

**ATTACHMENT 3b**

**REVISED DATA COLLECTION TOOL #1**

Million Hearts® Hypertension Control Champion  
Application Form

0920-0976

## Million Hearts® Hypertension Control Champion Application

Public reporting burden of this collection of information is estimated at 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road, NE, MS D-74, Atlanta, GA 30333, ATTN: PRA 0920-0976.

**Applicant information: Please provide the following information for the provider or practice being entered into the Challenge. Apply as either practice or provider, but not both.**

Practice Name (if the practice is the applicant):

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Provider Name (if the provider is the applicant):

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Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business E-mail: \_\_\_\_\_

Check the box which best represents the applicant:

- A healthcare system
- A single clinician or group practice  
or clinic

Check the box which best represents the applicant's practice:

- Obstetrics/gynecology
- Family practice
- Internal medicine
- Osteopathy
- Cardiovascular care
- Other \_\_\_\_\_

**Contact information (for individual submitting the application):**

Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business E-mail: \_\_\_\_\_

Check the box which represents your relationship with the applicant:

- I am the applicant
- Employee of the applicant
- Contract with the applicant
- State health department
- Other \_\_\_\_\_

**Population served**

Number of patients enrolled in the practice or health system: \_\_\_\_\_

Describe patient demographics that support the practice or health system's care for a population with a high prevalence of hypertension:

Geographic location of clinic (select both if you are a health system and both apply):

Rural  Urban

Percent of patients who belong to a racial/ethnic minority: \_\_\_\_\_

Percent of patients whose primary language is not English: \_\_\_\_\_

Percent of patients who are enrolled in Medicaid: \_\_\_\_\_

Percent of patients who have no health insurance: \_\_\_\_\_

Other \_\_\_\_\_

Of the number of number of patients enrolled in the practice or health system, how many adult patients (18 – 85 years old) were seen at least once during the reporting period?

\_\_\_\_\_

Of this number of patients seen, distribute them by age:

Percent of patients: Age: 18-44 \_\_\_\_\_

Percent of patients: Age 45-64: \_\_\_\_\_

Percent of patients: Age 65-74: \_\_\_\_\_

Percent of patients: Age 75-85: \_\_\_\_\_

Of the number of adult patients (18-85 years old) seen during the reporting period, what was the prevalence of hypertension? \_\_\_\_\_ Report this as a percent.

## Hypertension Control

Nominees are asked to provide two hypertension control rates: a current rate for a 12-month period and a previous rate for a 12-month period a year or more before.

CDC supports the definition of “hypertension control” as patients aged 18 through 85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140 mmHg systolic and <90 mmHg diastolic).

For the current Hypertension Control Rate:

What is the reporting period (e.g., 1/1/2017 to 12/31/2017)? \_\_\_\_\_.

For the current reporting period, the nominee used which of the following clinical quality measure to define hypertension control. Please check the appropriate box below and provide the requested information:

- National Quality Forum (NQF) 0018 guidelines Describe the exclusions the nominee includes (e.g., pregnant women, patients with end-stage renal disease).  
\_\_\_\_\_
- CMS Physician Quality Reporting System (PQRS) 236 guidelines. Describe the exclusions the nominee includes (e.g., pregnant women, patients with end-stage renal disease).\_\_\_\_\_
- CMS 165v3 guidelines. Describe the exclusions the nominee includes (e.g., pregnant women, patients with end-stage renal disease).\_\_\_\_\_
- NCQA HealthCare Effectiveness Information Set (HEDIS). Describe the exclusions the nominee includes (e.g., pregnant women, patients with end-stage renal disease).\_\_\_\_\_
- HRSA Uniform Data System (UDS). Describe the exclusions the nominee includes (e.g., pregnant women, patients with end-stage renal disease).\_\_\_\_\_
- Other. Describe how the nominee calculates the measure; including who is included in the denominator and what is considered adequate control.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Calculation of Hypertension Control Rate**

Of the number of adult patients (18-85 years old) seen during the reporting period, how many were diagnosed with hypertension? \_\_\_\_\_

Of the number of adult patients (18-85 years old) diagnosed with hypertension, how many are included in the control rate denominator (after removing the exclusions listed above; e.g., pregnant women, patients with end-stage renal disease)? \_\_\_\_\_

How many of the patients were excluded from the denominator? \_\_\_\_\_

How many of the patients in the denominator had their blood pressure in control (numerator)? \_\_\_\_\_

What was the Hypertension Control Rate for the practice or healthcare system's adult hypertensive population during this reporting period (numerator/denominator)?

