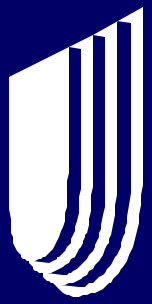


UnitedHealth Group

Advancing, Promoting and Facilitating Health

UnitedHealth Group Initiatives to Improve Quality, Safety and Consumer Decision Making

Joint Hearings on
Health Care and Competition Law and Policy

May 30, 2003

Reed V. Tuckson, M.D.
Senior Vice President, Consumer Health & Medical Care Advancement

Who Are We?
A Diversified Health & Wellness Company

We Enable, Facilitate and Advance Health

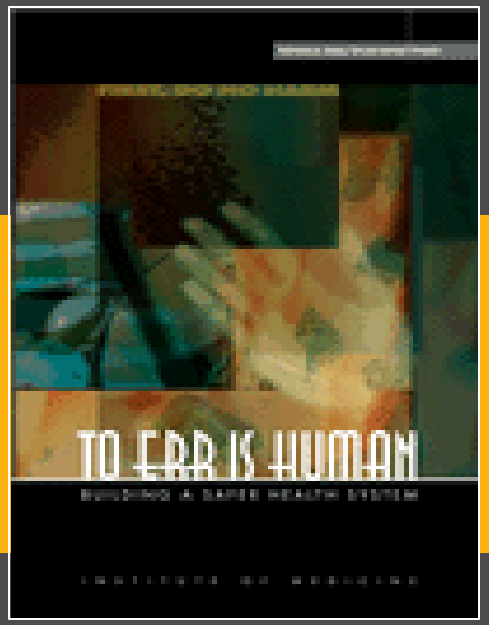
- Localized network-based health care services for small and mid-sized commercial employers, government and specialized groups
- Large, multi-site corporations and administrative intermediaries
- Americans over 50 years of age
- Specialized health and well-being markets
- Knowledge and information applications

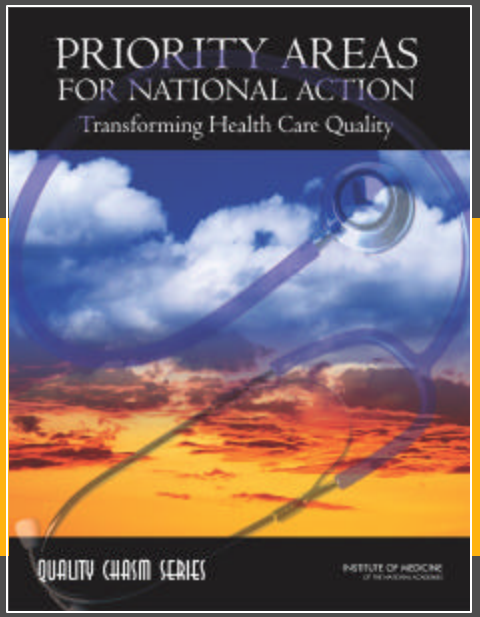
We touch >40 million lives, coordinate care for 17 million people, interact with 400,000 physicians and 4,000 health care institutions

Introduction: Important Forces in Health Care Significantly Effect the Quality and Safety of Clinical Care

"The American health care delivery system is in need of fundamental change. The current care systems cannot do the job. Trying harder will not work. Changing systems of care will."

"The Institute of Medicine's Committee on Quality Health Care in America"

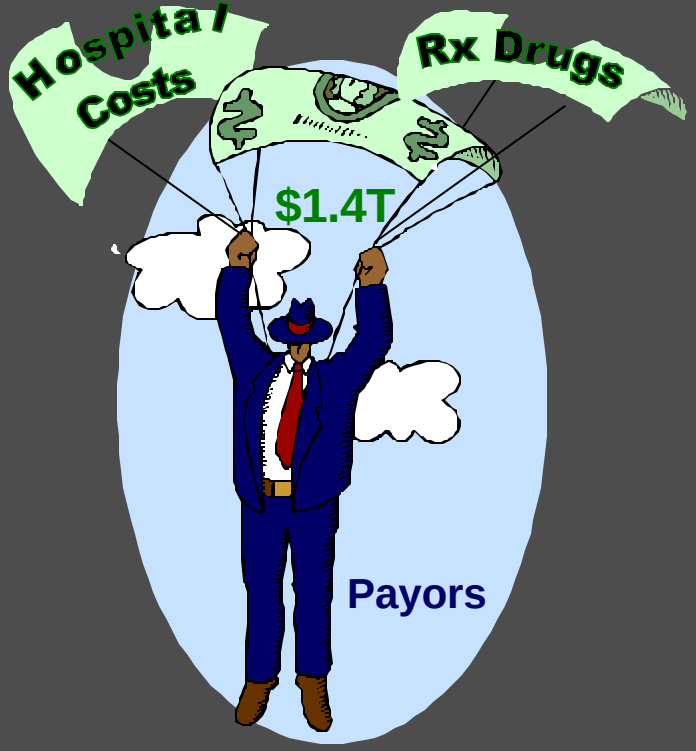




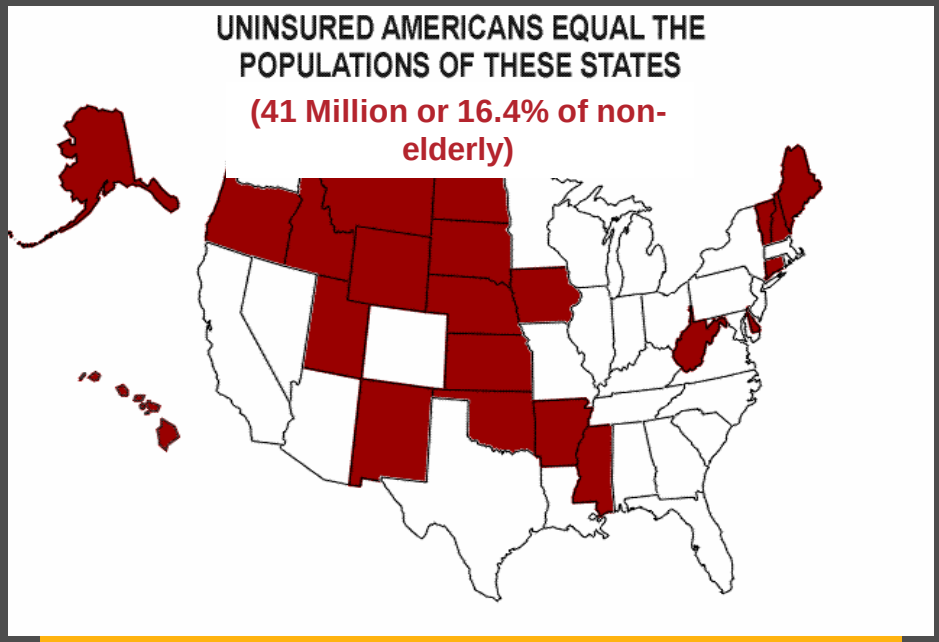
www.iom.edu

Two Forces in Health Care that Significantly Effect the Quality and Safety of Clinical Care

Escalation in health care costs: The U.S. health care economy grows $100 billion per year

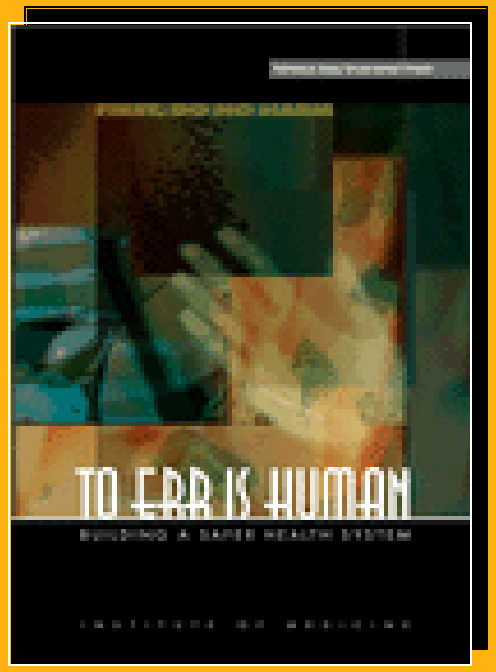


The $ bottom line



41 million Americans without health insurance

New Attentiveness and Scrutiny on the Safety and Quality of Health Care Delivery

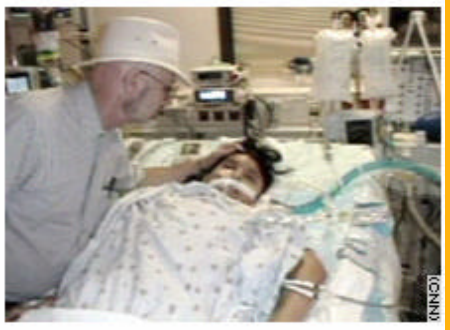


Victim of botched transplant declared dead

Hospital: 'We very much regret these tragic circumstances'

Sunday, February 23, 2003 Posted: 1:36 PM EST (1836 GMT)

DURHAM, North Carolina (CNN) -- Doctors at Duke University Hospital declared Jesica Santillan dead at 1:25 p.m. Saturday and removed her from a respirator soon after. The 17 year-old girl had two heart and lung transplants this month, the first of which used organs with the wrong blood type.

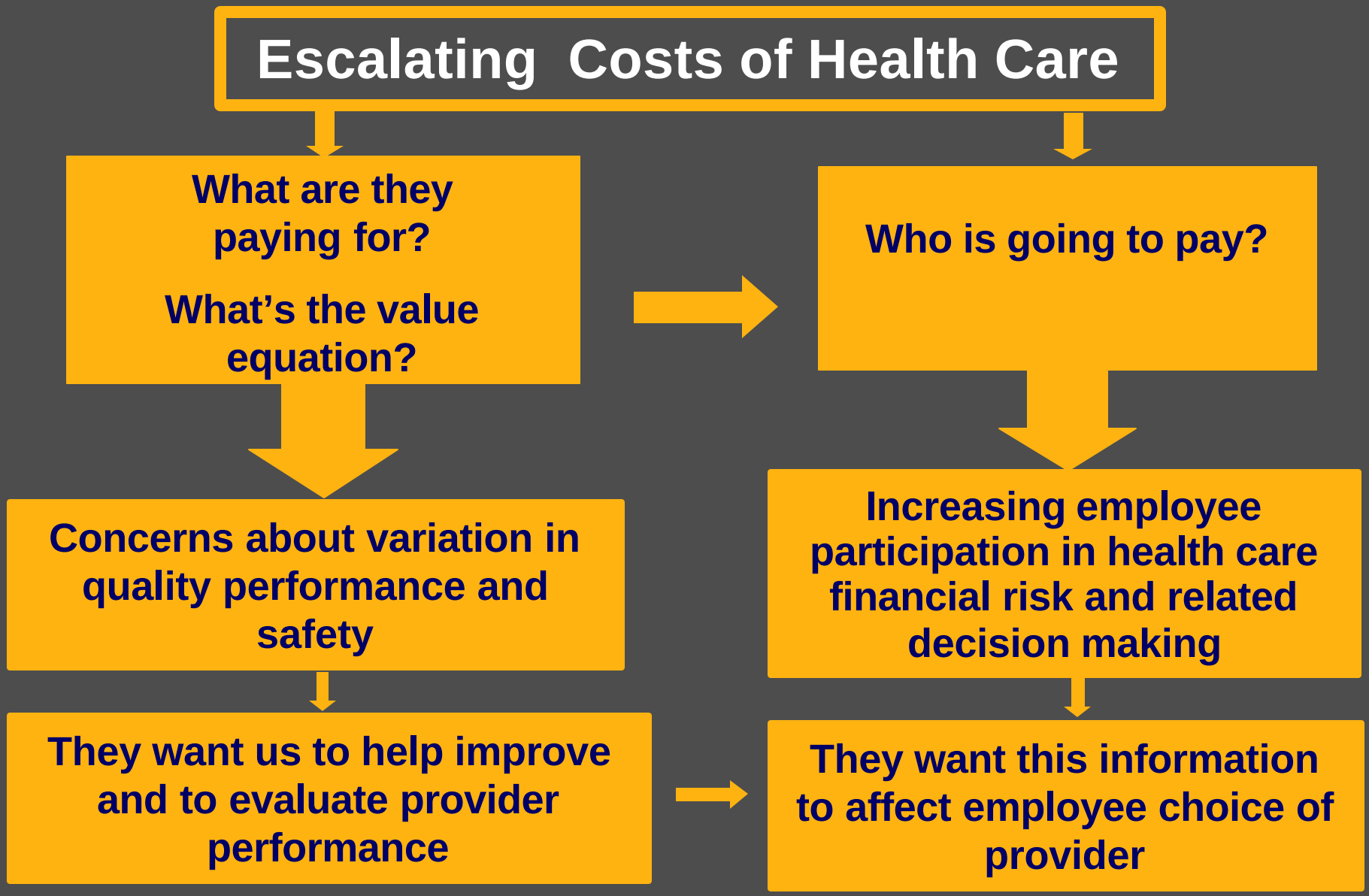


Family spokesman Mack Mahoney visits Jesica Santillan, 17, in the hospital after her second transplant operation.

