REVENUE CYCLE KEY PERFORMANCE INDICATORS AND STANDARDS

Scheduling

1. Overall scheduling rate of potentially eligible patients:	100%
> Scheduling rate for elective and urgent inpatients	100%
> Scheduling rate for ambulatory surgery patients	100%
> Scheduling rate for high-$ outpatient diagnostic patients	100%
2. Scheduled patients' preregistration rate	98%

Preregistration/Preauthorization

1. Overall preregistration rate of scheduled patients	≥ 98%
2. Overall insurance verification rate of preregistered patients	≥98%
3. Deposit request rate for copayments and deductibles	≥98%
4. Deposit request rate for elective admissions/procedures	≥100%
5. Deposit request rate for prior unpaid balances	≥98%
6. Data quality compared with pre-established department standards	≥99%

Insurance Verification

1. Overall insurance verification rate of scheduled patients	≥98%
2. Overall insurance verification rate of preregistered patients	≥98%
3. Insurance verification rate of unscheduled inpatients within one business day	≥98%
4. Insurance verification rate of unscheduled high-$ outpatients within one business day	≥98%
5. Data quality compared with pre-established department standards	≥99%

Patient Access/Registration

1. Average registration interview duration	≤ 10 minutes
2. Average patient wait time	≤ 10 minutes
3. Average inpatient registrations per registrar per shift	35
4. Average outpatient registrations per registrar per shift	40
5. Average ED registrations per registrar per shift	40
6. Data quality compared with pre-established department standards	≥ 99%
7. ABNs/MSPQs obtained when required	100%
8. MPI duplicates created daily as a % of total registrations	≤ 1

Financial Counseling

1. Collection of elective services deposits prior to service	100%
2. Collection of inpatient patient-pay balances prior to discharge	≥ 65%
3. Collection of outpatient patient· pay balance priorto service	≥75%
4. Collection of ED patient-pay balances prior to departure	≥50%
5. Screening of uninsured inpatients and high-balance outpatients for financial assistance	≥98%
6. Payment arrangements for noncharity eligible inpatients/ high-balance outpatients	≥98%
7. Prompt-payment discount %	5-20%

Health Information Management

Inpatient charts coded per coder per day	23-26
2. Observation charts coded per coder per day	36-40
3. Ambulatory surgery charts coded per coder per day	36-40
4. Outpatient charges coded per coder per day	150-230
5. ED charts coded per coder per day	150-230
6. Chart delinquency greater than 30 days (Joint Commission definition) ,	≤5%
7. Total chart delinquency	≤10%
8. HIM "PRG development" hold greater than late charge hold	≤2 AIR days
9. Copies of medical records pursuant to payers' requests.	≤2 work days
10. Transcription rate per line	$0.08-$0.12
11.Transcription backlog	≤1 work day
12. Chart retrieval pursuant to physicians' requests	≤ 90 minutes
13. MPI duplicates as a % of total MPI entries	≤0.5%
14. PEPPER potential overcodes beyond 75th percentile	≤2%
15. PEPPER potential undercodes below 10th percentile	≤2%

Charge Entry/Revenue Protection

1.Late charge hold period	2-4 days
2. Late charges as a % of total charges	≤2%
3. Lost charges as a % of total charges	≤1%
4. Chargemaster duplicate items	0
5. Charge master incorrect/missing HCPCS/CPT-4 codes	0
6. Chargemaster incorrect/ invalid revenue codes	0
7. Chargemaster revenue code lacks necessary HCPCS/CPT-4 code	0
8. Charge master item has invalid/ incorrect modifier	0
9. Chargemaster item has missing' modifier	0
10. Chargemaster item price less than HOPPS APC rate	0
11. Chargemaster item price is $0	0
12. Chargemaster item description is "miscellaneous"	0
13. Chargemaster item description/ price is editable online	0

Billing/Claim Submission

1. HIPAA-compliant electronic claim submission rate 100%

2. Final-billed/claim not submitted backlog ≤1A/Rday

3. Medicare supplement insurance billing following adjudication ≤2 business days

4. Non-Medicare COB-2 insurance billing following COB-l payment ≤2 business days

5. Medicare return to provider denials rate ≤3%

6. Outsourced guarantor statement cost to produce/ mail (without stamp) $0.20-$0.25

Third-Party and Guarantor Follow-Up 1.

