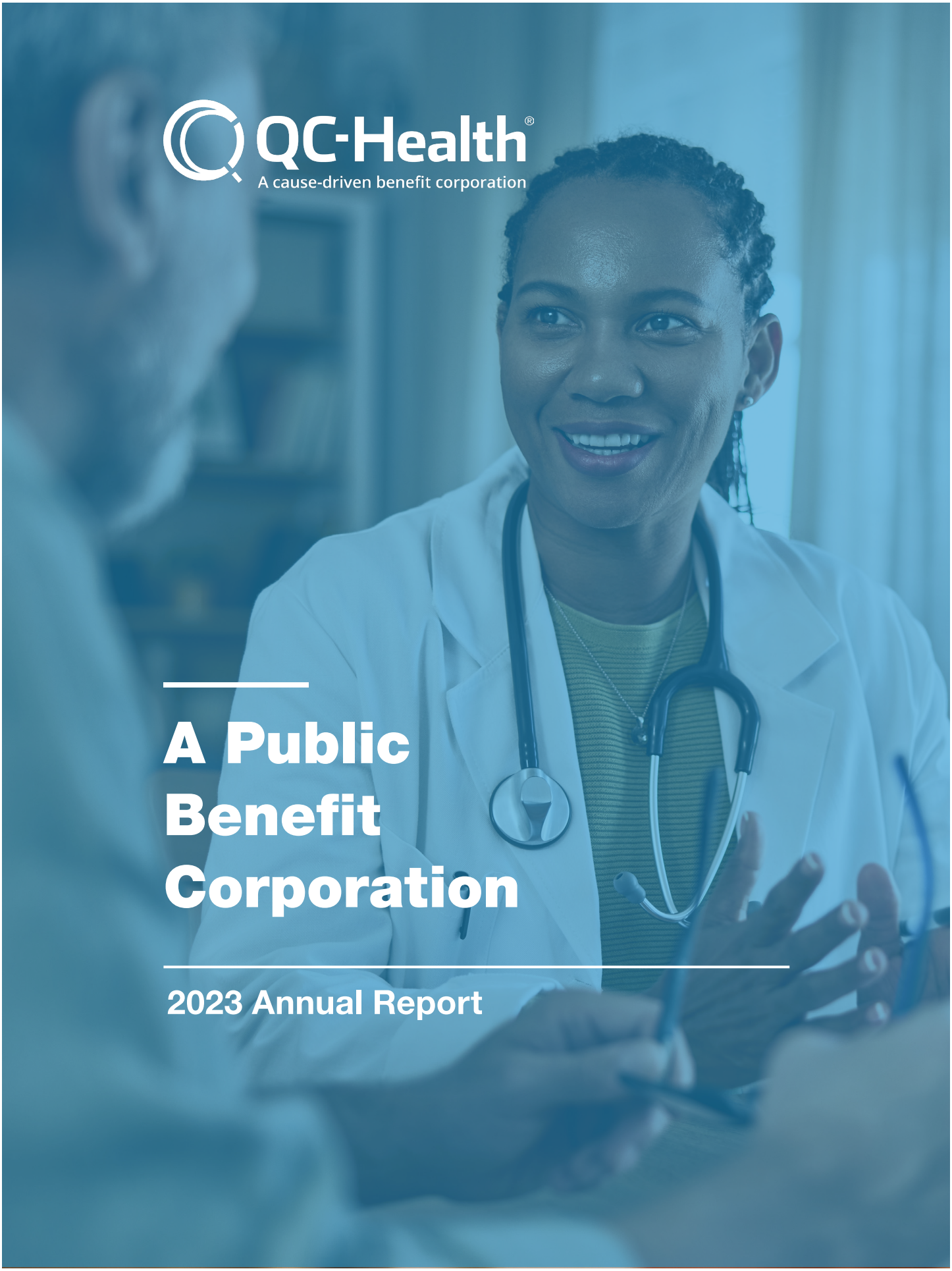
