

**Maryland Department of Health and Mental Hygiene
Center for Chronic Disease Prevention and Control
Request for Proposals (RFP)**

TITLE: Quality Improvement in Health Systems

Funding Opportunity:

The Maryland Department of Health and Mental Hygiene (DHMH), Center for Chronic Disease Prevention and Control (CCDPC), with funding from the Centers for Disease Control and Prevention (CDC), will award up to seven (7) Local Health Departments (LHDs) up to \$125,000 each to improve quality in health systems by working with at least two (2) health systems/practices to implement strategies to prevent and control diabetes and hypertension. The project period will be July 1, 2016 to June 29, 2017; however, it is anticipated that successful projects will be extended and will receive a second year of funding (July 1, 2017-June 29, 2018), dependent on available funds, sufficient year one progress, and the submission and approval of a year two budget and work plan.

All LHDs in Maryland are eligible to apply. LHDs interested in submitting a proposal in response to this RFP may also apply for funding through the “Identifying Undiagnosed Hypertension in Health Systems” RFP (if eligible), which will be made available by CCDPC during the same timeframe; however, any LHD applying for both awards must identify different target health systems/practices in each proposal.

Competitive applications will be detailed and comprehensive. All applications will be objectively reviewed and scored by a grant review team based on criteria outlined in this RFP.

Background:

Chronic diseases—including heart disease, cancer, stroke, diabetes, and obesity,—are the leading causes of death and disability in both the United States and Maryland, accounting for 7 of every 10 deaths. Heart disease, cancer and stroke account for more than 50% of deaths each year in both the United States and Maryland¹. Less than half of people with hypertension have their blood pressure adequately controlled and millions more (45% or 16 million people) are taking blood pressure medicines, but still are not under control.^{2 3} Nearly 90% of U.S. adults with uncontrolled hypertension have a usual source of health care and insurance, representing a missed opportunity for hypertension control.⁴ At the present time, medical care costs for people with chronic diseases account for more than 75% of the nation’s \$2.6 trillion medical care costs. In 2010, the total costs of cardiovascular diseases in the United States were estimated to be \$444 billion and treatment costs for heart diseases account for about \$1 of every \$6 spent on health care in this country.⁵ The direct and indirect costs of diabetes are \$174 billion a year. Medical expenses for people with diabetes are more than two times higher than for people without diabetes.

¹ Maryland Vital Statistics Administration. Maryland Vital Statistics Annual Report, 2013. Baltimore MD: Maryland Department of Health and Mental Hygiene. Available from: <http://dhmh.maryland.gov/vsa/Documents/13annual.pdf>

² Vital Signs: Prevalence, Treatment and control of High Levels of Low-Density Lipoprotein Cholesterol- United States, 1999-2002 and 2005-2008. MMWR February 2, 2011;60(4); 109-112.

³ CDC. Vital Signs: Awareness and Treatment of Uncontrolled Hypertension Among Adults-United States, 2003-2010. MMWR September 4, 2012;61(35);703-709.

⁴ Centers for Disease Control and Prevention. Vital Signs: Awareness and Treatment of Uncontrolled Hypertension Among Adults-United States, 2003-2010.

⁵ Centers for Disease Control and Prevention. Heart Disease and Stroke Prevention At-a-Glance. <http://www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm>

Improved chronic disease control will require an expanded effort and an increased focus on blood pressure and diabetes from health care systems, clinicians, and individuals.⁶ Local Health departments have the unique opportunity to improve clinical outcomes in chronic diseases through population-based quality improvement efforts. Activities and strategies outlined in the Scope of Work section in this RFP focus on health system interventions to improve the effective delivery and use of clinical and other preventive services.

Summary:

Total Award Amount: Up to \$125,000 per LHD

Approximate Number of Awards: 7

Approximate Project Period: July 1, 2016 to June 29, 2017

Note: It is anticipated that successful projects will be extended and will receive a second year of funding (July 1, 2017-June 29, 2018), dependent on available funds, sufficient year one progress, and the submission and approval of a year two budget and work plan.

Eligibility: All LHDs in Maryland

Application Deadline Date: April 29, 2016, 2:00pm Eastern Daylight Savings Time

The overarching purpose of this RFP is to prevent and control hypertension and diabetes through the implementation of policy, systems, and environmental changes in health systems/practices to improve population level health.