Insurance A/R aged more than 90 days from service/ discharge ≤15-20%

2. Insurance A/R aged more than 180 days from serv.ice/ discharge ≤ 5%

3. Insurance A/R aged more than 365 days from service/ discharge ≤ 2%

4. Bad debt write-offs as a % of gross revenue

5. Charity write-offs as a % of gross revenue ≤3%

6. Cost to collect ([patient accounts + PFS + agency expenses] / cash) ≤3%

7. AIR cash as a % of net revenue ~100%

a.in-house AIR days ~ average LOS

9. DNFB A/R days ~ 4-6 AIR days

10. Net AIR days ~ 55 AIR days

11.AIR cash as a % of cash goal ~ 100%

12. Total point-of-service cash as a % of cash goal ~ 2-3%

Cashiering/Refunds/Adjustment Posting

1. HIPAA-compliant electronic payment posting % 100%

2. Transaction posting backlog (during the month) ≤ 1 business day

3. Transaction posting backlog (end ofthe month) 0 business days

4. Credit-balance AIR (gross) ≤ 2 A/R days

5. Medicare credit-balance report submission timeliness ≤ due date

Denials

1. Overall initial denials rate (% of gross revenue) ≤4%

2. Clinical initial denials rate (% of gross revenue) ≤5%

3. Technical initial denials rate (% of gross revenue) ≤3%

4. Underpayments additional collection rate ≥75%

5. Appealed denials overturned rate 40-60%

6. Electronic eligibility rate ≥75%

7. Physician precertification double-check rate 100%

a. Case managers' time spent securing authorizations rate ≤20%

9. Total denial reason codes ≤25%

Customer Service 1.

Correspondence backlog ≤ 1 business day

2. Walk-in patients' wait time ≤5minutes

3. ACD system average hold time ≤2minutes

4. ACD system abandoned call % (calls on hold ~ 30 seconds) ≤2%

5. ACD system % of calls answered in ~ 20 seconds ≥75%

6. ACD system % of calls resolved in ~ 5 minutes ≥85%

7. ACD system % of calls not resolved in ~ 10 minutes ≤5%

a. Calls resolved in unit, without complaint/referral to PFS director ≥ 95%

Collection/Outsourcing Vendors 1.

Bad debt net back ([collections - fees] / placements) % 7-11 %

2.Bad debtfee % 15-18%

3.Third-party EBO fee % (IP + OP + ED blend) 6-10%

4. Self-pay EBOfee % (IP + OP + ED blend) 10-12%

5.Legal collections fee % 20-30%

6. Medicaid eligibility assistance fee % 12-18%

Physician Practice Management 1.

Visits without charges as % of total visits 0%

2. Copay collections as % of total copay office visits ≥95%

3. EDI claims as % of total claims ≥90%

4.Charge-entry lag period ≤ 1 business day

5. Claims passing claim edits as % of total claims ≥98%

6. Appointment no-show rate ≤2-3%

7. Appointment bumped rate ≤2-3%

a. Net A/R days (nonspecialty practices) ≤40 days

9. Collections as % of net revenue ≥100%

10. Collections as % of gross revenue (nonspecialty practices) ≥ 60%

11. Third-party AIR aging > 90 days from service date ≤10%

12. Denials as % of net revenue (including "incidental to" services) ≤ 2%

13. Claims with no activity > 90 days from last activity date 0%

14. Credit balances ≤2 A/R days

15.Average patient wait time after office arrival ≤15 minutes

Managed Care Contracting 1.

