistent lack of data on actual awareness levels among healthcare practitioners indicated that significant gaps in the literature remained.

### **Research Gaps in Literature**

Despite initial enthusiasm for BSC research in healthcare through 2015, the subsequent decline in scholarly investigation left several gaps in the literature, which offered opportunities for further investigation and understanding. The most fundamental gap was the absence of empirical data on actual BSC awareness levels among healthcare practitioners. While numerous studies examined BSC implementation in select organizations, no research had systematically assessed whether healthcare leaders and managers were even familiar with the framework, creating uncertainty about the true extent of BSC knowledge in the healthcare sector.

Another significant gap was the limited exploration of the factors influencing BSC comprehension and adoption among healthcare leaders and managers (Trotta et al., 2013). While studies had examined the benefits and challenges of BSC implementation in healthcare organizations, there was limited research on the individual and organizational characteristics that shape the perception and uptake of this strategic management tool (Rabbani et al., 2011). Understanding these factors was crucial for developing targeted interventions and support

mechanisms to promote BSC adoption and effective utilization in healthcare settings (Behrouzi et al., 2014).

An additional research gap pertained to the lack of comparative studies on BSC implementation between different types of healthcare organizations, such as non-profit and for-profit institutions (Gurd & Gao, 2008). The majority of existing research on the BSC in healthcare had focused on single case studies or homogeneous samples, limiting the generalizability of findings and the understanding of how organizational context influences BSC adoption and outcomes (Grigoroudis et al., 2012). Conducting comparative studies across diverse healthcare settings could provide valuable insights into the unique challenges, adaptations, and best practices for BSC implementation in different organizational environments (Lin et al., 2014).

Furthermore, there remained a need for longitudinal research on the long-term impact and sustainability of BSC initiatives in healthcare organizations (Inamdar et al., 2002). Most studies had examined short-term effects of BSC implementation, with limited evidence on the sustained benefits and challenges over time (Trotta et al., 2013). Longitudinal research designs could help assess the evolution of BSC initiatives, identify the factors contributing to their long-term success or failure, and provide insights into the strategies for maintaining the momentum and effectiveness of these initiatives in the face of changing priorities and resources (Rabbani et al., 2011).

### ***Justification for the Current Study***

The study addressed several of the identified research gaps and contributed to the limited but important knowledge on the BSC in healthcare. Firstly, this study focused on exploring the factors influencing BSC awareness, comprehension, and adoption criteria among healthcare

managers and leaders in a non-profit healthcare system. By investigating these individual and organizational characteristics, the study provided valuable insights into the enablers and barriers to BSC adoption, informing strategies for promoting the effective utilization of this strategic management tool in healthcare settings (Behrouzi et al., 2014). The findings of this study could guide healthcare organizations in developing targeted interventions, training programs, and support mechanisms to enhance BSC awareness and facilitate successful implementation (Trotta et al., 2013).

Secondly, the study provided insights from a non-profit healthcare system, offering a unique perspective on the challenges and adaptations specific to this organizational context (Gurd & Gao, 2008). The findings of this study can be compared and contrasted with existing research on BSC implementation in for-profit healthcare organizations by future researchers, enhancing the understanding of how organizational characteristics influence the adoption and outcomes of this strategic management tool (Grigoroudis et al., 2012). These insights could inform the development of context-specific guidelines and best practices for BSC implementation in non-profit healthcare settings (Lin et al., 2014).

Lastly, the study laid the foundation for future longitudinal research on the long-term impact and sustainability of BSC initiatives in healthcare organizations. By examining the factors influencing BSC awareness and adoption criteria, this study identified current knowledge gaps and implementation considerations. The insights gained from this study could inform the design and execution of longitudinal research projects, contributing to the much-needed evidence base on the sustained benefits and challenges of BSC implementation in healthcare settings (Rabbani et al., 2011). Moreover, the findings of this study could guide healthcare organizations in developing strategies for addressing awareness gaps and implementation barriers, potentially

improving their impact on organizational performance and patient care (Trotta et al., 2013). Most critically, this study addressed the fundamental gap in the literature by directly assessing actual BSC awareness levels among healthcare practitioners for the first time.

### **Summary**

This comprehensive literature review explored the BSC as a strategic management tool, with particular focus on its limited adoption in healthcare organizations. The review began by outlining the literature search strategy, which utilized keywords such as “balanced scorecard,” “strategic performance measurement system,” “adoption,” and “healthcare” combined with Boolean operators to identify relevant scholarly works. The search encompassed peer-reviewed articles from 2014 to 2024, seminal pre-2014 works, doctoral dissertations, and carefully vetted gray literature from databases including EBSCO, ProQuest, Emerald Insight, Sage Journals, and Google Scholar. Notably, the literature search revealed a decline in BSC healthcare publications after 2015, suggesting diminished scholarly engagement as widespread adoption failed to materialize, which further justified incorporating diverse academic sources to ensure comprehensive coverage.

The review examined the conceptual framework, which integrated three organizational behavior theories to provide a comprehensive lens for understanding BSC adoption dynamics. Rogers’s (1962) diffusion of innovations theory explains the spread of new tools and ideas within organizations through stages of knowledge, persuasion, decision, implementation, and confirmation. DiMaggio and Powell’s (1983) institutional theory examines organizational culture, norms, and isomorphic pressures that influence innovation adoption, while Barney’s (1991) resource-based view theory provides insights into how organizational resources impact capacity to implement strategic changes. The integration of these three theoretical perspectives

enabled a multifaceted investigation of the personal, cultural, and systemic dynamics that shape assimilation of strategic performance reporting systems in healthcare settings, with Johnson and Walston (2022) demonstrating the value of this multi-theoretical approach for understanding complex healthcare innovation adoption.

The review traced the BSC's origins from Kaplan and Norton's (1992) seminal work through its evolution from a performance measurement tool to a comprehensive strategic management system. The examination revealed how the BSC's theoretical foundations integrate cybernetics control theory, organizational performance measurement scholarship, and strategic performance systems research. The framework's four perspectives of financial, customer, internal process, and learning and growth provide balanced assessment of organizational performance beyond traditional financial metrics. Evidence shows widespread BSC adoption across many industries, with over 50% of large U.S. firms implementing the framework by the early 2000s. However, the review revealed that healthcare organizations did not follow this adoption pattern, despite the framework's theoretical relevance to the sector's challenges.

The review's examination of BSC in healthcare revealed a significant gap between theoretical promise and actual implementation. While early awareness showed some growth through 2015, driven by recognition of the need for comprehensive performance measurement tools, actual understanding and adoption lagged considerably behind other sectors. Although Zelman et al.'s (2003) survey reported approximately 60% of respondents claiming BSC usage, this figure appears inflated compared to more recent assessments and likely reflects confusion about what constitutes true BSC implementation. The literature identified substantial barriers preventing adoption, including resource constraints, organizational complexity, resistance to change, and difficulties defining meaningful clinical performance indicators. These combined

barriers help explain why BSC adoption remains limited in healthcare despite its theoretical benefits, creating a cycle where limited implementation prevents the research needed to address concerns that may be deterring adoption.

The review explored qualitative methodological approaches, demonstrating their particular value in capturing complex BSC adoption dynamics in healthcare settings. Studies by Kollberg and Elg (2011) using semi-structured interviews uncovered organizational resistance patterns that quantitative measures alone could not capture, while Rabbani et al. (2011) employed case study methodology to identify critical contextual factors influencing implementation success. The interpretative descriptive methodology emerged as especially suited for exploring practitioner perspectives that had been underrepresented in the predominantly case study-based literature. These qualitative approaches provided valuable insights into BSC implementation challenges, though the decline in BSC research after 2015 and persistent lack of data on actual awareness levels among healthcare practitioners indicated that significant gaps remained.

The review identified several critical research gaps from the literature analysis. Most fundamentally, the absence of empirical data on actual BSC awareness levels among healthcare practitioners represented a significant knowledge deficit. While some studies examined BSC implementation in select organizations, no research had systematically assessed whether healthcare leaders and managers were even familiar with the framework. Additional gaps included limited exploration of factors influencing BSC comprehension and adoption among healthcare leaders (Trotta et al., 2013), lack of comparative studies between different types of healthcare organizations (Gurd & Gao, 2008), and insufficient longitudinal evidence on long-term sustainability and effectiveness of BSC initiatives (Inamdar et al., 2002). The post-2015

decline in BSC healthcare research meant these gaps persisted largely unaddressed, reinforcing the cycle where limited adoption prevented the research needed to understand and promote BSC implementation.

These identified gaps justified the need for research examining BSC awareness levels and adoption criteria within non-profit healthcare systems. Most critically, the study addressed the fundamental gap by directly assessing actual BSC awareness levels among healthcare practitioners for the first time. The qualitative interpretative descriptive methodology was well-suited to explore the complex and context-specific factors shaping BSC perception and uptake. The comprehensive analysis of existing research, theoretical frameworks, and methodological approaches provided the foundation for developing appropriate research questions and selecting suitable data collection methods. The insights gained from this literature review informed the methodological approach detailed in Chapter 3, which provides a detailed description of the study design, sampling strategy, data collection methods, and data analysis techniques.

### **Chapter 3: Research Method**

The problem addressed in this study was the apparent deficiency in the adoption and integration of standardized strategic performance reporting frameworks and systems, including the balanced scorecard (BSC) methodology, among healthcare leaders and managers in non-profit healthcare organizations. This deficiency highlights the need to explore the mechanisms underlying the adoption of strategic performance reporting systems like the BSC, in order to enhance the body of knowledge on effective strategic planning and management in healthcare organizations. Understanding these mechanisms was essential for identifying pathways to improve strategic management practices in healthcare settings.

The purpose of this qualitative interpretative descriptive study was to describe the levels of BSC awareness and comprehension, and the adoption criteria of strategic performance reporting systems for leadership and management at a multistate non-profit U.S. healthcare system operating in the Midwest and Mid-Atlantic regions. This research intended to contribute to the existing body of knowledge by offering insights into the levels of BSC awareness and factors that influenced the adoption and implementation of the BSC and related strategic performance reporting systems in the context of a non-profit healthcare organization. Through this investigation, the study sought to provide practical guidance for healthcare organizations considering the implementation of strategic performance reporting frameworks.

This chapter provides an overview of the research methodology and design that was utilized in this study on BSC awareness and adoption factors in a non-profit healthcare setting. First, the interpretivist research philosophy underpinning the methodology is outlined, along with a rationale for the qualitative approach. The chapter then identifies the specific qualitative interpretative descriptive methodology and multiple data sources design that was adopted,

including the use of semi-structured interviews and questionnaires for data collection. Details regarding the study population, purposive sampling methods, sample size considerations that achieved saturation, and participant recruitment procedures are provided. Additionally, the chapter describes the interview guide and questionnaire development process, grounded in the literature review and research questions. An explanation of the data analysis methods, including both deductive and inductive coding, and thematic analysis using NVivo and Microsoft Excel is presented. Issues related to trustworthiness, ethical considerations, assumptions, limitations, and delimitations are also addressed. In sum, this chapter provides a detailed overview of the qualitative interpretative descriptive methodology, grounded in an interpretivist paradigm, that guided this research on BSC awareness, comprehension, and adoption criteria for strategic performance reporting systems in a non-profit healthcare context.

### **Research Methodology and Design**

This study employed a qualitative research methodology to explore the levels of BSC awareness, comprehension, and adoption factors for strategic performance reporting systems among healthcare leaders and managers. Qualitative research emphasizes understanding the meaning individuals or groups ascribe to social or human problems through an inductive process that focuses on words rather than numbers (Creswell & Poth, 2018). This approach is particularly appropriate when seeking to understand complex phenomena where limited existing literature exists, which is the case regarding BSC awareness, comprehension, and adoption factors in healthcare settings (Yin, 2015). The flexibility and exploratory orientation of qualitative research made it well-suited to capture the nuanced personal, organizational, and contextual factors that influenced BSC adoption in healthcare.

Within qualitative research, this study was grounded in an interpretivist philosophical paradigm. The interpretivist paradigm assumes that reality is socially constructed through human interactions and that knowledge is gained through understanding the subjective meanings people assign to their experiences (Schwandt, 1994). Unlike positivist approaches that seek objective truth through hypothesis testing, interpretivism recognizes that multiple valid interpretations of phenomena exist and that researchers and participants co-create understanding through their interactions (Creswell & Poth, 2018). This philosophical stance aligned directly with the study goals of gaining insights into healthcare leaders' awareness, knowledge, and decision-making related to the BSC, as these are inherently subjective experiences shaped by individual and organizational contexts.

The specific qualitative design selected was interpretative description, which allowed the flexibility needed to comprehensively investigate awareness, comprehension, and adoption considerations related to the BSC. Interpretative description is designed to generate knowledge relevant to applied disciplines by providing coherent conceptual descriptions of phenomena while acknowledging the researcher's interpretive role (Thorne et al., 2004). This design facilitated gathering subjective perspectives from participants while also incorporating the researcher's interpretations to develop broad understandings of the phenomenon (Elliott & Timulak, 2021). The open-ended inductive approach of interpretative description enabled thoroughly capturing diverse perspectives without restricting the investigation to a single experience, culture, or context (Yin, 2015).

The integration of these methodological elements (qualitative approach, interpretivist paradigm, and interpretative descriptive design) created a comprehensive framework for investigating BSC awareness and adoption in healthcare. This framework was operationalized

through multiple data collection methods, including semi-structured interviews and open-ended questionnaires, which fostered rich, contextual insights through triangulation (Yin, 2015). The interpretative descriptive design was implemented through thematic analysis, employing both deductive and inductive coding approaches to balance theory-driven investigation with openness to emergent themes. The flexibility and inductive nature of qualitative interpretative description made this approach particularly well-suited for addressing the study's problem, purpose, and research questions. Specifically, this research methodology and design enabled an in-depth investigation of the complex personal, organizational, and contextual factors that influenced BSC awareness and adoption in a setting with limited prior research such as non-profit healthcare organizations (Yin, 2015). While the interpretative descriptive design proved optimal for this study, several alternative methodologies and designs were carefully considered.

The most prominent alternative, a quantitative methodology utilizing surveys and statistical analysis, could have been employed. This would have involved deductively testing theories by examining relationships between predefined variables related to BSC awareness, comprehension, and adoption (Edmonds & Kennedy, 2017). However, quantitative methods prioritize confirmation over discovery, which was opposing to the exploratory nature of this research problem (Creswell & Creswell, 2017). Statistically testing hypotheses risked overlooking the nuanced personal, organizational, and contextual factors that influence BSC adoption in healthcare. Predetermined surveys might have failed to capture perspectives outside the researcher's lens. Additionally, the flexible, iterative approach needed to thoroughly investigate this issue would have been restricted by quantitative methods.

Other qualitative designs like phenomenology, grounded theory, ethnography, and case studies were contemplated but ultimately ruled out. Phenomenology aims to identify the essence

of shared lived experiences around a phenomenon (Creswell & Poth, 2018). While phenomenology could have provided insights into using or implementing the BSC, it would have been too narrow to also understand attitudes, perceptions, and decision-making processes that factor into adoption (Yin, 2015). Another qualitative alternative, grounded theory, seeks to derive new theories directly from data (Corbin & Strauss, 2014). However, this study aimed to explore awareness, comprehension, and adoption within existing theoretical frameworks rather than generate new theories. A third qualitative approach, ethnography, focuses on describing how a phenomenon is embedded within a group's culture (Creswell & Poth, 2018). Studying BSC adoption ethnographically could have revealed cultural dynamics within an organization (Yin, 2015). Nevertheless, culture was only one facet; other personal, systemic, and contextual factors also likely influenced adoption. The final qualitative alternative considered was case study design, which explores an issue within a bounded context (Yin, 2015). While case studies can provide in-depth understanding of phenomena within organizations, this approach would have treated the entire healthcare system as a single bounded case, potentially obscuring the variation in individual perspectives across different organizational levels, departments, and geographic locations within this large multistate system (Creswell & Creswell, 2017). Moreover, case study design typically emphasizes organizational-level analysis, whereas this study sought to understand individual leaders' and managers' varying levels of awareness and adoption criteria rather than the organization's overall approach to strategic performance measurement (Yin, 2015).

In contrast, the flexible and adaptive nature of interpretative description was ideally suited to richly describe this multi-faceted phenomenon without restricting the investigation to a single experience, culture, or context (Thorne et al., 2004). The goal of interpretative description

aligned well with revealing personal, organizational, and contextual factors shaping awareness, comprehension, and adoption while remaining open to emergent themes (Elliott & Timulak, 2021). For these reasons, the combination of qualitative methodology, interpretivist paradigm, and interpretative descriptive design provided the methodological rigor and flexibility necessary to explore the complex phenomenon of BSC awareness, comprehension, and adoption within the studied healthcare organization.

### **Population and Sample**

The population for this study comprised leadership and management within a large non-profit healthcare system operating in the Midwest and Mid-Atlantic regions of the U.S. This healthcare system includes approximately 50 hospitals and over 1,000 care sites, with annual revenues exceeding \$11 billion (Healthcare System Annual Report, 2022). The system has over 60,000 employees, including approximately 3,500 individuals in leadership and management positions across hospitals and corporate offices based on employee totals and industry management-staff ratios (BLS, 2022).

This population was selected intentionally based on the study's purpose of exploring BSC awareness, comprehension, and adoption considerations among healthcare leaders and managers, specifically in a non-profit setting. The study sought to address three key areas: first, to assess whether healthcare leaders and managers demonstrated awareness of the BSC framework; second, to evaluate their level of comprehension if they were familiar with it; and third, to understand the adoption criteria and mechanisms that influence the implementation of strategic performance reporting systems such as the BSC in healthcare organizations. This healthcare system, as one of the largest non-profit healthcare organizations in the U.S., served as a standard representation of top-tier non-profits in terms of size, scope, structure, revenue profile, and

operating environment, thus making it an ideal population for this study (Healthcare System Annual Report, 2022). Furthermore, concentrating on a single organization provided a consistent organizational context for all participants, allowing the study to examine BSC awareness, comprehension, and adoption considerations within a shared strategic environment.

The specific sample was drawn from a broadly distributed subset of the estimated 3,500 managers and leaders across this healthcare system. While the total management population included approximately 3,500 individuals, the accessible population for this study consisted of 964 leaders and managers who were members of a pre-existing email group used exclusively for organizational leaders and managers. This group included executives, directors, medical directors, nurse managers, and others in roles encompassing decision-making authority and responsibility for performance improvement. The inclusion criteria were that these individuals had exposure to strategic initiatives and responsibility for monitoring strategic performance and progress within their areas. While not all participants were directly involved in organization-wide strategic planning, they possessed foundational knowledge of strategic performance measurement systems and contributed to achieving strategic objectives within their respective departments, making them an appropriate population for providing insights into adoption considerations for systems like the BSC. To qualify for inclusion, participants had to: (1) currently hold a formal leadership or management position with direct reports; (2) have decision-making authority and responsibility for strategic planning, performance improvement, budgets, or personnel management; (3) have been in their current role for a minimum of one year, ensuring they had sufficient experience with organizational planning and strategic performance reporting systems relevant to the research questions; and (4) be at least 18 years of age, though this was inherent given the managerial positions required for inclusion. The large size of this

managerial population offered variability in perspectives while maintaining a common organizational context.

A purposeful sampling method was used to recruit participants for this study. Purposeful sampling, also known as purposive or judgmental sampling, is a non-probability sampling technique commonly employed in qualitative research (Yin, 2015). The method involves the intentional selection of individuals or groups who are especially knowledgeable about or experienced with the phenomenon under study. Unlike probability sampling methods, where each member of the population has an equal chance of being selected, purposeful sampling relies on the researcher's judgment to choose participants who can provide rich, relevant, and diverse data (Creswell & Plano Clark, 2011). For this study, the sample comprised 36 management and leadership individuals within the identified non-profit healthcare system, including 34 who completed questionnaires and 2 who participated in semi-structured interviews.

To elicit a breadth of perspectives, this study employed maximum variation sampling techniques in the recruitment of participants. As Palinkas et al. (2015) explain, maximum variation sampling aims to capture and describe central themes that emerge across a wide range of participant variation. The use of the pre-existing email group facilitated maximum variation as it included members across all organizational levels from frontline managers through C-suite executives, representing various departments, geographic locations, and years of experience. By inviting all 964 members of this diverse group, the study promoted maximum diversity across characteristics including leadership level, department, years of experience, and geography (Patton, 2015). This heterogeneous sample generated richer insights into the research questions by uncovering awareness, comprehension, and adoption considerations that persisted despite variations among the participants (Creswell & Poth, 2018). The maximum variation approach

revealed common themes, facilitating a nuanced exploration of the complex organizational and leadership dynamics that influenced BSC adoption (Yin, 2015). Examining these central factors across a spectrum of participants enhanced understanding of core elements impacting strategic performance reporting system adoption within healthcare settings.

To implement this maximum variation sampling approach, initial contact with prospective participants was made through email solicitation, where a single invitation to participate in the study, along with the study's purpose and requirements, was sent to members of the pre-existing email group for leadership and managerial roles within the healthcare system. Recruitment involved utilizing this pre-existing email group used exclusively for leaders and managers at the study site to ensure alignment with the study's inclusion criteria. This email group represented a broadly distributed subset of the organization's total management population. Email invitations to participate in the study were sent to all 964 members of this group over a 14-day data collection period (see Appendix A). The recruitment email provided background information on the study, participation requirements, both data collection options (open-ended questionnaire via Qualtrics link and/or semi-structured interview), and researcher contact details. Participants could choose to complete the questionnaire or participate in an interview. The questionnaire was accessed through a secure Qualtrics link included in the email invitation, while interview participants scheduled their sessions directly with the researcher. This dual-method approach yielded 34 completed questionnaires and 2 semi-structured interviews, providing rich qualitative data from multiple sources.

The final sample size of 36 participants for this study fell within the appropriate range recommended for qualitative research aiming to reach data saturation. According to recommendations by Mason (2010), samples for qualitative studies should generally follow the

principle of adequacy rather than representativeness, meaning the sample size is determined by reaching data saturation rather than statistical power calculations. For interpretivist studies using interviews and questionnaires, Guest et al. (2006) found data saturation often occurred within the first 12 interviews. However, for topics with potentially greater variability, a sample size between 30-50 has been shown to allow for the emergence of themes and useful interpretations (Malterud et al., 2016).

Given the diversity of this study's management population across multiple divisions, leadership levels, and geographic regions, a sample size toward the lower range of 20-40 participants was considered appropriate. While oversampling with a higher number, such as 70 participants, could have resulted in diminishing analytic returns, a sample size under 30 might not have achieved full saturation (Malterud et al., 2016). The target range of 20-40 provided flexibility to continue recruitment until the data collected consistently pointed to emergent themes and meaningful conclusions could be drawn. This range also allowed for potential attrition and nonresponses while still ensuring the minimum sample size for saturation would be obtained (Yin, 2015).

The achieved sample size of 36 participants, representing diverse organizational levels and educational backgrounds, proved sufficient for achieving data saturation. The participants included frontline managers (41.7%), middle managers (33.3%), and upper management (11.1%), with educational backgrounds ranging from associate degrees to doctoral/professional degrees. Despite the 3.7% response rate from the 964 invited individuals, the diversity and richness of responses from the 36 participants enabled the identification of clear themes and patterns across both research questions, confirming that data saturation was reached (Malterud et al., 2016).

## **Instrumentation**

The two instruments used for data collection in this study were a semi-structured interview guide and an open-ended questionnaire. Both instruments contained the same ten open-ended questions to ensure consistency across data collection methods and allow for response triangulation. The ten questions were developed based on the purpose statement, research questions, literature review themes, and conceptual framework to explore the topics of BSC awareness, comprehension, and perceptions of adoption factors among the participants. The interview questions for this study are listed in Appendix B, which also includes a crosswalk linking each question to its corresponding research question from the study.

