Hypertension Care Recognition Clinician Assessment Guide

Bridges to Excellence
13 Sugar Street
Newtown, CT 06470

bteinformation@bridgestoexcellence.org
http://www.bridgestoexcellence.org
Rev: 5/7/10

Table of Contents

Introduction 2
Overview 3
Clinician Benefits of Recognition 4
Background on the Measurement Criteria 4
Recognition Program Structure 5
What Recognition Requires 6
Eligibility for Clinician Participation 10
Applying for Recognition 11
Duration of Recognition 12
Reporting Results to BTE and Its Partners 14
Terms of Recognition 14
Appendix: Sample Results Report 15

Introduction

Bridges to Excellence (BTE) is excited to offer this opportunity for clinicians to pilot its automated EMR/Registry performance assessment system. The BTE EMR/Registry performance assessment system allows for rapid and independent medical record-based clinician performance evaluations by connecting local and national medical record data sources to a network of performance assessment organizations. BTE's goals are to: reduce the reporting burden for clinicians; leverage existing reporting/data aggregation initiatives; reduce data collection and reporting costs; facilitate the connection between quality improvement and incentives; and speed up cycle times between reporting, improvement and reporting. Clinicians who meet BTE performance thresholds may be eligible for BTE incentives through participating health plans, employers and coalitions.

BTE is partnering with two Performance Assessment Organizations (PAOs) to implement its automated EMR/Registry performance assessment system: Minnesota Community Measurement (MNCM) and IPRO.

MN Community Measurement (MNCM) was formed in 2002 by several local health plans as a collaborative to collect performance data. By aggregating health plan claims data and collecting clinical information from physician offices, MNCM publicly reports physicians' performance results in Minnesota. MNCM's goals include improving care and supporting the quality initiatives of providers, reducing reporting-related expenses for medical groups, health plans, and regulators through more efficient and effective regulation, and communicating findings in a fair, usable and reliable way to medical groups, regulators, purchasers and consumers.

IPRO is one of the nation's largest and most experienced not-for-profit quality assessment and improvement organizations. IPRO's mission is to improve the quality and value of health care services, and does so by supporting the development and implementation of performance measures; increasing the capacity of providers and government agencies for performance improvement; and fostering an environment through transparency and payment reform efforts, that rewards high-quality, high-value care. With 400 staff, IPRO performs work in over 30 states, serving federal, state and local government, and private clients.

Overview

Bridges to Excellence is a not-for-profit organization developed by employers, physicians, health care services, researchers, and other industry experts with a mission to create significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable and patient-centered care.

The Hypertension Care Recognition Program is a BTE Clinician Recognition Program intended to identify clinicians who deliver high-value hypertension care to adult patients. The program is designed with an understanding that adult patients may seek the care of various types of practitioners— primary care (PCPs), cardiologists, nephrologists, and others —for treatment and management of their hypertension. Accordingly, the measures reflect that clinicians should do the following.

- Deliver high-quality care from the outset of patient contact
- Understand and consider previous treatment history to help avoid inappropriate treatment

The program comprises a set of measures, based on available clinical evidence, that promote a model of care that includes the following criteria.

- Comprehensive patient assessment and reassessment
- Patient education
- Shared decision making

BTE's Hypertension Care requirements assess clinical measures representing standards of care for patients with hypertension. BTE believes that the Hypertension Care Recognition program has the potential to significantly improve the quality of care experienced by patients with hypertension and to reduce the financial and human burden of unnecessary hospitalizations and complications.

To earn Hypertension Care Recognition, clinicians and medical practices voluntarily submit medical record data documenting their delivery of care to patients with hypertension. BTE has partnered with two objective third-party independent Performance Assessment Organizations (PAOs) to evaluate clinician data based on standard measures to publicly recognize those that meet the BTE Hypertension Care performance thresholds. Those clinicians not meeting the BTE Hypertension Care performance thresholds remain anonymous to BTE and its health plan licensees. BTE's Hypertension Care Recognition Program has three performance thresholds.

