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Inter-Organizational Culture Model Based on the Balanced Scorecard at Kusuma Pertiwi Clinic

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Abstract
Primary healthcare organizations require an integrated culture that can translate strategic objectives into consistent service behavior. This study developed an inter-organizational culture model using the Balanced Scorecard at Kusuma Pertiwi Clinic, Kediri Regency, East Java. A descriptive-exploratory qualitative case study was conducted through semi-structured interviews, non-participant observation, and document review involving seven key informants across managerial roles and generations. Data were analyzed using the Miles, Huberman, and Saldana model through data condensation, data display, conclusion drawing, triangulation, and member checking. The findings showed that the clinic's culture was anchored in family orientation, openness, discipline, flexibility, and honesty, but required stronger financial transparency, clearer role distribution, digital coordination, and structured accountability. The Balanced Scorecard analysis indicated good patient satisfaction and learning culture, while the financial and internal process perspectives required more systematic improvement. The proposed model integrates core cultural values, new professional values, operational mechanisms, collaborative leadership, and cross-generational mentoring to strengthen clinic performance.

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1. INTRODUCTION

The development of healthcare services in Indonesia has become increasingly complex because primary healthcare providers are expected to deliver services that are fast, safe, accountable, and responsive to patient needs. Clinics occupy a strategic position as first-contact healthcare facilities and therefore need management systems that can connect service quality, human resource behavior, operational processes, and financial sustainability. In the thesis that became the source of this manuscript, Kusuma Pertiwi Clinic was positioned as a primary healthcare facility facing accreditation requirements, service quality demands, competition among healthcare providers, and regulatory adaptation. These conditions make organizational culture not merely a symbolic managerial issue, but a practical mechanism that shapes how employees coordinate, communicate, and translate standards into daily service behavior [1], [2].

Organizational culture is commonly understood as a shared pattern of assumptions, values, and norms learned by members of an organization in solving problems of external adaptation and internal integration [3]. In a service organization, culture influences the way employees interpret patient needs, coordinate across units, follow standard operating procedures, and respond to managerial priorities. Robbins and Judge emphasized that inconsistency in organizational culture may reduce work effectiveness, service quality, and

coordination among units [4]. In the context of a clinic, this issue is particularly important because medical, nursing, pharmacy, administration, finance, and supporting units must interact in a continuous service chain. A weak or fragmented culture can create delays, communication gaps, and inconsistent patient experiences.

The concept of inter-organizational culture in this article refers to culture across internal organizational units within the clinic. The term was retained from the thesis title, but analytically it is interpreted as inter-unit cultural alignment among functional units. This interpretation is relevant because the empirical problem was not the relationship between two independent organizations, but the way different units and generations within the same clinic formed shared values, patterns of communication, and performance practices. The thesis identified that differences in culture across units appeared in variations of work values, communication styles, perceptions of procedures, and understanding of organizational performance targets.

Balanced Scorecard is relevant to analyze this problem because it provides a holistic framework for measuring organizational performance beyond financial indicators. Kaplan and Norton introduced Balanced Scorecard as a strategic management system that balances financial and non-financial measures across four perspectives: financial, customer, internal business process, and learning and growth [5], [6]. In healthcare organizations, this framework is useful because service outcomes are influenced not only by revenue or cost control, but also by patient satisfaction, safety, process efficiency, staff competence, and learning capacity [7]-[9]. For a clinic, Balanced Scorecard can become a bridge between cultural values and measurable performance outcomes.

The urgency of this research also lies in generational diversity. Kusuma Pertiwi Clinic involves employees and managers from different generations, including Baby Boomers, Millennials, and Generation Z. Generational theory suggests that each generation may carry different preferences regarding communication, authority, technology, work-life balance, loyalty, and problem solving [10]-[13]. In the clinic's context, senior generations tend to rely on experience, direct communication, and practical wisdom, whereas younger generations are more adaptive to digital tools and faster information exchange. This diversity can become either a source of friction or a strategic resource, depending on the quality of leadership, communication, and shared cultural mechanisms.

Previous studies have shown that strong organizational culture can support service quality, patient satisfaction, process efficiency, and human resource performance. At the same time, healthcare Balanced Scorecard studies demonstrate that the framework can improve strategy integration, performance monitoring, and decision making in hospitals and primary healthcare facilities [7], [9], [14]. However, research that combines inter-unit organizational culture, cross-generational workforce dynamics, and Balanced Scorecard in the context of a primary clinic remains limited. Most Balanced Scorecard applications emphasize performance indicators, while cultural alignment is often treated as a background variable rather than a model component.