To enhance the instrument's trustworthiness and alignment with study objectives, the ten instrument questions underwent a Delphi review process. The Delphi technique was selected for its systematic approach to achieving expert consensus through iterative rounds of feedback and refinement, particularly valuable when validating instrument content in specialized fields like healthcare management (Hasson & Keeney, 2011). This method allows experts to independently evaluate items, provide structured feedback, and reach consensus without the influence of group dynamics that can occur in face-to-face validation meetings. A panel of two qualitative research experts independently evaluated the questions, gave feedback on question construction, clarity, and relevance, and rated each item on a 5-point relevance scale (Powell, 2003). This feedback was collated and content validity ratio (CVR) values were computed for each item to guide revisions, aiming for a minimum CVR of .80 per item and an overall content validity index (CVI) of .90 (Hasson & Keeney, 2011). Given the small expert panel ( $n = 2$ ), CVR and CVI values were interpreted as agreement indices rather than traditional validity coefficients. The first round of Delphi review yielded near unanimous agreement from the expert panel, with most

items achieving CVR values of 1.0. Based on expert feedback, minor wording refinements were made to enhance question clarity, and the experts recommended placing demographic questions at the end of both instruments to maximize data capture if participants discontinued before completion. The second round of review achieved unanimous agreement across all items, with an overall CVI exceeding 0.90.

Following the Delphi validation process, the ten validated questions were incorporated into both the interview guide and the online questionnaire. While traditional reliability measures are less applicable to open-ended qualitative instruments, consistency was enhanced through the use of identical questions across both data collection methods and structured protocols for administration (Creswell & Poth, 2018). Pilot testing was not conducted as the Delphi review process with expert validation was deemed sufficient for establishing instrument validity and clarity.

The interview guide served as the protocol for conducting 20-30 minute semi-structured interviews with participants (see Appendix C). The guide included comprehensive protocols for consent verification, including confirmation that participants had received and reviewed the consent letter with opportunity to ask questions before providing verbal consent to proceed. The guide also included technical setup procedures for Zoom interviews and a structured format with four distinct sections: Strategic Management Experience, Current Organizational Practices, Future Perspectives, and Professional Context. The guide followed best practices by presenting the ten content questions organized by research objectives first, with seven demographic questions placed at the end (Castillo-Montoya, 2016). The semi-structured format allowed for follow-up questions and clarification, with specific probing prompts provided such as “Could you tell me more about that?” and “Could you give me an example?” to elicit detailed responses.

Additionally, the guide included three debriefing questions to capture any final insights and a member checking process where participants would receive a summary of key themes for review within 2-3 weeks. Similar to the questionnaire, interview participants were informed they would receive a \$30 gift card following completion of the summary review.

The open-ended questionnaire was administered online through the Qualtrics platform (see Appendix D). The questionnaire began with an informed consent page clearly stating the inclusion criteria and study purpose, followed by the same ten validated content questions formatted as text boxes allowing for paragraph-length responses. Similar to the interview guide, the questionnaire was structured with four content sections (Strategic Management Experience, Current Organizational Practices, and Future Perspectives) followed by the seven demographic questions of the Professional Context section. Each section included introductory text orienting participants to the topic area and reassuring them that lack of experience with any question was acceptable. This online format provided an additional avenue of participation for recruiting an adequate sample and allowed participants to complete responses at their own pace and convenience. As an additional data source, the questionnaire enabled response triangulation to enhance credibility while accommodating participants who might prefer written communication over verbal interviews or who had scheduling constraints. The questionnaire estimated 15-30 minutes for completion and included instructions for receiving the \$30 gift card incentive upon completion.

### **Study Procedures**

Prior to undertaking this study, approval was obtained for the dissertation proposal. Following this approval, an application was presented to the National University Institutional Review Board (IRB) which granted exemption status. Additionally, the healthcare system's IRB

also reviewed the study and granted exemption status, ensuring adherence to ethical standards and guidelines at both the academic institution and research site. Furthermore, operational approval to utilize the identified email list was obtained from the healthcare system's Vice President of Human Resources, separate from the IRB approval process.

At the onset of the study, participants were recruited through a multi-pronged approach involving email and newsletter outreach. Email addresses of leaders and managers across the healthcare system were obtained by utilizing a pre-existing email group that included a subset of leaders and managers within the organization. An initial recruitment email was sent to 964 individuals from this group that provided background information on the study, outlined participation requirements, emphasized the voluntary nature of participation, and provided contact details. In addition, a recruitment announcement was pre-scheduled to appear in an organizational internal newsletter for two consecutive weeks. Due to newsletter length constraints, this announcement was brief and simply informed associates that if they held qualifying leadership or management roles, they would have received an email invitation and encouraged them to check for that email, as emails are often overlooked. The recruitment email contained embedded links where interested participants could schedule an interview through an online booking application ([youcanbook.me](https://youcanbook.me)) or access the online questionnaire (Qualtrics). Within either pathway, participants were provided the informed consent form at the onset of the process. The informed consent made clear that individuals could decline or withdraw participation at any time, even after beginning the questionnaire or interview.

Semi-structured interviews were scheduled at 20-30 minutes with participants who completed scheduling and the informed consent process. Two interviews were conducted within the first week of data collection. Participants were given the option to conduct interviews via

Zoom with video (preferred), Zoom without video, or phone. Both conducted interviews utilized Zoom with full video functionality. Zoom with video allowed for both audio and visual communication, enabling observation of non-verbal cues such as facial expressions, gestures, and body language in addition to supporting rapport with the participant. These cues offered valuable context and additional layers of meaning to the verbal responses, enriching the data collected (Roulston, 2010). The interviews followed the semi-structured guide developed as described in the instrumentation section. With participant permission, interviews were audiovisually recorded. Recordings were transcribed with identifying information removed. Member-checking was employed by sending transcriptions to participants to review for accuracy and provide any additional thoughts.

The initial recruitment email sent to the 964 participants included a link to the anonymous questionnaire in Qualtrics (with IP address collection disabled to ensure anonymity), providing direct access to this participation option. To accommodate busy schedules, participants were given a two-week timeframe to complete the 15-30 minute questionnaire. While a reminder email was available as an option, it was not deemed necessary as 34 questionnaire responses were received within the first four business days, and cursory analysis indicated thematic saturation was being achieved. Given the monetary incentives connected with participation and the achievement of thematic saturation, no follow-up recruitment was pursued, though the data collection period remained open for the full 14 days.

Throughout data collection, an audit trail was maintained documenting the process, tracking participant response rates, and noting any other contextual details. Given the nature of this qualitative research, a recruitment period of four to six weeks is often recommended to allow potential participants ample time to become aware of and consider participation in the study

(Creswell & Creswell, 2017; Guest et al., 2006). However, it should be noted that access to the targeted population was confined by the organization to minimize disruptions to their routine business operations. Therefore, data collection from interviews and questionnaires proceeded concurrently over a 14-day timeframe. The study achieved robust participation with 34 questionnaire responses received within four business days and 2 interviews completed, totaling 36 participants (3.7% response rate). The rapid achievement of thematic saturation, combined with monetary considerations, eliminated the need for the follow-up email reminder, though the second newsletter announcement proceeded as pre-scheduled and the data collection window remained open for the full 14 days.

### **Data Analysis**

The data collected from semi-structured interviews and open-ended questionnaires underwent a rigorous process of qualitative analysis integrating deductive and inductive approaches to develop significant themes in relation to the research questions (Williams & Moser, 2019). The analysis was supported by NVivo qualitative software and Microsoft Excel for systematic coding and organization, while incorporating multiple strategies to enhance trustworthiness including triangulation, member checking, and detailed audit trails. Specifically, this study employed thematic analysis, following the six phases outlined by Braun and Clarke (2006): familiarization, generating codes, searching for themes, reviewing themes, defining and naming themes, and finalizing analysis.

The first phase involved familiarization through immersion in the qualitative data by thoroughly reading all interview transcripts and open-ended questionnaire responses multiple times to gain maximum insight (Braun & Clarke, 2006; Terry et al., 2017). Detailed notes and memos were taken on initial observations and impressions from the data (Williams & Moser,

2019). While the deductive codes had been predetermined from the research questions and theoretical framework, preliminary ideas for potential inductive codes were also recorded during this phase through active engagement with the data to search for emergent meanings and patterns (Braun & Clarke, 2006; Terry et al., 2017).

The next phase focused on applying the predetermined deductive codes and generating inductive codes from the data using the qualitative analysis software NVivo (QSR International, 2020), complemented by Microsoft Excel for additional sorting and organization of coded units. NVivo allows for systematic organization and coding of diverse forms of qualitative data from interviews, open-ended questionnaires, focus groups, and other sources (Woods, et al., 2016). The coding process integrated both approaches: deductive codes developed from the study's conceptual framework and research questions were systematically applied to relevant data segments, while additional codes emerged organically from participant responses during this phase. This dual approach was utilized to identify and categorize elements in the transcripts and questionnaire responses that were relevant to answering the research questions (Elliott, 2018; Williams & Moser, 2019). This involved assigning descriptive labels to excerpts of data that pertained to topics such as awareness, comprehension, perceptions, and adoption considerations related to the BSC framework or other strategic performance reporting systems. Coded units consisted of text segments ranging from phrases to complete responses that contained meaningful information related to the research questions, with both interview transcripts and questionnaire responses analyzed line-by-line and treated as equal qualitative data sources. To ensure consistency and transparency in the coding process, a comprehensive codebook was developed that included operational definitions for each of the eleven deductive codes and descriptions for the six inductive codes as they emerged. The deductive code definitions were

established prior to analysis based on the theoretical framework, while inductive code descriptions were refined iteratively as new patterns were identified in the data. The complete coding framework ultimately comprised eleven predetermined deductive codes aligned with the theoretical framework and six inductive codes that emerged during analysis.

In the third phase, broader patterns across the initial codes were analyzed to develop higher-level conceptual categories and overarching themes (Allen, 2017; Williams & Moser, 2019). Related codes were grouped together based on shared characteristics and meanings uncovered through careful examination of the coded data (Braun & Clarke, 2006). The comprehensive process of searching for themes synthesized the granular detail of codes into candidate themes that represented the major concepts and findings emerging from the data (Yin, 2015).

The fourth phase involved reviewing and refining the candidate themes that were identified in the previous stage (Braun & Clarke, 2006). This phase used constant comparison between codes, cases, and different datasets to further develop coherent, consistent, and distinctive themes that accurately depicted the qualitative findings (Boeije, 2002). Data were revisited as needed during this phase to gather additional evidence for the themes and assess whether they told a compelling story about the data in relation to the research questions (Braun & Clarke, 2006). NVivo tools such as queries and visualizations supported uncovering meaningful patterns and relationships among the themes. Microsoft Excel facilitated cross-tabulation and frequency analysis of themes across different participant demographics and organizational levels. This review process confirmed that the candidate themes were supported by sufficient data and maintained both internal coherence and external distinctiveness.

In the fifth phase, the themes that emerged from the review process were clearly defined, named, and delineated (Braun & Clarke, 2006). This involved examining conceptual relationships between codes and grouping related codes into cohesive themes that captured their shared meaning. Comprehensive theme names were developed that provided an immediate sense of what each theme encompassed (Braun & Clarke, 2006). Clear working definitions for each theme were also generated to articulate the essence of each theme and provide inclusion/exclusion criteria for assigning data extracts (Braun & Clarke, 2006; Terry et al., 2017). Defining and naming the themes required capturing the complexity of the data patterns in concise but informative labels and descriptions. Three themes emerged for RQ1 and four themes emerged for RQ2, each incorporating multiple related codes that shared conceptual characteristics and meanings.

The final phase involved writing up the analysis and findings in a coherent narrative supported by vivid examples from the data extracts (Braun & Clarke, 2006). The written analysis provided a logical, non-repetitive, and engaging account of the themes related to the research questions (Braun & Clarke, 2006). Microsoft Excel was instrumental in organizing and presenting the findings, enabling the categorization and refinement of themes, creation of frequency tables, code distribution analyses, and cross-tabulations that revealed patterns across organizational levels and educational backgrounds. Extracts from the interview and questionnaire data were embedded within the narrative to illustrate the themes in participants' own words (Braun & Clarke, 2006). Overall, the culminating phase of analysis synthesized the meanings uncovered through the thematic analysis process into a compelling set of findings.

Several strategies were utilized throughout the coding/analysis process to enhance trustworthiness. Methodological triangulation was employed by collecting data from two distinct

sources (open-ended questionnaires and semi-structured interviews), allowing for cross-validation of participant insights across formats and role levels. Member checking was employed by sharing summaries of findings with interview participants to gather their feedback and insights (Birt et al., 2016). The dual coding approach, incorporating both deductive codes derived from the theoretical framework and inductive codes generated from emergent patterns, ensured both theoretical alignment and openness to participant-driven themes. Additionally, detailed memoing tracked interpretive insights and analytic decisions throughout the process. Furthermore, audit trails, comprehensive codebooks, and systematic documentation in NVivo and Excel helped ensure confirmability and transparency of the analysis procedures (Williams & Moser, 2019).

The thematic analysis approach was specifically designed to ensure alignment between the analytical procedures and the study's research objectives. The deductive codes aligned directly with RQ1's focus on awareness and comprehension (e.g., BSC Awareness, BSC Comprehension codes) and RQ2's focus on adoption criteria (e.g., Adoption Criteria, Implementation Barriers codes). The inductive codes allowed for unexpected insights about adoption factors not anticipated in the theoretical framework. This dual approach ensured that the analysis could both test theoretical predictions and remain open to emergent patterns relevant to addressing the identified problem of deficient BSC adoption in healthcare.

The researcher's role as the primary instrument in this qualitative study required maintaining reflexivity throughout the analysis process. Reflexivity refers to the critical self-examination of how the researcher's background, assumptions, and positioning might influence the research (Braun & Clarke, 2006). This involved acknowledging prior experience in healthcare administration while bracketing assumptions about strategic performance systems to

minimize bias. Detailed memoing documented analytical decisions and potential biases, while the systematic use of the codebook and audit trails ensured transparency in interpretation. The researcher's responsibilities included immersion in the data, iterative code application and refinement, and synthesis of patterns into meaningful themes while maintaining fidelity to participants' perspectives (Yin, 2015).

### **Assumptions**

Assumptions refer to premises that are accepted as true by the investigator without definitive proof or verification (Bloomberg & Volpe, 2018). Connelly (2016) explains that assumptions are premises taken for granted in a study. Simon and Goes (2013) similarly describe assumptions as beliefs the researcher accepts as true without actual verification. Assumptions provide foundational beliefs that underpin the research design, methods, and interpretation of results (Creswell & Creswell, 2017). In qualitative studies, common assumptions include believing that participants will respond honestly, that researchers can bracket their own biases, and that findings may be transferable to other settings (Bloomberg & Volpe, 2018; Connelly, 2016). However, assumptions may introduce risks regarding validity and objectivity if not addressed transparently (Simon & Goes, 2013). As a result, making assumptions explicit and explaining the rationale for them is an important component of high-quality research (Creswell & Creswell, 2017).

This study made several assumptions based on the research approach, design, and methods chosen. First, it assumed that a qualitative methodology was appropriate for investigating the research problem. This aligned with the assumption that a complex social phenomenon is best understood through subjective experiences rather than objective

measurements. The study also assumed an interpretivist paradigm was suitable for gaining insights into individuals' perspectives and meanings (Yin, 2015).

Additionally, the use of purposeful sampling assumed that this technique would lead to selecting information-rich cases relevant to the phenomenon under study (Palinkas et al., 2015). It was also assumed participants would respond honestly and comprehensively, given the voluntary nature of participation and assurances of confidentiality in the professional research context. The interview and questionnaire guides presumed the questions would evoke data useful for answering the research questions. Likewise, thematic analysis assumed that the dual approach of applying theory-driven deductive codes while remaining open to emergent inductive codes would accurately capture both anticipated and unexpected aspects of participants' viewpoints and the phenomenon. Lastly, there was an assumption that qualitative research could generate transferable findings that would potentially inform practices in other settings (Connelly, 2016).

These assumptions were inherent to the qualitative interpretative descriptive approach and aligned with established practices in healthcare management research (Thorne, 2016; Yin, 2015). While these assumptions were necessary for investigating participants' subjective experiences and perspectives regarding BSC awareness, comprehension, and adoption criteria, they also introduced certain constraints on the study's scope and findings. The following section addresses the limitations that arose from both these foundational assumptions and other methodological choices.

### **Limitations**

Limitations refer to potential weaknesses, shortcomings, or conditions that may influence the interpretation of findings or ability to generalize conclusions (Bloomberg & Volpe, 2018). Connelly (2016) explains that limitations are uncontrollable threats to internal validity that

researchers cannot fully control or eliminate. These inherent aspects of research methodology, design, analysis, sample, or other factors may restrict validity, accuracy, completeness, or generalizability of results, including issues such as sample size and characteristics, data collection methods, analysis techniques, researcher biases, and self-reported data (Simon & Goes, 2013). Clearly identifying and transparently discussing limitations is essential for high-quality research, as it allows readers to critically evaluate the context and properly interpret findings while demonstrating that the researcher has critically reflected on factors that may influence outcomes or conclusions (Edmonds & Kennedy, 2017; Roberts & Hyatt, 2019). The remainder of this section delineates key limitations identified for the current study and discusses how they impacted the research.

First, the qualitative sample was restricted to 36 healthcare managers and leaders within one large non-profit healthcare system, which presented constraints on generalizing findings more broadly (Connelly, 2016; Malterud et al., 2016). While statistical generalizability is not a goal of qualitative research, readers may still judge the applicability of findings to their contexts (Connelly, 2016). To assist this transferability judgment, the study thoroughly described details on the research context, sample population, demographics, and setting so readers could discern how similar it is to their own situation and infer usefulness of findings (Yin, 2015).

Another limitation stemmed from the voluntary nature of participation and the resulting low response rate. The study achieved only a 3.7% response rate, with 36 participants from 964 invitations. As involvement was completely optional, individuals had to proactively volunteer through completing the online questionnaire or scheduling an interview (Bryman & Bell, 2015). This self-selection likely excluded certain perspectives, particularly from leaders with limited strategic framework knowledge who may have avoided participation, or those facing substantial

challenges with performance systems who opted out. Conversely, leaders engaged with the BSC may have been more inclined to participate, potentially skewing the data toward more favorable viewpoints regarding adoption (Rogelberg & Stanton, 2007).

While maximum variation sampling techniques sought diversity, the study still risked omitting insights from individuals who were too busy, insufficiently interested, or reluctant to participate (Rogelberg & Stanton, 2007). Strategies to mitigate voluntary response limits included transparently communicating research aims, emphasizing confidentiality, sending reminder notifications, and reducing participation burden through straightforward questionnaires. Despite these mitigation efforts, the compressed 14-day data collection timeframe, necessary due to organizational constraints, may have limited participation from busier executives. While strategies were employed to maximize participation within constraints, self-selection bias remained an inherent limitation of the voluntary participation design.

Further limitations arose from the subjective nature of self-reported data in interviews and questionnaires. While first-hand perspectives are invaluable, self-reported data has inherent subjectivity that can introduce validity issues (Rosenman et al., 2011). Participants provided information filtered through their own perceptions, interpretations, and biases, with factors like recollection, articulation skills, mood, hindsight bias, and attribution errors affecting accuracy (Austin et al., 1998). Direct verification of whether self-reports precisely reflected reality was not possible, requiring assumptions about participant honesty, introspective ability, and insight (Darawsheh, 2014). While triangulation and member-checking helped mitigate these subjectivity limitations, the data interpretation necessarily relied on participant truthfulness and accurate recall (Rosenman et al., 2011).

Related to self-reported data limitations, social desirability bias presented an additional concern. This tendency for participants to provide responses that make themselves or their organization look favorable rather than answering truthfully can occur consciously or unconsciously (Nederhof, 1985). In this study, healthcare leaders might have exaggerated their BSC knowledge or implementation extent to appear competent, or downplayed adoption barriers to avoid seeming resistant to innovation. Such discrepancies between true attitudes and reported responses result in biased data that does not accurately reflect reality (Yin, 2015). While strategies were employed to mitigate this bias, including careful question wording, building rapport, ensuring confidentiality and anonymity, and triangulating across multiple sources, social desirability bias remained a potential influence on participant responses (Creswell & Creswell, 2017).

Finally, the researcher's background in healthcare administration represented a potential limitation requiring acknowledgment. This professional experience, while providing valuable context for understanding the phenomenon, could have influenced data interpretation through preconceived notions about strategic performance systems in healthcare settings. To mitigate this limitation, reflexivity was maintained throughout the research process, documented through detailed memoing, bracketing of assumptions, systematic codebook application, and transparent audit trails. While these measures helped minimize the influence of researcher bias on the findings, complete elimination of such influence was not possible given the interpretative nature of qualitative analysis.

### **Delimitations**

Delimitations refer to the intentional choices made by the researcher regarding the study scope, boundaries, sample, objectives, framework, and other parameters (Connelly, 2016).

Simon and Goes (2013) explain that delimitations arise from specific decisions during study design about the theories examined, constructs explored, population sampled, methodology utilized, and questions posed for investigation. These informed decisions impose boundaries that identify relevant features to investigate while excluding marginal issues, allowing readers to interpret the breadth and limits of study conclusions (Creswell & Creswell, 2017). This study incorporated several delimitations pertaining to its setting, timeframe, sample population, data collection methods, and conceptual scope to conduct an in-depth yet focused investigation into the stated research problem.

These delimitations directly addressed the problem of deficient adoption and integration of standardized strategic performance reporting systems, including the BSC, among healthcare leaders and managers in non-profit healthcare organizations. By focusing on those with decision-making authority, the study aligned with the theoretical framework's emphasis on how innovations diffuse through organizational hierarchies (Rogers, 1962), how institutional pressures influence adoption at different organizational levels (DiMaggio & Powell, 1983), and how human capital resources shape strategic capabilities (Barney, 1991). The delimitations supported the study's purpose of describing levels of BSC awareness and comprehension and identifying adoption criteria by targeting the specific population most relevant to these phenomena. Furthermore, the boundaries established through these delimitations enabled focused investigation of the two research questions regarding how leadership and management demonstrate awareness and comprehension of the BSC (RQ1) and how they perceive adoption criteria for strategic performance reporting systems (RQ2).

Specifically, the study was delimited to leadership and management within one large non-profit healthcare system operating in the Midwest and Mid-Atlantic regions of the U.S.

Focusing on a single organization provided a consistent organizational context for the participant population versus including multiple healthcare systems with diverse characteristics. This delimitation aligned with institutional theory's emphasis on understanding how organizational context shapes adoption decisions and allowed for examining how coercive, mimetic, and normative pressures operate within a specific institutional environment (DiMaggio & Powell, 1983). Together, these delimitations provided the focused scope necessary to examine how organizational, management, and leadership factors interact to shape strategic performance reporting awareness, comprehension, and adoption within a specific institutional context. (Creswell & Poth, 2018).

The participant sample was delimited to individuals with decision-making authority for strategic planning and performance improvement, as well as those involved in implementing strategic initiatives, specifically those in frontline management, middle management, and upper management positions. As Palinkas et al. (2015) discussed, purposeful sampling focuses on information-rich cases closely tied to the phenomenon of interest. This delimitation connected directly to diffusion of innovations theory's emphasis on opinion leaders and change agents who influence adoption decisions (Rogers, 2003), as well as resource-based view theory's focus on human capital as a strategic resource (Barney, 1991). The study did not include other stakeholders like frontline staff or patients, as the aim was to understand decision-making considerations specifically among those in leadership and management roles responsible for adopting or using strategic performance reporting systems. Delimiting the sample by role ensured participants had relevant knowledge and experience with the research topic to provide meaningful insights into the adoption considerations for strategic performance reporting systems such as the BSC (Patton, 2015). Furthermore, while multiple demographic attributes were

collected, the analysis was delimited to examining patterns based on organizational role and educational level, as these variables aligned most directly with the theoretical framework's emphasis on institutional hierarchies and human capital resources.