An informational webinar will be held on Thursday, April 7, 2016 from 1:00 – 2:00 PM EDT. All LHDs interested in applying for this RFP should participate. Prior to the webinar, please contact marti.deacon@maryland.gov to register. LHDs may participate by [clicking here to join the WebEx meeting](#) (Meeting Number: 649 786 034) and joining by phone at 1-415-655-0003 (Access Code: 649 786 034).

Scope of Work:

LHDs have the opportunity to play an important role in integrating public health approaches into health care delivery through collaboration with health systems partners. The purpose of this RFP is to encourage LHDs to work with health systems/practices to institutionalize:

1. The reporting and monitoring of population health data based on standardized quality measures at the provider and systems level; and,
2. The use of population health data for quality improvement purposes.

Funded LHDs will work within their jurisdictions to develop and implement interventions in health systems/practices to address hypertension, diabetes, and associated risk factors and to improve health outcomes. Interventions must align with the priority strategies identified in this RFP and should improve the quality and effectiveness of clinical services and enhance community-clinical linkages to support hypertension and diabetes prevention and control efforts. Interventions should result in health system/practice improvements that help providers and patients prevent disease, detect disease early, reduce or eliminate risk factors, and mitigate or manage complications.

Strategies:

Applicants must address the following strategy during the grant period:

- I. Increase the institutionalization and monitoring of aggregated, standardized quality measures at the provider and systems level.

⁶ MMWR; September 4, 2012;61(35); 703-709

Applicants must also select at least two (2) additional strategies to address during the grant period:

- II. Increase electronic health records (EHR) adoption and the use of health information technology to improve performance.
- III. Implement decision support which assists health care providers in gathering and using data to improve quality of care and promote strategies for maintaining good health.
- IV. Use health information technology to facilitate bi-directional data sharing to support care coordination and to improve health outcomes.
- V. Increase engagement of non-physician team members (i.e., nurses, pharmacists, and patient navigators) in hypertension and diabetes management in health care systems.

Mandatory requirements for proposals:

- All proposals must clearly identify a minimum of two (2) target health systems/practices.
- All proposals must include baseline data for each target health system/practice, using the official National Quality Forum definitions for hypertension control (NQF18) and diabetes poor control (NQF59). (Attachment B)
- All proposals must clearly identify a minimum of three (3) strategies to address.
- All proposals clearly describe the interventions and activities that will be used to address each strategy.
- All proposals must address hypertension and diabetes separately for all strategies and interventions.
- All proposals must demonstrate a minimum reach of 400 patients (including at least 200 with hypertension and 200 with diabetes) through targeted or system-wide interventions. While targeted interventions are acceptable, system- or practice-wide interventions are encouraged.

Key Outcomes:

Outcome 1: Enhanced quality and effectiveness in the delivery and use of clinical services to improve prevention and management of hypertension and diabetes.

Outcome 2: Improved control of hypertension.

Outcome 3: Improved control of diabetes.

Performance Measures:

Throughout the duration of the grant period, funded LHDs must provide **quarterly data** for the following performance measures from all health systems partners:

- NQF18: The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year (See Attachment B for full definition, including numerator, denominator, and exclusions)
- NQF 59: The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year (See Attachment B for full definition, including numerator, denominator, and exclusions)

Awardee/Reporting Requirements:

LHDs will be required to work with at least two (2) health systems/practices to:

- Complete a summary of each health system/practice at the beginning and end of the grant period, and submit to CCDPC. (Attachment C)
- Complete at least one process mapping exercise with each health system/practice, and use the results to identify areas to target quality improvement efforts. Include a summary of the exercise/results in LHD monthly narrative updates.

- Guide health systems/practices in completing Plan-Do-Study-Act worksheets (Attachment D) monthly to describe quality improvement interventions, and submit to DHMH as an attachment to LHD monthly narrative updates.
- Work with health systems/practices to report clinical outcome performance measures for diabetes (Attachment E) and hypertension (Attachment F) on a quarterly basis, and submit data reporting templates to CCDPC.
- Complete an online pre- and post- survey to assess access to practice-level data, commitment to using data for quality improvement, and systems changes resulting from quality improvement efforts.