\_\_\_\_\_

**For the previous period Hypertension Control Rate:**

For the previous reporting period, did the nominee use the same clinical quality measure guidelines as the current reporting period?

- Yes.
- No.

If not, which clinical quality measure guideline was used? \_\_\_\_\_

Using the same steps, what was the Hypertension Control Rate for the practice or healthcare system's adult hypertensive population during previous reporting period? \_\_\_\_\_

What was the previous reporting period (e.g., 1/1/2016 to 12/31/2016): \_\_\_\_\_

**Additional Information**

Were the data obtained from an electronic health record system? \_\_\_\_\_.

If not, how were the data obtained? \_\_\_\_\_

For the current reporting period, were you participating in any of the following programs?

- |  |   |
|--|---|
| <input type="checkbox"/> Medicare Shared Savings Program                       | <input type="checkbox"/> QIO/QIN participant                              |
| <input type="checkbox"/> Pioneer ACO   | <input type="checkbox"/> Health Department Lead QI initiative participant |
| <input type="checkbox"/> Federally Qualified Health Center provider            | <input type="checkbox"/> Comprehensive Primary Care Plus (CPC+) practice  |
| <input type="checkbox"/> Indian Health Service provider                        | <input type="checkbox"/> WISEWOMAN program participant                    |
| <input type="checkbox"/> CMS Million Hearts Risk Reduction Model               | <input type="checkbox"/> AMGF MUPD participant*                           |
| <input type="checkbox"/> EvidenceNOW participant                               | <input type="checkbox"/> Medicare Shared Savings Program                  |
| <input type="checkbox"/> Transforming Clinical Practice Initiative participant | Other: _____  |

## Clinical system supports

Please check the button before each sustainable process for providing care in the clinic or healthcare system that is used on a regular basis. Provide a brief description of as many “other” processes or systems as applicable to your practice or health system. You may also add details to many of the systems described below to support the nomination.

- Written treatment protocols
- Electronic Medical Records (EMR): Registry features
- Electronic Medical Records (EMR): With clinical decision supports
- Electronic Medical Records (EMR): With e-prescribing
- Electronic Medical Records (EMR): With treatment/testing reminders
- Electronic Medical Records (EMR): With patient summary reports
- Team Based Care: Nurse engagement
- Team Based Care: Nurse Practitioner engagement
- Team Based Care: Pharmacist engagement
- Team Based Care: Patient Navigator/Care Coordinator
- Team Based Care: Other

Please describe: \_\_\_\_\_  
\_\_\_\_\_

- Provider Incentives: Financial

Please describe: \_\_\_\_\_  
\_\_\_\_\_

- Provider Incentives: Administrative

Please describe: \_\_\_\_\_  
\_\_\_\_\_

- Provider Incentives: Recognition

Please describe: \_\_\_\_\_  
\_\_\_\_\_

- Provider Incentives: Other

Please describe: \_\_\_\_\_  
\_\_\_\_\_

Patient Incentives

Please describe: \_\_\_\_\_  
\_\_\_\_\_

Non-electronic reminders or alerts for providers or patients

Free blood pressure checks

Provider Dashboards

Please describe:

\_\_\_\_\_  
\_\_\_\_\_

Home blood pressure monitoring support or equipment

Please describe:

\_\_\_\_\_  
\_\_\_\_\_

Medication adherence strategies

Please describe: \_\_\_\_\_  
\_\_\_\_\_

Outreach to patients

Please describe: \_\_\_\_\_  
\_\_\_\_\_

Other

Please describe: \_\_\_\_\_  
\_\_\_\_\_

Is there anything else you would like to add to support the nomination?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Agreement to Participate



Please enter your name below to indicate that you, as the nominee, agree to the following:

If you are not the nominee, please enter your name below assuring that you have consulted with the nominee, and the nominee agrees to the following:

- All information provided is true and accurate to the best of your knowledge.
- To participate in a data verification process if selected as a candidate for champion.
- Consent to a background check if selected as a candidate for champion.
- To be recognized by provider or practice name and location if selected as a champion, to participate in recognition activities, and to share best practices for the development of publically available resources.
- To assume any and all risks and waive claims against the Federal Government and its related entities, except in the case of willful misconduct, for any injury, death, damage, or loss of property, revenue, or profits, whether direct, indirect, or consequential, arising from my participation in this prize contest, whether the injury, death, damage, or loss arises through negligence or otherwise.
- To indemnify the Federal Government against third party claims for damages arising from or related to competition activities.”
- To complete, without revisions, a required Business Associate Agreement form and/or other forms that may be required by applicable law.

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Thank you for participating.

Submit Nomination