UHC Overview and Capabilities of the Clinical Data Base

America's Essential Hospitals
August, 2013

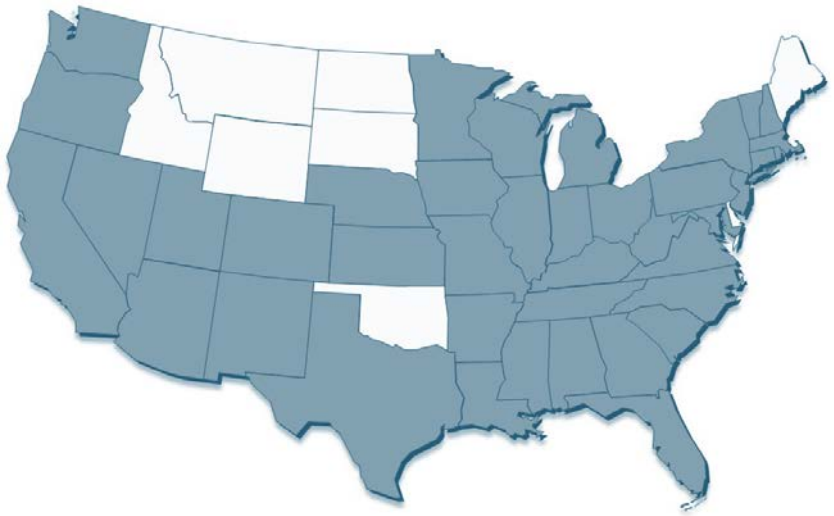
Steve Meurer, PhD, MBA, MHA
Senior Vice President
Clinical Data & Informatics

What is UHC?

UHC Membership

Found throughout the US

118	**Principal Members** Academic Medical Centers (AMC's)
290	**General Members** Teaching hospitals & community affiliates of principal members



- Member-owned alliance of more than 95% of the nation's nonprofit AMCs and their affiliates
- Board of Directors are the CEOs from the Principal Members
- Profits go back to members
- Specific competencies in comparative data, performance improvement, networking, and supply chain

AEH Members in UHC

Boston Med Center
Cambridge Health Alliance
San Francisco General
Denver Health
Regents (GA)
Grady
Harris Health
Hennepin
Howard
Kern
LA County
Parkland
UMass
UMDNJ
Nevada
Riverside
Santa Clara
Shands
Stony Brook
SUNY Upstate
SUNY Downstate
Temple
Ohio State
Tampa General
Univ of Arizona
Univ of Kansas
UTMB
Truman
Univ of Kentucky
UAB
Metro Health (OH)
UCLA
UC San Diego
UC Irvine
UC Davis
UCSF
Santa Monica
Univ of Colorado
Poudre Valley
Memorial (CO)
UIC
South Alabama
Univ of Utah
Univ of New Mexico
Univ of Washington
VCU
WVU

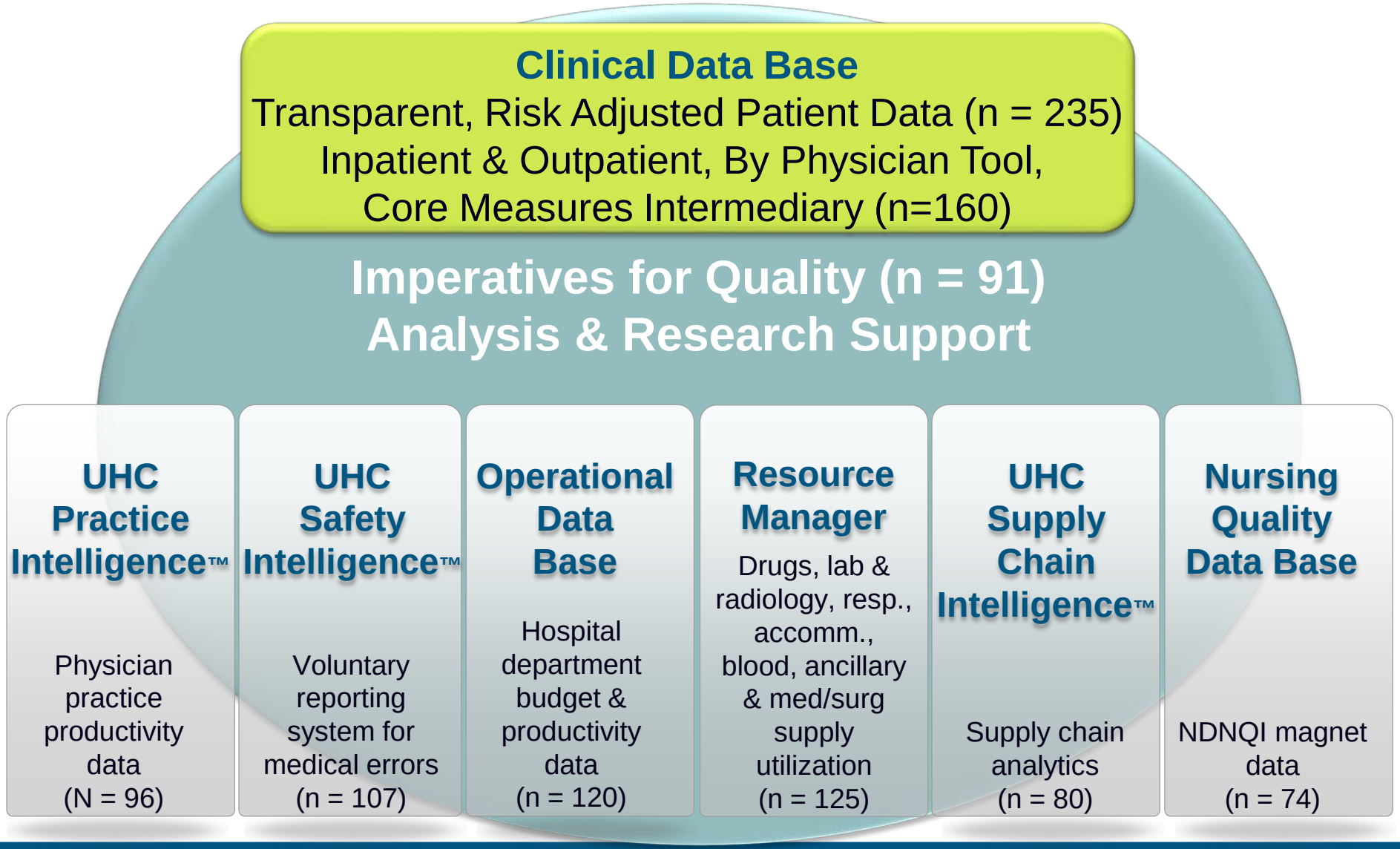
Performance Improvement in 2013

- Process Improvement = Data + Change
- Useful data moves organizations to acceptance and action

Stages of ~~Grief~~ Quality Measurement

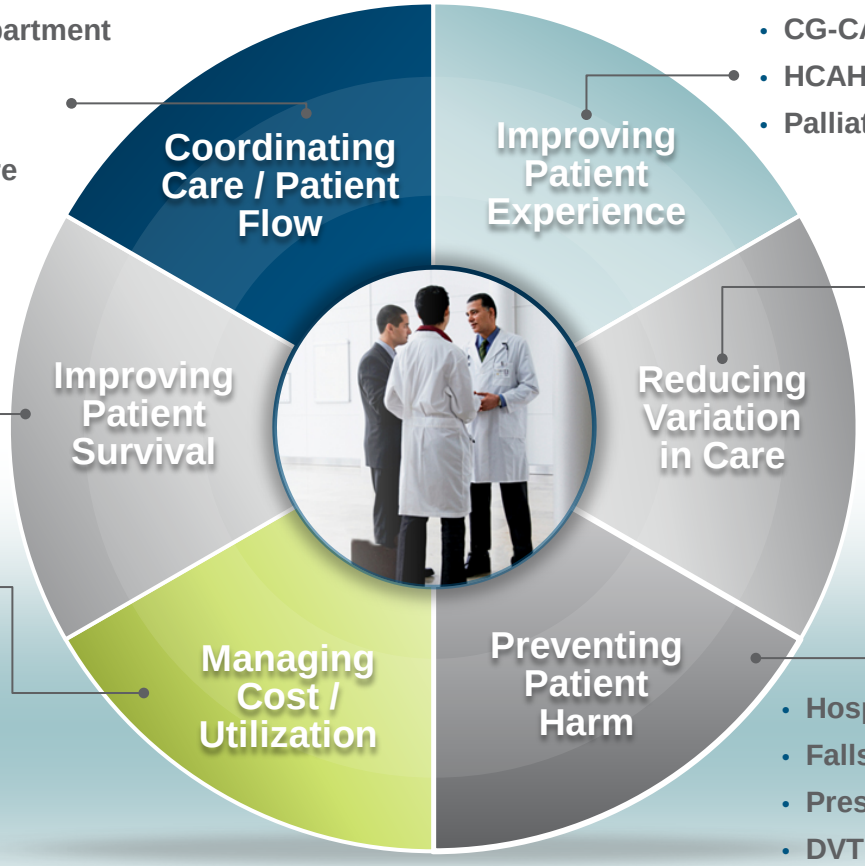
Kübler-Ross	Shannon Sims, MD, PhD
Denial	There's not a problem
Anger	Data is ***completely*** wrong
Bargaining	Need different metrics
Depression	My patients are sicker
Acceptance	OK, maybe we can do better

UHC Performance Improvement & Data Competencies



Imperatives for Quality – Core Imperatives

Improving Patient Outcomes And Financial Operations



- Emergency Department
- Length of stay
- Readmissions
- Ambulatory Care

- CG-CAHPS
- HCAHPS
- Palliative and Hospice Care

- Sepsis Management
- Mortality Review
- Improving Patient Population Survival

- Core Measures
- Total Joint Replacement
- Interventional cardiology
- Stroke

- Labor Practices
- Supply Utilization
- Medication Utilization

- Hospital Acquired Infection
- Falls
- Pressure Ulcers
- DVT
- Obstetrical Adverse Events
- Adverse Drug Events

Unique Features of UHC's CDB / RM for Members

Prestigious Comparators

- All of the 2012-2013 U.S.News & World Report Honor Roll Hospitals
- 95% of all major not-for-profit academic medical centers

Transparency

- You can see other participants' data by name
- You can see and react to the models
- You drive the database enhancements
- You have access to networking among all participants

U.S.News Hospital Honor Roll	
Rank	**Hospital**
1	Massachusetts General
2	Johns Hopkins
3	Mayo Clinic
4	Cleveland Clinic
5	Ronald Reagan UCLA
6	Barnes-Jewish
7	NY-Presbyterian
8	Duke University
9	Brigham and Women's
10	UPMC
11	NYU Langone
12	Northwestern Memorial
13	UCSF Medical Center
14	Mount Sinai Medical Center
15	University of Pennsylvania
16	Indiana University Health System
17	University of Michigan

Customized Services to Meet Your Unique Needs

Expert Analytics

- We are not sales people; instead we are analysts, researchers, statisticians, clinicians and administrators
- We consider ourselves an extension of your staff

Training and Support

- There is no extra cost for training, analysis support, research support

PROFILE (GENERAL) | PROFILE (FEATURE) | BASE MSDRG | CCS PROC | CCS DX | CCS PROC (MY HOSPITAL) | CCS DX (MY HOSPIT

BED SIZE All | MEDICARE CMI All | INPATIENT DISCHARGES All

PRE-SELECTED COMPARISON GROUPS

Send Hospital list to CDB/RM

2012 Quality & Accountability Study Hospitals
AAMC Teaching Hospitals
C4QI Hospitals
CHA Hospitals
CRM Hospitals
NAPH HCOs
NCCN Hospitals
Non-AAMC Community Hospitals
Nurse Magnet HCOs
PfP Hospitals
Top UHC Quality & Accountability HCOs (2010)
Top UHC Quality & Accountability HCOs (2011)
Top UHC Quality and Accountability HCOs (2012)
UHC General Members
UHC Peer Group A Hospitals
UHC Peer Group B Hospitals
UHC Principal Members
UHC Top 20 Pediatric Hospitals (% of discharges)
UHC Top 20 Pediatric Hospitals (by volume)
USNEWS Honor Roll HCOs (2010)
USNEWS Honor Roll HCOs (2011)
USNEWS Honor Roll HCOs (2012)
USNEWS Honor Roll HCOs (2013)
USNEWS Top 20 Specialty HCOs: Cancer (2010)
USNEWS Top 20 Specialty HCOs: Cancer (2011)
USNEWS Top 20 Specialty HCOs: Cancer (2012)
USNEWS Top 20 Specialty HCOs: Heart (2010)
USNEWS Top 20 Specialty HCOs: Heart (2011)
USNEWS Top 20 Specialty HCOs: Heart (2012)
USNEWS Top 20 Specialty HCOs: Neuro/Neurosurg (20

Hospital Profiler

Choose custom compare groups with all subscribers using many different attributes

