Harvard Pilgrim HealthCare

HPHC LCU Reporting User Guide

Provider Analytics Interactive Dashboard

The Provider Analytics Interactive Dashboard (PAID) provides an overview of

- Cost and utilization (overall and key service categories)
- Vital statistics,
- High cost claimant information, and
- Readmission/ReER experience

The report contains drilldowns into patient level information and functionality to export outputs to Excel and flash adobe.

Commercial population only.

For questions regarding access and/or report content, please email HPHC_NMM@point32health.org

This User Guide is posted at *www.harvardpilgrim.org/LCUReporting*

April 2022

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1 Introduction

1.1 Overview

Harvard Pilgrim is committed to increased transparency with its provider community as we move forward into a new world of collaborative partnership.

The Provider Dashboard gives our provider community "one-stop shopping" for online, self-service analytics. The dashboard is integrated with HealthTrio, Harvard Pilgrim's web-based platform that allows providers to conduct data transactions with us.

The PAID dashboard enables providers to view key cost and utilization trends and drill down to the claims level for their patients, with the goal of improving the efficiency and quality of the care they deliver. Provider Dashboard analytics include:

- 'Type of Service' level statistics on cost and utilization, compared to network benchmarks, and
- 'Heat maps' highlighting areas of concern requiring action, and
- Population risk levels with information about gaps in care and high risk/high cost members that could benefit from care management or other support services , and
- User-defined drill-downs into inpatient and outpatient service types, servicing providers, members or specific services
- Drill downs to actionable information about patients at risk: high cost claimants, readmissions, admissions for ambulatory sensitive conditions, returns to ER (ReER), and ER visits for ambulatory sensitive admissions.
- Functionality within this report enables export of this data to external formats such as Excel for further manipulation by the LCU user.

1.2 Personal Information (PI) / Personal Health Information (PHI) Notice

Harvard Pilgrim Health Care continues to invest in data availability and tools to improve your ability to manage medical cost and quality trends. We have recently enhanced this application to permit **member level** analysis.

Our Business Associate Agreement (Privacy and Security Agreement) with you outlines HPHC's expectations and your responsibilities for safeguarding member data. We expect any further disclosure of the information would be narrowly limited in order to achieve the specific clinical objective of coordinating care across the continuum.

Please share this expectation with the Privacy Officer at your organization and all who access the data within the Local Care Unit (LCU).

2 Data Scope

2.1 Time Period

- Data is shown for costs incurred over a rolling 3-year time period with 2 months run out from last completed monthly load of our data warehouse.

2.2 Claims, Costs, and Utilization Count

- All costs are based on allowed amounts (HPHC and member payment responsibility combined).
- All claims use a logic of paid and denied global claims.
- Utilization measures for services are based on admits for Facility Inpatient, claims for Facility Outpatient, Primary Care, and Specialty Care, prescriptions for Pharmacy, and claims and prescriptions for Ancillaries.
- Behavioral Health claims are not included.

2.3 Line of Business and Product Type

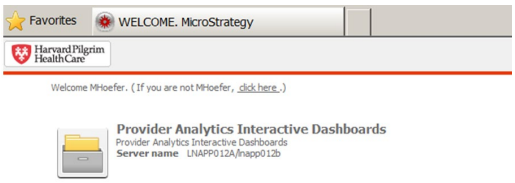
- Data is from the Commercial line of business only.
- Data from HPHC's products managed through its relationship with United Health Care are not included
- Data for self insured commercial products managed by the HPHC subsidiary Health Plans Inc (HPI) are not included
- Report can be viewed by the user for all lines of business/all products (Select All option) or for various subsets of population:
  - Funding Arrangement/Carrier: Fully Insured or Self Insured
  - Product Line: HMO/POS or EPO/PPO
  - Age Band: Pediatric, Adult, Over 65
- EPO/PPO members are not required to select a PCP. HPHC has developed an attribution algorithm which attributes a member to a PCP based on their claims history for preventive services delivered by PCP type physicians.

3 Running the Dashboard

Note that access to the HPHC Provider Performance Reporting Tools requires a handoff from the secure HPHConnect account to a secure MicroStrategy portal. The firewalls in place for some users have blocked this. If you receive an error message upon trying to execute this shift, please contact HPHC_NMM@point32health.org so we may assist you in troubleshooting the issue.

3.1 Navigating to the Dashboard

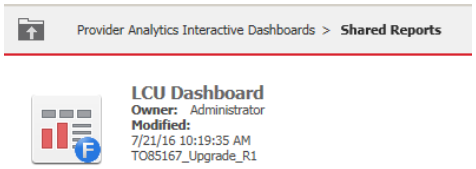
Once you are logged in to the web application, you will see the following screen:



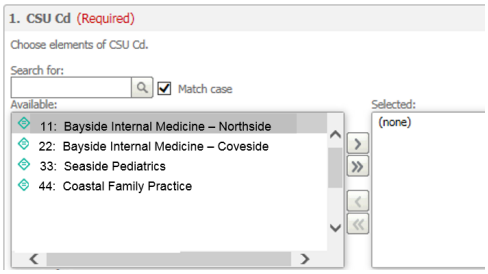
Click on Provider Analytics Interactive Dashboard and you will be brought to this screen. Select Shared Reports

Please note the PI/PHI Privacy Notice displayed.

Select LCU Dashboard



Select the desired Care Sub Units (CSUs) among the list of groups authorized for access.

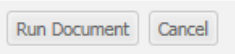


All the CSU's that your *HPHConnect* ID has access to will be displayed in the "CSU Cd" menu under the heading "Available". You can search among the available CSU's by typing in the box labeled "Search for:" and clicking on the button. To search for more than

one CSU at a time, enter the list of codes separated by commas into the search box.

Using the arrow buttons (> or >> ; < or <<) you can move CSU's between the "Available" and "Selected" sections.