Additionally, LHDs will be required to:

- Participate in a social network analysis project to identify key partners in health systems improvement.
- Participate in monthly Community of Practice calls organized by CCDPC.
- Participate in monthly one-on-one calls organized by CCDPC.
- Submit narrative updates monthly to CCDPC (template will be provided).
- Submit expenditure reports on a quarterly basis.
- Submit a final evaluation report (template will be provided).

Technical Proposal Submissions:

Interested LHDs shall send a narrative technical proposal that must be no smaller than 12-point font, double-spaced, with one-inch margins. Technical proposals shall be no longer than 10 pages (this excludes work plan attachment, budget, budget narrative, letters of commitment, letters of support, and any additional attachments).

Technical Proposals:

The narrative technical proposal must be no longer than 10 pages and must include the following:

1. Contact Information
 1. Organization name, billing address, Federal Employer Identification Number (FEIN), and DUNS
 2. Name, address, telephone number, e-mail address, fax number, and position/title of the individual who will serve as the primary contact for this contract.
2. Background Information
 1. Description of the burden of hypertension and diabetes in the jurisdiction.
 2. Description of the problem statement.
3. Approach
 1. Identification and description of at least two (2) target health systems/practices. Include the rationale for selecting these health systems/practices.
 2. Identification of selected strategies.
 3. Description of interventions and activities to address selected strategies. Include the rationale for proposed interventions and activities. Include estimated reach, and specify whether the proposed interventions and activities will impact the entire health system/practice population or will focus on a targeted subgroup.
4. Capacity and Commitment
 1. Description of organizational capacity, including quality improvement expertise and experience working with health systems partners.

2. Description of proven ability to collect population health data based on standardized quality measures at the provider or systems level.
 3. Description of key staff/contractors, including their role, time commitment to interventions and activities described in the approach/work plan, and relevant skills and experience.
 4. A realistic timeline for filling staff vacancies to meet project outcomes.
 5. Description of organization commitment to the project, such as in-kind staff support, leadership involvement, leveraging additional funding, or other opportunities to enhance the impact and sustainability of this project.
5. Demonstrated Readiness to Implement Scope of Work
 1. Established commitment of at least two (2) target health systems/practices to implement proposed strategies and interventions, as supported by attached Letters of Commitments.
 2. Inclusion of baseline data (NQF 18 and 59) for target health systems/practices. Specify the reporting period used for baseline NQF data.
6. Program Evaluation
 1. Description of process and outcome measures for proposed interventions. Include targets as applicable.
 2. Description of the process for data collection and reporting. Include the frequency with which data will be collected and staff responsible. Include a clear description of ability to collect and report NQF 18 and 59 data for target health systems/practices on a quarterly basis.
 3. Description of how evaluation findings will be used for continuous improvement during the project period.
7. Sustainability
 1. Description of plans to promote program sustainability.
 2. Description of how work will result in sustainable policy, systems, and environmental changes.

Required Work Plan Attachment:

LHD applicants are required to submit a Work Plan Attachment using the template (Attachment A) included in this RFP. The required Work Plan Attachment is not counted in the 10 page limit.

Other Required Attachments:

The following attachments must also be included (and are not counted in the 10 page limit):

1. A minimum of two signed Letters of Commitment from health systems partners detailing past collaborative efforts, current role, alignment with strategic direction, description of expectations for strategy implementation, and if applicable in-kind contributions.
2. A detailed, narrative budget including a justification or rationale for all line items.
 - Funds may not be used for food, lobbying, the purchase of medical equipment (including blood pressure cuffs/monitors), the delivery of evidence-based community programs (such as the Diabetes Prevention Program, Chronic Disease Self-Management Programs, or Diabetes Self-Management Education), or the provision of direct clinical services (education and screening are acceptable).
 - LHDs are encouraged to budget at least 5-10% of the total funding award to evaluation activities which could include data analysis support.
3. A budget submitted using the DHMH UFD Excel template.