Will be changing to read America's Essential Hospitals

Hospital Name					# Qtrs	Acute Care Beds	Inpatient Discharges	Inpatient Surgeries	Births	Medicare CMI	Transfers In	Inpatient Days	%ICU Cases	Mean Dx Codes	Proc Codes
UAB Hospital					4	1144	48970	17668	3765	1.94	5558.00	290342	22	9.8	3.3
University of South Alabama Health System					4	131	6421	2329	0	2.16	171.00	37594	28	4.2	2.1
University of South Alabama Children's and Women's Hospital					4	271	10662	2005	2562	0.91	686.00	57100	15	2.4	3.0
University of Arizona Health Network, (The University of Arizona Medical Center, University Campus)					4	487	27424	8456	1851	1.82	2159.00	129363	22	4.3	2.0
Mayo Clinic Scottsdale															1
University of Arkansas for Medical Sciences (UAMS) Medical Center															2
UC San Diego Health System															2
Santa Clara Valley Health & Hospital System					4	454	25640	5249	4199	1.61	1006.00	117938	24	7.1	2.0
Olive View-UCLA Medical Center					4	198	11950	2447	533	1.24	0.00	53903	4	3.6	2.8
Santa Monica UCLA Medical Center and Orthopaedic Hospital					4	315	15840	4139	1336	1.52	1183.00	73824	11	8.5	2.1
City of Hope National Medical Center	CITYOFHOPE	050146	CA	Duarte	4	179	6217	3049	0	1.98	165.00	57385	22	11.1	3.5
San Francisco General Hospital	SFGEN	050228	CA	San Francisco	4	415	14377	2791	1046	1.36	108.00	81881	10	3.6	2.0
UCLA Health System	UCLA	050262	CA	Los Angeles	4	450	25310	10261	2095	2.35	1546.00	153080	22	8.7	3.1
Riverside County Regional Medical Center	RIVERSIDE	050292	CA	Moreno Valley	4	421	23803	4050	2350	1.27	139.00	116109	12	3.7	2.8
UC Irvine Medical Center	UCIRVINE	050348	CA	Orange	4	422	17842	5517	1227	1.88	906.00	99038	24	10.0	3.1
LAC + USC Healthcare Network	LAC-USC	050373	CA	Los Angeles	4	676	33425	8492	951	1.51	1091.00	193866	24	2.9	2.8

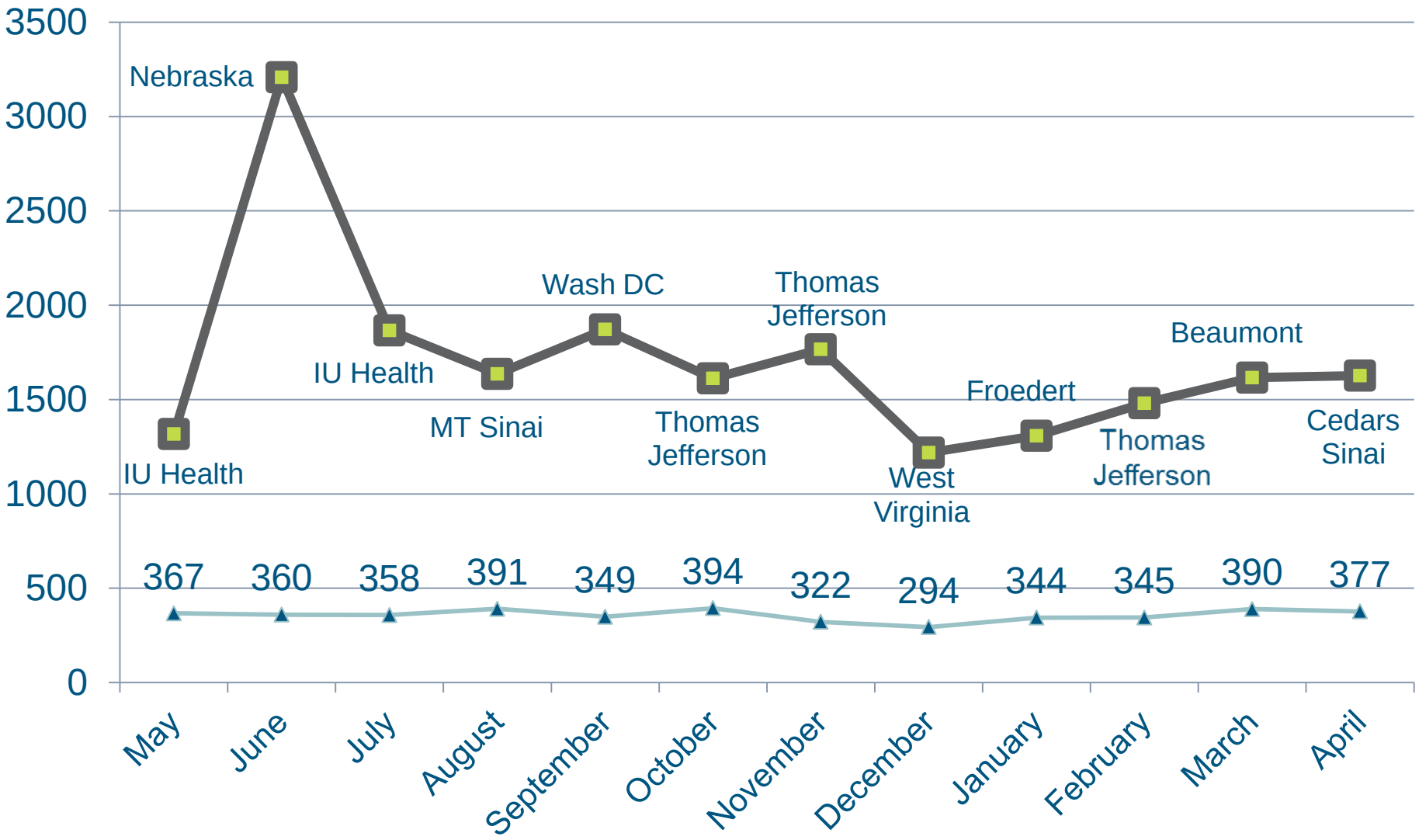
UHC

Enhancements Based on Member Feedback
Standard Restrictions for Readmissions

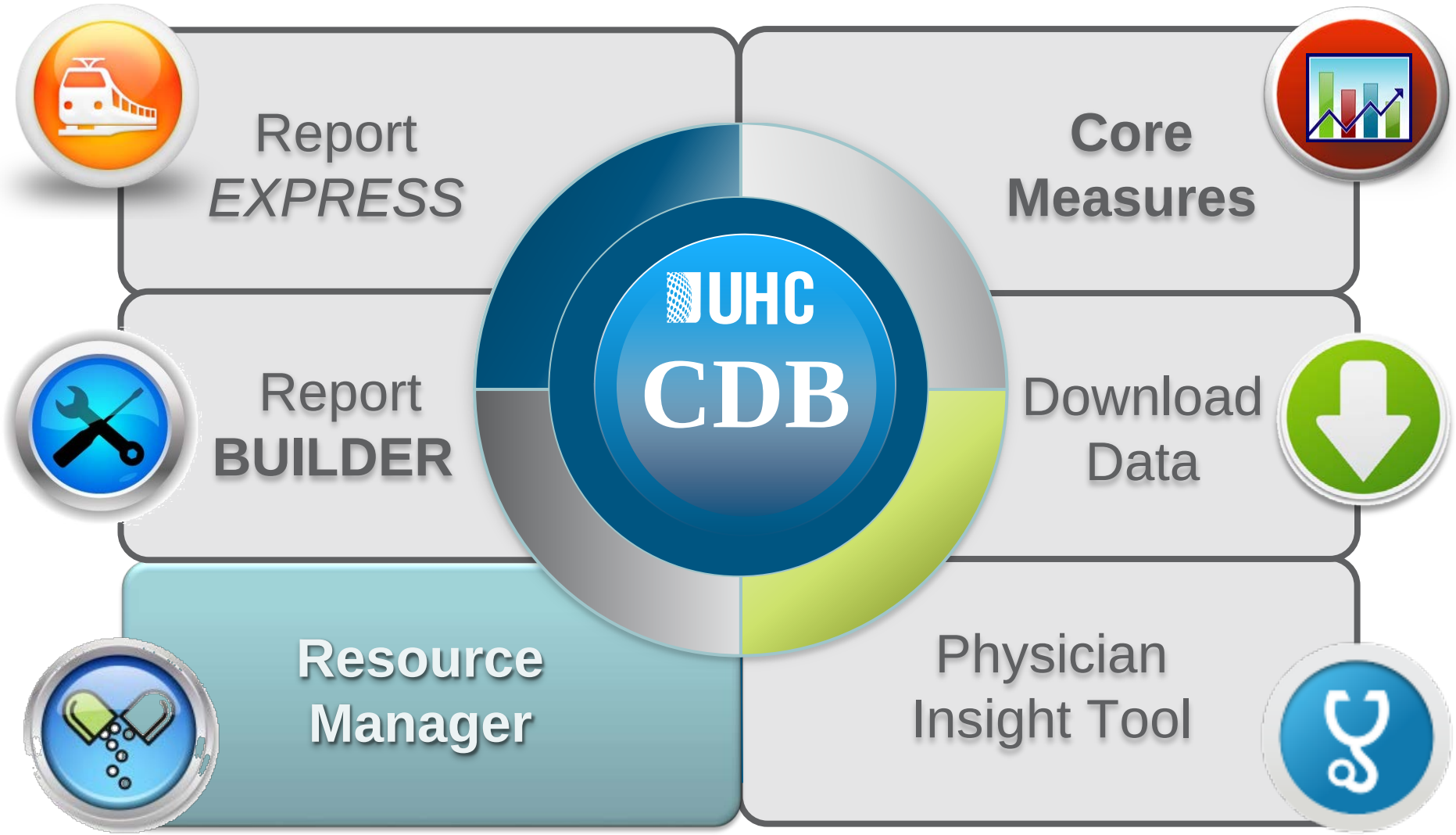
Standard restrictions

LOS Outlier	(•) Include All ( ) Include Only ( ) Exclude All
Early Death	(•) Include All ( ) Include Only ( ) Exclude All
Bad Data	( ) Include All ( ) Include Only (•) Exclude All
Normal Newborn	(•) Include All ( ) Include Only ( ) Exclude All
Nonviable Neonate	( ) Include All ( ) Include Only (•) Exclude All
Medical Tourism	(•) Include All ( ) Include Only ( ) Exclude All
Prison Population	(•) Include All ( ) Include Only ( ) Exclude All
Hospice	( ) Include All ( ) Include Only (•) Exclude All
Readmit Type	(•) Related Only ( ) Unrelated Only ( ) All
Index/Readmission	**Exclude:** **Affects numerator (readmit case) cases only:** ☑ Chemotherapy ☑ Radiation Therapy ☑ Rehabilitation ☑ Dialysis ☑ Delivery / Birth ☑ Mental Diseases/Alcohol & Drug use ☑ Death 1st Admit **(Affects numerator and denominator cases)**

The Clinical Data Base is Heavily Utilized
Top CDB/RM Users: May 2012 – April 2013



Components of the CDB / RM



Download Data

Downloaded data includes:

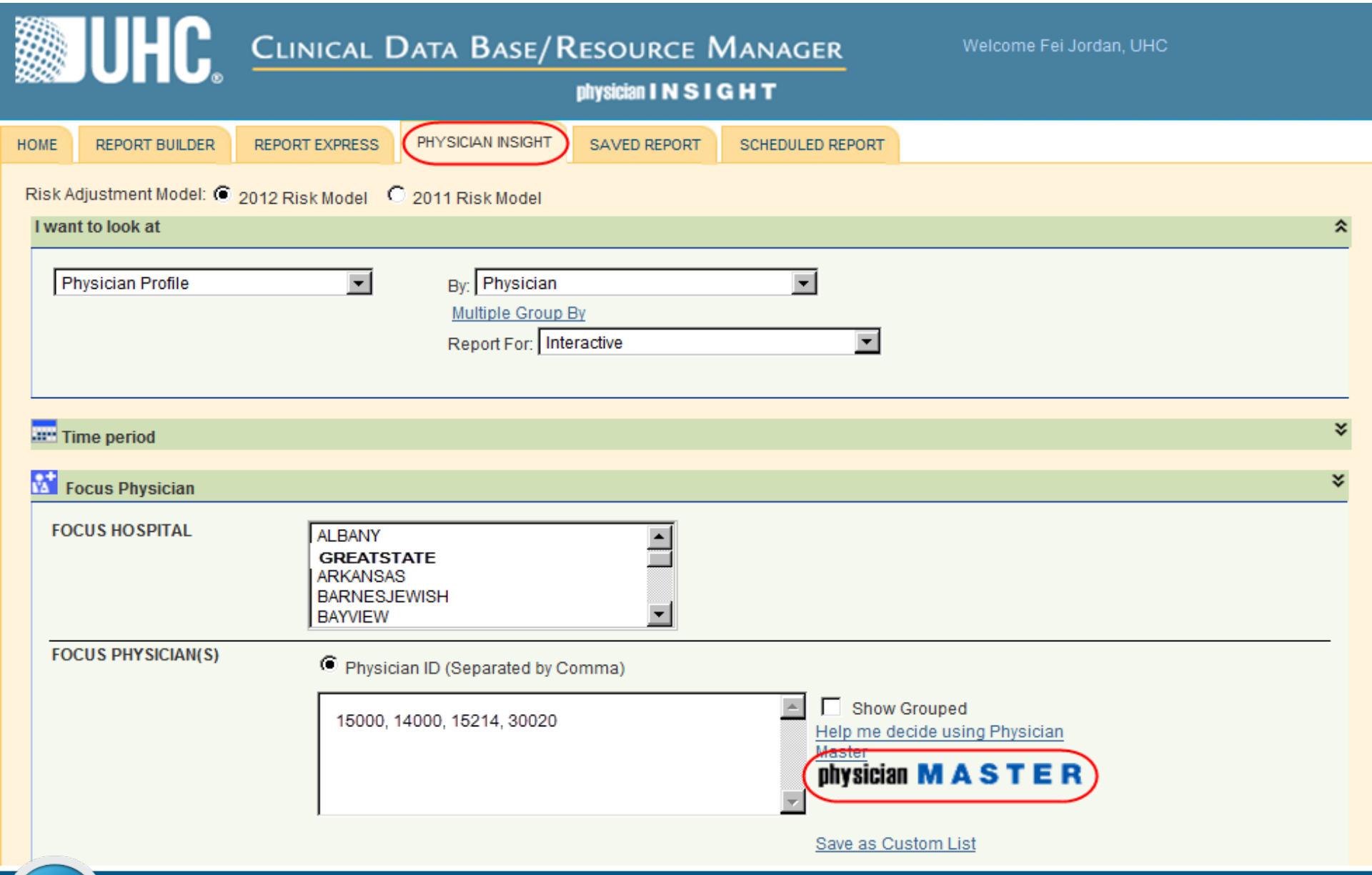
- APRDRG, risk of mortality, severity of illness
- Flags for AHRQ PSIs and IQIs
- Flags for readmissions
- Flags for CMS' HACs
- Flags for UHC's complications
- Risk adjusted expected values for mortality, LOS and costs

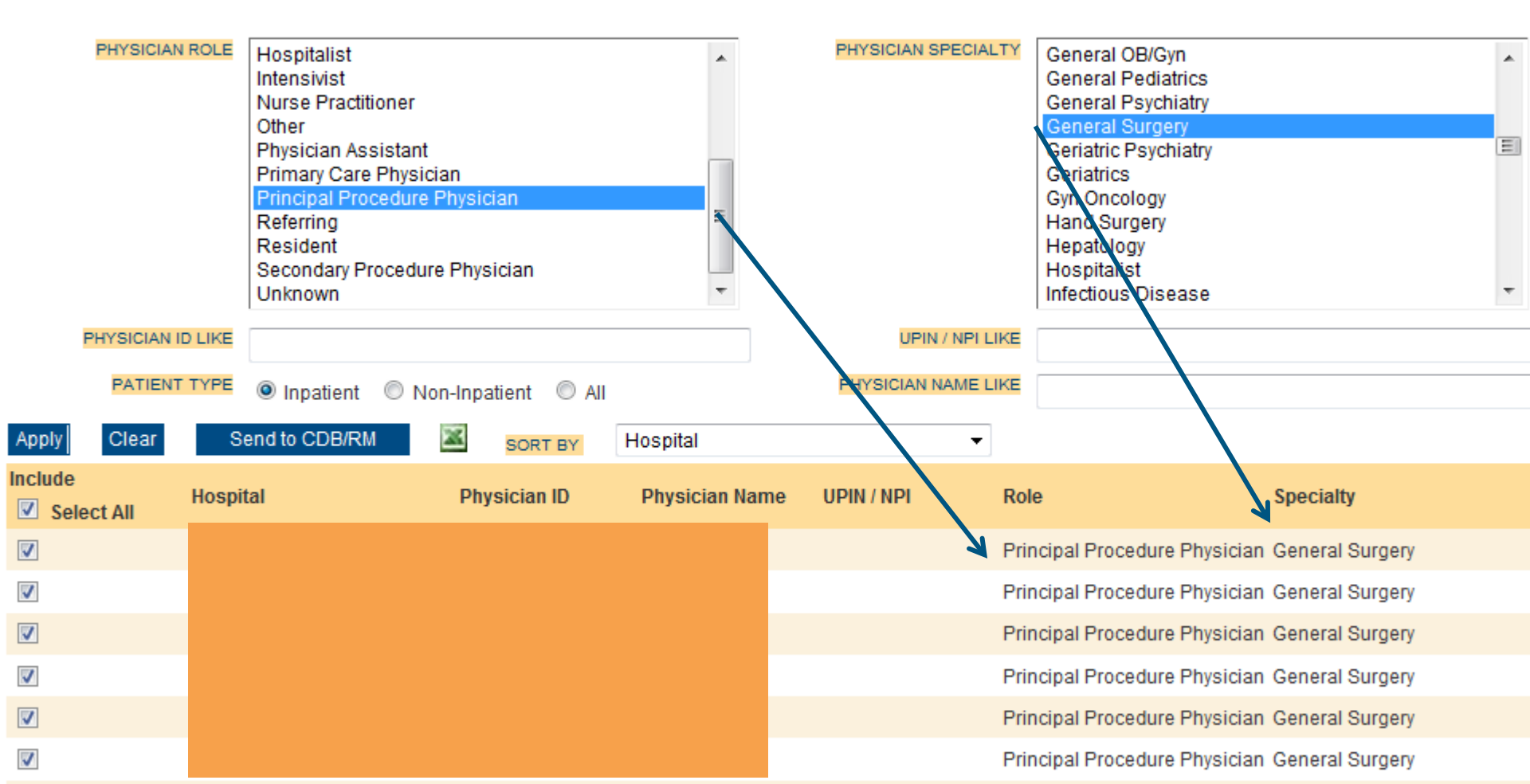
Ability to schedule downloads

Ability to determine which fields to download

Ability to download all other CDB hospital's patients (patient and hospital are de-identified)

Physician Insight Tool





The tool allows you to narrow specific physicians by Role & Specialty, and provides pages of inpatient, outpatient and core measures data

Tabs In the Physician Insight Reports

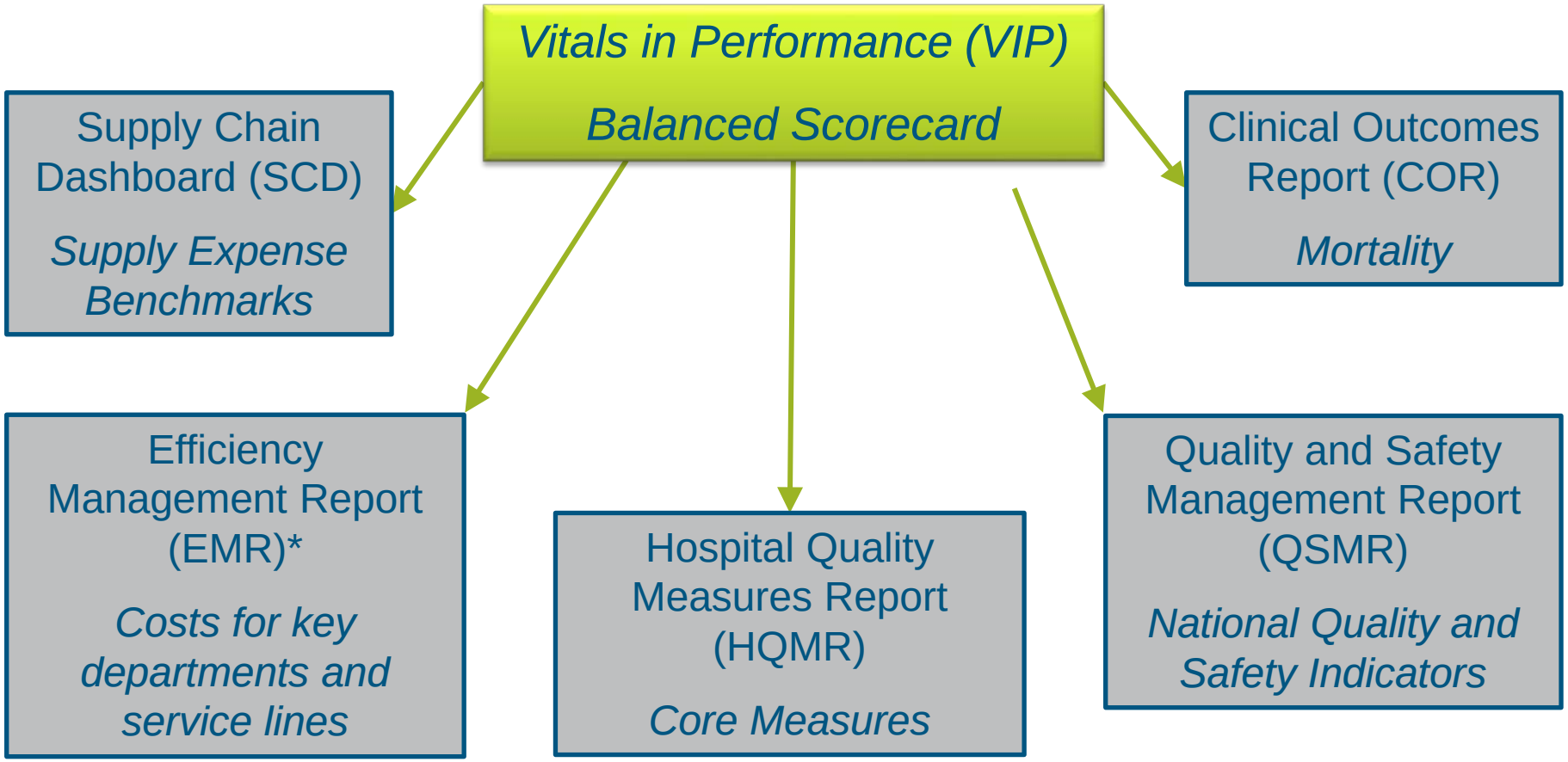
- Inpatient Volumes
- Hospital-Based Outpatient Volumes
- Severity (both 3M and UHC)
- LOS
- Cost
- ICU Utilization
- Readmissions
- Mortality

- Complications (HACs, PSIs, UHC)
- Index / Rescue Drug Pairs
- Core Measures
- Role and Specialty Counts

A report portal with template reports ready to be printed & used

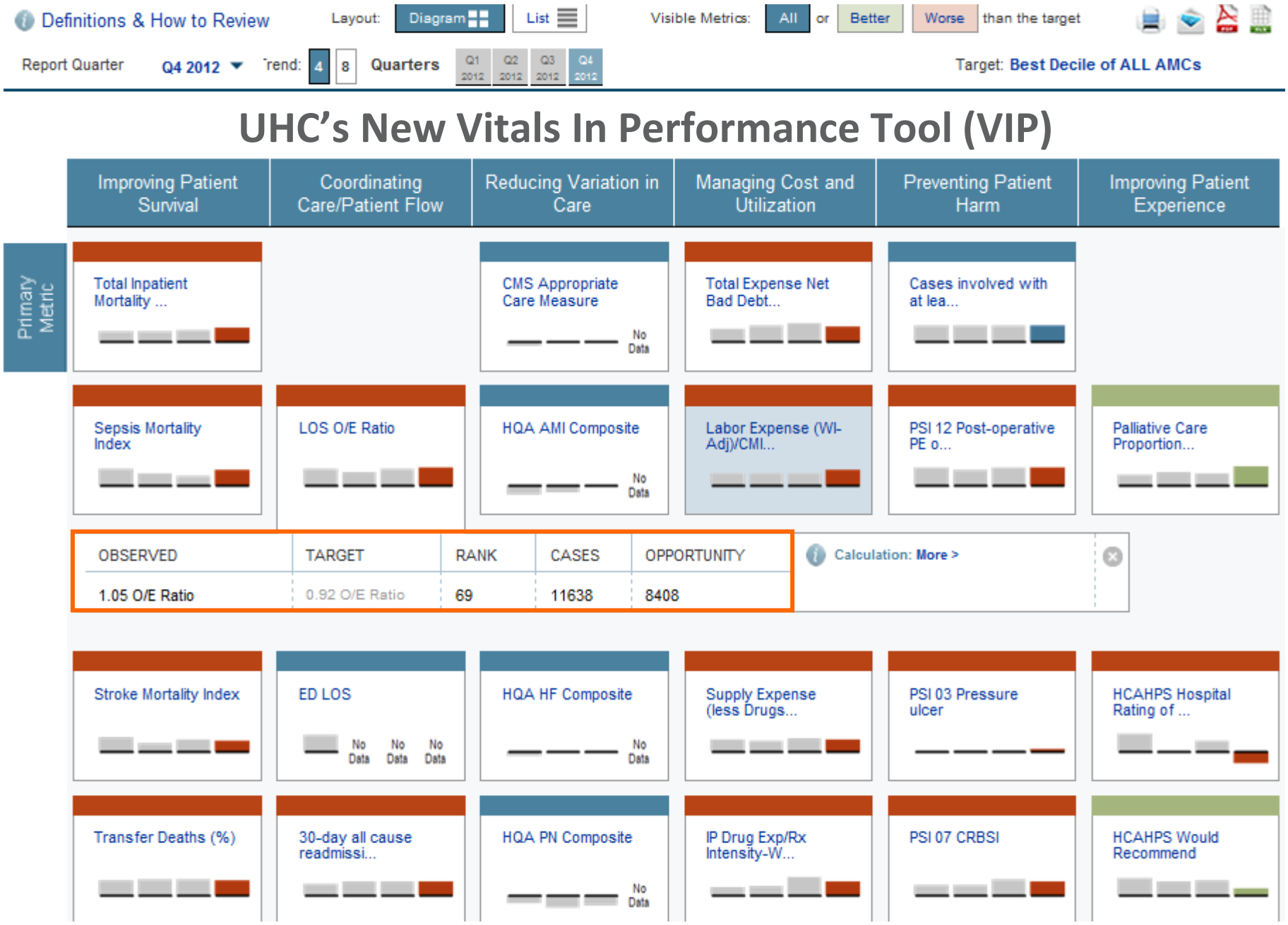
- Easy Access to management reports, Q & A Scorecard, documentation and coding, and resource utilization reports
- Future home of enhanced scorecards focused on integrating clinical, operational, financial, and supply chain performance data
- Designed to target and engage senior and physician leadership