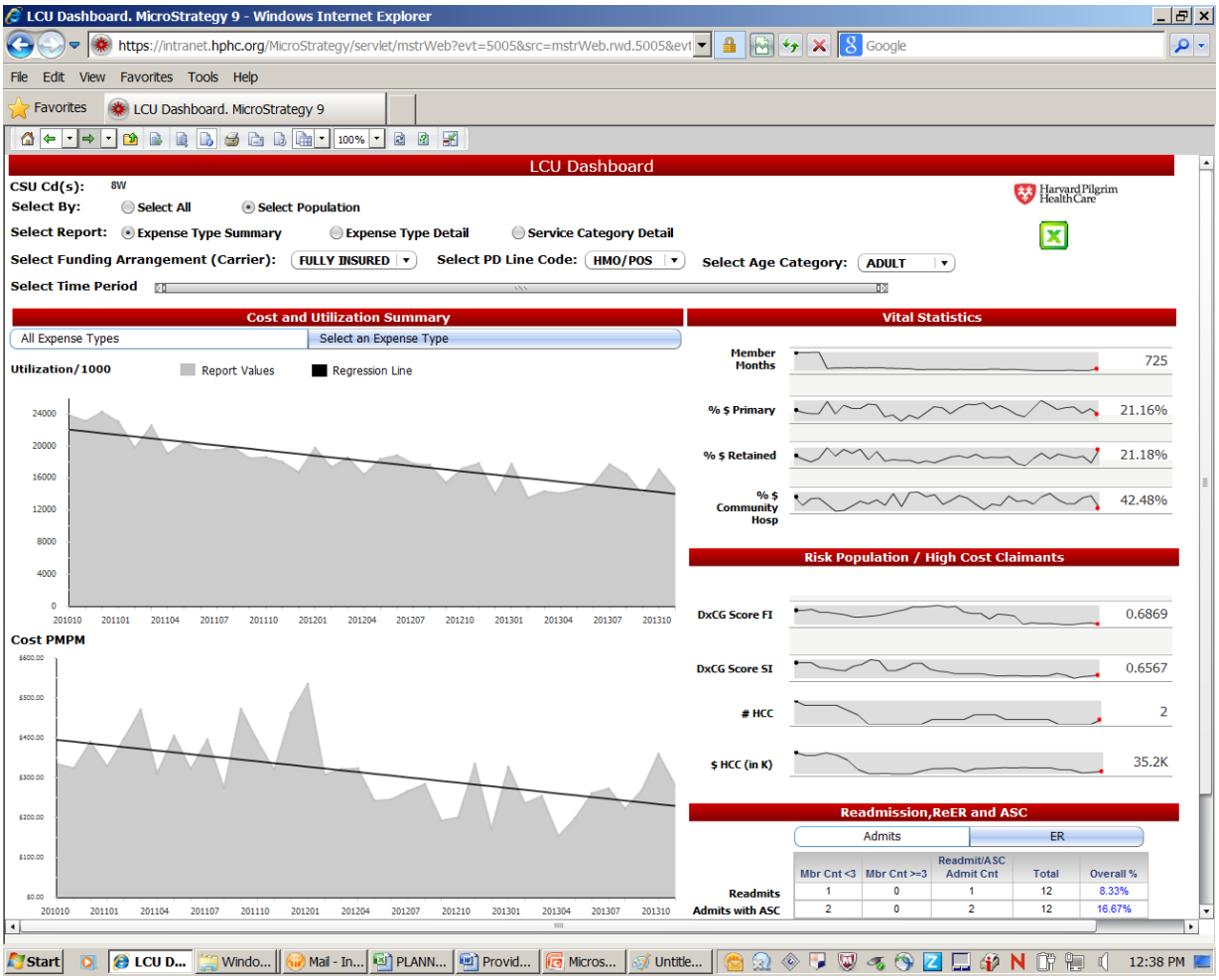
Run document



Once the desired CSU's are in the "Selected" column, click on Run Document at the bottom left side of the screen. To return to the previous screen without running the dashboard, click on Cancel.

Due to the large amount of data contained within the dashboard and the variability of internet connection speeds, it may take several minutes for the dashboard to load. Please be patient and do not use the "reload" feature on your browser. Once the dashboard appears, response times for user actions will only be a few seconds.

4 Expense Type Summary



4.1 Landing Page

The expense type summary is the default landing page when the dashboard is opened. To return to this page after navigating to another page of the dashboard, click on “Expense Type Summary” in the menu at the top of the dashboard. The current selection is indicated by the ◉ button, while available selections are indicated with the ○ button.

4.2 Select time period for review

Upon opening the landing page, there is no visible data until you select the time period until you reposition the time slider at the top of the landing page.

The arrows (,) at either end of the time slider can be dragged to change the currently selected time period. Hovering your cursor over the arrows will display the specific time periods in a YYYYMM format. The time period extends 36 months prior to the date last HPHC financial data extracts (including 2 months claims runout).

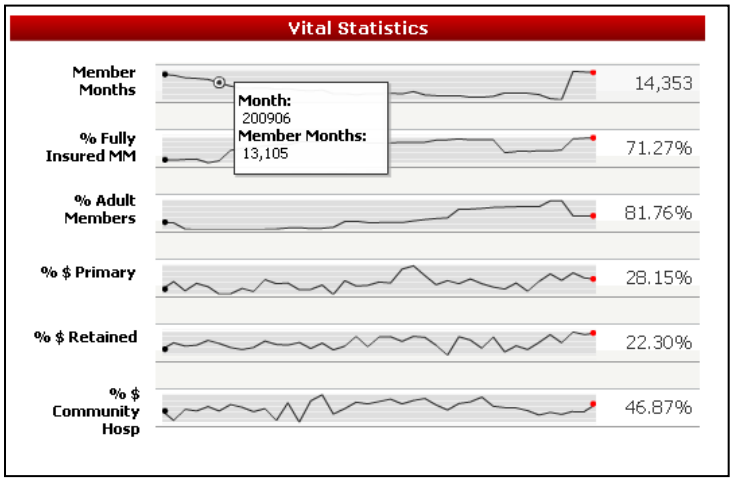
4.3 Selecting Sub Populations

If you are interested in looking at sub populations, click on the "Select Population" button. A new row of selection options appears, offering the opportunity to select different funding arrangements, products, and age bands. The screen shot in above in 4.1 shows the options that are available for selection of your desired population.