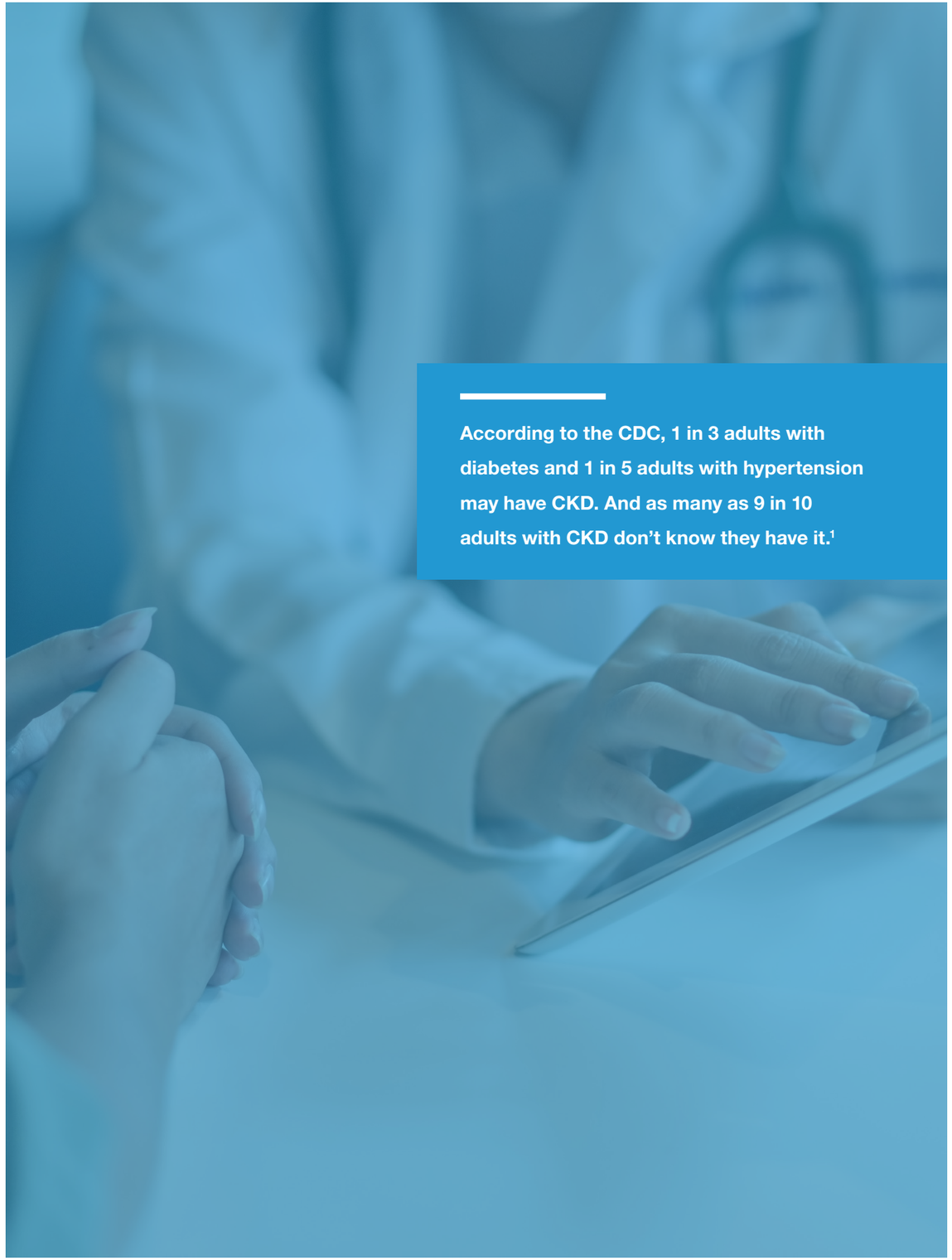