Management Reports



- Semi-static, snapshot reports; distributed quarterly
- Widely dispersed among the membership

* Efficiency Management Report distributed semiannually

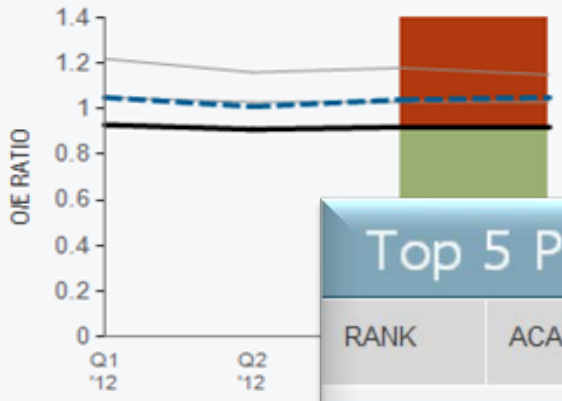

Definitions & How to Review
Layout: Diagram List
Visible Metrics: All or Better Worse than the target
Report Quarter Q4 2012
Trend: 4 8 Quarters
Q1 2012 Q2 2012 Q3 2012 Q4 2012
Target: Best Decile of ALL AMCs
UHC's New Vitals In Performance Tool (VIP)
Improving Patient Survival
Coordinating Care/Patient Flow
Reducing Variation in Care
Managing Cost and Utilization
Preventing Patient Harm
Improving Patient Experience
Primary Metric
Total Inpatient Mortality ...
CMS Appropriate Care Measure
No Data
Total Expense Net Bad Debt...
Cases involved with at lea...
Sepsis Mortality Index
LOS O/E Ratio
HQA AMI Composite
No Data
Labor Expense (WI-Adj)/CMI...
PSI 12 Post-operative PE o...
Palliative Care Proportion...
OBSERVED
TARGET
RANK
CASES
OPPORTUNITY
1.05 O/E Ratio
0.92 O/E Ratio
69
11638
8408
Calculation: More >
Stroke Mortality Index
ED LOS
No Data
No Data
No Data
HQA HF Composite
No Data
Supply Expense (less Drugs...
PSI 03 Pressure ulcer
HCAHPS Hospital Rating of ...
Transfer Deaths (%)
30-day all cause readmissi...
HQA PN Composite
No Data
IP Drug Exp/Rx Intensity-W...
PSI 07 CRBSI
HCAHPS Would Recommend

Metric Performance

TREND: 4 | 8 Quarters

NUMBERS: Q4 2012 (Most Recent)

LOS O/E Ratio



1.15 Worst Decile

1.05 Obs.

Observed - - - -

MEASURE: 1.05 (O/E Ratio)

TARGET: 0.92 (O/E Ratio)

RANK: 69 / 117

Top 5 Performing AMCs Q4 2012

RANK	ACADEMIC MEDICAL CENTER
1	Denver Health
2	Mayo Clinic in Florida
3	Mayo Clinic in Arizona
4	Mayo Clinic in Rochester
5	Johns Hopkins Bayview Medical Center

Breakdown a

METRICS

TARGET

Breakdown by LOS

Length of Stay (all cases)	5.96 Days 6.65		n/a
Expected LOS	5.68 Days 6.31		n/a

COMMENTS

PERFORMANCE IMPROVEMENT

Member Examples

CASE STUDY

UHC

Length-of-Stay Improvement Strategy Portfolio

Problem Statement/Goal

In fiscal year 2009, Tufts Medical Center began an initiative to decrease length of stay (LOS).

Background

Using information from the Clinical Data Base/Resource Manager™, UHC identified Tufts MC as one of only a few organizations that improved the LOS observed-to-expected ratio by more than 3% for the 2-year period ending June 30, 2011, and sustained that improvement for the subsequent 2 quarters.

Interventions

To reduce hospital LOS, Tufts MC has implemented a portfolio of case management strategies that must be operationalized in a collaborative environment with the full participation of the entire health care team and support services.

Change to unit-based case management. Each Tufts MC case manager is assigned to a specific unit. This approach allows the case manager to be present at the point of patient discharge, promotes a stronger alliance between the case manager and the nursing staff, maintains a connection with physicians, and improves the case manager's productivity and focus.

Reevaluate the case manager caseload goals. Tufts MC recognized that caseload goals must account for units with rapid turnover (e.g., cardiology, surgery, pediatrics) or complex discharges (e.g., oncology). While a "regular" unit may have 1 case manager for 20 patients, units with high patient turnover or complex discharges may need a 1:12 or 1:15 ratio. Tufts MC has observed a correlation between improved case manager caseloads and LOS reduction.

Assess 100% of cases. Case managers screen all patients in their unit for discharge needs.

Hold extended-stay meetings. At Tufts MC, all case managers and social workers meet to discuss patients with an LOS equal to or longer than the budgeted LOS. The meetings promote team management of complex cases, provide an opportunity to identify improvement areas for specific case managers, and motivate case managers to be accountable for LOS.

AT A GLANCE

ORGANIZATIONAL PROFILE

Tufts Medical Center (Tufts MC) in Boston, Mass., has 415 beds.

USE OF UHC DATA AND RESOURCES

Tufts MC participates in the UHC Clinical Data Base/Resource Manager™ and shared its improvement strategies as part of an Imperatives for Quality member spotlight.

CONTACT INFORMATION

Tufts MC:
June Stark
Director, Case Management
(617) 636-4571
jstark@tuftsmedicalcenter.org

UHC:
Danielle Carrier
Project Manager, Quality Operations
(312) 775-4142
carrier@uhc.edu

KEY TAKEAWAYS

- Assign case managers by unit rather than clinical service to better facilitate patient discharges.
- Modify case manager caseloads to account for high patient turnover and complex discharges.
- Implement "extended-stay meetings" that focus on cases with hospital stays at or longer than the budgeted length of stay.

For more information about Imperatives for Quality, visit uhc.edu

Initiate discharge plan early.

Begin before admission or within 24 hours; use benchmarks to set target LOS

Use case management.

Employ multidisciplinary, collaborative

UHC

Imperatives for Quality focuses on driving change

Improving Hospital Length of Stay Educational Series

Join us for this series of 4 Web conferences exploring potential opportunities to lower observed length of stay. Each Web conference focuses on specific drivers and other operational and clinical factors that can prolong or otherwise interfere with a safe and efficient hospital stay. In addition to an in-depth study of potential opportunities to improve risk-adjusted length of stay, the information in the series can be used to:

- Assess the overall or broad contributors to your longer than expected length of stay
- Isolate problem areas
- Develop measures for high level goals and/or specific areas of interest/opportunity
- Grow service lines/programs

Before each Web conference, participant
Clinical Data Base/Resource Manager to r
Each guide includes exercises to be comp
structured to be interactive and will inclu
highlighted.

UHC IQ

High Level View of Length of Stay and Length of Stay Drivers, Part 1

Review a high level review of length of stay to identify potential opportunities. Key drivers of length of stay will be introduced with a focus on planning for discharge and implications of the 5-day work week.

Length of Stay Drivers, Part 2

Topics relate to patients that tend to have longer lengths of stay including patient with potentially avoidable complications, critical care patients, and length of stay outliers.

Patient Transfers from Other Acute Care Hospitals

Look at the potential impact on outcomes and length of stay for patients transferred from other facilities and review patient conditions/characteristics that can contribute to longer lengths of stay.

Transitions of Care

Address care transition implications for length of stay, such as transfers to skilled nursing facilities, and will examine possible links to readmissions and returns to the emergency department.

UHC Clinical Outcomes Report
Risk-Adjusted Mortality by UHC Service Line

	Oct - Dec 2012 (Q4)						Jan 2012 - Dec 2012 (recent year)					
	Relative Performance	Denom (Cases)	Obs Mort(%)	Obs/Exp Ratio	UHC Median	Rank	Relative Performance	Denom (Cases)	Obs Mort(%)	Obs/Exp Ratio	UHC Median	Rank
Summary												
Post-Surgical		2,301	2.04	0.80	0.91	27/110		9,055	2.01	0.76**	0.88	22/113
Quality and Accountability Aggregate		6,842	2.51	0.83*	0.89	40/114		27,278	2.41	0.79**	0.88	30/116
Total Inpatient		8,010	2.21	0.80**	0.88	37/113		32,213	2.13	0.78**	0.87	28/116
Service Line												
BMT		50	6.00	3.99**	0.62	62/ 65		165	3.64	1.90	0.89	65/ 68
Burns		47	8.51	1.18	0.87	32/ 47		213	6.57	1.13	1.04	29/ 46
Cardiology		503	3.98	0.94	0.89	66/117		1,991	3.11	0.74*	0.89	25/118
Cardiac Surgery		95	2.11	0.85	0.99	36/100		424	3.54	0.92	0.98	46/103
Thoracic Surgery		97	1.03	0.26	0.85	18/115		428	1.40	0.39*	0.83	5/117
Gastroenterology		578	2.25	0.82	0.81	62/117		2,354	2.17	0.85	0.80	66/118
Gynecology		63	0.00	0.00	0.00	62/ 81		287	0.00	0.00	0.00	48/ 86
Gynecology/Oncology		37	0.00	0.00	0.00	20/ 85		218	0.46	0.61	0.77	33/ 87
Heart Transplant or Implant of Heart Assist System		10	10.00	0.79	0.85	31/ 64		29	13.79	1.16	0.98	45/ 63
HIV		12	0.00	0.00	0.66	24/ 90		52	3.85	0.54	0.77	23/ 92
Kidney/Pancreas Transplant		20	0.00	0.00	0.00	36/ 59		68	0.00	0.00	0.00	34/ 59
Liver Transplant		9	11.11	2.70	0.00	44/ 45		31	6.45	1.61	0.72	44/ 49
Lung Transplant		2	0.00	0.00	0.00	21/ 36		14	0.00	0.00	0.60	8/ 37
Med Oncology		278	3.60	0.81	0.82	58/117		1,395	1.86	0.59**	0.84	23/118
Medicine General		1,578	3.55	0.90	0.90	56/117		6,130	3.43	0.86*	0.89	52/118
Neonatology		388	1.03	0.32*	0.57	30/103		1,566	1.47	0.56**	0.69	41/104
Neurology		447	4.03	0.79	0.84	51/117		1,694	3.72	0.74*	0.87	34/118
Neurosurgery		247	4.05	0.75	0.94	34/112		855	3.98	0.73	0.95	20/115
Obstetrics		592	0.00	0.00	0.00	53/101		2,326	0.09	1.62	0.00	82/103
Orthopedics		465	0.65	1.09	0.75	76/112		1,793	0.39	0.58	0.82	31/114
Otolaryngology		80	1.25	2.73	0.00	76/ 88		333	1.20	1.37	0.85	75/ 93
Plastic Surgery		44	0.00	0.00	0.00	26/ 68		155	0.00	0.00	0.75	9/ 75
Rheumatology		47	0.00	0.00	0.00	24/102		170	0.59	0.47	0.87	34/107
Spinal Surgery		187	0.53	1.32	0.00	67/ 95		650	0.46	1.21	0.75	74/ 97
Surg Oncology		29	6.90	1.34	0.72	74/ 91		121	2.48	0.66	0.83	29/ 95
Surgery General		522	1.92	0.66	0.86	21/117		2,222	2.16	0.72*	0.86	27/118
Trauma		464	2.59	0.63	0.91	18/111		1,953	3.99	0.78*	0.91	19/109
Urology		248	0.40	0.83	0.55	66/109		869	0.69	1.22	0.82	92/113
Va...ry		91	3.30	1.05	0.90	62/106		338	2.96	1.19	0.95	78/106

Clinical Outcomes Report Drill Down

Definition - Liver Transplant
Service lines are defined by UHC and displayed in the CDB. This service line includes inpatient discharges in MS-DRGs 5-6 (base MS-DRG 4). This list is based on the effective MS-DRGs for the reported current quarter. Bad data, nonviable neonates, hospice, and records with a null expected mortality are excluded. For prior periods, service line assignments were based on the effective MS-DRGs at that time.

