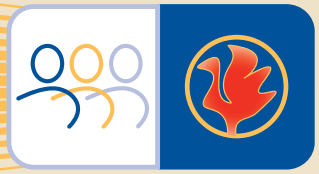
A VISION TO TRANSFORM U.S. HEALTH CARE.

The programs to make it a reality.



HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE®

HCI^3

IMPROVING HEALTH CARE QUALITY AND VALUE

with evidence-based incentive programs and a fair and powerful model for payment reform.

We have a vision for the US health care system. And every day it comes a little closer to reality. In our vision:

- Doctors know which treatment patterns provide the best outcomes, especially for the chronic conditions most harmful to our nation's health and finances. The guidelines are easy to follow and based on years of empirical study.
- Hospitals manage and treat patients with greater effectiveness and far fewer mistakes. The rate of unnecessary readmissions is vastly reduced, and patients view hospitals as beacons of excellence.
- Doctors and hospitals are rewarded for the quality of care they provide, not the number of tests or procedures they perform. They have incentives to collaborate closely, and information to improve patient health without over-treatment or under-treatment.
- The massive inefficiencies in today's system are eliminated. Money is re-directed in ways that make proven medical and financial sense, and top performers earn the most.

In this vision, our innovative and dynamic society finally has a health care system to match. Here is how we at Health Care Incentives Improvement Institute (HCI^3) are working to achieve it.

HCI³ is a non-profit organization, guided by a Board of Directors that includes physicians, employers, health plans, and others.

To provide a path to real health care reform, we have been leading a revolution from within, creating a broad range of programs to:

- Measure outcomes
- Reduce care defects
- Promote a team approach to caring for patients
- Realign payment incentives around quality, and
- Reward excellence wherever we find it.

We do this by implementing our programs in communities across the country, working collaboratively with physicians, hospitals, employers, health plans and others.

- **Bridges to Excellence® (BTE):** A family of programs to reward Recognized physicians, nurse practitioners and physician assistants who meet certain performance measures.

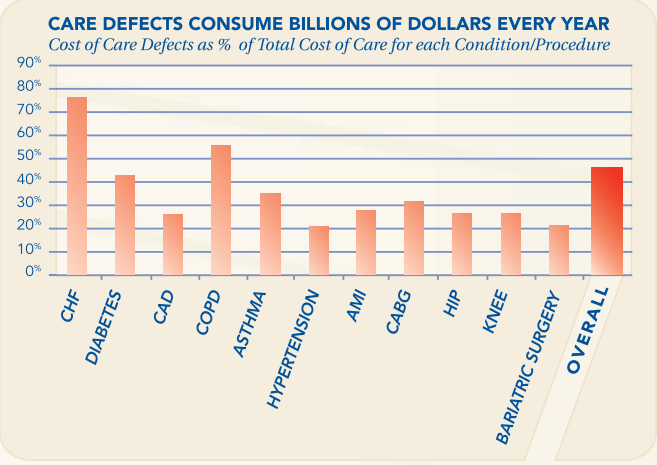
- **PROMETHEUS Payment®:** A compensation approach, based on medical episodes of care, that provides a fair and realistic blueprint for true payment reform.

Everyone knows the US spends too much on health care and gets too little in return. Our programs offer concrete solutions.

For chronic conditions like congestive heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease, asthma and hypertension, we have found that 40 cents of every dollar are spent on potentially avoidable complications, or PACs. Maybe the doctor didn't perform the right tests at the right time. Maybe the patient was hospitalized unnecessarily—and caught an infection that made things worse. According to our research, eliminating these kinds of inefficiencies would save at least $500 billion.

- **Bridges to Excellence:** Our programs measure the quality of care delivered in physician practices. We place a special emphasis on managing patients with chronic conditions, who are most at risk of incurring PACs.

- **PROMETHEUS Payment:** Our model offers direct incentives for providers to reduce PACs, work in teams, share information, and take collective responsibility for delivering better treatment value and outcomes.



All HCI³ programs are designed around three key lessons gained from our research and experience.

First, it's critical to measure what matters most—the handful of indicators that have truly significant clinical and financial impact.

These are the quality measures most predictive of improved patient health—the things every physician should do every time. These measures also form a set of indicators that can help the practice identify patients who are not well controlled and need more proactive management.

Second, doctors who follow those quality measures will consistently provide better care at lower costs.

Typically, they outperform their peers on process measures of quality, and have lower average costs per patient and per episode. In part, this is because they tend to rely more on evaluation and management and less on tests and procedures; they know that costlier care is not always better care. Most importantly, their patients are better managed and incur fewer potentially avoidable hospitalizations and emergency department visits.

Third, incentives only work if they are fair and designed to increase over time, so doctors who continually improve their practices are rewarded in kind.