Rate increases compared with CPI medical-care component ≥ CPI MCC

2. Outlier $ fraction of total contract revenue ±5%

3. Contract profitability compared with IRR "hurdle rate" ≥IRR HR

4. Eligibility/authorization/ certification availability	*24/7/365*
5. Retrospective review/ timely filing periods (keep in balance)	90-120 days
6. Termination notification period	90 days
7.Renegotiation planning begins prior to renewal date	6 months
8. Optimal contract term	2-3 years

Pay for Performance: Clinical Decision Support/Finance	
1. P4P demonstration project percentile ranking	≥80%
2. P4P demonstration project bonus achievement	≥1%
3. LOS, by DRG	≤ DRG average

4. Readmission rate,byDRG	≤ DRG average
5. Adherence to quality indicators, by condition	≥80%
6. Adherence to quality indicators, by mode	≥80%
7. Overall P4P program ROI	≥:0%

REVENUE CYCLE SUGGESTED PRACTICE PROCESSES CHECKLIST

The suggested practice answer to each question is "yes." If financial managers can answer yes to most of the questions, and the numeric indicators look good, they can be reasonably sure that their revenue cycle operations are in good shape.

Scheduling

1. Use online scheduling software organizationwide?
2. Have central scheduling unit?
3. Central scheduling answers to CRO?
4. Surgery uses same scheduling software as other departments?
5. Scheduling system integrated with registration system?
6. Use online outpatient medical necessity system prior to service?
7. Precertification requirements shared with physicians' offices?
8. Physicians and patients able to make online appointment requests?
9. Nonemergency services scheduled 12+ hours in advance?
10. Process and IT integrated between scheduling and preregistration?
11. Services postponed if not pre-authorized? 12. Financial counseling part of scheduling process?
> Patient balances and payment obligations discussed?
> Hospital policy for point-of-service payment explained?
> Reminder to bring required payment and insurance cards given?

Preregistration/Pre-authorization

1. Have dedicated preregistration/ pre-authorization unit?
2. Process and IT integrated between scheduling and preregistration?
3. Services postponed if not pre-authorized?
4. Financial counseling part of preregistration/pre-authorization process?
> Patient balances and payment obligations discussed?
> Hospital policy for point-of-service payment explained?
> Reminder to bring required payment and insurance cards given?

Insurance Verification

1. Have dedicated insurance verification unit?
2. Process and IT integrated between insurance verification/patient access?
3. Use online insurance verification system?
4. Financial counseling part of insurance verification process?
> Alternate arrangements for noncovered patients explored?
> Hospital policy for point-of-service payment explained?
> Reminder to bring required payment and insurance cards given?

Patient Access/Registration

1. Patient access reports to CRO?
2. All registrars report to patient access or within revenue cycle?
3. Use online document imaging system?
4. Financial counseling part of patient access process?
> Patient balances and other payment obligations collected?
> Policy fo"r payment alternatives explained (credit cards, etc.)?
> Copies of required payment and insurance cards obtained?
5. Registrars' incentive compensation tied to quality indicators?
6. Registration system integrated/ interfaced with PFS system?
7. Use online/web-enabled patient self-registration system?
8. Use online outpatient medical necessity system prior to service?
9. Use online registration data quality tracking system?
10. Have online interface to owned physicians' registration system?

Financial Counseling

1. Financial counseling reports to CRG?
2. Uninsured inpatients and high-balance outpatients screened for financial assistance?
> Medicaid eligibility?
> State, local, and hospital charity programs?
> Grants, studies, etc.7
3. Financial counselors interview patients in their rooms?
4. Prompt payment discounts offered?
5. Financial counselors' incentive compensation tied to collections?

6. Discuss payment alternatives with noncharity-eligible patients?
> Credit cards?
> Bank loan financing?
> Interest-bearing hospital-funded payment arrangements?

