



QUALITY ALLIANCE
INSIGHTS & ACHIEVEMENTS
2023

CONTENTS

- 3 Letter From Our Board Chair
- 5 Our Mission
- 5 Program Description
- 5 Program Governance
- 6 Board Members
- 6 Finance Committee
- 7 Quality Committee
- 8 Membership
- 9 New Practices Joining the Quality Alliance
- 10 Geographic Distribution of Physicians
- 11 Professional Team
- 12 Physician Engagement Team
- 12 Data Team
- 13 Care Coordination Team
- 14 Care Coordination
- 15 2023 Highlights
- 16 Provider Engagement
- 17 Population Health
- 18 Cleveland Clinic Medicare Accountable
Care Organization
- 23 Ongoing Initiatives



LETTER FROM OUR BOARD CHAIR

With the COVID-19 pandemic in the rearview mirror, 2023 was a year of new beginnings, taking a deep breath, and finally having a moment to pause for reflection. The pandemic taught us both the strengths of our healthcare system (resiliency, courage, innovation, research, communication) and the dangers (burnout, fatigue, supply shortages, revenue losses). Telemedicine is here to stay, the need for changes in care delivery is pressing, and the demand for payment innovation and value-based models is dire.

To survive, our clinically integrated network needs to re-establish data collection and reporting; to revise, improve and expand our contracting; and to move toward downside risk. With solid data soon to resume, our ability to take on some downside risk — carefully mitigated and limited for our independent practices — will be crucial to increasing our potential upside gains.

On the data front, our data blackout as we transitioned from Explorys to Arcadia lasted longer than expected because of the complexity of implementation. This included more than 300 data feeds and connections from laboratories, payers, CMS, our employed and independent practices from our electronic medical records (EMRs), billing feeds and outside sources. In the absence

of data, you all have done an admirable job of providing and improving upon delivering high-quality, cost-efficient care to our patients. Data reporting will resume shortly, allowing us to show you once again where you are doing well, where you may be able to improve, and where you can help the network achieve shared savings and quality payments for the work you provide.

On the contracting side, with data available again we anticipate gains in our existing contract outputs. More importantly, we expect that additional contracts will carry significant possibilities for benefit to our network with the addition of modest downside risk. Legal and compliance teams are working with QA management and Cleveland Clinic's Market and Network Services Division to bring valuable new contracting models to the QA that enhance our ability to generate revenue. We will ensure that our independent practices are rewarded for all the high value care provided outside of traditional evaluation and management (E&M) coded visits and procedural payments. Population healthcare delivery (filling gaps in care, reviewing charts, contacting patients) should not have to occur only after hours and without reimbursement.

The year 2023 was a time of expansion for the Quality Alliance, with the acquisition of Union Hospital and the addition of its employed and

See next page

Continued from previous page

allied independent physicians. We added 256 independent providers (MDs, DOs, PAs and NPs) and expect continued growth this year. Our number of network providers now exceeds 9,600.

Our accountable care organization (ACO) had significant shared savings in 2022. Although 2023 results are not final, there is a strong possibility of shared savings for a second consecutive year.

As always, I would like to remind everyone that the Quality Alliance is more than just a business model or a contracting entity. It is a collection of high-quality, like-minded

providers in Northeast Ohio whose main purpose is to provide the highest quality care using a value-based population health strategy. We share best practices, support each other, share care coordination and navigation when needed, and stay engaged as a community.

Please contact us for support, questions or concerns, or just to let us know what's on your minds. This year is going to be a great, and I look forward to working with everyone!

Sincerely,

A handwritten signature in black ink that reads "Bruce I. Rogen MD MPH". The signature is fluid and cursive.

Bruce I. Rogen, MD, MPH



OUR MISSION

To transform the delivery of healthcare into a collaborative system where resources are used in a fiscally and socially responsible manner while improving the quality of care and patient experience.

PROGRAM DESCRIPTION

The Quality Alliance is an integrated network comprising independent provider practices and employed Cleveland Clinic providers. We are uniquely positioned to transform patient care by collaborating on assessment, training and education. Our focus is on improving healthcare quality, the provider and patient experience, and patient outcomes while managing costs.

PROGRAM GOVERNANCE

The Quality Alliance is a physician-led organization composed of a board of trustees and various committees responsible for overseeing the program, monitoring member compliance, setting policy and guiding strategic development.



BOARD MEMBERS

Matthew Andresen, MD

Broadview Heights Family Medicine

Fadi Bashour, MD

Digestive Disease Consultants of Medina

John Bertsch, MD

Cleveland Clinic

Georgeanne Botek, DPM

Cleveland Clinic

Kenneth Braman, DO

Cleveland Clinic

Preti Chaturvedi, MD

Kidney Health Group

Keith Fuller, MD

Cleveland Clinic

Jessica Hohman, MD

Cleveland Clinic

Leslie Jurecko, MD

Cleveland Clinic

Ahmad Kilani, MD

Cleveland Clinic

Michael Lew, MD

Orthopaedic Associates, Inc.