Data collection was delimited to a 14-day timeframe due to organizational access constraints, as the healthcare organization limited the data collection window to reduce interference with normal operations. Although a longer period might have yielded more data, the condensed timeframe aligned with recommendations for qualitative data collection, as saturation often occurs early and the focused research questions were conducive to an abbreviated but intensive recruiting effort (Yin, 2015). While a short timeframe risked insufficient data, careful planning and recruitment yielded quality insights, with 36 participants providing rich data through 34 questionnaire responses and 2 interviews. This delimitation reflected the practical realities of conducting research in busy healthcare environments where extended data collection periods could interfere with patient care and operational priorities.

Methodologically, the study was delimited to semi-structured interviews and open-ended questionnaires versus other qualitative data collection methods. Leveraging these multiple data sources not only permitted triangulation to bolster credibility but also provided participants flexibility in how they engaged with the study, accommodating the varying schedules and preferences of busy healthcare leaders and managers (Creswell & Creswell, 2017; Yin, 2015). This approach also supported the interpretivist paradigm's emphasis on subjective experiences from diverse perspectives (Creswell & Poth, 2018).

Theoretically, the study was delimited to the integrated framework of diffusion of innovations, institutional theory, and resource-based view theories, which prior literature has successfully applied to similar innovation adoption phenomena in organizational contexts. Other

theoretical perspectives were considered but excluded to maintain analytical focus and avoid unnecessary complexity. Conceptually, the study was delimited to exploring awareness, comprehension, and adoption considerations regarding the BSC and strategic performance reporting systems, directly addressing the research questions. It did not encompass implementation or effectiveness, as the initial priority was gaining insights into these foundational areas where the literature revealed gaps existed. This focus on pre-implementation factors aligned with diffusion of innovations theory's knowledge and persuasion stages, institutional theory's emphasis on understanding adoption pressures before organizational change occurs, and resource-based view's assessment of capabilities required for strategic innovation (Barney, 1991; DiMaggio & Powell, 1983; Rogers, 2003).

### **Ethical Assurances**

This study required review by the National University Institutional Review Board (IRB) before any data collection or contact with participants could proceed. The IRB, which is responsible for ensuring ethical research practices, reviewed the study protocol and determined it qualified for exemption from full IRB review based on federal criteria for minimal risk research (see Appendix E). The required IRB application documents were submitted, including the study protocol, data collection instruments, informed consent forms, and evidence of completing the CITI human subjects training course. No recruitment, data gathering, or other study procedures commenced until after receiving formal notification of the exemption determination.

In addition to National University's IRB exemption determination, the research site's internal IRB conducted its own evaluation of the study protocol. The healthcare system's IRB provided oversight for the organization where the research was conducted and similarly determined the study qualified for exemption from full IRB review (see Appendix F). This

exemption determination signified that the study posed minimal risk to participants and met federal criteria for exempt research. Beyond the IRB exemption determinations, formal operational approval to conduct research activities at the healthcare facility was also obtained from the healthcare system's Vice President of Human Resources. This involved submitting both IRB exemption determinations along with the study protocol for administrative review and specifically included authorization to utilize the identified email list for participant recruitment. No data collection activities commenced until both IRB exemption determinations were received and operational approval was secured. Obtaining these multiple levels of review, including National University's IRB exemption determination, the healthcare system's IRB exemption determination, and operational site approval, ensured appropriate research ethics and participant protections were upheld. Adherence to ethical guidelines and oversight at both the university and site levels safeguarded that participant rights, safety, and wellbeing were protected.

Since this study involved human participants, assessing potential risks and ethical issues was an important consideration (Sieber, 1992). Based on the qualitative design using interviews and questionnaires, the risks to participants were minimal and no greater than those encountered in everyday life situations (Emanuel et al., 2000). While risks were minimal, ethical research requires that potential benefits justify any participant risks (Yin, 2015). Some potential benefits that justified the risks included generating insights to improve organizational practices and providing participants with professional development through reflecting on experiences. No unanticipated ethical issues arose during the study; however, protocols were in place to address any concerns per ethical guidelines (APA, 2020). Protection of human participants remained paramount, with systematic assessment and mitigation of risks implemented at each stage of the research process.

The informed consent delivery process was tailored to each data collection method while ensuring all participants understood the voluntary nature of their participation. The same informed consent document was used for both methods (see Appendix G). For interview participants, the informed consent document was sent via email at least three business days before their scheduled interview appointment. At the beginning of each interview, participants were asked whether they had received and reviewed the informed consent document and if they had any questions. Upon confirming they had no questions, participants were asked if they consented to proceed with the interview, and verbal consent was obtained before beginning. For questionnaire participants, the informed consent disclosure was presented on the initial screen before entering the survey. Participants were required to read the disclosure and click an acknowledgment button to proceed with the questionnaire, or they could exit if they did not wish to provide consent. Both informed consent documents clearly stated that participation was entirely voluntary and that participants could withdraw from the study at any time without penalty or consequence. The informed consent documents also disclosed the expected time commitment of approximately 20-30 minutes for the interview and 15-30 minutes for the questionnaire, as well as the compensation of a \$30 Amazon gift card for completed participation. This compensation level was deemed appropriate by both IRBs as reasonable acknowledgment for participants' time without creating undue influence to participate.

Several precautions were taken to protect participant confidentiality and anonymity throughout this study. In the context of this study, confidentiality involved protecting the privacy of interview participants by avoiding disclosure of identifying information in disseminated results. Anonymity was ensured by collecting no identifying information from questionnaire respondents and conducting a de-identification process to remove any inadvertently included

personal details from responses, with each participant assigned a numeric code for analysis and reporting purposes. For interview participants, confidentiality was preserved by assigning each participant a unique alphabetic identifier not linked to any identifiers. Any study records, transcripts, or data analysis documents would only include these alphabetic and numeric identifiers. Potentially identifying details from interviews such as names, locations, organizations, or positions were removed during transcription and replaced with generic labels through a de-identification process (Kaiser, 2009). Interview data from Zoom sessions (including video, audio, and transcripts) were securely stored in encrypted files, password-protected, and accessible only through restricted access. Zoom recordings were deleted after transcription and member-checking were complete. All physical study materials were stored in a locked desk drawer with restricted office access. Electronic data was housed on password-protected devices using encryption with limited accessibility. When discussing the study methodology and findings, any personal or organizational information that could identify participants was avoided.

To ensure anonymity among questionnaire participants, no personal identifiers or contact information were collected in the online questionnaire platform. Questionnaire responses were gathered anonymously without linking data to individual respondents' identities (Creswell & Creswell, 2017). To further protect anonymity, IP address tracking was disabled in the questionnaire platform's settings to prevent tracking geographic locations of respondents. Upon questionnaire completion, response data was exported from the secure platform and stored locally in encrypted files on password-protected devices with restricted access. These measures aligned with best practices for protecting participant anonymity in qualitative research (British Psychological Society, 2021).

Maintaining confidentiality and anonymity in research outputs and communications was essential and was accomplished through various safeguards. Direct quotes from participants were used extensively throughout the findings, but all potentially identifying information was removed or modified to prevent identification of individuals. The healthcare system's name was consistently redacted, and organizational characteristics were described in general terms rather than providing specific details that could enable identification. For example, approximate rather than exact numbers were used when describing the system's size and scope, and specific state locations were described regionally rather than individually. Participant quotes were carefully selected to ensure they contained no information that could reveal individual identities. Any quotes containing specific details about roles, departments, or unique circumstances that might identify participants were excluded from the findings. Together, these confidentiality measures allowed for detailed, quote-rich findings while fully protecting participant and organizational identities.

To ensure confidential data management and secure storage, all physical and electronic study records were kept in restricted access files with usage limited through password protection (Kaiser, 2009). Electronic data was housed on password-protected devices with restricted access (British Psychological Society, 2021). For data storage and retention, Zoom interview recordings were password-protected within the encrypted Zoom account, with restricted access (Sieber, 1992). Zoom recordings were deleted after transcription and member-checking (Sanjari et al., 2014). Any physical forms were digitized then destroyed and stored as password-protected files. Study records are being retained for at least three years after completion, following U.S. Department of Health and Human Services guidelines (45 CFR § 46.115(b)). All physical documents used in this study were destroyed by means of a cross-cut micro-cut shredder that was

available at the researcher's place of employment for secure physical destruction (Patton, 2015). The Qualtrics account used for questionnaire delivery was password-protected and restricted. Questionnaire data followed the same retention protocol described above. Implementing these protections for physical and electronic records maintained confidentiality and allowed secure data storage and management.

As the sole researcher in this qualitative study, it was critical to address subjectivity and mitigate potential biases. Prior professional experience as a healthcare administrator and educator could have introduced preconceived perspectives related to strategic performance measurement systems that could threaten the credibility of the study (Sanjari et al., 2014). Although there was no direct experience with the BSC framework specifically, an overall background in healthcare management and education could have shaped assumptions that could unduly influence the data analysis and interpretation if left unaddressed (Chenail, 2011). To prevent personal experiences or views from imposing biases or subjectivity, several strategies were employed. Reflexive journaling was utilized to critically examine assumptions and how these might unconsciously impact analysis (Dodgson, 2019). Reflexive journaling involved regularly writing introspective entries throughout the study to critically examine assumptions, positions, and possible biases that might influence the research (Dodgson, 2019). This allowed conscious evaluation and minimization of the ways subjective perspectives or experiences might impose biases during data analysis and interpretation. In addition, member checking allowed interview participants to review summaries of the findings to confirm the analysis reflected their perspectives rather than researcher biases (Candela, 2019). Consultation with the dissertation committee also provided external input to identify any issues related to subjectivity (Chenail,

2011). Through diligent critical self-reflection, participant validation, and oversight, qualitative standards were upheld and biases were minimized throughout data collection and analysis.

### **Summary**

This chapter presented the research methodology and design employed to investigate BSC awareness, comprehension, and adoption criteria among healthcare leaders and managers within a multistate non-profit healthcare system. The study utilized a qualitative interpretative descriptive methodology grounded in an interpretivist paradigm, which allowed for the exploration of subjective experiences and meanings that participants attributed to strategic performance reporting systems. This methodological approach proved well-suited for addressing the research problem of deficient adoption and integration of standardized strategic performance reporting frameworks in healthcare organizations.

The study drew participants from a population of leadership and management within a large non-profit healthcare system operating in the Midwest and Mid-Atlantic regions. Through purposeful sampling with maximum variation techniques, 36 participants were recruited from a pre-existing email group of 964 organizational leaders and managers. The sample included frontline managers (41.7%), middle managers (33.3%), and upper management (11.1%), with varied educational backgrounds ranging from associate to doctoral degrees. This diversity enabled the capture of perspectives across organizational levels and educational backgrounds, providing rich insights into the research questions.

Data collection employed two instruments containing identical open-ended questions: a semi-structured interview guide and an online questionnaire. These instruments underwent Delphi review by qualitative research experts to ensure alignment with study objectives. The dual data collection approach yielded 34 completed questionnaires and 2 semi-structured

interviews over a 14-day data collection period. Despite the compressed timeframe necessitated by organizational constraints, the data achieved thematic saturation, confirming the adequacy of the sample size for qualitative analysis.

The data analysis followed Braun and Clarke's (2006) six-phase thematic analysis framework, integrating both deductive and inductive coding approaches. Eleven predetermined deductive codes were developed from the theoretical framework and research questions, while six additional inductive codes emerged organically from participant responses. NVivo software facilitated systematic coding and organization, while Microsoft Excel enabled cross-tabulation and frequency analysis across participant demographics. Multiple strategies enhanced trustworthiness, including methodological triangulation between data sources, member checking with interview participants, detailed audit trails, and reflexive memoing throughout the analysis process.

The study acknowledged several limitations that influenced the interpretation of findings. The focus on a single healthcare system limited generalizability to other organizational contexts. The voluntary participation and 3.7% response rate may have introduced self-selection bias, potentially excluding perspectives from those less engaged with strategic frameworks. The reliance on self-reported data presented inherent subjectivity concerns, including potential social desirability bias. Additionally, the 14-day data collection period may have constrained participation from busier executives. These limitations were mitigated through strategies including transparent reporting, triangulation, and member checking.

Delimitations established appropriate boundaries for the investigation. The study was delimited to leadership and management with decision-making authority, excluding frontline staff and other stakeholders. The focus on one healthcare system provided consistent

organizational context for examining the phenomenon. Data collection methods were restricted to interviews and questionnaires, excluding other qualitative approaches. The theoretical framework was bounded by the integration of diffusion of innovations, institutional theory, and resource-based view theories. These delimitations enabled focused investigation of the research questions while maintaining methodological rigor.

Ethical considerations were addressed through multiple levels of review and approval. Both National University and the healthcare system's IRBs granted exemption determinations, confirming minimal risk to participants. Operational approval was obtained from the healthcare system's Vice President of Human Resources. Participant protection was ensured through comprehensive informed consent procedures, maintenance of confidentiality and anonymity, secure data storage, and transparent communication about voluntary participation. The researcher addressed potential bias through reflexive journaling, member checking, and systematic documentation of analytical decisions.

This chapter established a rigorous methodological framework for investigating BSC awareness, comprehension, and adoption criteria among healthcare leaders and managers. The qualitative interpretative descriptive design, combining interviews and questionnaires with systematic thematic analysis, provided comprehensive data addressing both research questions. Implementation of these procedures yielded rich insights into strategic performance reporting perspectives within the healthcare context. The following chapter presents the findings that emerged from this methodological approach.

## Chapter 4: Findings

The problem addressed in this study was the apparent deficiency in the adoption and integration of standardized performance reporting frameworks and systems, including the Balanced Scorecard (BSC) methodology, among healthcare leaders and managers in non-profit healthcare organizations. The deficiency in implementation of such strategic tools created a knowledge gap regarding the mechanisms that influence adoption decisions among healthcare leadership. This gap represented an important area for investigation, as understanding these adoption mechanisms could enhance strategic planning and management practices across the healthcare sector. The use of strategic performance reporting systems like the BSC has been recognized as a best practice in various industries, yet its application in healthcare remains relatively understudied compared to other sectors. Researchers Jeronimo et al. (2022) and Amer et al. (2022) noted that despite evidence of success in healthcare organizations and widespread recognition as a best practice, the factors contributing to the utilization of BSC systems within the broader healthcare sector remain ambiguous.

The purpose of this qualitative interpretative descriptive study was to describe the levels of BSC awareness and comprehension, and the adoption criteria of strategic performance reporting systems for leadership and management at a multistate non-profit U.S. healthcare system operating in the Midwest and Mid-Atlantic regions. The research was conducted with the goal of expanding the knowledge base surrounding strategic management implementation in healthcare contexts. Through investigating both awareness levels and adoption considerations, the study provided insights into the practical and theoretical factors that influenced the adoption and implementation of the BSC and related systems within non-profit healthcare settings. This exploration was particularly relevant given the complex operating environment and unique

challenges faced by healthcare organizations in balancing financial performance with patient health outcomes.

This chapter presents findings derived from the qualitative analysis of two data sources: open-ended questionnaire responses and semi-structured interviews. The results are organized according to the study's research questions and are supported by representative participant quotations. Thematic analysis was employed to identify and interpret recurring patterns across responses. To ensure methodological rigor, strategies to establish trustworthiness, including triangulation, member checking, and audit trails were implemented. A total of 964 individuals were invited to participate in either the questionnaire or interview, resulting in 34 complete questionnaire responses and two interviews. These invitations were distributed through a pre-existing email group used exclusively for leaders and managers within the organization to ensure alignment with the study's inclusion criteria. Participants represented a range of leadership roles and experience levels across the multistate non-profit healthcare system. This chapter begins with an overview of data trustworthiness, followed by detailed findings for each research question, an evaluation of the findings, and a summary of key results.

### **Trustworthiness of the Data**

Establishing trustworthiness is a critical component of qualitative research and serves as a foundation for ensuring that findings are credible, dependable, and ethically sound. Lincoln and Guba (1985) proposed four essential criteria for qualitative rigor: credibility, transferability, dependability, and confirmability. Credibility refers to the confidence in the truth of the findings and is achieved through prolonged engagement, triangulation, and member-checking. Transferability involves the extent to which findings can be applied in other contexts, supported through thick, rich descriptions that allow readers to make informed judgments. Dependability

pertains to the stability and consistency of the research process over time and can be demonstrated through transparent documentation and audit trails. Confirmability emphasizes the neutrality of the findings, ensuring that interpretations are grounded in participant experiences rather than researcher bias, often supported through reflexivity and systematic memoing (Creswell & Poth, 2018). Together, these four criteria provide a structured framework for evaluating the rigor and integrity of qualitative inquiry. Each of these four criteria is discussed in the sections that follow to demonstrate how trustworthiness was established in the present study.

### ***Credibility***

Credibility refers to the extent to which the findings accurately represent participants' perspectives and experiences (Lincoln & Guba, 1985). To enhance credibility in this study, multiple strategies were employed. First, methodological triangulation was used by collecting data from two distinct sources: open-ended questionnaires (n = 34) and semi-structured interviews (n = 2). This allowed for cross-validation of participant insights across formats and role levels. Second, the coding process incorporated both deductive and inductive strategies. Deductive codes were derived from the study's conceptual framework and research questions, while inductive codes were generated from emergent patterns in the data, allowing for the identification of unanticipated themes and concepts not initially anticipated in the conceptual framework. This dual approach ensured both theoretical alignment and openness to participant-driven themes (Creswell & Poth, 2018).

All interview transcripts were reviewed and annotated in detail, with representative quotations extracted to illustrate key themes. Questionnaire responses were analyzed line-by-line to ensure consistent treatment of each entry as a qualitative data unit. After separate analysis of interviews and questionnaires, a triangulation phase was conducted to compare and contrast

themes, identify areas of convergence and divergence, and detect patterns based on management or educational level. Member checking was also employed to enhance credibility; interview participants received summaries of their transcripts and were invited to confirm the accuracy of their responses and provide any clarifications (Lincoln & Guba, 1985). Throughout the process, the researcher engaged in memoing to track interpretive insights and analytic decisions, further enhancing the integrity of the findings (Saldana, 2021). These procedures collectively contributed to the overall credibility of the results.

### ***Transferability***

Transferability refers to the extent to which the findings of a qualitative study can be applied to other contexts or settings. In qualitative research, this is achieved not through statistical generalizability but by providing thick, rich descriptions that allow readers to determine the applicability of findings to their own environments (Lincoln & Guba, 1985). To support transferability in this study, detailed demographic and contextual data were collected from participants, including role level, years of experience, and educational background. Participant quotations are presented throughout the findings to illustrate themes and provide insight into the lived experiences of healthcare leaders and managers.

Additionally, the study setting, a large multistate non-profit healthcare system, provides a relevant context for other similarly structured organizations. By transparently describing the organizational structure, participant characteristics, and data collection procedures, the study allows readers to assess how closely their own settings align with the research context. This level of detail enhances the ability of other researchers, practitioners, and policymakers to consider the relevance of the findings to their own institutions (Creswell & Poth, 2018).

### *Dependability*

Dependability involves demonstrating that the research process is logical, traceable, and clearly documented (Lincoln & Guba, 1985). In this study, dependability was supported through the use of an audit trail that documented key stages of the research process, including participant recruitment, data collection, coding, theme development, and interpretation. The analysis process followed an iterative, multi-phase structure, beginning with deductive and inductive coding of interview and questionnaire responses and followed by theme refinement, triangulation, and cross-source comparison (Creswell & Poth, 2018).

The study employed a qualitative interpretative descriptive methodology grounded in an interpretivist paradigm. This design was selected to allow for rich, contextual exploration of participants' lived experiences and professional insights concerning the BSC and strategic performance reporting systems. Participants were selected using purposive sampling to ensure they met inclusion criteria: current employment in a non-profit healthcare organization, holding a formal leadership or management position with direct reports, and a minimum of one year in their current role. Data collection consisted of two components, both offered in a single email invitation sent to 964 eligible participants: (1) an open-ended questionnaire accessed via a Qualtrics link, which yielded 34 complete responses, and (2) the option to schedule a semi-structured interview, resulting in two interviews conducted to deepen qualitative insights and support triangulation.

The questionnaire and interview instruments were designed to align with the study's research questions and conceptual framework. Both instruments underwent a Delphi review by a panel of qualitative experts, who provided feedback leading to consensus on each tool's clarity

and alignment. Data analysis followed Braun and Clarke's (2006) six-phase thematic analysis model: familiarization with the data, initial coding, searching for themes, reviewing themes, defining and naming themes, and producing the report. Coding decisions, analytic memos, and category development were systematically recorded throughout the process using NVivo software. Additionally, Microsoft Excel was utilized to complement the NVivo analysis by facilitating further sorting and organization of coded units, enabling cross-tabulation and frequency analysis of themes across different participant demographics and organizational levels. The coding process integrated both deductive codes, developed from the study's conceptual framework and research questions, and inductive codes that emerged organically from participant responses.

The use of NVivo and Microsoft Excel ensured consistency in managing and organizing large volumes of textual data, providing a clear audit trail and supporting transparency in the analytic process. This detailed and structured approach to data collection and analysis provides a clear methodology that can be repeated by future researchers in similar contexts. The Delphi-validated instruments, the alignment of codes to theoretical constructs, and the dual-source data triangulation all contribute to a robust and repeatable research design. Together, these procedures ensure that the study could be repeated with similar results in a comparable context.

### ***Confirmability***

Confirmability refers to the degree to which the findings of a qualitative study are shaped by the participants' experiences and not researcher bias, motivations, or interests (Lincoln & Guba, 1985). In this study, confirmability was supported through ongoing reflexivity and analytic memoing. The researcher maintained detailed memos throughout the coding and interpretation process to document thought processes, analytic decisions, and emergent insights.

These memos served as a tool for bracketing personal assumptions and maintaining focus on participant perspectives (Saldana, 2021).

The use of verbatim quotations throughout the findings provides a transparent connection between the data and the interpretations presented. NVivo and Microsoft Excel software facilitated the organization of codes, memos, thematic development, and supporting evidence, creating an audit trail that allows others to trace how conclusions were reached. Additionally, member checking with interview participants added another layer of verification, allowing them to affirm or clarify their responses. These measures ensured that the findings were grounded in the data and not influenced by researcher bias, thereby enhancing the overall confirmability of the study.

## **Results**

This qualitative interpretative descriptive study aimed to describe the levels of BSC awareness and comprehension, and the adoption criteria of strategic performance reporting systems for leadership and management at a multistate non-profit U.S. healthcare system operating in the Midwest and Mid-Atlantic regions. The research utilized semi-structured interviews and open-ended questionnaires, collecting rich qualitative data from healthcare leaders and managers across various organizational levels. Two research questions guided this investigation: (RQ1) In what ways do leadership and management demonstrate awareness and comprehension of the BSC? and (RQ2) How do leadership and management perceive the adoption criteria for the BSC or other strategic performance reporting systems?

Thirty-six healthcare professionals participated in this study, representing diverse roles, educational backgrounds, and experience levels across the healthcare organization. The dataset included 34 questionnaire responses and 2 in-depth semi-structured interviews. Data was

analyzed through thematic analysis using both deductive and inductive coding approaches, guided by the study's conceptual framework integrating diffusion of innovations, institutional theory, and resource-based view theories (Johnson & Walston, 2022).

The deductive coding framework employed in this study comprised eleven predetermined codes strategically aligned with the conceptual framework integrating diffusion of innovations, institutional theory, and resource-based view theories. As shown in Table 1, these codes were distributed across both research questions, with four codes addressing awareness and comprehension (RQ1) and seven codes examining adoption criteria (RQ2). Each code was explicitly linked to a specific theoretical construct, such as BSC Awareness connecting to the awareness stage in diffusion of innovations theory and implementation barriers relating to resource constraints in resource-based view theory. This theoretically informed deductive coding approach provided a structured foundation for the thematic analysis while maintaining alignment with both the research questions and the study's conceptual underpinnings (Merriam & Tisdell, 2016).