7. All inpatients cleared through financial counselors before discharge?

8. Proof of income/assets obtained from charily applicants?

Health Information Management

1. HIM reports to CRO?

2. Use online DRG and APC groupers?

3.Use online, bar-code-enabled chart localion system?

4. Use online, scanning-enabled HIM records imaging system?

5. Use online and/or voice-recognition transcription system?

6. Use online clinical abstracting system?

7.Physicians able to view and/or e-sign records outside of the hospital?

8. Storage/retrieval/release of records HIPAA-compliant?

9. Use online, up-to-date coding compli-ance system?

10. All coding done by employees report· ing to HIM director?

11. All coding done by certified coders who are retrained often?

12. All coding done in descending bal-ance order; not first in, first out?

13. All coding done in "best payer" order (fee for service, managed care, health maintenance organization)?

14. All coding done when information is sufficient, not 100 percent complete?

15. Receive and discuss denials information provided by PFS or others?

16. Provide and discuss denials/delin-quency information with physicians?

17. Have effective tracking system to locate missing records?

18. Have appropriate staffing to prevent process backlogs?

19. Consislently monitor/control DNFB AIR due 10 HIM?

20. Perform internal quality-control audits at least quarterly?

21. Have external quality-control audits done at least annually?

22. Review PEPPER to compare managed care payments with state and national averages?

23. Use PEPPER to identify problem-proneDRGs?

24. Use PEPPER/OIG work plans to focus internal reviews?

25. Track/trend all outside record audit requests?

26. Self-review all charts selected for audit by RACs/others?

27. Submit all self-reviews with "things done right" cover letters?

Charge Entry/Revenue Protection 1. Chargemaster coordinator reports toCRO?

2. Have formal charge master change management process?

3. Have formal annual chargemaster review process with clinical departments?

4. Modifiers "static coded" in chargemas-ter, chosen via order-entry system?

5. All charge items ordered via online order-entry system?

6. Late/lost charge performance standards in department managers' job descriptions?

7. Annual HCPCS/CPT-4 changes in place by January each year?

8. Surgery HCPCS/CPT-4 appear in UB-04form 10cator44?

9. Surgery laboratory/X-ray charges properly unbundled?

10. Chargemaster pricing methodology standardized/defensible?

11. Departments understand the difference between billable and payable?

12. Chargemaster items have PATIENT FRIENDLY BILLING® descriptions?

13. Have formal annual charge sheet/ticket review process?

14. Receive/review CPT-4 manual/Addendum B annually?

15. Nursing procedures (cardiopulmonary resuscitation, infusion, etc.) built into chargemaster?

16. HIM assigns interventional/surgical procedure codes?

17. ED nursing levels match Medicare descriptions?

18. Physicians' outpatient orders received with requisite CPT-4 code(s)?

19. Order-entry ilems map accurately to service codes?

20. Charge tickets, etc., map ilccurately to service codes?

21. Appropriate charge in chargemaster for all services delivered?

22. Charge dala flow reliably from points of service to claims?

23. Modifiers are conveyed correctly/reliably to claims?

24. CCI edit conflicts controlled by correct registration/charge entry?

25. Units of service accurate/flow reliably to claims?

26. Clinical departments' "charge awareness" monitored/enhanced?

Billing/Claim Submission

1. Primary/secondary billing completed by dedicated team?

2. Staffing sufficient to minimize/prevent billing backlogs?

3. Quantity/quality performance stan-dards part of billers' job descriptions?

4. Perform regular quality-control reviews of billers' work?

5. All billers finish the CMS' s Medicare billing training?

6. All billers receive annual Medi~are compliance training?

7. Billers cross-trained on more than one payer type?

8. Use online electronic billing system?
> Easy to add new billing edits? .
> Automatic daily downloads from PFS system?
> Provides biller-specific work lists?
> Major payer edits supplied/supported by vendor?

> Claim-submit notice automatically uploaded to PFS system?
> Claim corrections automatically uploaded to PFS system?
> All claims (paper and electronic) editable?
> Standard errors automatically corrected?
> Provides biller-specific productivity and error reporting?
> Provides clinical department-specific error reporting?
> Automates Medicare-supplement! COB-2 claim submission?
> Interfaces with online Medicare compliance system?