Clinician Benefits of Recognition

- Clinicians can demonstrate to the public and to their professional peers that they meet the standards of care assessed by the program by issuing a press release, as well as having their recognition achievements posted on BTE's consumer portal, HealthGrades (www.healthgrades.com), and communicated to both health plans and employers.
- Clinicians may use the BTE Recognition to demonstrate that they meet the standards of care assessed by the program when contracting with health organizations and purchasers of health services.
- Clinicians can identify areas of their practice that vary from the performance criteria and take steps to improve quality of care.
- Where applicable, clinicians can establish eligibility for pay-for-performance bonuses or differential reimbursement or other incentives from payers and health plans.
- Clinicians who achieve Hypertension Care Recognition by submitting data through a CCHIT-certified[1] electronic health record or through an electronic health record certified to meet the federally-defined Meaningful Use criteria will also receive BTE Level II Physician Office Link (POL) recognition.

Background on the Measurement Criteria

Eligible clinicians and medical practices voluntarily apply for BTE Recognition by submitting information on how they treat and manage their patients with regard to the following.

Clinical measures[2]
1. Blood pressure (BP) control
2. LDL control
3. Complete lipid profile
4. Use of aspirin
5. Documentation of urine protein test
6. Documentation of annual serum creatinine test
7. Documentation of smoking status and cessation advice and treatment
8. Documentation of diabetes screening test
9. Documentation of counseling for diet and physical activity

[1] The Certification Commission for Healthcare Information Technology or CCHIT is a recognized certification body for electronic health records and their networks, and an independent, voluntary, private-sector initiative, whose mission is to accelerate the adoption of health information technology by creating an efficient, credible and sustainable certification program. A list of CCHIT-certified products can be found at http://cchit.org/.

[2] *Clinical measures* evaluate performance based on care provided to a sample of individual patients and documented in the medical records of those patients. Clinical measures are scored based on the percentage of the sample (denominator) which meet or comply (numerator) with the measure threshold.

Clinicians who demonstrate high-quality performance based on these measures are awarded BTE Hypertension Care Recognition.

Recognition Program Structure

Given the evidence in the literature advocating the creation of clinician quality reward programs that promote continuous quality improvement amongst its participants, the BTE Hypertension Care Recognition Program is designed to include 3 levels or tiers of recognition. Assessment for recognition in all 3 tiers is based upon data submitted on the same hypertension measures (listed above).

Level I: Focuses on a clinician-centric[3] view of measurement, looking at individual metrics summed to produce a composite score, with the inclusion of "minimum" performance requirements for all intermediate outcome control measures, both poor and superior (i.e., BP control and LDL control). Thresholds have been set to focus on above average performance.

Level II: Focuses on a combination of clinician and patient-centric[4] measurements. Level II includes the measurement of individual metrics summed to produce a composite score, with the inclusion of "minimum" performance requirements for all intermediate outcome control measures. Also looks at the defect rate of care delivery across poor control measures on a per patient basis. Thresholds have been set to focus on very good performance.

Level III: Focuses on patient-centric view of measurement, looking at the defect rate of care delivery across superior control measures on a per patient basis. Clinicians must demonstrate that they are using advanced processes and delivering all the right care on a per patient basis. Thresholds have been set to focus on exceptional performance.

[3] Clinician-centric refers to performance assessment involving evaluation of clinician performance based upon discrete measures (i.e. BP <140/90), which is applied across the eligible patient panel. The results provide a picture of a clinician's performance on a given measures across his or her eligible patient panel. Since the process leads to clinician-focused results it is said to be "clinician-centric."

[4] Patient centric refers to performance assessment involving evaluation of clinician performance based upon composite measures, created by combining 2 or more separate discrete measures into a single measure (i.e. combining BP <140/90 and LDL <130mg/dl into 1 single measure), which is applied on a per patient basis. The results provide a picture of an individual patient's performance on a set of measures which make–up the composite measure. Since the process leads to patient-focused results it is said to be "patient-centric."

