1**ATTACHMENT 3a**

APPLICATION FORM

DATA COLLECTION TOOL #1

For Million Hearts® Hypertension Control Challenge Submissions

0920-0976

Form Approved
OMB No. 0920-0976
Exp. Date XX/XX/XXXX

Million Hearts® Hypertension Control Champion Application

Application contact information:

Your name: _____

Your email address:_____

Your phone number: _____

Which best describes the applicant?

- ☐ Single clinician
- ☐ Practice or clinic
- ☐ Healthcare system

Check the box that represents your relationship with the applicant:

- ☐ I am the applicant
- ☐ Employee of applicant
- ☐ Contractor of applicant
- ☐ State health department
- ☐ Other

Applicant information:

Please provide the following information for the clinician, practice/clinic, or health system applying to the Million Hearts® Hypertension Control Challenge (i.e., the applicant).

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Name of applicant:

_____

Business Address:

_____

City: _____ State: _____ Zip Code: _____

Business Phone: _____Business E-mail: _____

Name of primary contact for applicant: _____

Phone number of primary contact for applicant: _____

Email of primary contact for applicant: _____

Name of secondary contact for applicant: _____

Phone number of secondary contact for applicant: _____

Email of secondary contact for applicant: _____

_____

Check the box which best represents the applicant's practice

- ☐ General practice (i.e., primary care)
- ☐ Obstetrics/gynecology
- ☐ Cardiovascular care
- ☐ Other specialty clinic: (Please Specify) _____

Population served

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

Geographic location of clinic (select all that apply):
☐ Rural ☐ Urban ☐ Suburban

Describe the patient demographics of the applicant:

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 _____

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.

For purposes of this application “hypertension control” is defined 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., 1/1/2025 to 12/31/2025?

_____

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

☐ CMS 165
☐ HRSA Uniform Data System (UDS) Controlling High Blood Pressure
☐ CBE (consensus-based entity) ID 0018 (formerly NQF 0018)
☐ CMS MIPS Clinical Quality Measures Quality ID 236
☐ NCQA HealthCare Effectiveness Information Set (HEDIS) Controlling High Blood Pressure.
☐ Other. Describe how the applicant calculates the measure; including who is included in the denominator and what is considered adequate control.

_____
___
_____
___
_____
___

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

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

_____

Of the above patients, indicate the number in each age group:

Ages: 18-44: _____
Ages 45-64: _____
Ages 65-74: _____
Ages 75-85: _____

Of adult patients (18-85 years old) seen during the reporting period, how many had a diagnosis of hypertension?

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 measures as the current reporting period?

☐ Yes.
☐ No.

If not, which measures were 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., 1/1/2024 to 12/31/2024):

_____

Additional Information

For the current reporting period, were you affiliated with and/or participating in any of the following programs/entities? Check all that apply.

☐ Medicare Shared Savings Program

☐ HRSA Funded Health Center (e.g. Federally Qualified Health Center)

Please provide grant ID number: _____

Please indicate which best describes the patient population:

☐ Entire health center

☐ Individual health center site

If individual site, provide name of site:_____

☐ Health Center Controlled Network (please specify): _____

☐ Indian Health Service (IHS) provider

☐ Value-based contracting

☐ Accountable care organization

☐ Target: BP recognition

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

☐ State, tribal, local, and/or territorial health department

☐ WISEWOMAN program participant

☐ Other: _____

Clinical system supports

Please check the button before each 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.

- ☐ Hypertension treatment protocols
- ☐ Clinician dashboards/performance reports
- ☐ Patient registries
- ☐ Team Based Care: Nurse engagement
- ☐ Team Based Care: Pharmacist engagement
- ☐ Team Based Care: Patient Navigator/Care Coordinator
- ☐ Team Based Care: Other
- ☐ Clinician Incentives: Financial
- ☐ Clinician Incentives: Administrative
- ☐ Clinician Incentives: Recognition
- ☐ Clinician Incentives: Other
- ☐ Patient Incentives
- ☐ Free blood pressure checks
- ☐ Self-measured or home blood pressure monitoring
- ☐ Medication adherence strategies
- ☐ Outreach to patients
- ☐ Assess and address social drivers of health
- ☐ Other

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 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.

Thank you for participating.

Submit