**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: | |
| **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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