A Public Benefit Corporation

2023 Annual Report



According to the CDC, 1 in 3 adults with diabetes and 1 in 5 adults with hypertension may have CKD. And as many as 9 in 10 adults with CKD don't know they have it.[1]

Letter From the Co-President

In 2023, we continued to build on our successful digital Outcome Guided Engagements® (OGEs®) and other efforts with sponsors, but notably, we also sought to make a meaningful impact directly in chronic kidney disease (CKD) without a sponsor.

It was shocking for us to discover how often CKD goes undiagnosed and improperly staged. This is important because, according to the Centers for Disease Control and Prevention (CDC), 1 in 3 adults with diabetes and 1 in 5 adults with hypertension may have CKD. And as many as 9 in 10 adults with CKD don't know they have it.[1] Add the complication that many also have cardiovascular disease, and there is a recipe for a healthcare disaster that costs Medicare more than $87 billion annually.[2] The sad truth is that most people who have CKD die of cardiovascular disease, often without knowing they had CKD.

One of our top goals for 2023 was to take on at least two clinical partners to work with us to improve CKD patient outcomes. We chose to work with an accountable care organization in Maryland, and we are currently in discussions with another organization in New York.

We kicked off our CKD groundswell movement. We held six separate working sessions with a Board of Clinical Advisors (BoCA). Working closely with this group, we quickly identified a "golden mean," a problem big enough to matter yet small enough to solve. We identified not only a CKD problem and its root causes but came up with ways to address it. We also began adding CKD healthcare providers to our QC-Health network.

Although there are existing guidelines for primary care physicians (PCPs) for properly screening, diagnosing, and staging diabetic patients for CKD, these guidelines are, by and large, not being followed.

Kidney Disease Improving Global Outcomes (KDIGO) guidelines call for two tests in screening diabetic patients for CKD: an estimated glomerular filtration rate (eGFR) and urine albumin-to-creatinine ratio (UACR) test. Yet these tests are typically only done 20% to 50% of the time. Even of the 20% to 50% of high-risk patients who are properly screened, many PCPs lack the proper tools or take the next steps to properly diagnose and stage and end up just recording the results without taking action.

In 2023 we aimed to close that gap with the help of our BoCA and put the necessary steps needed to fix this gap into effective tools for changing behavior.

Our team, working closely with the BoCA and other national experts, developed a CKD-specific OGE, which included physician education; a modified easy-to-use heat map; a checklist for physicians, reminding them of the appropriate tests to order; as well as patient information. We also digested and reduced the 129-page KDIGO guidelines to a single page for clinicians. The impact of our work was almost immediate. Physicians changed their behavior by ordering both tests, staging patients appropriately, and making referrals to nephrologists in a timelier manner. We are now working with that clinical partner to quantify and publish the impact of this initiative.

We ended the year building alliances with other interested parties, including the American Heart Association (AHA). Indeed, in November 2023, an article titled, “Cardiovascular-Kidney-Metabolic Health: A Presidential Advisory From the American Heart Association” was published in the journal *Circulation*. The AHA recognizes that undiagnosed and untreated CKD often leads to atherosclerotic cardiovascular disease, heart failure, atrial fibrillation, and stroke.

As QC-Health continues to build our network and technology solutions, we are optimistic to see the impact of last year’s efforts in 2024 on improved screening for better patient outcomes.

Sincerely,

Stacey Richter
Co-President of QC-Health, Inc.

References: 1. Centers for Disease Control and Prevention. Chronic Kidney Disease in the United States, 2023. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2023. https://www.cdc.gov/kidneydisease/pdf/CKD-Factsheet-H.pdf **2.** Betts KA, Song J. Medical costs for managing chronic kidney disease and type 2 diabetes. *Am J Manag Care*. 2021;27:S369-S374. https://www.ajmc.com/view/medical-costs-for-managing-chronic-kidney-disease-and-related-complications-in-patients-with-chronic-kidney-disease-and-type-2-diabetes

Contents

Benefit Corporation

A benefit corporation is a type of corporate entity that includes positive impact on society, workers, the community, and the environment as part of its legally defined goals.

The business purpose of QC-Health, Inc., is to be a general public benefit corporation that provides services and free or low-cost health tools for the improvement of human health.

The genuine intent of the individuals behind QC-Health is to realize a shared mission to help patients who need the tools and resources that QC-Health is readily equipped to provide.

Stacey Richter

Co-President, QC-Health, Inc.

Stacey is a 20+-year healthcare innovator. She is also the co-president of Aventria Health Group and the host of the Relentless Health Value™ podcast.

Dave Dierk

Co-President, QC-Health, Inc.

Dave is a 30+-year thought leader in pharmaceutical diagnostics, biomedical, long-term care, managed care, employer, and pharmacy communications.

John F. Rodis, MD, MBA, FACHE, CPHQ

Benefit Director, QC-Health, Inc.

John is the founder and president of Arista Health, LLC, a healthcare consulting company whose mission is to drive quality, safety, and patient experience and reduce risk in hospitals and health systems. He served as president of Saint Francis Hospital from 2015 to 2020, the eighth leader of Saint Francis and the first physician to serve as president since its founding in 1897.

