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DEPT. OF HEALTH AND HUMAN SERVICES

Heart Disease Prevention & Management Request for Application

"Nebraska Heart Disease and Stroke Clinical Quality Improvement"

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, CHRONIC DISEASE PREVENTION AND CONTROL PROGRAM
Contact Information: DHHS.CDPCprogram@nebraska.gov

Introduction and Overview:

The purpose of this request for application (RFA) is to solicit applications from qualified Clinics and Health Systems invested in planning and implementing sustainable policy and systems change(s) around cardiovascular health through a partnership with the Nebraska Department of Health & Human Services (DHHS) Chronic Disease Prevention & Control Program (CDPCP).

This opportunity focuses on improving clinical detection and management of adult patients (ages 18-85) that have undiagnosed and/or unmanaged high blood pressure. This award supports awardees in identifying gaps in care and then planning and implementing focused interventions in two strategies: Electronic Health Record (EHR) utilization and Team-Based care (TBC). Awardees will also develop comprehensive Self Monitored Blood Pressure (SMBP) Programs and Social Determinants of Health (SDOH) Screening and Referrals Programs.

Heart disease was the leading cause of death in both Nebraska and the United States in 2021[1]. High blood pressure and high blood cholesterol are major risk factors for heart disease and strokes. In 2021, approximately 31.7% of adults in Nebraska reported having high blood pressure and 31.7% reported having high blood cholesterol[2]. This award provides clinics the opportunity to devote time to the development of policies and programs that are proven to improve outcomes in hypertensive patients.

Purpose

The purpose of this award is to support qualified clinics and health systems in the design, implementation, and evaluation of evidence-based interventions aimed at improving the prevention and management of cardiovascular diseases. More specifically, the development of Self Monitored Blood Pressure (SMBP) Programs and Social Determinants of Health (SDOH) Screening and Referral Programs.

[1] Centers for Disease Control and Prevention (CDC). CDC Wonder. National Vital Statistics System Data, 2021.
[2] Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data, 2019.

Evidence-Based Interventions

This award supports clinics and health systems in the design, implementation, and evaluation of the following interventions for adults:

1. Social Determinants of Health (SDOH): Social determinants of health are defined as "nonmedical factors that influence health outcomes." They are factors such as access to nutritious food, adequate housing, transportation, financial ability to pay for medications, utilities, and basic household items, childcare, freedom from racial discrimination, abuse of any kind, or any other nonmedical factor that may inhibit their ability to remain healthy. *Current data shows that 47% of a person's health is attributed to social determinants of health*, while healthy behaviors account for 35%, 16% is attributed to clinical care, and 3% to physical environment[3]. Clinics will develop a comprehensive screening program utilizing the Unite Us Platform. This technology allows data on the number, type, and outcome of referrals for patients with hypertension. By the end of the 18-month project, the clinic should have a written policy for screening all patients, send referrals to appropriate community organizations, and track the outcomes of these referrals. This program will be developed over 9 months of the project period with quarterly deliverables to help guide the creation of your clinics policy.

2. Self-Measured Blood Pressure Monitoring (SMBP) with Clinical Support: SMBP is also referred to as remote patient monitoring and is the use of a blood pressure monitoring device at the patient's home to assess and record blood pressure across different points in time outside of a clinical setting. When combined with clinical support (e.g., one-on-one counseling, web-based or telephonic support tools, education), this intervention can enhance the quality and accessibility of care for people with high blood pressure and improve blood pressure control[4]. These programs are also useful for diagnosing masked hypertension or ruling out white coat syndrome. Awardees will develop and implement a SMBP with clinical support program by creating policies or systems that integrate SMBP into the care of patients with high blood pressure. They will spend a total of 9 months of the project period developing and implementing this program. Please review the attached deliverable documents for more information, along with the resource guide.

3. EHR Utilization: Utilizing EHR systems to their full capacity promotes efficient team-based care and improves outcomes. The EHR should serve as the main information hub for the care team. Participants should work on evidence-based practice changes around the way they use electronic documentation for gather demographic data, SDOH needs, tracking referrals, and facilitating team-based care. Sub-awardees may also work on enhancing the development and usage of various reports for priority populations within their patient population.