	Relative Performance	Denom (Cases)	Obs/Exp Ratio	UHC Median	Rank
Current Quarter		9	2.70	0.00	44/ 45
Recent Year		31	1.61	0.72	44/ 49

Data Source: UHC CDB
Related Report: VIP

	Current Quarter	Last Quarter	Recent Year
Cases (denom.)	9	7	31
Observed Deaths	1	0	2
Expected Deaths	0.37	0.25	1.24
Observed Mortality (%)	11.11	0.00	6.45
Expected Mortality (%)	4.10	3.57	3.99
Observed/Expected Ratio	2.70	0.00	1.61

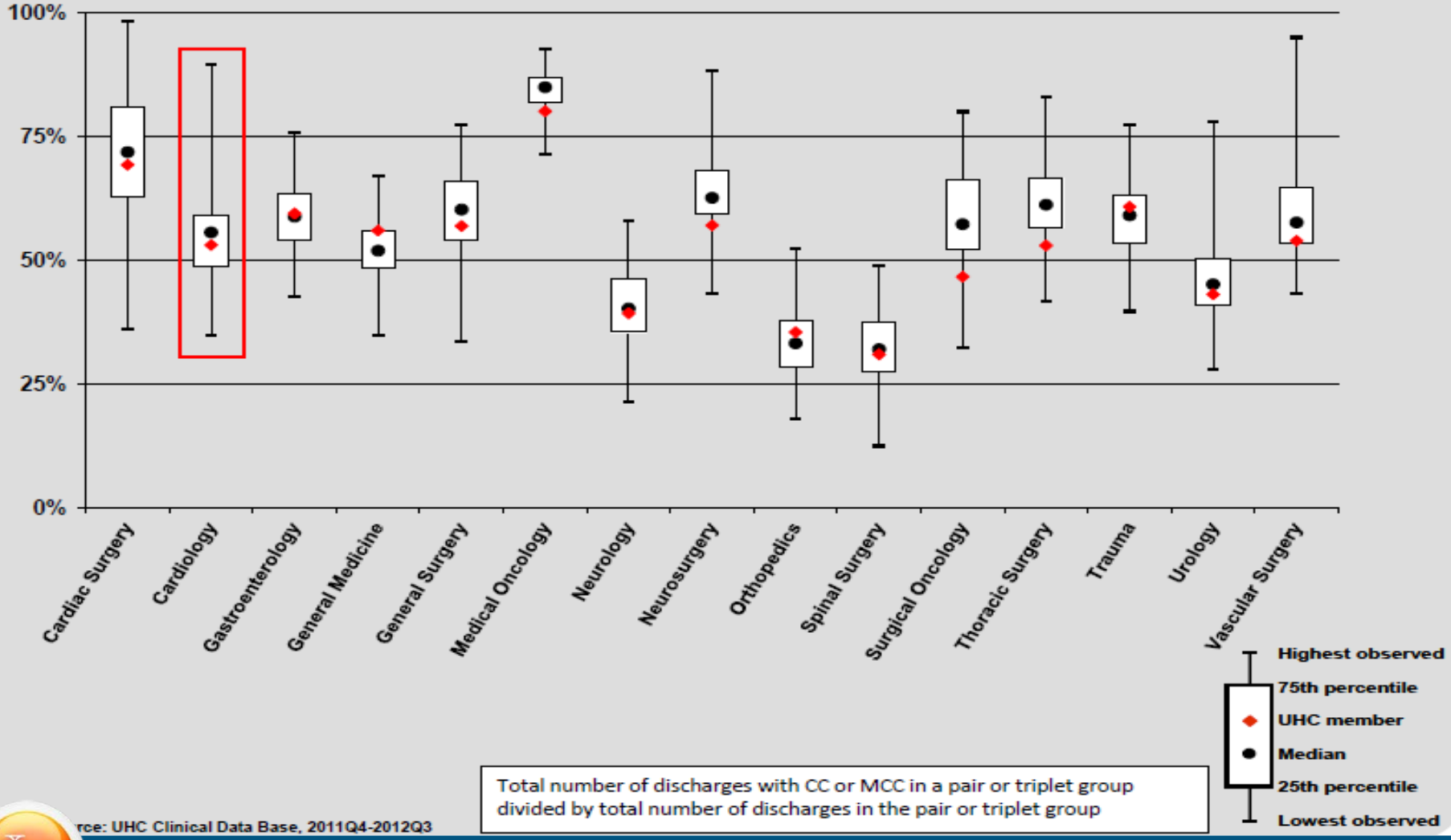
Benchmarks:			Percentiles:				
	Compare Group (n)	Percentile	10th	25th	50th	75th	90t
Current Quarter	UHC Primary Population (45)	96	0.00	0.00	0.00	1.09	1.5
Recent Yr	UHC Primary Population (49)	88	0.00	0.45	0.72	1.29	2.1

Recent Year Five Base MS-DRGs with Highest Excess Deaths (>=25 cases):		Cases	O/E Ratio	Excess Deaths
Base MS-DRG 4	LIVER/INTESTINAL TRANSPLANT	31	1.62	0.76

Recent Year UHC Top-10 Mortality O/E in Liver Transplant	Mort O/E	Cases	LOS O/E	Readmit Rate
Hospital 1	0.00	77	0.95	37.66
Hospital 2	0.00	59	0.59	23.73
Hospital 3	0.00	51	0.93	27.45
Hospital 4	0.00	37	0.89	40.54
Hospital 5	0.00	36	1.20	30.56
Hospital 6	0.20	83	0.77	45.12
Hospital 7	0.25	106	0.83	25.71
Hospital 8	0.31	118	0.64	25.00
Hospital 9	0.32	72	0.86	18.31
Hospital 10	0.33	161	0.64	22.78

Other Report *EXPRESS* Reports

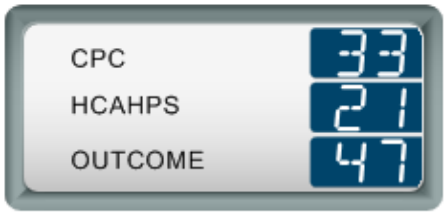
Complication and Comorbidity (CC and Major CC) Capture Rate



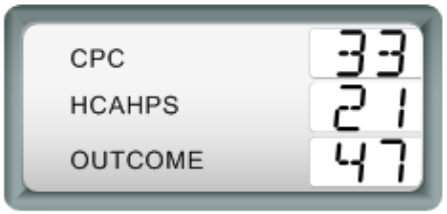
Total number of discharges with CC or MCC in a pair or triplet group divided by total number of discharges in the pair or triplet group

rce: UHC Clinical Data Base, 2011Q4-2012Q3

2014-UHC VBP Calculator



	Current	Adjusted
Annual Medicare Revenue	$82,663,598	$82,663,598
Earn Back	$469,740	$469,740
Holdback	$1,033,295	$1,033,295
Net	($563,555)	($563,555)
Difference Due To Adjustment:		**$183,638**



For hospitals that use UHC for Core Measure

Submit Adjustments

Clinical Process of Care Domain (CPC)
2011 Q2 - 2012 Q1 (Performance Period)

Load UHC Core Measure Data (2011 Q4 - 2012 Q3) | Reset

Measure	Cases	Performance Rate	Current Points (0 - 10)	National Median	Target	Adjust Score	Adjusted Points (0 - 10)
AMI-7a	0	N/A	N/A	80.66	96.30	*Insufficient Cases*	N/A
AMI-8a	41	85.0	0	93.44	100.00	85.00	0
HF-1	547	92.0	6	92.66	100.00	92.00	6
PN-3b	115	98.0	7	97.30	100.00	98.00	7
PN-6						00	5
SCIP-Inf-1						00	3
SCIP-Inf-2						.00	2
SCIP-Inf-3	35	95.0	0	96.63	99.96	95.00	0
SCIP-Inf-4	113	95.0	1	96.34	100.00	100.00	10
SCIP-VTE-1	704	100.0	10	94.62	100.00	100.00	10

SCIP-Inf-4 X

Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

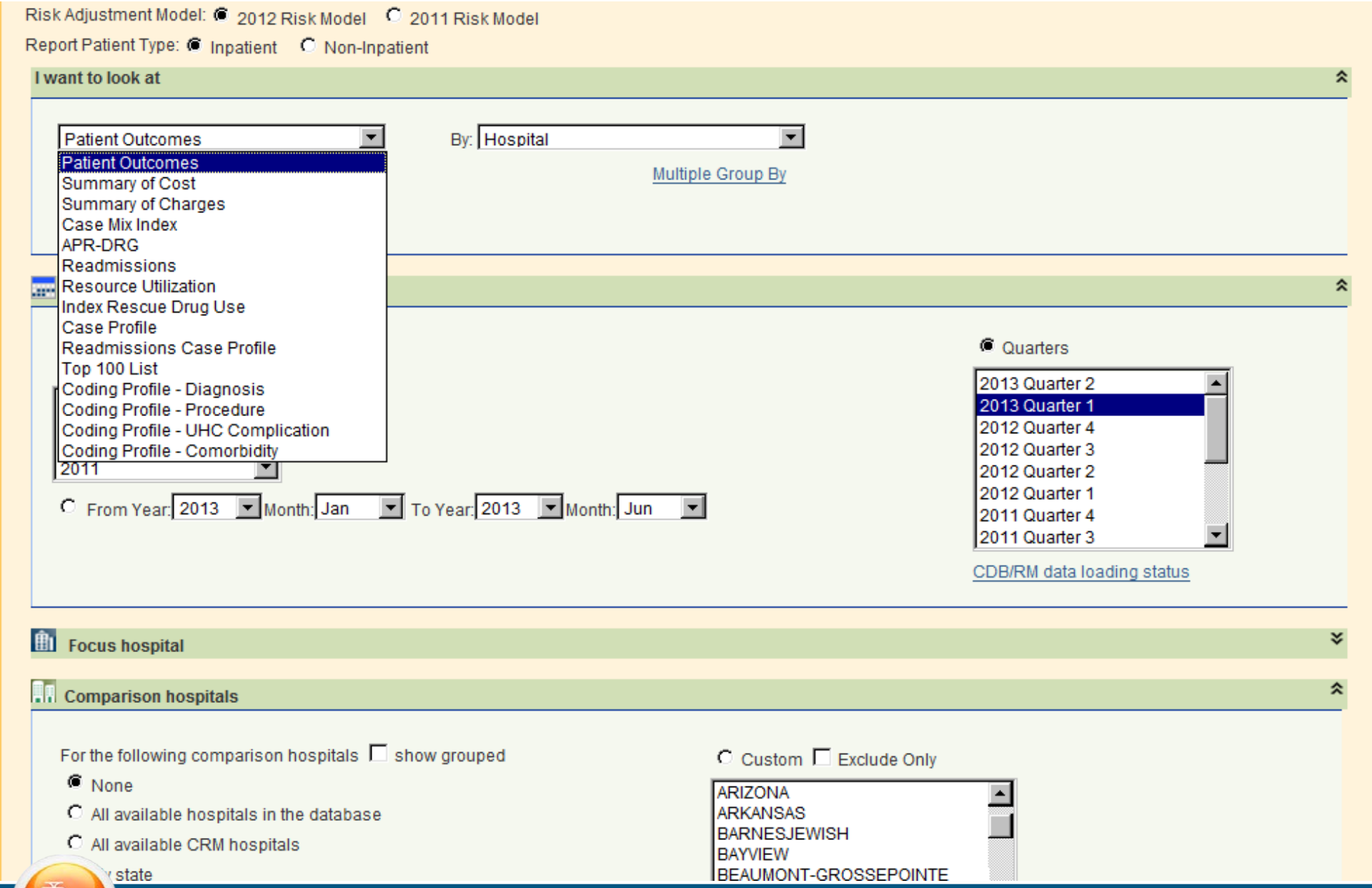
Patient Experience of Care Domain (HCAHPS)
2011 Q2 - 2012 Q1 (Performance Period)

Reset

Measure	Performance Score	Current Points (0 - 10)	National Median	Target	Adjust Score	Adjusted Points (0 - 10)
Nurse Communication	75.0	1	75.79	84.99	75.00	1
Doctor Communication	77.0	2	79.57	88.45	77.00	2
Responsiveness	57.0	0	62.21	78.08	57.00	0
Pain Management	63.0	0	68.99	77.92	63.00	0
Medications	59.0	0	59.85	71.54	59.00	0
Cleanliness and Quietness	60.0	0	63.54	78.10	60.00	0
Discharge Information	84.0	2	82.72	89.24	84.00	2
Overall Rating	65.0	1	67.33	82.55	65.00	1

Consistency Score (HCAHPS)
2011 Q2 - 2012 Q1 (Performance Period)