What Recognition Requires

To seek BTE Hypertension Care Recognition, clinician applicants must submit medical record data that demonstrates they meet BTE's Hypertension Care performance requirements. Each measure has an assigned maximum available point value; the total of all the measures is the same across all levels of recognition. A clinician achieves points for a measure based on the percentage of his or her patient sample that meets or exceeds the set thresholds for that measure.

Performance Assessment Organizations (PAOs) award recognition to clinicians who achieve at least:

Level I: 60% of the total possible points
Level II: 60% of the total possible points
Level III: 60% of the total possible points

Minimum Requirements

To be eligible for recognition, clinicians must attain at least 60 percent of the total of possible points. In the case of clinical measures, this means a minimum of 25 patients for the denominator of each measure for individual clinician applicants, and a minimum of 10 patients for the denominator of each measure for each individual clinician in a practice level applicant, with a minimum practice average of 25 patients per clinician.

To achieve points for the discrete intermediate outcomes control measures (i.e., BP, LDL) and some process measures, applicants must meet certain minimum criteria. Applicants who fail to meet the minimum criteria on a measure will receive 0 points for that measure. Applicants must qualify for each level of recognition before they can be assessed for a subsequent level (e.g., must pass Level I to be assessed for Level II).

Tables 1, 2 and 3 show the program measures and the associated point values for scoring clinicians' performance.

Table 1: Hypertension Care Level I Measures, Performance Criteria and Scoring

Level I focuses on a clinician-centric view of measurement, looking at individual metrics summed to produce a composite score, with the inclusion of minimum requirements for intermediate outcome control measures (i.e., BP control and LDL control). Thresholds have been set to focus on above average performance.

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
Poor Control Measures[5]			
Blood Pressure Control	≥ 160/100	≤ 45% of pts in sample	15
LDL Control	≥ 160 mg/dl	≤ 40% of pts in sample	15
Superior Control Measures			
Blood Pressure Superior Control	< 140/90	≥ 20% of pts in sample	10
LDL Superior Control	< 130 mg/dl	≥ 25% of pts in sample	10
Process Measures			
Complete Lipid Profile	N/A	N/A	5
Use of Aspirin[6]	N/A	≥ 65% of pts in sample	10
Urine Protein Test	N/A	N/A	10
Annual Serum Creatinine Test	N/A	N/A	5
Smoking Status and Cessation Advice and Treatment	N/A	N/A	10
Diabetes Screening Test	N/A	N/A	5
Counseling for Diet and Physical Activity	N/A	N/A	5
		Total Points	100
		Percentage of Total Points Needed to Achieve Recognition	60

[5] Poor control measures, both discrete and composite, are measures of poor care. A lower percentage is representative of good care. The number of points awarded to the applicant for a poor control measure is calculated by (1 – the percentage of patients meeting the threshold) x the maximum points for that measure.

[6] Measure is applicable to a subset of the eligible patient population only and requires a minimum of 25 eligible patients for the denominator subset. Applicants who do not meet this measure-specific patient minimum will not be scored on this measure, and the maximum points for the measure will be removed from the total possible points. 60 percent of the total possible points are needed to achieve recognition in these cases.

Table 2: Hypertension Care Level II Measures, Performance Criteria and Scoring

Level II focuses on a combination of clinician and patient-centric measurements. Level II includes the measurement of individual metrics summed to produce a composite score, with the inclusion of "minimum" requirements for all intermediate outcome control measures. Also looks at the defect rate of care delivery across poor control measures on a per patient basis. Thresholds have been set to focus on very good performance.

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
Poor Control Composite Measure[5]			
Blood Pressure Control	≥ 160/100	N/A	30
LDL Control	≥ 160 mg/dl		
Superior Control Measures			
Blood Pressure Superior Control	< 140/90	≥ 20% of pts in sample	10
LDL Superior Control	< 130 mg/dl	≥ 25% of pts in sample	10
Process Measures			
Complete Lipid Profile	N/A	N/A	5
Use of Aspirin[6]	N/A	≥ 65% of pts in sample	10
Urine Protein Test	N/A	N/A	10
Annual Serum Creatinine Test	N/A	N/A	5
Smoking Status and Cessation Advice and Treatment	N/A	N/A	10
Diabetes Screening Test	N/A	N/A	5
Counseling for Diet and Physical Activity	N/A	N/A	5
		Total Points	100
Percentage of Total Points Needed to Achieve Recognition			60

[5] Poor control measures, both discrete and composite, are measures of poor care. A lower percentage is representative of good care. The number of points awarded to the applicant for a poor control measure is calculated by (1 – the percentage of patients meeting the threshold) x the maximum points for that measure.

