**Cardiac Care – Heart Failure and Screening Quality Payment Program Crosswalk**

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| **Goal** |  |
|  To achieve performance in the 9th or 10th deciles in selected CQMs  | **Note: highlighted areas reference MIPS activities** |
| **Indicate which of the following are in place. (Select all that apply)*** Write and display public commitments demonstrating commitment to hypertension
* Sign up for the [Million Hearts® Hypertension Control Challenge](https://millionhearts.hhs.gov/partners-progress/champions/challenge.html)
* Identify a single leader to direct hypertension initiative in your practice
* Communicate with all clinic staff to set patient expectations
 | * Achieved hypertension control rates of at least 80%
* Implement a method for Quality Improvement such as Plan-Do-Study-Act (PDSA)
* Other:
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| **Action**  | **MIPS Cross Walk** |
|  Implemented policies, procedures and technology to improve hypertension control and screening | **Merit-based Incentive Payment System (MIPS) Improvement Activity** |
| **Indicate which interventions are in place. (Select all that apply)*** Use of [Million Hearts resources](https://millionhearts.hhs.gov/tools-protocols/index.html)

⭘ Use of Template - [Protocol for Controlling Hypertension in Adults](https://millionhearts.hhs.gov/tools-protocols/protocols.html#HTP)⭘ Implement tested strategies from the [Hypertension Control: Action Steps for Clinicians](https://millionhearts.hhs.gov/files/MH_HTN_Clinician_Guide.pdf)⭘ Implement evidence-based change concepts or ideas from [Hypertension Control: Change Package for Clinicians](https://millionhearts.hhs.gov/files/HTN_Change_Package.pdf)* Use patient education materials related to hypertension or engagement of patient through patient portal
* Implement EHR Clinical Decision Support (CDS) at the point of care to improve HTN screening and provide care plan options for HTN control / improvement
* Utilize EHR / HIT reporting to identify hypertensive patients for follow-up
* Utilize staff for outreach to hypertensive populations
* Effectively communicating between providers regarding management of HTN
* Established practice workflows for hypertension screening and disease management
* Other:
 | **IA** – **medium** – Chronic care and preventative care management for empaneled patients (IA\_PM\_13)**IA–medium** – Use of clinical decision support (IA\_PSPA\_16)**IA – medium** – Participation in CMMI models such as Million Hearts Campaign**IA – high –** Provide 24/7 access to clinicians/groups who have real-time access to patient’s medical record  |
| **Tracking and Reporting** |
| Monitor performance for screening, improvement and control of hypertension |  **MIPS Quality Measures** |
| **Indicate which of the following are in place for your reporting strategy. (Select all that apply)*** Established workflows for appropriate documentation in EHR
* Established baseline for CQMs and other measures
* Process for validating data
* Identification of population through EHR / HIT reporting
* Operationalize the generation of patient lists
* Regular monitoring of Reports / Dashboards
* Other:
 | **Quality ID 317/CMS 22** Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented**Quality ID 236/CMS 165** Controlling High Blood Pressure**Quality ID 373/CMS 65** Hypertension: Improvement in Blood Pressure**Quality ID 226/CMS 138** Preventive Care and Screening: Tobacco Use Screening and Cessation Intervention**Quality ID 130/CMS 68** Documentation of Current Medications in the Medical Record**Quality ID 128/CMS 69** Preventive Care and Screening: BMI**Quality ID 005/CMS135** Heart Failure: ACE or ARB Therapy**Quality ID 008/NQF 2908** Heart Failure: Beta Blocker Therapy for LVSD**Quality ID 431/ \*NQF 2152** Preventive Care and Screening: Unhealthy Alcohol Use**Quality ID 047/\*NQF 0326** Care Plan |
| **Education and Expertise** |
|  Resources to clinicians and patients to improve hypertension control |  **MIPS Promoting Interoperability** |
| * Indicate how your practice provides resources and patient education for hypertension control

⭘ Provide referrals to community programs as needed / appropriate⭘ Use patient education for appropriate lifestyle modifications⭘ Use patient education for medications⭘ Use of patient portal to deliver education material⭘ Other:* Indicate how your clinicians / staff are provided resources and education for hypertension control

⭘ Provide face-to-face educational training, webinars or continuing education activities for clinicians ⭘ Provide training and documentation on current standards of care and practice policies and procedures⭘ Ensure timely access to persons with expertise⭘ Training for clinicians / staff on site policies and procedures for engaging patients with patient portal / patient education⭘ Other: | **IA** – **medium with PI bonus** - Engagement of patients through implementation of improvements in patient portal (IA\_BE\_4)**ACI\_PEA\_1** – Provide patient Electronic Access**ACI\_CCTPE\_2** - Secure Messaging**ACI\_PEA\_2** – Patient Specific Education |

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