"As of approximately 5 p.m., she is no longer on a respirator," a hospital

Increasing availability of clinical performance and outcomes data

New Attentiveness and Scrutiny on the Safety and Quality of Health Care Delivery



Our Strategy is Closely Aligned with the Observations and Recommendations of the IOM

SIX AIMS FOR IMPROVEMENT

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

TEN RULES TO GUIDE THE REDESIGN OF CARE

- Continuous Healing Relationships
- Evidence Based Decisions
- Customized Care
- Patient as Source of Control
- Shared Knowledge
- Transparency
- Safety as a System Property
- Cooperation Among Clinicians
- Needs are Anticipated
- Waste is Decreased

The key to all this is…

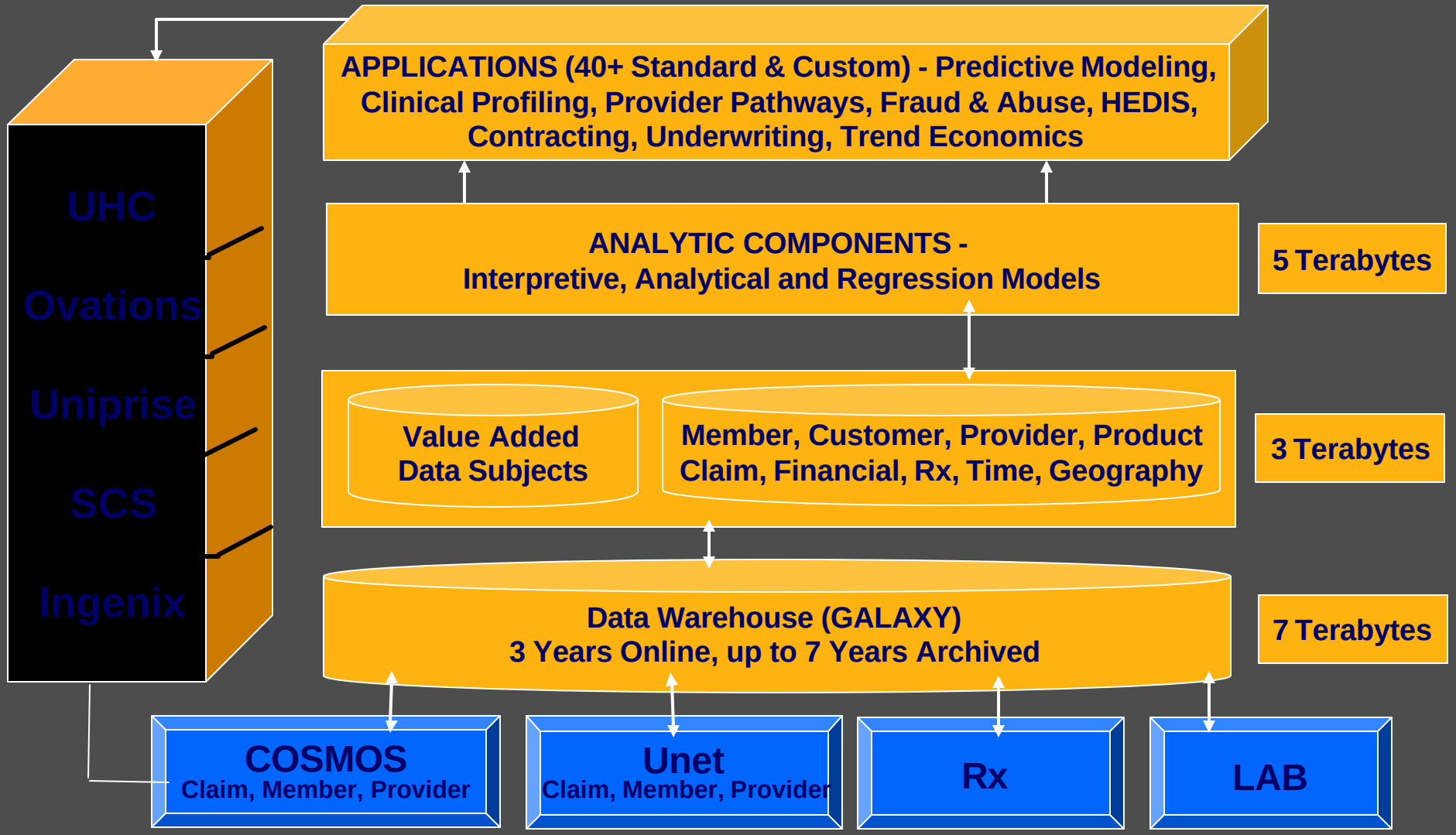
EFFECTIVE ORGANIZATIONAL SUPPORT

- Invest in Information Technology
- Coordinate Care
- Redesign Care Processes
- Manage Knowledge and Skills
- Develop Effective Multidisciplinary Teams
- Measure and Improve Performance and Outcomes

Dx and Rx Observations From the Institute of Medicine's "Crossing the Quality Chasm" Report

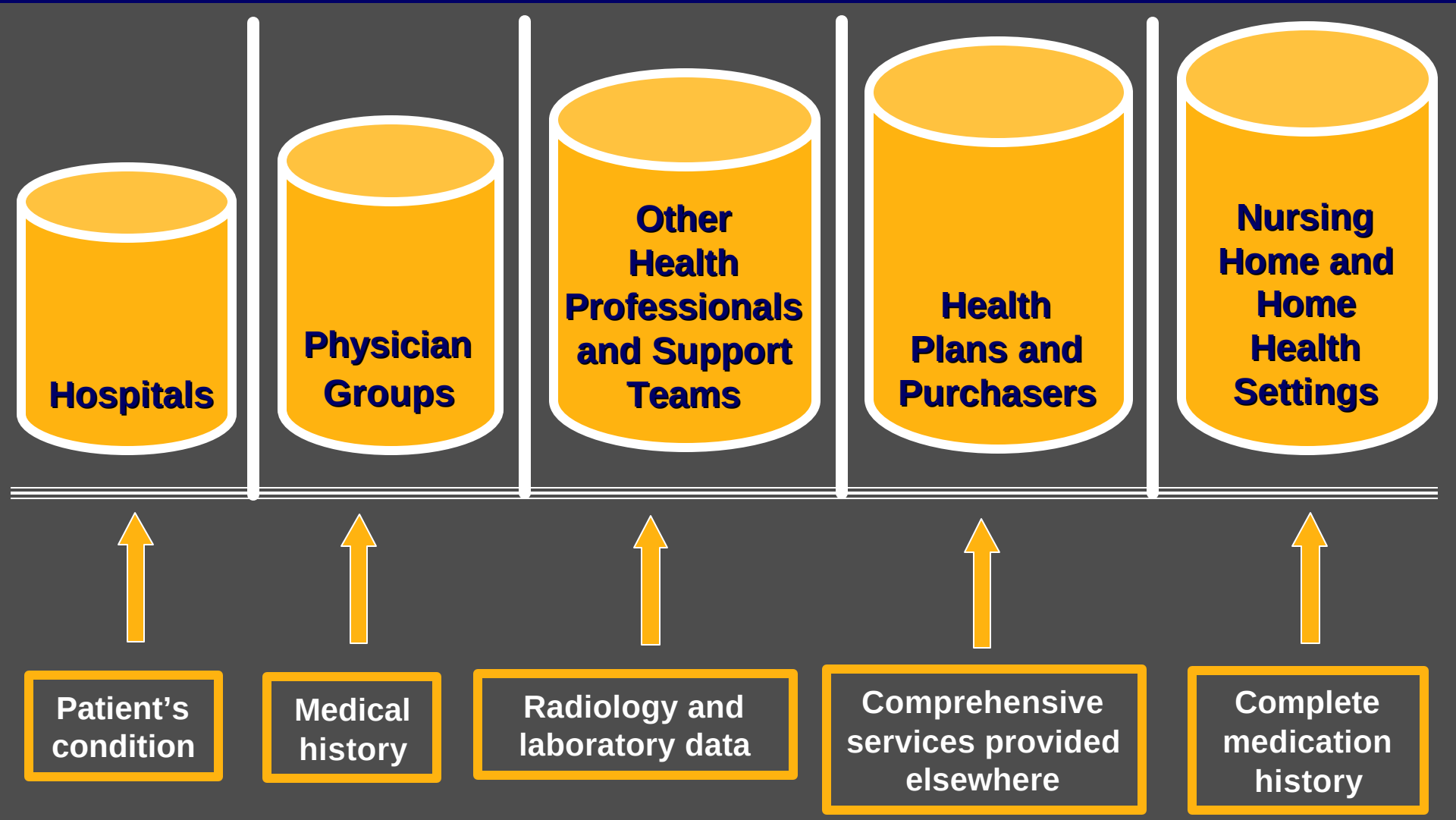
- Gaps exist between the care people should receive and the care they do receive
- Physicians, hospitals, and health care organizations operate as silos, providing care without the benefit of complete information
- The system falls short in translating knowledge into practice and care depends upon the clinical decision-making capacity of autonomous individual practitioners for problems often beyond unaided human cognition
- The system falls short in applying technology safely in a manner that decreases waste
- Care should be centered on patient's choices, needs and values
- Continuous healing relationships are needed that provide care beyond face-face visits

We Have Considerable Data Assets and We Employ Them in a Variety of Ways



“The Health Care System is Highly Fragmented and Lacks Even Rudimentary Clinical Information Capabilities”

Institute of Medicine



Why is it that this works for money and not for health care?!

Dx and Rx Observations From the Institute of Medicine's "Crossing the Quality Chasm" Report

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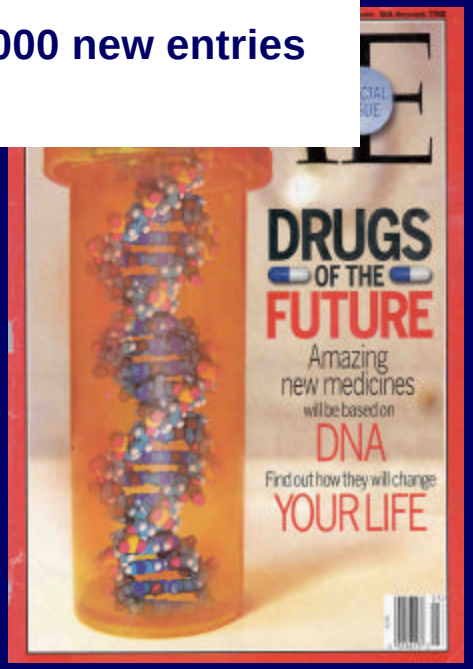
Explosion in Development of New Clinically Relevant Knowledge, Pharmaceuticals and Technology

