Project Northern Lights

Clinical Opportunities Subgroup

Data Request to Support Clinical Area Focus Groups
Draft as of 2/20/19

INTRODUCTION

To support development of a compelling definitive agreement for the combination of Dartmouth-Hitchcock Health and GraniteOne Health, the Executive Planning Group comprising leaders from the two organizations have initiated a joint planning process that includes exploring opportunities in select clinical areas that will result in lower costs, higher quality, and better access to care. The 8 clinical areas for focus include: Behavioral Health, Heart and Vascular, Cancer, Pediatrics, Orthopedics, Neuro/Spine, Trauma, Bariatrics. Individual small working groups of clinicians and executives from each organization will focus on each of the eight clinical areas. The Clinical Area Focus Groups will begin with a "fact pack" of information regarding the current state of their particular focus area at each organization and, to the extent possible, in the market as a whole.

The Chartis Group, as a jointly contracted third party, will serve as the collector of data and compiler of these fact packs to facilitate comparability and ensure compliance with applicable standards for data sharing.

DATA REQUEST

This document outlines the data requested by The Chartis Group to prepare for kick-off and planning meetings of the Clinical Opportunities Subgroup and, more pointedly, the Clinical Area Focus Groups. Given the primary objectives of the groups, the focus of the request is on data on CMC, DHMC, and the D-H Community Group Practices (CGPs). However, to the extent relevant data is available from other D-HH and GOH members, please provide that as well.

To the extent possible, data should be provided electronically – most file formats (e.g., flat text file, MS Excel, MS Word, MS Access, dB, etc.) are acceptable. For each field in any data set where codes or abbreviations are used, please provide a full description. We have established a secure file transfer process via ShareFile, which will allow approved designees (initial designees: Nicole Batulis (D-HH), Sue Manning (CMC)) from each organization to upload and view their data. Only Chartis will have viewing privileges to both D-HH and GOH data.

Furthermore, The Chartis Group is committed to keeping our clients' data confidential and protected. We have implemented appropriate administrative, technical, and physical safeguards to protect the confidentiality of Protected Health Information (PHI) in accordance with the HIPAA and HITECH Privacy Standards, Security Standards and other applicable law.

To that end, we request that data files containing PHI are transmitted to Chartis employees using a secure transmission method.

Also in accordance with the HIPAA and HITECH regulations, The Chartis Group makes reasonable efforts to limit the request, receipt, or use of data to the minimum amount of PHI necessary to accomplish the work required by the engagement. Therefore, data fields beyond what is listed in our request should not be included as part of data files transmitted to Chartis consultants. Many PHI data fields are never required by The Chartis Group and therefore should not be included in data files being prepared for transmission to Chartis consultants. These fields include the following data regarding *individual patients*:

- Names;
- Phone & Fax numbers;
- Electronic mail addresses;
- Social Security numbers (SSN);
- Health plan beneficiary numbers or account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;
- Web Universal Resource Locators (URLs);
- Internet Protocol (IP) address numbers;
- Biometric identifiers, including finger, retinal and voice prints; and
- Full face photographic images and any comparable images.

Importantly, Chartis will not share any competitively sensitive information with the other party, including: cost or reimbursement data, sensitive strategic projects, raw data, etc. Prior to sharing any analyses with either party, Chartis will vet all content with D-HH's and CMC's anti-trust counsel.

Questions regarding this Data Request should be directed to David Kates of The Chartis Group at dkates@chartis.com or (617) 840-0567.

DEFINING SERVICE LINES

To ensure that proper comparisons can be made between D-HH, GOH, and other third-party data, it is important to use a standard service line definition for each clinical focus area. Chartis will provide initial service line definitions for each clinical area focus group based on DRG and ICD diagnosis code for the D-HH and GOH physician leads of each clinical area focus group to review. Please contact David Kates if there are additional modifications to the service area definitions, including changes to approved DRG/ICD diagnosis, inclusion/exclusion by procedural/attending clinician, clinician specialty, site of care, etc.

PHYSICIAN INPUT & CLINICAL FOCUS AREA-SPECIFIC QUESTIONS

Each "fact pack" will help answer common questions:

A. Where do you see the greatest strengths, weaknesses, and threats to the current program?
B. What opportunities does D-HH/GO provide for improving access, enhancing quality, and lowering cost?

To ensure we have collected and analyzed as much relevant data as possible prior to the subgroup kick-off meeting, Chartis recommends reaching out to physician leads ahead of time to review these questions and identify any additional data or analytic needs that may be specific to the clinical focus area and are not at present addressed in the request below.

Section 1: Community Need Overview

This data will help us answer the following questions: (1) what amount and kind of care does the community need, (2) what other factors might influence demand or patients' ability to access these services?, (3) what volume and type of care leaves the state for higher-cost providers in Massachusetts?

For each clinical focus area, please provide:

A. Any existing projections for IP/OP demand.
B. Estimates of or insight to outmigration patterns from New Hampshire to Massachusetts (e.g. Crimson reports on estimated downstream revenue by service line).
C. Any existing profiles or analyses of other key needs (e.g. community health needs assessment, employer trends, payor trends, etc.).

Section 2: Program Overview

This data will help us answer the following questions: (1) what do the D-HH and CMC programs currently look like across a range of clinical and operational measures?, (2) what gaps are there that could potentially be solved by working together (e.g. different quality profile, different ability to support certain cases, etc.)?