9. Use Patient Friendly Billing concepts for guarantor billing?

10. Use proration to bill insurance and guarantor simultaneously?

11. Guarantor statements include credit card option?

12. Guarantor statements clearly communicate payment policies?

13. Guarantor statements provide customer service phone number?

14. Guarantor statements provide customer service web address?

15. Guarantor billing cycle designed to optimize collections?

Third-Party and Guarantor Follow-Up 1. High-balance follow-up completed by dedicated team?

2. Staffing sufficient to minimize/prevent aged AIR build-up?

3. Quantity/quality performance standards part of collectors' job descriptions?

4. Perform regular quality-control re~iews of collectors' work?

5. All collectors finish CMS's Medicare billing module?

6. All collectors receive annual Medicare compliance training?

7. Collectors cross-trained on more than one payer type?

8. Use online "receivables work station" system?
> Easy to add new collector assignments? > Automatic daily downloads from PFS system?
> Full interface for collection notes, etc. to PFS system?
> Provides collector-specific work lists? > Work lists presented in descending-balance order?
> Next activity date automatically uploaded to PFS system?

9. Use online, web-enabled third-party payer inquiry system(s)?

10. Guarantor follow-up outsourced or on predictive dialer?

11. Collectors receive third-party/ guarantor follow-up training?

12. Collectors use third-party/guarantor follow-up scripts?

13. Collectors have no competing duties (customer service, etc.)?

14. Collectors receive performance-based incentive compensation?

Cashiering/Refunds/Adjustment Posting

1. Cashiering completed by dedicated team with no other duties?

2. Refunds completed by dedicated team with no other duties?

3. Quantity/quality performance standards part of cashiers' job descriptions?

4. Perform regular quality-control reviews of cashiers' work?

5. All cashiers receive annual Medicare compliance training?

6. Cashiers cross-traihed on more than one payertype?

7. Use lockbox for nonelectronic/ non-ED I payments?

8. Lockbox remits payment data electronically/EDI/optical character reader?

9. Denial transaction codes entered to facilitate follow-up?

10. Use online system to compare expected versus actual payments?

11. Post contractual adjustments at time of final billing?

Denials

1. Denials tracked by payer, reason, financial consequence?

2. Denials distinguished between technical and clinical?

3. Denials tracked by physician, DRG, and department?

4. Contractual allowances increasing slower than gross revenue?

5. Dedicated denials unit with payer-specific appeals experience?

6. Respond to clinical documentation requests within 14 days?

7. Use online system to compare expected versus actual payments?

8. Use online payment tracking software?

9.Use online contract management software?

10. Maintain denials database, self-developed or purchased?

11. Use online outpatient medical necessity system prior to billing or service?

12. All denial reason codes actionable?

13.Observation and inpatient authorizations tracked separately?

14. Precertification, authorization, and recertification functions in a single department?

15. Precertification requirements shared with physicians' offices?

16. Provide physicians with regular feedback on clinical denials rates?

17. Hold regular payer meetings to discuss denials issues?

18. Contract terms regularly distributed to revenue cycle employees?

19. Revenue cycle employees learn of contract changes in advance?

20. Structured feedback between revenue cycle and managed care departments?

21. Nonemergency services scheduled 12+ hours in advance?

Customer Service

1. Customer service handled by dedicated team with no other duties?

2. Customer service unit responsible for walk-ins, phone calls, mail, and e-mail?

3. Quantity/quality performance standards part of customer service representatives' job descriptions?

4. Perform regular quality control reviews of customer service representatives' work?

5. All customer service representatives receive annual Medicare compliance training?

6. Customer service representatives cross-trained on more than one responsibility?

7. Customer service representatives cross-trained on most/all PFS system functions?

8. Use voice-mail system so patients can request basic information/itemized bills?

9. Use ACD system?

10. ACD system automatically maintains unit/representative statistics?

Collection/Outsourcing Vendors

1. Use two or more bad-debt agencies?

2.Use different agencies for bad debt andEBO?

