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LETTER FROM OUR BOARD CHAIR

I think we would all agree that 2020 was an unusual year for physicians and our healthcare system, and that is of course an understatement! The COVID-19 global pandemic and its impact on the US and the state of Ohio meant almost constant changes throughout the year in how healthcare was provided and in some cases how it was paid for. A massive shift in the spring to telemedicine as an alternative to traditional face-to-face visits accelerated what had been a slow shift in the healthcare system. Within several months online visits went from a few percent of all visits to a high proportion of visits, then shifted back in the late summer and fall to what appears to be a new baseline where it remains a significant volume of visits.

Throughout 2020 and during difficult times, our Quality Alliance partner providers across the board stepped up and did an amazing job. They continued to provide high quality care to patients by pivoting to new care platforms and delivery methods while adapting rapidly to constantly changing guidelines and protocols and handling the evaluation, diagnosis, and treatment of a novel new and deadly virus spreading through our patient population. Thank you to our providers for the frontline work done every day all year long to combat this pandemic, and for all that you do for your patients year after year!

The Quality Alliance (QA) throughout the pandemic has supported our independent colleagues with multiple ‘red banner’ COVID related communications covering testing and treatment guidelines, practice tips and suggestions, and updates on vaccines and COVID-19 protocols developed by the Cleveland Clinic and public health sources. Our COVID Home Monitoring Program has followed thousands of patients through the summer and fall.

In 2020 we continued to refine our quality measures and targets, with new measures released and others retired. We expanded our Care Coordination of high risk and transitional care managed patients by over 75%. We rolled out an updated Quality Alliance participation agreement to all practices. We continued to enhance and refine our processes around Patient Satisfaction surveys and scores. We continue work on updating our Performance Improvement algorithms and are committed to assisting practices that are trying hard to achieve improvements in quality and utilization but need more support to do so.

As we look forward to a time where the pandemic is in the rear view mirror, and we resume a normal pattern of practice and personal life, please continue to reach out to us with questions and concerns. Our goal is to work together as a team, share best practices, assist with data and analytics and reporting, and expand the value based contracts the Quality Alliance participates in, so that we can bring that value back to you in your practices as well as to be of value to the providers of the Quality Alliance.

Here’s hoping for a wonderful 2021!

Sincerely,

Bruce I. Rogen, MD, MPH

Bruce I. Rogen, MD, MPH
OUR MISSION

To share the future of healthcare delivery and transform it into a system where healthcare dollars and other resources are used in a fiscally and socially responsible manner.

PROGRAM GOVERNANCE

The Quality Alliance is a physician-led organization comprised of a Board of Trustees and various committees that are responsible for overseeing the program, ensuring member compliance, setting policy and guiding strategic development.

BOARD

Fadi Bashour, MD
Digestive Disease Consultants of Medina

John Bertsch, MD
New Family Physicians Associates, Inc.

Georgeanne Botek, DPM
Cleveland Clinic

Kenneth Braman, DO
Cleveland Clinic

Robert de Swart, MD
Orthopaedic Associates, Inc.

Keith Fuller, MD
Cleveland Clinic

Bob Jones, MD
Cleveland Clinic

Kamal Khalafi, MD
Kamal Khalafi, MD, Inc.

Ahmad Kilani, MD
Cleveland Clinic

Michelle Medina, MD
Cleveland Clinic

Adam Myers, MD
Cleveland Clinic

Amy O’Linn, DO
Cleveland Clinic

Joseph Payton, DO
Fairlawn Family Practice, Inc.

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
Matthew Andresen, MD
Broadview Heights Family Medicine
John Bertsch, MD
New Family Physicians Associates, Inc.
Preti Chaturvedi, MD
The Kidney Health Group, Inc.
Erick Kauffman, MD
Neighborhood Family Practice
Kamal Khalafi, MD
Kamal Khalafi, MD, Inc.
Ahmad Kilani, MD
Cleveland Clinic
Jan Kriwinsky, MD
Pediatric Place, Inc.
Vijay Mistry, MD
Vijay G. Mistry, MD, Inc.
Kishor Patel, MD
Kishor Patel, MD, Inc.
Joseph Payton, DO
Fairlawn Family Practice, Inc.
Jeffrey Roberts, MD
Orthopaedic Associates, Inc.
Bruce Rogen, MD
Cleveland Clinic