Review Criteria and Scoring:

1. Background Information (10 points) – The extent to which the applicant:
 - a. Describes the burden/need. (5)
 - b. Describes the problem statement. (5)

2. Approach/Work Plan Attachment (25 points) – The extent to which the applicant:
 - a. Identifies and describes at least two target health systems/practices, and provides a rationale for selecting those systems/practices. (4)
 - b. Clearly describes selected strategies and proposed interventions/activities, including rationale. (5)
 - c. Clearly describes the reach of proposed interventions/activities, and specifies whether interventions/activities will impact the entire health system/practice population or will focus on a targeted subgroup. Meets the minimum reach requirements of 200 patients with diabetes and 200 patients with hypertension. (4)
 - d. Work plan demonstrates alignment with the strategies and performance measures listed in the RFP. (2)
 - e. Work plan outlines SMART (specific, measureable, achievable, realistic, and time-phased) objectives for the project period including plans for identifying and accessing data for any performance measures where data is currently unavailable. (5)
 - f. Work plan lists appropriate objectives and activities that will be done to accomplish the work and achieve the performance measures for each strategy selected. (5)

3. Capacity and Commitment (15 points) – The extent to which the applicant:
 - a. Describes organizational capacity, including quality improvement expertise and experience working with health systems partners (5)
 - b. Demonstrates proven ability to collect population health data based on standardized quality measures at the provider or systems level (4)
 - c. Describes key staff/contractors, including their role, time commitment to interventions and activities described in the approach/work plan, and relevant skills and experience (3)
 - d. Includes a realistic timeline for filling staff vacancies to meet project outcomes (1)
 - e. Describes organization commitment to the project, such as in-kind staff support, leadership involvement, leveraging additional funding, or other opportunities to enhance the impact and sustainability of this project. (2)

4. Demonstrated Readiness (15 points) – The extent to which the applicant:
 - a. Describes established health systems partnerships relevant to the strategies and interventions and provides supporting Letters of Commitments from those partners. (5)
 - b. Includes baseline NQF 18 and 59 data (using complete definition of measures) for at least two health systems partners. (10)

5. Program Evaluation (20 points) – The extent to which the applicant:
 - a. Describes process and outcome measures for proposed interventions, including targets as applicable. (5)
 - b. Description of the process for data collection and reporting. Include the frequency with which data will be collected and staff responsible. Include a clear description of the

process for collecting and reporting NQF 18 and 59 data for target health systems/practices on a quarterly basis. (10)

- c. Describes how evaluation findings will be used for continuous improvement during the project period. (5)

6. Sustainability (15 points) – The extent to which the applicant:

- a. Describes plans to promote program sustainability. (5)
- b. Describes how work will result in sustainable policy, systems, and environmental changes. (10)

SUBMISSION DEADLINE:

Completed proposals with all required attachments must be emailed to marti.deacon@maryland.gov, no later than 2:00 p.m. (Eastern Time) on April 29, 2016. You will receive an email confirming receipt.

(Attachment A) Work Plan Template

Instructions:

1. Use the below work plan template to outline strategies, objectives, and activities for the project period (July 1, 2016 to June 29, 2017).
2. Add further sections or rows as necessary.
3. Refer to the following definitions for use in this document:
 1. **Strategies:** Applicants must address Strategy I. below, plus at least two additional strategies:
 - I. Increase the institutionalization and monitoring of aggregated, standardized quality measures at the provider and systems level.
 - II. Increase electronic health records (EHR) adoption and the use of health information technology to improve performance.
 - III. Implement decision support which assists health care providers in gathering and using data to improve quality of care and promote strategies for maintaining good health.
 - IV. Use health information technology to facilitate bi-directional data sharing to support care coordination and to improve health outcomes.
 - V. Increase engagement of non-physician team members (i.e., nurses, pharmacists, and patient navigators) in hypertension and diabetes management in health care systems.
 2. **Outcome Objectives:** Measureable changes in supportive policy, systems, or environments. Objective must be SMART (Specific, Measurable, Achievable, Realistic, Time-phased). CDC Guide to Writing SMART Objectives: <http://www.cdc.gov/healthyyouth/evaluation/pdf/brief3b.pdf>
 3. **Activities:** A list of key actions that will be implemented. If possible, these actions should be specific, measurable and sufficient in quantity such that their completion should lead to the accomplishment of the outcome objective.

Jurisdiction:	
Contact Person:	
Email Address:	
Phone Number:	

Strategy #1:	Increase the institutionalization and monitoring of aggregated, standardized quality measures at the provider and systems level.			
Outcome Objective #1:				
Activity	Person Assigned	Key Partners	Measure	Timeline

Strategy #2:				
Outcome Objective #1:				
Activity	Person Assigned	Key Partners	Measure	Timeline

Strategy #3:				
Outcome Objective #1:				
Activity	Person Assigned	Key Partners	Measure	Timeline

(Attachment B) Definitions of NQF18 and NQF59

National Quality Forum (NQF) is a nonprofit, nonpartisan, public service organization committed to transforming health care. NQF reviews, endorses, and recommends use of standardized healthcare performance measures. Performance measures, also called quality measures, are essential tools used to evaluate how well healthcare services are being delivered.