Therefore, this article aims to develop an inter-organizational culture model based on the Balanced Scorecard at Kusuma Pertiwi Clinic. Specifically, the study describes the existing culture across units, analyzes clinic performance through the four Balanced Scorecard perspectives, explains the relationship between culture and performance, identifies internal and external determinants of culture, and formulates a recommended culture model to improve clinic performance. The novelty of this manuscript lies in the integration of family-oriented clinic culture, professional accountability, digital coordination, and cross-generational mentoring within a Balanced Scorecard-based model for primary healthcare management.

2. RESEARCH METHOD

This study used a qualitative approach with a descriptive-exploratory case study design. A qualitative design was chosen because the research focused on understanding meanings, values, communication patterns, and managerial experiences rather than testing numerical relationships among variables. The case study design was appropriate because Kusuma Pertiwi Clinic represented a bounded system in which organizational culture, cross-unit coordination, and performance practices could be examined in their real-life context [15], [16].

The research was conducted at Kusuma Pertiwi Clinic, Kediri Regency, East Java. The clinic provides several service functions, including administration, outpatient care, pharmacy, nursing, laboratory support, finance, and other supporting units. Data collection was conducted on 9-12 December 2025. Although field data collection took place within a short period, analysis, verification, and triangulation continued until the main themes were adequately saturated. In qualitative research, the adequacy of data is determined by the depth and relevance of information rather than merely by the length of fieldwork [16], [17].

Participants were selected using purposive sampling. The main criteria included having a managerial or coordination role, being involved in cross-unit work processes, understanding the clinic's culture and performance issues, and being willing to provide information openly. Seven key informants participated in the study, representing different managerial roles and generations. The use of key informants was considered appropriate because the research emphasized managerial interpretation, strategic culture, and performance alignment. Table 1 presents the informant profile used in coding and analysis.

Table 1. Key Informants and Coding Profile

Code	Position/Role	Generation	Analytical relevance
R1	Manager of Administration	Millennial/Y	Administrative workflow, coordination, digital communication, reporting
R2	Internal Business Manager	Baby Boomer	Historical development of the clinic, service process, inter-unit collaboration
R3	Head of Foundation	Baby Boomer	Strategic direction, leadership values, organizational culture, policy orientation
R4	Clinic Director	Millennial/Y	Overall management, cultural pillars, financial and service strategy
R5	Midwifery and Nursing Manager	Millennial/Y	Clinical service process, staffing, patient care, inter-professional coordination
R6	Finance Manager	Millennial/Y	Financial reporting, budgeting, cash flow constraints, transparency
R7	Pharmacy Manager	Generation Z	SOP discipline, medication service, stock control, digital readiness, patient information

Data were collected through three techniques. First, semi-structured in-depth interviews were conducted to explore the informants' perceptions of culture, coordination, Balanced Scorecard performance, leadership, and the ideal culture model. Second, non-participant observation was used to understand service flow, communication patterns, and daily work behavior without interfering with clinical operations. Third, document review was used to examine supporting evidence, including organizational structure, standard operating procedures, financial information, patient feedback, internal reports, and available service documents. Combining interviews, observation, and documents strengthened source and method triangulation [17]-[19].

The researcher served as the main research instrument. Supporting instruments included an interview guide, observation sheet, field notes, recording device, and documentation checklist. The interview guide was organized around four major domains: inter-organizational culture, organizational performance based on Balanced Scorecard, factors influencing culture, and the recommended model. The use of a semi-structured guide allowed the researcher to maintain focus while still allowing informants to elaborate on their experiences and provide contextual explanations [17].

Data analysis followed the interactive model of Miles, Huberman, and Saldana, consisting of data condensation, data display, and conclusion drawing/verification [20]. Data condensation was conducted by selecting relevant interview excerpts, coding them according to cultural values and Balanced Scorecard perspectives, and grouping them into analytical categories. Data display was developed through matrices, thematic summaries, and a proposed model. Conclusions were drawn progressively and verified through triangulation, repeated reading of the data, and consistency checks against documentary and observational evidence.