Funding Arrangement (Carrier)	• **Fully Insured**: This includes only members whose coverage is fully insured by HPHC. • **Self Insured:** This includes members whose coverage is self insured by the policy holder, who has responsibility for the cost of all claims, with HPHC as a claims intermediary.
Product Line Code	• **HMO/POS:** Health Maintenance Organization / Point of Service products require the member to name a primary care physician (with POS members able to see out of network providers for higher patient costs) • **EPO/PPO:** Exclusive Provider Organization / Preferred Provider Organization products do not require a member to name a PCP and allow members freedom of choice for obtaining care from a broader network of providers, without PCP referral requirements.
Age Band	• **Pedi**: ages < 17 years old • **Adult**: ages 17-64 years old • **65 and over**: ages 65 and older on a commercial product (i.e., not Medicare)

4.4 Vital Statistics

The Vital Statistics section is made up of six small graphs. Placing the cursor over any point on a graph will display the month and the value for the graph at that time. The number to the right of each graph is the value for the most recent month being displayed.

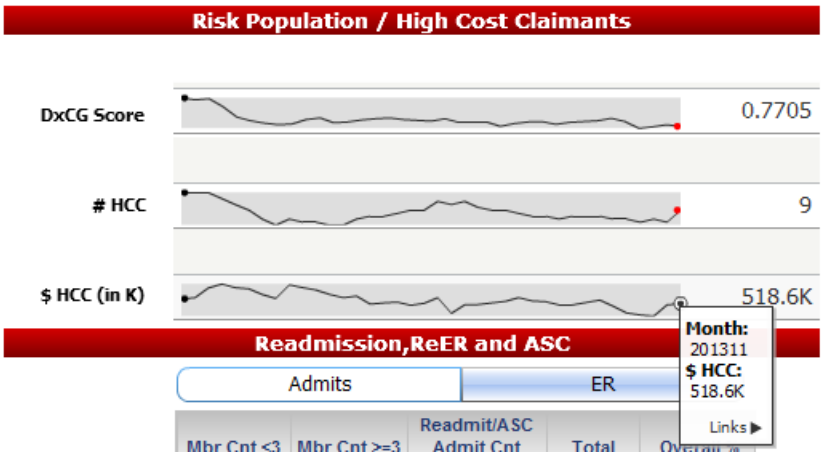


Hovering the mouse cursor over the label of any graph will display a short description of that graph's data. Hovering over any data point in the graph will display the specific values.

Member Months:	The number of member months using the wash method as of the 15th of each month
% Fully Insured MM	Percentage total member months for fully insured members
% Adult Members	Percentage of adults within defined membership, an adult is defined as being 17 or older
% $ Primary	Percentage of allowed payments for professional services paid to primary care providers
% $ Retained	Percentage of allowed payments for professional services paid to providers within this LCU
% $ Community Hosp	Percentage of acute facility (Inpatient and Outpatient) allowed payments paid to community level facilities

4.5 Risk Population and High Cost Claimants

The Risk Population and High Cost Claimants graphs have the same functionality as the Vital Statistics graphs. Hovering your cursor over any data point will show the value for that metric.



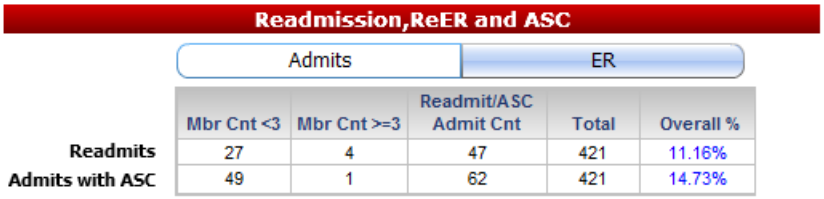
DxCG Score:	Diagnostic Cost Group score for the previous 12 months ending in the month displayed. This is a risk score weighted based on member months for the defined patient population, with a median score of 1.0. A decreasing score indicates a decrease in medical risk, while an increasing score indicates a corresponding increase.
# HCC	This is the number of High Cost Claimants with costs greater than $100k in the previous 12 months ending in the month displayed
$ HCC (in K):	This is the total dollar amount spent over the $100k threshold in the previous 12 months ending in the month displayed

This graph enables drill down into identifying who are the High Cost Claimants. Hover over any data point and the pop up will show you a links option to select the HCC Members. The dollar values displayed reflect the payments made on behalf of the high cost claimant, in excess of the $100,000 threshold.

HPHC MB Nbr	12 Month's ending in this month	Carrier	Age Category	Product	Amount over 100K
PHI	201311	FULLY INSURED	ADULT	PPO/EPO	$211,175.67
	201311	SELF INSURED	ADULT	PPO/EPO	$178,249.80
	201311	SELF INSURED	ADULT	PPO/EPO	$52,690.58
	201311	FULLY INSURED	ADULT	HMO/POS	$24,840.06
	201311	FULLY INSURED	PEDI	HMO/POS	$21,926.10
	201311	SELF INSURED	ADULT	PPO/EPO	$15,624.70
	201311	FULLY INSURED	ADULT	HMO/POS	$10,371.89
	201311	SELF INSURED	ADULT	HMO/POS	$3,575.79
	201311	SELF INSURED	PEDI	HMO/POS	$100.93
Total					$518,555.52

4.6 Readmission, Returns to ER, and Ambulatory Sensitive Conditions

The lower right quadrant provides information on another type of high risk members: those receiving repeated care in the inpatient setting and ER, as well as those treated in these settings that ideally are managed in the ambulatory care setting.



	Mbr Cnt <3	Mbr Cnt >=3	Readmit/ASC Admit Cnt	Total	Overall %
Readmits	27	4	47	421	11.16%
Admits with ASC	49	1	62	421	14.73%

The user can select either Admits or ER using the top bar below the header.

4.6.1 Readmissions

Readmissions are defined as a second admission within 30 days of discharge of a previous admission, regardless of diagnosis/DRG. Admissions with 0 days in between (i.e., date of discharge at hospital A and admission date at hospital B are the same) are considered transfers and are not reported in this data.

