Why Keeping Score Matters: 
Investing in a SCORE Card Management System™
White Paper

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The saying goes, “If you aim at nothing, you will hit it every time.” So, keeping score makes a difference. If you don’t believe that, observe college students casually shooting basketball on the courts, and then watch a sanctioned college or professional basketball game. What you’ll see is a dramatic difference in the intensity of energy, focus and effort. And what is it that is foremost on the coach’s mind? There are two primary factors: the score and the amount of time left. Those are the two variables that drive the pace and strategy of the game.

Scenario

With 15 seconds left, Team A is down by three points and returning from a timeout; Team B has possession of the ball. During the timeout, Team A’s coach instructs his team to urgently commit a foul. This is Team A’s only chance, given the score and the length of time left in the game. The players expect the instruction, and the viewers expect the foul.

What if we had that level of intensity, energy and focus within our healthcare organizations? What if your next tactical move was so self-evident, that even the front line employees were engaged and expected it? To create this type of environment, we must know the “score” and have a strong sense of urgency.

A SCORE Card Management System™ serves to:

- Define measurable goals at the front line that are in alignment with the organization’s mission, vision, values and strategic plan
- Reflect the baseline (current status) of the domains to be measured
- Align the desired goal(s)
- Define frequency of measurement
- Identify the source of information, who will distribute it and when

A SCORE Card Management System is a process that could help healthcare organizations maintain transparency and urgency while achieving their goals.

Many organizations have not gone through the process and discipline of developing a SCORE Card Management System. For those organizations, we’ll take a closer look at the playbook and the critical questions to ask.

A Closer Look at the Playbook: What to Measure

When it comes to improving your “score”, the first question to ask is, “What should be measured?” Kforce has found that five major categories are critical to a hospital’s success, and have conveniently ascribed these domains to the acronym “SCORE”:
**Service:** The level of service is defined by the customer. Identifies the level of service from the customer’s perception and determines what opportunities exist to improve service to the customer.

**Connections:** The connections domain promotes teamwork. Effective outcomes are interdependent to the ability of people to work synergistically. The intent of this domain is to define relevant processes that transverse departmental boundaries.

**Operations:** Operations consist of inputs, processes and outputs. This defines and measures the core processes that require timeliness and accuracy.

**Revenue/Cost:** Any hospital’s access to cash must outweigh its cost to further invest in the mission of the organization. Hospitals have definitive goals for overall revenue, cash flow and cost containment. The intent of this domain is to define, measure and improve departmental processes that relate to their primary goals.

**Excellence:** Hospitals are beholden to specific quality measures. The intent of this domain is to capture all quality data required by regulation, and integrate additional quality measures as needed.

**Emergency Department: Improving the Score**

Now that the domains are established, the hospital should determine what will be specifically measured by department or area. Let’s consider the Emergency Department (ED) as an example:

A large regional hospital did not have a culture of “keeping score” on the front lines. The hospital sought assistance through the implementation of a SCORE Card Management System. The ED was one of the key areas in which leadership felt there was an opportunity for improvement.

The patient satisfaction surveys reflected average service at best; patient wait times were well above industry standards, and the time from arrival to triage was high. Also, once the decision was made to discharge the patient to home, the wait time to provide home instructions was a source of frustration for both the patients and registration staff. The registration staff was being bombarded with questions from pending patients.

**What’s the Game Plan?**

We met with the clinical and business teams and came to an agreement that these were, indeed, valid issues that should be addressed. In order for the teams to understand the magnitude of the issues, data was needed. We facilitated the development of a SCORE Card (see example on next page). In time, the team gained measurable data and held regular briefings to develop action items to improve the outcomes. The Nursing department was invited to the team to assist with the “time to admit” monitor.

Over the course of six months, the outcomes improved considerably. Of note, the time to admit dropped below the goal and had definitive financial ramifications for the hospital.

We calculated that a one-day reduction in DNFB meant the acceleration of $525,000 to the facility.
The category of leaving without being seen dropped by 50%. At an average net revenue of $742 per ED patient, this represented approximately $371,000 annually for the hospital. Initially, the ED had to divert incoming ambulance patients because the rooms were full; this number fell to almost zero. Given the high percentage of patients who are admitted when they present from an ambulance, we calculated the net annual impact to the facility of approximately $1.7 million. See ED SCORE Card below.