The inductive coding process yielded six emergent codes that were not anticipated in the initial framework but proved significant during data analysis, as shown in Table 2. These inductive codes primarily related to RQ2 concerning adoption criteria for strategic performance reporting systems, revealing deeper organizational dynamics influencing implementation. Two notable patterns emerged within these inductive codes: barriers to sustained implementation (distrust/cynicism, time constraints, and fade effect) and systemic organizational challenges (financial dominance and disconnected decision-making). Additionally, the emergence of anticipation of AI as an inductive code reflected participants' forward-looking perspectives on technological transformation in healthcare performance measurement.

**Table 1***Deductive Coding Framework*

Code Name	Description	Theoretical Framework Linkage	Research Question
BSC Awareness	Captured explicit mentions of familiarity with the Balanced Scorecard framework	Diffusion of Innovations (awareness stage)	RQ1
BSC Comprehension	Identified segments demonstrating understanding of BSC components and functions	Diffusion of Innovations (knowledge stage)	RQ1
Strategic Tools Experience	Documented participants' exposure to and usage of strategic management tools	Diffusion of Innovations (trialability)	RQ1
Current Measurement Practices	Described existing strategic performance measurement approaches	Resource-Based View (current capabilities)	RQ1
Training Exposure	Cataloged formal and informal training in strategic frameworks	Institutional Theory (normative pressures)	RQ2
Adoption Criteria	Outlined conditions necessary for adopting performance reporting systems	Diffusion of Innovations (relative advantage)	RQ2
Implementation Facilitators	Identified factors supporting implementation of strategic systems	Institutional Theory (enabling mechanisms)	RQ2
Implementation Barriers	Documented obstacles hindering adoption of performance frameworks	Resource-Based View (resource constraints)	RQ2
Decision-Making Process	Captured organizational processes for strategic tool adoption	Institutional Theory (coercive pressures)	RQ2
Future Expectations	Recorded projections about future strategic measurement evolution	Diffusion of Innovations (future adoption cycle)	RQ2
Implementation Advice	Collected recommendations for improving strategic system implementation	Resource-Based View (optimization strategies)	RQ2

**Table 2***Inductive Coding Framework*

Code Name	Description	Research Question
Distrust/Cynicism	Reflected persistent skepticism due to past failed initiatives	RQ2
Anticipation of AI	Captured expectations about artificial intelligence transforming performance measurement	RQ2
Financial Dominance	Identified focus on financial metrics to the exclusion of other considerations	RQ2
Time Constraints	Highlighted capacity limitations affecting adoption of new frameworks	RQ2
Fade Effect	Documented the tendency of strategic initiatives to lose momentum over time	RQ2
Disconnected Decision-Making	Reflected misalignment between organizational levels in strategic choices	RQ2

The frequency of code applications across all data sources provides insight into the relative prominence of different themes within the dataset. Table 3 presents the frequency counts for all deductive and inductive codes, ordered from most to least frequently applied. This analysis reveals that current measurement practices was the most frequently coded theme, appearing 82 times across participant responses, followed by strategic tools experience and adoption criteria, each occurring 76 times. The high frequency of these codes aligns with the study's focus on existing organizational practices and future adoption considerations.

Among the inductive codes that emerged during analysis, financial dominance appeared most frequently with 21 applications, indicating the significant role of financial considerations in participants' discussions of strategic performance measurement. The remaining inductive codes showed lower frequencies, with disconnected decision-making appearing 15 times and anticipation of AI occurring 13 times. The relatively lower frequencies of codes such as fade

effect (3 applications) and distrust/cynicism (5 applications) suggest these themes, while present, were mentioned by fewer participants or appeared less frequently in individual responses.

**Table 3**

*Frequency of Code Applications by Code Type*

<b>Code</b>	<b>Frequency</b>	<b>Code Type</b>
Current Measurement Practices	82	Deductive
Strategic Tools Experience	76	Deductive
Adoption Criteria	76	Deductive
Implementation Advice	67	Deductive
Implementation Barriers	60	Deductive
Training Exposure	54	Deductive
Future Expectations	51	Deductive
Decision Making Process	46	Deductive
BSC Comprehension	35	Deductive
Implementation Facilitators	35	Deductive
BSC Awareness	23	Deductive
Financial Dominance	21	Inductive
Disconnected Decision-Making	15	Inductive
Anticipation of AI	13	Inductive
Time Constraints	10	Inductive
Distrust / Cynicism	5	Inductive
Fade Effect	3	Inductive

The development of themes from individual codes followed an iterative analytical process guided by the study's research questions and theoretical framework. Table 4 illustrates how specific codes were grouped into broader themes for each research question, demonstrating the logical connection between granular coding and thematic interpretation. This code-to-theme development process involved examining patterns within and across codes, identifying

conceptual relationships, and organizing related codes into cohesive themes that captured the essence of participants' experiences and perspectives (Merriam & Tisdell, 2016).

**Table 4**

*Code-to-Theme Development*

Research Question	Theme	Related Codes
RQ1: In what ways do leadership and management demonstrate awareness and comprehension of the BSC?	1.1: Limited BSC Awareness Among Healthcare Leaders and Managers	BSC Awareness
	1.2: Varied Depth of BSC Comprehension	BSC Comprehension
	1.3: Diverse Strategic Management Tool Experience	Strategic Tools Experience, Current Measurement Practices
RQ2: How do leadership and management perceive the adoption criteria for the BSC or other strategic performance reporting systems?	2.1: Adoption Criteria and Implementation Facilitators	Adoption Criteria, Implementation Facilitators, Training Exposure, Implementation Advice, Financial Dominance
	2.2: Implementation Barriers	Implementation Barriers, Distrust / Cynicism, Time Constraints, Fade Effect
	2.3: Organizational Decision-Making Processes	Decision Making Process, Disconnected Decision-Making
	2.4: Future Directions and Expectations	Future Expectations, Anticipation of AI

For RQ1, three themes emerged from four primary codes, with Theme 1.3 incorporating both strategic tools experience and training exposure codes due to their conceptual overlap in describing participants' broader exposure to performance management approaches. For RQ2, four themes were developed from a more complex array of codes, with some themes incorporating multiple related codes that captured different aspects of the same underlying

concept. For example, Theme 2.1 combined adoption criteria, implementation facilitators, implementation advice, and financial dominance codes, as these all related to factors that influence the decision to adopt strategic performance systems.

Table 5 summarizes the scope of the interview data by listing each session's duration, the length of the verbatim transcript in words, and the number of coded units produced during analysis. Presenting these metrics illustrates the depth and richness of the narrative material that supported theme development. Together, they also demonstrate that sufficient data was gathered from both interviews to achieve analytic rigor and support thematic saturation.

**Table 5**

*Interview Data Overview*

Participant ID	Role Level & Education	Duration (min:sec)	Transcript Length (words)	Coded Units
A	Middle management (doctoral/professional)	21:26	3768	40
B	Frontline management (bachelor's)	13:55	1869	28

Table 6 summarizes the range of the questionnaire data collected for this study. It lists the number of completed questionnaires, total and average word counts, and the distribution of coded units across respondents. These metrics demonstrate that the questionnaire responses offered a substantial and information-rich data source that complemented the interview narratives and supported thematic saturation.

***Demographic Information***

Participant demographic information was collected to provide context for the analysis and facilitate an examination of patterns based on role and educational background. While the

**Table 6***Questionnaire Data Overview*

Metric	Value
Number of completed questionnaires	34
Total words (all responses)	9620
Mean words per respondent	282
Total coded units	602
Mean coded units per respondent	17.7
Range of coded units per respondent	1 – 49

questionnaire and interview captured multiple demographic attributes including gender, age range, current role/position, years of experience, highest level of education, and department or division, this study focused specifically on analyzing patterns related to current role/position and highest level of education. Table 7 presents the demographic distribution of the 36 healthcare professionals who participated in this study. The participants represented diverse organizational levels, with the largest proportion (41.7%) serving in frontline management positions, followed by middle management (33.3%), and upper management (11.1%). A small segment (13.9%) either held other positions or did not specify their role. Regarding educational qualifications, the majority of participants held master's degrees (33.3%), followed by bachelor's degrees (27.78%), and doctoral or professional degrees (19.44%). Only one participant (2.8%) reported having an associate degree, and six participants (16.67%) did not specify their educational background.

Current role/position and highest level of education were selected as primary demographic variables for thematic analysis because they aligned directly with the study's conceptual framework. Current role/position relates to institutional hierarchies and power dynamics referenced in institutional theory (DiMaggio & Powell, 1983), while highest level of

education connects to knowledge resources and capabilities emphasized in resource-based view theory (Barney, 1991). Together, these attributes provide insight into how organizational position and educational background might influence awareness, comprehension, and adoption considerations regarding strategic performance reporting systems. Other demographic attributes collected in this study, while not central to the current analysis, offer valuable context for future research that may explore additional factors influencing BSC awareness, comprehension, and adoption.

**Table 7**

*Demographic Attributes*

Attribute	Category	Frequency	Percentage
Current Role/Position	Upper Management	4	11.1%
	Middle Management	12	33.3%
	Frontline Management	15	41.7%
	Other/Not Specified	5	13.9%
Highest Level of Education	Associate Degree	1	2.78%
	Bachelor's Degree	10	27.78%
	Master's Degree	12	33.3%
	Doctoral or Professional Degree	7	19.44%
	Not Specified	6	16.67%

***Research Question 1: In what ways do leadership and management demonstrate awareness and comprehension of the BSC?***

The first research question explored how leadership and management demonstrate awareness and comprehension of the BSC. Analysis revealed varying levels of familiarity with the BSC framework, ranging from complete unfamiliarity to sophisticated understanding. Three

major themes emerged: (1) Limited BSC Awareness, (2) Varied Depth of BSC Comprehension, and (3) Diverse Strategic Management Tool Experience.

Table 8 summarizes the three key themes related to RQ1, examining BSC awareness and comprehension across the organization. Frontline managers constituted the majority of participants expressing limited BSC awareness (11 participants) and varied comprehension (1 participant). Participants with bachelor's degrees most frequently reported limited BSC awareness, while those with master's degrees predominantly discussed both varied comprehension and experience with alternative tools. Experience with alternative tools was the most widely mentioned theme (31 participants) across all leadership levels. Middle managers showed moderate levels of BSC awareness and comprehension. Upper management demonstrated the highest levels of BSC awareness and comprehension relative to their representation in the sample.

**Table 8**

*Thematic Overview of RQ1*

Theme	Constituent code(s)	Participants mentioning theme (n = 36)	Upper (4)	Middle (12)	Front-line (15)	Other (5)	Most-cited education level
1.1 Limited BSC awareness	BSC Awareness	21	1	5	11	4	Bachelor's
1.2 Varied depth of BSC comprehension	BSC Comprehension	8	3	3	1	1	Master's
1.3 Diverse strategic management tool experience	Strategic Tools Experience; Current Measurement Practices	31	3	8	15	5	Master's

The following sections examine each of these three themes in detail, providing specific examples from participant interviews and questionnaires. Each theme is analyzed according to participants' responses and also through the lens of organizational level and educational background. Direct quotes from participants illustrate the variations in BSC awareness and comprehension across different segments of the organization's leadership structure and education level.

**Theme 1.1: Limited BSC Awareness.** Analysis of participant responses revealed that 21 out of 36 participants (58%) indicated unfamiliarity with the BSC framework. Participants directly stated their lack of awareness with responses such as "Not familiar with this" (Participant 2), "I do not know anything about Balanced Scorecard framework" (Participant 14), "This is the first time hearing about it" (Participant 16), "no" (Participant 5), and "I have zero understanding of the BSC" (Participant 28). Moreover, some participants admitted complete unfamiliarity with statements like "I don't have any knowledge of it but am interested in it" (Participant 24) and "I do not know what the BSC framework is" (Participant 26). This pattern of limited awareness was widespread throughout the organization, suggesting a significant knowledge gap regarding this strategic framework. Several participants confused the BSC with other reporting tools or metrics, further demonstrating the lack of clear understanding about the framework's distinct approach to balanced performance measurement.

When examining how BSC awareness varied across the organizational levels, patterns emerged in the distribution of knowledge about the BSC framework. The data revealed notable differences in familiarity with the BSC among participants based on their positions within the organization's leadership and management structure. Frontline managers were most likely to report unfamiliarity with the BSC, with 11 out of 15 participants expressing limited awareness

through statements such as “Not familiar with this” (Participant 2) and “I do not know what that is” (Participant 14). Middle managers demonstrated slightly better awareness, though still limited, with 5 out of 12 participants expressing unfamiliarity: “I do not know anything about balanced scoreboard framework. This is the first time hearing about it” (Participant 17). Interestingly, one middle manager noted: “The KPIs are financial and based on my understanding, would not qualify as a balanced scorecard” (Participant 12), indicating some awareness of what the BSC is not, but lacking comprehensive understanding of what it is. Upper management showed the highest relative awareness, with only 1 participant indicating limited knowledge of the BSC framework.

When examining awareness by educational background, bachelor’s degree holders most frequently demonstrated limited BSC awareness. This educational cohort represented the largest segment of participants expressing unfamiliarity with the BSC framework, with statements such as “Not familiar with this” (Participant 2) and “I understand that it a way to measure success but am not familiar with details” (Participant 25). Of the 21 participants reporting limited BSC awareness, the majority held bachelor’s degrees, pointing to a potential gap in strategic management education at this level. Participants with master’s degrees demonstrated slightly higher BSC awareness than those with bachelor’s degrees, though the difference was modest. One frontline manager with a master’s degree stated, “I am not familiar with the balanced scorecard specifically” (Participant 17). Doctoral degree holders showed variable awareness, with some having sophisticated understanding and others complete unfamiliarity.

In summary, Theme 1.1 revealed a knowledge gap regarding the BSC framework across the organization, with 58% of participants (21 out of 36) indicating unfamiliarity with the BSC. This limited awareness was most pronounced among frontline managers, where 11 participants

expressed a lack of familiarity with the framework, while middle management showed moderate awareness gaps (5 participants), and upper management demonstrated the highest relative awareness (only 1 participant with limited knowledge). The educational analysis indicated that bachelor's degree holders most frequently demonstrated limited BSC awareness, while participants with master's degrees showed slightly higher awareness levels. Doctoral degree holders displayed variable levels of understanding across the spectrum. Several participants across all organizational levels demonstrated confusion between the BSC and other reporting tools or possessed only partial understanding of the framework.

**Theme 1.2: Varied Depth of BSC Comprehension.** Analysis of participant responses revealed that 8 out of 36 participants (22%) demonstrated some level of comprehension of the BSC framework, though the depth of understanding varied considerably. The data showed a range from sophisticated comprehension of the framework's core principles to rudimentary awareness of its basic purpose. Specific aspects of BSC comprehension that varied among participants included knowledge of the four BSC perspectives, understanding of how the BSC aligns organizational strategy with measurements, and familiarity with practical applications of the framework in healthcare settings. Participants with sophisticated understanding articulated knowledge of the BSC's multidimensional approach with statements such as: "The balanced scorecard is a strategic management framework that helps organizations translate their vision and strategy into measurable objectives across four key perspectives: financial, customer (or patient), internal processes, and learning and growth" (Participant 13) and "Not just from a financial sustainability perspective, but also by looking at patient care, operational efficiency, and employee growth during their employment" (Participant 11).

When examining BSC comprehension across organizational levels, the data revealed distinct patterns in the distribution of understanding about the BSC framework. Upper management participants demonstrated the highest level of comprehension, with 3 out of 4 upper managers (75%) showing understanding through statements such as: “We utilize a BSC framework to drive the continuum of care and achieve our objectives to include quality and patient access amongst other identified goals” (Participant 28). Frontline management exhibited the lowest level of comprehension, with only 1 out of 15 (7%) demonstrating understanding, though those who did often showed sophisticated knowledge: “My understanding of a BSC framework is that the organization translates goals into strategic activities/actions that cascade throughout the organization” (Participant 12). Middle managers showed significant variation, with 3 out of 12 (25%) demonstrating some understanding, ranging from basic descriptions like “An approach to maintain focus and direction with planning” (Participant 18) to more detailed explanations: “The BSC checks how things are going in four areas, money, patients, how work gets done, and associate learning and improvement” (Participant 16).

Analysis of educational backgrounds revealed that master’s degree holders most frequently demonstrated BSC comprehension. Participants with master’s degrees articulated practical applications in healthcare settings: “In healthcare, it’s used to track cycle times, provider productivity, financial performance, and staff development” (Participant 7). Doctoral degree holders who demonstrated BSC comprehension typically showed the most detailed understanding of the framework, providing comprehensive definitions and noting organizational alignment: “I think that using a more balanced approach at [health system name redacted] also supports the mission based aspect of our health system, because there are goals related to social justice” (Participant 12). Bachelor’s degree holders displayed the widest variation in

comprehension levels, ranging from detailed understanding with specific examples across multiple BSC perspectives to minimal awareness of the framework's purpose.

In summary, Theme 1.2 revealed that while 22% of participants demonstrated some level of BSC comprehension, the depth and sophistication of understanding varied significantly across the organization. Upper management showed the highest proportion of comprehension (75%), followed by middle managers (25%), and frontline managers (7%). Educational background analysis indicated that participants with master's degrees most frequently demonstrated BSC comprehension, while doctoral degree holders showed the most detailed understanding of the framework's principles, and bachelor's degree holders displayed the widest variation in comprehension levels. The data showed that both organizational role and educational background influenced participants' BSC comprehension, suggesting uneven exposure to this strategic management framework throughout the organization.

**Theme 1.3: Diverse Strategic Management Tool Experience.** Analysis of participant responses revealed that 31 out of 36 participants (86%) described experience with various strategic performance management tools other than the BSC. These alternative tools ranged from formal methodologies such as Lean Six Sigma to organization-specific dashboards and key performance indicators (KPIs). Participants described their experience with dashboards and software platforms: "We use a tool to manage labor called Laborlytics" (Participant 30) and "I rely on data analytics in Power BI to track key performance metrics like patient flow and provider productivity" (Participant 9). Others mentioned formal strategic frameworks: "I have used the Plan-Do-Study-Act (PDSA) cycle in my DNP practice change project to evaluate the impact of SBAR on nurse handoff communication" (Participant 13) and "I use SWOT analysis and benchmarking throughout the years" (Participant 14). Additionally, participants noted

specific applications: “Benchmarking-Huddle boards to track specific department metrics (targets/actuals)” (Participant 22) and “KPI tracking is vital to our strategic goals” (Participant A).

Experience with alternative tools varied across organizational levels. Upper management participants (3 out of 4, 75%) described experience with strategic management tools: “My experience has been positive and productive with strategic management tools as I have encountered them in my early work as a clinician in hospital settings as progressively as an administrator in various roles” (Participant 1). Middle managers demonstrated moderate engagement with alternative tools (8 out of 12, 67%), often describing specific methodologies: “I was trained as a green belt six sigma” (Participant 13) and “As a Supply Chain professional there is a constant horizon look to ensure disruptions within the supply chain do not adversely effect our organization” (Participant 10). Frontline managers demonstrated the highest proportional experience with alternative tools among all participant groups, with all respondents in this category (15 out of 15) reporting use of multiple tools, particularly for operational applications: “We use strategic management tools to optimize operations across multiple ER locations” (Participant 16) and “I have used strategic management tools to track KPI data” (Participant 29).

When analyzed by educational background, participants with master’s degrees most frequently reported experience with alternative strategic tools. These participants described applications and multiple tools: “As a Project Manager, it’s common to have other departments, leadership team members, and your own department resource to bring in tools that help best align with a project/team that you are supporting” (Participant 22) and “I also apply Lean principles to streamline workflows and enhance efficiency” (Participant 13). Doctoral degree holders demonstrated diverse tool experience, mentioning formal methodologies: “I have applied

tools such as SWOT analysis to assess program strengths and identify opportunities for improvement in nursing education” (Participant A). Bachelor’s degree holders showed varied experience with alternative tools, mentioning organization-specific applications: “We used strategic management tools like Power BI reports and monthly reports provided from strategic team to managers/leaders” (Participant 5) and “I use my quality management team to help develop planning elements like SWOT analysis, goal setting, and stakeholder involvement to develop actionable strategies” (Participant 19).

In sum, Theme 1.3 showed that 86% of participants had experience with alternative performance management tools, representing the most commonly reported theme across RQ1. This experience was distributed across all organizational levels, with frontline managers showing particularly high exposure to multiple tools (15 of 15). Master’s degree holders most frequently reported experience with alternative tools, though substantial experience was evident across all educational levels. The tools mentioned ranged from formal methodologies (Lean Six Sigma, SWOT analysis, PDSA cycles) to specific software platforms (Power BI, Laborlytics) and organization-wide frameworks (KPIs, dashboards). Unlike the more variable awareness and comprehension dimensions of the BSC framework, alternative strategic tools appeared to be widely used throughout the organization across all positions and educational backgrounds.

***Research Question 2: How do leadership and management perceive the adoption criteria for the BSC or other strategic performance reporting systems?***

The second research question investigated how management and leadership perceive the adoption criteria for the BSC or other strategic performance reporting systems. Analysis revealed an array of factors that influence the adoption of strategic performance frameworks in healthcare organizations. Four major themes emerged from the data: (1) Adoption Criteria and

Implementation Facilitators, (2) Implementation Barriers, (3) Organizational Decision-Making Processes, and (4) Future Directions and Expectations.

Table 9 summarizes the four key themes related to RQ2, examining adoption criteria, implementation factors, decision-making processes, and future expectations across the organization. Adoption criteria and implementation facilitators were the most frequently mentioned theme (29 participants), followed by organizational decision-making processes and future directions and expectations (27 participants each), with implementation barriers mentioned by 25 participants. Frontline managers constituted the majority of participants discussing adoption criteria and implementation facilitators (15 participants), implementation barriers (10 participants), organizational decision-making processes (14 participants), and future directions and expectations (14 participants). Middle managers showed consistent engagement across all themes, with 9 participants discussing adoption criteria and implementation facilitators, 9 discussing implementation barriers, 8 discussing organizational decision-making processes, and a further 9 discussing future directions and expectations. Participants with master's degrees predominantly contributed to the themes of adoption criteria and implementation facilitators, implementation barriers, and future directions and expectations, while both bachelor's and master's degree holders equally contributed to organizational decision-making processes. Upper management demonstrated consistent engagement across all four themes, with 2 participants represented in each thematic area.

The following sections examine each of these four themes in detail, providing specific examples from participant interviews and questionnaires. Each theme is analyzed according to participants' responses and also through the lens of organizational level and educational background. Direct quotes from participants illustrate the variations in perceptions of adoption

criteria, implementation factors, decision-making processes, and future expectations across different segments of the organization's leadership structure and education level.

**Table 9**

*Thematic Overview of RQ2*

Theme	Constituent code(s)	Participants mentioning theme (n = 36)	Upper (4)	Middle (12)	Front-line (15)	Other (5)	Most-cited education level
2.1 Adoption criteria & implementation facilitators	Adoption Criteria; Implementation Facilitators; Training Exposure; Implementation Advice; Financial Dominance	29	2	9	15	3	Master's
2.2 Implementation barriers	Implementation Barriers; Distrust / Cynicism; Time Constraints; Fade Effect	25	2	9	10	4	Master's
2.3 Organizational decision-making processes	Decision Making Process; Disconnected Decision-Making	27	2	8	14	3	Bachelor's / Master's (tie)
2.4 Future directions & expectations	Future Expectations; Anticipation of AI	27	2	9	14	2	Master's

**Theme 2.1: Adoption Criteria and Implementation Facilitators.** Analysis of participant responses revealed that 29 out of 36 participants (81%) identified specific adoption criteria and implementation facilitators for strategic performance reporting systems. The adoption criteria mentioned varied widely but centered around several key areas: system usability, demonstrated value, alignment with organizational goals, and proper training and education. Participants described the importance of user-friendly systems: "Being user friendly

and intuitive is essential” (Participant 1) and “For managers who are already so busy, it is important that it is easy to interpret, easy to use” (Participant 11). Others highlighted alignment with organizational objectives: “If it addresses specific challenges and goals within the organization while aligning with our mission and values” (Participant 9) and “The framework must align with long-term objectives and mission of the organization” (Participant 14). Implementation facilitators mentioned by participants included education, leadership support, and stakeholder engagement: “Education, education, education” (Participant 20), “Strong leadership, organizational culture, resources, employee engagement are supporting factors” (Participant 14), and “Asking the right questions and making sure to capture the correct audience is crucial to successfully implementing a new system as well as gaining staff buy in” (Participant 30).

