1**ATTACHMENT 3b**

REVISED DATA COLLECTION TOOL #1

Million Hearts® Hypertension Control Champion Application Form

0920-0976

Million Hearts® Hypertension Control Champion Application

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

Practice Name (if the practice is the applicant):

_____

Provider (if the provider is the applicant):

_____

Business Address:

_____

City: _____ State: _____ Zip Code: _____

Business Phone: _____Business E-mail:_____

Check the box which represents your relationship with 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 applicant
☐ Contract with applicant
☐ State health department

Other _____

Population served

Number of patients enrolled in the practice or health system that the applicant cares for:
_____

Describe the 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? Include only patients for whom you provide primary care services (e.g., exclude behavioral health and dental patients or clinics). _____

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

Applicants 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 applicant 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 applicant includes (e.g., pregnant women, patients with end-stage renal disease).
_____

☐ CMS Physician Quality Reporting System (PQRS) 236 guidelines. Describe the exclusions the applicant includes (e.g., pregnant women, patients with end-stage renal disease)._____

☐ CMS 165v3 guidelines. Describe the exclusions the applicant includes (e.g., pregnant women, patients with end-stage renal disease)._____

☐ NCQA HealthCare Effectiveness Information Set (HEDIS). Describe the exclusions the applicant includes (e.g., pregnant women, patients with end-stage renal disease)._____

☐ HRSA Uniform Data System (UDS). Describe the exclusions the applicant includes (e.g., pregnant women, patients with end-stage renal disease)._____

☐ Other. Describe how the applicant calculates the measure; including who is included in the denominator and what is considered adequate control.

_____
_____
_____

Calculation of Hypertension Control Rate

A. Total hypertensive population: Of the number of adult patients (18-85 years old) seen during the reporting period, how many were diagnosed with hypertension? _____

B. Exclusions: How many of the patients were excluded from the denominator? _____

C. Denominator: 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 (A minus B)? _____

D. Numerator: How many of the patients in the denominator had their blood pressure in control ?_____

E. What was the Hypertension Control Rate for the practice or healthcare system's adult hypertensive population during this reporting period (numerator [D]/denominator [C])? _____

For the previous period Hypertension Control Rate:

For the previous reporting period, did the applicant 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?

☐ Medicare Shared Savings Program

☐ Pioneer Accountable Care Organization (ACO)

☐ Federally Qualified Health Center (FQHC) provider

☐ Indian Health Service (IHS) provider

☐ CMS Million Hearts Risk Reduction Model

☐ EvidenceNOW participant

☐ Transforming Clinical Practice Initiative participant (TCPI)

☐ Quality Improvement Organization-Quality Innovation Network (QIO-QIN) participant

☐ Health Department Lead QI initiative participant

☐ Comprehensive Primary Care Plus (CPC+) practice

☐ WISEWOMAN program participant

☐ American Medical Group Foundation Measure Up Pressure Down participant

☐ Medicare Shared Savings Program

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 application.

☐ 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 application?

_____

_____

_____

Agreement to Participate

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

If you are not the applicant, please enter your name below assuring that you have consulted with the applicant, and the applicant 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.

Thank you for participating.

Submit Applicationation