[6] Measure is applicable to a subset of the eligible patient population only and requires a minimum of 25 eligible patients for the denominator subset. Applicants who do not meet this measure-specific patient minimum will not be scored on this measure, and the maximum points for the measure will be removed from the total possible points. 60 percent of the total possible points are needed to achieve recognition in these cases.

Table 3: Hypertension Care Level III Measures, Performance Criteria and Scoring

Level III focuses on patient-centric view of measurement, looking at the defect rate of care delivery across superior control measures on a per patient basis. Clinicians must demonstrate that they are using advanced processes and delivering all the right care on a per patient basis. Thresholds have been set to focus on exceptional performance.

Clinical Measures	Threshold	Criteria	Maximum Points
Poor Control Composite Measure[5]			
Blood Pressure Control	≥ 160/100	N/A	30
LDL Control	≥ 160 mg/dl		
Superior Control Composite Measure			
Blood Pressure Superior Control	< 140/90	N/A	20
LDL Superior Control	< 130 mg/dl		
Process Measures			
Complete Lipid Profile	N/A	N/A	5
Use of Aspirin[6]	N/A	≥ 65% of pts in sample	10
Urine Protein Test	N/A	N/A	10
Annual Serum Creatinine Test	N/A	N/A	5
Smoking Status and Cessation Advice and Treatment	N/A	N/A	10
Diabetes Screening Test	N/A	N/A	5
Counseling for Diet and Physical Activity	N/A	N/A	5
		Total Points	100
		Percentage of Total Points Needed to Achieve Recognition	60

For a sample clinician scoring report, see Appendix B.

[5] Poor control measures, both discrete and composite, are measures of poor care. A lower percentage is representative of good care. The number of points awarded to the applicant for a poor control measure is calculated by (1 – the percentage of patients meeting the threshold) x the maximum points for that measure.

[6] Measure is applicable to a subset of the eligible patient population only and requires a minimum of 25 eligible patients for the denominator subset. Applicants who do not meet this measure-specific patient minimum will not be scored on this measure, and the maximum points for the measure will be removed from the total possible points. 60 percent of the total possible points are needed to achieve recognition in these cases.

Eligibility for Clinician Participation

Clinicians may apply for BTE Hypertension Care Recognition as individuals or part of a medical practice. To be eligible, applicants must meet the following criteria.

- Applicants must be licensed as a medical doctor (M.D. or D.O.), nurse practitioner (N.P.), or physician assistant (P.A.).
- Applicants must provide continuing care for patients with hypertension and be able to meet the minimum patient sample sizes.
- Applicants must complete all application materials and agree to the terms of the program by executing a data use agreement and authorization with a data aggregator partner.
- Applicants must submit the required data documenting their delivery of care for all eligible patients in their full patient panel.
- Applicants must use PAO-supplied or approved methods for submitting data electronically.

Individual clinician applicant

An individual clinician applicant represents one licensed clinician practicing in any setting who provides continuing care for patients with hypertension[7].

Medical practice applicant

A medical practice applicant represents any practice with three or more licensed clinicians who, by formal arrangement, share responsibility for a common panel of patients and practice at the same site, defined as a physical location or street address. For purposes of this assessment process practices of two clinicians or less must apply as individual applicants.

