March 10, 2017

Dear ACO Participating Provider:

We are excited to announce our ACO Provider Portal is now LIVE!

http://www.christushealth.org/

The Provider Portal (Portal) is a secure, password-protected website providing convenient access to the latest updates and notices from your ACO, monthly performance data, educational tools, monthly calendars of upcoming events and activities, and current and prior issues of your ACO Participant Newsletter.

The Portal is a secure, easy-to-use, one-stop shop intended to keep you up-to-date and informed about ACO activities so you can effectively participate in and support continuous improvement to help our ACO achieve better clinical outcomes and lower cost. A secure login ID and password is required to access the Portal. If you are a provider on staff at one of our CHRISTUS Hospitals, you already have access to the Portal by simply using your NOVELL login.

Among the most significant attributes of our Portal is the availability of the most current, practice-level performance data based on a combination of monthly claims information plus clinical data which may be accessible from your EHR (only if an interface is in place).

In addition, we continue to develop narrated educational modules on a variety of relevant topics, such as those listed below, which you can view at your convenience on your personal computer. We have developed these videos based on input from our participants and always appreciate feedback on any new topics you would like to learn more about.

- Population Health, MACRA, and MSSP
- MSSP - I’m a Participant: What Now?
- MSSP Quality Measurement Overview
- ACO Privacy and Security Training
- Compliance Training for ACOs
- NCQA Recognition Redesign 2017
- Medicare Chronic Care Management
- Medicare Annual Wellness Visits
- Health Risk Assessment
- Advance Care Planning
- Depression Screening
- Fall Risk Screening

2017 Metrics

Accessing the Portal

More on Page 5
In January, we began a series of articles to highlight the ACO metric measures complete with descriptions and rationales. We have covered the Patient/Caregiver Experience and Care Coordination/Patient Safety domains. This month we focus on the Preventive Health Domain and ACO Measures 14-20 & 42.

ACO – 14: Preventive Care and Screening: Influenza Immunization

**Description**
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of influenza immunization. “Previous Receipt” means receipt of the current season’s influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

**Rationale**
Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza vaccine is recommended for all persons aged > 6 months who do not have contraindications to vaccination. Vaccination optimally should occur before onset of influenza activity in the community.

ACO – 15: Pneumonia Vaccination Status for Older Adults

**Description**
Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.

**Rationale**
Pneumonia is a common cause of illness and death in the elderly and persons with certain underlying conditions such as heart failure, diabetes, cystic fibrosis, asthma, sickle cell anemia, or chronic obstructive pulmonary disease. In 1998, an estimated 3400 adults aged >65 years died as a result of invasive pneumococcal disease (IPD). (CDC, 2003)

**BMI above Normal Parameters**
Obesity continues to be a costly public health concern in the United States. This is because obesity is associated with several comorbid health problems including increased risk for CAD, DM II, various types of cancer, gallstones, and disability. These comorbid conditions are associated with higher medical care utilization and costs among obese patients (Moyer, 2012, p. 373).

**Padula, Allen & Nair (2014)** examined data from a commercial claims and encounter database to estimate the cost for obesity and associated comorbidities between 2006-2007 and found that on average, obesity contributed to $1907 more in cost per patient per visit for inpatient and outpatient claims, while the increase in cost for comorbidities ranged from $527 for obesity with congestive heart failure to $15,733
for combination of obesity, diabetes, hypertension, and depression. The national aggregate for obesity related costs across all payers was estimated to be equivalent to $147 billion using 2008 dollars (Finkelstein, Trogdon, Cohen & Dietz, 2009).

BMI below Normal Parameters
On the other end of the body weight spectrum is underweight (BMI <18.5 kg/m²) which is equally detrimental to population health. When compared to normal weight individuals (BMI 18.5-25 kg/m²), underweight individuals have significantly higher death rates with a Hazard Ration of 2.27 and 95% confidence intervals (CI) = 1.78, 2.9 (Borrell & Lalitha, 2014).