The top row in the table focuses on **Readmissions**, showing the following metrics:

Mbr Cnt < 3	count of members who had 1 or 2 readmissions within the past 12 months ending with the last month displayed in the time slider
Mbr Cnt >= 3	count of members who had 3 or more readmissions within the past 12 months ending with the last month displayed in the time slider
ReadmitASC Adm Cnt	shows the count of readmissions within the past 12 months ending with the last month displayed in the time slider
Total	shows the number of admissions within the past 12 months ending with the last month displayed in the time slider
Overall %	calculates the readmission rate (# Readmissions in 3rd column divided by total admission count in 4th column

The metric reported in this last column displays in **blue**, indicating a drill down option

Drilldown: Readmissions
The initial screen of patient drilldowns displays a patient listing, including

- insurance product
- funding arrangement
- age category
- patient first name and last name
- HPHC Member number
- date of birth
- count of readmissions

The HPHC Mb Nbr is underlined, indicating opportunity for further drill down displaying the following information:

Insurance Information	• Carrier • Product • Age Category
PCP Information	• PCP number (HPHC provider ID) • First Name • Last Name
Servicing Provider Information	• Servicing Provider Number (HPHC provider ID) • Servicing Provider Name • Servicing Provider State • Facility Type (tertiary/community)
Admission Information	• Authorization Number • Admission Type • Admit Date • Discharge Date • Age on Admission • Discharge Date • Service Category Code/Type (e.g., IP Medical, IP Surgical),
Diagnosis Information	• DRG Code/Description • Primary Diagnosis Code/Description • Procedure Code/Description for any procedures done while inpatient
Discharge Status	• Defines what setting the patient went to upon discharge
Readmission Information	• Readmission Indicator (all admissions are shown, those which occur within 30 days of an Index admission date are flagged with a Y) • Date of Index Admission (12/31/9999 is the default if the admission is not a readmission within 30 days) • Days post index shows the number of days between admission

The discharge date is underlined, indicating a further drilldown. This drilldown displays the prescriptions filled within 30 days of the discharge, to facilitate medication reconciliation.

Insurance Information	• Carrier • Product • Age Category
Drug Information	• Therapeutic Class Code • Therapeutic Class Description • NDC Code • NDC Name • Tier Level • Brand/Generic Flag (Y=Generic)
Prescriber	• First Name • Last Name
Specialty Drug Flag	• Specialty Drug Code • Specialty Drug Description
Claim Information	• Fill Date • Claim Count

4.6.2 Admissions due to Ambulatory Sensitive Conditions

The second row in the tables focuses on admissions due to Ambulatory Sensitive Conditions (ASC), as defined by the NYU algorithm developed by John Billings under a Robert Wood Johnson grant.

Mbr Cnt < 3	count of members who had 1 or 2 admissions within the past 12 months ending with the last month displayed in the time slider
Mbr Cnt >= 3	count of members who had 3 or more admissions within the past 12 months ending with the last month displayed in the time slider
Readmit/ASC Adm Cnt	shows the count of admissions within the past 12 months ending with the last month displayed in the time slider
Total	shows the number of admissions within the past 12 months ending with the last month displayed in the time slider
Overall %	calculates the admission rate (# ASC admissions in 3rd column divided by total admission count in 4th column

Drilldown: Admissions for Ambulatory Sensitive Conditions

The initial screen of patient drilldowns displays a patient listing, including
- insurance product
- funding arrangement
- age category
- patient first name and last name
- HPHC member number
- date of birth
- count of admissions for ambulatory sensitive conditions

The HPHC Mb Nbr is underlined, indicating opportunity for further drill down displaying the following information:

Insurance Information	• Carrier, Product, Age Category
PCP Information	• PCP number (HPHC provider ID) • First Name • Last Name
Servicing Provider Information	• Servicing Provider Number (HPHC provider ID) • Servicing Provider Name • Servicing Provider State • Facility Type (tertiary/community)
Admission Information	• Authorization Number • Admission Type • Admit Date • Discharge Date • Age on Admission • Discharge Date • Service Category Code/Type (e.g., IP Medical, IP Surgical),
Diagnosis Information	• DRG Code/Description • Primary Diagnosis Code/Description • ASC Description (all admissions are shown, those due to ASC display the ASC, those not ASC related display “not an ASC”) • Procedure Code/Description for any procedures done while inpatient

Discharge Status	• Defines what setting the patient went to upon discharge

The discharge date is underlined, indicating a further drilldown. This drilldown displays the prescriptions filled within 30 days of the discharge, to facilitate medication reconciliation. This information is described in section 4.6.1.

4.6.3 Returns to the ER (ReER)

ReER visits are defined as a second ER visits within 30 days of an ER visit, regardless of diagnosis.

The top row in the table focuses on **ReERs**, showing the following metrics:

Mbr Cnt < 3	count of members who had 1 or 2 ReER visits within the past 12 months ending with the last month displayed in the time slider
Mbr Cnt >= 3	count of members who had 3 or more ReER visits within the past 12 months ending with the last month displayed in the time slider
ReER/ASC ER Cnt	shows the count of ReER visits within the past 12 months ending with the last month displayed in the time slider
Total	shows the number of ER visits within the past 12 months ending with the last month displayed in the time slider
Overall %	the ReER rate (# ReER visits in 3rd column divided by total ER visit count in 4th column)

The metric reported in this last column displays in **blue**, indicating a drill down option

Drilldown: ReER
The initial screen of patient drilldowns displays a patient listing, including

- insurance product
- funding arrangement
- age category
- patient first name and last name
- HPHC Member number
- date of birth
- count of ReER visits

The HPHC Mb Nbr is underlined, indicating opportunity for further drill down displaying the following information:

Insurance Information	• Carrier, • Product • Age Category
PCP Information	• PCP number (HPHC provider ID) • First Name • Last Name
Servicing Provider	• Servicing Provider Number (HPHC provider ID)

Information	• Servicing Provider Name • Servicing Provider State • Facility Type (tertiary/community)
ER visit Information	• Claim Number • Claim Beg Date (i.e., Date of Service) • Claim End Date • Day of Week • Age
Diagnosis Information	• Primary Diagnosis Code • Description
ReER Information	• ReER (all ER visits are shown, those which occur within 30 days of an Index ER Visit date are flagged with a Y) • Date of Index Admission (12/31/9999 is the default if the ER Visit is not a return to the ER within 30 days)

The Claim End date is underlined, indicating a further drilldown. This drilldown displays the prescriptions filled within 30 days of the discharge, to facilitate medication reconciliation. This information is described in section 4.6.1.

4.6.4 ER Visits due to Ambulatory Sensitive Conditions

The second row in the tables focuses on ER visits due to Ambulatory Sensitive Conditions (ASC), per the source described above.