QUALITY
Ken Braman, DO
Akron General Partners Physician Group
Robert de Swart, MD
Orthopaedic Associates Inc
Baruch Fertel, MD
Cleveland Clinic
Melanie Golembiewski, MD
Neighborhood Family Practice
Adrienne Hester, MD
Fairlawn Family Practice, Inc.
Robert Jones, MD
Cleveland Clinic
Ahmad Kilani, MD
Cleveland Clinic
Amy O’Linn, DO
Cleveland Clinic
Bruce Rogen, MD
Cleveland Clinic
Mark Rood, MD
Cleveland Clinic
Ranjit Tamaskar, MD
Atrium Medical Group, Inc.
Elaine Thallner, MD
Cleveland Clinic
Nirav Vakharia, MD
Cleveland Clinic
Terry Wagner, MD
Hudson Family Practice, Inc.
MEMBERSHIP

Quality Alliance is comprised of physicians and allied health professionals who are employed, independent or affiliated with Cleveland Clinic Health System.

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleveland Clinic Medical Group (QAE-Employed)</td>
<td>5,393</td>
<td>5,879</td>
<td>9%</td>
</tr>
<tr>
<td>Quality Alliance Independent (QAI)*</td>
<td>1,495</td>
<td>1,579</td>
<td>6%</td>
</tr>
<tr>
<td>Both</td>
<td>139</td>
<td>146</td>
<td>5%</td>
</tr>
<tr>
<td>CVS</td>
<td>88</td>
<td>113</td>
<td>28%</td>
</tr>
<tr>
<td><strong>TOTAL MEMBERSHIP</strong></td>
<td>7,115</td>
<td>7,717</td>
<td>8%</td>
</tr>
</tbody>
</table>

*includes ACMC, Akron PPG, Community and Union

Welcome New Network Members
Beavercreek Dermatology
Buckeye Dermatology
Dermatologists of Greater Columbus
Dermatologists of Southwest Ohio LLC
Family Care Plus Clinic
Premier Plastic Surgery and Dermatology Associates
Traveling Foot Doctors LLC
Twin Oaks Dermatology and Eye Surgery
Westlake America Clinic LLC
QUALITY ALLIANCE MEMBERSHIP INCLUDES SPECIALTY PRACTICES

<table>
<thead>
<tr>
<th>Allergy &amp; Immunology</th>
<th>Obstetrics &amp; Gynecology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>- Addiction Medicine</td>
<td>- Oncology</td>
</tr>
<tr>
<td>- Psychiatry</td>
<td>- Ophthalmology</td>
</tr>
<tr>
<td>- Psychology</td>
<td>- Optometry</td>
</tr>
<tr>
<td>Cardiac Electrophysiology</td>
<td>Orthopaedic Surgery</td>
</tr>
<tr>
<td>Cardiology</td>
<td>- Otolaryngology</td>
</tr>
<tr>
<td>Child &amp; Adolescent Psychiatry</td>
<td>- Pain Management</td>
</tr>
<tr>
<td>Chiropractic Medicine</td>
<td>- Pediatric Nephrology</td>
</tr>
<tr>
<td>Critical Care Medicine</td>
<td>- Pediatric Pulmonology</td>
</tr>
<tr>
<td>Dermatology</td>
<td>- Pediatrics General</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>- Physical Medicine &amp; Rehab</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>- Physical Therapy</td>
</tr>
<tr>
<td>Family Practice</td>
<td>- Plastic Surgery</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>- Podiatry</td>
</tr>
<tr>
<td>General Surgery</td>
<td>- Pulmonary Medicine</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>- Radiation Oncology</td>
</tr>
<tr>
<td>Hand Surgery</td>
<td>- Rheumatology</td>
</tr>
<tr>
<td>Hematology &amp; Oncology</td>
<td>- Sleep Medicine</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>- Sports Medicine</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>- Surgical Critical Care</td>
</tr>
<tr>
<td>Interventional Cardiology</td>
<td>- Surgical Oncology</td>
</tr>
<tr>
<td>Marriage and Family Therapist</td>
<td>- Thoracic Surgery</td>
</tr>
<tr>
<td>Nephrology</td>
<td>- Urology</td>
</tr>
<tr>
<td>Neurocritical Care</td>
<td>- Vascular Neurology</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>- Vascular Surgery</td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
</tr>
</tbody>
</table>