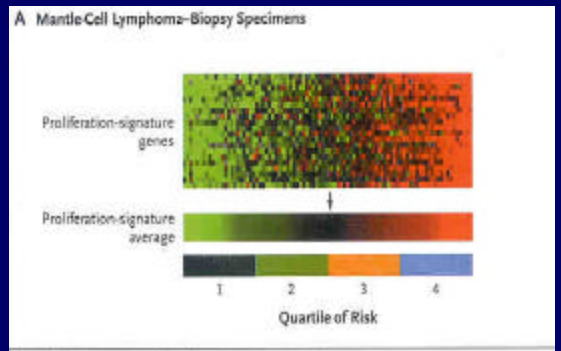
20,000 journals

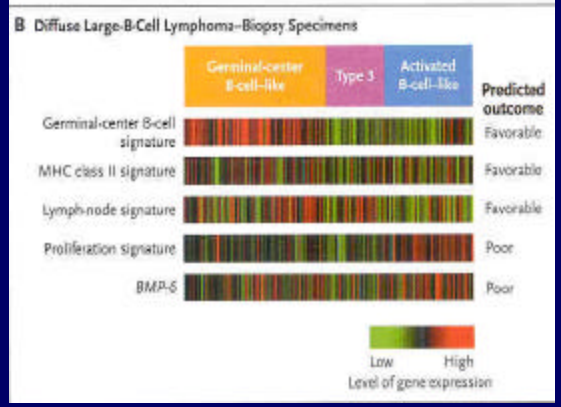
17,000 new books

6,000,000 references

400,000 new entries

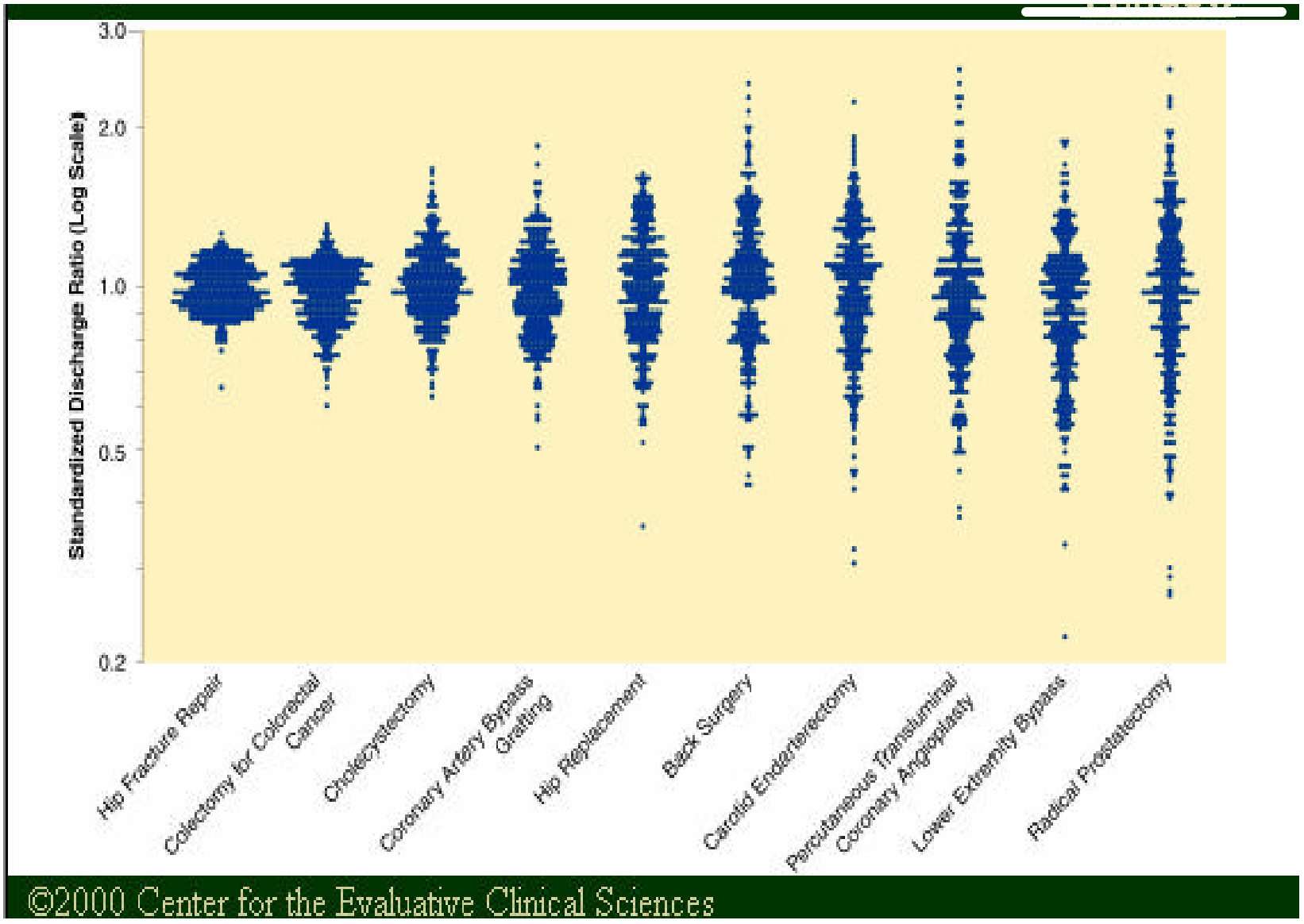




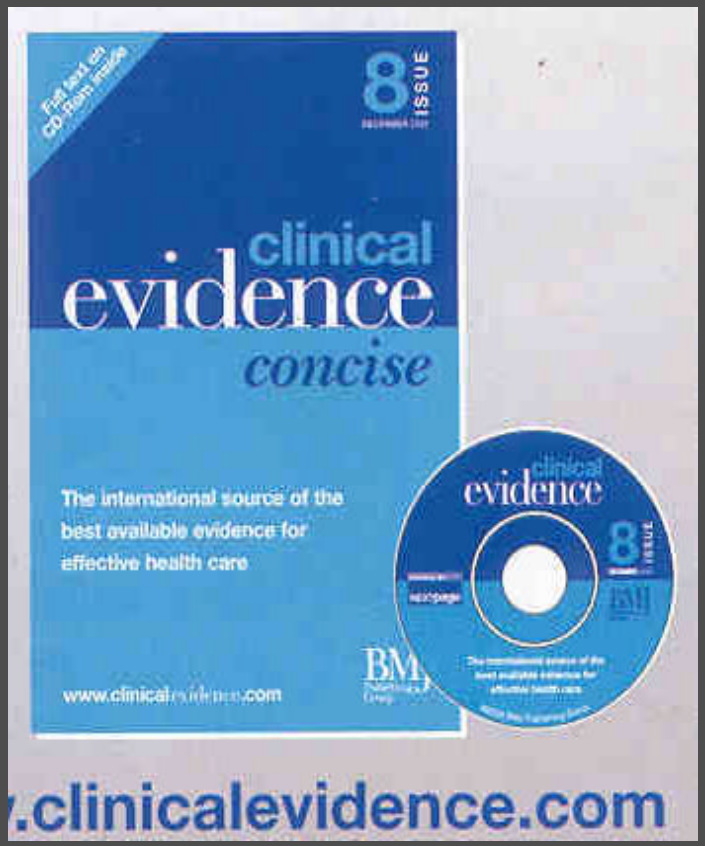


Performance Concern is Fueled by Increasing Awareness That Existing Technology and Knowledge Are Not Used Consistently or Effectively

VARIATION



Providing Physicians with the Best Evidence-based Clinically Relevant Knowledge is Essential



500,000 copies twice a year → **Physicians, Residents, Medical Students, Advanced Practice Nurses**

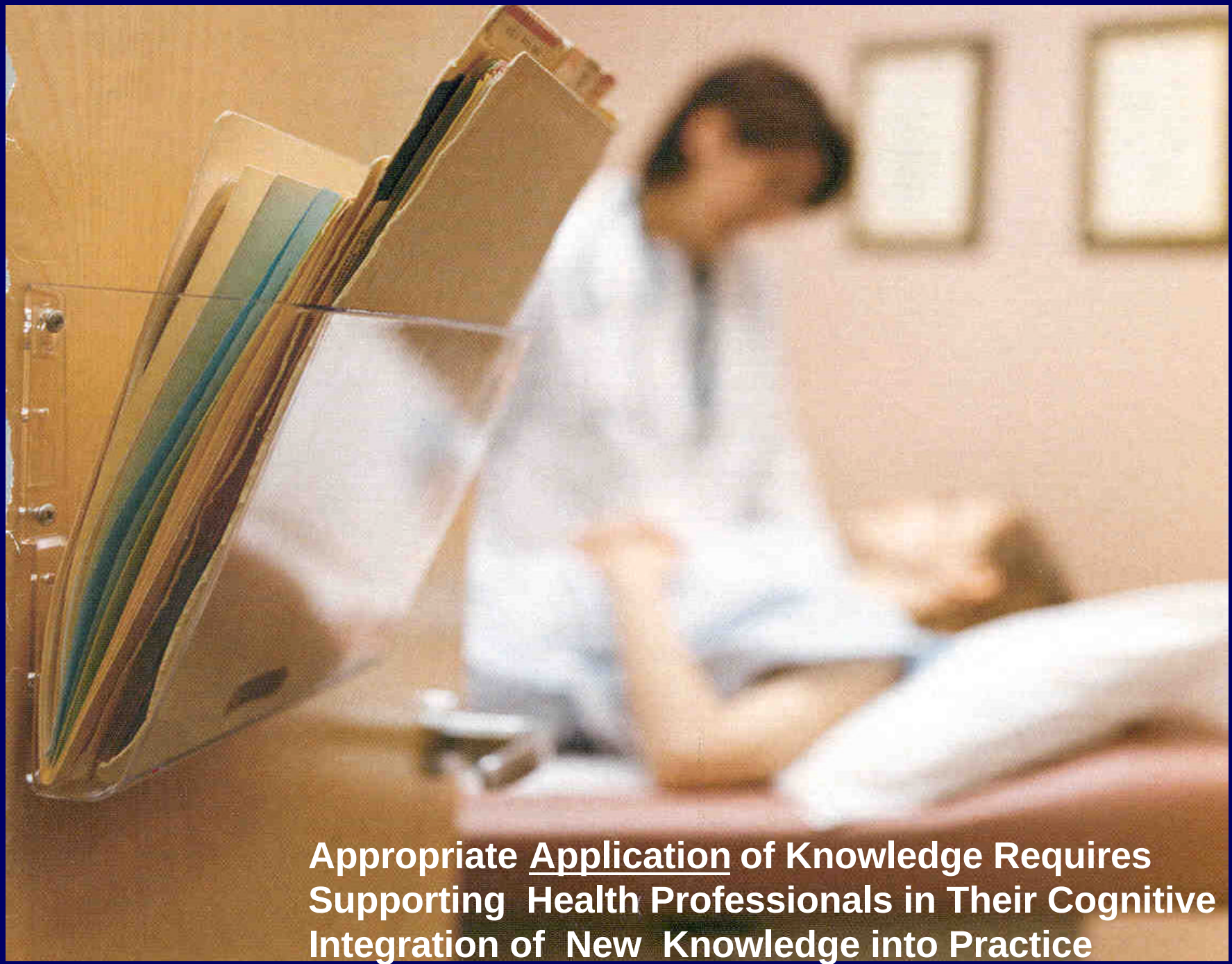
Workshops → **Physician Specialty and State Medical Societies**

Information at the point of care → **CD Rom**

Internet → Free access

PDA's → "ePocrates" trial

United Health Foundation


Appropriate Application of Knowledge Requires
Supporting Health Professionals in Their Cognitive
Integration of New Knowledge into Practice

Aiding Human Cognition: Data and Information Infrastructures for "Just in Time" Access to Evidence-Based Science

- 300,000 registered physicians
- 30 million transactions per year run rate

Facilitated search for the relevant information from the best possible sources

It is important to connect physicians and patients with the same evidenced-based information

Increasingly Physician Performance Assessment Serves to Improve Quality

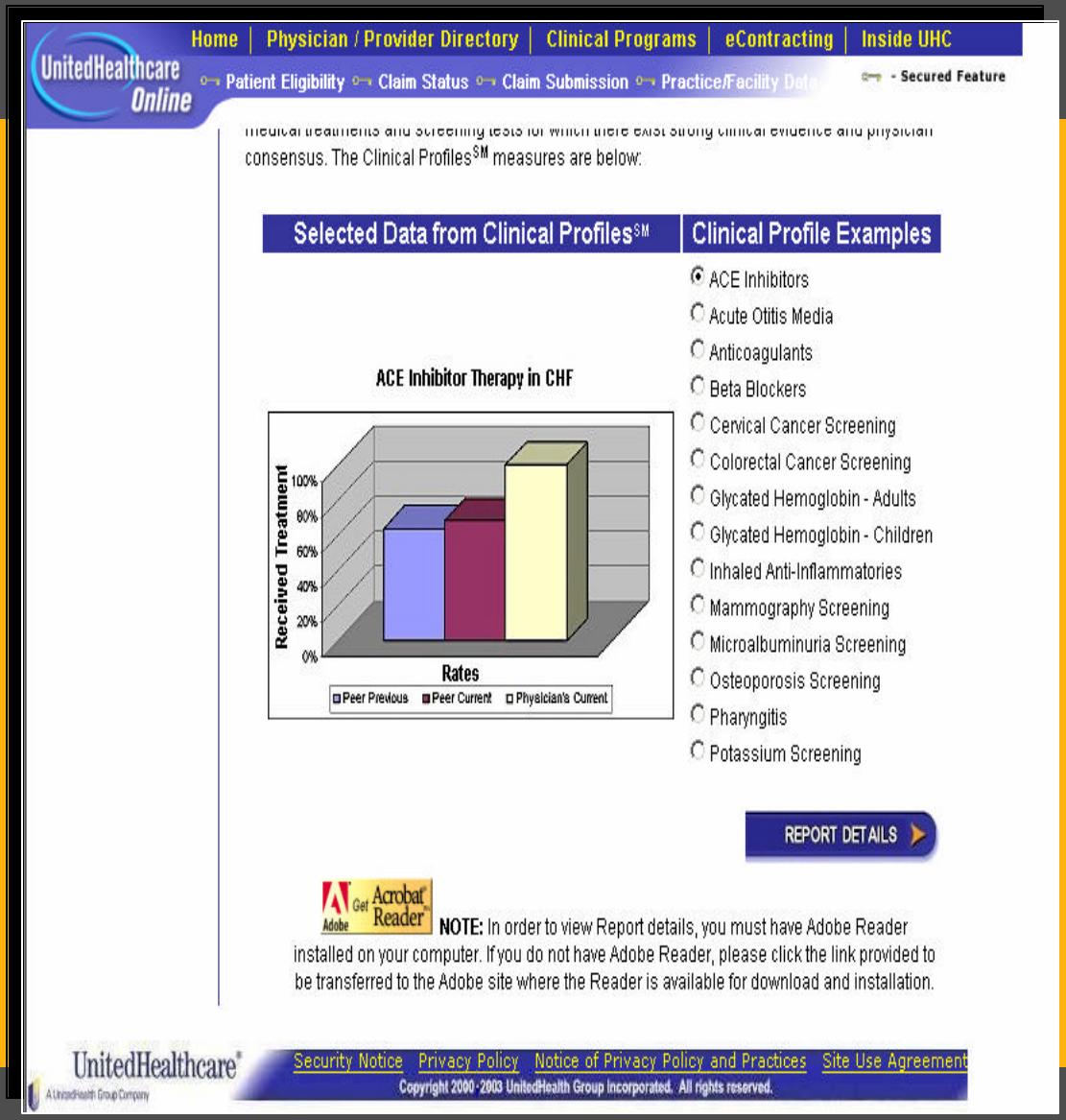
Organization of medical, pharmacy, and laboratory data