CDB Report Builder



Selection of CDB / RM Metrics & By Variables

- In Hospital Mortality
- Length of Stay
- Readmissions
- Severity
- Costs
- CMI
- Utilization
- Volumes
- Diagnoses & Procedures

- Physicians
- Demographics
- MSDRG and other Patient Groupings
- Severity
- Admit and Discharge Source
- Payer
- Hospital Characteristics

Volumes & Length of Stay – Q4 2012 and Q1 2013

Hospital	Cases	LOS Outliers	% LOS Outliers	Mean LOS (Obs)	StDev LOS (Obs)	Mean LOS (Exp)	LOS Index
AEH Hospitals	11,721	(127)	1.1%	5.62	10.01	5.26	1.07
Principal Members w/out AEH	17,332	(165)	1.0%	5.72	9.10	5.51	1.04
All Hospitals w/out AEH	10,342	(89)	0.9%	5.17	7.16	5.15	1.00

Hospital	Cases
YANEWHAVEN	40,121
NYPRESCOLUMBIA	31,046
ROYALOAK	30,243

Hospital	Cases
PARKLAND	25,554
ALABAMA	25,435
OHIOSTATE	24,086

Length of Stay

Hospital	Cases	LOS Outliers	Mean LOS (Obs)	StDev LOS (Obs)	Mean LOS (Exp)	LOS Index
MAYOCLINIC_MN	28,875	(143)	4.91	6.92	5.88	0.83

Hospital	Cases	LOS Outliers	Mean LOS (Obs)	StDev LOS (Obs)	Mean LOS (Exp)	LOS Index
WISHARD	8,347	(40)	4.68	7.17	4.96	0.94

Hospital	Cases	LOS Outliers	% LOS Outliers
MAYOCLINIC_MN	28,875	(143)	0.5%
NYU	11,885	(59)	0.5%
CINCINNATI	2,297	(12)	0.5%
WISCONSIN	13,445	(74)	0.6%

Hospital	Cases	LOS Outliers	% LOS Outliers
WISHARD	8,347	(40)	0.5%
BOSTONMC	13,099	(70)	0.5%
CAMBRIDGE	6,609	(36)	0.5%

Vitals In Performance Tool

Top 5 Performing AMCs Q1 2013

RANK	LOS O/E RATIO	ACADEMIC MEDICAL CENTER
1	0.78	Mayo Clinic in Arizona
2	0.79	Mayo Clinic in Florida
3	0.82	Mayo Clinic in Rochester
4	0.88	University of Missouri Health Care (University Hospital)
5	0.9	NYU Langone Medical Center

VIP Tool - Integrated Content with Data

Member Examples

LOS Improvement Strategy Portfolio

Tufts Medical Center decreased length of stay by 17% (0.9 days) over 2 years, at the same time that its case mix index increased by 5%.

Answering Challenge to Reduce LOS

The University Hospital of UMDNJ improved its length of stay observed-to-expected ratio by 17% and its length of stay by 0.9 days to 5.1 days.

Tackling Extended-Stay Cases

By implementing a series of structural changes and process redesign, NYU Langone Medical Cetner improved its length of stay performance by 12% overall and 30% for Medicare patients.

Suggested Best Practice

Initiate discharge plan early.

Begin before admission or within 24 hours; use benchmarks to set target LOS

Use case management.

Employ multidisciplinary, collaborative model featuring unit-based manager; take anticipatory approach to discharge needs

Conduct daily rounds.

Focus multidisciplinary care coordination communications on progress toward discharge goal

Imperatives for Quality Takes it a Step Further

AT A GLANCE

ORGANIZATIONAL PROFILE

The University Hospital at UMDNJ has 388 staffed beds and 19,762 admissions per year. It serves as a safety-net hospital for the Newark, NJ, area.

USE OF UHC DATA AND RESOURCES

UMDNJ participates in Imperatives for Quality and the UHC Clinical Data Base/Resource Manager™. Data analysis identified UMDNJ as a most improved organization in terms of length of stay for the 2-year period ending June 30, 2011.

The University Hospital at UMDNJ Answers CEO's Challenge to Reduce Length of Stay

Problem Statement/Goal

The chief executive officer of The University Hospital at UMDNJ challenged the organization to reduce length of stay (LOS) from 6.2 days to 5.0 days and become a UHC top performer in LOS index (observed-to-expected ratio).

Interventions

UMDNJ used a structured project management approach and began by identifying a project leader, forming an executive committee, and creating a project plan with clearly articulated time frames, roles, and responsibilities. The executive committee approved the project plan and was updated monthly on the progress of 5 key strategies:

Maintaining visibility of the project's importance and progress. The project plan was presented to numerous hospital groups, including senior leaders, clinical chairs, managers, and clinical and ancillary staff. Performance metrics—actual LOS and the LOS index—were kept simple to easily show progress. The project team also produced a quarterly newsletter to keep everyone informed.

Readmissions & Diagnoses - Q2 2012 through Q1 2013

	30 Day Avg	30 Day Min	30 Day Max
AEH related all cases	4.94	2.81 (Nevada)	7.21
Non AEH related all cases	5.20	4.05 (Dartmouth)	7.49
AEH all cases	10.44	7.06 (Nevada)	13.36
Non AEH all cases	10.77	6.64 (NYU)	16.52
AEH related HF	10.9	4.71 (Utah)	18.9
Non AEH related HF	9.78	4.92 (Dartmouth)	15.6

Diagnoses	Avg	Min	Max
AEH Hospitals	9.98	6.7	13.5 (UW)
Non AEH Teaching Hospitals	10.52	6.2	15 (CCF)
Community Hospitals	10.19	5.1	16.7 (Southpointe – CCF)

Impact of Complications Cases
Q3 12

Hospital	Complication	No Complication
Cases	133	7,977
Mean LOS (Obs)	28.85	5.93
Mean LOS (Exp)	10.72	4.88
LOS Index	2.69	1.22
% ICU Cases	73.68	14.77
Mean ICU Days	13.58	4.68
% Deaths (Obs)	24.81	1.19
% Deaths (Exp)	5.45	1.41
Mortality Index	4.56	0.84
Mean Direct Cost (Obs)	75,583	9,922
Mean Direct Cost (Exp)	27,931	7,981
Direct Cost Index	2.71	1.24

UHC Service Line	Well Above	Above	Below	Well Below	Grand Total
Burns	0	1	2	1	4
Cardiac Surgery	0	2	1	0	3
Cardiology	11	7	2	0	20
Dermatology	0	1	0	0	1
Gastroenterology	1	3	2	0	6
Heart Transplant or Implant of Heart Assist System	1	1	0	0	2
Injuries/complications of prior care	1	0	2	0	3
Liver Transplant	0	1	0	0	1
Lung Transplant	0	1	0	0	1
Med Oncology	0	2	0	0	2
Medicine General	8	14	8	1	31
Neonatology	1	1	1	0	3
Neurology	4	0	0	0	4
Neurosurgery	0	1	0	0	1
Orthopedics	0	0	1	0	1
Surg Oncology	0	0	0	1	1
Surgery General	1	6	3	0	10
Thoracic Surgery	1	0	2	1	4
Tra					5
Va					1
Ventilator Support	0	3	11	0	14
Grand Total	32	53	39	4	128

Expired Patients by Relative Expected Mortality by Service Line

Drilldown to Case Profile

Patient ID	Encounter Number	Admission Date	Admission Day	Admission Source	Emergency Room Patient	Admission Status
		06/18/2012	Monday	Clinic referral	No	Elective

Discharge Date	Discharge Day	Discharge Status	Age	Norm NB	Sex	Race	Ethnicity
07/17/2012	Tuesday	Expired (all in-hospital deaths except for Medicare or CHAMPUS hospice patients)		No	Male	White	Non Hispanic Origin

ICU Days Obs	Early Death	Base MS-DRG	MS-DRG	Mortality Model Group (2012 models)	Admit APR-DRG	UHC Service Line
0	No	294	871	903	720	Medicine General

Admit Severity of Illness	Admit Risk of Mortality	Princ Proc MD	Discharge MD	Discharge MD Specialty
Major	Major			Bone Marrow Transpla

UHC Primary Payer	UHC Secondary Payer	HCO Primary Payer	HCO Secondary Payer
Commercial/Private Traditional/Indemnity	Other NOS		400 - CREDIT BAL INS NOTIFIED

LOS Observed	LOS Expected (2012 Risk Model)	LOS Outlier	Mortality Expected (2012 Risk Model)	Total Cost Observed	Direct Cost Observed	Direct Cost Expected (2012 Risk Model)	Charges Observed
29	4.31	No	0.03426	151,921	106,948	7,940	1,230,721

Relative Expected Mortality (2012 Risk Model)	REM Model Observed (2012 Risk Model)
Well Below	0.18027

Seq	POA	CC/MCC Flag	Diagnosis
1	Y	No Influence	0389 - septicemia nos
2	Y	Diagnosis MCC	486 - pneumonia organism nos
3	Y	Diagnosis CC	20502 - aml in relapse
4	Y	Diagnosis CC	28419 - pancytopenia nec
5	N	Diagnosis CC	2760 - hyperosmolality
6	N	Diagnosis CC	2869 - coag defect nec & nos
7	N	Diagnosis CC	5119 - pleural effusion nos
8	N	Diagnosis CC	5180 - pulmonary collapse
9	Y	No Influence	28802 - cyclic neutropenia
10	Y	No Influence	28804 - neutropenia d/t inf
11	Y	No Influence	57510 - cholecystitis nos
12	Y	No Influence	5778 - pancreatic disease nec
13	Y	No Influence	78061 - fever w cce
14	Y	No Influence	99592 - severe sepsis
15	Y	No Influence	52800 - stomat & mucositis nos
16	Y	No Influence	4739 - chronic sinusitis nos
17	N	No Influence	37272 - conjunctival hemorrhage
18	Y	No Influence	5728 - oth sequela chr liv dis
19	N	No Influence	v4986 - dnr status

Seq	Procedure	Procedure Date	Physician Code	Specialty
1	3324 - closed bronchus biopsy	07/02/2012		Pulmonary/Crit Care
2	4131 - bone marrow biopsy	06/27/2012		Bone Marrow Transpla
3	9925 - inject ca chemo agent	06/29/2012		Bone Marrow Transpla
4	9904 - packed cell transfusion	06/20/2012		Bone Marrow Transpla
5	9905 - platelet transfusion	06/19/2012		Bone Marrow Transpla
6	9907 - serum transfusion nec	06/27/2012		Bone Marrow Transpla
7	4131 - bone marrow biopsy	07/10/2012		Bone Marrow Transpla
8	5101 - perc aspiration of gb	07/10/2012		Gen Diag/Interv Radiology
9	3893 - venous catheter nec	06/28/2012		Gen Diag/Interv Radiology
10	8752 - iv	07/10/2012		Gen Diag/Interv

