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Million Hearts® Hypertension Control Champion Application

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Million Hearts Hypertension Control Challenge

PID 3812

Actions: Download PDF of instrument(s) | Share instrument in the Library — Video: Basic data entry

Million Hearts® Hypertension Control Champion Application

Survey response is read-only — Go to Survey

Response was completed on 02/11/2025 3:42pm. Response was initially started on 02/11/2025 2:16pm. The total completion time of the response is **1 hours, 26 minutes**. You have not been given permission to edit survey responses. However, your permissions may be changed on the User Rights page in order to allow editing of survey responses. View all contributors to this response.

Record ID 60 (ewrtyu)

Trigger PDF Snapshots

Record ID — 60

This online application form is the official entry form for the 2025 Million Hearts® Hypertension Control Challenge.

Please provide specific information about your practice, patient population and the tools and techniques used to treat hypertension. You can download and print a copy of the application form to help gather the information you will need in order to successfully complete and submit the application form.

Answer each question as fully and accurately as possible. Your application is complete when you agree to the assurances by signing in the box provided and hit the "Submit Application" button at the end of the form. You will be able to print a copy of your completed application form after it is submitted.

Applications that are emailed or scanned will not be accepted.

The deadline to submit an application is April 7, 2025.

Attachment: Million Hearts Hypertension Control Challenge Application.pdf (157.9 kB)

Applicant Information

Please select which best describes the applicant for this Challenge: * must provide value — Practice / Provider

Provider: * must provide value — wertyu

Practice Name: * must provide value

Business Address: * must provide value — 23 hill road

City: * must provide value — boston

State: * must provide value — Maine

Zip Code: * must provide value — 12345

Business Phone: * must provide value — (234) 567-7890

Business E-mail: * must provide value — ash@asdf.org

Check the box which best describes the applicant: * must provide value
- A healthcare system
- A single clinician or group practice or clinic

Check the box which best represents the applicant's specialty or practice type: * must provide value
- Obstetrics/gynecology
- Family practice
- Internal medicine
- Osteopathy
- Cardiovascular care
- Other

Contact Information

Please enter the contact information for the person who will be the primary contact throughout the application process.

Contact information is the same as the applicant's entered above: * must provide value — Yes / No

Name: * must provide value — asdf

Business Address: * must provide value — asdf

City: * must provide value — Boston

State: * must provide value — Maine

Zip Code: * must provide value — 12345

Business Phone: * must provide value — (258) 859-1234

Business E-mail: * must provide value — adsf@asdf.org

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: — 1000

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 the single clinician / practice or health system (select both if you are a health system and both apply): — Rural / Urban

Percent of patients who belong to a racial/ethnic minority: — 50 (report this as a percent)

Percent of patients whose primary language is not English: — 30 (report this as a percent)

Percent of patients who are enrolled in Medicaid: — 2000 (report this as a percent)

Percent of patients who have no health insurance: — 10900 (report this as a percent)

Hypertension Control

Applicants are asked to provide two hypertension control rates: a current rate for a 12-month period with a start date no earlier than January 1, 2024 and a previous rate for the 12-month period a year before the current reporting period.

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., 1/1/2024 to 12/31/2024)?

Current Period Start: * must provide value — 02-02-2024 (COPY)

Current Period End: * must provide value — 01-31-2025 View equation; 1 year from Current Period Start date

For the current reporting period, please select which of the following clinical quality measure to define hypertension control. Please check the appropriate box below and provide the requested information: * must provide value
- National Quality Forum (NQF) 0018 guidelines
- CMS Physician Quality Reporting System (PQRS) 236 guidelines
- CMS 165v3 guidelines
- NCQA HealthCare Effectiveness Information Set (HEDIS)
- HRSA Uniform Data System (UDS)
- Other

Describe the exclusions the applicant includes: * must provide value — pregnant women (e.g., pregnant women, patients with end-stage renal disease)

Hypertension Prevalence

Of the 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 current reporting period? Include only patients who were provided primary care services (e.g., exclude behavioral health and dental patients or clinics): * must provide value — 1000 (must be >/= 500)

Of this number of patients seen, what percent of them were: **ages 18-44:** * must provide value — 25

Of this number of patients seen, what percent of them were: **ages 45-64:** * must provide value — 45

Of this number of patients seen, what percent of them were: **ages 65-74:** * must provide value — 10

Of this number of patients seen, what percent of them were: **ages 75-85:** * must provide value — 20

Percentage Total: — 100 (Must sum to 100%) View equation

Of the number of adult patients (18-85 years old) seen during the reporting period, what was the prevalence of hypertension? * must provide value — 50 (report this as a percent)

Calculation of Hypertension Control Rate

A. Total hypertensive population: Of the number of adult patients (18-85 years old) seen during the current reporting period, how many were diagnosed with hypertension? * must provide value — 1000

B. Exclusions: How many of the patients were excluded from the denominator? * must provide value — 200

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)? * must provide value — 800

D. Numerator: How many of the patients in the denominator had their blood pressure in control? * must provide value — 400

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])? * must provide value — 500 (report this as a percent)

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? * must provide value — Yes / No

Using the same steps, what was the Hypertension Control Rate for the practice or healthcare system's adult hypertensive population during previous reporting period? — 200 (report this as a percent)

What was the previous reporting period (e.g., 1/1/2023 to 12/31/2023)

Previous Period Start: * must provide value — 02-02-2023 (COPY)

Previous Period End: * must provide value — 02-01-2024 View equation; 1 year from Previous Period Start date

Additional Information

Were the data obtained from an electronic health record system? * must provide value — Yes / No

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-led QI initiative participant
- Comprehensive Primary Care Plus (CPC+) practice
- WISEWOMAN program participant
- American Medical Group Foundation Measure Up Pressure Down participant
- Target: BP
- Other: asdfasdfasdf

Clinical System Supports

Please check the boxes 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
- Provider Incentives: Financial
- Provider Incentives: Administrative
- Provider Incentives: Recognition: asdf
- Provider Incentives: Other
- Patient Incentives
- Non-electronic reminders or alerts for providers or patients
- Free blood pressure checks
- Provider Dashboards: asfd
- Home blood pressure monitoring support or equipment
- Medication adherence strategies
- Outreach to patients
- Other

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

Expand

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 and validation 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 publicly 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.

* must provide value

(signature_2025-02-11_1545.png (5.01 MB))

Form Status

Complete? — Complete

The REDCap Consortium | Citing REDCap | CDC REDCap Resource Center

Submit a REDCap Support Request

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