Table 2. Analytical Framework and Coding Orientation

Analytical domain	Main codes	Source of evidence	Expected output
Inter-organizational culture	Family orientation, openness, discipline, flexibility, honesty, collaboration, SOP compliance	Interviews, observation, field notes	Description of existing culture across clinic units
Financial perspective	Budgeting, transparency, cash flow, manual reporting, cost control, revenue sources	Finance interview, management interviews, documents	Identification of financial strengths and weaknesses
Customer perspective	Patient satisfaction, friendliness, waiting time, patient feedback, complaint handling	Interviews, patient feedback documents, observation	Assessment of service experience and patient-oriented culture
Internal process perspective	SOP, workflow, coordination, registration, privacy, pharmacy process, facility constraints	Interviews, SOP review, observation	Assessment of process consistency and bottlenecks
Learning and growth perspective	Training, knowledge sharing, digital capability, mentoring, evaluation, staff development	Interviews, training information, meetings	Assessment of organizational learning and generational collaboration
Model development	Core values, new values, operational mechanisms, leadership, generational management	Synthesis of all evidence	Balanced Scorecard-based culture model

3. RESULTS AND DISCUSSION

3.1.Existing Inter-Organizational Culture sil Penelitian

The findings showed that the culture of Kusuma Pertiwi Clinic is strongly anchored in family orientation. Informants repeatedly described the clinic's culture using terms such as family, openness, compassion, discipline, flexibility, honesty, collaboration, and

professionalism. The Clinic Director summarized the dominant culture through four pillars: family orientation, discipline, flexibility, and honesty. The Head of Foundation emphasized openness and compassion, while the Internal Business Manager explained that the clinic's culture emerged from a historical transformation from independent midwifery practice into a structured primary clinic. This transformation shaped a culture that is personal and relational, but increasingly required to comply with professional standards.

The family-oriented culture has several strengths. It supports informal communication, mutual help, emotional closeness, and quick problem solving when the clinic faces service pressure. In the Indonesian healthcare context, this culture can strengthen patient trust because employees approach service not only as a technical process but also as a caring relationship. However, the same culture also creates managerial challenges when informal practices are not balanced by clear systems. Several informants noted that role distribution, reporting, financial transparency, and digital coordination still needed improvement. Therefore, the clinic's culture can be understood as a transitional culture: it has strong relational values but is moving toward structured professionalism.

A key feature of the culture is cross-generational diversity. Senior informants tended to emphasize experience, direct communication, consistency, and the need to preserve the clinic's original values. Younger informants emphasized SOP compliance, structured documentation, digital communication, and service speed. These differences did not necessarily create conflict, but they influenced work rhythm and expectations. Generation Z, for example, was described as more adaptive to technology and faster in digital communication, while senior employees were viewed as more careful, experience-based, and direct in their communication style. This confirms that generational diversity can become a resource when it is managed through mutual respect and clear coordination mechanisms [10], [12].

Communication and coordination across units combined formal and informal channels. Formal mechanisms included periodic reports, meetings, briefings, and coordination among unit managers. Informal mechanisms included direct personal approach, WhatsApp communication, and spontaneous discussion when a problem appeared. Informants perceived these mechanisms as generally effective, but the Administrative Manager observed that coordination still depended strongly on leadership initiative. If leaders were passive, lower-level coordination also tended to slow down. This finding supports the theoretical view that culture is reproduced through leadership behavior and repeated organizational practices [3], [4].

Table 3. Summary of Existing Cultural Values Across Units

Cultural theme	Empirical indication	Managerial meaning
Family orientation	The clinic emphasizes kinship, compassion, openness, and personal approach in daily work.	Builds emotional attachment and supports informal problem solving, but requires clearer rules to prevent ambiguity.
Discipline and SOP compliance	Pharmacy, nursing, and clinical units emphasize standard procedures and patient safety.	Strengthens process reliability and reduces clinical risk when supported by consistent supervision.
Flexibility	Work schedules and coordination are relatively adaptive to operational needs.	Improves staff acceptance but may create inconsistency if not supported by accountability.

Collaboration	Units such as medical service, pharmacy, administration, and finance must complement each other in the patient journey.	Creates integrated service when communication is fast and task boundaries are clear.
Openness and honesty	Informants value transparent communication and open discussion when problems arise.	Serves as a foundation for trust, financial transparency, and shared decision making.

3.2. Organizational Performance Based on the Balanced Scorecard

The Balanced Scorecard analysis produced a comprehensive picture of clinic performance. It showed that Kusuma Pertiwi Clinic had strong relational and service-oriented strengths, particularly in patient satisfaction and learning culture, but faced managerial weaknesses in financial systems, digital integration, workload distribution, and transparent reporting. The following discussion presents the four perspectives.

