**Cardiac Care – Hypertension Control and Screening and Coronary Artery Disease (CAD)**

**Quality Payment Program Crosswalk**

|  |  |  |
| --- | --- | --- |
| **Goal** | |  |
| To achieve performance in the 9th or 10th deciles in selected CQMs | | **Note: highlighted areas reference Merit-based Incentive Payment System (MIPS) activities** |
| **Indicate which of the following are in place. (Select all that apply)**   * Write and display public commitments demonstrating commitment to control HTN and CAD * 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 * Use a team-based approach, involving all staff in setting clinic/patient expectations | * Achieved hypertension control rates of at least 80% * Implement a method for Quality Improvement such as Plan-Do-Study-Act (PDSA) * Other: | |
| **Action** | | **MIPS Cross Walk** |
| Implement policies, procedures and technology to improve hypertension control and screening | | **Hypertension and CAD MIPS Improvement Activities** |
| **Indicate which interventions are in place. (Select all that apply)**   * Use of [Million Hearts](https://millionhearts.hhs.gov/tools-protocols/index.html) and Mountain-Pacific resources   ⭘ Use of Protocol Templates for [Hypertension, Cholesterol and Smoking Cessation](https://millionhearts.hhs.gov/tools-protocols/protocols.html)  ⭘ Implement tested strategies from the [Hypertension Control/Smoking Cessation: 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, Work with your EHR vendor as needed * Utilize staff for outreach to hypertensive populations * Effectively communicating between providers regarding cardiac management * Established practice workflows for 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-high**-Provide 24/7 access to clinicians/groups who have real-time access to patient’s medical record  **IA-high** - Participate in systematic anticoagulation program (IA\_PM\_1)  **IA-high** - Anticoagulant management Improvements (IA\_PM\_2) |
| **Tracking and Reporting** | | |
| Monitor performance for screening, improvement and control of hypertension | | **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 431/NQF 2152** Preventive Care and Screening: Unhealthy Alcohol Use  **Quality ID 047/\*NQF 0326** Care Plan |
| **CAD MIPS Quality Measures** |
| **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 431/NQF 2152** Preventive Care and Screening: Unhealthy Alcohol Use  **Quality ID 047/\*NQF 0326** Care Plan  **Quality ID CMS 164** Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet  **Quality ID 007** CAD:Beta Blocker Therapy – Prior MI or LVEF<40% **\*Quality ID 118** CAD: ACE or ARB Therapy  **\*Quality ID 006** CAD: Antiplatelet Therapy  **\*Quality ID 438** Statin Therapy for the Prevention and Treatment of Cardiovascular Disease  *\*Cannot be reported through EHR* |
| **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 and/or CAD   ⭘ 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 and/or CAD   ⭘ 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 |

This material has been created by Mountain-Pacific Quality Health, the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Montana, Wyoming, Alaska, Hawaii and the U.S. Pacific Territories of Guam and American Samoa and the Commonwealth of the Northern Mariana Islands, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Contents presented do not necessarily reflect CMS policy. 11SOW-MPQHF-AS-B1-18-10