Michelle Medina, MD

Cleveland Clinic

Amy O'Linn, DO

Cleveland Clinic

Christopher Reese, MD

Urology Partners, LLC

Bruce Rogen, MD

Cleveland Clinic

Bindu Sehgal, MD

Premier Physicians Centers, Inc.

Ranjit Tamaskar, MD

Atrium Medical Group, Inc.

FINANCE COMMITTEE

Matthew Andresen, MD

Broadview Heights Family Medicine

John Bertsch, MD

Cleveland Clinic

Preti Chaturvedi, MD

Kidney Health Group

Erick Kauffman, MD

Neighborhood Family Practice

Ahmad Kilani, MD

Cleveland Clinic

George Khuri, MD

Lakepoint Medical Group

Vijay Mistry, MD

Vijay G. Mistry, MD, Inc.

Shelly Senders, MD

Senders Pediatrics

Bruce Rogen, MD

Cleveland Clinic

Eric Trattner, DPM

Eric D. Trattner DPM, Inc.

QUALITY COMMITTEE

Ken Braman, DO

Akron General Partners Physician Group

Susan Clark-Frantz, MD

Generations Women's Healthcare

Melanie Golembiewski, MD

Neighborhood Family Practice

Jessica Hohman, MD

Cleveland Clinic

Robert Jones, MD

Cleveland Clinic

Michael Kalus, MD

Michael Kalus, MD

Ahmad Kilani, MD

Cleveland Clinic

Matthew Miller, DO

Cleveland Clinic

Eliot Mostow, MD

Akron Dermatology

Karen Murray, MD

Cleveland Clinic

Amy O'Linn, MD

Cleveland Clinic

Ted Peterson, DPM

Ted S. Peterson, DPM, Inc.

Bruce Rogen, MD

Cleveland Clinic

Steven Shook, MD

Cleveland Clinic

Ranjit Tamaskar, MD

Atrium Medical Group, Inc.

Terry Wagner, MD

Hudson Family Practice



MEMBERSHIP

Quality Alliance physicians and allied health professionals are employed by, independent of, or affiliated with Cleveland Clinic.

QUALITY ALLIANCE MEMBERS	2022	2023	% Change
Cleveland Clinic Medical Group (Quality Alliance Employed, QAE)	6,444	6,810	8.2%
Quality Alliance Independent (QAI)*	2,071	2,390	19.7%
Both**	170	207	18.3%
TOTAL MEMBERSHIP	8,013	8,876	10.8%
*Includes Ashtabula County Medical Center, Akron Partners Physician Group, Community, Mercy and Union. **Providers employed by both Cleveland Clinic and a Quality Alliance Independent practice.			

MEMBERSHIP	2018	2019	2020	2021	2022	2023
Community	1,023	1,043	1,062	1,145	1,404	1,613
Akron PPG	439	481	513	503	564	679
Ashtabula County MC	76	78	72	71	80	72
Union	38	45	65	68	68	73
Mercy				116	125	160
Community % Increase	7.0%	2.0%	1.8%	7.8%	22.6%	14.9%

NEW PRACTICES JOINING THE QUALITY ALLIANCE

Comprehensive Minds, LLC

Diabetes and Endocrinology Associates of Stark County, Inc.

Miami Valley Plastic Surgeons

OrthoUnited, Inc.