Across organizational levels, frontline managers constituted the majority of participants (15 out of 15, 100%) discussing this theme. Frontline managers identified practical criteria such as ease of use and training: “Leadership buy in; staff education and buy in for anything new as well as support once the process is initiated” (Participant B) and “Education and hands on learning” (Participant 8). They also specified value criteria: “Improves efficiency and client outcomes” (Participant 2) and “Improve patient outcomes? Improve efficiency? Improve patient satisfaction?” (Participant 6). Middle managers (9 out of 12, 75%) identified strategic alignment factors: “A framework would need to cost the same or less to implement and operate, and meet the criteria of being good at producing data that can be adapted to audiences at every level of the organization” (Participant 12) and “Clear strategic alignment, leadership commitment and support, adequate resources, training and development, change management, reliable data, and ongoing review and adaptation” (Participant 14). Upper management participants (2 out of 4,

50%) specified system attributes: “Being reliable, adaptable, user friendly and intuitive are essential criteria” (Participant 1).

Analysis by educational background showed that participants with master’s degrees most frequently discussed adoption criteria and implementation facilitators. Master’s degree holders specified comprehensive implementation requirements: “Collaborative leadership, comprehensive understanding of strategic measurement system by all levels, effective communication, communication and understanding of the why thorough education of key stakeholders that are responsible for measuring, analyzing, utilizing, interpreting, etc. any data” (Participant 6). Doctoral degree holders identified leadership and organizational factors: “Every single person needs to see how their role fits into the big picture, and why what they do matters” (Participant 12) and “I would suggest a crucial condition must be the understanding portion. By that, I mean to say all stakeholders must be informed not only on the technical aspect of how the platform works, but on the why is this is beneficial to us as an organization” (Participant 10). Bachelor’s degree holders identified implementation prerequisites: “We must have a clear goal and have admin support to help drive the change” (Participant 3) and “Value: If the new strategic framework adds value to patient care, to employees and saves money for the healthcare system overtime” (Participant 21).

In sum, Theme 2.1 showed that a substantial majority of participants (81%) identified specific adoption criteria and implementation facilitators for strategic performance reporting systems. The criteria focused on system usability, demonstrated value, alignment with organizational goals, and proper training and education. Frontline managers unanimously discussed practical considerations like ease of use and effective training, while middle managers focused more on strategic alignment and organizational integration. Educational background

analysis revealed that master's degree holders contributed most frequently to this theme, specifying comprehensive implementation approaches. The data showed multiple types of adoption criteria and implementation facilitators that varied by both organizational level and educational background of the participants.

**Theme 2.2: Implementation Barriers.** Analysis of participant responses revealed that 25 out of 36 participants (69%) identified specific barriers to implementing strategic performance reporting systems in healthcare settings. The implementation barriers mentioned clustered around several recurring challenges: resistance to change, lack of time and resources, insufficient training, and organizational complexity. Participants frequently cited resistance to change as a significant obstacle: "I would suggest one factor is the if it is not broken, we do not need to fix type of attitude" (Participant 10) and "I think there are times where team members feel as though new initiatives are going to cause more work instead of streamlining or reducing work rations" (Participant 20). Time and resource constraints were also prominently mentioned: "Technology has provided more options than most institutions have time to vet" (Participant 1) and "So often I see managers just trying to keep up with the demands of their job, their team members needs, leadership focused projects, and more" (Participant 22). Other barriers included organizational complexity: "We are a huge organization and it is difficult when making changes to connect everyone needed" (Participant 3) and "Because everything is metro or [health system name redacted] wide, it makes it harder for specific facilities to make changes that affect their sites" (Participant 11).

Implementation barriers varied across organizational levels. Frontline managers (10 out of 15, 67%) frequently identified practical barriers related to day-to-day operations: "Staff acceptance and hesitation toward change as well as the approach by leadership play a big role in

the support or hinderance when implementing new strategies” (Participant 30) and “I find time and time again when people don’t fully understand the why behind a new measurement they tend to push back on its implementation” (Participant 20). Middle managers (9 out of 12, 75%) identified both organizational and cultural barriers: “Within the Foundation we would struggle with new strategic initiatives because we have a very narrow focus on increasing revenue which leaves no breathing room for innovation” (Participant 12) and “academic settings tend to move slowly, working within a health system having to deal with all the steps” (Participant 13). Upper management participants (2 out of 4, 50%) highlighted systemic challenges: “Technology has provided more options than most institutions have time to vet and it makes it difficult to determine which tools works best based on the skillset of the team, sophistication of the organization, and the ability of the culture to see the need for a new system” (Participant 1) and “Inconsistent and limited communication, organizational leadership culture, levels of leaders engaged, and historical barriers of damaged trust” (Participant 32).

Educational background analysis showed that participants with master’s degrees most frequently discussed implementation barriers. Master’s degree holders identified complex organizational challenges: “It’s not often they can pause to even think strategically” (Participant 22) and “Culture/Time - Culture as we have people who have ‘always done it this way’ that are reluctant to change” (Participant 22). Doctoral degree holders often focused on systemic and cultural barriers: “Without measures that are not financial and are not strictly ‘post-mortem strategic tools lose their impact” (Participant 12) and “What hindered? Was the actual administration itself?” (Participant A). Bachelor’s degree holders highlighted practical implementation challenges: “Just a guess, but I would say knowledge, experience in how to

initiate the process” (Participant 4) and “We have lots of layers of people that need to come together to make a meeting happen” (Participant 3).

In summary, Theme 2.2 revealed that a significant majority of participants (69%) identified implementation barriers to strategic performance reporting systems. The barriers identified included resistance to change, lack of time and resources, insufficient training, and organizational complexity. Frontline managers focused on day-to-day operational barriers, while middle managers identified both organizational and cultural obstacles. Upper management highlighted technology selection challenges and organizational culture constraints. Educational background analysis showed that participants with master’s degrees most frequently discussed implementation barriers, often identifying complex organizational challenges. Doctoral degree holders tended to focus on systemic barriers, while bachelor’s degree holders emphasized practical implementation obstacles. The data indicated that implementation barriers occurred at multiple levels (individual, team, and organization wide) and varied by both organizational position and educational background of the participants.

**Theme 2.3: Organizational Decision-Making Processes.** Analysis of participant responses revealed that 27 out of 36 participants (75%) described organizational decision-making processes related to the adoption of strategic performance reporting systems. Participants’ descriptions encompassed both formal decision-making approaches and perceptions of disconnection between decision makers and implementers. Many participants described hierarchical decision-making structures: “Executives are making all the decisions with little effort to acquire buy in from even mid-tier management, let alone ground level employees” (Participant 28) and “A lot of decisions about adopting new strategic management tools or frameworks come from corporate level that then get communicated down to each of the markets”

(Participant 23). Others highlighted the role of committees or leadership teams: “It goes to admin council or operations council for review” (Participant 3) and “I believe there is a committee” (Participant 4). Several participants expressed uncertainty about decision-making processes: “I am unsure” (Participant 7) and “Unsure” (Participant 29). Some noted a disconnect between decision makers and frontline staff: “The tools used are usually chosen at the high level in the organization and they roll down to middle management” (Participant 27) and “The decisions come from the head and down to me from my manager, for me to pass on to my direct reports” (Participant 21).

Organizational decision-making processes varied across organizational levels. Frontline managers (14 out of 15, 93%) frequently described top-down decision processes and expressed uncertainty about how decisions were made: “For us it typically goes from the unit, to management, to administration” (Participant 11) and “This is done at the upper administrative level” (Participant 9). Several frontline managers noted disconnection in decision-making: “I would hope if they do try to adopt something that they would talk to the end users” (Participant B) and “Decisions are usually directed down for me to implement” (Participant 9). Middle managers (8 out of 12, 67%) described more detailed decision-making processes, though still predominantly top-down: “The decisions about our financial performance goals are made by leaders in collaboration with our Boards” (Participant 12) and “I believe it’s gonna be upper management. It’s gonna make that decision” (Participant A). Upper management participants (2 out of 4, 50%) provided fewer specifics about decision-making processes: “staying up on top of the current trends” (Participant 28) and “Mid-level managers and their teams are the producers of our product and their comfort and acceptance with a new system is a key factor in decisions about adopting new tools or frameworks” (Participant 1).

Educational background analysis showed that both bachelor's and master's degree holders frequently discussed organizational decision-making processes with equal representation. Bachelor's degree holders often described perceptions of disconnected decision-making: "It is VERY top down" (Participant 28) and "Decisions are usually directed down for me to implement" (Participant 9). They also expressed uncertainty about decision processes: "I really don't know how that is done from the top levels" (Participant B). Master's degree holders provided more detailed descriptions of formal processes: "We decide on new strategic management tools through team collaboration and a focus on improving both efficiency and patient care" (Participant 16) and "I feel like there is a lot of thoughtful insight gathered before changes are made" (Participant 20). Doctoral degree holders described institutional decision-making patterns: "I do believe involvement will be from top to bottom in developing the KPIs" (Participant A) and "If we wanted to adopt a new tool or framework I think that decision would likely be made at the president level, but he would consult with [health system name redacted] leaders and peers who have familiarity with the tool" (Participant 12).

In sum, Theme 2.3 revealed that a significant majority of participants (75%) described organizational decision-making processes related to strategic performance systems. The descriptions predominantly characterized hierarchical, top-down approaches to decision-making, with many participants perceiving disconnection between decision makers and implementers. Frontline managers most frequently discussed this theme (93%), often expressing uncertainty about how decisions were made or describing decisions as directives to be implemented. Middle managers provided more detailed descriptions of formal processes but similarly characterized them as primarily top-down. Educational background analysis showed that both bachelor's and master's degree holders frequently discussed decision-making processes, with bachelor's degree

holders more often noting disconnection and master's degree holders providing more detail about formal processes. The data showed that decision-making was widely perceived as hierarchical with limited input from frontline staff, though experiences varied somewhat by organizational level and educational background.

**Theme 2.4: Future Directions and Expectations.** Analysis of participant responses revealed that 27 out of 36 participants (75%) discussed future directions and expectations for strategic performance measurement systems in healthcare. The responses encompassed anticipated technological advances, evolving measurement priorities, and predictions about healthcare performance management. Many participants expressed expectations about the increasing role of technology, particularly artificial intelligence: "I think that AI will be huge in moving the needle" (Participant 11) and "I think finding ways to track performance in real time as much as possible is going to be key and probably leveraging AI to assist with that will be the way of the future" (Participant 7). Others anticipated shifts in measurement focus: "Healthcare organizations will need to adopt more real-time data analytics, patient-centered metrics, and value-based performance indicators to measure and manage strategic performance" (Participant 13) and "As healthcare evolves, organizations will need to continue to shift their performance measurement toward the patient experience across the entire care continuum" (Participant 19). Several participants noted expectations for increased accountability: "Accountability from leadership in all areas" (Participant 22) and "I think unfortunately there is going to be tighter and tighter grasp on strategic performance and I hope we can avoid micromanagement of this" (Participant 7).

Future directions and expectations varied across organizational levels. Frontline managers (14 out of 15, 93%) frequently anticipated technological changes and patient-centered

metrics: “As technology advances, I also anticipate a greater focus on predictive analytics to drive proactive improvements and help organizations stay agile in a rapidly changing healthcare landscape” (Participant 16) and “Things are constantly changing in healthcare. We are always looking for advanced ways to improve and provide the highest quality of care to the people we serve while maintaining compliance” (Participant 30). Other frontline managers noted specific technological applications: “They already have new devices like EKO stethoscopes that can take an EKG and give a definitive diagnosis for things like murmurs” (Participant 11). Middle managers (9 out of 12, 75%) focused on strategic and systemic changes: “With the rise of AI, predictive analytics, and digital health tools, organizations will shift toward proactive decision-making rather than reactive assessments” (Participant 13) and “Additionally, increasing emphasis on health equity, patient outcomes, and workforce well-being will drive a more holistic approach to performance measurement” (Participant 23). Upper management participants (2 out of 4, 50%) anticipated technological evolution: “I believe AI will be influential in this space” (Participant 28) and “More training for teams and more sophisticated team members who are charged with managing these new systems coming in the future” (Participant 1).

Educational background analysis showed that participants with master’s degrees most frequently discussed future directions and expectations. Master’s degree holders often anticipated technological advancements and system integration: “Tools will become more integrated, allowing for quicker decision-making based on patient outcomes, financial health, and operational efficiency” (Participant 16) and “I think it will be more length of stay and patient progress based in the future using measurement tools with AI” (Participant 31). Bachelor’s degree holders focused on practical applications and quality concerns: “I think the best managed healthcare systems will be the ones that are most successful” (Participant 21) and “There will

likely be a stronger emphasis on patient satisfaction and care quality metrics, alongside traditional financial indicators” (Participant 26). Doctoral degree holders discussed broader healthcare trends: “I anticipate that healthcare will also have to spend most of its time managing costs, and nearly all strategies will have to flow from that requirement” (Participant 12) and “Measuring and managing strategic performance should be enhanced by data analytics with more importance in the future” (Participant A).

In summary, a majority of participants (75%) discussed future directions and expectations for strategic performance systems in healthcare. The responses predominantly anticipated technological advancements, particularly the integration of artificial intelligence, alongside shifts toward more patient-centered metrics and real-time analytics. Frontline managers most frequently discussed this theme (93%), often focusing on technological changes and patient-centered approaches. Middle managers emphasized strategic and systemic changes in healthcare measurement, while upper management anticipated the need for technological sophistication. Educational background analysis showed that participants with master’s degrees most frequently discussed future directions, often emphasizing technological advancements and system integration. The data revealed consistent expectations for technology-driven evolution in healthcare performance measurement, with varying emphasis on specific applications and implications depending on organizational role and educational background.

### **Evaluation of the Findings**

The findings of this study provide insights into BSC awareness, comprehension, and adoption criteria among healthcare leaders and managers within a multistate non-profit healthcare system. This section interprets the results in relation to the study’s theoretical framework integrating diffusion of innovations theory (Rogers, 1962), institutional theory

(DiMaggio & Powell, 1983), and resource-based view theory (Barney, 1991). The evaluation is organized by research question and developed themes to examine how the findings align with or diverge from existing theoretical predictions and empirical research.

***Research Question 1: In what ways do management and leadership demonstrate awareness and comprehension of the BSC?***

**Theme 1.1: limited BSC awareness.** The finding that 58% of participants demonstrated unfamiliarity with the BSC framework aligns with the initial knowledge stage of Rogers' (1962) diffusion of innovations theory, which suggests that awareness represents the critical first step in the innovation-decision process. According to diffusion theory, individuals must first gain exposure to and understanding of an innovation's existence before progressing through subsequent stages of persuasion, decision, implementation, and confirmation (Rogers, 2003). The widespread lack of BSC awareness observed in this study suggests that this strategic management innovation has not successfully penetrated the communication and training channels within the healthcare organization, limiting its potential for adoption (Rogers, 2003). This finding is particularly significant given that the BSC has been recognized as one of the most influential management concepts of the past 75 years (Quesado et al., 2018) yet remains largely unknown to the majority of healthcare leaders and managers in this study.

From an organizational perspective, the hierarchical distribution of BSC awareness reflects institutional theory's emphasis on how knowledge and practices diffuse unevenly through organizational structures based on power dynamics and communication patterns (DiMaggio & Powell, 1983). The finding that upper management demonstrated the highest relative awareness (75% familiar) while frontline managers showed the lowest awareness (30% familiar) suggests that strategic management innovations may be concentrated at higher

organizational levels without effective mechanisms for cascading knowledge throughout the organization. This pattern aligns with institutional theory's concept of decoupling, where formal structures and practices adopted at the executive level may not penetrate operational levels (Meyer & Rowan, 1977). The moderate awareness among middle managers (58% unfamiliar) suggests a breakdown in transferring strategic management knowledge between organizational levels, creating what institutional theorists call loose coupling between these levels (Weick, 1976). This pattern of BSC awareness across organizational levels suggests institutional pressures affecting mainly upper management through professional networks, board interactions, and industry conferences, while leaving frontline managers disconnected from these influences (Scott, 2008).

The educational analysis reveals a pattern that partially contradicts resource-based view theory's predictions about the relationship between human capital and strategic capability development. While resource-based view theory suggests that higher levels of education represent valuable human capital resources that enhance an organization's capacity to adopt and implement strategic innovations (Barney, 1991), the findings show a more complex relationship. Although bachelor's degree holders demonstrated the most limited BSC awareness, the variable awareness among doctoral degree holders challenges the linear relationship between educational attainment and strategic knowledge advanced by resource-based view theory. The slightly higher awareness among master's degree holders compared to bachelor's degree holders provides some support for resource-based view predictions, but the overall pattern suggests that educational credentials as human capital resources do not automatically translate into awareness of strategic management innovations.

**Theme 1.2: varied BSC comprehension.** The finding that only 22% of participants demonstrated BSC comprehension, ranging from basic awareness to sophisticated understanding of all four perspectives, reflects the persuasion and knowledge stages of Rogers' (2003) diffusion of innovations theory. During these stages, individuals develop attitudes toward innovations based on their understanding of attributes like relative advantage, compatibility, and complexity (Rogers, 1962). The observed variation from simple descriptions to comprehensive explanations illustrates the non-uniform nature of knowledge acquisition during diffusion (Rogers, 2003). This limited comprehension rate suggests that few participants have progressed sufficiently through the knowledge stage to develop the understanding necessary for implementation, constraining the BSC's potential diffusion throughout the organization (Dearing & Cox, 2018).

The difference in understanding, with 75% of upper management versus 7% of frontline managers demonstrating understanding, exhibits institutional theory's predictions about knowledge concentration at organizational top levels through standardizing pressures (DiMaggio & Powell, 1983). Senior leaders' exposure to normative pressures through professional networks and industry conferences creates knowledge disparities, while middle managers' moderate comprehension (25%) reflects their position between executive and operational levels (Scott, 2008). This difference shows that organizational knowledge transfer processes may have failed to close understanding gaps between organizational levels.

The relationship between education and BSC comprehension partially supports resource-based view theory's assertions about human capital as a strategic resource (Barney, 1991). Master's degree holders most often understood the BSC, while doctoral degree holders showed the deepest understanding, aligning with resource-based view predictions that advanced education enhances understanding of strategic frameworks. However, the wide variation among

bachelor's degree holders and overall low comprehension rates across all educational levels challenge assumptions about credentials as reliable knowledge indicators. This pattern suggests the organization has not effectively used its employees' education and skills to develop understanding of strategic frameworks, showing a disconnect between educational backgrounds and strategic knowledge that weakens the organization's ability to adopt innovations (Grant, 1996; Teece et al., 1997).

**Theme 1.3: experience with alternative tools.** The finding that 86% of participants reported experience with various strategic performance tools beyond the BSC aligns with diffusion of innovations theory's concept of trialability, where exposure to related innovations influences receptivity to new frameworks (Rogers, 2003). The widespread use of tools ranging from formal methodologies like Lean Six Sigma and SWOT analysis to specific software platforms such as Power BI and Laborlytics suggests that participants have developed familiarity with performance measurement concepts, even without BSC exposure. This extensive experience with alternative tools may represent what Rogers (1962) describes as innovation clusters, where related practices diffuse together within organizational systems. However, the disconnect between high alternative tool usage (86%) and low BSC awareness (58%) indicates that experience with related innovations does not automatically translate to awareness of other strategic frameworks.

The universal experience with alternative tools among frontline managers (100%) compared to their limited BSC awareness (30%) reveals institutional theory's concept of selective adoption, where organizations embrace certain practices while remaining unaware of others (DiMaggio & Powell, 1983). This pattern suggests that tool adoption may be driven more by operational needs and pressure to copy industry-standard practices than by thorough strategic

planning (Boxenbaum & Jonsson, 2008). The consistent tool usage across all organizational levels shows successful implementation of operational performance tools, contrasting sharply with the differences in BSC awareness and comprehension across levels. This difference suggests that strategic tools may spread through organizations in different ways, with operational tools spreading through practical needs while comprehensive frameworks like the BSC stay limited to executive levels.

The finding that master's degree holders most frequently reported experience with alternative tools, while substantial experience existed across all educational levels, suggests that operational tool usage transcends educational boundaries in ways that BSC knowledge does not. From a resource-based view perspective, this universal tool experience represents distributed operational capabilities that the organization has successfully developed across its human capital base (Barney, 1991). However, the widespread use of alternative tools alongside limited BSC awareness shows that these operational skills have not led to adopting strategic frameworks. This pattern suggests that while the organization has technical skills in using performance measurement tools, it may lack the advanced capabilities needed to recognize, evaluate, and integrate comprehensive strategic frameworks like the BSC (Teece et al., 1997).

***Research Question 2: How do leadership and management perceive the adoption criteria for the BSC or other strategic performance reporting systems?***

**Theme 2.1: Adoption criteria and implementation facilitators.** The finding that 81% of participants identified adoption criteria centered on system usability, demonstrated value, organizational alignment, and training directly reflects diffusion of innovations theory's emphasis on perceived innovation attributes (Rogers, 2003). Participants' focus on user-friendliness aligns with Rogers' (1962) concept of complexity as a critical adoption barrier,

while emphasis on demonstrated value and organizational alignment reflects the relative advantage attribute, the strongest predictor of adoption rates. The prominence of training as an implementation facilitator supports diffusion theory's assertion that knowledge and how-to information must accompany innovation introduction (Green & Kreuter, 2005). This detailed listing of criteria suggests participants have clear expectations about strategic system implementation requirements, even when lacking specific BSC knowledge.

The universal discussion of adoption criteria among frontline managers (100%) versus lower engagement from upper management (50%) shows the opposite pattern from awareness levels. From an institutional theory perspective, frontline managers' emphasis on practical criteria reflects their position as implementation agents experiencing coercive pressures to adopt systems without participating in selection decisions (DiMaggio & Powell, 1983). Middle managers' focus on strategic alignment indicates their bridging role between institutional pressures and operational realities. Upper management's lower engagement may reflect assumptions that organizational acceptance alone drives adoption, potentially overlooking implementation challenges identified by operational staff (Meyer & Rowan, 1977).

The concentration of adoption criteria discussions among master's degree holders aligns with resource-based view predictions about human capital contributing to strategic capabilities, but with an operational focus (Barney, 1991). Their detailed description of requirements shows their ability to apply educational knowledge to implementation. Doctoral degree holders' emphasis on organizational understanding reflects advanced analytical skills that recognize adoption as both a technical and organizational process. However, bachelor's degree holders' identification of practical requirements suggests implementation knowledge comes as much from

operational experience as from formal education, challenging explanations based human capital theory and by extension resource-based view theory (Barney, 1991; Becker, 1993).

**Theme 2.2: Implementation barriers.** The finding that 69% of participants identified implementation barriers including resistance to change, time and resource constraints, insufficient training, and organizational complexity aligns with diffusion of innovations theory's recognition that innovation attributes interact with organizational conditions to affect adoption (Rogers, 2003). Participants' frequent citation of "if it is not broken, we do not need to fix" attitudes exemplifies what Rogers (1962) terms innovation resistance, where perceived risks and uncertainties emerge during the decision stage. Time and resource constraints reflect the organizational resources needed for adoption as described in diffusion theory, while insufficient training shows knowledge barriers that slow the adoption process. The identification of organizational complexity as a barrier aligns with diffusion theory's focus on how organizational characteristics affect the spread of innovations (Rogers, 2003).