3.2.1. Financial Perspective

The financial perspective was the most urgent area for improvement. The clinic relied on two primary sources of revenue: BPJS-related payments and general patient payments. The Clinic Director stated that BPJS funds were primarily allocated for salaries, while non-BPJS income was used for facilities and infrastructure. This allocation reflects an effort to separate sources and uses of funds, but the Finance Manager and Administrative Manager noted that the system was not yet fully effective because some reporting remained manual and some financial flows were not sufficiently transparent.

The main financial problems were manual reporting, incomplete recording, limited financial transparency, and the absence of dedicated human resources for daily financial reporting. The Finance Manager noted that personal and organizational expenses were not always fully separated, while the Administrative Manager stated that the clinic did not yet have a specific system for daily reporting transparency. From a Balanced Scorecard perspective, these problems weaken the clinic's ability to evaluate efficiency and financial sustainability because data are not yet integrated and may not fully reflect operational reality [5], [9].

The financial findings indicate that the clinic requires a shift from trust-based financial management to system-based financial accountability. Family-oriented culture remains important, but financial management must be supported by clear procedures, separation of personal and clinic expenses, digital reporting, budget control, and regular financial evaluation. Without this improvement, the clinic may find it difficult to connect operational performance with financial outcomes.

3.2.2. Customer Perspective

The customer perspective showed a more positive condition. Informants generally perceived patient satisfaction as good. Several sources of feedback were used, including Google reviews, suggestion boxes, and internal monthly surveys. One informant reported that patient satisfaction reached approximately 90 percent based on online reviews. Patients appreciated friendly service, professional medical and nursing actions, relatively clear information, and the family-oriented service approach.

Nevertheless, customer-related problems remained visible. Patient complaints commonly related to waiting time during peak hours, occasional decline in friendliness, cleanliness, and the comfort of waiting areas. These complaints suggest that patient satisfaction is influenced by staffing adequacy, workload pressure, space arrangement, and the ability of employees to maintain service standards when patient volume increases. In

this sense, the customer perspective cannot be improved by front-office behavior alone; it requires internal process improvement and learning capacity across units [5], [7].

The clinic's strength in the customer perspective lies in its relational culture. Patients were not only treated through procedural interaction, but also through a caring and personal approach. However, to make this advantage sustainable, the clinic must institutionalize patient-centered values into measurable service standards, including maximum waiting time, complaint response mechanism, communication standards, and patient information protocols.

3.2.3. Internal Business Process Perspective

From the internal process perspective, the clinic had several strengths. Informants described the existence of service flow from registration, doctor examination, supporting examination, pharmacy, and payment. Clinical units used Ministry of Health SOPs and internal SOPs agreed upon by the clinic. The pharmacy unit emphasized accurate recording, compliance with dispensing procedures, stock monitoring, and fast coordination with other units. These findings indicate that the clinic already has the basic process infrastructure needed for safe and consistent service delivery.

However, several bottlenecks were identified. The clinic needed more professional staff, a better financial management system, expanded emergency service space, more integrated facilities, a separate registration area to protect patient privacy, and digital systems to reduce waiting time and improve service accuracy. These findings are consistent with the Balanced Scorecard logic that internal process weaknesses can reduce patient satisfaction and financial efficiency [5], [6].

The internal process perspective therefore requires a more disciplined balance between flexibility and standardization. Flexibility is valued by employees because it reflects family-oriented leadership and adaptive scheduling. Yet, healthcare quality depends on consistency, documentation, privacy protection, and process control. A clinic can maintain flexible human relations while still enforcing standardized work systems.

3.2.4. Learning and Growth Perspective

The learning and growth perspective was relatively strong. Informants reported that the clinic provided opportunities for competency development through training, workshops, professional development, and knowledge sharing. In clinical units, training was also connected to professional credit requirements and license renewal. The Head of Foundation stated that employees were given opportunities to develop themselves, either independently or with clinic support. The Administrative Manager described monthly knowledge-sharing meetings through Zoom, while the Pharmacy Manager noted routine briefing and discussion when new cases emerged.