↓

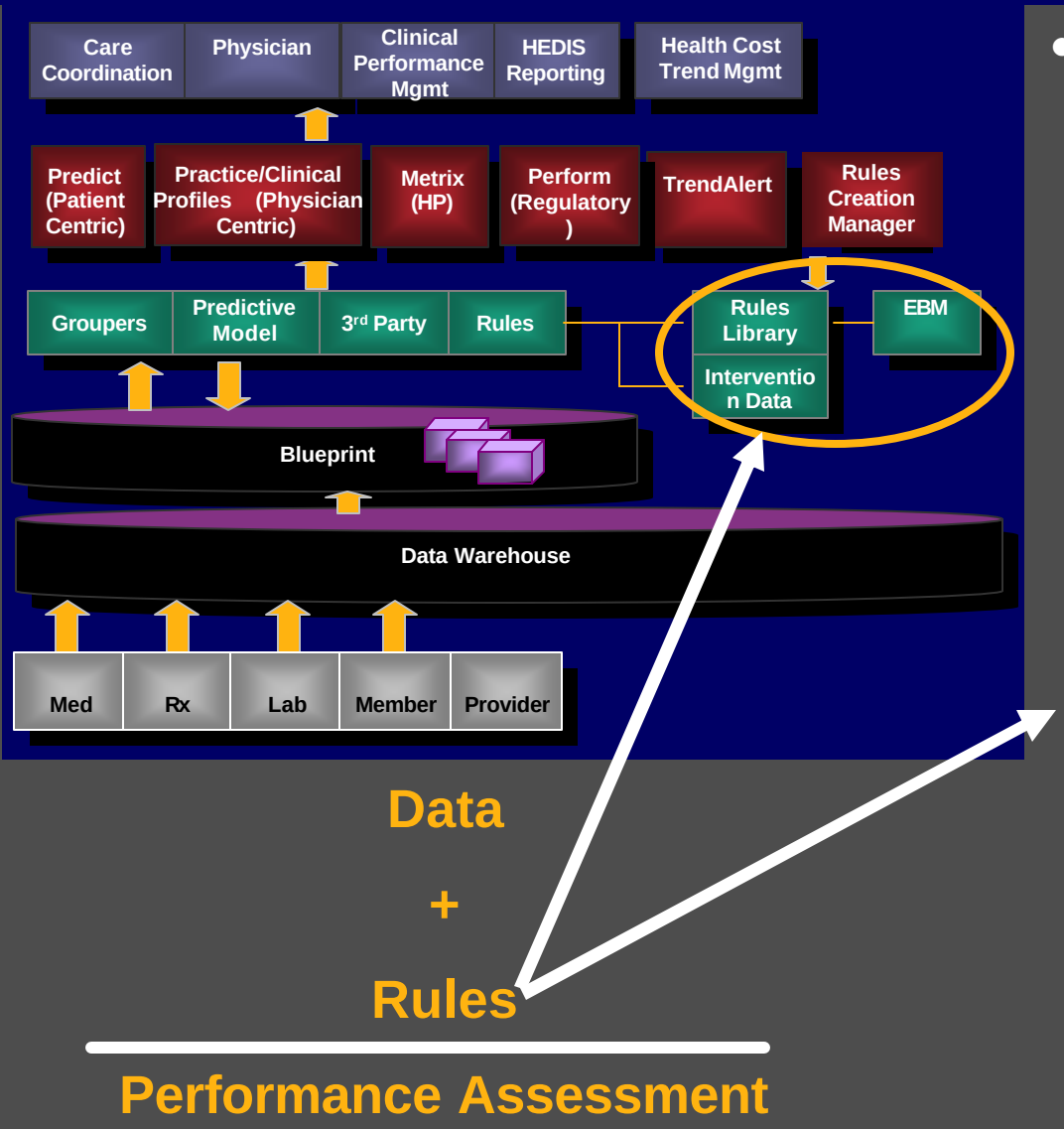
Performance Profiles

↕

Nationally accepted, physician derived, evidence-based best practices

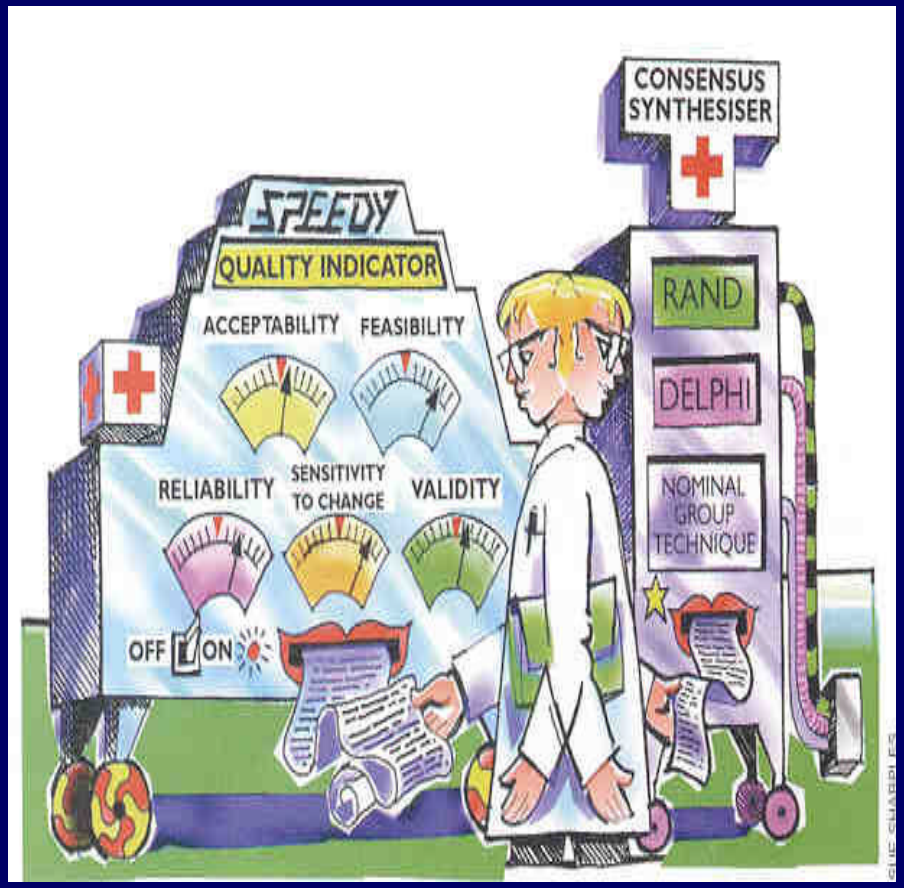


An Example of Organizing Data for Performance Assessment

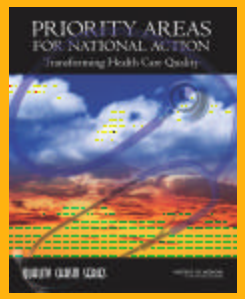


- Five Categories of Rules
  - Level 1: Derived from & supported by published professional societies, specialty organizations, or national clearinghouse guidelines that have highest level of strength based on published research
  - Level 2: All other rules derived from and supported by published professional society or specialty organizations
  - Safety – Duplications & Interaction: Involve safety issues – primarily related to medication use
  - Medication Adherence: Patient adherence to prescribed medications based on Rx filling patterns
  - Care Pattern – Commission or Informational: current practice patterns which identify unnecessary services or identify under-utilization of services

An Industry Standard for Physician Performance Assessment is Necessary



- Identify 'significant' conditions that can demonstrate differences in quality
- Public reporting vs. physician quality improvement
- Data collection and statistical issues



CMS

BRIDGES to Excellence
Rewarding Quality across the Healthcare System

NCQA Measuring the Quality of America's Health Care

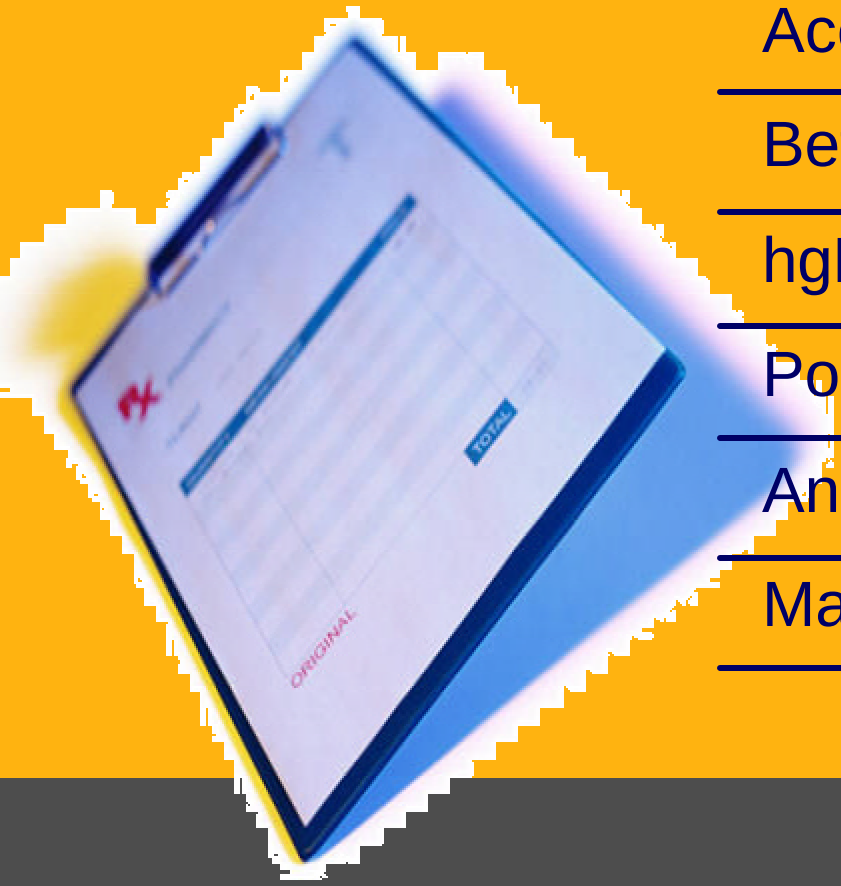
THE LEAPFROG GROUP for Patient Safety
Rewarding Higher Standards

American Medical Association
Physicians dedicated to the health of America

The Physician Consortium for Performance Improvement

NQF .The National Quality Forum

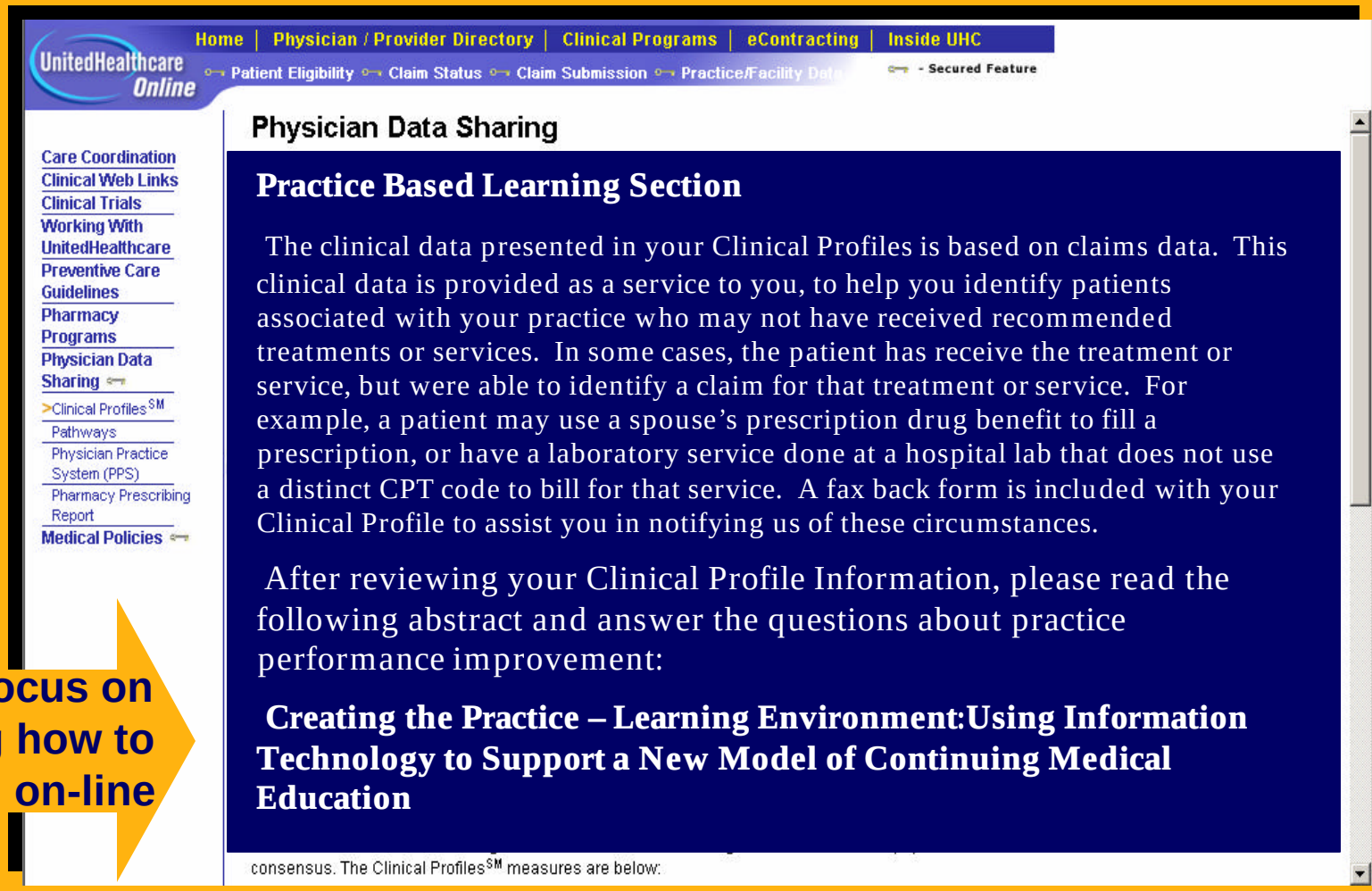
Providing Performance Data to Physicians <u>Does</u> Change Behavior and Improve Quality