QUALITY ALLIANCE MEMBERSHIP INCLUDES SPECIALTY PRACTICES
GEOGRAPHIC DISTRIBUTION OF PHYSICIANS
LEADERSHIP

Bruce I. Rogen, MD, MPH
Board Chair, Quality Alliance

Ahmad Kilani, MD, MBA,
MLS, CHCQM, FACP, FACHE
Regional Medical Director
Chair, Quality Committee
Internal Medicine

Thomas Atkinson, MBA,
MHA
Senior Director,
Quality Alliance
The Quality Alliance professional team is comprised of both clinical and non-clinical expertise with a broad range of backgrounds and experience.

Stephanie Brashear, BS, RHIA
Provider Engagement Manager

Lisa Fortin, MSN, BSN, RN
Director, Practice Transformation & Physician Engagement

Wendy Carrell, MPH, BSN, RN-BC, CCM
Care Coordination Manager

Jeanne Ineman, MBA
Administrator

Betty Mercurio, MSM
Population Health Navigation Manager

Namrata Patel, MBA
Program Manager

Patricia Radatz, MBA, CHRC, CPC
Regulatory Manager
2020 HIGHLIGHTS

Covid-Related Activities

Quality Measurement and Improvement

Network Operations
Covid-related Activities
› 29 COVID related communications were released
› Care Coordination Covid Home Monitoring Program Ongoing
   - 2,000 Patients Followed Since April 2020
   - 30,455 Outreach encounters performed
› Monoclonal Antibody Treatment Training for 7 specialties rolled out

Quality Measurement and Improvement
› 89 Quality Measures Reviewed & Targets Updated
   - 12 new quality measures were released
     - Quality measures were released to 4 new specialties
› Clinovations HCC coding tool implemented in all MPC practices
› Patient Experience for “Provider Overall” exceeds 90th percentile
› 98% retention rate for Performance Improvement program
› 4% decrease in readmissions for patients in TCM program

Network Operations
› DrConnect Pilot for 19 physicians in 9 non-Epic practices
› 240 practices executed new participation agreements
› Network growth of 4.1%
› 77% Increase in patients in Care Coordination
› Board of Trustees formally adopted the Cleveland Clinic compliance program
The Quality Alliance employs a stringent and comprehensive data auditing process to ensure we are capturing the best possible data set for our providers. We use internal reporting and analysis to optimize performance improvement in the field, continuously improve data accuracy, and document quality efforts for the clinically integrated network.

Our external reporting delivers consistent performance feedback to member physicians with the goal of improving the documentation of quality and driving efficiency in patient care. In addition to the online availability of quality metrics, which are refreshed nightly, quarterly scorecards and physician ranking reports are distributed electronically to ensure physicians are afforded the opportunity to adjust their performance.
The provider engagement (PE) team is a team of professionals committed to the success of each Quality Alliance community practice. The main role of the PE team is to build a connection to the Quality Alliance and Cleveland Clinic Foundation for each community practice they partner with. Traditional areas of focus to optimize practice functions include: workflow reengineering, improved EMR utilization, data capture optimization and quality measure education.

The challenges of 2020 required creativity to safely deliver patient care while navigating new protocols like virtual visits, COVID testing, vaccination procurement, delayed preventive care and chronic disease management. The QA network has shown flexibility and versatility through the global pandemic and the PE team remains dedicated to our Quality Alliance network of providers.
The Population Health Navigation team is a valuable Quality Alliance (QA) resource that is available for your practice needs. Similar to our Care Coordination and Practice Facilitator teams, the Population Health Navigation team will also support your practice by focusing on quality measures for QA value base contracts. If you participate in our value based contracts and consent to outreach efforts, our team will work to resolve your open quality measures (gaps in care and Health Maintenance items).

Our Population Health Navigator will collaborate with your practice and align patients with QA affiliated providers, unless otherwise requested, to facilitate care gap closures.