3. Write off long-term payment accounts/use agency to monitor?

4. Apply Medicare bad-debt "120 days" rule to all financial classes?

5. Agencies/outsource vendors accept referrals electronically?

6. EBO vendor able to "mirror" PFS system to get notes, ete.?

7. Medicaid-eligible vendors have good relations with state agencies?

8. Agencies remit gross payments/submit invoices for fees?

9. Agencies willing to put own support FTEs on site?

10. Agencies willing to assign dedicated FTEs to your accounts?

Physician Practice Management

1. Send voice and mail reminders for regular annual visits?

2. Send voice and mail reminders for other scheduled visits?

3. Use "open scheduling"
> To increase walk-in capacity?
> To minimize appointment bumping? > To increase patient satisfaction?
> To reduce nursing callbacks?

4. Calculate net revenue and net receivables?

5. Use dedicated billing/follow-up FTEs with no other duties?

6. Use collection agencies?

Managed Care Contraeting*

1. Contract contains automatic renewal clause?

2. Contract contains inflation index?

3.All hospital *services* included/specific exclusions defined?

4. Termination notification period = 90 days?

5. Duties for ongoing patient carel payment at termination defined?

6. ABN or equivalent acceptable for noncovered services?

7. Provider authorized to bill guarantor for noncovered services?

8. Provider authorized to collect deposits for noncovered services?

9. Contract discloses all subcontracting relationships?

10. Contract contains an independent contractor clause?

11. Contract stipulates all parties pay own legal fees?

12. Definition!criteria for all key terms clearly stipulated?
> Medical necessity?
> Emergency condition/admission?
> Trauma/trauma services/trauma team? > Covered services?
> Material breach?
> Prompt payment?
> Stop-loss/outlier?
> Carve-out?
> Medicare rate (should include pass-throughs)?
> Sentinel event(s)? > Medical-loss ratio? > Silent PPO?
> Clean claim?
> Timely notification/timely filing? > Authorization/certification?
> Service level(s)?
> Denial/rejection/null event?
> Negotiation/mediation/arbitration? > Plan agreement?
> Inpatient/outpatient/emergency patient/observation patient?
> Substantial impact?
> Member/insured/dependent?

13. Advance notice time for contract changes clearly stipulated?
> Payment/reimbursement rates? > Covered services/procedures? > Plan documents/requirements? > Major groups?

14. Contract includes warranty of HIPAA compliance?

15. Contract forbids reassignment without mutual consent?

16. Payer's reporting requirement duties clearly stipulated?

17. Perform annual internal analysis of all contracts?
> Contractual discounts balanced to gross volumes/net revenue?
> Use analysis to identify renegotiation/ termination targets?
> Compare all contracts to Medicare fee .schedule?
> Calculate relative profitability using payer-specific costs?
> All contracts cover their direct costs, at minimum?
> Use relative profitability for leverage during renegotiation?
> Recognize internal review cannot identify below-market contracts?
> Recognize internal review silent on case mix, stop-loss, etc.?

18. Perform annual external analysis of all contracts?
> Compare (legally) your rates with those of similar providers?
> Use outside firms/databases to obtain comparative information?
> Challenge data's age/geographic relevance before using?
> Compare specific service lines, as well as overall rates?
> Target biggest upside opportunities during renegotiation?
> Compare payment structures (charge %/DRGs) plus overall rates?
> Understand impact of inpatient stop-loss/outpatient maximum-pay clauses? > Try to end all "cost-plus" payments in favor of percentage of charges?
> Review contract language, especially key terms/clauses?
- Claim submission and payment?
- Protection against catastrophic cases?
- Procedure-based carve-out payments?
- Stop-loss payment structures?