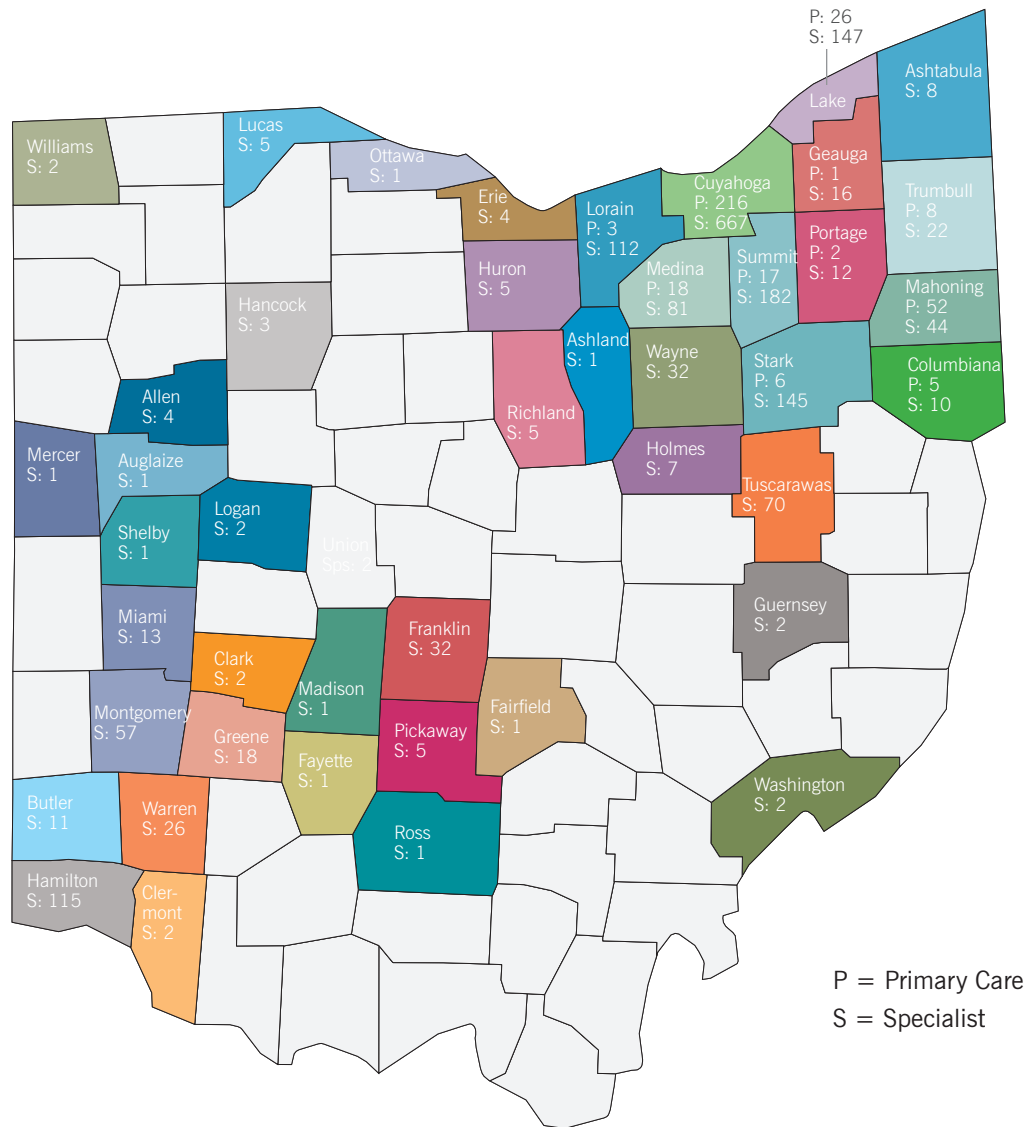
Phoenix Dermatology

Premier Renal Care Associates, LLC

Stark Primary Care, LLC



GEOGRAPHIC DISTRIBUTION OF PHYSICIANS



Counties

Allen	Fayette	Lorain	Richland
Ashland	Franklin	Lucas	Ross
Ashtabula	Geauga	Madison	Shelby
Auglaize	Greene	Mahoning	Stark
Butler	Guernsey	Medina	Summit
Clark	Hamilton	Mercer	Trumbull
Clermont	Hancock	Miami	Tuscarawas
Columbiana	Holmes	Montgomery	Warren
Cuyahoga	Huron	Ottawa	Washington
Erie	Lake	Pickaway	Wayne
Fairfield	Logan	Portage	Williams

PROFESSIONAL TEAM

The Quality Alliance team is composed of clinical and non-clinical professionals with a broad range of backgrounds and experience.

LEADERSHIP



Bruce I. Rogen, MD, MPH

Board Chair, Cleveland
Clinic Quality Alliance



Ahmad Kilani, MD, MBA, MLS, MSIT, CHCQM-PHYADV, FACP, FACHE

Regional Medical Director;
Chair, Quality Committee,
Cleveland Clinic Quality
Alliance