Therefore, patients should be equally screened for underweight and followed up with nutritional counselling to reduce mortality and morbidity associated with underweight.

ACO – 17: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Description
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as tobacco users.

Rationale
This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products.

There is good evidence that tobacco screening with brief cessation intervention (including counseling and/or pharmacotherapy) is successful in help tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

ACO – 18: Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan

Description
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

A follow-up Plan is documentation of follow-up for a positive depression screening and must include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Rationale
In 2008, the Geriatric Mental Foundation reported that of the population aged 65 and older in the US, 15-20 percent of adults had experienced depression (geriatric Mental Foundation, 2008), while 7 million of the same population were affected by depression (Steinman, 2007, p. 175) and accounted for 16 percent of suicide deaths in 2004 (CDC, 2007). The World Health Organization found that major depression was the leading cause of disability worldwide.

The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages. “While PCPs serve as the first line of defense in the detection of depression, studies show 2016 that PCPs fail to recognize up to 50% of depressed patients, purportedly because of time constraints and the lack of brief, sensitive, easy-to-administer psychi-
The substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. This measure seeks to achieve this goal and aligns with the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults.

**ACO – 19: Colorectal Cancer Screening**

**Description**
Percentage of adults 50 – 75 years of age who had appropriate screening for colorectal cancer. Appropriate screenings are defined as
- Fecal occult blood test during the measurement period
- Fecal immunochemical DNA test (FIT-DNA) during the measurement period or the two years prior to it
- Flexible sigmoidoscopy during the measurement period of the four years prior to the measurement period
- Computed tomography (CT) colonography during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period

**Rationale**
An estimated 132,700 men and women were diagnosed with colon cancer in 2015. In the same year, 49,700 were estimated to have died from the disease, making colorectal cancer the third leading cause of cancer death in the US.

Screening for colorectal cancer is extremely important, as there are no signs or symptoms of the cancer in the early stages. If the disease is caught in its earliest stages, it has a five-year survival rate of 90%; however, the disease is often not caught this early. While screening is extremely effective in detecting colorectal cancer, it remains underutilized.

**ACO – 20: Breast Cancer Screening**

**Description**
Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer.

**Rationale**
Breast cancer is one of the most common types of cancers, accounting for a quarter of all new cancer diagnoses for women in the US. It ranks as the second leading cause of cancer-related mortality in women, accounting for nearly 40,000 estimated deaths in 2013 (American Cancer Society, 2011).

According to the National Cancer Institute’s Surveillance Epidemiology and End Results program, the chance of a woman being diagnosed with breast cancer in a given year increases with age. By age 30, it is one in 2,212. By age 40, the chances increase to one in 235. By age 50, it becomes one in 54, and by age 60, it is one in 25. From 2004 to 2008, the median age at the time of breast cancer diagnosis was 61 years among adult women.

In the US, costs associated with a diagnosis of breast cancer range from $451 to $2,520, factoring in continued testing, multiple office visits, and varying procedures. The total costs related to breast cancer add up to nearly $7 billion per year in the US, including $2 billion spent on late-stage treatments.

**ACO – 42: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**

**Description**
Percentage of the following patients – all considered at high risk of cardiovascular events – which were prescribed or were on statin therapy during the measurement period:
- Adults ages ≥21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD)
- Adults ≥21 years who have ever had a fasting or direct laboratory result of LDL-C ≥190 mg/dL or were previously diagnosed with or currently have an active diagno-
sis of familial or pure hypercholesterolemia.

OR

- Adults ages 40-75 years at the beginning of the measure period with Type 1 or Type 2 diabetes an LDL-C result of 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period.

*All patients who meet one or more of the criteria indicated above would be considered at “high risk” for cardiovascular events under 2013 ACC/AHA Guidelines.

Note: In order to meet the measure, current statin therapy use must be documented in the patient’s med list or ordered during the measurement period. Other cholesterol lowering medications will not meet the criteria. Adherence to statin therapy is not calculated in this measure.