The learning culture was strengthened by digital communication, especially WhatsApp groups and online meetings. This practice enabled quick sharing of updated information and informal learning among staff. However, the learning system still needs to become more structured. The clinic should ensure that training outcomes are documented, shared across units, and linked to performance indicators. Cross-generational mentoring can also become a strategic mechanism: senior employees can transfer experience and clinical wisdom, while younger employees can support digital adoption and information speed.

In Balanced Scorecard logic, learning and growth is a foundation for internal process improvement, customer satisfaction, and financial sustainability. The clinic already has a learning-oriented culture, but it should be strengthened through competency mapping, training plans, post-training knowledge dissemination, and digital capability development [6], [14].

Table 4. Balanced Scorecard Findings and Improvement Priorities

BSC perspective	Main strengths	Main weaknesses	Improvement priority
Financial	Two main revenue sources; commitment to budget use; emergency reserve funds.	Manual system; incomplete reporting; unclear separation of personal and clinic expenses; limited transparency.	Digital financial reporting, expense separation, dedicated finance staff, monthly budget review.
Customer	High perceived satisfaction; friendly service; family-oriented complaint handling; clear information in several units.	Waiting time during peak hours; occasional decline in friendliness; cleanliness and waiting-room comfort issues.	Service time standards, complaint dashboard, patient communication protocol, waiting-area improvement.
Internal process	Service flow exists; SOPs are used; pharmacy procedures are careful; inter-unit collaboration exists.	Limited space, manual coordination, privacy issue in registration area, insufficient staff during busy periods.	Workflow redesign, privacy-sensitive registration space, digital coordination, clear task distribution.
Learning and growth	Training opportunities, knowledge sharing, WhatsApp updates, monthly sharing sessions.	Learning is not yet fully mapped to performance; digital competence varies across generations.	Training roadmap, cross-generational mentoring, competency evaluation, digital literacy support.

3.3. Relationship Between Culture and Performance

The findings indicate that inter-organizational culture and Balanced Scorecard performance are strongly connected. Culture influenced how employees understood their roles, communicated across units, responded to patient complaints, followed SOPs, and handled organizational change. A culture of family orientation supported patient-centered service and informal problem solving, while a culture of discipline supported SOP compliance. However, the absence of a strong culture of transparency and accountability contributed to weaknesses in financial reporting and role distribution.

Generational differences also shaped performance. Senior generations contributed experience, carefulness, and direct communication. Millennials tended to balance practical decision making with collaboration, while Generation Z showed stronger digital orientation and speed in communication. When these differences were recognized and combined, they supported service effectiveness. When they were not explicitly managed, differences in communication style and work rhythm could slow coordination. Therefore, generational diversity must be treated as an organizational capability rather than a problem.

The relationship between culture and performance can be explained through the four Balanced Scorecard perspectives. In the financial perspective, honesty and accountability are required to improve reporting transparency. In the customer perspective, empathy and family orientation support patient satisfaction. In the internal process perspective, discipline and coordination are necessary for SOP compliance and service flow. In the learning and growth perspective, openness and knowledge sharing encourage training, mentoring, and adaptability. Thus, each BSC perspective requires specific cultural values to operate effectively.

This relationship confirms that Balanced Scorecard should not be treated only as a measurement tool. For Kusuma Pertiwi Clinic, it can become a cultural alignment framework. Performance indicators must be translated into values, behaviors, and routines. For example, a target to reduce waiting time requires not only a time indicator, but also a culture of punctuality, digital coordination, staff readiness, and inter-unit responsiveness. A target to improve financial sustainability requires not only revenue monitoring, but also transparency, accurate documentation, and shared responsibility.

3.4. Factors Influencing Inter-Organizational Culture

The study identified internal and external factors influencing the clinic's culture. Internal factors included human resource capability, mindset, willingness to communicate, knowledge, workplace conditions, leadership, discipline, SOP compliance, reward systems, and performance evaluation. These factors shape how employees behave in daily work and how they respond to organizational expectations. Among these internal factors, leadership emerged as the most important driver because leaders define policies, model discipline, build communication, and create attention to staff welfare.

External factors included BPJS demands, health office policies, Ministry of Health regulations, patient expectations, competition with surrounding healthcare facilities, and the increasing knowledge of patients. These external pressures forced the clinic to become more systematic, more competitive, and more responsive. In particular, patient knowledge and competition require the clinic to improve service quality continuously, while regulatory demands require better documentation, SOP compliance, and accountability.