[7] **Eligible Hypertension patients** are 18-75 years of age, with a documented diagnosis of essential hypertension (as defined by criteria labeled "Patient Eligibility Criteria") for at least 12 months AND have been under the care of the applicant clinician or practice for at least 12 months. This is defined by documentation of two face-to-face visits for hypertension care between the clinician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

Applying for Recognition

Clinician applicants opt to voluntarily submit their data to a PAO for performance assessment through the Hypertension Care Recognition program. Participating clinicians must execute a data use agreement with the data aggregator partner through which they plan to submit data for BTE's automated performance assessment process. All data aggregator partners have data use agreements executed with their partnering PAO. All necessary steps will be taken by the data aggregator and PAO to protect the confidentiality of patient data, as required by The Health Insurance Portability and Accountability Act of 1996 (HIPAA). To assist with clinician compliance with HIPAA, the data aggregator partner provides a Business Associate addendum referenced in the data use agreement, which states that both the data aggregator and the clinician applicant will comply with HIPAA requirements.

Clinicians considering applying for recognition should:

1. Determine eligibility. See "Eligibility for Clinician Participation" on page 10 for more information.

2. Familiarize themselves with the BTE Hypertension Care measures and specifications. See "What Recognition Requires" on page 6.

3. Determine whether to apply as an individual clinician or medical practice.

Clinicians submitting through a data aggregator partner are required to submit medical record data for all eligible patients across their full patient population on a quarterly calendar schedule. Clinicians are required to continue submitting data for all eligible patients each quarter unless they cease using the data aggregator's electronic system.

Clinicians that are new to an electronic data aggregator partner's system, where the system is not yet fully integrated in the clinicians' office and patient records have not been backloaded, are required to prospectively enter all eligible patients from their full patient panel into the data aggregator's electronic system. For individual applicants, clinician assessment will automatically be triggered after all required data is submitted through the data aggregator's electronic system for the minimum requirement of 25 eligible patients. For practice level applicants, assessment will automatically be triggered after all required data is submitted through the data aggregator's electronic system for 10 patients per individual clinician and a practice average of 25 patients per clinician. It is assumed that after one full year of usage of the data aggregator's electronic system that all eligible patients will be included.

Completed applications are processed for compliance with performance requirements, and applicant-specific reports with results for all Hypertension Care measures are produced within 30 days. The begin recognition date is calculated based on the date that the applicant's data is scored. BTE issues an official certificate to each recognized clinician or medical practice.

Additionally, BTE reserves the right to complete an audit of any individual or practice application for Recognition. PAOs or specified local organization subcontractors conduct audits of at least 5 percent of applicants from each data aggregator partner each year. Hypertension Care audits may be completed by fax, mail, electronically or on site, as determined by the PAO. Any data identified by the PAO as irregular will be subject to audit. The remainder of the 5 percent will be selected through a random sampling methodology.

The PAO will notify the data aggregator which will notify the applicant if their application is chosen for audit, ascertain that audit personnel have no conflict of interest with the audited organization and provide instructions on audit requirements. Obtaining final Recognition results takes longer than usual for applicants chosen for audit. For those applicants selected for audit, final Recognition determination will be made within 60 days of the date of data submission. Upon passing an audit, the applicant's recognition dates are assigned retroactively to the date the applicant's data was scored. Failure to pass an audit results in no further consideration for the Hypertension Care program for six months to two years (depending on the audit score) from the date of submission of the application.

Duration of Recognition

For Hypertension Care Recognitions achieved on or before December 31, 2009, Recognition status remains in effect for **3 years** from the date on which a PAO awards recognition. Beginning January 1, 2010, the Hypertension Care Recognition duration will be shortened to **2 years** from the date on which a PAO awards recognition.

For continuously assessed applicants who maintain their current level of recognition, new begin and end recognition dates will be assigned at the time of the most recent assessment. Recognition determinations are made on the basis of a specific patient population. Recognition status remains in effect for the duration of recognition as long as the clinician maintains his or her current practice and patient base. Clinicians are responsible for informing the data aggregator within 30 days who will inform the PAO if they move or change practices.