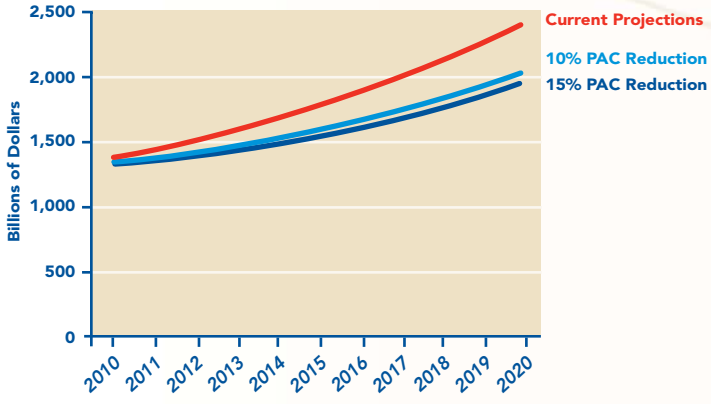
The better they get, the more incentives they deserve—and the more patients should be encouraged to utilize them. Quality is a constant process, and the incentives must reflect that. And as in any industry, the best performers should earn the most and have the biggest market share.

BENDING THE COST CURVE:
Why reducing PACs is crucial.

This chart shows the projected increase in health care costs for the private sector over the next decade.

At the current rate, $1 trillion will be added on to the backs of employers and employees, a recipe for financial disaster. HCI³ programs attack this problem head on. If we can help reduce PACs by 10% or 15% per year, the growth curve becomes much more manageable.

Projected private sector national health expenditures under current assumptions; data are from the Department of Health and Human Services 2009 and our own analysis. Published in the New England Journal of Medicine, Sept 2009.



Bridges to Excellence: Programs to assess and reward superior physician performance.

Our Recognitions cover all major chronic conditions, plus preventive care, office systems—and a real Medical Home measurement scheme to promote comprehensive care delivery and strong relationships between patients and their care teams. They include:

ASTHMA Care Recognition™	CONGESTIVE HEART FAILURE Care Recognition™	DIABETES Care Recognition™	PHYSICIAN OFFICE Systems Recognition™
CARDIAC Care Recognition™	CORONARY ARTERY DISEASE Care Recognition™	HYPERTENSION Care Recognition™	PRIMARY CARE PHYSICIAN Recognition™
COPD Care Recognition™	DEPRESSION Care Management Recognition™	MEDICAL HOME Recognition™	SPINE Care Recognition™

Physicians, nurse practitioners and physician assistants who meet our performance benchmarks can earn a range of incentives, often including substantial cash payouts. Insurers and employers fund these payouts from the savings they achieve through lower health care costs and increased employee productivity. Put very simply, we take money that's being spent poorly, and redirect it in ways that help the best doctors build their practices, help patients get healthier, and help insurers and employers manage costs better.

The chart below shows how physicians recognized by our Physician Office Link and Diabetes Care Link programs reduced cost per episode.

Differences in Numbers of Episodes and Costs per Episode for Primary Care Physicians and Endocrinologists Recognized by Bridges to Excellence vs. Others

SPECIALTY	POL RECOGNIZED	POL COMPARISON GROUP	DIFFERENCE BETWEEN RECOGNIZED AND COMPARISON PHYSICIANS	DCL RECOGNIZED	DCL COMPARISON GROUP	DIFFERENCE BETWEEN RECOGNIZED AND COMPARISON PHYSICIANS
PRIMARY CARE PROVIDERS						
Avg episodes/patient	2.09	2.22	-0.13	2.61	2.44	0.17
95% C.I.	(2.08 – 2.09)	(2.22 – 2.23)	(-0.15 – -0.13)	(2.58 – 2.64)	(2.44 – 2.45)	(0.14 – 0.20)
Number of episodes	191,527	1,114,334		25,080	577,278	
Avg standardized resource use/episode	$570	$700	-$130	$623	$649	-$26
95% C.I.	($561 – $579)	($697 – $703)	(-$140 – -$119)	($602 – $643)	($645 – $653)	(-$47 – -$5)
ENDOCRINOLOGISTS						
Avg episodes/patient				1.66	1.58	0.08
95% C.I.				(1.62 – 1.70)	(1.55 – 1.61)	(0.03 – 0.13)
Number of episodes				2,980	4,037	
Avg standardized resource use/episode				$2,671	$2,534	$137
95% C.I.				($2,556 – $2,786)	($2,404 – $2,664)	(-$45 – $320)

SOURCE: *AUTHORS' ANALYSIS OF MASSACHUSETTS GROUP INSURANCE COMMISSION DATA.*

CONFIDENCE INTERVALS BASED ON GENERALIZED LINEAR MODELS CONTROLLING FOR PHYSICIAN SPECIALTY AND PATIENT CHARACTERISTICS (MEAN PATIENT AGE, PERCENT FEMALE, CASEMIX). *Note: a "confidence interval" is a calculation that shows the range within which the true impact is likely to fall.*

POL= *PHYSICIAN OFFICE LINK* ***DCL=*** *DIABETES CARE LINK*

PROMETHEUS Payment: A rational, sustainable pathway to fundamental change.