For each clinical focus area, please provide:

A. Description of program, including: location of facilities, size and composition of clinical staff (e.g. physician, nurse, other clinician FTEs), overview of services/capabilities offered at each location, overview of outreach (if any) to non-DHH/GOH facilities, number of dedicated IP beds/surgical suites (if any), etc.
B. Overview of current clinical research and/or clinical trial programs.
C. A description of awards or accolades for clinical, operational, and/or financial performance.
D. Recent quality studies, dashboards, and targets (HCAHPS, CMS Core Measures performance, readmission rates, mortality rates, CMI-adjusted length of stay, EHR/clinical integration adoption information and any other internal or external benchmarking reports of clinical quality and patient safety).
E. Recent service-line specific patient satisfaction studies, if available.
F. Recent service-line specific physician satisfaction surveys, if available.
G. If available, service-line specific internal operating and financial statistics reports for FYTD and most recent three fiscal years showing admissions, IP/OP surgeries, OP visits, cost per adjusted discharge, supply cost ratio, utilization, payor mix, etc.

H. If available, service-line specific internal or external benchmarking reports of operational and financial performance.

Section 3: Internal Patient Level Data

This data will help us answer the following questions: (1) how many cases do the D-HH/CMC clinical programs treat and how has that changed over time?, (2) where do most patients come from and are there opportunities to offer services closer to home?, (3) at a high level, what is the cost per case and how does this compare to MA providers?, (4) how significant are D-HH/CMC as providers for vulnerable populations (e.g. Medicaid, Veterans, etc.)?

Please provide for each system / facility (e.g. DHMC, CGP clinics, CMC, and other D-HH/GOH members as available):

A. **Inpatient Data:** Inpatient patient-level dataset for the last three years (as available): Please do not include any patient identifiable information in the data. If additional "mapping" files or "keys" are required, please provide those as well, to allow for mapping to the main datasets. Fields that may require a "key" are marked with an asterisk (*). Requested fields include:
   - Hospital ID and Name*
   - Encounter Number (unique identifier: do not use name or social)
   - Medical Record Number
   - Patient Location Code
   - Patient Location Description*
   - Admission Type (emergent, elective, etc.)*
   - Patient Type (inpatient, observation, etc.)*
   - Age
   - Gender
   - Admission Date
   - Discharge Date
   - LOS (Days)
   - Admission Source (e.g. ED, Transfer, etc)*
   - Patient Zip Code
   - Payor
   - Final MS-DRG
   - MS-DRG Description
   - Inpatient Service Line Description
   - APR-DRG (if available)
   - APR-DRG Description (if available)
   - APR-DRG Severity (if available)
   - Principal Diagnosis (ICD-10 code)
   - Secondary Diagnoses (provide up to 5) (ICD-10 codes)
   - Principal Procedure (ICD-10 Procedure Code)
   - Gross Revenue / Charges
   - Net Revenue / Payments
   - Variable Direct Expenses
   - Fixed Direct Expenses
   - Variable Indirect Expenses
   - Fixed Indirect Expenses

B. **Outpatient data:** Outpatient (including imaging, ambulatory surgery, clinic and emergency/urgent care) patient-level dataset for most recently completed fiscal year through year to date of the current year (as available): Please do not include any patient identifiable information in the data. If additional "mapping" files or "keys" are required, please provide those as well, to allow for mapping to the main datasets. Fields that may require a "key" are marked with an asterisk (*). Requested fields include:
   - Hospital ID and Name*
   - Clinic ID/Patient Location and Name*
   - Visit Type (Ambulatory surgery, imaging, office visit, lab test, etc.)*, if available
   - Outpatient Service Line Description (e.g. GI Lab, Emergency/Trauma)*, if available
   - Service / Practice Location*, if available
   - Encounter Number (unique identifier - do not use name or social)
   - Medical Record Number
   - Age
   - Gender
   - Service Encounter Date
   - Zip Code
   - Payor
   - ICD-10 Diagnosis Codes
   - ICD-10 Procedure Codes
   - CPT Codes
   - Gross Revenue / Charges
   - Net Revenue / Payments
   - Variable Direct Expenses
   - Fixed Direct Expenses
   - Variable Indirect Expenses
   - Fixed Indirect Expenses

Section 4: Other

This data will help us answer the following questions: (1) how could D-HH/GOH work together to alleviate capacity constraints that force them to deny patients?, (2) are there ways in which D-HH can help CMC avoid having to transfer patients out of state where care may be more expensive?, (3) what is the current complement of clinicians that support each program and what opportunities are there for working together?, (4) what opportunities are there to improve performance on value-based contracts and advance other population health initiatives?

Please provide general information for each system / facility (e.g. DHMC, CGP clinics, CMC, and other D-HH/GOH members as available), and, to the extent relevant, any program-specific detail:

A. Report on denials (capacity and medical broken out) for FYTD and last three years.
B. Report on transfers to DHMC/CMC from other facilities for FYTD and last three years. Please include patient DRG/ICD diagnosis and originating facility, if possible.
C. Report on transfers from DHMC/CMC to other facilities for FYTD and last three years. Please include patient DRG/ICD diagnosis and target facility, if possible.

D. Physician and mid-level roster for D-HH/GOH owned physician group, clinical faculty (if applicable), and any affiliated community physicians and mid-level providers. Requested fields include:
   - Clinician name
   - Specialty / subspecialty
   - Department
   - Division
   - Age
   - Physician Group / Employer Name (if applicable)
   - Hospital affiliations
   - Office location
   - NPI Provider Number
   - UPIN Provider Number
   - Start Date
   - Termination Date / End Date (if applicable)
   - Status

B. Description of value-based contracts and summary of risk methodologies used in the contracts as well as number of lives covered. Please provide any clinical program-specific contracts, if applicable.

C. Population health initiatives, including business plan, operating model and parties involved if available. Please provide any clinical program-specific contracts, if applicable.