In 2020, The Population Health Navigation team provided support for:

› Pending orders for due colonoscopies, mammograms, Hba1c and albumin
› Scheduling services such as mammograms, colonoscopies or diabetic retinal exams
› Sending MyChart messages (if active) and/or mailed letters as a reminder of opened care gaps

**POPULATION HEALTH NUMBERS**

- **Charts Reviewed**: 1,366
- **MyChart Messages Sent**: 249
- **Orders Placed**: 298
- **Letters Sent**: 196
- **Supported Practices**: 16
We support open care gaps which include:

› Colorectal Cancer Screening
› Breast Cancer Screening
› Diabetes Eye Exam
› DM hbA1C
› DM Kidney Monitoring/Nephropathy
› Controlling Blood Pressure

Services provided include:

› Mailed letters for health maintenance items due
› Uploading EPIC medical records to payer portals or partnering with your offices to secure care gap documentation
› Onboarding for Anthem and Humana Narrow Network plans
› Quality for Aetna MA and Anthem MA if primary care practices opt in
WAYS WE CAN SUPPORT YOUR PRACTICE

- **Schedule** for Mammograms or Diabetic Eye Exams
- **Send** MyChart messages or mail letters to patients requesting them to contact your office to schedule an appointment or to complete labs
- **Review** EPIC and Care Everywhere for open quality measures
  - Submit medical records to the payer to close the quality gap (if completed)
  - Update health maintenance field in EPIC (if completed)
“Thank you for working on this project for our group!”

“Any help that you can give us would be appreciated. This list consists of very tough patients and maybe coming from a third party and not us would sway them into cooperating.”

“Please send MyChart messages to call us to schedule appointments and complete labs. Thank you, Amy”

“Thank you Amy, and help will be great!”

“Thank you. I received the orders in my in box, and will continue to work with that.”

“Thank you for your help, Amy!”

“Yes, please! Place the orders and let us know if there is anything to do on our part! Thanks.”

“That is awesome and FAST! We truly appreciate all the efforts on our behalf.”
Care Coordination Team

Benajmin Boroway, BSN

Jill Bunnell, RN-BC, CCM

C. Elizabeth Burley, BSN, NE-BC, CPXP, CPHQ

Tammy Chesser, BSN

Bridget Mundy, RN, CCM

Linda Nearhood, RN

Candice Short, BSN
Quality Alliance has 7 registered nurse (RN) care coordinators who provide support to the primary care physician offices. They assist high risk patients with transitions of care from the hospital or skilled nursing facility to home, securing resources for their social determinants of health, chronic disease education for their co-morbidities, and navigating the healthcare system to avoid expensive ED utilization and hospital admissions. Due to Covid-19 restrictions, these care coordinators relied solely on telephonic means to work with the patients in 2020. We met with practices on a monthly basis to build stronger relationships and keep the lines of communication open while working with the patients and physicians.

This year has been different for primary care coordination at Quality Alliance due to Covid-19. With the pandemic, the care coordination team shifted their focus to monitor Covid-19 positive patients and patients suspected to have Covid-19. The team transitioned to work from home in March. There were technology transitions that were resolved to continue the workflow of calling patients daily. The team worked weekends and holidays to provide 24/7 monitoring to help patients avoid hospital admissions and made a big impact for patient outcomes.

Despite Covid-19, the primary care coordination team worked to reach even more patients than in 2019. The focus was to grow the program and the patient panels for each care coordinator. They accomplished this and more despite the patients with Covid-19. They will transition that focus in 2021 to connect with more patients for care coordination to avoid readmissions to the hospitals despite the volume of patients.

We have provided care coordination for the following:

<table>
<thead>
<tr>
<th>METRIC</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent physicians enrolled in care coordination</td>
<td>125</td>
<td>125</td>
</tr>
<tr>
<td>Actively Care Coordinated Patients</td>
<td>173</td>
<td>457</td>
</tr>
<tr>
<td>Graduated patients</td>
<td>255</td>
<td>307</td>
</tr>
<tr>
<td>TCM patients</td>
<td>4577</td>
<td>4876</td>
</tr>
<tr>
<td>Bundled Patients</td>
<td>411</td>
<td>751</td>
</tr>
<tr>
<td>Covid Patients</td>
<td>N/A</td>
<td>1983</td>
</tr>
<tr>
<td><strong>TOTAL PATIENTS</strong></td>
<td>5416</td>
<td>8374</td>
</tr>
</tbody>
</table>
QUALITY ALLIANCE CARE COORDINATORS ASSIST WITH:

- HOSPITAL follow up calls
- REVIEWING hospital discharge instructions
- MEDICATION review with a patient or caregiver
- MOTIVATIONAL interviewing and developing an individualized plan of care
- FACILITATING referrals to community and social resources for financial strains, transportation issues, and food insecurities
- CHRONIC DISEASE patient education for COPD, Diabetes, CHF, heart disease and more
- LIFESTYLE COACHING for disease symptom management
QA primary care physicians participate in value based contracts which the QA negotiates on their behalf with payors. Some of our contracted Medicare Advantage plans pay for quality performance and, in some cases, payments are provided to enhance the level of care by supporting care coordination for patients with complex medical conditions.

We appreciate that changing clinical operations to succeed in a population management environment requires additional effort by office staff. The QA is pleased to provide support for the efforts of our primary care physician offices by distributing care coordination funds based on a PMPM patient attribution.

In order to receive support practices were required to participate in the following four activities during 2020:

› Completion of measure review virtual education modules
› Completion of HCC education session
› Quality composite score improvement or maintenance of high score
› Active participation in QA programs:
  - Care Coordination
  - Network Navigation
MEASURE RESULTS

14 NEW MEASURES ROLLED OUT IN 2020:

› Appropriate testing for Pharyngitis Measure
› Influenza Vaccination for Older Adults - 2019-2020 Flu Season
› Preventive Care and Screening: Influenza Vaccination 2020-2021 Flu Season
› HEDIS® 2020 - Chlamydia Screening in Women
› HEDIS® 2020 - Non-Recommended Cervical Cancer Screening in Adolescent Females
› Falls: Screening for Future Fall Risk
› Diabetes Foot Ulcer A1c Completed
› Diabetes Foot Ulcer - Post Ulceration Follow-Up
› Elective Diabetes Foot Surgery A1c Less Than 8.0%
› Non-Invasive Arterial Test: Pulse Volume Recording/ Ankle Brachial Index/ Toe Brachial Index
› Hospital Re-admissions/Complications within 30 Days of TRUS Biopsy (lower is better)
› Stones: Urinalysis Documented 30 Days before Surgical Stone Procedures
› Hypogonadism: Hematocrit and serum testosterone levels measured within 6 months prior to starting testosterone replacement
› Utilization of Bevacizumab

MEASURES ROLLED OUT TO 4 NEW SPECIALTIES:

› Pain Management
› Physical Medicine & Rehab
› Podiatry
› Urology
### Measure Results

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment</td>
<td>97%</td>
<td>94%</td>
</tr>
<tr>
<td>Annual Review Age 65+</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>73%</td>
<td>68%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>79%</td>
<td>69%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>66%</td>
<td>72%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure - Hypertension</td>
<td>74%</td>
<td>64%</td>
</tr>
<tr>
<td>Diabetes BP Control Less Than 140/90 mm Hg</td>
<td>77%</td>
<td>64%</td>
</tr>
<tr>
<td>Diabetes Foot Exam (PCP)</td>
<td>64%</td>
<td>50%</td>
</tr>
<tr>
<td>Diabetes HbA1c Control Less Than 8.0%</td>
<td>63%</td>
<td>55%</td>
</tr>
<tr>
<td>Diabetes HbA1c Poor Control Greater Than 9.0% (lower is better)</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Diabetes Medical Attention For Nephropathy</td>
<td>90%</td>
<td>84%</td>
</tr>
<tr>
<td>Diabetes Retinal Eye Exam Performed (PCP)</td>
<td>52%</td>
<td>43%</td>
</tr>
<tr>
<td>Influenza Vaccination For Older Adults (2019 - 2020 Flu Season)</td>
<td>82%</td>
<td>80%</td>
</tr>
<tr>
<td>Nutritional Counseling for CKD</td>
<td>72%</td>
<td>80%</td>
</tr>
<tr>
<td>Pneumonia Vaccination For Older Adults</td>
<td>79%</td>
<td>76%</td>
</tr>
<tr>
<td>Screening for Depression and Follow-Up Plan</td>
<td>66%</td>
<td>52%</td>
</tr>
<tr>
<td>Weight Assessment And Counseling For Children: BMI</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td>Weight Assessment And Counseling For Children: Nutrition</td>
<td>82%</td>
<td>77%</td>
</tr>
<tr>
<td>Weight Assessment And Counseling For Children: Activity</td>
<td>82%</td>
<td>77%</td>
</tr>
<tr>
<td>Well Child Visits Age 3 - 6 Years</td>
<td>82%</td>
<td>77%</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life</td>
<td>72%</td>
<td>70%</td>
</tr>
</tbody>
</table>
Accountable Care Organization: MSSP Program Results