Thomas Atkinson, MBA, MHA

Senior Director, Cleveland
Clinic Quality Alliance

TEAM



Jeanne Ineman, MBA

Administrator



Patricia Radatz, MBA, CHRC, CPC

Regulatory & Privacy
Director



Benjamin Boroway, MSN, MBA, RN, CCM

Manager, Care
Coordination



Stephanie Brashear, BS, RHIA, MBA

Provider Engagement
Manager

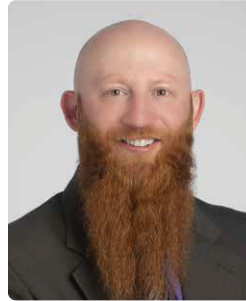
PHYSICIAN ENGAGEMENT TEAM



Melissa Brazis
Practice Facilitator



Kathleen Dickson
Practice Facilitator



Eric Zehner
Practice Facilitator



Chris Stevens
Practice Facilitator

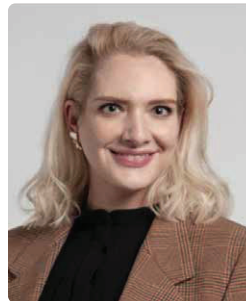
DATA TEAM AND ADMINISTRATION



Garrett Baddorf
Systems Analyst



Belinda Watson
Data Scientist II



C. Elizabeth Burley,
MSN, MBA, RN,
CPHQ, NE-BC
Program Manager



Erin Steidel, MBA
Program Manager



Debi Schlegelmilch
Executive Assistant



Jami Balazs
Executive Assistant

CARE COORDINATION TEAM



Tammy Chesser,
BSN, RN
Care Coordinator



Colleen Cummins,
MSN, BBA, RN, CEN
Care Coordinator



Candice Short,
BSN, RN
Care Coordinator



Jill Bunnell,
BSN, RN, RN-BC, CCM
Care Coordinator



Linda Nearhood,
RN, CCM
Care Coordinator



Lonnie Weekley,
MSN, RN, CAPA
Care Coordinator



Renee Mohr,
BSN, RN
Care Coordinator



Sara Booher,
BSN, RN
Care Coordinator

CARE COORDINATION

The care coordination team consists of eight registered nurse care coordinators who provide support to the independent primary care physicians and their offices. Throughout 2023, this support was provided in four primary ways:

Transitional Care Management

As a primary approach to help reduce readmissions and improve patient outcomes, the care coordination team continued transitional care management (TCM) calls to all high-risk patients in the days following stays in the hospital or skilled nursing facility. In 2023, over 10,000 calls for TCM were made to patients. During these calls, the coordinators reviewed discharge instructions, follow-up appointments, and medication changes – all aspects that have been proven to affect patient outcomes. The team concentrated on the strategic focus of post-discharge appointment completion, which has been shown to reduce readmissions by helping patients schedule appointments, providing timely appointment reminders, and helping to set up transportation for patients when needed.

Actionable Finding Support

This work involved reviewing imaging recommendations from radiology and following up with providers and patients to ensure follow-through on incidental findings. In 2023, the care coordination team averaged more than 350 encounters per month, which included notifying providers of findings, receiving orders, and assisting patients with scheduling follow-up. More than 2,500 findings were addressed and closed throughout the year.

Primary Care Coordination

Primary care coordination continued to focus on chronic disease education for patients and their families, appropriate utilization, social determinants of health, and securing resources. In 2023, the care coordination team completed more than 14,000 primary care coordination encounters.

Patients were primarily identified from TCM and provider referral. However, the team also chart-reviewed over 900 patients to evaluate for possible care coordination. On average, the team managed a panel of about 625 patients per month.

Value-Based Contract Medication Adherence

As a measure to improve both patient outcomes and Quality Alliance metrics, the care coordination team continued medication adherence work for value-based contracts in 2023. This effort involved reviewing payer lists and reaching out to patients to ensure timely refilling of medications. Outreach was completed to local pharmacies, provider offices for refills, and patients for reminders to pick up medication and to highlight the importance of medication compliance. Over 3,300 encounters for medication adherence were documented in 2023.

The care coordination team truly puts patients first and strives for best outcomes for the Quality Alliance.

2023 HIGHLIGHTS

Quality Alliance is highly engaged and dedicated to serving the needs and interests of our member practices. 2023 highlighted our teams' ability to respond to novel challenges and demands. We continue to move toward a reliable source of quality data to support members in providing the best care possible. In the absence of that data, we have maintained our provision of core programs and services, such as patient navigation, transitional care management and care coordination.

We remain confident in the value the network brings to its members, and we are proud to report network growth in the addition of seven practices during 2023. Our growth is evident not only in numbers but also in geographic reach, as we continue to expand beyond Greater Cleveland; we are present in 44 Ohio counties.

QA remained steadfast in our financial resources and is committed to distributing the rewards earned in our value contracts in the most efficient, equitable and timely manner. In 2023, we were challenged by a lack of reliable quality data on which to base our annual incentive program. The thoughtful approach we developed was received well by our members and allowed us to maintain our normal distribution pattern of releasing funds in May.

In addition to our normal care coordination and incentive programs, we managed an ACO shared savings distribution for members who participate in that program on behalf of ACO management. We anticipate that the 2023 incentive program will be based on actual performance data instead of historical data, and that a reconciliation of 2022 program payments, if necessary, will occur on schedule.