	1997	2002
Ace inhibitors	65%	75%
Beta blockers	72%	82%
hgBA1C	71%	86%
Potassium	69%	83%
Anticoagulation	59%	71%
Mammography	76%	79%

Continuing Medical Education Credits for On-Line Data Analysis

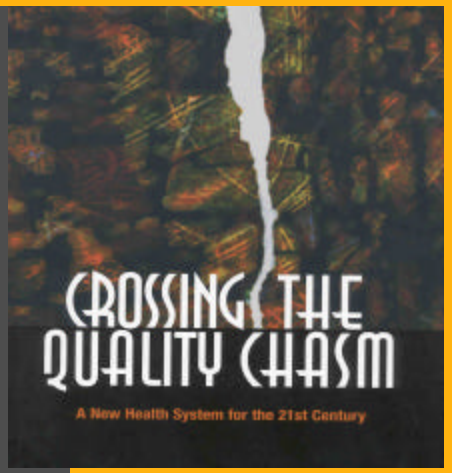
CME credits for on-line data analysis plus review of Evidenced-based literature and Specialty Society Guidelines



We focus on 'learning how to learn' on-line

Some Consider Financial Incentives and Rewards as a Necessary Next Step to Get to Improved Quality

"Bridges To Excellence"



Diabetes, Cardiovascular and Office Infrastructure

Performance Data

+

NCQA Certification

$$$ Reward

Aligning Incentives

The Informed Patient / *By Laura Landro*

A New Way to Get Doctors to Take Better Care of Patients: Bribe Them

AMERICANS GET MEMBERSHIP points for spending on their credit cards, booking flights, even buying groceries. But for taking your medicine?

Programs that reward doctors for taking better care of patients are starting to catch on in health care—and now patients are getting cut in on the deal as well.

Starting today, a group including **General Electric Co.**, **Ford Motor Co.**, **Verizon Communications**, **United Parcel Service** and **Procter & Gamble** will launch a pilot program to pay doctors in Boston, Cincinnati, and Lexington, Ky., bonuses of up to 10% if they prove they are taking better care of cardiovascular and diabetes patients.

Borrowing a page from membership rewards programs, the group will also offer patients an optional "CareRewards" points system for following doctors' orders between visits. Though patients won't typically get cash bonuses, they will be able to redeem points for merchandise coupons, time off from work or other perks.

The "Bridges to Excellence" program is the most ambitious effort yet in the "pay-for-performance" movement that is gaining adherents among big employers and health plans. Integrated Healthcare Association, whose members include California health organizations covering eight million enrollees, expects to make bonus payments to doctors next year that could exceed $100 million. "Doctors need to realize that this is the way they will be paid, and they need to get with the program," says Bess Carter, executive director.

It may sound strange to have to essentially bribe doctors and patients to do what they should be doing anyway. But the programs are designed to address what remains one of the central oddities of American health care. In many cases, the current payment system actually makes it more lucrative for doctors and hospitals to provide substandard care. They get rewarded for high volume—in other words, brief office visits—and not the long-term management of care between visits.

Margaret O'Kane, president of the nonprofit National Committee for Quality Assurance, which will audit doctors' results for "Bridges to Excellence," admits that the program may raise eyebrows. "Employers are staring at unbelievable cost rises, so it's hard to make the case that you have to pay doctors extra to do the job right," she says. The long-term payoff, she adds, could be fewer absentees and serious medical complications.

Francois de Brantes, program leader for healthcare initiatives at GE, says the bonus programs are a response to the alarming rates of medical error and studies of quality problems in U.S.

...complications.
...ary focus is chronic conditions like asthma, diabetes and heart disease that require constant long-term care.

For example, diabetes patients can sign on to www.bridgestoexcellence.org for an interactive online tool that will let them enter data about their hemoglobin levels and medication compliance, and earn CareRewards points when they meet the goals set by their doctor.

Those points will be redeemable for, say, a $25 coupon for a diabetes care kit or credits to pay off health plan deductibles and co-payments.

"Airlines figured it out a long time ago with frequent-flier miles," says Vince Kerr, director of health-care management for Ford, whose health plan covers 650,000 members. Though he admits the rewards in the program don't compare with, say, a free airline ticket, "we think people will respond to incentives, particularly if it's also good for them."

Doctors, meanwhile, would receive a yearly bonus of $100 for each patient covered by a participating employer if their practice has a high percentage of diabetic patients whose blood pressure, blood sugar, and lipid levels are sufficiently measured and controlled.

The program is estimated to generate savings of $350 per diabetic patient a year, and cost employers no more than

...diabetic patient a year. A cardiac-care program will make its debut this year.

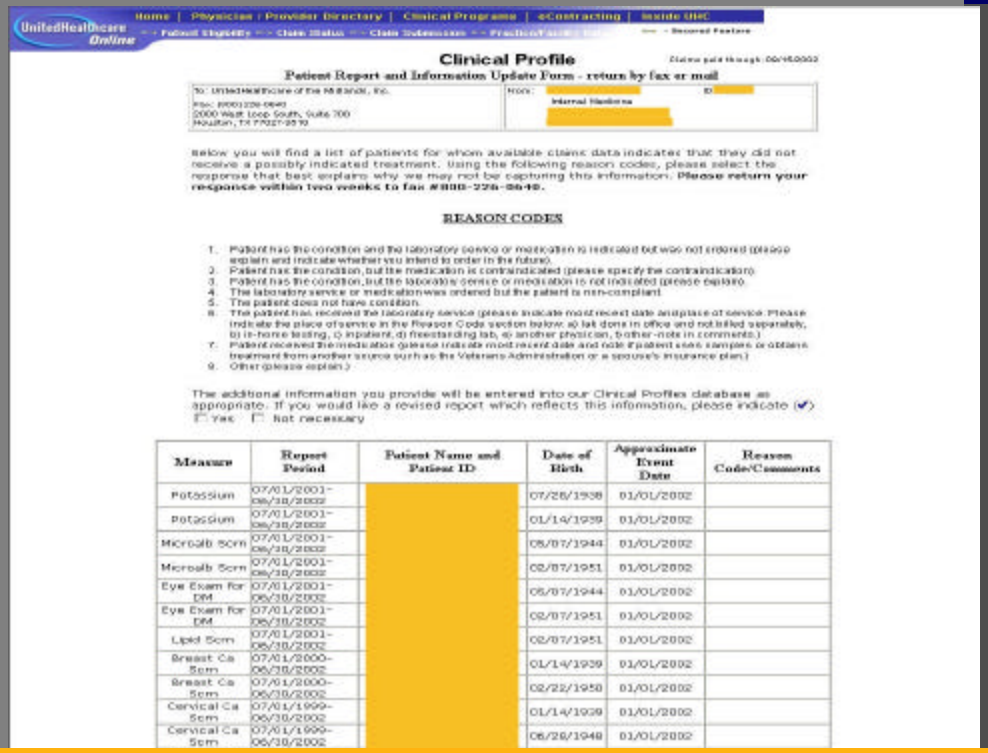
Yet a third program will reward doctors for investing in technology to improve patient care, says Thomas H. Lee, medical director of Boston-based Partners Healthcare System, which helped design the compensation systems. Doctors will get bonuses of $65 per patient annually for investing in systems such as computer-based records and care-management software programs for chronically ill patients. A doctor caring for 300 employees or family members could earn a year-end bonus of up to $16,500.

The Leapfrog Group, another large employer coalition, and the Robert Wood Johnson Foundation are evaluating pay-for-performance pilot projects too.

All of this is consistent with a study in the latest policy journal Health Affairs. It concludes that the business case for quality is "weak or nonexistent" in health care, and advocates providing such financial rewards to doctors and health systems who invest in quality measures. "In some instances you have to put money into the health-care system, at least in the short term, to reward the delivery of better care," says Stephen Schoenbaum, a vice president at the Commonwealth Fund, a nonprofit health foundation. Though he warns that bonus payments alone can't solve all the quality problems in health care, he adds, "As my grandmother used to say, 'It couldn't hurt.'"

Some doctors agree. David Wilson of Eastern Hills Internal Medicine in Cincinnati says his group paid for an audit by the American Diabetes Association and NCQA to win recognition in an existing Diabetes Provider Recognition Program that doesn't carry any financial incentives for participating. "We got a nice plaque for it but not much else," Dr. Wilson says. "Why go through that process and not get any reward?" Health plans and insurers "talk about quality all the time, but now is the time to start putting their money where their mouth is," he adds.

Aiding Human Cognition: Physician Offices Require Electronic Information Support Infrastructures to Successfully Manage Care



UnitedHealthcare Online — Home | Physician | Provider Directory | Clinical Programs | eContracting | Inside UHC

Clinical Profile

Patient Report and Information Update Form - return by fax or mail

To: UnitedHealthcare of the Midlands, Inc.
Fax: (800) 226-9649
2000 West Loop South, Suite 700
Houston, TX 77027-3519

From: [redacted]
ID: [redacted]
Internal Reference

Below you will find a list of patients for whom available claims data indicates that they did not receive a possibly indicated treatment. Using the following reason codes, please select the response that best explains why we may not be capturing this information. **Please return your response within two weeks to fax #800-226-9649.**

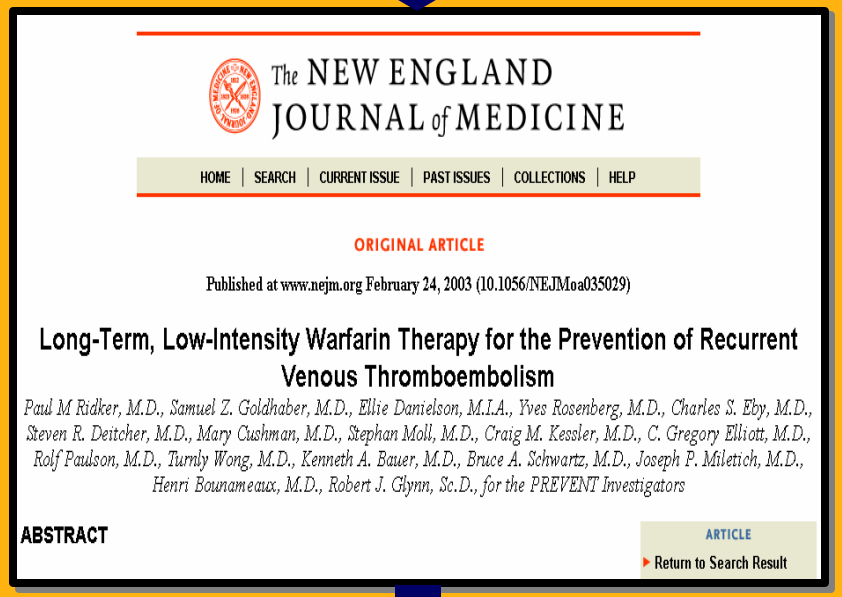
REASON CODES

1. Patient has the condition and the laboratory service or medication is indicated but was not ordered (please explain and indicate whether you intend to order in the future).
2. Patient has the condition, but the medication is contraindicated (please specify the contraindication).
3. Patient has the condition, but the laboratory service or medication is not indicated (please explain).
4. The laboratory service or medication was ordered but the patient is non-compliant.
5. The patient does not have condition.
6. The patient has received the laboratory service (please indicate most recent date and place of service. Please indicate the place of service in the Reason Code section below: a) lab done in office and not billed separately, b) in-home testing, c) inpatient, d) freestanding lab, e) another physician, b other--note in comments.)
7. Patient received the medication (please indicate most recent date and note if patient uses samples or obtains treatment from another source such as the Veterans Administration or a spouse's insurance plan.)
8. Other (please explain.)