Leadership mediates the effect of internal and external factors on culture. The Clinic Director stated that authoritarian leadership would only produce obedience, whereas adaptive and understanding leadership could make the organization run more smoothly. The Head of Foundation emphasized that management must provide clear rules, adequate facilities, routine evaluation, and disciplinary examples. This finding is consistent with organizational culture theory: leaders create, embed, and maintain culture through what they pay attention to, how they respond to crises, and how they reward behavior [3].

Table 5. Determinants of Inter-Organizational Culture

Category	Factors identified	Implication for the clinic
Internal factors	HR capability, mindset, communication willingness, knowledge, workplace environment, discipline, SOP compliance, reward and evaluation.	The clinic must strengthen competency, task clarity, and performance feedback to make family-oriented culture more professional.
External factors	BPJS requirements, health regulations, competition, patient knowledge, service expectations.	The clinic must become more systematic, transparent, responsive, and quality-oriented.
Leadership factors	Policy direction, communication style, attention to staff conditions, example of discipline, supportiveness, evaluation.	Leadership must integrate relational culture with accountability, digitalization, and measurable performance indicators.

3.5. Proposed Inter-Organizational Culture Model Based on the Balanced Scorecard

Based on the findings, the recommended model integrates five components: core cultural values, new professional values, operational mechanisms, collaborative leadership, and cross-generational management. The core values that should be preserved

are family orientation, openness, collaboration, discipline, and commitment to patient safety. These values represent the identity and relational strength of the clinic. However, the clinic also needs new professional values, especially transparency, accountability, innovation, structured professionalism, and digital readiness. These values are necessary to respond to weaknesses in finance, reporting, role clarity, and process coordination.

Operational mechanisms are needed to make cultural values visible in daily routines. The model recommends daily briefings for fast coordination, monthly evaluation meetings for strategic review, digital communication platforms for real-time updates, transparent reporting systems, and routine training with post-training knowledge sharing. These mechanisms prevent culture from remaining abstract. They translate values into repeated actions and measurable practices.

Collaborative leadership is the central integrator of the model. Leaders must provide direction, model discipline, facilitate dialogue, make transparent decisions, and ensure that every unit understands its role in the Balanced Scorecard. Leadership should not rely solely on personal closeness; it must be supported by clear accountability and consistent evaluation. At the same time, leadership must preserve the human and family-oriented characteristics that make the clinic trusted by employees and patients.

Cross-generational management strengthens the model by converting generational differences into complementary capabilities. Senior employees can contribute experience, prudence, direct mentoring, and historical understanding of the clinic. Millennials can support coordination, team-based decision making, and managerial balance. Generation Z can accelerate digital communication, data accuracy, and technology adoption. A mentoring system should therefore work in two directions: senior-to-junior transfer of professional wisdom and junior-to-senior support in digital practices.

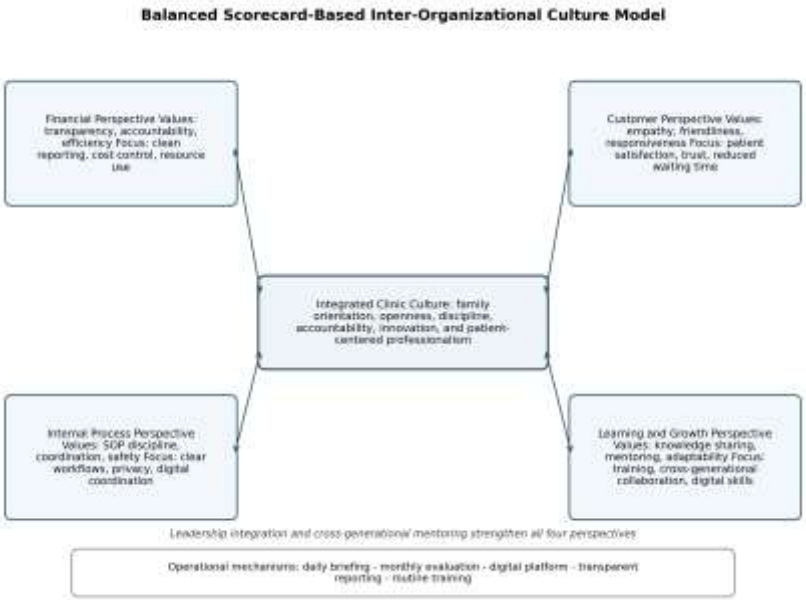

Figure 1. Proposed Balanced Scorecard-Based Inter-Organizational Culture Model

Table 6. Components of the Recommended Model

Model component	Content	Expected contribution to BSC performance
Core cultural values	Family orientation, openness, collaboration, discipline, honesty,	Strengthens patient trust, teamwork, and service consistency.