The differences in barrier identification across organizational levels shows institutional theory's predictions about how coercive, normative, and mimetic pressures appear differently across organizational structures (DiMaggio & Powell, 1983). Frontline managers' focus on operational barriers and staff resistance (67%) shows how they face coercive institutional pressures; they must implement mandated changes without authority to modify them, creating tension between institutional demands and operational realities. Middle managers identified both organizational and cultural barriers (75%), particularly the "narrow revenue focus" that "leaves no breathing room for innovation" (Participant 12), showing how mimetic pressures drives organizations to copy financially successful models even when these conflict with healthcare's mission-based goals (Scott, 2008). Upper management's focus on systemic challenges like

technology proliferation and damaged trust (50%) shows how normative pressures from professional networks and industry standards create expectations for technological applications that may exceed what organizations can handle. This pattern of how different levels see barriers matches institutional theory that organizations often adopt structures and practices for legitimacy rather than efficiency, creating implementation challenges when formal adoption meets operational reality (Meyer & Rowan, 1977).

The pattern of master's degree holders most frequently discussing implementation barriers corresponds with resource-based view theory's connection between human capital and organizational analysis capabilities (Barney, 1991). Their identification of cultural resistance and time constraints shows they recognize multiple resource constraints affecting implementation. Doctoral degree holders' focus on systemic barriers reflects analytical skills gained from advanced education, as described in resource-based view theory. Bachelor's degree holders' emphasis on knowledge gaps and process induction challenges highlights a different set of resource-related barriers. This pattern of barrier identification across education levels aligns with resource-based view theory that different types of human capital provide different perspectives on organizational challenges (Grant, 1996).

**Theme 2.3: Organizational decision-making processes.** The finding that 75% of participants described hierarchical, top-down decision-making processes with limited input from implementers reflects diffusion of innovations theory's emphasis on communication channels and social system structures in innovation adoption (Rogers, 2003). Participants' descriptions of decisions flowing from "corporate level" (Participant 23) down through organizational layers show what Rogers (1962) identifies as centralized diffusion systems, where innovation decisions are made at higher levels with limited participation from potential adopters. The uncertainty

about decision processes expressed by many participants relates to diffusion theory's concept of communication gaps that block innovation awareness and adoption. This top-down structure contrasts with diffusion theory's finding that decentralized systems often achieve higher adoption rates through increased user participation in innovation decisions (Rogers, 2003).

The differences in decision-making perceptions across organizational levels align with institutional theory's predictions about power structures and organizational hierarchies. Frontline managers' frequent expressions of decision-making uncertainty (93%), along with their descriptions of receiving directives to implement, reflect their position as those who must carry out decisions without participating in strategic choices (DiMaggio & Powell, 1983). Middle managers' more detailed descriptions of formal processes (67%) though still described as top-down, reflect their intermediate position, which offers some visibility into decision-making processes but limited influence, consistent with institutional theory. Upper management's limited detail about decision processes (50%) aligns with institutional theory's observation that those in positions of power may take decision-making mechanisms for granted rather than critically examining them (Scott, 2008).

The equal participation of bachelor's and master's degree holders discussing decision-making processes, with different emphases on disconnection versus formal procedures, relates to resource-based view theory that different types of human capital provide different organizational insights (Barney, 1991). Bachelor's degree holders' focus on disconnection and uncertainty about processes reflects their operational position and limited access to strategic decision-making. Master's degree holders' more detailed descriptions of formal processes reflects the analytical skills gained from advanced education, as described in resource-based view theory.

Doctoral degree holders' ability to analyze organizational systems broadly aligns with advanced cognitive resources described in resource-based view theory (Grant, 1996).

**Theme 2.4: Future directions and expectations.** The finding that 75% of participants anticipated technological advances, particularly artificial intelligence integration, alongside shifts toward patient-centered metrics and real-time analytics shows diffusion theory's concept of innovation clusters and technological convergence (Rogers, 2003). Participants' expectations that "AI will be huge in moving the needle" (Participant 11) and emphasis on "real-time data analytics" (Participant 13) show awareness of new innovations that may reshape performance measurement practices. This forward-looking view aligns with Rogers' (1962) observation that exposure to one innovation increases openness to related innovations within the same area. The anticipated shift from traditional financial indicators to "patient-centered metrics" and "value-based performance indicators" (Participant 13) reflects changing perceptions of relative advantage as healthcare priorities evolve, matching diffusion theory's emphasis on how social system values influence innovation paths (Rogers, 2003).

The high engagement with future directions among frontline managers (93%) compared to moderate engagement from upper management (50%) represents an unexpected pattern given institutional theory's typical concentration of strategic knowledge at higher levels. Frontline managers' focus on technological applications and patient-centered approaches reflects their close work with operations and emerging demands for healthcare transformation (DiMaggio & Powell, 1983). Middle managers' emphasis on systemic changes including AI adoption and health equity considerations (75%) matches their position facing both professional healthcare standards and organizational mandates. Upper management's focus on technological applications

aligns with institutional theory's prediction that executives respond to industry pressures for credibility through technology adoption (Scott, 2008).

The focus on future expectations among master's degree holders relates to resource-based view theory's link between educational resources and strategic foresight capabilities (Barney, 1991). Their descriptions of integrated technology systems and comprehensive performance approaches reflect analytical skills developed through advanced education. Bachelor's degree holders' focus on practical applications and quality metrics represents operational knowledge that complements strategic perspectives. Doctoral degree holders' discussion of broader healthcare trends and cost management needs matches the advanced analytical abilities that enable environmental analysis and strategic positioning. This educational pattern in future orientation aligns with resource-based view theory's recognition that different human capital resources provide different perspectives on organizational capabilities across time horizons (Grant, 1996).

### **Summary**

This chapter presented findings from a qualitative interpretative descriptive study examining BSC awareness, comprehension, and adoption criteria among 36 healthcare leaders and managers within a multistate non-profit healthcare system. Through thematic analysis of questionnaire responses (n = 34) and semi-structured interviews (n = 2), the study revealed significant patterns in strategic performance measurement knowledge and implementation considerations. To ensure reliability, the study employed multiple strategies including methodological triangulation, member checking, audit trails, and systematic memoing. These methods strengthened confidence in the findings and their potential applicability to similar healthcare contexts.

The participant demographic distribution showed frontline managers comprising 41.7% of participants, middle managers 33.3%, and upper management 11.1%. Educational backgrounds varied, with master's degrees most common (33.3%), followed by bachelor's degrees (27.78%), and doctoral or professional degrees (19.44%). For RQ1, three major themes emerged from the data analysis. Limited BSC awareness was reported by 58% of participants, with frontline managers showing the highest unfamiliarity rates (73%) and bachelor's degree holders most frequently reporting limited awareness. Varied depth of BSC comprehension was demonstrated by 22% of participants, with understanding highest among upper management (75%) and master's degree holders. Additionally, 86% of participants reported experience with alternative strategic tools, including Lean Six Sigma, SWOT analysis, and various software platforms, with this experience distributed across all organizational levels.

For RQ2, four themes emerged regarding perceptions of adoption criteria and implementation considerations for strategic performance reporting systems. Adoption criteria and implementation facilitators were identified by 81% of participants, who emphasized user-friendliness, demonstrated value, organizational alignment, and comprehensive training. Frontline managers universally discussed practical criteria, while middle managers focused on strategic alignment factors. Implementation barriers were noted by 69% of participants, including resistance to change, time and resource constraints, insufficient training, and organizational complexity, with middle managers most frequently identifying these challenges. Organizational decision-making processes were described by 75% of participants as predominantly hierarchical and top-down with limited input from implementation staff. Future directions and expectations were described by 75% of participants, who anticipated technological

advances particularly in artificial intelligence, shifts toward patient-centered metrics, and real-time analytics capabilities.

Theoretical analysis examined the findings through the integrated framework of diffusion of innovations theory, institutional theory, and resource-based view theory. The limited BSC awareness aligned with diffusion theory's knowledge stage, while the concentration of comprehension at upper organizational levels aligned with institutional theory's predictions about knowledge distribution through standardizing forces. Resource-based view theory explained how educational background and experiential knowledge as human capital influenced strategic framework comprehension. The widespread use of operational tools alongside minimal BSC awareness showed distinct diffusion patterns within the organization. The relationship between organizational role, educational background, and strategic framework knowledge reflected how human capital and institutional position interact as described in the theoretical framework. Participants' descriptions of adoption criteria despite limited BSC knowledge, combined with identified barriers and decision-making patterns, showed the organizational structures and processes found in strategic innovation adoption.

The findings from this study provide a comprehensive view of BSC awareness, comprehension, and adoption criteria within a multistate non-profit healthcare system. The data revealed distinct patterns in knowledge distribution, tool usage, and perceptions of implementation factors across organizational levels and educational backgrounds. These patterns, analyzed through the study's theoretical framework, help to understand how strategic performance measurement frameworks are perceived and potentially adopted in healthcare organizations. Chapter 5 will present implications, recommendations for practice, recommendations for future research, and conclusions based on these findings.

## **Chapter 5: Implications, Recommendations, and Conclusions**

The problem addressed in this study was the apparent deficiency in the adoption and integration of standardized performance reporting frameworks and systems, including the balanced scorecard (BSC) methodology, among healthcare leaders and managers in non-profit healthcare organizations. The purpose of this qualitative interpretative descriptive study was to describe the levels of BSC awareness and comprehension, and the adoption criteria of strategic performance reporting systems for leadership and management at a multistate non-profit U.S. healthcare system operating in the Midwest and Mid-Atlantic regions. This investigation sought to address critical gaps in understanding how strategic performance measurement frameworks are perceived and potentially adopted within the complex healthcare environment.

This study employed a qualitative interpretative descriptive methodology grounded in an interpretivist paradigm, utilizing semi-structured interviews and open-ended questionnaires to collect data from healthcare leaders and managers across various organizational levels. The theoretical framework integrated diffusion of innovations theory (Rogers, 1962), institutional theory (DiMaggio & Powell, 1983), and resource-based view theory (Barney, 1991) to provide a comprehensive lens for examining awareness, comprehension, and adoption considerations. Data collection involved 36 participants from a large multistate non-profit healthcare system, including 34 questionnaire responses and 2 in-depth interviews, representing diverse roles from frontline management to upper leadership positions. Thematic analysis following Braun and Clarke's (2006) six-phase approach was employed to identify patterns and themes, utilizing both deductive codes aligned with the theoretical framework and inductive codes that emerged organically from participant responses. The analysis was supported by NVivo software to ensure systematic organization and transparent audit trails throughout the coding and interpretation

process. Additionally, Microsoft Excel was utilized to complement the NVivo analysis by facilitating further sorting and organization of coded units, enabling cross-tabulation and frequency analysis of themes across different participant demographics and organizational levels.

The findings revealed significant gaps in BSC awareness, with 58% of participants indicating unfamiliarity with the framework, while simultaneously demonstrating extensive experience with alternative strategic management tools among 86% of participants. Three major themes emerged for RQ1: limited BSC awareness among healthcare leaders and managers, varied depth of BSC comprehension, and diverse experience with alternative performance management tools. For RQ2, four themes were identified: adoption criteria and implementation facilitators, implementation barriers, organizational decision-making processes, and future directions and expectations. The results showed that both organizational role and educational background influenced BSC awareness and comprehension, with upper management demonstrating higher awareness levels and master's degree holders most frequently showing BSC knowledge. Participants across all levels emphasized the importance of user-friendly systems, demonstrated value, organizational alignment, and proper training as key adoption criteria, while identifying resistance to change, resource constraints, and organizational complexity as primary implementation barriers.

The study contained several limitations that warranted consideration in interpreting the findings. The research was conducted within a single healthcare system, which limited the generalizability of findings to other organizational contexts, though detailed descriptions were provided to support transferability assessments (Yin, 2015). The voluntary nature of participation potentially introduced selection bias, as individuals with stronger opinions about strategic management tools may have been more likely to participate (Rogelberg & Stanton, 2007). The

reliance on self-reported data introduced potential subjectivity concerns, including social desirability bias and varying levels of introspective ability among participants (Rosenman et al., 2011). Additionally, the compressed 14-day data collection timeframe, while necessary due to organizational constraints, may have limited the depth of recruitment and response rates compared to longer collection periods typically employed in qualitative research (Creswell & Creswell, 2017).

This chapter presents the implications of these findings for both theoretical understanding and practical application in healthcare organizations, followed by recommendations for practice and future research directions. The chapter concludes with a synthesis of the study's contributions to the literature on strategic performance reporting systems in healthcare settings. The discussion demonstrates how the findings address the original research problem and contribute to closing identified gaps in the existing literature, while providing actionable insights for healthcare leaders considering the adoption of strategic performance measurement frameworks.

### **Implications**

The findings of this study carry implications for understanding strategic performance measurement adoption in healthcare organizations, particularly regarding the BSC framework. The implications extend across theoretical, practical, and organizational dimensions, offering insights into how healthcare leaders and managers perceive, understand, and consider implementing strategic performance reporting systems. The following discussion examines implications for each research question, connecting the empirical findings to the study's theoretical framework while highlighting their significance for healthcare management practice.

***Research Question 1: In what ways do leadership and management demonstrate awareness and comprehension of the BSC?***

The findings related to BSC awareness and comprehension among healthcare leaders and managers revealed implications for both theoretical understanding and practical application of strategic performance measurement systems in healthcare organizations. The discussion first considers factors that may have influenced the interpretation of findings, including study limitations and participant characteristics. The analysis then examines the three themes of limited BSC awareness (58% unfamiliar), varied depth of BSC comprehension, and diverse experience with alternative strategic management tools through the integrated theoretical framework of diffusion of innovations theory, institutional theory, and resource-based view theory. Following the theoretical analysis, the findings are compared with the limited existing BSC healthcare literature to identify consistencies and divergences. The section then explores practical implications for healthcare organizations and professional development before concluding with the probable and improbable societal implications of continued BSC unfamiliarity in healthcare.

**Factors Influencing Interpretation.** Several factors may have influenced the interpretation of these findings. The study's focus on a single non-profit healthcare system may have captured organization-specific knowledge distribution patterns. The 14-day data collection timeframe, while generating sufficient data for thematic saturation, may have limited participation from busier executives who might possess greater BSC knowledge. Additionally, the voluntary nature of participation could have resulted in self-selection bias, potentially excluding leaders and managers who felt less confident about their strategic management knowledge. These factors suggest that the 58% unfamiliarity rate may represent a conservative estimate of the actual knowledge gap.

**Theoretical Analysis.** From a diffusion of innovations perspective, the limited BSC awareness indicates that the framework has failed to progress beyond the initial knowledge stage for the majority of healthcare leaders and managers in this study. According to Rogers (2003), awareness represents the first step in the innovation-decision process, without which subsequent stages of persuasion, decision, implementation, and confirmation cannot occur. The finding that frontline managers demonstrated the lowest awareness levels (73% unfamiliar) while upper management showed relatively higher awareness (only 25% unfamiliar) suggests that communication channels within healthcare organizations may be inadequate for disseminating strategic management innovations. This hierarchical gradient in awareness levels implies that knowledge of strategic frameworks remains concentrated at executive levels without mechanisms for cascading information throughout organizational structures (Argote & Ingram, 2000). The failure of a management innovation to achieve broad awareness in healthcare suggests that sector-specific barriers may impede the transfer of business management practices to healthcare contexts (Waring & Bishop, 2010).

The varied depth of BSC comprehension, with only 22% of participants demonstrating understanding of the framework, carries implications for institutional theory's predictions about knowledge distribution in organizations. The contrast between upper management's comprehension rate (75%) and frontline managers' understanding (7%) exemplifies what Meyer and Rowan (1977) describe as decoupling, where formal structures and practices adopted at executive levels fail to penetrate operational levels. This comprehension gap suggests that even when healthcare organizations formally adopt strategic performance measurement systems, the lack of widespread understanding may result in formal compliance rather than substantive implementation. The concentration of BSC knowledge at higher organizational levels reflects

institutional theory's emphasis on how normative and mimetic pressures primarily influence executives through professional networks and industry associations, while leaving operational managers disconnected from these knowledge sources (DiMaggio & Powell, 1983). The hierarchical distribution of BSC knowledge supports institutional theory's predictions about organizational stratification but also reveals the limitations of executive-level adoption without organizational learning mechanisms.

The educational analysis revealed implications for resource-based view theory's assertions about human capital as a source of competitive advantage. While master's degree holders most frequently demonstrated BSC comprehension and doctoral degree holders showed the deepest understanding, the overall low comprehension rates across all educational levels challenge assumptions about the relationship between formal education and strategic management knowledge. This finding suggests that healthcare organizations may not be leveraging their human capital resources to build strategic management capabilities. The disconnect between educational credentials and BSC awareness indicates that formal education alone does not guarantee familiarity with contemporary strategic management tools, highlighting the need for targeted professional development initiatives. From a resource-based view perspective, the findings indicate that healthcare organizations may possess latent strategic management capabilities through their use of alternative tools but lack the integrative framework that the BSC could provide to synthesize these approaches (Grant, 1996).

**Comparison With Existing Literature.** These findings diverge from the limited existing literature on BSC adoption in healthcare across all three RQ1 themes. For Theme 1.1 (limited BSC awareness), the 58% unfamiliarity rate contrasts sharply with previous research. While Trotta et al. (2013) suggested growing interest in performance frameworks, this study reveals

widespread unfamiliarity with the BSC among healthcare leaders and managers. This finding particularly contradicts Zelman et al.'s (2003) report that approximately 60% of healthcare organizations claim BSC usage, suggesting actual awareness among leaders and managers is inverted. The discrepancy may reflect the difference between organizational claims of BSC adoption and actual leader awareness, supporting Behrouzi et al.'s (2014) observation about inconsistent definitions of BSC usage.

Regarding Theme 1.2 (varied depth of BSC comprehension), the finding that only 22% of participants demonstrated understanding of the framework, with stark differences between upper management (75% comprehension) and frontline managers (7% comprehension), extends Kollberg and Elg's (2011) findings about implementation challenges. This hierarchical distribution of comprehension reveals more severe knowledge gaps than previously documented in the literature and supports Grigoroudis et al.'s (2012) observation that BSC adoption in healthcare faces unique barriers not present in other sectors.

For Theme 1.3 (diverse strategic management tool experience), the finding that 86% of participants use alternative strategic tools while 58% remain unaware of the BSC contradicts assumptions in the literature about tool adoption patterns. Unlike Rabbani et al.'s (2011) suggestion that BSC awareness precedes other framework adoption, this study indicates healthcare organizations implement multiple performance tools without exposure to integrated frameworks. This fragmented approach to performance measurement aligns with Nippak et al.'s (2014) observations about piecemeal adoption of management innovations in healthcare settings. The findings underscore the research gap identified in Chapter 2 regarding current BSC awareness levels and adoption patterns in U.S. healthcare organizations.

**Practical Implications.** For healthcare practice, these findings carry implications for how organizations approach strategic performance measurement adoption. The unfamiliarity with the BSC framework suggests that healthcare leaders and managers may be making decisions about performance measurement systems without awareness of available options. The concentration of BSC knowledge at upper management levels indicates a need for more inclusive approaches to strategic management education that engage middle and frontline managers. The experience with alternative tools demonstrates that healthcare professionals are capable of and willing to adopt performance measurement approaches, suggesting that the issue is not resistance to measurement itself but rather a lack of exposure to comprehensive frameworks.

The implications extend to how healthcare organizations structure their strategic planning and performance measurement initiatives. The disconnect between operational tool usage and strategic framework awareness suggests that many healthcare organizations may be implementing strategic solutions without the benefit of an overarching strategic architecture. This fragmented approach may result in duplicated efforts, misaligned metrics, and missed opportunities for integrated performance improvements. The findings indicate that healthcare organizations could benefit from assessments of their current performance measurement practices and educational initiatives to raise awareness of integrative frameworks like the BSC.

Furthermore, the results have implications for healthcare management education and professional development. The limited BSC awareness across all educational levels suggests that both academic programs and professional training may need to place greater emphasis on strategic performance measurement frameworks. The finding that master's degree holders showed slightly better awareness and comprehension indicates that graduate education may provide some exposure to strategic management concepts, but the overall low rates suggest room

for improvement. Healthcare organizations and educational institutions should consider partnering to ensure that emerging and current healthcare leaders and managers receive exposure to strategic management frameworks.

**Societal Implications.** The societal implications of these findings relate to healthcare quality and organizational efficiency. The probable consequence of continued BSC unfamiliarity is that healthcare organizations will persist with fragmented performance measurement approaches, potentially missing opportunities for integrated improvements that could enhance patient care quality and reduce costs. Given that strategic performance measurement systems have been linked to improved organizational outcomes (Grigoroudis et al., 2012), the lack of BSC awareness may contribute to the ongoing challenges of healthcare cost containment and quality improvement. However, it would be improbable to suggest that BSC adoption alone would resolve healthcare's challenges. More realistically, increased awareness and thoughtful implementation of integrated frameworks like the BSC could contribute to incremental improvements in organizational alignment, resource utilization, and ultimately, patient outcomes. Healthcare organizations appear capable of adopting comprehensive frameworks, but their limited exposure to such tools may hinder implementation.

***Research Question 2: How do leadership and management perceive the adoption criteria for the BSC or other strategic performance reporting systems?***

The findings about adoption criteria and implementation considerations for strategic performance reporting systems revealed complex organizational dynamics shaping healthcare leaders' approaches to these frameworks. This section examines four key themes that emerged from the data: adoption criteria and implementation facilitators (81% of participants), implementation barriers (69%), organizational decision-making processes (75%), and future

directions and expectations (75%). The analysis considers factors that may have influenced these findings, explores their meaning through each component of the theoretical framework separately, compares results with existing literature, and discusses practical implications for healthcare organizations and society.

**Factors Influencing Interpretation.** Several factors may have shaped how these adoption-related findings should be interpreted. The high response rates for adoption criteria (81%) and barriers (69%) suggest participants felt comfortable discussing topics relevant to their daily management experiences. The organizational context of a large, multistate healthcare system may have amplified certain barriers such as organizational complexity and hierarchical decision-making that might be less pronounced in smaller settings (Scott, 2008). Data collection occurred during a period of healthcare industry pressures including staffing shortages, financial constraints, and technological changes, potentially heightening participants' awareness of implementation challenges. The voluntary participation approach may have attracted leaders particularly engaged with or frustrated by strategic performance systems, possibly influencing the emphasis placed on both facilitators and barriers (Bryman & Bell, 2015).

**Theoretical Analysis.** From a diffusion of innovations perspective, participants' emphasis on user-friendliness and demonstrated value as primary adoption criteria reflects Rogers' (2003) innovation attributes of complexity and relative advantage. The finding that participants across all organizational levels stressed systems must be "easy to interpret, easy to use" (Participant 11) demonstrates how perceived complexity influences adoption decisions. According to diffusion theory, innovations viewed as difficult to understand or implement face barriers regardless of their potential benefits. The demand for comprehensive training and education, expressed as "education, education, education" (Participant 20), underscores the

necessity of building both awareness-knowledge and how-to knowledge to support progression through the innovation-decision process. Time constraints and resistance to change emerged as primary barriers, exemplifying Rogers' (1962) concept of innovation resistance where uncertainty and perceived risks halt adoption during the decision stage. The finding that participants could articulate detailed adoption criteria (81%) despite limited BSC awareness (58%) challenges traditional diffusion theory by suggesting that managers can develop preferences for innovation characteristics before learning about specific available frameworks.

Institutional theory provides insights into the organizational dynamics revealed in participants' responses. The finding that 75% of participants described decision-making as hierarchical and top-down, with decisions flowing from "corporate level" down through organizational layers (Participant 23), exemplifies the coercive isomorphic pressures (forces that make organizations become similar) described by DiMaggio and Powell (1983). Frontline managers' expressions of disconnection from decision processes, noting they receive "decisions directed down for me to implement" (Participant 9), illustrates how institutional structures can generate compliance without fostering commitment. The inductively emerged theme of financial dominance, with participants observing that "everything comes back to does it make financial sense to the organization" (Participant 9), reveals how mimetic pressures drive healthcare organizations to prioritize financial metrics when facing industry-wide economic challenges. This financial focus creates what Scott (2008) identifies as institutional logic conflicts between business efficiency imperatives and healthcare's mission-driven purpose. These findings suggest that when frontline managers must implement decisions they had no role in making, while prioritizing financial metrics that may conflict with healthcare's mission, the result may be compliance without genuine commitment to strategic initiatives.