Support of our practices through care coordination and patient navigation efforts increased quality performance in the Anthem

MA plan. In addition to performing normal activities, these teams made significant strides in helping practices identify and care for thousands of plan members with identified care gaps. These efforts are rewarding and should result in recognition by Anthem in the form of increased quality payments for the 2023 performance year (PC2023). Care coordination continued to focus on health equity issues, addressing these specific needs of patients during all care coordination and transitional care management encounters. Access to the Unite Us platform was expanded in 2023 to members of the care coordination team. This allowed for effective and streamlined processes for connecting patients with community resources.

QA continued to improve health system collaboration and coordination with the activities of our member practices in transitions of care. These efforts have resulted in strong relationships between QA leadership and the Quality and Utilization leaders at our system hospitals. Through ongoing meetings, we were able to identify and support ways our health system facilities support activities of our member practices.

Technology allowed us to enhance efficiency. A new customer relationship management platform has improved our ability to track correspondence and communications with members. We initiated a process to enable the electronic transfer of funds to our member groups. This is a more secure and streamlined process and will result in members receiving funds sooner. Lastly, we resumed in-person meetings for Quality, Finance and Board of Trustee meetings. We intend to maintain this pattern to balance the convenience of video meetings with the impact of in-person interactions.

PROVIDER ENGAGEMENT

The goal of the Provider Engagement (PE) team is to provide independent practices a dedicated partner to support their success. These partners support each community practice in initiatives involving quality improvement, evidence-based care, operational efficiency, coordination of care and more.

The team strives to build a meaningful connection between QA practices and Cleveland Clinic and provide representation of the

independent practices in Cleveland Clinic discussions.

The PE team is thankful for the patience and perseverance of our practices as we worked to make our data vendor, Arcadia, valuable for our members. We recognize our network's dedication to delivering quality patient care, and we are confident that Arcadia will support our practices in harnessing data and advancing timely quality care.



From left, Provider Engagement team members Eric Zehner, Stephanie Brashear, Kathleen Dickson, Melissa Brazis, and Chris Stevens.

POPULATION HEALTH

The Population Health Navigation Team supports practices by focusing on quality measures for Quality Alliance value-based contracts.

When practices participate in our value-based contracts and consent to outreach efforts, our team works to resolve open quality measures such as gaps in care and health maintenance items. Population Health navigators help align patients with Quality Alliance providers, unless otherwise requested, to help close care gaps in areas such as:

- › Colorectal cancer screening.
- › Breast cancer screening.
- › Diabetes eye exams.
- › HbA1C testing for patients with diabetes.
- › Kidney/nephropathy monitoring for patients with diabetes.
- › Controlling blood pressure.

In 2023, the population health navigation team:

- › Provided support for pending orders for colonoscopies, mammograms, HbA1C testing and albumin testing.
- › Called patients, sent MyChart messages and/or mailed letters reminding patients of care gaps.
- › Mailed letters for health maintenance items due.
- › Called patients and mailed letters for Fidelity (primary care provider).
- › Uploaded Epic medical records to payer portals.
- › Helped secure care gap documentation.