	commitment to service quality and patient safety.	
New professional values	Transparency, accountability, innovation, digital readiness, structured professionalism, evidence-based decision making.	Improves financial reporting, process efficiency, and strategic adaptability.
Operational mechanisms	Daily briefing, monthly evaluation, digital platform, transparent reporting, SOP alignment, routine training.	Connects cultural values with measurable routines and performance indicators.
Collaborative leadership	Leaders model discipline, facilitate communication, clarify roles, provide feedback, and integrate unit targets.	Maintains alignment among units and balances relational culture with accountability.
Cross-generational mentoring	Experience sharing from senior staff, digital support from younger staff, forum for different perspectives.	Improves learning, reduces generational gaps, and supports digital transformation.

3.6. Discussion of Theoretical and Practical Implications

Theoretically, this study contributes to the integration of organizational culture theory and Balanced Scorecard in the context of primary healthcare. Organizational culture theory explains why shared values and assumptions influence behavior [3], while Balanced Scorecard explains how organizational performance can be viewed through interconnected perspectives [5], [6]. The proposed model connects these two theories by showing that each Balanced Scorecard perspective requires particular cultural values. Financial performance requires transparency and accountability; customer performance requires empathy and responsiveness; internal process performance requires discipline and coordination; learning and growth requires openness and knowledge sharing.

The study also extends the discussion of generational diversity in healthcare organizations. Rather than viewing generational differences as a source of conflict, this manuscript positions them as a cultural resource. The clinic can gain from the experience of senior generations, the collaborative tendency of Millennials, and the digital orientation of Generation Z. This perspective is consistent with contemporary literature suggesting that generational diversity should be managed through inclusive leadership, communication adaptation, and learning mechanisms [10]-[13].

Practically, the findings provide clear priorities for Kusuma Pertiwi Clinic. The first priority is financial digitalization and transparency because manual and incomplete financial reporting can weaken decision making. The second priority is process redesign, including clearer task distribution, privacy-sensitive registration flow, and digital coordination to reduce waiting time. The third priority is institutionalized learning through training roadmaps, mentoring, and post-training dissemination. The fourth priority is leadership alignment, ensuring that all managers consistently model discipline and openness.

The model should be implemented gradually. In the first stage, the clinic can standardize briefing, meeting, and reporting routines. In the second stage, it can introduce a simple digital dashboard covering financial reporting, patient complaints, waiting time, SOP compliance, and training participation. In the third stage, it can formalize mentoring and cross-generational knowledge sharing. In the fourth stage, performance indicators can

be reviewed periodically through the Balanced Scorecard to ensure that cultural improvement is connected to measurable organizational outcomes.

This study has limitations. It was conducted in a single clinic and involved key informants from managerial roles, so the findings should not be generalized to all clinics without contextual consideration. The data were qualitative and reflected participant perceptions, although triangulation was used to improve credibility. Future research may use mixed methods, compare several clinics, include patient perspectives quantitatively, and evaluate the implementation of the proposed model longitudinally.

4. CONCLUSION

This study developed an inter-organizational culture model based on the Balanced Scorecard at Kusuma Pertiwi Clinic. The findings show that the clinic's culture is strongly rooted in family orientation, openness, discipline, flexibility, honesty, collaboration, and commitment to service. These values support patient satisfaction and informal coordination, but they need to be strengthened with transparency, accountability, digital readiness, and structured professionalism.

Balanced Scorecard analysis revealed that the customer and learning-growth perspectives were relatively strong, while the financial and internal process perspectives required more systematic improvement. The main improvement needs were financial digitalization, clearer separation of clinic and personal expenses, transparent reporting, better task distribution, additional human resources, service-space improvement, and more integrated digital coordination. The relationship between culture and performance was evident across all four BSC perspectives: cultural values shape financial behavior, patient service, process compliance, and learning capacity.

The proposed model consists of five components: preserved core values, new professional values, operational mechanisms, collaborative leadership, and cross-generational mentoring. This model can help the clinic translate culture into measurable performance practices. Future implementation should be supported by leadership commitment, digital systems, routine evaluation, training, and a mentoring mechanism that uses the strengths of each generation. Further research should test the model in other primary healthcare facilities and examine its impact over time.

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