National Quality Forum - Measure 18 (NQF18)

The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

NQF 18 Numerator Statement:

The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.

NQF 18 Denominator Statement:

Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.

Note NQF 18 Exclusions:

1. Exclude all patients with evidence of end-stage renal disease (ESRD) on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.
2. Exclude all patients with a diagnosis of pregnancy during the measurement year
3. Exclude all patients who had an admission to a non-acute inpatient setting during the measurement year.

National Quality Forum - Measure 59 (NQF59)

The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.

NQF 59 Numerator Statement:

Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

NQF 59 Denominator Statement:

Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Note NQF 59 Exclusions:

1. Exclude patients with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by the end of the measurement year.
2. Exclude patients with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year.

(Attachment C) *Sample* Health Systems/Practice Summary Template

Funded LHDs will be required to work with at least two (2) health systems/practices during the project period. LHDs will be required to submit the following information for each target health system/practice at the beginning and end of the project period (template will be provided):

- Practice Name
- Total number of patients [All patients in practice at point of time]
- Total number of adult patients [All patients 18 and over in practice at point of time]
- FQHC or Private practice (select one)
- Using EHR (Y/N)
 - ONC certified (Y/N)
- NCQA PCMH certified (Y/N)
 - NCQA PCHM level (1/2/3)
- RFP strategies being addressed in practice
- Practice team includes pharmacist(s) (Y/N)
- Practice team includes community health worker(s) (Y/N)
- Practice team includes other (fill in)
- Practice refers to:
 - National Diabetes Prevention Program or YMCA Diabetes Prevention Program (NDPP or YDPP)
 - Stanford licensed Chronic Disease Self-Management Programs (CDSMP or Living Well)
 - Stanford licensed Diabetes Self-Management Programs (DSMP or Living Well with Diabetes)
 - ADA-recognized or AADE accredited Diabetes Self-Management Education (DSME)
- [End of Project Report Only] Number of patients referred to each program during the project period:
 - National Diabetes Prevention Program or YMCA Diabetes Prevention Program (NDPP or YDPP)
 - Stanford licensed Chronic Disease Self-Management Programs (CDSMP or Living Well)
 - Stanford licensed Diabetes Self-Management Programs (DSMP or Living Well with Diabetes)
 - ADA-recognized or AADE accredited Diabetes Self-Management Education (DSME)

(Attachment D) Sample PDSA Template

**Tests of Change
Plan-Do-Study-Act (PDSA) Cycle Worksheet**

1. **Local Health Department:**
2. **Contact Person:**
3. **Email:**
4. **Phone Number:**

5. **Name of Health System/Practice:**

6. **Title of PDSA Test of Change:**

7. **Is this PDSA Test of Change...?**
 - In progress/Not finalized
 - Final

	ACTIVITY OR TEST OF CHANGE
PLAN Describe the test, including the purpose and goal(s). Include a SMART objective.	
DO List observations from the test.	
STUDY List what worked. Include successes. Include (or attach) all relevant data, including reach and outcomes.	
STUDY List what didn't work. Include barriers and lessons learned. Include (or attach) relevant data.	
ACT Indicate whether you adopted, adapted, or abandoned the change you tested. List next steps based on decision.	

NOTE: Practices should complete the PDSA Cycle above, describing a major grant activity or test of change being implemented. Include all relevant data in the PDSA or as an attachment. DO NOT include "anticipated result" in the Do, Study, or Act sections as was done in the previous year. Only report on actual results.