Mbr Cnt < 3:	count of members who had 1 or 2 ER visits within the past 12 months ending with the last month displayed in the time slider related to ASC
Mbr Cnt >= 3	count of members who had 3 or more ER visits within the past 12 months ending with the last month displayed in the time slider related to ASC
ER ReER/ASC ER Cnt	shows the count of ER visits within the past 12 months ending with the last month displayed in the time slider related to ASC
Total	shows the number of ER Visits within the past 12 months ending with the last month displayed in the time slider
Overall %	calculates the ER ASC rate (# ASC ER in 3rd column divided by total ER visit count in 4th column

The last column in each of these views displays in **blue**, indicating a drill down option

Drilldown: ER visits for Ambulatory Sensitive Conditions

The initial screen of patient drilldowns displays a patient listing, including

- insurance product
- funding arrangement
- age category
- patient first name and last name
- HPHC Member number
- date of birth
- count of ReER visits due to ambulatory sensitive conditions

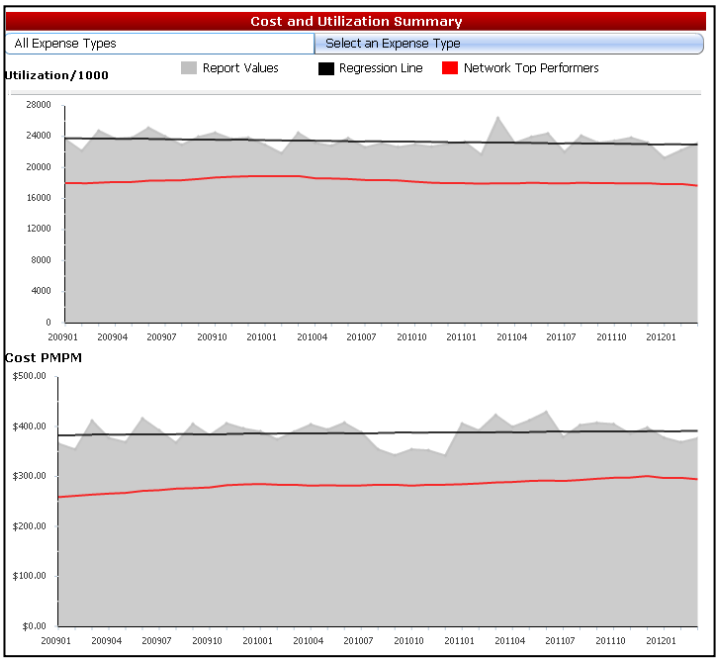
The HPHC Mb Nbr is underlined, indicating opportunity for further drill down displaying the following information:

Insurance Information	• Carrier • Product • Age Category
PCP Information	• PCP number (HPHC provider ID) • First Name • Last Name
Servicing Provider Information	• Servicing Provider Number (HPHC provider ID) • Servicing Provider Name • Servicing Provider State • Facility Type (tertiary/community)
Admission Information	• Claim Number • Claim Beg Date (i.e., Date of Service) • Claim End Date • Age
Diagnosis Information	• Primary Diagnosis Code • Primary Diagnosis Code Description • Identification of the Ambulatory Sensitive Condition

The Claim End date is underlined, indicating a further drilldown. This drilldown displays the prescriptions filled within 30 days of the discharge, to facilitate medication reconciliation. This information is described in section 4.6.1.

4.7 Cost and Utilization Summary

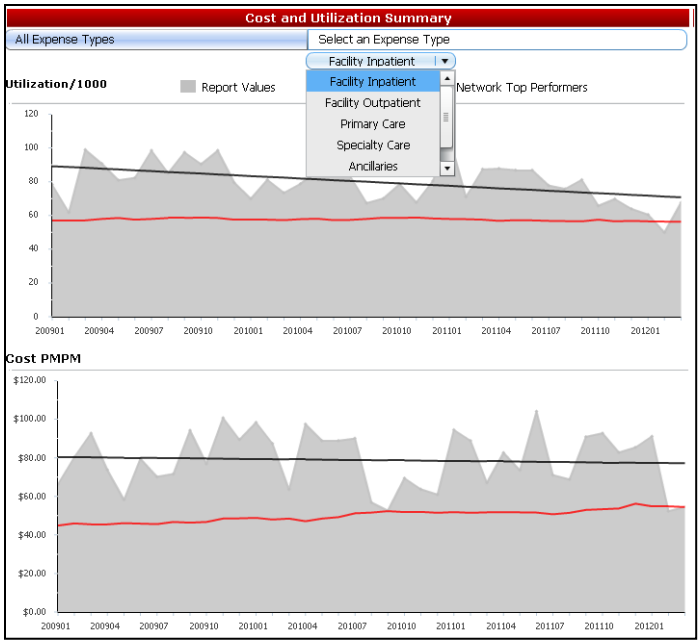
The Cost and Utilization Summary consists of two graphs.



Utilization/1000 members	This is the total monthly count of admissions (for inpatient), prescriptions (for pharmacy), or claims (all other categories) per 1000 members. At the highest aggregate level (all service types), this combined rate is not meaningful (combines low volume admissions and high volume prescription). Selecting specific expense types enables meaningful information.
Cost PMPM	This is the allowed cost for the given month divided by the total number of member months for that month. Costs PMM can be combined across service types.

4.7.1 Selecting Expense Type

The blue menu selector under the “Cost and Utilization Summary” label can be used to select the expense type category. Click on **All Expense Types** to see the data for all expense types combined (the default). To view the data for an individual expense type categories (e.g., Facility Inpatient, Facility Outpatient, Primary Care, Specialty Care, Ancillaries, Pharmacy), click on **Select an Expense Type**. Click the down blue arrow ( ) to reveal a drop-down menu, then click on the name of the desired expense type.



4.7.2 Graph Components

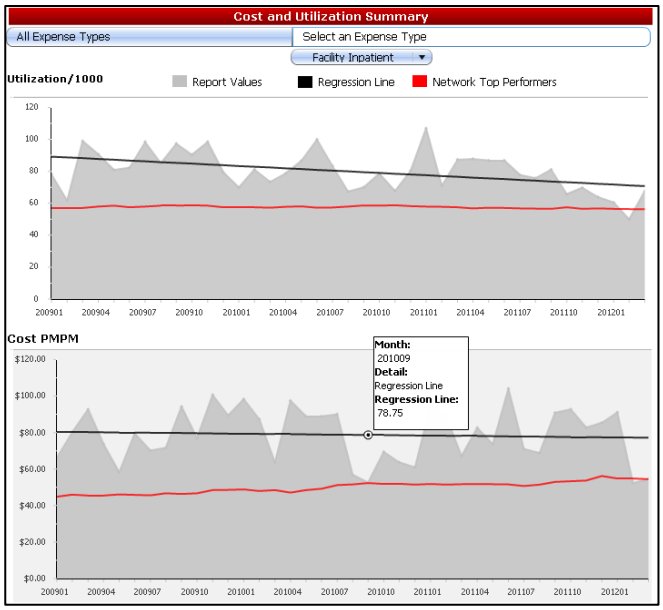
Each graph consists of three sets of data. Placing the mouse cursor over any point on a graph will display the month and the value for the graph at that time.