Resource-based view theory reveals the relationship between organizational capabilities and adoption readiness evident in the findings. The prominence of resource constraints as implementation barriers, with 69% of participants citing time, financial, and human resource limitations, reflects resource-based view theory's emphasis on resource availability as a determinant of strategic capability development (Barney, 1991). Participants' recognition that successful implementation requires "strong leadership, organizational culture, resources, employee engagement" (Participant 14) demonstrates awareness that both tangible and intangible resources are necessary for strategic innovation adoption. The pattern of master's degree holders providing the most comprehensive implementation requirements aligns with resource-based view theory's assertions about human capital resources influencing strategic change capacity (Barney, 1991). However, the finding that participants across all educational levels could identify practical adoption criteria suggests experiential knowledge gained through operational roles may be equally valuable as formal education in understanding implementation requirements. Resource-based view theory's emphasis on resource constraints is validated through participants' frequent citation of time, financial, and human resource limitations. However, the findings reveal a more nuanced understanding of human capital than traditional resource-based view theory suggests. While the theory typically emphasizes formal education and credentials as valuable human capital resources that enable strategic capabilities (Barney, 1991), this study found that participants with bachelor's degrees often demonstrated equally practical insights about implementation requirements as those with advanced degrees. These insights, derived from hands-on operational experience rather than formal education, suggest that resource-based view theory may undervalue experiential knowledge as a form of human capital. The ability of frontline managers to articulate specific, actionable adoption criteria despite limited formal

strategic management education suggests that organizations may possess untapped strategic capabilities within their operational workforce that traditional human capital assessments overlook. This finding extends resource-based view theory's understanding of human capital by highlighting how practical, experiential knowledge gained through operational roles may be as valuable as formal educational credentials in developing strategic capabilities.

**Comparison With Existing Literature.** These findings both confirm and extend the limited existing literature on strategic performance system adoption in healthcare across all four RQ2 themes. For Theme 2.1 (adoption criteria and implementation facilitators), the identification of user-friendliness, demonstrated value, and organizational alignment as key criteria by 81% of participants aligns with Grigoroudis et al.'s (2012) findings on BSC implementation challenges in healthcare settings. However, this study provides more specific insights about facilitators, particularly the emphasis on comprehensive training and education. For Theme 2.2 (implementation barriers), the 69% of participants who identified resistance to change, time constraints, and organizational complexity as barriers extends beyond previously documented obstacles, revealing these may be more significant than earlier studies suggested. Regarding Theme 2.3 (organizational decision-making processes), the finding that 75% of participants described hierarchical, top-down approaches with limited implementer input extends Rabbani et al.'s (2011) observations but reveals greater disconnection between decision-makers and frontline managers than prior research indicated. Finally, Theme 2.4 (future directions and expectations) represents a novel contribution, as the 75% of participants anticipating AI and technological integration in performance measurement suggests the field has evolved beyond the primarily manual and static systems described in earlier studies by Inamdar et al. (2002) and Kollberg and Elg (2011).

**Practical Implications.** For healthcare practice, these findings provide guidance for strategic performance system implementation. The clear articulation of adoption criteria by 81% of participants offers a practical roadmap emphasizing user experience, value demonstration, and comprehensive training. Organizations should prioritize selecting or designing systems that minimize complexity while maximizing intuitive use, as frontline managers emphasized ease of use as essential. The finding that participants at all organizational levels could identify specific adoption criteria indicates implementation planning must incorporate input from diverse stakeholders rather than relying solely on executive preferences. This inclusive approach could prevent the disconnection between decision-makers and implementers that participants frequently described.

The organizational implications extend to governance structures and decision-making processes. The predominant pattern of hierarchical decision-making, with 75% of participants describing top-down processes, suggests traditional governance approaches may undermine strategic system adoption. When frontline managers feel excluded from decisions they must implement, the resulting compliance lacks the commitment necessary for sustained utilization. Healthcare organizations should consider establishing cross-functional teams that include frontline representation in system evaluation and selection. This participatory governance approach could bridge the gap between strategic intent and operational reality, increasing the likelihood of successful implementation and meaningful use.

Educational and professional development implications emerge from both the adoption criteria and barrier findings. The emphasis on training and education as facilitators, combined with the identification of knowledge gaps as barriers, indicates that healthcare organizations must invest in capability building. This investment should extend beyond technical training to

include strategic thinking, change management, and system integration skills. The finding that participants with different educational backgrounds brought complementary perspectives, including formal knowledge from advanced degrees and practical insights from operational experience, suggests professional development programs should blend theoretical frameworks with practical application. Healthcare management education programs should also incorporate more emphasis on strategic performance systems, preparing future leaders to evaluate and implement comprehensive frameworks.

**Societal Implications.** The societal implications of these adoption findings affect healthcare delivery across communities. The probable outcome of continued reliance on hierarchical decision-making and insufficient attention to implementation barriers is the perpetuation of failed strategic initiatives, maintaining inefficiencies in healthcare delivery. Given that participants clearly articulated adoption criteria and implementation requirements, ignoring these insights represents a missed opportunity to improve healthcare system performance. The emphasis on financial metrics potentially at the expense of quality, equity, and patient experience considerations probably contributes to ongoing tensions in healthcare between cost containment and care quality. However, it would be questionable to expect that addressing adoption considerations alone could transform healthcare delivery or resolve systemic challenges. Strategic performance systems cannot compensate for fundamental resource limitations, workforce shortages, or healthcare policy inadequacies. More realistically, thoughtful application of the adoption insights revealed in this study could enable incremental but meaningful improvements in organizational performance measurement and management. Over time, these improvements could accumulate to benefit communities through more efficient resource utilization and enhanced care delivery.

## **Recommendations for Practice**

The findings from this qualitative study of BSC awareness and adoption criteria in a large non-profit healthcare system suggest several recommendations for healthcare practice. These recommendations emerge from the specific organizational context studied and should be considered within the limitations of the single-system focus. While the findings provide insights that may be relevant to similar healthcare organizations, the applicability of these recommendations should be evaluated based on each organization's unique circumstances. The following recommendations link study findings to actionable practices, grounded in the literature reviewed in Chapter 2, and directly address the problem of deficient adoption and integration of standardized performance reporting frameworks and systems in healthcare organizations.

### ***Professional Development and Comprehensive Education***

Based on the finding that 58% of participants demonstrated unfamiliarity with the BSC framework, with frontline managers showing the highest unfamiliarity rate (73%), combined with the finding that BSC awareness varied across educational levels with overall low familiarity even among those with advanced degrees, healthcare organizations may benefit from implementing comprehensive strategic framework education programs. This recommendation aligns with the literature reviewed in Chapter 2, particularly Bisbe and Barrubés (2012) emphasis on knowledge sharing and Nippak et al.'s (2014) findings about the importance of education in promoting BSC awareness within healthcare organizations. It also builds on Inamdar et al.'s (2002) observations about the role of education in BSC success and extends the human capital development concepts discussed in Chapter 2. Organizations similar to the study site could consider developing multi-level educational programs that introduce strategic performance frameworks to leaders at all organizational levels, with particular attention to frontline and

middle managers who demonstrated the greatest knowledge gaps. These programs might include workshops, online modules, and peer learning opportunities that present the BSC alongside other strategic frameworks. Additionally, healthcare organizations could collaborate with both baccalaureate and graduate healthcare administration programs, as well as their programmatic accreditors, to ensure curricula include exposure to strategic performance frameworks and develop continuing education partnerships that blend theoretical framework knowledge with practical application, addressing the gap between academic preparation and strategic management practice. By addressing the fundamental knowledge gap that underlies the adoption deficiency, this recommendation targets the root cause preventing healthcare organizations from even considering standardized performance reporting frameworks like the BSC.

### ***Bridging Current Tools to Comprehensive Frameworks***

The finding that 86% of participants reported experience with alternative strategic management tools while only 42% demonstrated BSC awareness suggests an opportunity to build on existing capabilities. This recommendation is supported by Greenhalgh et al.'s (2004) research on leveraging existing practices to facilitate innovation adoption and aligns with Lin et al.'s (2014) observations about incremental implementation approaches in healthcare, both discussed in Chapter 2. Healthcare organizations could assess their current portfolio of performance measurement tools and explore how comprehensive frameworks like the BSC might integrate existing initiatives such as Lean Six Sigma, SWOT analysis, and KPI dashboards into a cohesive strategic system. Rather than replacing familiar tools, organizations might position integrated frameworks as methods to synthesize and align existing measurement efforts. This approach would build on the demonstrated competence with multiple performance tools while introducing the integrative benefits of comprehensive strategic frameworks. This approach

bridges existing capabilities with comprehensive frameworks, making standardized performance reporting systems more accessible and less disruptive.

### ***Inclusive Decision-Making and Implementation***

Based on the finding that 81% of participants could articulate specific adoption criteria while 75% described hierarchical decision-making processes with limited input from implementers, healthcare organizations should consider adopting more inclusive approaches to strategic system selection and implementation. This recommendation aligns with Rabbani et al.'s (2011) findings about the importance of stakeholder engagement and Kollberg and Elg's (2011) emphasis on participatory approaches in Swedish healthcare services, both discussed in Chapter 2's review of BSC implementation factors. Organizations might establish cross-functional teams that include frontline management representation in the evaluation, selection, and design of strategic performance systems. These teams could ensure that the practical criteria identified by operational leaders, such as user-friendliness, demonstrated value, and adequate training, are incorporated into implementation planning from the outset. This inclusive approach could prevent the disconnection between decision-makers and implementers that participants frequently described, bridging the gap between strategic intent and operational reality to increase the likelihood of successful implementation and meaningful use. By transforming the decision-making process from top-down to participatory, this recommendation addresses a key organizational barrier contributing to the adoption deficiency, ensuring that standardized strategic frameworks are selected and implemented with buy-in from those who must use them daily.

### ***Resource Management and Barrier Reduction***

The finding that 69% of participants identified implementation barriers, with time constraints and resource limitations being prominent concerns, suggests that healthcare organizations must proactively address these challenges in their strategic planning. This recommendation is supported by Grigoroudis et al.'s (2012) identification of resource constraints as significant BSC implementation barriers and Trotta et al.'s (2013) findings on the importance of adequate resource allocation, both discussed in Chapter 2's analysis of BSC adoption challenges in healthcare. Healthcare organizations similar to the study site might consider phased implementation approaches that acknowledge time and resource limitations while building capacity incrementally. This could begin with pilot testing in a single department or unit, allowing organizations to refine the framework and demonstrate value before broader deployment. Implementation components should include dedicating protected time for strategic planning activities, providing implementation support teams, and establishing realistic timelines that account for the competing demands faced by healthcare managers. Throughout the phased approach, organizations should maintain consistent communication strategies that keep all stakeholders informed of progress, celebrate early successes, and maintain engagement across extended implementation timelines. Organizations should also anticipate and plan for the resistance to change that participants frequently mentioned, developing change management strategies that address both cultural and practical barriers to implementation. This systematic approach to barrier reduction addresses the implementation challenges that prevent adoption. It transforms standardized performance reporting frameworks from overwhelming organizational changes into manageable, phased initiatives that work within resource constraints while building lasting capabilities.

These recommendations acknowledge that the findings emerge from a specific organizational context and may not apply uniformly across all healthcare settings. The voluntary nature of study participation and the focus on a single healthcare system limit the generalizability of these recommendations. Additionally, implementing these recommendations requires organizational commitment, resources, and sustained effort that may vary based on each organization's circumstances. Healthcare leaders should evaluate these recommendations within their unique contexts, considering their organizational culture, resource availability, and strategic priorities. While the study findings suggest these practices may support improved strategic performance measurement, their effectiveness will ultimately depend on thoughtful adaptation to local conditions and needs.

### **Recommendations for Future Research**

The findings of this study provide a foundation for future research on strategic performance measurement adoption in healthcare. Based on the integrated theoretical framework of diffusion of innovations theory, institutional theory, and resource-based view theory, combined with the empirical findings, implications, and acknowledged limitations, three primary research directions emerge that could extend understanding of this phenomenon. These recommendations build upon the theoretical and practical implications discussed earlier while addressing the study's limitations to advance knowledge in this domain.

#### ***Expanding Geographic and Organizational Scope***

Future research should investigate BSC awareness and adoption criteria across multiple healthcare systems to determine whether the patterns identified in this study represent broader trends or organization-specific characteristics. The finding that 58% of participants were unfamiliar with the BSC framework, despite its recognition as a leading management tool,

warrants validation across diverse healthcare contexts. This expanded scope would address the limitation of the single-system focus and enable researchers to identify how organizational characteristics such as ownership structure (for-profit versus non-profit), size, and geographic distribution influence strategic framework awareness and adoption patterns.

Building on the institutional theory implications that revealed how coercive and mimetic pressures shape adoption decisions differently across organizational levels, multi-site research could examine whether these institutional dynamics vary by organizational type or regional healthcare markets (DiMaggio & Powell, 1983). Researchers could employ the same integrated theoretical framework, validated interview protocol, and dual coding approach (deductive and inductive) developed for this research, facilitating direct comparison of results while allowing for emergent themes specific to different contexts. Such research would determine whether the hierarchical distribution of BSC awareness (75% familiarity among upper management versus 30% among frontline managers) and the predominance of hierarchical decision-making processes represent sector-wide phenomena or unique organizational characteristics. This expanded investigation would build on the practical implications regarding knowledge dissemination and inclusive decision-making, testing whether these patterns persist across healthcare settings with different governance structures and organizational cultures.

### ***Longitudinal Investigation of Implementation Processes***

Given that this study captured awareness and adoption criteria at a single point in time, future research should employ longitudinal designs to track how strategic performance systems are actually implemented and sustained over time (Ployhart & Vandenberg, 2010). The compressed 14-day data collection period limited this study's ability to observe evolving perceptions and implementation dynamics. A longitudinal approach would enable researchers to

follow healthcare organizations through the complete innovation-decision process described in diffusion of innovations theory, from initial awareness through implementation and confirmation stages, while simultaneously tracking how institutional pressures and resource constraints evolve throughout the implementation process (Rogers, 1962; Ployhart & Vandenberg, 2010).

Building on the resource-based view implications that revealed how both formal education and experiential knowledge contribute to implementation readiness, longitudinal studies could examine how organizations develop and deploy these human capital resources over time (Barney, 1991; Ployhart & Vandenberg, 2010). Such research could track whether the adoption criteria identified by 81% of participants (user-friendliness, demonstrated value, organizational alignment) actually predict successful implementation and whether the barriers identified by 69% of participants (time constraints, resistance to change, organizational complexity) persist or evolve during implementation. Additionally, longitudinal research could investigate the “fade effect” that emerged inductively from the data, examining why strategic initiatives lose momentum over time and identifying factors that contribute to sustained versus abandoned implementations. This longitudinal research would help address the societal implications discussed earlier by examining how fragmented performance measurement approaches persist over time and affect healthcare efficiency and patient outcomes.

### ***Mixed Methods Approaches to Strengthen Generalizability***

Future researchers should employ mixed methods designs that combine the rich qualitative insights gained in this study with quantitative measurement of BSC awareness, comprehension, and implementation outcomes. While this study’s qualitative approach revealed participant perspectives on adoption criteria and barriers, the voluntary participation and reliance on self-reported data introduce potential biases that quantitative methods could help address

(Creswell & Plano Clark, 2018). A sequential explanatory design would first survey BSC awareness among a representative sample of healthcare leaders and managers from different organizational levels, then conduct follow-up interviews to understand why awareness varies across groups (Creswell & Plano Clark, 2018).

Building upon this study's theoretical integration, researchers could develop and validate quantitative scales that operationalize constructs from all three theories: innovation attributes from diffusion theory, institutional pressures from institutional theory, and resource capabilities from resource-based view theory. The quantitative scales could incorporate the specific adoption criteria and implementation barriers identified in this study, enabling statistical analysis of relationships between organizational factors, individual characteristics, and strategic framework adoption. This mixed methods approach would not only address the limitations of the 3.7% response rate but also test whether the qualitative findings regarding disconnected decision-making and financial dominance represent measurable phenomena that predict implementation outcomes. By combining the contextual depth of qualitative inquiry with the generalizability of quantitative methods, future research could validate and extend the practical implications for professional development, inclusive decision-making, and resource management identified in this study (Creswell & Plano Clark, 2018).

These recommendations for future research build on this study's theoretical framework and empirical findings while systematically addressing its methodological limitations. The single healthcare system focus, compressed timeframe, and self-selection bias all present opportunities for methodological improvements that would strengthen confidence in the findings. By pursuing these research directions, scholars can develop more robust understanding of strategic performance framework adoption in healthcare, moving from the exploratory insights provided

by this study toward more generalizable knowledge that informs both theory and practice. The next logical step involves testing whether the patterns identified here (limited BSC awareness despite extensive alternative tool usage, hierarchical knowledge distribution, and specific adoption criteria) represent consistent phenomena across the healthcare sector or context-specific findings that vary by organizational characteristics. Such research would contribute to addressing the fundamental problem of deficient adoption and integration of standardized performance reporting frameworks and systems in healthcare organizations.

### **Conclusions**

This qualitative interpretative descriptive study examined BSC awareness and the factors influencing strategic performance reporting system adoption among 36 healthcare leaders and managers within a multistate non-profit healthcare system. The problem to be addressed in this study is the apparent deficiency in the adoption and integration of standardized performance reporting frameworks and systems, including the BSC methodology, among healthcare leaders and managers in non-profit healthcare organizations. The purpose of this qualitative interpretative descriptive study is to describe the levels of BSC awareness and comprehension, and the adoption criteria of strategic performance reporting systems for leadership and management at a multistate non-profit U.S. healthcare system operating in the Midwest and Mid-Atlantic regions. Guided by an integrated theoretical framework combining diffusion of innovations theory, institutional theory, and resource-based view theory, this study investigated two research questions: (RQ1) In what ways do leadership and management demonstrate awareness and comprehension of the BSC? and (RQ2) How do leadership and management perceive the adoption criteria for the BSC or other strategic performance reporting systems?

Using semi-structured interviews and open-ended questionnaires, the study gathered perspectives from participants across various organizational levels and educational backgrounds. The findings revealed that 58% of healthcare leaders and managers lack familiarity with the BSC framework while simultaneously utilizing various operational performance tools. Additionally, 81% of participants could articulate specific adoption criteria for strategic performance systems despite limited BSC knowledge, identifying barriers such as resource constraints and hierarchical decision-making processes. These findings provide insights for addressing the gap between performance measurement potential and actual implementation in healthcare organizations.

The study's importance extends beyond documenting awareness levels to revealing gaps in how strategic knowledge moves through healthcare organizations. The concentration of BSC comprehension at upper management levels (75%) compared to frontline managers (7%) shows limitations in how strategic knowledge is shared within organizations, preventing established frameworks from reaching implementation levels. This pattern where upper management possess more strategic knowledge than operational managers, combined with the finding that 86% of participants actively use alternative performance tools, demonstrates that healthcare professionals possess both capability and willingness to adopt measurement systems but lack exposure to comprehensive strategic frameworks. The research further revealed that while participants could articulate clear adoption criteria emphasizing user-friendliness, demonstrated value, and organizational alignment, persistent barriers including resistance to change, resource constraints, and top-down decision-making processes continue to obstruct strategic innovation adoption. These insights are relevant given healthcare's ongoing challenges with quality improvement, cost management, and the need for integrated performance measurement approaches that balance financial sustainability with patient care.

The take-home message from this research is that improving strategic performance measurement in healthcare requires more than introducing new tools or frameworks; it requires changes in how organizations disseminate strategic knowledge, engage diverse management levels, and structure implementation processes. The contrast between operational tool usage (86%) and strategic framework awareness (42%) reveals that healthcare organizations are attempting to address performance challenges with fragmented approaches rather than comprehensive systems. This fragmentation may contribute to the difficulties healthcare organizations face in achieving sustained performance improvements despite investments in various quality and efficiency initiatives. The findings suggest that the healthcare sector's limited adoption of strategic frameworks like the BSC may stem not from inherent unsuitability or resistance but from challenges in knowledge transfer, inclusive engagement, and implementation support structures.

The results of this study carry implications for both previous research and future healthcare management practice. While some literature has explored BSC adoption in healthcare settings, actual awareness and utilization levels have remained relatively unknown. This research reveals that leader and manager awareness is only 42%, providing evidence that BSC knowledge remains limited despite academic interest in the topic. This finding fills a gap in the literature by providing concrete data on BSC awareness levels among healthcare leaders and managers. Building on these findings, the implications for practice emphasize that successful strategic framework implementation requires comprehensive approaches addressing knowledge sharing across all management levels, not just executive awareness. Longitudinal studies could examine how BSC knowledge and implementation evolve over time, while mixed-methods research could quantify the relationship between awareness levels and organizational performance outcomes.

The participants' understanding of adoption requirements, despite limited BSC exposure, suggests that healthcare organizations possess readiness for strategic innovation that remains underutilized due to structural and procedural barriers rather than employee resistance.

In conclusion, this study demonstrates that improving strategic performance measurement in healthcare requires more than introducing new frameworks or tools; it requires fundamental changes in how strategic knowledge is shared throughout organizations, how decisions about performance systems are made, and how implementation is supported and sustained over time. The path forward involves recognizing that healthcare's operational complexity and institutional pressures create unique challenges for implementing strategic frameworks. While this study examined one healthcare system and relied on self-reported data from voluntary participants, the patterns revealed suggest broader implications for how healthcare approaches strategic performance measurement. By addressing the knowledge distribution failures and decision-making structures identified here, healthcare organizations can better leverage strategic frameworks to achieve the integration and alignment necessary for improving both organizational performance and patient outcomes. This research reveals that healthcare's strategic performance measurement crisis is not a failure of capability or willingness but a failure of knowledge architecture: while managers actively use performance tools and can clearly articulate what they need for successful implementation, the strategic frameworks that could integrate these fragmented efforts remain trapped at executive levels, never reaching the operational managers who would implement them.

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**Appendix A**  
**Recruitment Email**

**Subject Line: \$30 Gift Card for Supporting Strategic Management Research**

Dear Healthcare Managers and Leaders,

My name is Chris Gibbons, and I am a doctoral student at National University. I am seeking participants for an independent research study aimed at understanding how healthcare managers and leaders approach strategic performance reporting systems and other tools that measure and enhance organizational performance. This study is conducted independently and is not affiliated with Bon Secours Mercy Health.

I am recruiting individuals who meet all of these criteria:

1. You currently work for a non-profit healthcare organization.
2. You are a manager with direct reports within the healthcare field.
3. You have been in your current role for at least one year.
4. You are age 18 or older.

If you decide to participate in this study, you will be asked to do **ONE** of the following options:

**Option 1: Questionnaire Completion**

Complete an online questionnaire to share your perspectives on strategic performance measurement systems. This will take approximately 20-30 minutes.

**OR**

**Option 2: Interview Participation**

Participate in a 20-30 minute interview via Zoom (phone or in-person options available upon request) to discuss your views on strategic performance measurement systems. After the interview, you will review a brief written summary of key themes for accuracy, which will take an additional 8-10 minutes.

During these activities, you will be asked questions about:

- Basic demographic details (age range, gender, educational background).
- Your current role, years in your role, experience in the field, and years in healthcare.
- Your experience with strategic performance reporting systems in healthcare.
- Your familiarity with tools like the Balanced Scorecard and other strategic planning methods.
- Factors you feel impact the adoption of performance reporting systems within your organization.

Participants will receive a **\$30 Amazon gift card**, which will be emailed to them after completing either the questionnaire or the interview summary review.

If you are interested in participating in this study, please select **ONE** of the following options:

1. Complete the online questionnaire here: [QUESTIONNAIRE LINK HERE]
2. Schedule an interview here: <https://christophergibbons.youcanbook.me>

If you have any questions, please contact me at [C.Gibbons8750@o365.ncu.edu](mailto:C.Gibbons8750@o365.ncu.edu).