Changes in Recognition Levels

Continuous data submission applicants are eligible for changes in recognition level. Clinicians who achieve at least Level I Hypertension Care Recognition will maintain their Hypertension Care Recognition for the duration of recognition outlined above. However, during this time it is possible for the recognition status to move between program levels (I, II and III) based on changes in clinical data from quarter to quarter. Changes to program level and recognition dates occur according to the following rules:

- Clinicians who achieve a higher level of recognition for two consecutive assessment periods will have their recognition level changed effective the date of the most recent assessment.
- Clinicians recognized at Level II or III can drop in levels of recognition based on lower scoring results for two consecutive assessment periods.

- Each time a clinician's recognition status changes levels in either direction a new begin recognition date is assigned for the date of the most recent assessment and a new end recognition date is calculated.
- Clinicians who drop below Level I for two consecutive quarterly assessments will be assigned or maintain Level I Hypertension Care Recognition status and maintain their current begin and end recognition dates.

Example 1: Clinician A assessment history

Assessment period	*Assessment date*	*Assessed (Scored) Level*[8]	*Recognition Level*[9]	*Recognition Dates*
10/1/07-9/30/08	10/22/08	Level III	Level III	10/22/08-10/22/2011
1/1/08-12/31/09	1/21/09	Level III	Level III	1/21/09-1/21/2012
4/1/08-3/31/09	4/18/09	Level III	Level III	4/18/09-4/18/2012
7/1/08-6/30/09	7/25/09	Level II	Level III	4/18/09-4/18/2012
10/1/08-9/30/09	10/16/09	Level II	Level II	10/16/09-10/16/2012

Example 2: Clinician B assessment history

Assessment period	*Assessment date*	*Assessed (Scored) Level*	*Recognition Level*	*Recognition Dates*
10/1/08-9/30/09	10/22/09	Not Pass	N/A	N/A
1/1/09-12/31/10	1/21/10	Level II	N/A	N/A
4/1/09-3/31/10	4/18/10	Level II	Level II	4/18/2010-4/18/2012
7/1/09-6/30/10	7/25/10	Not Pass	Level II	4/18/2010-4/18/2012
10/1/09-9/30/10	10/16/10	Not Pass	Level I	4/18/2010-4/18/2012
Assessment period	Assessment date	Assessed (Scored) Level	Recognition Level	Recognition Dates
10/1/08-9/30/09	10/22/09	Not Pass	N/A	N/A
1/1/09-12/31/10	1/21/10	Level II	N/A	N/A
4/1/09-3/31/10	4/18/10	Level II	Level II	4/18/2010-4/18/2012
7/1/09-6/30/10	7/25/10	Not Pass	Level II	4/18/2010-4/18/2012
10/1/09-9/30/10	10/16/10	Not Pass	Level I	4/18/2010-4/18/2012

[8] A clinician's Assessed Level is the BTE level at which the clinician's data is scored for the current measurement period.

[9] A clinician's Recognition Level is the BTE level at which the clinician is currently recognized and the level that is distributed to BTE's health plan licensees and the BTE consumer portal at HealthGrades. A clinician's Recognition Level may or may not be the same as a clinician's Assessed Level.

Reporting Results to BTE and Its Partners

As part of BTE's mission to identify and promote quality, PAOs report results to the following:

- To the data aggregator partner through which the recognition application was submitted. The data aggregator is required to share results reports with the clinician applicant to facilitate quality improvement. See Appendix for a sample results report.
- To BTE: Only Recognized statuses are reported to BTE for display on BTE's consumer portal for recognition information hosted by HealthGrades and transmission to BTE-licensed health plans for associated rewards payments. Once the final decision is made, the PAO will reveal the identity, program name and program level of the recognized clinicians only. No clinical data is shared with BTE at any point in the process.

Terms of Recognition

When communicating with patients, third-party payers, managed care organizations (MCOs) and others, clinicians or practices who receive BTE Hypertension Care Recognition may represent themselves as BTE-recognized and meeting NQF/AQA quality measure requirements; however, clinicians or practices may not characterize themselves as "NQF/AQA-Approved" or "NQF/AQA-Endorsed." The use of this mischaracterization or other similarly inappropriate statements will be grounds for revocation of status.