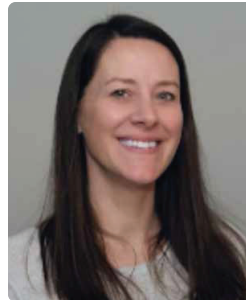
Mallory Reinking

Navigation Manager
702.218.3899
reinkim@ccf.org



Miranda Guy

Navigation Work Leader
216.986.1213
guym3@ccf.org



Kristy Owens

Navigator
216.986.1119
durrrk@ccf.org

CLEVELAND CLINIC MEDICARE ACCOUNTABLE CARE ORGANIZATION

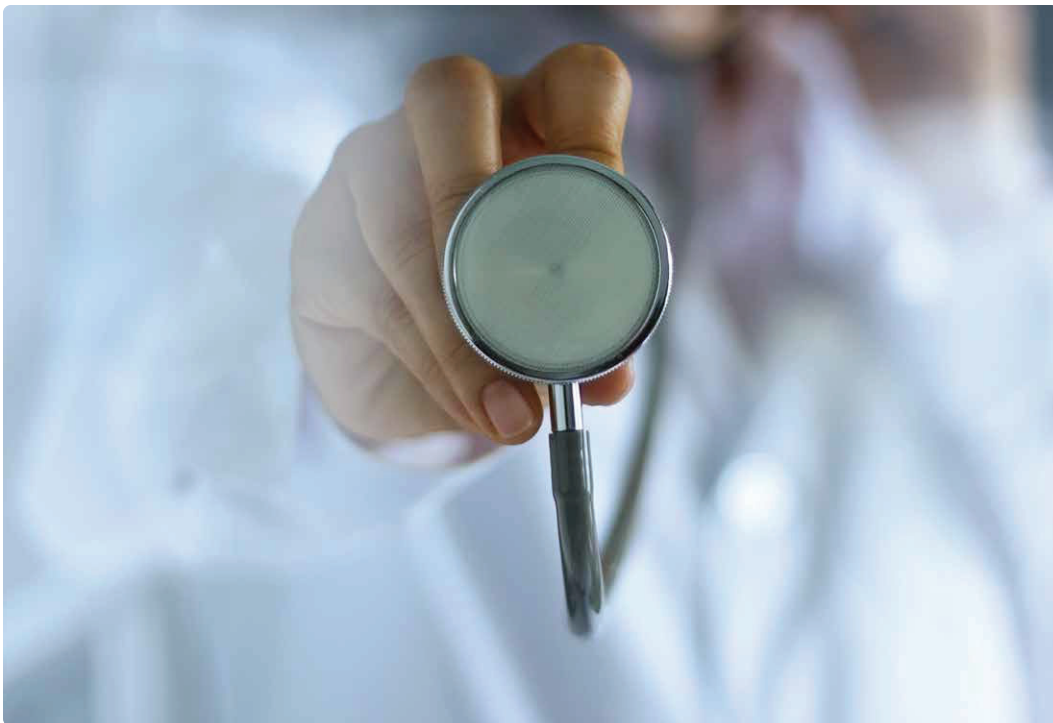
Highlights and Celebrations

The Cleveland Clinic Medicare Accountable Care Organization (CCMACO) is the organization's participating entity in the Medicare Shared Savings Program, and the ACO is a separate entity from Cleveland Clinic Quality Alliance. Program Year 2023 saw a number of exciting developments for the CCMACO. The organization's core team grew by three new pharmacists, three administrative fellows and two community health worker interns, who joined to help support our expanding portfolio of population health programs.

CCMACO was recognized in several national forums for its efforts to move more post-acute care into the home by way of new care models.

Our team shared our successful and cost-effective HomeCare Plus program, a collaboration with Cleveland Clinic Connected Care to bring into home settings care that is at the level of skilled nursing and acute rehabilitation facilities.

CCMACO also was selected to participate in the West Health Learning Action Network. Supported by a grant from West Health Institute, CCMACO and Cleveland Clinic's Geriatric Emergency Department are collaborating on more senior-centered and home-based alternatives.



CLEVELAND CLINIC MEDICARE ACCOUNTABLE CARE ORGANIZATION

2023 Performance

2023 IN REVIEW



POST-ACUTE CARE (PAC)

TARGET: 1,585
SNF DAYS/K

- Implementation of the ACO Home Health Network
- Comprehensive PAC performance management rollout
- Refinement and expansion of PAC triad
- Growth of HomeCare+
- SNF mortality model creation



CHRONIC DISEASE MANAGEMENT

- Re-launched Optimal Transitions Program (OTP) in partnership with Kidney Medicine for ACO
- Launched ACO COPD pilot at Fairview
- ACO Ecosystem outreach refinement
- Launched DaVita program for end-stage renal disease
- Care coordination pursuit lists
- Care gap closure pursuit lists



HEALTH EQUITY

- Development of strategy to support enrollment
- To support identification of Medicaid eligibility and enrollment



AVOIDABLE ACUTE UTILIZATION (AAU)

- Primary Care Provider First campaign
- Community health intern to address high ED utilization
- Geriatric ED/ACO collaboration

Workstreams were utilized to provide a platform for strategic planning, sharing of best practices, and regular data transparency to engage stakeholders in performance accountability and innovation.

CLEVELAND CLINIC MEDICARE ACCOUNTABLE CARE ORGANIZATION

2023 Performance

For 2023, institutional post-acute care utilization, chronic disease management and avoidable acute utilization remained key strategic priorities. In addition, targets for health equity were also set, specifically around improving the identification of Medicaid-eligible patients and improving their connection to services. From a health equity perspective, 2023 was largely exploratory in focus. We used and integrated data across sources to better explore and understand potential disparities in care while improving data collection efforts around the social needs of our patients and connection to appropriate resources.

A flurry of new programs helped us achieve our targets. Highlights included:

- › Launch of the West Health LAN-sponsored CCMACO-Geriatric ED collaboration to develop two admission diversion pathways for appropriate patients.
- › Development of a program of community health worker outreach and social need screening for frequent ED users within the ACO.