Report Values: These are the Utilization/1000 or Cost PMPM values for the given month.

Regression Line: This is a best fit linear regression line calculated using all the report values. This trend line gives an idea of how the report values are changing over time

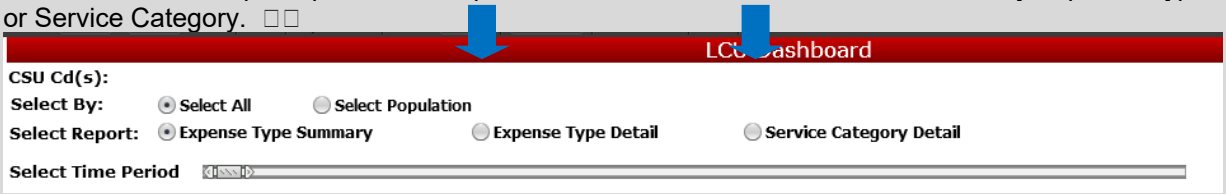
Network Top Performers: This value represents the top 25th percentile of all LCU's in the network's performance. This benchmark allows a

provider population to be compared against network's best performers. This is context specific, i.e. benchmark changes for expense groups i.e. Facility Inpatient, Facility Outpatient, Primary Care, Specialty Care, Ancillaries and Pharmacy for different carriers, and also for each distinct service category and expense type.

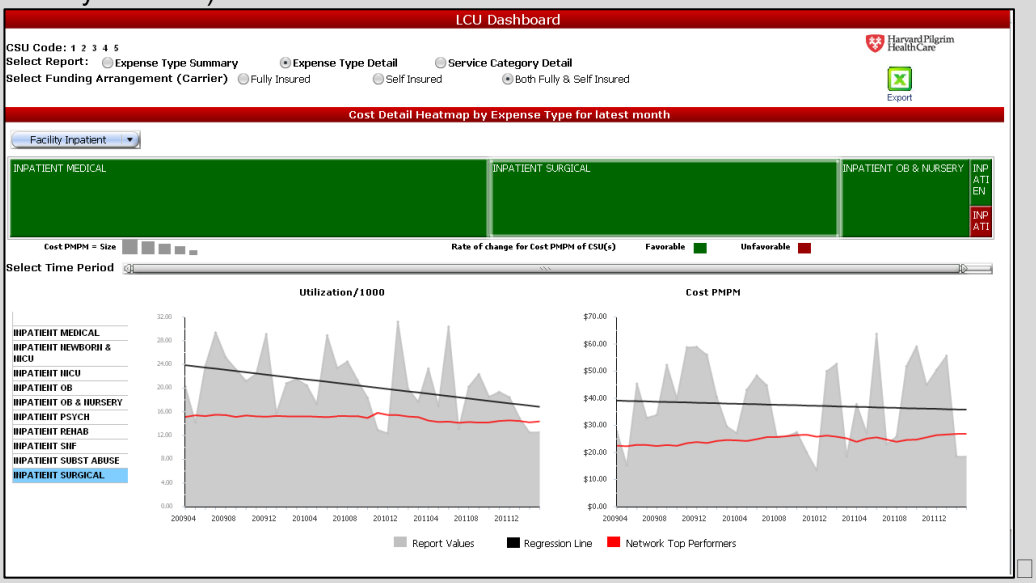


5 Expense Type Detail and Service Category Detail

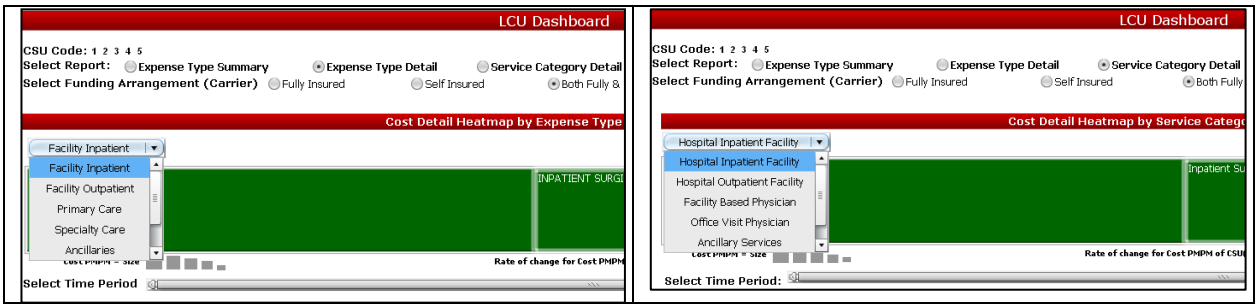
Under the Select Report option at the top of PAID, the use can view additional detail by Expense Type or Service Category.



These two views have the same functionality. The only difference is the grouping of costs by Expense Type (aligned with the HPHC financial reporting categories) or by Service Category (more industry standard).



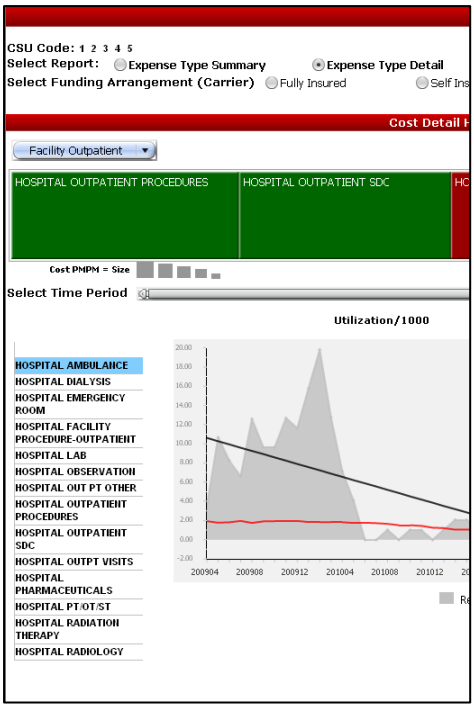
Selecting Expense Type Group/ Service Category Group The blue menu displays the currently selected Expense Type Group/ Service Category Group. To change your selection, click on the arrow ( ) to display the drop-down menu. Then click on the desired expense type or service category.