The additional information you provide will be entered into our Clinical Profiles database as appropriate. If you would like a revised report which reflects this information, please indicate (✔)
☐ Yes ☐ Not necessary

Measure	Report Period	Patient Name and Patient ID	Date of Birth	Approximate Event Date	Reason Code/Comments
Potassium	07/01/2001-06/30/2002		07/26/1938	01/01/2002	
Potassium	07/01/2001-06/30/2002		01/14/1939	01/01/2002	
Microalb Scrn	07/01/2001-06/30/2002		08/07/1944	01/01/2002	
Microalb Scrn	07/01/2001-06/30/2002		02/07/1951	01/01/2002	
Eye Exam for DM	07/01/2001-06/30/2002		08/07/1944	01/01/2002	
Eye Exam for DM	07/01/2001-06/30/2002		02/07/1951	01/01/2002	
Lipid Scrn	07/01/2001-06/30/2002		02/07/1951	01/01/2002	
Breast Ca Scrn	07/01/2000-06/30/2002		01/14/1939	01/01/2002	
Breast Ca Scrn	07/01/2000-06/30/2002		02/22/1950	01/01/2002	
Cervical Ca Scrn	07/01/1999-06/30/2002		01/14/1939	01/01/2002	
Cervical Ca Scrn	07/01/1999-06/30/2002		06/26/1948	01/01/2002	

As new clinically-relevant knowledge emerges…



The NEW ENGLAND JOURNAL of MEDICINE

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ORIGINAL ARTICLE

Published at www.nejm.org February 24, 2003 (10.1056/NEJMoa035029)

Long-Term, Low-Intensity Warfarin Therapy for the Prevention of Recurrent Venous Thromboembolism

Paul M Ridker, M.D., Samuel Z. Goldhaber, M.D., Ellie Danielson, M.I.A., Yves Rosenberg, M.D., Charles S. Eby, M.D., Steven R. Deitcher, M.D., Mary Cushman, M.D., Stephan Moll, M.D., Craig M. Kessler, M.D., C. Gregory Elliott, M.D., Rolf Paulson, M.D., Turnly Wong, M.D., Kenneth A. Bauer, M.D., Bruce A. Schwartz, M.D., Joseph P. Miletich, M.D., Henri Bounameaux, M.D., Robert J. Glynn, Sc.D., for the PREVENT Investigators

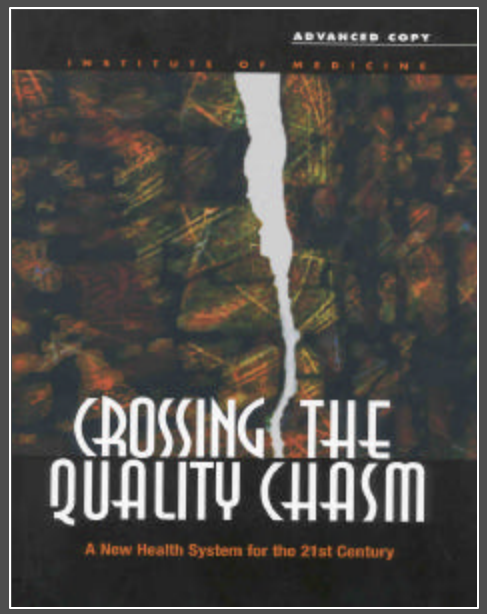
ABSTRACT

ARTICLE
Return to Search Result

<u>On-line Disease Registries</u> and Reminder Programs provide physicians with detailed listings of their patients who should receive, or who did not receive, an appropriate intervention

…we can support physicians in appropriately applying it to their patients

Dx and Rx Observations From the Institute of Medicine's "Crossing the Quality Chasm" Report



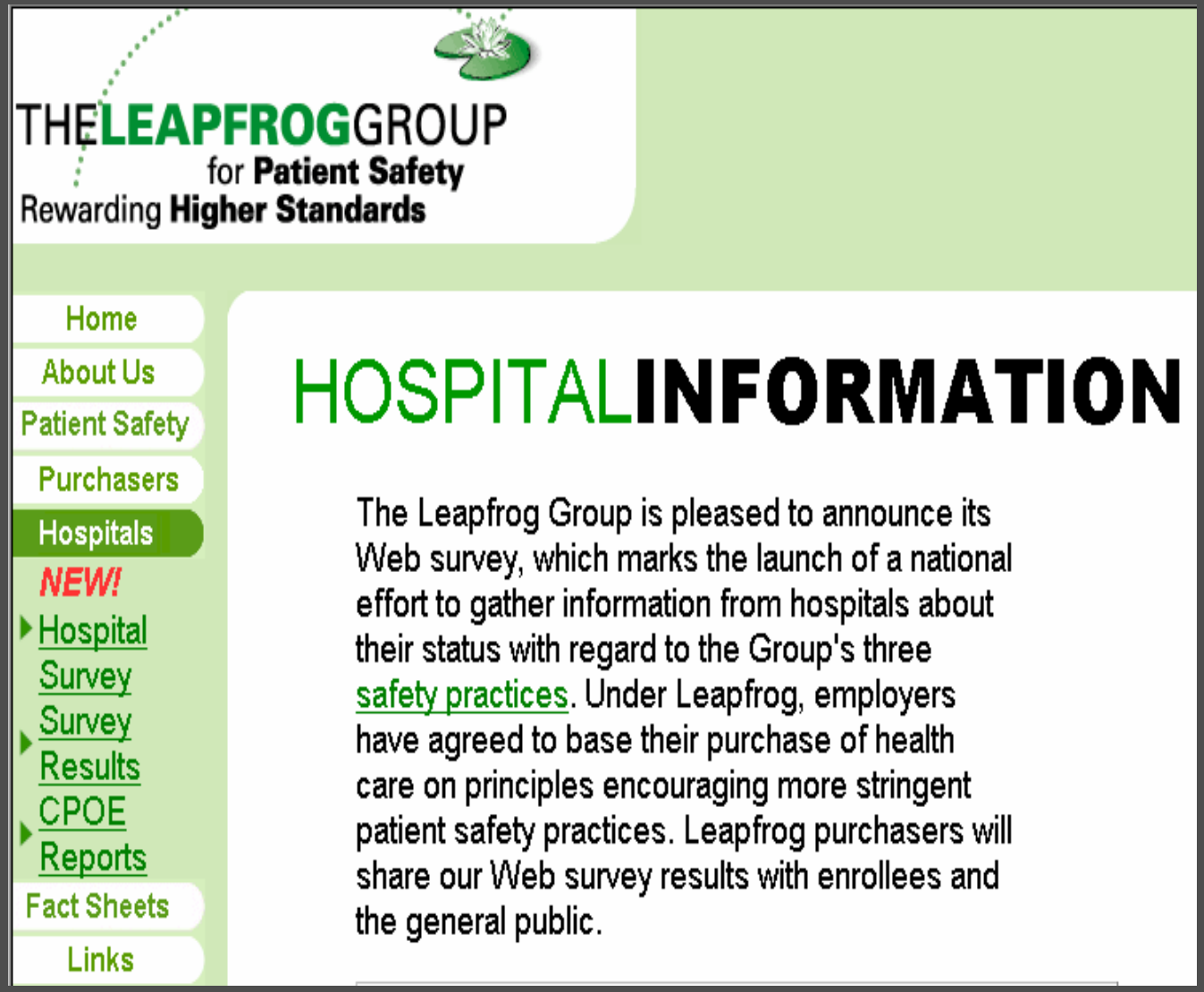
- Gaps exist between the care people should receive and the care they do receive
- Physicians, hospitals, and health care organizations operate as silos, providing care without the benefit of complete information
- The system falls short in translating knowledge into practice and care depends upon the clinical decision-making capacity of autonomous individual practitioners for problems often beyond unaided human cognition
- **The system falls short in applying technology safely in a manner that decreases waste**
- Care should be centered on patient's choices, needs and values
- Continuous healing relationships are needed that provide care beyond face-face visits

Performance Evaluation of Institutions

- More work remains to define, measure, and communicate "evidenced-based" hospital performance criteria
- We need better criteria and tools to assess quality (i.e., most appropriate care sites, care providers, interventions, etc.)

“Leapfrog” is an Important Employer-Initiated Safety Movement

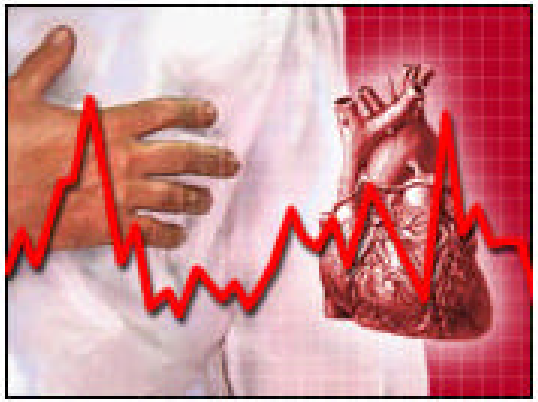
- CPOE
- Hospital volume for special procedures
- ICU staffing by trained Intensivists
- Physician performance measurement coming soon



Leapfrog is a good start but we have a ways to go: for example, "volume" metrics alone are not good enough

Unhealthy Diagnosis

Feb. 13, 2003

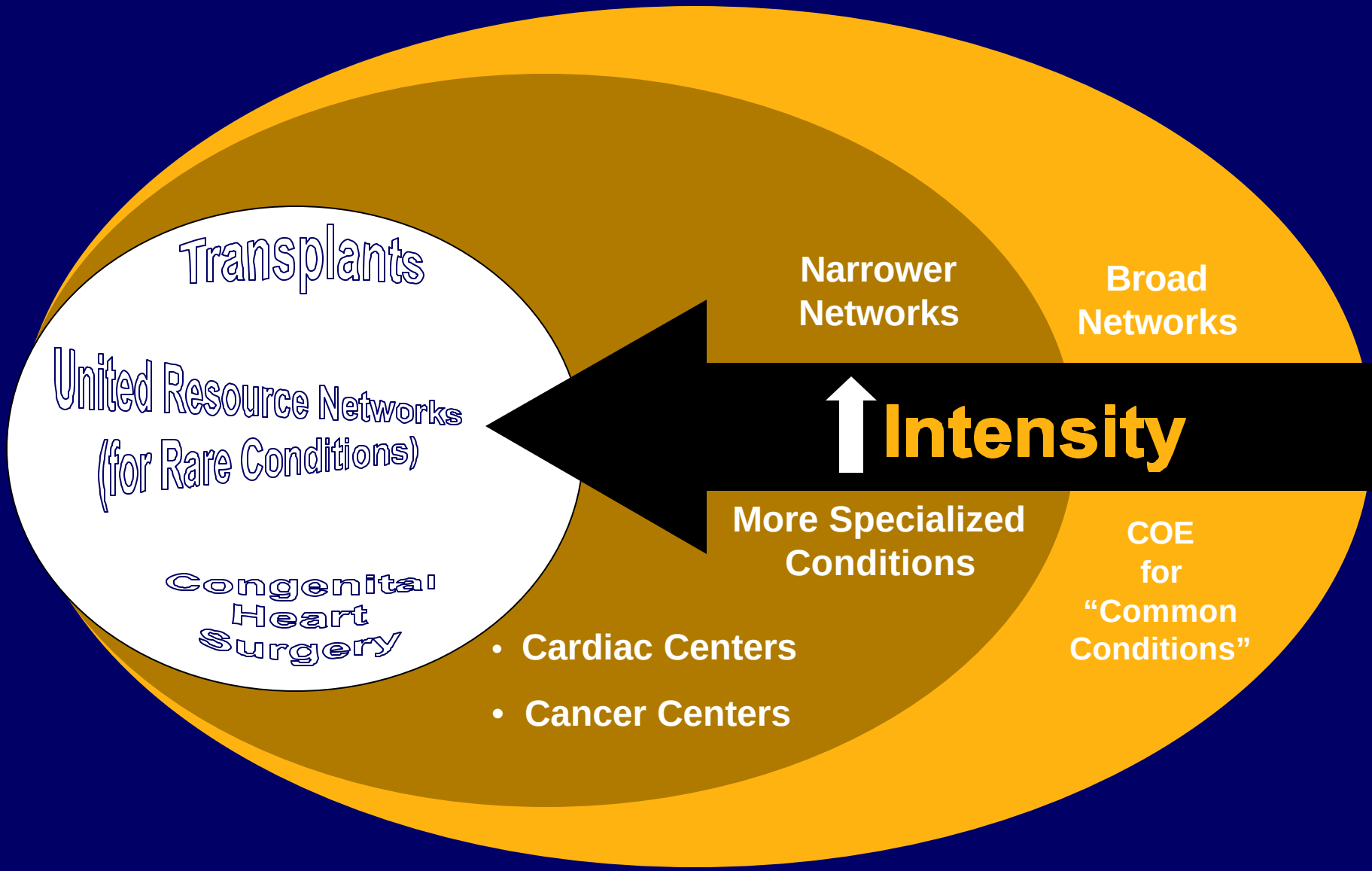


(CBS) Rep. Pete Stark (D-Calif.) tells **Ed Bradley** that executives at the nation's second largest healthcare company are "poster children for unethical business practices" in a ***60 Minutes*** report on one of the company's California hospitals accused of performing unnecessary heart surgeries.