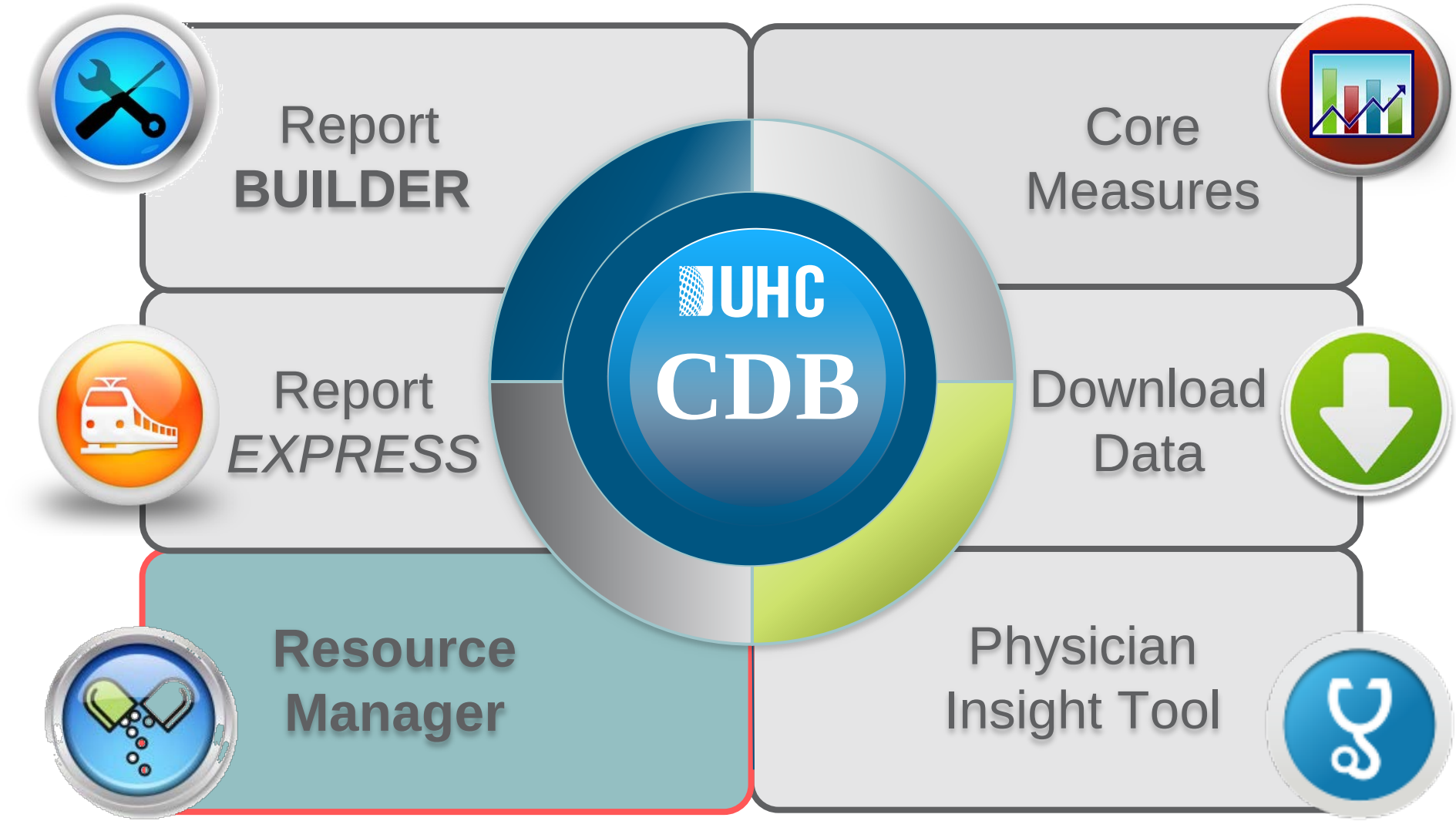
Model Group: # 903 - (Age >= 18) Septicemia w MV 96+ hours (MSDRG 870), Septicemia w/o MV 96+ hours w MCC (MSDRG 871), Septicemia w/o MV 96+ hours w/o MCC (MSDRG 872)
Model Diagnostics: Calculation: Chi-sq = 202.16 Validation: Chi-sq = 180.35, F = 0.892, p = 0.5698
Final: Max VIF = 1.887, Hosmer-Lemeshow = 542.726, p < 0.001, df = 10, C = 0.841
Mean Observed = 0.1803, Mean Expected = 0.1803
Cases = 113,050
Model Method = Logistic Regression

Model Results (Significant Predictors)

Explanatory Variable	Beta	OR	LCL	UCL	P-Value
intercept	-5.673				
Any Dx Group: Sepsis	1.748	5.742	4.570	7.213	<.0001
Female, Age >= 85	1.418	4.131	3.802	4.487	<.0001
CC Metastatic Cancer	1.307	3.695	3.490	3.912	<.0001
Male, Age >= 85	1.293	3.643	3.328	3.987	<.0001
Vent on Admission Day	1.199	3.318	3.160	3.484	<.0001
Female, 80 <= Age < 85	1.022	2.780	2.527	3.058	<.0001
Male, 80 <= Age < 85	0.926	2.525	2.291	2.783	<.0001
Sec Dx Group: Intracranial Bleed	0.909	2.481	2.034	3.027	<.0001
Sec Dx Group: Shock	0.893	2.443	2.349	2.540	<.0001
Female, 75 <= Age < 80	0.776	2.173	1.967	2.400	<.0001
CC Lymphoma	0.769	2.158	1.981	2.351	<.0001
Male, 75 <= Age < 80	0.717	2.047	1.859	2.255	<.0001
Sec Dx Group: Liver	0.708	2.029	1.908	2.158	<.0001
Sec Dx Group: GI	0.668	1.951	1.796	2.120	<.0001
CC Liver Disease	0.587	1.798	1.692	1.911	<.0001
CC Solid Tumor w/o Metas	0.514	1.673	1.554	1.800	<.0001
Female, 65 <= Age < 75	0.505	1.656	1.531	1.792	<.0001
Sec Dx Group: Ischemic Stroke	0.473	1.605	1.378	1.869	<.0001
Male, 65 <= Age < 75	0.467	1.595	1.478	1.721	<.0001
Sec Dx Group: Respiratory Failure	0.459	1.582	1.510	1.658	<.0001
S Group: Other Pulmonary	0.434	1.543	1.400	1.701	<.0001

UHC

Components of the CDB



Inpatient Drug Cost by MS-DRG

Kidney Transplant represent san opportunity of $1.26M if Hospital X brought their drug cost/case to the 10th %tile of all CRM Hospitals

MSDRG Code	MSDRG	Hospital X				UHC Cost / Case				
		Cases	Total Cost	Mean Cost / Case	Rank	HCOs	Mean	Max	10th Pctl.	Variance
652	Kidney transplant	221	$2,346,585	$10,618	66	71	$7,395	$27,614	$3,962	$1,265,768
3	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	258	$2,023,035	$7,841	76	95	$6,096	$30,488	$2,727	$1,097,407
1	Heart transplant or implant of heart assist system w MCC	138	$1,439,258	$10,429	35	55	$10,811	$37,246	$3,841	$606,102
699	Other kidney & urinary tract diagnoses w CC	214	$540,241	$2,524	86	95	$1,064	$4,850	$150	$473,263
14	Allogeneic bone marrow transplant	20	$702,935	$35,147	59	61	$20,911	$99,386	$11,326	$395,107
205	Other respiratory system diagnoses w MCC	73	$280,448	$3,842	89	95	$972	$5,278	$107	$267,204
7	Lung transplant	51	$562,777	$11,035	19	34	$12,379	$33,129	$6,364	$193,271
698	Other kidney & urinary tract diagnoses w MCC	110	$253,084	$2,301	80	95	$1,453	$8,758	$449	$184,859
206	Other respiratory system diagnoses w/o MCC	213	$181,990	$854	81	95	$469	$4,429	$39	$171,231
981	Extensive O.R. procedure unrelated to principal diagnosis w MCC	115	$295,927	$2,573	75	95	$2,028	$8,793	$777	$168,705
871	Septicemia or severe sepsis w/o MV 96+ hours w MCC (FY2009+)	793	$614,460	$775	49	95	$942	$5,981	$443	$168,338
4	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	107	$429,827	$4,017	58	95	$4,602	$40,071	$1,726	$163,561
314	Other circulatory system diagnoses w MCC	257	$333,988	$1,300	71	95	$1,135	$3,950	$494	$163,271
885	Psychoses	1,052	$230,311	$219	86	94	$135	$2,565	$38	$161,202
700	Other kidney & urinary tract diagnoses w/o CC/MCC	60	$150,368	$2,506	88	95	$748	$4,977	$36	$146,684
287	Circulatory disorders except AMI, w card cath w/o MCC	672	$219,054	$326	78	94	$227	$1,357	$77	$143,908
945	Rehabilitation w CC/MCC	325	$242,950	$748	33	41	$527	$2,870	$193	$139,281
[illegible]	[illegible]	166	[illegible]	372	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	$136,307

Report Express
High-Impact Drug Utilization Benchmarking Report

Global Measures - MS-DRG 652 - Kidney Transplant; Any Procedure 0093 - Cadaver Donor

Hospital	Cases	Mean LOS (obs)	Mean LOS (exp)	LOS Index	% Deaths (obs)	% Deaths (exp)	Mortality Index	Estimated Pharmacy Cost/Case
Hospital X	111	8.72	6.81	1.28	0.00%	0.51%	0.00	$11,043
UHC Benchmark Group	1,097	5.39	6.75	0.80	0.46%	0.46%	0.99	$5,491
All UHC CRM Participants	4,803	7.06	6.73	1.05	0.56%	0.48%	1.18	$7,331

Drug Utilization External Benchmarking

	HCO		UHC Benchmark Group		All UHC CRM Participants	
Drug	% Use	Duration (days)	% Use	Duration (days)	% Use	Duration (days)
Albumin, human	27.0%	2.5	26.2%	1.3	34.0%	1.5
Alemtuzumab	0.0%		24.4%	1.0	14.5%	1.0
Anti-thymocyte globulin (equine)	0.9%	1.0	0.0%		3.2%	3.1
Anti-thymocyte globulin (rabbit)	90.1%	4.1	51.9%	3.0	53.0%	3.6
Basiliximab	13.5%	1.9	24.3%	1.5	26.3%	1.8
Belatacept	0.0%		0.4%	1.3	0.4%	1.6
Esmolol	0.9%	1.0	21.9%	1.0	15.5%	1.2
Ganciclovir	2.7%	2.7	1.3%	2.4	16.6%	4.1
Immune globulin (igiv)	6.3%	6.0	3.7%	2.1	5.0%	2.3
Mycophenolate mofetil	12.6%	4.6	67.0%	4.8	75.3%	6.4
Rituximab	1.8%	1.0	1.2%	1.1	1.9%	1.1
Tacrolimus	98.2%	7.8	88.5%	4.7	88.5%	5.7
Thrombin	35.1%	1.2	3.7%	1.0	10.1%	1.1
Valganciclovir	98.2%	3.4	68.5%	3.1	73.0%	3.3
Recombinant human erythropoietin	57.7%	1.8	10.2%	1.2	21.0%	1.5

Created: 03/15/2013

UHC Benchmark Group: South Carolina (420004), Barnes Jewish (260032), Wake Baptist (340047), Methodist Houston (450358), Mt. Sinai (330024), Nebraska (280013), Vanderbilt (440039), Mississippi (250001), UK Chandler (180067), Arkansas (040016), UVA (490009)

Data Strategy Task Force Priorities (Fall 2010)

1. **Ability to analyze patient data across the continuum of care**

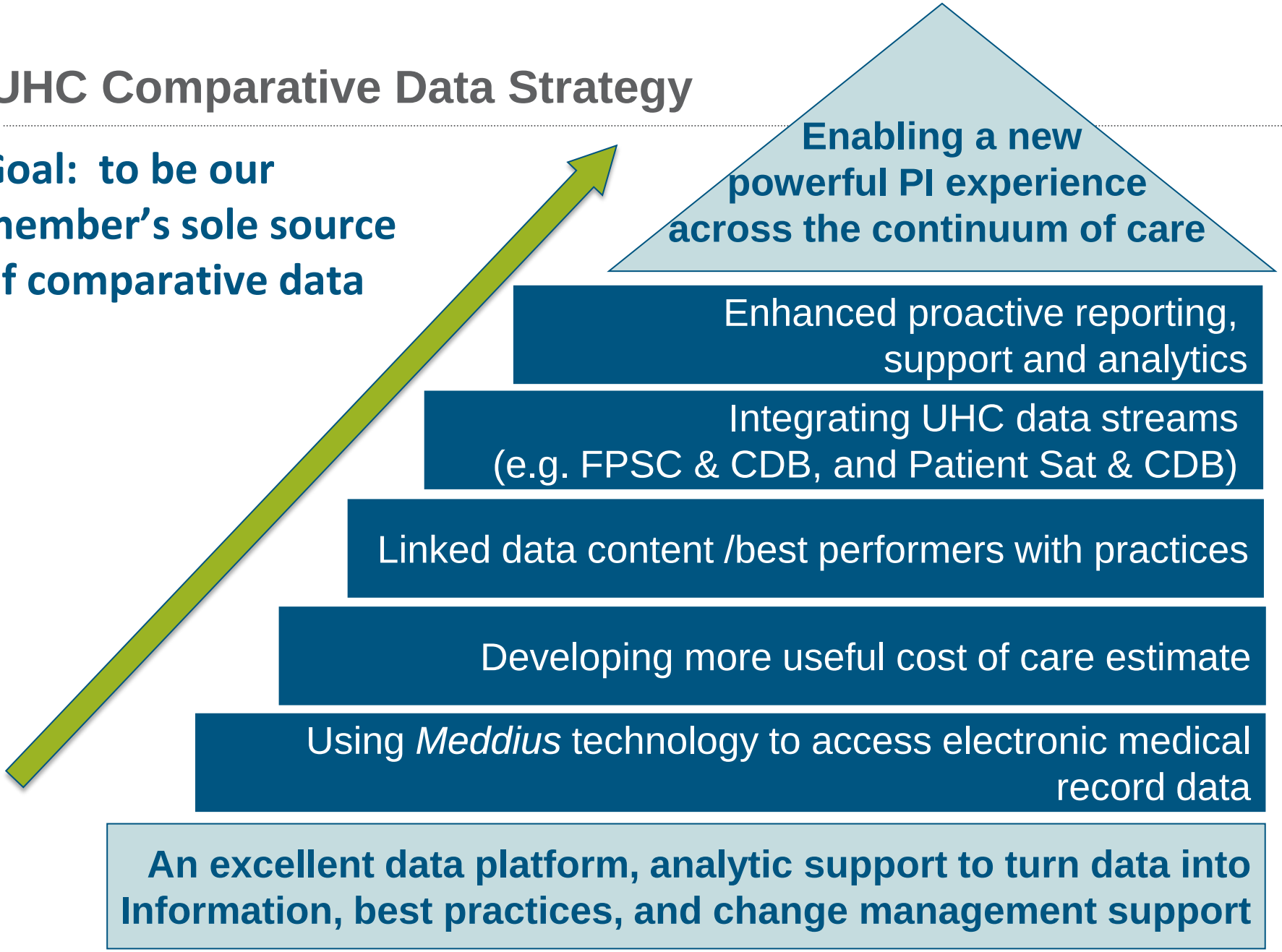
2. **UHC more proactive in providing hospitals with opportunities from the data**