(Attachment E) Sample Diabetes Data Reporting Template

POOR DIABETES CONTROL					
Name of Health System or Practice:					
Measure:	Baseline	Q1	Q2	Q3	Q4
Health Systems or Practice Level Data (REQUIRED)					
Recommended measurement year (please change and highlight if a different measurement year is used)	4/1/15-3/31/16	9/1/2015-8/31/2016	12/1/2015-11/30/2016	3/1/2016-2/29/2017	6/1/2016-5/31/2017
#1: Total number of patients, 18 to 75 years of age, in the practice					
#2: NQF 59 denominator statement*: Number 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or 2) during measurement year or the year prior to measurement year					
#3: Percent of patients, ages 18-75, in practice with diabetes					
#4: NQF 59 Numerator statement**: Number of those in #2 (above) whose most recent HbA1c level is greater than 9.0% or is missing a result, or if an HbA1c test was not done during measurement year					
#5: Percent 18-75 years of age with diabetes (type 1 and 2) whose most recent HbA1c level during measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year (Should equal #4 divided by #2)					
<p>**NQF 59 Numerator Statement:</p> <p>Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.</p> <p>*NQF 59 Denominator Statement:</p> <p>Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.</p> <p>Note NQF 59 Exclusions:</p> <ol style="list-style-type: none"> 1. Exclude patients with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by the end of the measurement year. 2. Exclude patients with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the 					

measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year.

Participant Level Data (OPTIONAL) (For practice- and/or community-based interventions with data on a select number of target participants)

Recommended measurement period (please change and highlight if a different measurement period is used)	Baseline (if applicable & prior to Q1)	Q1 (08/1/15-09/30/15)	Q2 (10/1/15-12/31/15)	Q3 (1/1/16-03/31/16)	Q4 (4/1/16-06/29/16)
#7: Number of participants in project or intervention					
#8: Number of participants 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or 2) during measurement year or the year prior to measurement year					
#9: Number of those in #2 (above) whose most recent HbA1c level is greater than 9.0% or is missing a result, or if an HbA1c test was not done during measurement year					
#10: Time period used for data in #8 and #9					
#11: Percent 18-75 years of age with diabetes (type 1 and 2) whose most recent HbA1c level during measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year (Should equal #9 divided by #8)					

(Attachment F) Sample Hypertension Data Reporting Template

HYPERTENSION CONTROL					
Name of Health System or Practice:					
Measure:	Baseline	Q1	Q2	Q3	Q4
Health Systems or Practice Level Data (REQUIRED)					
Recommended measurement year (please note if a different measurement year is used)	4/1/15-3/31/16	9/1/2015-8/31/2016	12/1/2015-11/30/2016	3/1/2016-2/29/2017	6/1/2016-5/31/2017
#1: Total number of patients, 18 to 85 years of age, in the practice					
#2: NQF 18 denominator statement*: Number of patients, 18 to 85 years of age, in practice with a diagnosis of HTN					
#3: Percent of patients, 18 to 85 years of age, in practice with a diagnosis of HTN (Should equal #2 divided by #1)					
#4: NQF 18 numerator statement**: Number of patients in #2 (above) and whose blood pressure was adequately controlled (<140/90) during measurement year					
#5: NQF18: Percent of those 18 to 85 years of age who had a diagnosis of HTN whose blood pressure was adequately controlled (<140/90) during measurement year (This should equal #4 divided by #2)					
<p>**NQF 18 Numerator Statement:</p> <p>The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.</p> <p>*NQF 18 Denominator Statement:</p> <p>Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.</p> <p>Note NQF 18 Exclusions:</p> <p>1. Exclude all patients with evidence of end-stage renal disease (ESRD) on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD.</p>					

Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.

2. Exclude all patients with a diagnosis of pregnancy during the measurement year

3. Exclude all patients who had an admission to a non-acute inpatient setting during the measurement year.

Participant Level Data (OPTIONAL) (For practice- and/or community-based interventions with data on a select number of target participants)

Recommended measurement period (please change and highlight if a different measurement period is used)	Baseline (if applicable & prior to Q1)	Q1 (08/1/15-09/30/15)	Q2 (10/1/15-12/31/15)	Q3 (1/1/16-03/31/16)	Q4 (4/1/16-06/29/16)
#7: Number of participants ages 18-85 in project or intervention					
#8: Number of participants 18 to 85 years of age (#7) with a diagnosis of HTN					
#9: Number of participants in #8 (above) and whose blood pressure was adequately controlled (<140/90) during measurement year (Note: A one year period may not be appropriate for some interventions).					
#10: Time period used for data in #8 and #9					
#11: Percent of those 18 to 85 years of age who had a diagnosis of HTN whose blood pressure was adequately controlled (<140/90) (Should equal #9 divided by #8)					
#12: Average blood pressure among participants					
#13: Number and percent of participants with improved blood pressure compared to baseline (or first data point)					
#14: Time period used for data in #12 and #13					