The Cleveland Clinic’s Accountable Care Organization (ACO) 2018 performance year marked a new phase as we transitioned into the two-sided Tract 1 + ACO program. The 2019 and 2020 performance years were a continuation of the two-sided Tract 1 + ACO program. As a Track 1+ participant, the ACO assumes limited downside risk based on our performance compared to the specific savings benchmark. By taking on greater risk, the Cleveland Clinic Medicare ACO is also able to share higher quality and performance-based savings. Due to the COVID-19 pandemic, CMS is extending our current agreement through performance year 12/31/2021.

Although the ACO did not meet its benchmark in the 2018 performance year, the ACO was protected from losses because its performance fell in the 1% corridor. Regarding quality, the Cleveland Clinic quality score came in at 86% which remained stable from 2017 results. Additionally, the Per Beneficiary Per Year spend (PBPY) came in $104 above benchmark.

In the 2019 performance year, the program focus was on overall performance and optimizing quality, cost, and utilization of our program’s attributed patients. The goal was to improve upon our 2018 quality performance and drive improvements in the following key areas: ED Cases (without admission), Inpatient Medical Cases, Ambulatory Care Sensitive (ACS) Admissions and Skilled Nursing Days. The 2019 quality score rose to 93% improving upon our 2018 results. PBPY came in higher than benchmark at $151. The ACO did not realize shared savings, as performance fell within the 1% corridor. The following displays performance over time:
The key successes and barriers leading to 2019 performance results include:

- Quality score up from 85.85% in 2018 to 93% in 2019 driven by Care Coordination/Patient Safety domain.
- The key successes and barriers leading to 2019 performance results include:
- Quality score up from 85.85% in 2018 to 93% in 2019 driven by Care Coordination/Patient Safety domain.
- Success in key utilization areas that were the focus of target setting:
  - Inpatient admissions down 2% from 2018
  - Skilled nursing facility down 3% from 2018
- Population mix adjustment lowered the benchmark significantly and hurt the chances for savings in 2019; risk adjustment methodology has prohibited an increase in the benchmark historically.
- Increase in outpatient pharmacy was a large reason for not making savings, driving up expenditures year over year (YOY).
  - Part B pharmacy spend is a significant portion of outpatient spending, an area in which CCMACO is high relative to other regional ACO’s
  - On a rolling 12-month basis, outpatient pharmacy PBPY has increased by over 30%
ACCOUNTABLE CARE ORGANIZATION

decrease appropriate Pharmacy Part B Spend, strengthen engagement with Specialty Institutes, and continue a data driven approach to identify opportunities and evaluate progress. 2020 CMS results were not available at time of print. The 2021 ACO action plan continues to focus on overall performance, quality, cost, and utilization but is also shifting towards stronger linkage between targets and interventions. Target areas for reduction include: Medical Admission trends, ACS Admissions, Skilled Nursing Days, ER Cases, and Pharmacy Part B Spend, and Post-Acute Care.

Quality Alliance (QA) analytics has developed personalized performance targets for both the independent and the employed physicians in the ACO. These targets are based on: 2019 targets, a careful consideration of each group’s risk, population size, and current / trending cost and utilization performance. The goal is to identify reasonable and actionable performance targets for each group.