Rationale
Cardiovascular disease (CVD) is the leading cause of death in the US, causing approximately one of every 7 deaths in 2011. The same year, stroke caused approximately one of every 20 deaths in the U.S. The estimated annual costs for CVD and stroke were $320.1 billion in 2011, including $195.6 billion in direct costs (hospital services, physicians and other professionals, prescribed medications, home health care, and other medical durables) and $124.5 billion in indirect costs from lost future productivity (cardiovascular and stroke premature deaths). CVD costs more than any other diagnostic group.

In 2013, guidelines on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults were published by the American College of Cardiology (ACC) and the American Heart Association (AHA). This document concludes the addition of statin therapy reduces the risk of ASCVD among high-risk individuals, defined as follows: individuals with clinical ASCVD; those with LDL-C ≥190 mg/dL or those with diabetes and LDL-D 70-189 mg/dL. However, one study that surveyed US cardiovascular practices participating in the Pinnacle registry, found that 32.4% of patients with an indication for statins under the 2013 ACC/AHA cholesterol guidelines were not currently receiving them. In general terms, the benefits of statins to prevent non-fatal myocardial infarction, revascularization, stroke, and CVD mortality, far outweighs any potential harm related to the drug.

We also recently launched a Beneficiary Portal featuring online copies of the ACO Beneficiary Newsletters, community events calendars, and health education offerings.

Your ACO Board is establishing annual requirements for our participating providers to access the Portal to track practice level performance, and to complete a minimum number of educational courses, among which will be the Compliance Training modules. More information on these requirements is forthcoming. Therefore, we encourage you to start access the Portal now to check out its features.

If you have not received access to the Portal or are having trouble accessing it, please contact Roxanne Jenkins, Regional Director Clinical Integration, Population Health Management at 210.321.8036 or roxanne.jenkins@christushealth.org or Kay Franklin, Clinical Integration Program Manager for Education at 210.704.4468 or kay.franklin@christushealth.org.

We would certainly value any feedback you have on your experience using the Portal or any improvements you would like to see.

Sincerely,

Warren Albrecht, M.D.
ACO Board Chairman
Accessing the Provider Portal

You can now access the CHRISTUS ACO Provider Portal using the login ID and password you received in email.

The portal hosts:
- online versions of newsletters,
- educational modules on various ACO related topics, and
- your performance scorecard based on the ACO quality metrics

To visit the Provider Portal, follow the simple step-by-step instructions below.

If you have not received your personal login ID, you may contact ______ to request it.

1. **To access the portal**, from your browser navigate to [http://www.christushealth.org/](http://www.christushealth.org/). A page should open up as shown below.

2. Under the ACO tab, click on ACO Providers. This should open up the provider portal as shown below. This is the main landing page for the providers which shows their announcements, quality metrics.
3. Click on ‘Education’ icon to open the Education page which should look similar to below screenshot. This dashboard has 4 panes – MSSP/PHM, Clinical, Care Coordination and Links. Click on the radio buttons next to each of the sections to view files or web links that are uploaded for each of these sections.

4. Click on ‘News/Calendar’ to open the News/Calendar Page which should look similar to below screenshot. This dashboard has 3 panes – Newsletter, Calendars and Links. Click on the radio buttons next to each of the sections to view files or web links that are uploaded for each of these sections.
5. Click on ‘Metrics’ to open the Metrics Dashboard. This dashboard shows the details for that physician for each ACO measure. This screen shows the Numerator, Denominator, Rate, Goal, Individual and Group Rank and the physicians Group Rank within their ACO.

To contact us:
CHRISTUS Health Quality Care Alliance
919 Hidden Ridge
Irving, Texas 75038

Website:
http://www.christushealth.org/chqca

Beneficiary Help Line
(844) 361-HELP (4357)

Compliance Hot Line
(844) 881-INFO (4636)