- Payments for implants/prosthetics/ orthotics/high-$ drugs?
- Cut-off date for timely filing, retro review, refunds, etc.?
- Utilization review process?
- New services/technologies?

> Compare payment levels with premium increases?
> Ensure that rate trends mirror premium increase trends?
> Compare payers' relative profitability trends?
> Compare rate trends with medical-care component of CPI?

19. Conduct annual "payment performance" analysis of all contracts?
> Contracts comply with statutory processing/payment regulations?
> Report habitual violators to insurance commissioner?
> Compare payers' denial/payment discrepancy trends, by group? - Insurance plan?
-Patient type?
-Service line?
-Reason code?
-Physician?

20. Contract reviewed by attorney before renewal?

21. "Soft" contract provisions ("quality"!" affordable") avoided?

22. "Best efforts"language used to deHne providers'duties?

23. Supplemental documents included by reference/attached?

24. Amendments required in writing with mutual signatures?

25. Participating corporations/entities clearly stipulated?

26. Assignment clauses clearly stipulatedlrequire signatures?

27. Contract parties independent and able to compete?

28. Provider listed as "participating" in directories, web sites?

29. Complete list of covered services attached to contract?

30. Ambiguous service descriptions avoided?
> Avoid "serVices including but not limited to"?
> Avoid "services customarily provided"? > Avoid "services covered by the plan"?

31. Services not directly provided defined/contracted in advance?
> Out-of-area services?
> Hospital-based physician services?

32. Capitation rates/benefits design (if any) clearly stipulated?

33. LicensinglJoint Commission standards adequate for credentialing?

34. Provider not required to report "in accordance with HEDIS"?

35. Contract/payment terms administratively feasible?

36. Current HIS adequate to handle contract terms/AIR needs?

37. Mutual information requirements clearly stipulated?
> Specific information/reports described? > "Information including but not limited to" avoided?
> Provider's confidential/proprietary information protected?
> Provider's duty to provide information to payer strictly limited?
> Payer obligated to reimburse costs of providing records?

38. Mutual duties regarding care reviews clearly stipulated?

39. Provider's duty to notify payer regarding adverse events limited?

Pay for Performance: Clinical Decision Support/Finance

1. Use advanced clinical systems to support patient care?

2. Use electronic medical record system to support patient care?

3. Use advanced decision support/ performance management system?

4. Use executive information (scorecard) system?

5. Use data warehouse to support DSS/EIS capabilities?

6. Participate in CMS demonstration project, if eligible?

7. Have clinical improvement teams in data-enabled departments?

8. Target greatest cost/quality improvement areas first?

9. Use root-cause analysis to focus improvement efforts?

'Sources lor Managed Care Contracting questions 1-16, "Thorough Assessment Is Key to Negotiating Effective Managed Care Contracts," *HFMA Wants* You to *Know,* April 21, 2004; questions 17-19, Wilson, D. B., Malloy, M., McCoy, J., and Turner, M., "3 Steps to Profitable Managed Care Contracts," *hfm,* May 2004; questions 20-39, Miller, T. R., and Belt, J. E., ·Conducting a Managed Care Contract Review;' *hfm.January1998.*

HELPFUL RESOURCES FOR KPI DATA

Almanac of Hospital Financial and Operating Indicators
Ingenix
(800) 765-6588
www.ingenixonline.com

AHA Hospital Statistics American Hospital Association (800) 242-2626
www.healthforum.com; www.ahaonlinestore.com

Hospital Accounts Receivable Analysis
Aspen Publishers
(800) 638-8437
www.aspenpublishers.com

KLAS HC Technology Ratings
KLAS Enterprises LLC
(800) 920-4109
www.healthcomputing.com/KLAS/Site

HFMA Resource library
Revenue Cycle Improvement
Includes sample indicators and improvement strategies
www.hfma.org/library/revenue

Financial Performance
Includes key financial ratios.
www.hfma.org/library/accounting/financialperformance