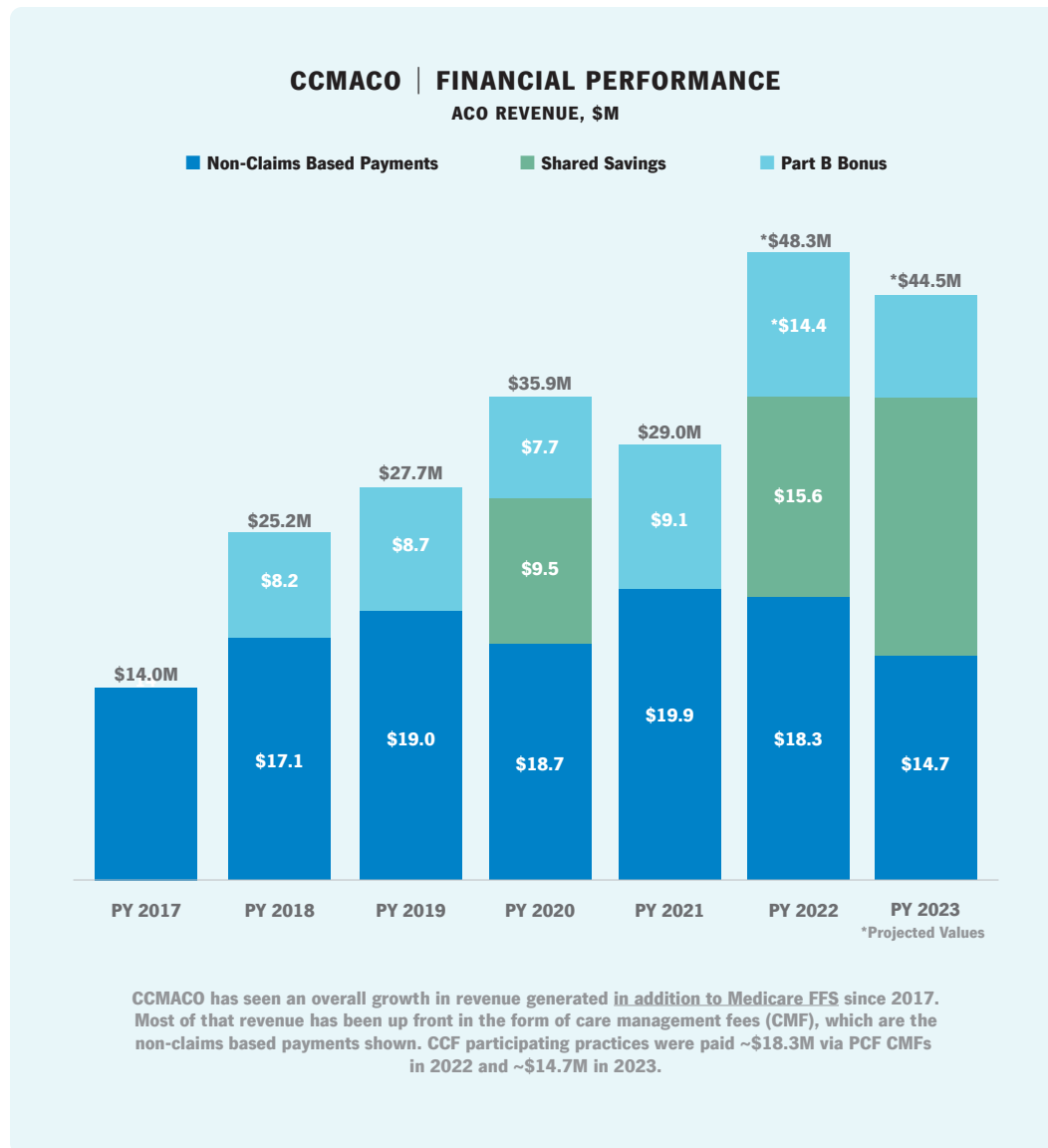
- › Start of the MVPs-HF study within CCMACO. In collaboration with Cleveland Clinic's Heart and Vascular Institute, we pursued this study, which deployed centralized outreach to heart failure patients in the ACO for pharmacist-driven titration of evidence-based therapy.
- › Expansion of the HomeCare Plus (SNF at Home) program to support increased discharge-to-home rates.
- › Entrance into a partnership with DaVita to better support patients with end stage renal disease (ESRD) in our ACO.
- › Collaboration with Pulmonary, Pharmacy, Respiratory Therapy and Connected Care to provide COPD wraparound post-discharge care.

We are thankful for the tremendous work and partnerships, internally and externally, that support this patient population.

While we will not see data on the final settlement for PY2023 until late summer, performance trends year-to-date were notable for sizeable reductions in use of institutional post-acute care settings, specifically skilled nursing facilities.

CLEVELAND CLINIC MEDICARE ACCOUNTABLE CARE ORGANIZATION

Below is a snapshot of our organization's year-to-date performance relative to PY2022:



CLEVELAND CLINIC MEDICARE ACCOUNTABLE CARE ORGANIZATION

[Final 2022 Medicare Shared Savings Program Results](#)

The final PY2022 MSSP Accountable Care Organization performance results were released in August 2023. The Cleveland Clinic Medicare Accountable Care Organization (CCMACO) achieved \$15.575M in shared savings. The organization's performance rose to around the 70th percentile nationally.