### EMERGENCY DEPARTMENT (ED) SCORE CARD

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>Baseline</th>
<th>Goal</th>
<th>Frequency</th>
<th>Source</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Patient rating of our services</td>
<td>3.9 (out of 1-5 score; 5 being the best)</td>
<td>More than 95% of patients rate our services at highest score (5)</td>
<td>Weekly</td>
<td>Third-party survey</td>
<td>ED staff (weekly); CEO (monthly); Board (quarterly)</td>
</tr>
<tr>
<td>Connections</td>
<td>Patient admission time from ED once admitting decision is made; both ED &amp; Nursing departments have a stake in the process</td>
<td>3.9 (out of 1-5 score; 5 being the best)</td>
<td>More than 95% of patients rate our services at highest score (5)</td>
<td>Weekly</td>
<td>Internal report</td>
<td>ED staff (weekly); CEO (monthly); Board (quarterly)</td>
</tr>
<tr>
<td>Operations</td>
<td>Arrival to triage time</td>
<td>22 minutes</td>
<td>15 minutes or less</td>
<td>Daily</td>
<td>Internal report</td>
<td>ED physicians and staff; Nursing bed management</td>
</tr>
<tr>
<td>Revenue/Cost</td>
<td>All charges entered accurately</td>
<td>1.75 business days at 84%</td>
<td>Same day of service</td>
<td>Daily</td>
<td>Internal report</td>
<td>ED staff; business office</td>
</tr>
<tr>
<td>Excellence</td>
<td>Average time patients spent in the ED before being discharged</td>
<td>182 minutes</td>
<td>130 minutes or less</td>
<td>Weekly</td>
<td>Internal report</td>
<td>ED staff; quality improvement</td>
</tr>
</tbody>
</table>
Health Information Management (HIM): Improving the SCORE

The Health Information Management (HIM) department was another key area in which leadership perceived an improvement opportunity. The discharged not final billed (DNFB) was well beyond expectations (9.5 days). Leadership received complaints from various physicians regarding what they perceived to be less than professional communication from the HIM department.

Leadership knew there were two sides to this coin; that is, HIM was pushing for reasonable turnaround times from the physicians regarding query responses. Because of the recent introduction of a Clinical Documentation Improvement (CDI) program, the number of physician queries had gone up dramatically.

In terms of service, there was a less than favorable perception of service from the Patient Financial Services (PFS) department. The PFS department felt they were “catching” a lot of the errors and omissions (edits) of the HIM department prior to submitting claims. This required rework by several people and was becoming an increasing source of frustration. The Quality Improvement Director also had concerns. Joint Commission was expected in the next six to nine months; an internal review revealed deficiencies regarding HIM policies and procedures in support of JCAHO requirements.

Time for a Team Huddle?

Kforce met with the HIM team and came to agreement that these were, indeed, valid issues that should be addressed. We facilitated the development of an HIM SCORE Card to provide the team with measurable data (see example on next page). We calculated that a one-day reduction in DNFB meant the acceleration of $525,000 to the facility.

We set a goal of six days or less and began a process improvement program that ultimately reduced DNFB to 6.5 days.

We included all billable departments in the discussions, setting the expectation that all charges would be complete within four days of an inpatient discharge and the same day of service in outpatient. We facilitated meetings and communications between PFS and HIM, clarifying roles and responsibilities through an open dialogue between members of the department. Over time, the number of coding clarifications was reduced dramatically.

Previously, the hospital had not conducted routine external reviews of their coding processes and outcomes. We facilitated a third-party review, which revealed a number of errors and omissions not previously detected by the internal review. The quantity of errors and omissions was reduced with each quarter’s audit.

Certainly, the change in the physicians’ response time to queries affected the DNFB. We facilitated the “re-introduction” of the CDI program and team members to the physicians. We presented a business case to show how timely responsiveness and accurate documentation -- reflecting the care and needs of the patient -- had a positive impact on all parties concerned. This was the slowest of all the processes, but ultimately, the hospital reached an average turnaround time of 32.4 hours. Not surprisingly, the hospital also experienced a 0.13 increase in the case mix index as well.

The hospital could not afford a poor JCAHO outcome. Thus, we provided resources to assist the HIM director in bringing the policies and procedures up to standard, as well as training and education to ensure all HIM staff was prepared.
# HEALTH INFORMATION MANAGEMENT (HIM) SCORE CARD

<table>
<thead>
<tr>
<th>Domain</th>
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<th>Baseline</th>
<th>Goal</th>
<th>Frequency</th>
<th>Source</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service</strong></td>
<td>Coding edits</td>
<td>75 per day</td>
<td>0 edits</td>
<td>Daily</td>
<td>Internal audit/report queue</td>
<td>Weekly to HIM and PFS; monthly to CFO</td>
</tr>
<tr>
<td><strong>Connections</strong></td>
<td>The cycle time with queries for physicians</td>
<td>4.5 days</td>
<td>24-hour query cycle</td>
<td>Daily</td>
<td>Internal query audit</td>
<td>Daily to each physician who received a query; weekly to CFO</td>
</tr>
<tr>
<td><strong>Operations</strong></td>
<td>Policies and procedures to support JCAHO review</td>
<td>75%</td>
<td>100% achievement of JCAHO policies and procedures</td>
<td>Weekly</td>
<td>P/P manual</td>
<td>Weekly to Quality Improvement team; monthly to JCAHO team</td>
</tr>
<tr>
<td><strong>Revenue/Cost</strong></td>
<td>DNFB (days)*</td>
<td>9.5</td>
<td>Less than or equal to 6 DNFB days</td>
<td>Daily</td>
<td>Internal audit</td>
<td>Weekly to CFO</td>
</tr>
<tr>
<td><strong>Excellence</strong></td>
<td>Third-party review of accuracy of coding</td>
<td>None</td>
<td>100% coding accuracy</td>
<td>Quarterly</td>
<td>Report of third-party</td>
<td>Quarterly to Coding staff, Coding Manager, HIM Director and CFO</td>
</tr>
</tbody>
</table>

* DNFB is a sensitive topic and can be measured different ways. Some facilities may measure the DNFB by the number of days, dollars or accounts. Another factor that has to be taken into consideration is the holding period for accounts, allowing departments to add charges. This number varies between three and seven days. The key point is to define the baseline that is relevant to your facility, and begin process improvement for better outcomes.
Are You Ready?