5.1 Selecting Expense Type/ Service Category

There are two ways to change the Expense Type or Service Category displayed on the cost and utilization graphs. The first is by clicking on your selection in the list to the left of the graphs. This list displays all possible Expense Types or Service Categories within the selected group. The second way to make a selection is to click on the expense type or service category name in the heat map.

Please note that the heat map only displays those expense types or service categories for which there is data in the most recent month.



5.2 Reading the Heat Map

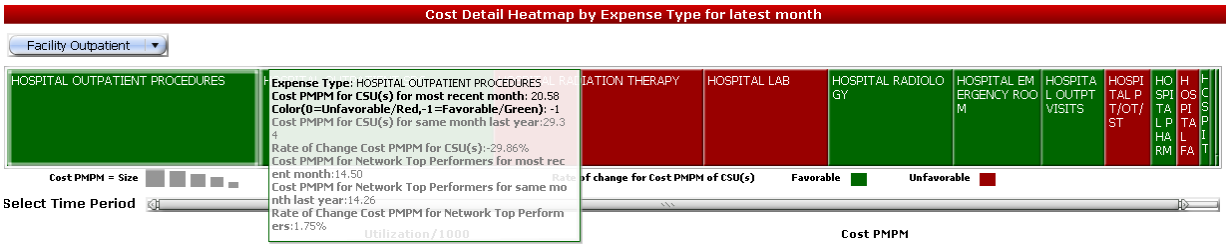
The heat map visualizes cost information for the most recent time period. Only those expense types or service categories which have information for the most recent month are displayed on the heat map. This most recent month corresponds to three or four months before the date you access the dashboard.

The information is presented in two dimensions, size and color.

- ***Size*** is determined by the cost PMPM for the most recent month for what you are looking at, and

- ***Color*** is determined by the rate of change in cost PMPM compared to last year's value.
  A Green colored tile means that cost PMPM have decreasing from same time point last year; this is a favorable change (although decreases in primary care services may be construed as a negative trend).
  A Red colored tile means that cost PMPM have increasing from same time point last year.

Hover the mouse cursor over any part of the heat map to see the cost PMPM values and rate of change for the CSU(s) on the report and for the network top performers.



5.3 Time Slider (Graphs Only)

Similar to the Summary page, there is a time slider which can be used to change the currently displayed time period. The heat map always refers to the most recent month of data, so the time slider applies only to the cost and utilization graphs.

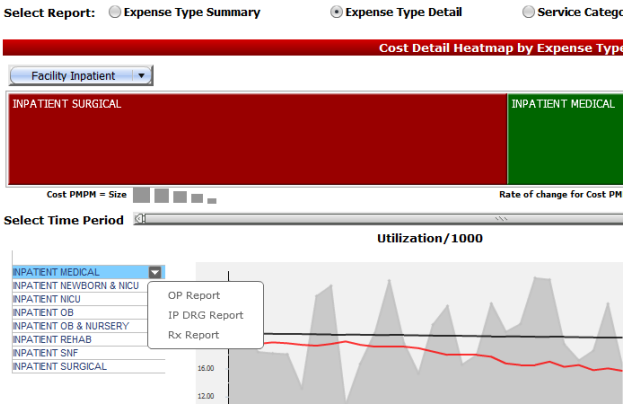
5.4 Cost and Utilization Graph Components

The cost PMPM and utilization per 1000 graphs function the same on the detail pages as on the summary page.

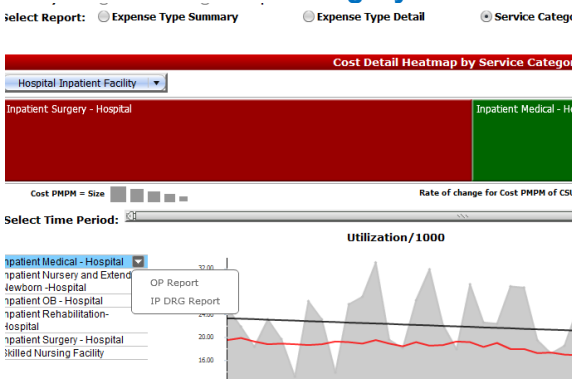
5.5 Navigating to the Drill Down Reports

When the selected expense type group is "Facility Inpatient" or the selected service category group is "Hospital Inpatient Facility", there is another level of reporting available called the "Inpatient DRG Report". To navigate to this report, click the small arrow ( ) on the right side of any expense type/service category and then click on "Inpatient DRG Report".

View in Expense Type Detail



View in Service Category Detail



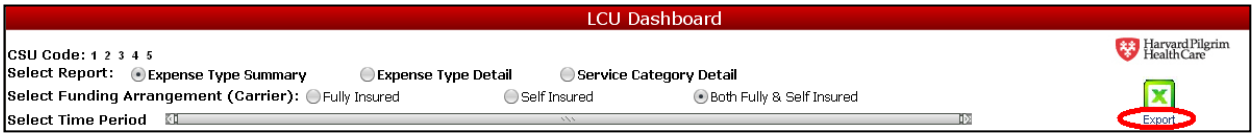
Note: 3 links are offered when you click on a detail category: OP Report, IP DRG Report, and Rx Report. Although you may be able to click on this link when a group other than "Facility Inpatient" or "Hospital Inpatient Facility" is selected, there will be no information displayed on the report. Clicking on

OP report when viewing an IP category will likewise display no information. You can select the Rx Report from any Category.

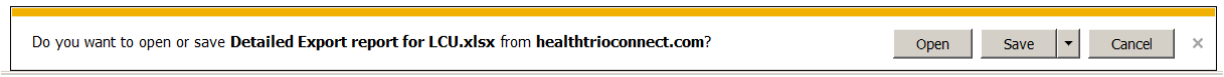
6 Exporting

6.1.1 Excel File

To export the data contained in the dashboard, click the “Export” link under the HPHC Logo in the top right corner of the screen. All the values displayed in the dashboard will be exported to a multi-tabbed Excel file.