Thank you for considering participating in this voluntary research!

Chris Gibbons  
Doctoral Candidate  
National University  
San Diego, California

## Appendix B

## Developmental Question Crosswalk

Question	Full Question Text	Primary RQ	Secondary RQ	Facet/Dimension Addressed	Contribution to Research
<b>Q1</b>	Please describe your experience with strategic management tools, including when and how you've encountered them in your healthcare career.	<b>RQ1</b>	-	<b>Awareness dimension:</b> General familiarity with strategic tools context	Establishes baseline knowledge and exposure to strategic management concepts; provides context for BSC awareness
<b>Q2</b>	Please describe any formal or informal training you have received in strategic management frameworks and performance measurement systems.	<b>RQ1</b>	RQ2	<b>Comprehension building:</b> Educational exposure and knowledge acquisition	Identifies formal/informal learning pathways that contribute to BSC understanding; reveals preparation for adoption
<b>Q3</b>	What is your understanding of the Balanced Scorecard (BSC) framework and how have you seen it applied in healthcare settings?	<b>RQ1</b>	-	<b>Direct BSC comprehension:</b> Specific knowledge and observed applications	Directly measures BSC awareness and depth of understanding; captures healthcare-specific applications

Question	Full Question Text	Primary RQ	Secondary RQ	Facet/Dimension Addressed	Contribution to Research
Q4	Please describe how strategic performance is currently measured and reported in your organization. What frameworks or tools are used?	RQ1	RQ2	<b>Contextual awareness:</b> Existing framework knowledge and usage	Documents current state of strategic measurement; provides baseline for comparing BSC adoption potential
Q5	What factors support or hinder the implementation of new strategic initiatives in your organization?	RQ2	-	<b>Adoption barriers and enablers:</b> Organizational readiness factors	Identifies specific conditions that support or hinder strategic system implementation
Q6	What resources and conditions do you consider crucial for successfully implementing a new strategic measurement system?	RQ2	-	<b>Adoption criteria:</b> Resource requirements and success factors	Reveals perceived prerequisites for successful strategic system adoption
Q7	How does your organization make decisions about adopting new strategic management tools or frameworks?	RQ2	-	<b>Adoption processes:</b> Governance and selection mechanisms	Uncovers how adoption decisions are made; identifies key stakeholders and processes

Question	Full Question Text	Primary RQ	Secondary RQ	Facet/Dimension Addressed	Contribution to Research
Q8	Looking ahead, what changes do you anticipate in how healthcare organizations will need to measure and manage strategic performance?	RQ2	-	<b>Evolution and trends:</b> Anticipated adoption drivers	Captures forward-looking perspectives on strategic measurement needs and directions
Q9	What would make a new strategic framework worth investing in for your organization? Please explain your criteria.	RQ2	-	<b>Adoption criteria:</b> Value propositions and decision factors	Explicitly identifies what would motivate framework adoption; reveals evaluation criteria
Q10	Based on your experience, what advice would you give about implementing strategic measurement systems in healthcare organizations?	RQ2	RQ1	<b>Practical adoption insights:</b> Lessons learned and best practices	Synthesizes experiential knowledge about implementation; may reveal awareness gaps

## Appendix C

### Interview Guide

**Study Title:** Balanced Scorecard Awareness and the Factors of Adoption for Strategic Performance Reporting Systems in a Non-Profit Healthcare Organization: A Qualitative Study

#### Informed Consent Protocol:

1. Email consent letter to participant at least 24 hours before interview
2. Request participant to read before interview
3. Confirm that participant reviewed consent letter
4. Ask participant if they have any questions about the research or the consent letter
5. Ask participants for verbal consent
6. Have consent forms available during interview if needed

#### Pre-Interview Checklist:

- Extra blank consent forms available (if in-person)
- Recording devices tested
- Quiet location secured
- Interview guide printed/readily accessible
- Participant contact information confirmed
- Backup recording method available
- Note-taking materials ready

#### Zoom Interview Protocol:

Before Interview:

- Test Zoom connection and settings
- Ensure quiet, professional background
- Check lighting and audio quality
- Have Zoom meeting link and password ready
- Send calendar invitation with Zoom details 24 hours in advance
- Test recording function
- Have backup recording method ready (e.g., voice recorder)
- Close unnecessary programs to prevent notifications
- Have participant's phone number available as backup

During Interview:

- Join meeting 5 minutes early

- Welcome participant and help with any technical issues
- Confirm audio and video are clear
- Explain recording process in Zoom
- Note that backup recording device may be used
- Remind participant they can discontinue video at any time
- Remind participant they can stop/pause the interview at any time

#### Technical Difficulties Protocol:

1. If Zoom connection fails:
  - Call participant's phone number
  - Send new meeting link if needed
  - Switch to phone interview if necessary
2. If audio issues occur:
  - Try reconnecting audio
  - Switch to phone audio while maintaining video
3. If recording fails:
  - Use backup recording device
  - Take detailed notes
4. If session needs to be rescheduled:
  - Apologize for inconvenience
  - Schedule new time immediately
  - Send new calendar invitation within 24 hours

#### Notes for Interviewer:

- Obtain verbal consent
- Record interview with participant's permission
- Take notes during interview
- Monitor time to ensure completion within 20-30 minutes
- Use probing questions as needed to elicit detailed responses
  - "Could you tell me more about that?"
  - "Could you give me an example?"
  - "How do you mean?"
  - "What makes you say that?"
  - "Could you elaborate on that point?"
  - "How does that relate to your experience?"
- Maintain professional and neutral demeanor throughout
- Document any non-verbal cues or contextual information
- Clarify any ambiguous responses
- Ask for specific examples when possible
- Verify unclear organizational terms/acronyms

**Introduction & Welcome:**

[SAY]: Welcome! My name is Chris Gibbons and I'm a doctoral candidate from National University. Thank you for taking the time to participate in this interview today.

I am conducting research to explore awareness and adoption considerations for strategic performance reporting systems, such as the Balanced Scorecard, among healthcare leaders and managers. This study aims to provide insights into how health organizations approach implementing frameworks to monitor strategic objectives and performance.

You may participate in this research if you meet all of the following criteria:

5. You currently work for a non-profit healthcare organization.
6. You are a manager with direct reports within the healthcare field.
7. You have been in your current role for at least one year.
8. You are 18 years of age or older.

Before proceeding, please confirm that you meet these criteria.

[WAIT FOR VERBAL CONFIRMATION]

[SAY]: The questions in this interview will focus on your knowledge and perceptions related to tools and systems for strategic performance measurement and reporting. There are no right or wrong answers. I am simply interested in learning more about your experiences and point of view through your responses.

This interview will take approximately 20-30 minutes to complete. Your participation is completely voluntary, and you may stop the interview at any time. Your responses will remain anonymous and confidential.

**Obtain Consent:**

[SAY]: Before proceeding, please confirm that you have read the consent letter that was emailed to you prior this interview.

[WAIT FOR RESPONSE] IF NO: I have a copy of the consent letter we can review now. Would you like me to share it with you? [If yes, email consent letter.]

[ALLOW TIME TO REVIEW IF NEEDED]

[SAY]: Do you have any questions about the research study or the consent letter?

[ADDRESS ANY QUESTIONS]

[SAY]: Do you agree to participate in this research study?

[WAIT FOR VERBAL CONSENT]

[SAY]: As noted in the consent letter, I will be recording this interview using Zoom's recording feature and a backup recording device. You can turn off your video at any time during the interview.

[START RECORDINGS] [CONFIRM RECORDINGS ARE WORKING]

[SAY]: Do you have any questions before we begin with the interview questions?

[ADDRESS ANY QUESTIONS]

[SAY]: Great, thank you! Let's get started!

### **SECTION 1: Strategic Management Experience (6-9 minutes)**

[SAY]: Let's begin by exploring your experience with strategic management tools, including the Balanced Scorecard (BSC). Please share your thoughts and experiences in as much detail as you feel comfortable. If you do not have experience or understanding of a particular question, that's completely fine—feel free to let me know.

1. Please describe your experience with strategic management tools, including when and how you've encountered them in your healthcare career.
2. Please describe any formal or informal training you have received in strategic management frameworks and performance measurement systems.
3. What is your understanding of the Balanced Scorecard (BSC) framework and how have you seen it applied in healthcare settings?

### **SECTION 2: Current Organizational Practices (5-7 minutes)**

[SAY]: Now, let's explore how strategic performance is currently managed in your organization.

4. Please describe how strategic performance is currently measured and reported in your organization. What frameworks or tools are used?
5. What factors support or hinder the implementation of new strategic initiatives in your organization?

### **SECTION 3: Future Perspectives (7-11 minutes)**

[SAY]: Next, I'd like to hear your thoughts about strategic performance measurement implementation and adoption considerations.

6. What resources and conditions do you consider crucial for successfully implementing a new strategic measurement system?
7. How does your organization make decisions about adopting new strategic management tools or frameworks?
8. Looking ahead, what changes do you anticipate in how healthcare organizations will need to measure and manage strategic performance?
9. What would make a new strategic framework worth investing in for your organization? Please explain your criteria.
10. Based on your experience, what advice would you give about implementing strategic measurement systems in healthcare organizations?

#### **SECTION 4: Professional Context (2-3 minutes)**

[SAY]: As we conclude, I'd like to gather some basic demographic information. This helps me understand different organizational perspectives.

1. What is your gender?
  - Male
  - Female
  - Non-binary
  - Prefer not to say
  - Other (please specify):
2. What is your age?
  - Under 20 years
  - 20–29 years
  - 30–39 years
  - 40–49 years
  - 50–59 years
  - 60 years or older
  - Prefer not to say
3. Which of the following best describes your current role/position?
  - Upper management (e.g., CEO, President, VP)
  - Middle management (e.g., Director, Senior Manager)
  - Frontline management (e.g., Manager, Supervisor)
  - Clinical leadership (e.g., Physician leader, Nursing director)

- Prefer not to say
  - Other (please specify):
4. How many years of experience do you have working in your current field?
    - Less than 5 years
    - 5–9 years
    - 10–14 years
    - 15–19 years
    - 20 years or more
  5. How many years of experience do you have working in healthcare?
    - Less than 5 years
    - 5–9 years
    - 10–14 years
    - 15–19 years
    - 20 years or more
  6. How long have you been in your current position?
    - Less than 1 year
    - 1–4 years
    - 5–9 years
    - 10–14 years
    - 15 years or more
  7. What is the highest level of education you have completed?
    - High school diploma/GED
    - Associate degree
    - Bachelor’s degree
    - Master’s degree
    - Doctoral or professional degree (e.g., MD, JD, PhD)
    - Prefer not to say
    - Other (please specify):

**Debriefing Questions:**

[SAY]: Before we end the interview, I’d like to ask a few final questions to ensure we’ve covered everything important and give you the opportunity to share any additional thoughts.

1. Participant’s Final Questions/Concerns:

Before we wrap up, do you have any questions or concerns about the interview or the research study?

2. Opportunity to Add or Clarify:

Is there anything you would like to add or clarify about your experiences with strategic performance measurement or the Balanced Scorecard that we may not have covered?

3. Key Takeaway or Most Important Insight:

What do you think is the most important point or insight you'd like me to take away from this interview?

**Closing Statement:**

[SAY]: Thank you again for your time and insights today. They will meaningfully inform this research on strategic performance systems in healthcare.

To ensure accurate representation, I will send you a summary of the key themes from our discussion within 2-3 weeks for your review. Please review the summary and let me know if it accurately captures your perspectives. Your feedback through this review process will help validate the study results. As a thank you for your time and perspectives shared today, you will receive a \$30 gift card. After you complete and return your review of the summary, the gift card will be sent to the email address you provided within three business days.

Do you have any final questions before we conclude?

[ADDRESS ANY QUESTIONS]

Thank you once more for contributing your valuable perspectives to this study. Your participation will help advance knowledge on this important topic.

**Post-Interview Checklist:**

- Verify recording saved properly
- Save backup copy of recording
- Complete initial field notes
- Schedule member checking follow-up
- Secure data according to protocol

## Appendix D

### Questionnaire

Hello,

My name is Christopher Gibbons, and I am a doctoral student at National University. I am conducting an online questionnaire to study strategic performance reporting systems in healthcare management, with a secondary focus on the Balanced Scorecard tool.

You may participate in this research if you meet all of the following criteria:

1. You currently work for a non-profit healthcare organization.
2. You are a manager with direct reports within the healthcare field.
3. You have been in your current role for at least one year.
4. You are 18 years of age or older.

The following questionnaire includes questions about:

Basic demographic information (age range, gender, and educational background).

Your current role, years in your role, total experience in your field, years with current employer, and time working in healthcare.

Your experience with strategic performance reporting systems in healthcare.

Your awareness and use of tools like the Balanced Scorecard and other strategic planning approaches.

Factors you believe influence the adoption of strategic performance reporting systems in your organization.

It will take 20-30 minutes of your time to complete the questionnaire.

As a thank you for completing this questionnaire, you will receive a \$30 Amazon gift card.

On the final page, you will be asked to provide an email address where you would like to receive your gift card. The gift card will be sent to this email address within three business days of completing the questionnaire. Your email address will be stored separately from your responses to maintain anonymity.

Your participation in this study is voluntary. If you decide to participate, your responses will be anonymous - that is, recorded without any identifying information that is linked to you. If you have any questions regarding this questionnaire, please contact me at C.Gibbons8750@o365.ncu.edu or (419) 344-7919.

If you have any questions regarding your rights as a human subject and participant in this study, or to report research-related problems, you may email the National University IRB at irb@nu.edu.

***By clicking the next button and completing the questionnaire you indicate that you have consented to participate in this research. If you do not want to participate, please close the browser.***

Do you agree to participate in this study?

- Yes, I agree
- No, I disagree
- 

*The following questions explore your experience with strategic management tools, including the Balanced Scorecard (BSC). Please share your thoughts and experiences in as much detail as you feel comfortable. If you do not have any experience or understanding of a particular question, that is perfectly fine, simply indicate this in your response.*

Q1 Please describe your experience with strategic management tools, including when and how you've encountered them in your healthcare career.

Q2 Please describe any formal or informal training you have received in strategic management frameworks and performance measurement systems.

Q3 What is your understanding of the Balanced Scorecard (BSC) framework and how have you seen it applied in healthcare settings?

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*Now, let's explore how strategic performance is currently managed in your organization. If you do not have any experience or understanding of a particular question, that is perfectly fine, simply indicate this in your response.*

Q4 Please describe how strategic performance is currently measured and reported in your organization. What frameworks or tools are used?

Q5 What factors support or hinder the implementation of new strategic initiatives in your organization?

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*In this section, please share your thoughts about the future of strategic performance measurement in healthcare. If you do not have any experience or understanding of a particular question, that is perfectly fine, simply indicate this in your response.*

Q6 What resources and conditions do you consider crucial for successfully implementing a new strategic measurement system?

Q7 How does your organization make decisions about adopting new strategic management tools or frameworks?

Q8 Looking ahead, what changes do you anticipate in how healthcare organizations will need to measure and manage strategic performance?

Q9 What would make a new strategic framework worth investing in for your organization? Please explain your criteria.

Q10 Based on your experience, what advice would you give about implementing strategic measurement systems in healthcare organizations?

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*Before we conclude, please tell me about your professional context. This helps me understand different organizational perspectives.*

QD1 What is your gender?

- Male
- Female
- Non-binary
- Prefer not to say
- Other (please specify)

QD2 What is your age?

- Under 20 years (1)
- 20-29 years (2)
- 30-39 years (3)
- 40-49 years (4)
- 50-59 years (5)
- 60 years or older (6)
- Prefer not to say (7)

QD3 Which of the following best describes your current role/position?

- Upper management (e.g., CEO, President, VP) (1)
- Middle management (e.g., Director, Senior Manager) (2)
- Frontline management (e.g., Manager, Supervisor) (3)
- Clinical leadership (e.g., Physician leader, Nursing director) (4)
- Prefer not to say (5)
- Other (please specify) (6) \_\_\_\_\_

QD4 How many years of experience do you have working in your current field?

- Less than 5 years (1)
- 5-9 years (2)
- 10-14 years (3)
- 15-19 years (4)
- 20 years or more (5)

QD5 How many years of experience do you have working in healthcare?

- Less than 5 years (1)
- 5-9 years (2)
- 10-14 years (3)
- 15-19 years (4)
- 20 years or more (5)

QD6 How long have you been in your current position?

- Less than 1 year (1)
- 1-4 years (2)
- 5-9 years (3)
- 10-14 years (4)
- 15 years or more (5)

QD7 What is the highest level of education you have completed?

- High school diploma/GED (1)
  - Associate degree (2)
  - Bachelor's degree (3)
  - Master's degree (4)
  - Doctoral or professional degree (e.g., MD, JD, PhD) (5)
  - Prefer not to say (6)
  - Other (please specify) (7)
- 

Thank you for completing this questionnaire. Your insights about strategic performance reporting systems in healthcare are valuable contributions to this research. To receive your \$30 Amazon gift card:

- Please send an email to [C.Gibbons8750@o365.ncu.edu](mailto:C.Gibbons8750@o365.ncu.edu)
  - Put "Strategy Study" in the subject line.
- Your gift card will be sent to your email address within three business days.

Note: Your email will be kept separate from your questionnaire responses to maintain anonymity.

I thank you for your time spent taking this questionnaire. Your responses have been recorded.

## Appendix E

### National University IRB Exemption



9388 Lightwave Ave.  
San Diego, CA 92123  
irb@nu.edu

#### Notice of Exemption

January 30, 2025

**To:** Christopher Gibbons

**Project Title:** Balanced Scorecard Awareness and the Factors of Adoption for Strategic Performance Reporting Systems in a Non-Profit Healthcare Organization: A Qualitative Study  
**NU IRB Number:** IRB-FY24-25-71

**Determination:** Exempt from further review 45 CFR 46.101 Category 2.(i). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

**Status: Active - Research activities may begin as of January 30, 2025**

Dear Christopher Gibbons:

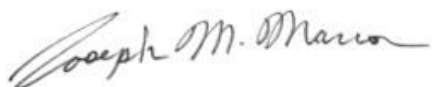
The study referenced above has been reviewed by the National University IRB. The IRB has determined your research is exempt from further review under 45 CFR 46.104, which means

you will not need to renew your study and may begin your study effective immediately. However, if you find the need to change your study in any way, you will need to submit a modification to the IRB prior to implementing the changes. This will allow the IRB to determine whether or not the study still meets exemption criteria.

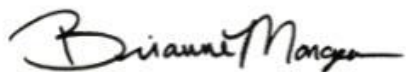
Please review your Post Approval Responsibilities here: [Approved Documents Guidelines](#)

For any questions regarding your protocol, please reach out to the IRB at [irb@nu.edu](mailto:irb@nu.edu).

Sincerely,



Dr. Joseph Marron, IRB Chair



Dr. Brianne Mongeon, Director, HRPP & IRB



Jenessa Eberhardt, Associate Director, HRPP & IRB

## Appendix F

### Site IRB Exemption



**BON SECOURS MERCY HEALTH**

BSMH Institutional Review Board (IRB)  
Research Participant Protection Program (RP<sup>3</sup>)

**DATE:** November 6, 2023  
**TO:** Christopher Gibbons MBA, CHFP, RT (R) (CT)  
**FROM:** Rod Irwin MS, CIP  
RP<sup>3</sup> Administrator  
**RE:** BSMH IRB: 62-2023-TOL-MCO-Gibbons  
Balanced Scorecard Awareness and the Factors of Adoption for Strategic Performance  
Reporting Systems in a Non-Profit Healthcare Organization: A Qualitative Study

On November 6, 2023 the above-referenced research study was determined to be **qualified for exemption** according to Exempt Category 2.

**INSTITUTIONAL APPROVALS:** This determination is from the RP<sup>3</sup> only. You are responsible for obtaining any other required institutional or departmental approvals.

Please inform the RP<sup>3</sup> when your study closes or if you require any amendments. The RP<sup>3</sup> will conduct an administrative check-in on the status of your study three (3) years from the date of this determination.

If you have any questions, please feel free to contact me.

Rod Irwin MS, CIP

RP<sup>3</sup> Administrator | Toledo/Lima  
Research Participant Protection Program (RP<sup>3</sup>)  
Bon Secours Mercy Health IRB  
[Rodney\\_Irwin@mercy.com](mailto:Rodney_Irwin@mercy.com)\*



**BON SECOURS MERCY HEALTH**

\* RP<sup>3</sup> Administrators work remotely. (419) 269-8452

## Appendix G

### Informed Consent Form

My name is Christopher Gibbons, and I am a doctoral student at National University (NU). I also work for Mercy College of Ohio, which is a business unit of Bon Secours Mercy Health (BSMH). At Mercy College of Ohio and BSMH, I hold roles as Healthcare Administration Director, Master of Health Administration Coordinator, Master of Health Administration Faculty Academic Advisor, and Associate Professor.

I am asking you to take part in a research study about strategic performance reporting systems in healthcare management, with a secondary focus on the Balanced Scorecard tool. The name of this research is “Balanced Scorecard Awareness and the Factors of Adoption for Strategic Performance Reporting Systems in a Non-Profit Healthcare Organization: A Qualitative Study.”

You may participate in this research if you meet all of the following criteria:

9. You currently work for a non-profit healthcare organization.
10. You are a manager with direct reports within the healthcare field.
11. You have been in your current role for at least one year.
12. You are 18 years of age or older.

I hope to include 30 people in this research.

Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

**What you will be asked to do:** If you agree to participate in this study, you will be asked to complete **ONE** of the following options:

**Option 1: Questionnaire Completion**

- Complete an online questionnaire sharing your perspectives on strategic performance measurement systems.
- The questionnaire will take approximately 20-30 minutes to complete.

**OR**

**Option 2: Interview Participation**

- Participate in a 20-30 minute interview sharing your perspectives on strategic performance measurement systems.
- The interview will be conducted via Zoom (alternative arrangements such as phone or in-person meetings can be accommodated upon request).
- Following the interview, you will be asked to review a written summary of key themes from your interview for accuracy (approximately 8-10 minutes).

During these activities, you will be asked questions about:

- Your experience with strategic performance reporting systems in healthcare.
- Your awareness and use of tools like the Balanced Scorecard and other strategic planning approaches.
- Factors you believe influence the adoption of strategic performance reporting systems in your organization.
- Basic demographic information, including age range, gender, and educational background.
- Your current role, years in your role, total experience in your field, years with your current employer, and time working in healthcare.

**Risks:** There are minimal foreseeable risks or discomforts associated with this research. Some possible risks include not being comfortable answering some of the interview questions.

Additionally, there is a slight risk that your identity could be determined based on your responses, despite strict controls to maintain confidentiality and anonymity. To decrease the impact of these risks, you can skip any question you do not wish to answer, skip any activity, or stop participation at any time.

**Benefits:** If you participate, there are no direct benefits to you. This research may increase the body of knowledge in the area of strategic performance reporting in healthcare organizations.

**Recording:** I would like to audio record your responses with a voice recorder during the interview. If the interview is conducted via Zoom, both audio and video may be recorded. You can disable the video function of the online meeting platform at any time.

**Compensation:** After you complete either the online questionnaire or the interview (including review of key themes), you will receive a \$30 Amazon e-gift card.

**Confidentiality:** I will keep the records of this study private and take reasonable measures to protect the security of all your personal information. In any report I make public, I will not include any information that will make it possible to identify you. Your responses will be confidential, data will be reported only in aggregate form, and records will be securely stored and then destroyed after 3 years.

**Taking part is voluntary:** Participation in this study is completely voluntary. You may quit at any time.

**If you have questions:** Please ask any questions you have now. If you have questions later, you may contact me at [C.Gibbons8750@o365.ncu.edu](mailto:C.Gibbons8750@o365.ncu.edu) or at (419) 344-7919.

If you have any questions or concerns regarding your rights as a subject in this study, you may contact the Institutional Review Board (IRB) via email at [irb@nu.edu](mailto:irb@nu.edu).