Overview

We started 2023 with a Board of Clinical Advisors (BoCA) with a clinical partner we recruited, as we had outlined as a goal in 2022. From our series of working sessions, we took our existing expertise and technology platform that we call Outcome Guided Engagements® and built clear and easy-to-use resources for primary care physicians (PCPs) to use directly in their practice.

These include a heat map that builds on the Kidney Disease Improving Global Outcomes (KDIGO) guidelines by adding in ICD-10 diagnosis codes, risk class, and staging, all mapped to the results of the two tests, an estimated glomerular filtration rate (eGFR) and urine albumin-to-creatinine ratio (UACR). This seemingly simple step forward is very significant, as it's a 1-page visual that a physician can use to quickly stage a patient with chronic kidney disease (CKD). We found that just showing this tool to physicians changed their behavior. Additionally, we took the 100+ pages of KDIGO guidelines and provided a 1-page summary of the most relevant and salient points for managing these patients. We also created an easy macro for referrals to a nephrologist and a patient education sheet that primary care providers can email directly to patients.

These tools are so critical and valuable because PCPs are:

1. Often struggling to keep up with the numerous guidelines across a very wide spectrum of healthcare issues
2. Increasingly called upon to manage chronic conditions such as CKD due to nephrologist shortages
3. In need of solutions that can fit into their workflow and demanding routines

These tools address these needs succinctly and help physicians do what they want to do most—the right thing by treating patients with evidence-based care.

The resources that the tool offers and the behavior it seeks to change directly align with HEDIS measures and STAR ratings. This means that as providers utilize these tools to change behavior, they can also better position themselves with payers.

Building From the Ground Up/ CKD Groundswell Movement

This past year, 2023, we started a groundswell movement in CKD without a sponsor. We knew going into the endeavor that it takes a village to make this kind of behavior change, and we engaged a variety of stakeholders to do this. In the latter half of the year, we launched a Web page to provide information to various stakeholders and we made the Outcome Guided Engagement tool available and free to clinicians. The CKD groundswell movement gave us the opportunity to continue to build our QC-Health network and expand our digital offerings.

Continuing Prior-Year Efforts

The following describes each of the programs launched, operational, or in development in 2023.

1 Board of Clinical Advisors Initiative
(Operational)

QC-Health, in conjunction with the team behind the Relentless Health Value™ podcast, created this initiative to help QC-Health strategically and effectively identify targeted problems that clinicians universally face in a specific disease state.

- Based on the ideation of our Chronic Kidney Disease Board of Clinical Advisors, the QC-Health team developed a tangible solution to address a problem; and the solution now lives in the new multi-brand cloud to be accessed by clinicians across the country. This initiative focuses on chronic kidney disease and how to slow disease progression.
- We were also instrumental in forming a Liver Disease Board of Clinical Advisors, whose primary mission is to change the course of liver disease.

2 Chronic Kidney Disease Program
(Unsponsored and operational)

This program targets primary care physicians (PCPs) and gastroenterologists who come in contact with patients with diabetes who are at risk of chronic kidney disease (CKD).

Patient population served: Patients with diabetes who are at risk of chronic kidney disease

Sponsor: N/A

2023 results: 20 orders placed, 142 users, 839 views of resources

Benefit delivered: This program helps PCPs identify patients with diabetes who are at risk of chronic kidney disease, then provides those PCPs with information about the appropriate tests to request to determine whether the patient has CKD and how to stage it. Other resources in the program provide a summary of CKD guidelines, a physician checklist, a PCP macro to send a message to the nephrologist, and patient education.

Lessons learned: PCP behavior can change merely by downloading the program and becoming aware of the guidelines.

3 Liver Health and Chronic Liver Disease Program
(Sponsored and operational)

This program targets PCPs, hepatologists, hospitalists, emergency medicine clinicians, case managers, discharge planners, and long-term care providers who come in contact with patients with chronic liver disease, cirrhosis, and/or hepatic encephalopathy (HE).

Patient population served: Patients with chronic liver disease

Sponsor: Pharmaceutical manufacturer

2023 results: 327 orders placed, 12,814 users, 41,463 page views

Benefit delivered: This program helps healthcare providers identify chronic liver disease patients who have overt hepatic encephalopathy (OHE), then provide those patients and/or their caregivers with vital education and resources about the disease to proactively reduce the risk of complications and HE-related readmissions.