The table (below) highlights the QA physicians’ collective 2021 ACO performance targets:

<table>
<thead>
<tr>
<th>SYSTEM-LEVEL TARGETS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Medical</strong></td>
</tr>
<tr>
<td>CURRENT</td>
</tr>
<tr>
<td>Cleveland Clinic Employed Ohio</td>
</tr>
<tr>
<td>Quality Alliance Independent</td>
</tr>
<tr>
<td>Cleveland Clinic Akron General</td>
</tr>
<tr>
<td>Ashtabula County Medical Center</td>
</tr>
<tr>
<td>Union Hospital</td>
</tr>
</tbody>
</table>

*Current* rates shown are 2019. Source: MedInsight Claims Date | *Source from: ACO 3/10/21 Perf Optimization Meeting

**Chronic Disease Management**

The Quality Alliance (QA) rolled out two separate population management campaigns in 2020. Both campaigns were focused on chronic disease management. The QA provided tools and resources to help practices with their outreach. The first campaign was congestive heart failure (CHF) and the second campaign incorporated a combined focus of hypertension (HTN) and diabetes mellitus (DM). The CHF campaign was rolled-out on June 25, 2020 and we had received positive feedback. We then launched the DM and HTN campaign on July 27, 2020. This campaign was paced and rolled-out over a four week time period. These two campaigns provided physicians an opportunity to provide outreach to their CHF, HTN and DM vulnerable patient populations and together develop a suitable treatment plan.
The 2020 quality incentive distribution model is designed to align with the incentives that our payors provide to drive performance related to value-based metrics.

An attribution-based model for PCPs distributed incentives for quality metrics based on the number of attributed patients each practice had in our value-based contracts.

For the 2020 program several changes were made to recognize the difficulty many practices experienced during the public health emergency and to provide for a more equitable distribution of available funds. Of note, instead of qualifying those providers in the top two-thirds of composite score performance we included all of those above our performance improvement threshold of 85% OR in the top two-thirds. In addition, instead of a step function for calculating the per-member amount paid, a linear distribution model was adopted. This rewards each incremental increase in composite score with an increase in the amount paid per attributed member.

An additional incentive for PCPs was provided for utilization metrics.

- **All Family Practice and Internal Medicine Physician Metrics**
  - Hospital Readmissions
  - ER cases per 1,000 Patients
  - Patient satisfaction

- **Additional Admitting Physician Metrics (10 or more discharges required):**
  - SNF Days per 1,000 Patients
  - CDI
  - Patient satisfaction

- **Pediatric Metrics**
  - ER cases per 1,000 Patients
  - Patient satisfaction

Specialists continued to receive an incentive per quality measure met.
**Improved system interoperability for independent practices**

We continue to focus on enhancing the ability for our private practices to interact with other members of the network, independent and employed. In particular, we are working to improve the capabilities available to our members that do not use Epic as their EMR through the activation of bidirectional functionality in our DrConnect portal. We also intend to more intentionally work with major EMR vendors and our state-wide health information exchange to make more seamless the ability to message providers across platforms.

**Implementation of new population health management system**

We are committed to bringing a updated, state of the art population management system to our membership in 2021. The system that has been chosen will significantly improve the ability of our members to engage with their patients in the quest for improved health outcomes. In addition, we see the new system bringing much more sophisticated tools to our analytics team so that we may help our members better understand the disparities in disease burden among their patients. These tools will also allow us to better craft our incentive programs to recognize and reward those that respond to these differences.

**Expansion in Stark and surrounding counties**

The addition of Mercy Hospital to the Cleveland Clinic Health System in February of 2021 creates the opportunity for a large number of independent providers in Stark County and the surround areas to join the Quality Alliance. As we have been much underrepresented in this market we are excited to engage with these practices throughout the latter half of 2021.
**Enhanced focus and support on utilization performance for inpatient and emergency department use**

Health systems and payors are increasingly focused on managing unnecessary utilization to control costs, to provide for better outcomes and to reduce the potential for patient harm. Working in collaboration with CCHS hospital leadership we will continue to engage with our members in these efforts. Throughout 2021 we will be conducting practice assessments to better understand current workflows so as to be better able to advise our members on best practices, resources available and recommended changes.

**Continuation of chronic disease management campaigns**

Launched in 2020 in part as a response to the public health emergency our chronic disease management campaigns provide targeted, specific strategies for practices to employ in the care of their patients. These have been well-received by our members and will continue to be released on a measured basis in the future.

**Integration of SDoH measures into our care coordination program and efforts**

The Care Coordination program continues to grow the number of patients under their care. We expect to continue this trend while simultaneously improving our understanding of each’s patient’s special social needs and their impact on an underlying chronic disease. Measures related to mood, physical activity, transportation, financial and transportation constraints, substance abuse and social connections are increasingly being incorporated into our work.
Quality Alliance

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