Is it time for you to aim at something? What is preventing you from making the investment in a SCORE Card Management System? Allow us to suggest two barriers that should be dealt with:

1. The source of the data and the amount of energy required to validate accurate information is one reason hospitals do not make the investment in SCORE Card Management. Some leaders and managers simply do not believe in the ROI, given the amount of energy it takes to get data that may be considered stale and unreliable. Leadership must make a decision to invest.

2. The SCORE Card must be relevant and meaningful to the line users. Perhaps the biggest mistake hospitals make is a hurried and superficial implementation of a SCORE Card Management System. A casual reader at this point might think, “How difficult can this be? There are only five domains, and the department director or manager should be able to develop a scoring system in his/her sleep. After all, who knows the department better?”

With this approach to a SCORE Card Management System, the scoring becomes “something else the director or manager has to do,” versus “part of who they are (culture).” Herein, lies the art of the SCORE Card Management System: to discover the measures to be monitored and improved that are both aligned with the mission and/or strategic intent of the organization, and that also have meaning and relevancy for the front line users. When both are accomplished, there is buy-in at the leadership and front line levels. The odds of sustainability go up dramatically.

Too Many Executive Goals?

In one hospital, the CFO had 27 executive goals. The number was unrealistic and unmanageable. In fact, had the CFO actually pursued these multiple, specific goals, she would have spent most of her time micro-managing versus leading the hospital. We convinced the Board to reduce the number of executive goals to five, consistent with the domains of our SCORE Card Management System.

For example, the executive’s revenue goal was changed from seven very discrete goals to one: The CFO is responsible for meeting the budget. The Board only developed the confidence to make this change, however, by understanding that each hospital department had a revenue or cost containment goal. This goal would need day-to-day management. It would become part of a disciplined SCORE Card Management System in which the outcomes were made visible each quarter to the Board.

Plan, Do, Check, Act

Finally, hospitals must stay out of the “monitoring only” game. In sports, scoreboards are meant to glance at, make any needed adjustments in strategy or tactic and move on. If the scoreboard becomes the primary object of focus in a hospital setting, then the staff has only succeeded in measuring suboptimal performance. The team must keep their eyes on the court, the ball and the opposition, and then use the scoreboard for its intended purpose. The most important aspect of the SCORE Card is to execute changes needed to improve the outcome. Do you have a winning SCORE Card?
Summary

As healthcare organizations work towards ICD-10 compliance, it has become clear that culture will play a significant factor in change management and project plans. Culture is unmistakably a key determinant for organizational performance.

Organizations that actively promote culture are intrinsically more employee and customer-focused. The positive growth of a culture requires leadership to define how they want change implemented. Leadership should clearly and consistently communicate expected behaviors, as well as relate culture to business performance. Leadership must also maintain sensitivity to the changing environment and evolving needs of the organization's constituencies.

About Kforce Healthcare, Inc.

Kforce Healthcare, a wholly owned subsidiary of Kforce Inc., is a professional staffing and solutions provider serving the healthcare industry since 1998. We work with healthcare providers across the United States, many of which are among the nation's top Honor Roll Hospitals. From acute care facilities to large hospital systems, Kforce Healthcare provides focused services and support for major health information technology (HIT), revenue cycle and health information management (HIM) initiatives.

We offer comprehensive services and support for electronic medical records/electronic health records (EMR/EHR) integration, ICD-10 implementation, clinical documentation improvement and revenue cycle management. Health Information Matters™ and we are committed to our valued clients and candidates.

Bios

John Britt is the Managing Director for Healthcare Solutions at Kforce and has been providing revenue cycle solutions to clients for over 20 years. He has a passion for helping his clients achieve optimal and sustainable results in the areas of organizational alignment and operational efficiency. John is a Registered Nurse and holds a Bachelor's degree in Management of Human Resources and a Master's degree in Organizational Management.

Trevor Snow is a Registered Health Information Administrator (RHIA) and has more than 20 years of healthcare experience in HIM operations, consulting, Information Services and implementing the electronic medical record. In previous positions, he has improved processes using LEAN concepts, reduced the DNFB, prepared departments and the organizations for the electronic medical record, and developed processes that support timely completion of the patient record.

To learn more about Kforce Healthcare's multi-stage ICD-10 solution contact:

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