Lessons learned: Segmenting clinician targets within the program by breaking out specific resources for PCPs enabled clinicians to more quickly find the resources that are most appropriate for them and their patient populations. Adding additional new resources to the program brought renewed attention to the program and resulted in an increase in clinician engagement.

4 (Branded) Liver Disease and IBS-D Program and Order Set Kit
(Sponsored and operational)

This program targets pharmacists, hepatologists, hospitalists, emergency medicine clinicians, case managers, and discharge planners who come in contact with patients with chronic liver disease and/or irritable bowel syndrome with diarrhea (IBS-D).

Patient population served: Patients with chronic liver disease and/or IBS-D

Sponsor: Pharmaceutical manufacturer

2023 results: 1196 orders placed (all time), 17,000 users, 63,000 page views

Benefit delivered: This program helps providers standardize care for patients within their organization so they can manage their patients living with OHE and/or IBS-D.

Lessons learned: Combining two programs into one larger program that covers two diseases served by the same set of providers brought renewed attention to the program and resulted in an increase in clinician engagement.

General Lessons Learned in 2023

- Building the QC-Health network enables us to reach more providers who are eager to have conversations about how to improve patient outcomes.
- For a resource to be utilized, it must be convenient to access within a provider's clinical workflow and available at the point of care. Not all providers use the same clinical workflow.
- While the typical way of measuring success is utilization of a resource, if a practice signs up for and downloads the program, behavior changes. We gained substantial insight into the best methods and datasets to measure the resulting behavior change. We continue to explore new measures and will implement these in 2024.
- To ensure successful uptake of a program within an organization, there needs to be a dedicated champion within the organization that supports its use and a mapped plan to expand engagement within that organization. In 2024, we will organize best practices relative to driving viral adoption within organizations and systematize how that happens.

QC-Health, Inc.®

Looking Ahead: 2024 Goals

Objectives:

- Continue to search for key partners across different stakeholder groups for our CKD groundswell movement.
- Continue to explore patient care gaps in CKD and chronic liver disease, which is closely related to CKD.
- Find a partner or partners who are willing to sponsor our efforts to improve patient outcomes.
- Expand the use of and improve upon the current Outcome Guided Engagement programs.
- Continue to identify key metrics that will allow us to measure the impact.

Definition of Success in 2024:

- Achieve measurable impact by accomplishing our objectives above.
- By the end of 2024, we would like to see that we have made measurable improvements in screening, diagnosis, appropriate referrals, and staging of patients to compare at least a 12% improvement from baseline with at least two clinical partners.
  - Co-publish the findings in print or via podcast to spread awareness.
- Engage in community dialogues and projects around the integration that is taking place between various related chronic conditions that are part of the cardio-kidney-metabolic syndromes.
- Continue tracking data points of our programs:
  - Patient population served
  - Target sponsor
  - Users, orders received, pages viewed
  - User data to validate behavior change after interventions
  - Benefit delivered
  - Lessons learned

Conclusion

We are pleased to report that in 2023 our Outcome Guided Engagements remained effective and successful at changing behavior. Our programs for chronic liver disease continued to inform clinicians and patients alike, and our IBS-D program is gaining substantial traction.

We spent a good portion of the year focusing on improving outcomes for patients with chronic kidney disease by providing screening resources for primary care providers.

The results of these efforts should be a greater awareness on the part of primary care providers and care coordinators about the importance of appropriate staging of CKD. More patients will be appropriately identified, informed, and treated. This will delay the progression of their disease and help prevent the long-term consequences, including the need for dialysis and/or kidney transplant, as well as reduce the likelihood of developing cardiovascular complications.

There is much work to be done, and we are eager to take on the challenge by engaging our passionate and ever-expanding QC-Health network. We believe key factors in our success in 2024 will be our ability to find more healthcare partners who are as dedicated to improving patient outcomes as we are and with our aptitude to learn and apply best practices from every step we take.

We look forward to seeing the positive impact of the work of QC-Health in 2024.

John F. Rodis, MD, MBA, FACHE, CPHQ
Benefit Director, QC-Health, Inc.

QC-Health, Inc.®

QC-Health Officers and Ownership

Benefit Director:

John F. Rodis

Persons owning 5% or more of the outstanding shares of the benefit corporation:

Stacey Richter

David Dierk

QC-Health®
A cause-driven benefit corporation