Revoking Recognition

PAOs may revoke a Recognition decision if any of the following occurs:

- The clinician or practice submits false data or does not collect data according to the procedures outlined in this manual, as determined by discussion with the clinician or practice or audit of application data and materials.
- The clinician or practice misrepresents the credentials of any of its clinicians.
- The clinician or practice misrepresents its Recognition status.
- The clinician or any of the practice's clinicians experience a suspension or revocation of medical licensure.
- The clinician or practice has been placed in receivership or rehabilitation and is being liquidated.
- State, federal or other duly authorized regulatory or judicial action restricts or limits the clinician or practice's operations.
- BTE identifies a significant threat to patient safety or care.

Data Use Terms

Data use terms are outlined in the data use agreement that the applicant signs with the selected data aggregator partner.

BRIDGES to Excellence
Rewarding Quality across the Healthcare System

Appendix B: Sample Results Report

COLOR KEY

Yellow = Those values which are numerator compliant for the poor control discrete measures OR Patient numerator compliant for poor control composite measure	Sky Blue = Those values which are numerator compliant for the superior control discrete measures OR Patient numerator compliant for superior control composite measure	Light Orange = Those values which are numerator compliant for each of the process measures

Sample Data Set Calculation

BTE Hypertension Care Recognition Sample Data Set Calculation

Clinical Measures	BP	LDL	Lipid profile	Aspirin Use	Urine Protein	Serum Creatinine	Smoking Status Cessation & Tx	DM Screening	Diet & Physical Activity
	-	-	-	-	-	-	-	-	-
Patient 1	125/75	122	NO	YES	YES	YES	NO	YES	YES
Patient 2	135/95	124	YES	YES	NO	NO	NO	YES	NO
Patient 3	160/90	175	YES	YES	YES	YES	YES	YES	YES
Patient 4	135/80	88	YES	NO	YES	NO	NO	NO	YES
Patient 5	155/110	118	YES	YES	NO	NO	YES	YES	YES
Patient 6	120/75	184	YES	NO	NO	NO	YES	YES	YES
Patient 7	140/85	120	YES	NO	YES	YES	YES	YES	NO
Patient 8	170/90	175	NO	YES	NO	YES	YES	NO	YES
Patient 9	130/75	180	YES	YES	YES	YES	YES	NO	YES
Patient 10	132/85	150	YES	YES	YES	YES	YES	YES	YES
Patient 11	145/85	160	YES	YES	NO	NO	NO	YES	NO
Patient 12	124/85	92	YES	NO	YES	YES	YES	NO	YES
Patient 13	145/85	98	YES	YES	YES	YES	NO	YES	YES
Patient 14	180/100	165	NO	NO	YES	YES	NO	YES	YES
Patient 15	135/85	128	YES	YES	NO	NO	NO	YES	NO
Patient 16	165/100	168	NO	YES	YES	YES	YES	YES	YES
Patient 17	130/70	145	YES	YES	NO	YES	YES	YES	YES
Patient 18	124/78	94	NO	YES	NO	NO	NO	YES	NO
Patient 19	135/85	170	YES	YES	YES	NO	YES	YES	YES
Patient 20	120/65	98	YES	YES	YES	YES	YES	YES	YES
Patient 21	110/75	110	YES	NO	YES	YES	YES	NO	YES
Patient 22	115/70	140	YES	YES	NO	YES	YES	YES	YES
Patient 23	125/75	155	YES	YES	YES	NO	NO	YES	YES
Patient 24	138/85	155	YES	YES	NO	YES	YES	YES	YES
Patient 25	120/80	84	NO	NO	YES	YES	NO	NO	YES

