

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 0920-0976.

Nominee: _____

Contact information (for individual submitting the nomination):

Name: _____

Business Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Business Phone: _____ **Business** E-mail: _____

Nominee information: Please provide the following information for the provider or practice being entered into the Challenge.

Name: _____

Business Address: _____

Business Phone: _____ Business E-mail: _____

Check the box which best represents the nominee:

A healthcare system

- A ~~primary care practice/single~~ clinician or group practice or clinic
- ~~An obstetrics/gynecology~~ practice/clinician
- ~~A family practice/clinician~~

- ~~An internal medicine practice/clinician~~
- ~~An osteopathic practice/clinician~~
- ~~A cardiovascular care practice/clinician~~
- Other _____

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

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

Nominee Reach and impact Population served

Number of patients enrolled in ~~your~~ the practice or health system: _____

Number of patients seen at least once in the previous 12 months ~~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 with a high prevalence of hypertension:

- o Geographic region served _____
 - o Is this urban, rural, or both? _____
- o Percent of patients who belong to a racial/ethnic minority _____
- o Percent of patients whose primary language is not English _____
- o Percent of patients who are eligible for enrolled in Medicaid _____
- o Percent of patients: Age 18 - 39 _____
 - Age 40 - 59 _____
 - Age 60 + _____
- o Other _____

~~CDC defines "hypertension control" as a blood pressure reading < 140 mmHg systolic and <90 mmHg diastolic among hypertensive patients.~~

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

Hypertension Control

Million Hearts[®]™ supports use of the National Quality Forum #0018 ([insert link](#)) or other nationally recognized measures for defining hypertension control. ~~(if other, please specify the measure used _____).~~ Please check the appropriate box below and provide the requested information:

The nominee uses NQF 18 guidelines for their controlling blood pressure measure. Describe the exclusions the nominee includes (e.g., pregnant women, patients with end-stage renal disease).

The nominee uses another measure for controlling blood pressure. Describe how the nominee calculates the measure; including who is included in the denominator and what is considered adequate control.

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

For the current Hypertension Control Rate:

What is the Reporting Period (e.g., 1/1/2013 to 12/31/2013)? _____.

How many adult patients (18 – 85 years old) were seen at least once during the reporting period? _____

Of these, how many were diagnosed with hypertension? _____

Of these, how many are included in the control rate denominator (are not in an excluded category)? _____

What is the Hypertension Control Rate for the practice or healthcare system's adult hypertensive population during this reporting period? _____ Date collected
_____.

Using the same steps, Wwhat was the Hypertension Control Rate for the practice or healthcare system's adult hypertensive population a year or more previous? _____ Reporting period (e.g., 1/1/2012 to 12/31/2012);Date collected: _____

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

Yes

Which one?

No

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

Were the data ~~were~~ obtained from an electronic health record system? _____.

If not, how were the data obtained? _____

Sustainable-Clinical systems 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.

o Written treatment protocols

- Electronic Medical Records (EMR): Registry features
- Electronic Medical Records: With clinical decision supports
- Electronic Medical Records: With e-prescribing
- Electronic Medical Records: With treatment/testing reminders
- Electronic Medical Records: 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: _____

o Provider dashboards

- 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 - please
Non-electronic reminders or alerts for providers or patients

Free blood pressure checks

Provider dashboards

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.”

Thank you for participating.