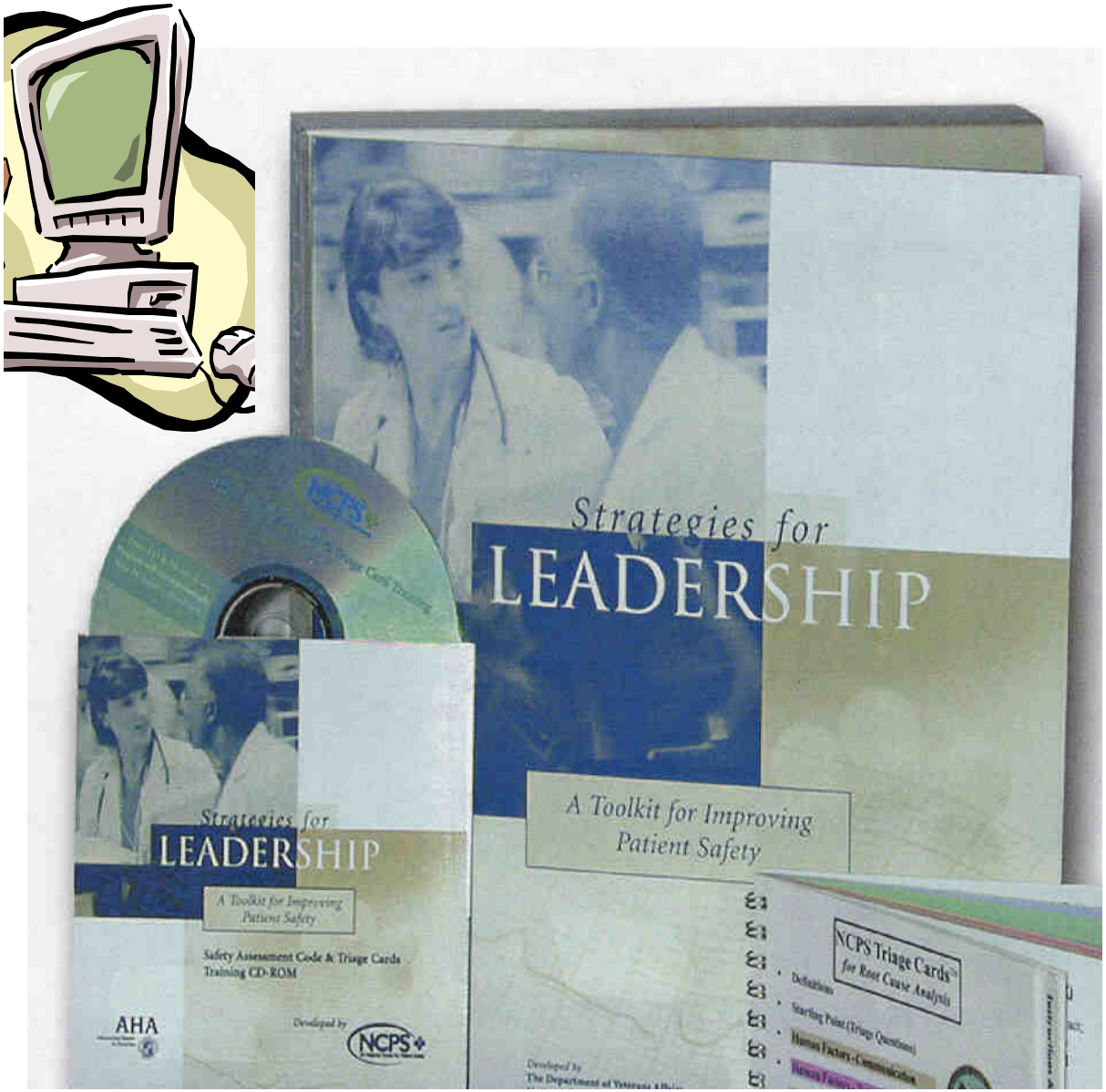
The sheer volume of procedures performed by Dr. as cited by the government as the basis for the raids last week. The 238-bed hospital reported performing 923 open-heart surgeries and more than 16,000 catheterizations in the 12 months ended May 31, 2001, according to the latest annual disclosure report filed with California's Office of Statewide Health Planning and Development.

WSJ.com THE WALL STREET JOURNAL. ONLINE

Centers of Excellence:
Data + Analytics → Steerage to 'Best' Centers



Patient Safety Partnership: AHA and UHF



AHA Advancing Health in America | United Health Foundation | DCHA District of Columbia Hospital Association

February 10, 2003

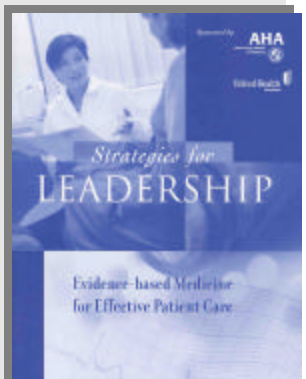
Dear Colleague:

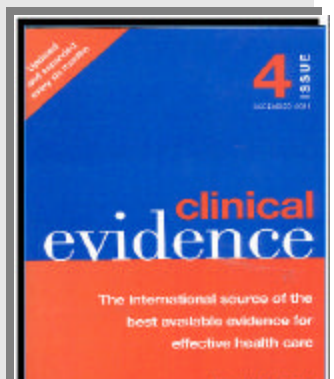
Our nation's hospitals deliver outstanding health care, but we all recognize that there's room for improvement. That's why over the past several years, the AHA and the District of Columbia Hospital Association have provided you with tools and resources that help you and your team improve the quality of care and patient safety in your hospital. Recently you received the *Strategies for Leadership Toolkit for Improving Patient Safety*. This toolkit featured a video, CD-ROM and workbooks to help you identify those aspects of care that may be at high-risk for causing patient harm.

We are all aware that medical care must be grounded in the most current scientific and clinically based evidence if we are to achieve our quality of care and patient safety goals. Indeed, the recent Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, states that the practice of evidence-based medicine is necessary to get the best care results. Consistent translation of the best science into practice, balanced by the expertise of the practitioner and the patient's values, will overcome the problems of misuse, overuse, and underuse of medical interventions that result in poor outcomes and may actually cause harm to a patient.

To provide further assistance to you in creating a hospital environment that supports clinicians in accessing and translating the best science into practice, the AHA, the District of Columbia Hospital Association, and UnitedHealth Foundation have partnered to bring you a new toolkit, *Strategies for Leadership: Evidence-based Medicine for Effective Patient Care*. In it you will find tools that you and your medical staff can use to increase the practice of evidence-based medicine in your hospital. This toolkit contains:

- A full text copy of the BMJ Publishing Group's *Clinical Evidence* Issue 8 – an international resource that is updated every six months after careful review of the most current clinical evidence by international experts from a variety of medical disciplines. UnitedHealth Foundation distributes *Clinical Evidence* twice a year to 500,000 physicians and medical professionals in the United States.
- A CD-ROM version of *Clinical Evidence* Issue 8.
- A set of instructions on how to access the Web-based version of *Clinical Evidence* where new and updated information is posted monthly. Hospitals can access *Clinical Evidence Online* for six months free as recipients of this toolkit.
- A compilation of papers, including a commentary from the National Patient Safety Foundation (www.npsf.org), that provide you with information as to how to use these tools within your hospital and how evidence-based medicine can be used in the development of clinical information systems.



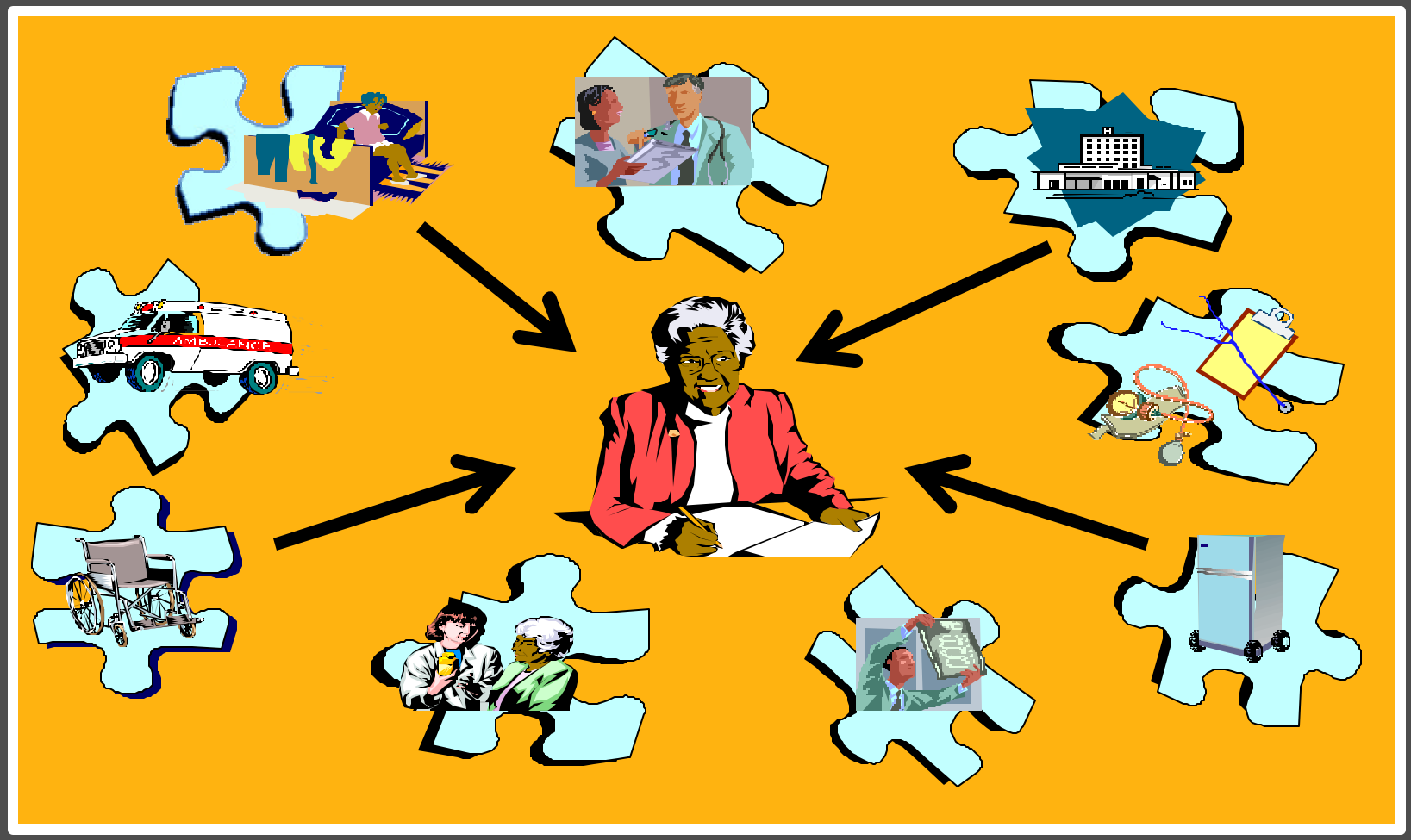


Dx and Rx Observations From the Institute of Medicine's "Crossing the Quality Chasm" Report

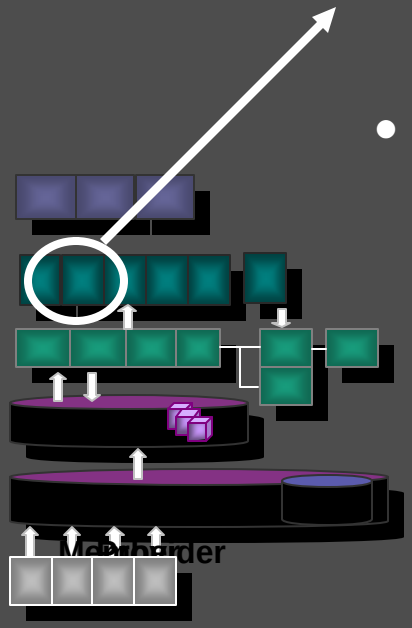
- Gaps exist between the care people should receive and the care they do receive
- Physicians, hospitals, and health care organizations operate as silos, providing care without the benefit of complete information
- The system falls short in translating knowledge into practice and care depends upon the clinical decision-making capacity of autonomous individual practitioners for problems often beyond unaided human cognition
- The system falls short in applying technology safely in a manner that decreases waste
- Care should be centered on patient's choices, needs and values
- Continuous healing relationships are needed that provide care beyond face-face visits

Aging of the Population and Increased Chronic Disease

Chronically ill people require coordinated health and supportive services

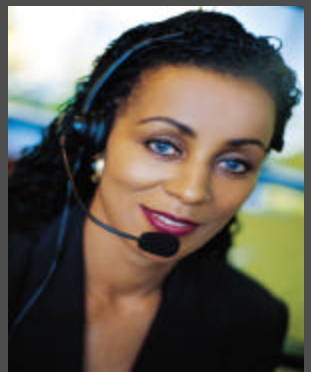


Using Data to Create Models that "Predict" At Risk Patients



- Identifies the presence or absence of interventions recommended by EBM
- Screens an individual's history and risk profile to determine probability for increased resource consumption based upon the following types of information:
  - Accelerated use of health care services
  - Co-morbidities
  - Drug use
  - Patient demographics (i.e., age and gender)

