**ATTACHMENT 3a**

# DATA COLLECTION TOOL #1

Million Hearts™ Hypertension Control Champion Nomination

Form Approved

OMB No. 0920-xxxx

Exp. date xx/xx/XXXX

Million Hearts™ Hypertension Control Champion Nomination

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 Reports Clearance Officer, 1600 Clifton Road, NE, M/S D74, Atlanta, GA 30333, ATTN: PRA 0920-xxxx.

Nominee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact information (for individual submitting the nomination):

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

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

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

Nominee information:

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

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

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

Check the box which best represents the nominee:

* A healthcare system
* A primary care practice/clinician
* An obstetrics/gynecology practice/clinician
* A family practice/clinician
* An internal medicine practice/clinician
* An osteopathic practice/clinician
* A cardiovascular care practice/clinician
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nominee Reach and impact

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

Number of patients seen at least annually: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of adult patients (18 – 85 years old) seen at least annually: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe patient demographics that support the practice or health system’s care for a challenging population:

* Geographic region served \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Is this urban, rural, or both? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Percent of patients who belong to a racial/ethnic minority\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Percent of patients whose primary language is not English \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Percent of patients who are eligible for Medicaid\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CDC defines “hypertension control” as a blood pressure reading < 140 mmHg systolic and <90 mmHg diastolic among hypertensive patients. There is no allowance for individuals on two or more medications.

How many adult patients in the total patient population seen annually are diagnosed with hypertension? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Million Hearts™ supports use of the National Quality Forum #0018 or other nationally recognized measures for defining hypertension control (if other, please specify the measure used\_\_\_\_\_\_\_\_\_).

What is the Hypertension Control Rate for the practice or healthcare system’s adult hypertensive population? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date collected \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

What was the Hypertension Control Rate for the practice or healthcare system’s adult hypertensive population a year or more previous? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date collected: \_\_\_\_\_\_\_\_\_\_\_

Do you report hypertension control rate to any other federal or regulatory agency?

 Which one?



If you have a hypertension registry, please describe how it is developed and maintained. If you don’t have a hypertension registry, please describe how the data were obtained.

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Sustainable systems

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.





















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

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Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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Is there anything else you would like to add to support the nomination?  
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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 champion.
* Consent to a background check if selected as a champion.
* To be recognized by provider or practice name and location if selected, 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.”

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

Thank you for participating.