HeartHealth+

HealthARCH
ADVANCING RESOURCES TO CHANGE HEALTHCARE
A Division of the UCF College of Medicine

Florida Heart Health Plus Learning Collaborative Health System Commitment Form

If you are interested in participating in the Heart Health Plus Learning Collaborative, please complete and return the form to JoinHealthARCH@ucf.edu or fax to 407-636-5142

Health Center Name:					
Health Center Address:					
City:		County:		Zip:	
Primary Contact:		Title:			
Email:		Phone:			
Total # of patients:					
Electronic Health Records System:					
Payer breakdown percentage:	Medicaid:		Medicare:	Self-pay:	
		Private Insurance:		Uninsured:	

Please select the type of practice that best describes you:

☐ **FQHC** ☐ **Hospital/ ER** ☐ **Private Practice** ☐ **Rural Health Center** ☐ **Community Health Center**

Name: _____

Signature: _____ **Date:** _____

Title: _____

This project is supported by the DP23-0004 The National Cardiovascular Health Program Cooperative Agreement number NU58DP007457, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

Note: This data sharing Appendix is for illustration purposes only. Do Not Complete. We will collect this data once the project starts.

EXHIBIT A Project No._____

APPENDIX A

HealthARCH **Heart Health Plus Learning Collaborative** **Required Hypertension and Hypercholesterolemia Data Measures**		
Person Completing Form:		
Contact Number:		
For which month and year are you reporting?		
Month:	Year:	
The following data is to be obtained from the individual providers during the timeframes defined by the project:		
By August 30th:		
• Insurance Payors accepted		
• EHR Vendor Used		
• Number of **provider types** using a certified EHR with the capacity for reporting on *CMS eCQM 22 (Screening for high BP and Follow-Up documented)*		
• Number of **provider types** using a certified EHR with the capacity for reporting on *CMS eCQM 165 (Controlling High BP)*		
• Number of **provider types** using a certified EHR with the capacity for reporting on *CMS eCQM 347 (Statin Therapy)*		
• Number of **patients** between **18-85 years of age**		
• Number of **patients 18-85 years of age** with hypertension (ICD-10 code I10)		
• Number of **hypertensive patients** who received follow-up care		
• Number of **patients 21-85 years of age** with hypercholesterolemia (ICD-10 code E78.00)		

1101 N Lake Destiny Rd, Suite 300, Maitland, FL 32751
407.266.4000 Phone | 407.636.5142 Fax | healthARCH.org

EXHIBIT A Project No._____

• Number of **patients with high cholesterol** who received statin therapy
• Number of **patients** with BP < 140/90 (blood pressure control)
• Number of **non-Hispanic white patients** with BP < 140/90 (blood pressure control)
• Number of **non-Hispanic black patients** with BP < 140/90 (blood pressure control)
• Number of **Hispanic patients** with BP < 140/90 (blood pressure control)
• Number of **patients** with hypertension or high cholesterol that use a multidisciplinary care team
• Name of Social Determinant of Health (SDOH) tool used
• Number of **patients** with hypertension referred to a Community Health Worker (CHW) to address social service needs (SSN)
• Number of **patients** with high cholesterol referred to a CHW to address SSN
• Demographic Information from the patient population served: age, race, sex, insurance status, income source, and education level
Within 30 calendar days after completing the 12-month QI cycle:
• Number of provider types with patient registries stratified by social demographics
• Number of **provider types** with policies or systems to encourage EHRs to track hypertension and high cholesterol
• Number of **provider types** using a tool to identify social service and support needs for patients with hypertension and high cholesterol
• Number of **provider types** tracking social service and support needs of patients with hypertension and high cholesterol
• Number of **provider types** with policies or systems to encourage the use of EHRs to track social service and support needs of patients with hypertension and high cholesterol
• Number of **provider types** with CDS within their EHR to support care coordination
• Number of **provider types** with policies or systems in place requiring CDS to support care communication
• Number of **provider types** adhering to current Patient-Centered Medical Home (PCMH) guidelines for team-based care
• Number of **provider types** with PCMH team-based care workflows

1101 N Lake Destiny Rd, Suite 300, Maitland, FL 32751
407.266.4000 Phone | 407.636.5142 Fax | healthARCH.org
UNIVERSITY OF CENTRAL FLORIDA

EXHIBIT A Project No._____

• Number of **provider types** with Collaborative Practice Agreements with CHW
• Number of **provider types** with Collaborative Practice Agreements with social service and support need (SSN) providers
• Number of **SSN providers** identified within health system service regions
• Type of SSN addressed by SSN providers
• Number of **patients** within partner health care and community settings with known high BP who have achieved BP control (<140/90)

1101 N Lake Destiny Rd, Suite 300, Maitland, FL 32751
407.266.4000 Phone | 407.636.5142 Fax | healthARCH.org