3. **Improve timeliness, accessibility and customization of UHC's data products**

4. **Enhanced Reporting / Dashboards**

UHC Comparative Data Strategy

Goal: to be our member's sole source of comparative data



Patient Level Satisfaction Data Collection

Organization	Vendor	Format of Data Submitted	Number of Patient Records Submitted	Number of Patient Records Matched with CDB	Percent Matched with CDB
University Health, Cincinnati	Press-Ganey	Excel	2,100	> 2,000	
University of Kansas	Press-Ganey	Text	958	957	99.8%
Edgecombe, Vidant System	Health Stream	Excel	715	706	99.0%
Roanoke, Vidant System	Health Stream	Excel	723	716	98.7%
Medical Center, Vidant System	Health Stream	Excel	4,766	4,711	98.8%

11 member hospitals are participating in the pilot program

Possibilities with Patient Level Satisfaction Data…

Allows for analysis of the following:

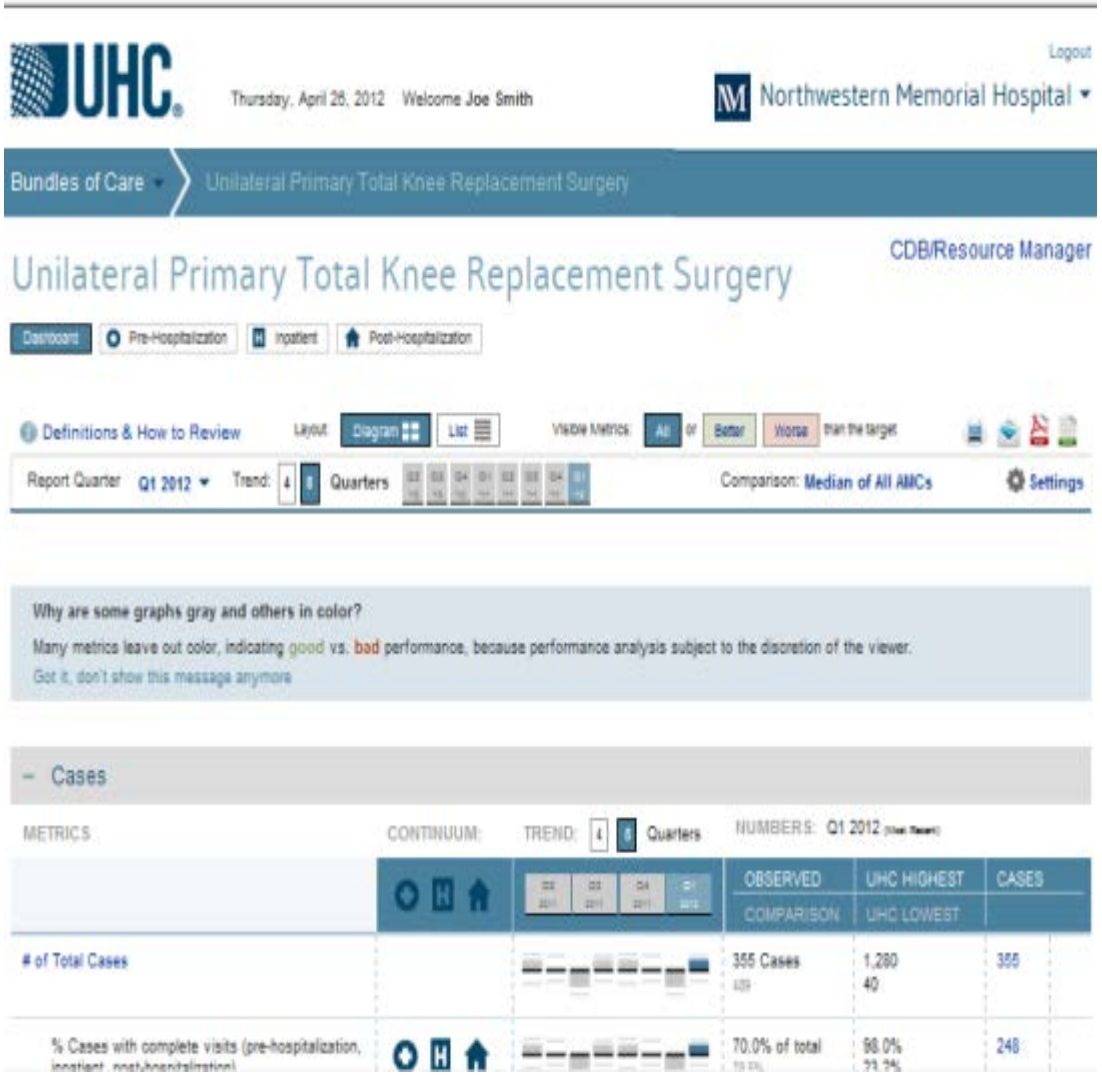
- **Length of stay & accommodations**
  - Continuity of care – how many times was the patient transferred within the hospital?
- **Demographics**
- **Diagnosis and comorbid conditions**
  - Impact of secondary psychiatric diagnosis on satisfaction
- **Clinical outcomes and severity of illness**
- **Complications / patient safety events**
  - CMS hospital acquired conditions (HAC)
  - AHRQ patient safety indicators (PSI)
  - UHC Complications
- **Distance patients traveled to hospital**
  - Responses of patients with rural zip code traveling to urban AMC

Bundles of Care

In December 2012, five condition specific bundles of care reports integrating FPSC and CDB data piloted with 13 members

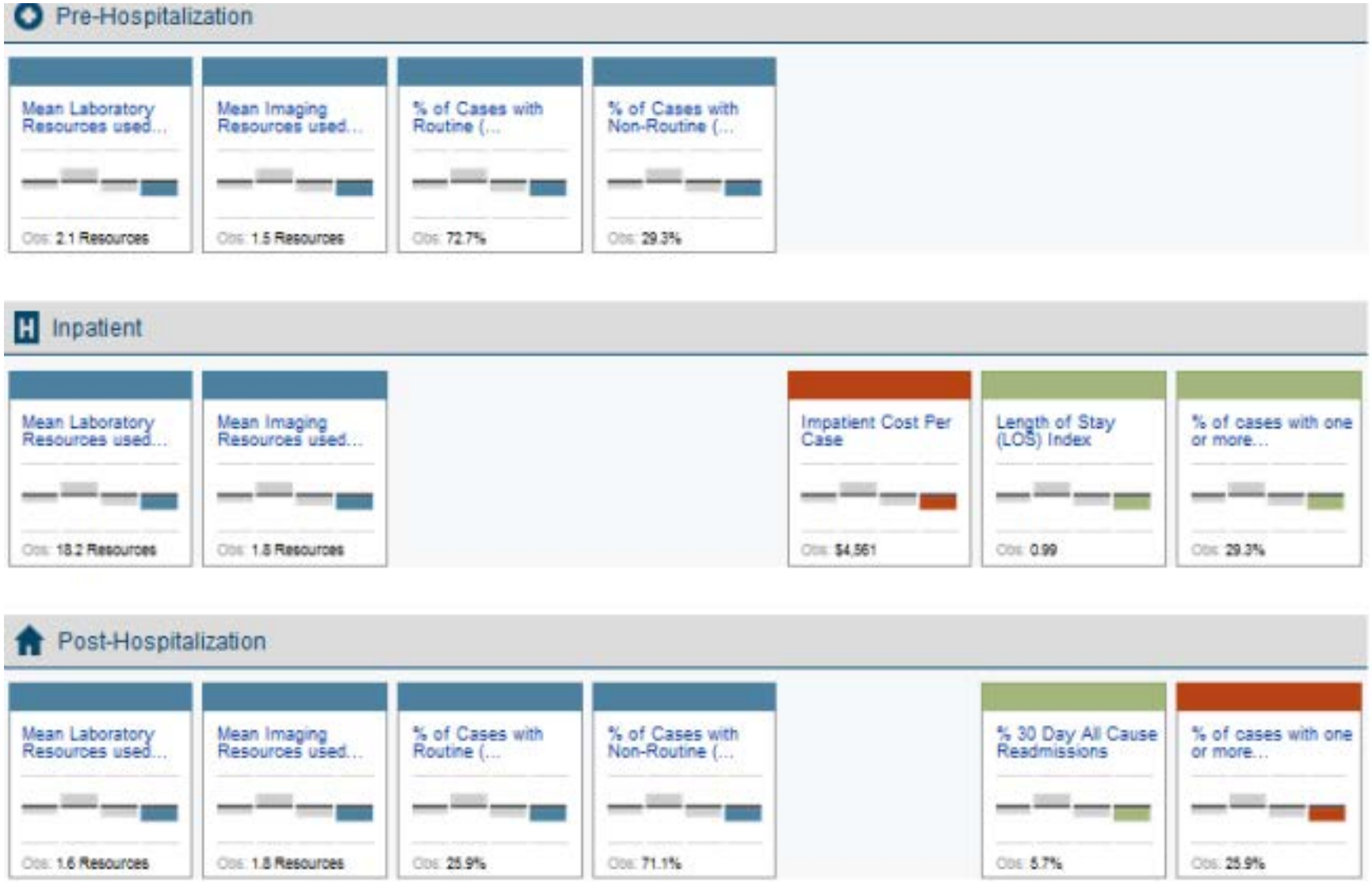
Conditions

- Total Knee Replacement
- Hip Replacement
- Aortic Valve Replacement
- CABG
- Kidney Replacement



Bundles of Care Dashboard

Summary View



Future of UHC Data Acquisition

1. Extraction straight from member's IT Systems

2.Transfer & Load into a secure space

3.Standardization & Normalization

UHC's CDB

Initial Use Case 1
Adding Clinical Variables to Risk Models

- Focus on 20 key labs identified by Michael Pine, et al
  - Albumin, hematocrit, potassium
- Key clinical measures found in EHR
  - APGAR, Glasgow Coma Scale, ASA Physical Status Classification, BMI, Ejection Fraction
- Pharmaceutical data (e.g. dose and timing)
- Expand in future to pathology (stage and grade), microbiology, radiology

Initial Use Case 2

Improved Benchmarking and Identification of Variation

- **Using the new variables such as lab values and EHR data to leverage current tools such as CDB-RM for analytics**
  - Able to better focus compare groups now limited by ICD-9 diagnoses and procedures
    - Look at outcomes for patients with craniotomy that have admit Glasgow Coma Score of <12
    - Surgical outcomes of patients with a low albumin
    - Resource Utilization differences in patients with abnormal labs vs. normal labs for the same condition
    - Outcomes based on pharma use and microbiology results
  - Longer term
    - Stratify Oncology by tumor grade and stage
    - Variability in radiology usage based on initial results within a condition

Use Case 3
Pre-populating Core Measure and Registry Data

- Decrease large member FTE burden of chart abstraction
  - Member would then verify information and only need to populate limited data
  - Focus on CMS/ TJC Core measures such as SCIP measures
  - Focus on NISQIP
- Long term
  - Focus on other registries such as STS, Trauma registry, Tumor registry
  - Focus on becoming super registry

Additional Member Benefits from the ETL Tool

- Using UHC as member's data intermediary to outside organizations, including registries;
- Reducing substantially the member's resources in manual abstraction of core measures and registries;
- Reducing substantially the member's IT resources needed to manage, abstract and submit the overwhelming number of data requests our member's are receiving;
- Receiving comparative information while the patient is still in the hospital;
- Using UHC as a member's data warehouse, or downloading data with value added fields (e.g risk adjusted values, complications) back to member's data warehouse;
- Satisfying the growing requests for Health Information Exchanges
- Reducing the increasing amount of IT infrastructure dollars

Analyst Certification Program & Analyst Pool

This program is intended for UHC member hospital staff to develop pragmatic skills for using data for improving healthcare performance - from understanding and procurement of data to application of analytics, to transformation of data into usable information and the subsequent presentation of that information to motivate improvement.

- A 7 week program including a 2 day on-site 'boot camp', and the following modules: Data Orientation, Using UHC Tools, Measurement & Analysis of Data, Evaluating Variation, Data & Risk Adjustment, Benchmarking, and Presenting Data
- Pilot to begin in mid-August with the expectation of completing two of these in 2014

Finance & Investment Plan

Estimated CY2012 – 16 PICD investment = $24.5M

- Projected investments can be funded from UHC's PI operating margin with modest growth in participants
- Growth in participation provides basis for funding investment with minimal price increases to members

PICD revenue currently $24M per year, growing at 6% with current operating margin of 20%

- *Performance Package* pricing introduced in CY2011:
  - Combines pricing for hospital-based performance improvement products (CDB/CRM/ODB/IQ)
  - Substantial savings over ala carte program pricing

Q & A

155 North Wacker Drive
Chicago, Illinois 60606
312 775 4100
www.uhc.edu