In developing our BTE Recognitions and the financial incentives tied to them, we gained important insights on how to best reform the industry's toxic payment system. So we developed PROMETHEUS Payment, a new compensation approach designed to reward excellence and control costs.

PROMETHEUS uses Evidence-informed Case Rates™ (ECRs) to price medical episodes of care for chronic conditions, hospitalizations and other procedures. Put more simply, it removes the current financial incentives that reward the health care system when patients fall into the quality chasm. Instead, the model increases provider margins as they work to close that chasm, and encourages them to collaborate effectively for a patient's overall health.

List of Evidence-informed Case Rates™

CAD	HIP REPLACEMENT	PNEUMONIA
CHF	KNEE REPLACEMENT	PREGNANCY & DELIVERY
HTN	BARIATRIC SURGERY	ANGIOPLASTY (PCI)
DIABETES	COLON RESECTION	AMI
COPD	CABG	STROKE
ASTHMA	KNEE ARTHROSCOPY	CHOLECYSTECTOMY
GERD	COLONOSCOPY	HYSTERECTOMY

By bringing economic incentives in line with the medical profession's strong desire to improve patient health, PROMETHEUS creates an environment where doing the right things for patients helps providers and insurers do well financially. And it does this without introducing new administrative burdens, or changing the way patients access care.

We believe PROMETHEUS will pay providers fairly, improve quality for patients, reduce some of the current administrative burdens, and generate transparent information to spur continuous improvements. As a result, it offers a realistic framework to transform today's fragmented and inefficient system into one that is far more integrated and accountable.

Implement our programs as designed—or let us design one for you.

To employers and health plans interested in our programs, we offer a great deal of flexibility. You can simply implement each program "off the shelf." Or we can take the basic elements—quality of care measurement (BTE Recognitions) and cost of care measurement (PROMETHEUS ECRs)—and create a customized solution, based on your population, geography, and other criteria. With this kind of "private label" arrangement, we stay behind the scenes, so you can brand and promote your program in the way that's best for your organization.

We work in the real world, balancing the needs of all stakeholders, finding common ground, and cultivating that ground for all it's worth.

Our work is about finding common areas of excellence in the current health care system. We then "build bridges" that allow participants to take maximum advantage. The bridges built so far will not span the divide between what is and what should be. Not even close. But the blueprints are drawn, the supports are in place, and we've begun to form the structure. We believe that, over time, the results can be transformative for our nation and its citizens. Join us. For every problem, there's a solution, and chances are we have one for you.

HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE®

Fair, Evidence-based Solutions. Real and Lasting Change.

Contact us at info@HCI3.org or visit www.HCI3.org, www.BridgesToExcellence.org, or www.PrometheusPayment.org.

OUR PROGRAMS ARE BACKED BY YEARS OF INTENSIVE RESEARCH.

Here is a partial list of papers we've published on Bridges to Excellence and PROMETHEUS Payment.

"Building a Bridge from Fragmentation to Accountability—The PROMETHEUS Payment Model"
New England Journal of Medicine, September 2009

"Prometheus Payment Model: Application to Hip and Knee Replacement Surgery"
Clinical Orthopedics and Related Research, September 2009

"Should Health Care Come With a Warranty?"
Health Affairs, June 2009

"Physicians Respond to Pay-for-Performance Incentives: Larger Incentives Yield Greater Participation"
American Journal of Managed Care, May 2009

"Home builders. Incentives, Time Needed to Make the Shift to Medical Homes"
Modern Healthcare, November 2008

"Motivating Public Use of Physician-level Performance Data: An Experiment on the Effects of Message and Mode."
Medical Care Research and Review, February 2009

"Bridges to Excellence—Recognizing High-quality Care: Analysis of Physician Quality and Resource Use"
American Journal of Managed Care, October 2008

"Evidence-informed Case Rates: Paying for Safer, More Reliable Care"
Commonwealth Fund, June 2008

"The Value of Ambulatory Care Measures: a Review of Clinical and Financial Impact from an Employer/Payer Perspective"
American Journal of Managed Care, June 2008

"The Potential of Health Information Exchanges as Infomediaries"
Journal of Healthcare Information Management, winter 2007

"The Right Incentives for High-quality, Affordable Care: A New Form of Regulated Competition"
International Journal for Quality in Health Care, June 2006

"Clinical Practice Guidelines for Older Patients with Comorbid Diseases"
Journal of the American Medical Association, January 2006

"Transparency is a Prerequisite of Pay for Performance"
The American Heart Hospital Journal, Summer 2004

"A Middle Ground on Public Accountability"
New England Journal of Medicine, June 2004

"Private Sector Slow to Act"
Health Affairs, March-April 2004

"The Quality of Health Care: an Employer's Perspective"
Managed Care, October 2003

"Bridges to Excellence: A Program to Start Closing the Quality Chasm in Healthcare"
Journal for Healthcare Quality, March-April 2003

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