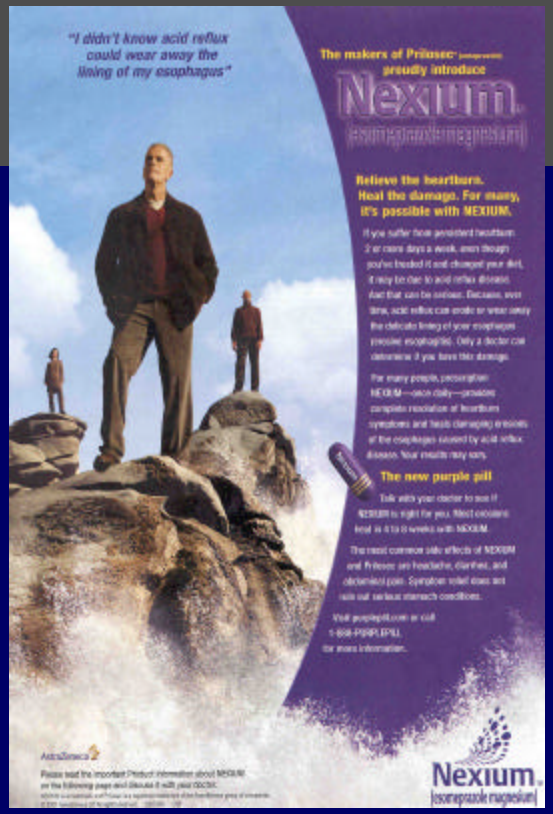
DATA + COUNSELORS

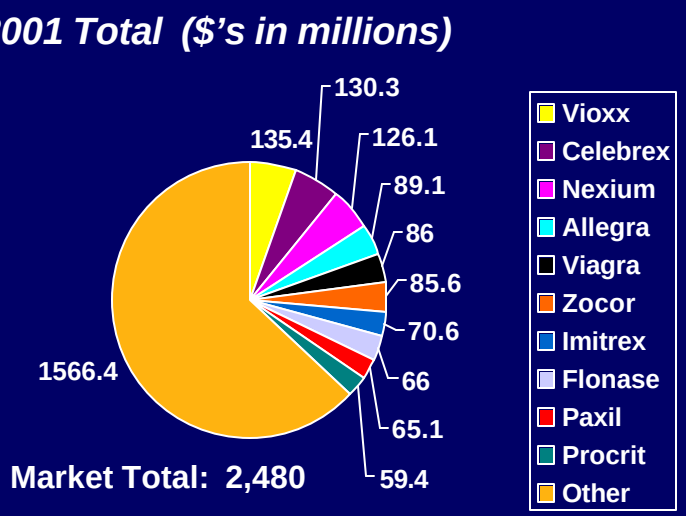


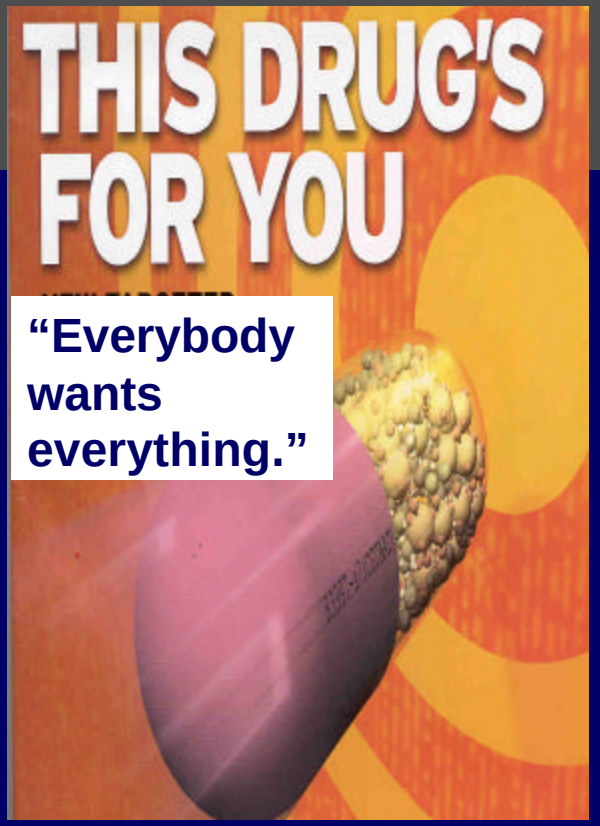
COORDINATED CARE

It is Essential to Provide Reliable Information for Patient/Consumer Decision Making

Increasing expectation of the American people for access to medical care interventions and for the outcomes of care







Using Internet Sites to Put Information and Control in the Patient's/Consumer's Hands

myuhc.com

Personalized for: JANE DEVINE
Last visited: May 28,2003
at 11:00 AM EDT

UnitedHealthcare®

Home | My Account | Personalize | Site Tour | Log Out

Customer Service
View Eligibility
View Claims
Find Physician/Hospital
Change Address

Pharmacy Online
Order Prescriptions
Order Status
Pharmacy Benefits
OTC/Other Products
Drug Pricing/Coverage
Find a Pharmacy

Health Services
Treatment Cost Info

Health Information
Healthwise
BestTreatments
Self-Care Tools
Live Events/Community
Health News & Articles
Hospital Comparisons
Patient Safety
Live Nurse Chat
Guidelines for Care

Forms
Medical Claim Form

Other Site Services
Contact Us
Give Feedback
UnitedHealthcare.com
UnitedHealthFoundation.com

View Eligibility

Review a Claim

Visit the Pharmacy Online

Find a Physician or Hospital

- **2 million registered households**
- **4.5 million members**
- **Transaction run rate of 30 million per year**

F Y I

- Wonder about the status of a recent claim? Check the Customer Service area in the left navigation bar.
- Have you heard the latest about online Coordination of Benefits?

What's New

- Announcing expanded access to online benefits information! Check the Customer Service area in the left navigation bar.
- Learn about Explanation of Benefits summaries.

Next Live Event

June 4: Sleep disorders at 11:30 a.m. Central time
Go to bed, sleephead! Not that easy? Then join us on June 4 to learn about common sleep disorders and how to get a good night's rest.

Health Highlights *updated daily*

- Report on young teens and sex reveals startling stats
- Battle against tobacco goes global

Health Research

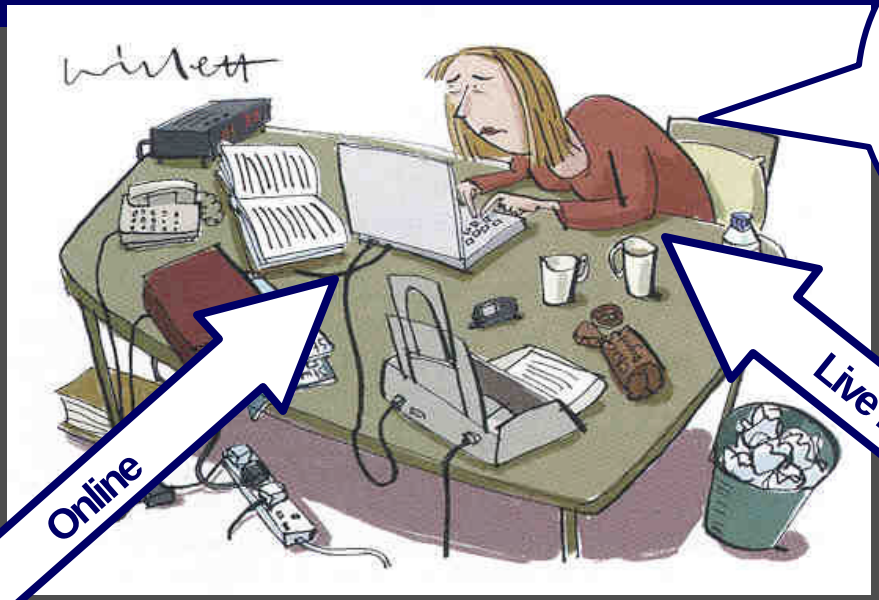
healthwise®

Use Healthwise to research:
- health topics
- medical tests
- medications
- support groups

BestTreatments

Let BestTreatments show how you can use medical research in your health decisions.
- back pain
- breast cancer
- heart attack
- high blood pressure
- osteoarthritis

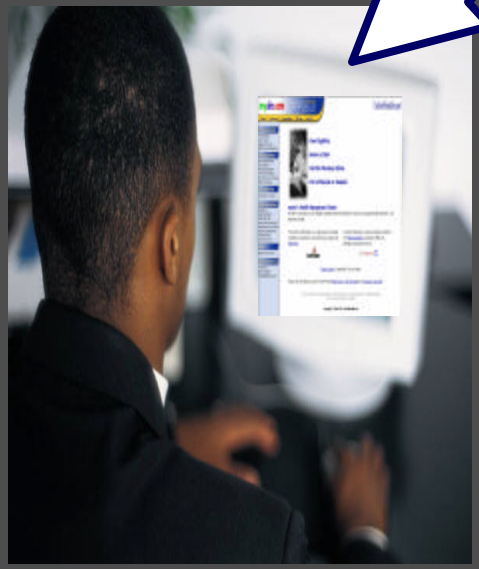
“Coaching Support” for Consumer Decision Making



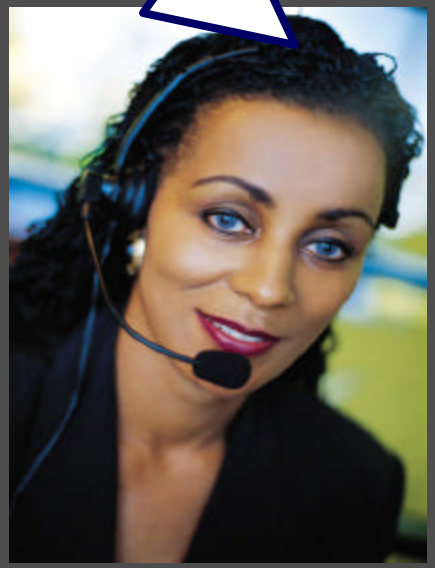
I still have questions, can someone help me to make the right decisions for ME?

Online

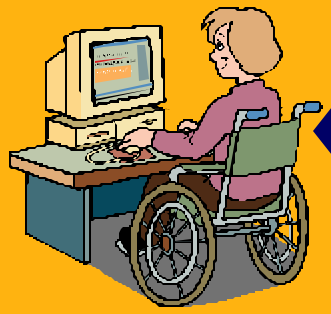
Live Nurse Chat



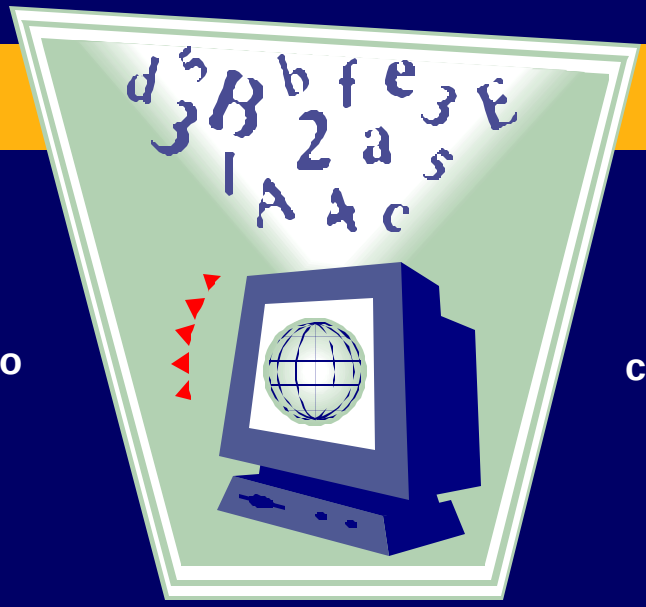
Building a relationship over time and several calls



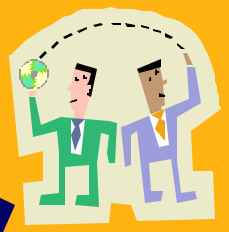
SUMMARY: Access to the Right Information by the Right People at the Right Time

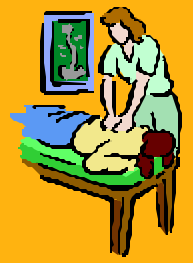


Sharing of knowledge and information to patients for decision-making

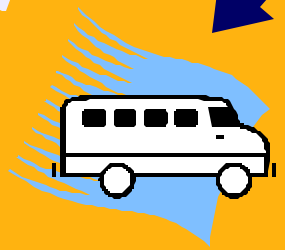


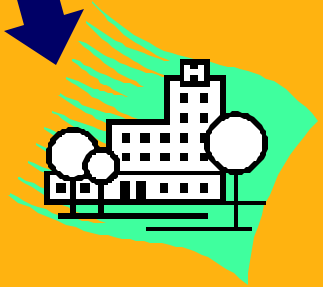
Seamless care coordination across clinical settings



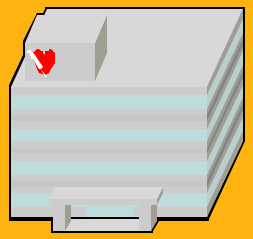


Connecting patients across hospital, nursing home, physician office, and community social support settings





Supporting safe care delivery



Assisting clinicians in evidenced-based clinical decision making