BRIDGES to Excellence
Rewarding Quality across the Healthcare System

Level I Recognition

Clinical Measures	Threshold	Minimum Criteria	Sample Meeting Threshold	Maximum Available Points	Points Earned
Poor control measures					
Blood Pressure Control	≥ 160/100	≤ 45% of pts in sample	5/25 = 20 %	15	**12.0**
LDL Control	≥ 160 mg/dl	≤ 40% of pts in sample	8/25 = 32%	15	**10.2**
Superior control measures					
Blood Pressure Superior Control	< 140/90	≥ 20% of pts in sample	16/25 = 64%	10	**6.4**
LDL Superior Control	< 130 mg/dl	≥ 25% of pts in sample	12/25 = 48%	10	**4.8**
Process measures					
Complete Lipid Panel	N/A	N/A	19/25 = 76%	5	**3.8**
Use of Aspirin	N/A	≥ 65% of pts in sample	18/25 = 72%	10	**7.2**
Urine Protein Test	N/A	N/A	15/25 = 60%	10	**6.0**
Annual Serum Creatinine	N/A	N/A	16/25 = 64%	5	**3.2**
Smoking Status and Cessation Advice & Tx	N/A	N/A	15/25 = 60%	10	**6.0**
DM Screening Test	N/A	N/A	19/25 = 76%	5	**3.8**
Diet and Physical Activity Counseling	N/A	N/A	20/25 = 80%	5	**4.0**
TOTAL POINTS				**100**	**67.4**
PERCENTAGE OF TOTAL POINTS NEEDED TO ACHIEVE RECOGNITION				**60**	**60**

Level II Recognition

Clinical Measures	**Threshold**	**Minimum Criteria**	**Sample Meeting Threshold**	**Maximum Available Points**	**Points Earned**
Poor control composite measure					
Blood Pressure Control	≥ 160/100	N/A	9/25 = 36%	30	**19.2**
LDL Control	≥ 160 mg/dl				
Superior control measures					
Blood Pressure Superior Control	< 140/90	≥ 20% of pts in sample	16/25 = 64%	10	**6.4**
LDL Superior Control	< 130 mg/dl	≥ 25% of pts in sample	12/25 = 48%	10	**4.8**
Process measures					
Complete Lipid Panel	N/A	N/A	19/25 = 76%	5	**3.8**
Use of Aspirin	N/A	≥ 65% of pts in sample	18/25 = 72%	10	**7.2**
Urine Protein Test	N/A	N/A	15/25 = 60%	10	**6.0**
Annual Serum Creatinine	N/A	N/A	16/25 = 64%	5	**3.2**
Smoking Status and Cessation Advice & Tx	N/A	N/A	15/25 = 60%	10	**6.0**
DM Screening Test	N/A	N/A	19/25 = 76%	5	**3.8**
Diet and Physical Activity Counseling	N/A	N/A	20/25 = 80%	5	**4.0**
TOTAL POINTS				**100**	**64.4**
PERCENTAGE OF TOTAL POINTS NEEDED TO ACHIEVE RECOGNITION				**60**	**60**

Level III Recognition

Clinical Measures	**Threshold**	**Minimum Criteria**	**Sample Meeting Threshold**	**Maximum Available Points**	**Points Earned**
	-	-	-	-	-
Poor control composite measure					
Blood Pressure Control	≥ 160/100	N/A	9/25 = 36%	30	**19.2**
LDL Control	≥ 160 mg/dl				
Superior control composite measure					
Blood Pressure Control	< 140/90	N/A	8/25 = 32%	20	**6.4**
LDL Control	< 130 mg/dl				
Process measures					
Complete Lipid Panel	N/A	N/A	19/25 = 76%	5	**3.8**
Use of Aspirin	N/A	≥ 65% of pts in sample	18/25 = 72%	10	**7.2**
Urine Protein Test	N/A	N/A	15/25 = 60%	10	**6.0**
Annual Serum Creatinine	N/A	N/A	16/25 = 64%	5	**3.2**
Smoking Status and Cessation Advice & Tx	N/A	N/A	15/25 = 60%	10	**6.0**
DM Screening Test	N/A	N/A	19/25 = 76%	5	**3.8**
Diet and Physical Activity Counseling	N/A	N/A	20/25 = 80%	5	**4.0**
TOTAL POINTS				**100**	**59.6**
PERCENTAGE OF TOTAL POINTS NEEDED TO ACHIEVE RECOGNITION				**60**	**60**