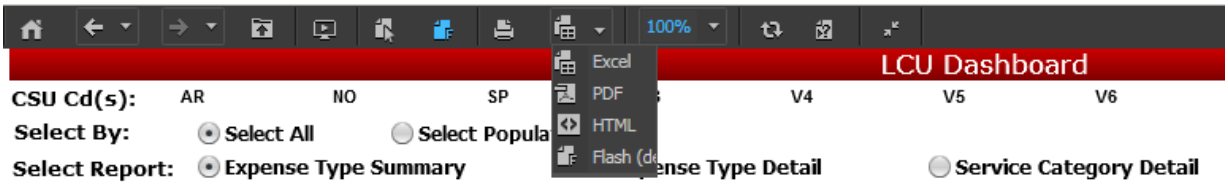
When the request has processed, you will be prompted to Open or Save (remember to save if you use the Open option). The excel data can be further analyzed or combined with other similar data.



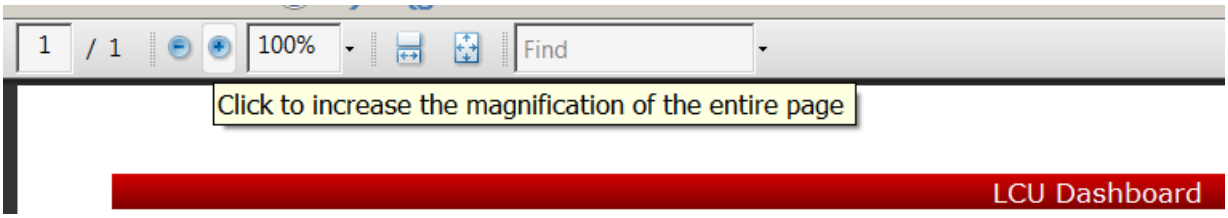
6.1.2 Flash Document

The dashboard can also be exported as a flash document. After saving this file to your computer, you can view the Expense Type Summary, Expense Type Detail, and Service Category Detail pages while offline. You will not be able to export to Excel or view any patient level drilldown data; HPHC security protocol requires you to have passed the security process during logon to access PHI.

To Export to Flash, use the menu on the top right side of the screen. Click the arrow for the export button (paper/spreadsheet icon) to display the export menu, then select Flash.

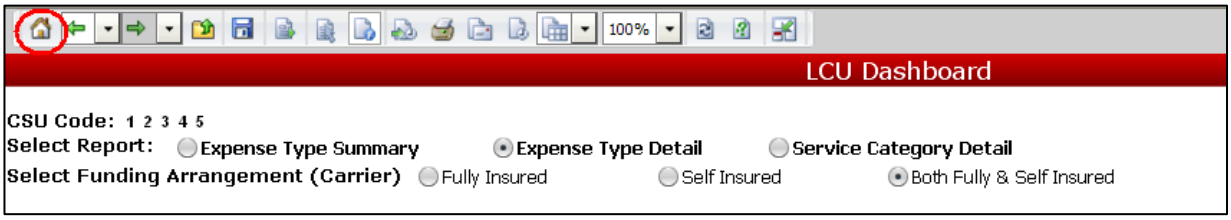


When complete, the dashboard will appear in it’s flash format. Increase the default view magnification to 100% to see the entire dashboard. Save the file locally.

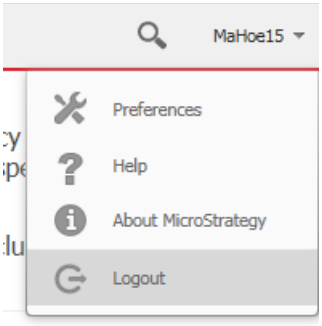


7 Logging Out

When you are ready to log out of the web application, click on the button in the top left corner of the screen:



This will bring you back to the home page for the web application.



Click the down arrow next to your user name, then select logout to end the session.

8 Technical Issues

I cannot access *HPHConnect*	Please contact your Network Contracting Consultant to confirm access
I cannot see all my assigned CSU's after accessing *HPHConnect*	Please contact your Network Contracting Consultant to confirm CSU's
I cannot run the Dashboard	Make sure you have selected CSU(s) and pressed "Run document" button in bottom right hand corner. Please close application and restart dashboard
I do not see any data; error message reads 'Filter applied may have excluded all data from this view.	This indicates that there has been no utilization and claims experience for defined population
I have an issue with the data shown or require more information on data definition	Please contact HPHC_NMM@point32health.org.
I cannot run the Inpatient DRG Report	Please close application and restart dashboard
I cannot open the Dashboard after it has been saved	Please use Internet Explorer to open mhtml file. Please ensure you have the necessary software installed on your computer e.g. Adobe Flash
For all other issues not covered above	Please contact HPHC_NMM@point32health.org

9 Glossary

Care Sub Unit (CSU)	Care Sub Unit is an aggregation in the provider hierarchy. The hierarchy goes from provider/physician to CSU to LCU
Diagnosis Related Group (DRG)	A system of classification for services based upon the following factors: principal diagnosis, secondary diagnosis, surgical procedures, age, sex, and presence of complications.
Expense Type	A financial categorization of an entire claim used for financial reporting. This tells you who billed for the service
Funding Arrangement (Carrier)	The portion of funding risk that the customer has agreed to share with HPHC for a given customer contract
Local Care Unit (LCU)	Local Care Unit is an aggregation in the provider hierarchy. The hierarchy goes from provider/physician to CSU to LCU
Member Months	A member month is defined as 1 member being enrolled for 1 month. Member months for an account are the total number of participants who are members for each month. Since we cannot determine participant status for every day of a month, we use the wash method and determine status on the 15th of the month, in the assumption that those who are new participants are balanced out by those who leave on the 15th of the month
Primary Care Physician (PCP)	A Provider designated by a Member in a POS or HMO plan for the member's primary care, and whose referral is required for the member to receive service from a specialist
Provider	A person or organization that provides health care. Examples include physicians, Licensed Nurse Practitioners, hospitals and clinics, pharmacies, psychiatrists, social workers, etc
Protected Health Information (PHI)	Protected Health Information is individually identifiable health information about the member that is transmitted or maintained by electronic media or in any other form or medium
Regression Line	The line which represents the best fit for a set of data
Service Category	An analytic categorization that describes what services were rendered