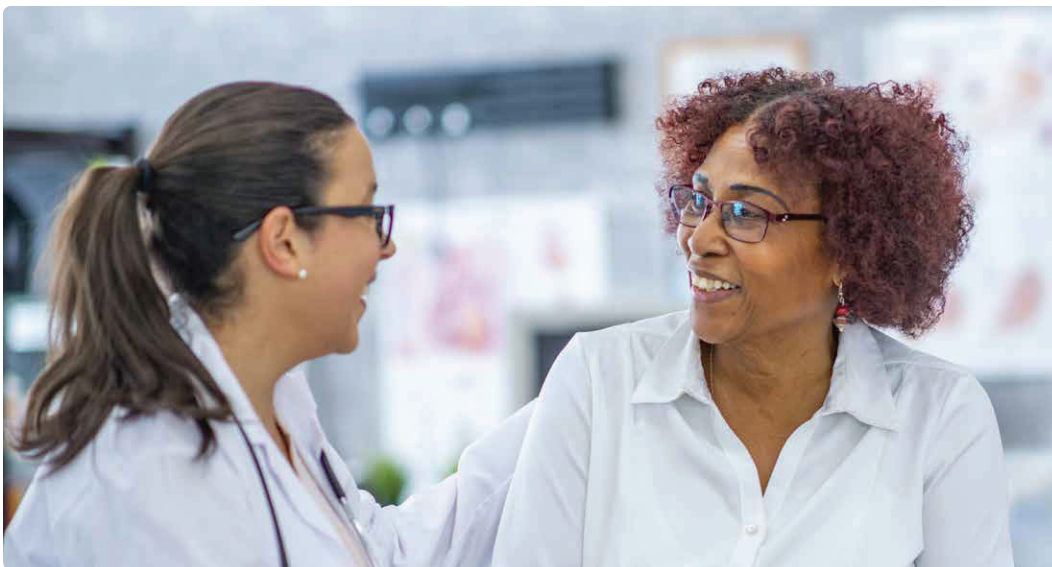
CCMACO outperformed its benchmark by over \$21M during PY2022, even after accounting for the roughly \$18.3M in care management fees received upfront for concurrent Primary Care First participation last year (these fees were later counted as ACO expenditures). For context, CCMACO has produced significant savings for Medicare in each of the last two years (\$20M in PY2020 and \$5.3M in PY2021).

Overall, CCF's PY2022 participation in the Medicare ACO program is anticipated to yield ~\$26.4M in revenue in addition to the traditional Medicare fee-for-service dollars generated from patient care, specifically

\$15.575M in gainshare and another projected \$14.4M in Advanced Payment Model Part B bonus that is projected to be received in 2024.

After entering into a more advanced two-sided risk model (MSSP Enhanced) in PY2022, CCMACO now receives 75% of the savings produced once the quality threshold is met. This reflects an increase from the previous 50% shared savings rate and a departure from the use of the quality score as a multiplier to determine the final savings rate during our last agreement period.

CCMACO's success in PY2022 was largely driven by significant reductions in inpatient admission rates, improved chronic disease management, and reduction in institutional post-acute care utilization. CCMACO also saw an improvement across several of its key quality measures, notably improved rates of diabetes control, breast cancer and depression screening, and readmission rates.



ONGOING INITIATIVES

Quality Alliance has been working closely with our Market and Network Services colleagues on the adoption of new contracts that offer the potential for greater quality-based rewards. These contracts will carry the potential for downside risk, and the compliance and financial considerations for the QA members are complicated. We are hopeful that at least one such arrangement will be available to QA members for 2025. In anticipation of new forms of value-based contracts, we will begin to bring more focus to contract-specific performance in our reporting packages and ultimately our incentive program design.

These efforts will be aided by the long-delayed implementation of Arcadia, our IBM Explorys replacement, in the second quarter. This rollout will begin with primary care practices, followed by specialty providers. QA management acknowledges the unacceptable delay in executing this transition and we apologize for our inability to provide actionable data and reporting to drive improved quality.

In another sign of the return to normalcy, we will begin hosting in-person QA town halls for our members on a twice-yearly basis. The first of these will be May 23. We look forward to providing an informative evening and opportunity for networking.

We fully intend to continue our efforts related to the application of technology to drive efficiency and effectiveness. This will be seen in the continued work to enable electronic payments with our members, to transition to an electronic document execution and management system, and to begin to use text-based interventions in our care coordination and navigation teams.