4. Team-Based Care (TBC): TBC is a multi-disciplinary approach to patient care. It utilizes the expertise of the patient, the primary care provider, and other non-physician team members such as nurses, pharmacists, dieticians, social workers, patient navigators, and/or community health workers to achieve coordinated, high-quality care. Principles of TBC

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[3] Assistant Secretary for Planning and Evaluation (ASPE), Office of Health Policy, Addressing Social Determinants of health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts, 2022.

[4] Centers for Disease Control and Prevention. *Best Practices for Cardiovascular Disease Prevention Programs: A Guide to Effective Health Care System Interventions and Community Programs Linked to Clinical Services*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2017.

include: (1) shared goals; (2) clear roles; (3) mutual trust; (4) effective communication; and (5) measurable processes and outcomes. Non-physician team members enhance the work of the primary care provider in the form of process support and shared responsibilities of care in areas such as: medication adherence, support, education and management; patient follow up and adherence; self-management support and education; community resources connections; dietary, physical activity, and weight loss counseling; and diagnosis and disease processes education. Awardees will develop policies and systems and explore innovative activities to enhance TBC for patients with high blood pressure. For guidance in advancing TBC, please refer to the "Resources" section of this RFP.

Note: The team may include external clinical partners like pharmacies, dieticians, local health departments, and others.

Project Structure and Timeline

Application Open	*03/05/2025-05/10/2025*
Decisions Released	*05/16/2025*
Scan and Plan Due	*06/13/2025*
Work Period Starts	*07/01/2025*
Work Period Ends	*12/31/2026*
1 year post sustainability assessment	*12/31/2027*

After completion of the application period, selected clinics will complete the Scan and Plan tool which serves as an assessment of their current practices. They will then create an action plan of 3-5 activities for the Team Based Care and EHR Integration sections that will span at least 1 year of work.

SMBP and SDOH will each utilize a 9-month project period for a total of 18 months of work. Clinics will select which program they would like to start with utilize the deliverable guides spend the first quarter "planning" their program, then "training" their staff, and lastly "implementing" the new policy/procedure. Both SDOH and SMBP will not be worked on at the same time.

1 year after the end of the project period 12/2027, clinics will be contacted for a final evaluation of the sustainability of the programs and assessment of their HTN rate. This allows DHHS to assess whether interventions made during the project period were sustainable and the long-term impact of these programs.

Who May Participate

The following entities located in Nebraska are eligible to submit an application in accordance with this RFA:

- For profit or nonprofit independent primary care, rural health, family medicine, or internal medicine clinics

If multiple clinics within one health system apply, each must have separate and unique patient populations and health care providers. The activities for this award are to be conducted at the individual clinic level and DHHS will communicate directly with each clinic. The health system will support the work of the individual clinics.

Ineligible Entities

- Awardees who currently receive funding from DHHS through the 2304 cooperative agreements with CDC.
- Organizations with a hypertension control rate greater than 88%

Benefits of Participation

While the focus of this award is to improve cardiovascular health outcomes as part of DHHS's cooperative agreement with the CDC, an awardee may experience many additional benefits through participating. An awardee may:

- Improve blood pressure control rates among their patient population.
- Improve the results of healthcare interventions for individuals with chronic diseases and conditions.
- Increase value-based pay and chronic disease care management reimbursement.
- Increase patient engagement and satisfaction.
- Receive supportive guidance, expertise, resources, funding, and technical assistance from DHHS and other partners.
- Share and promote successes to CDC, Nebraska medical professional associations, health systems, and clinics through DHHS reporting.
- Collect data that demonstrates clinical improvement efforts and supports application for the American Heart Association's Target BP program recognition.

Award Information

Estimated Total Funding: $177,500

Project Period: ~1.5 years

Maximum Award Amount per Clinic: $35,500

Anticipated Total Number of Awards: 5 clinics

This is an outcomes-driven award. Awardees must implement evidence-based interventions and demonstrate action towards sustained organization-level change around high blood pressure control and high blood cholesterol management. DHHS will monitor progress through:

- Regular check-in meetings conducted by phone or virtually.

- Progress reports for each work period.
- Completion of the post-Scan and Plan assessment.
- Participation in evaluation activities.

DHHS will award payments based on (1) the completion of all required deliverables and (2) the demonstration that work is positively contributing to the advancement of the awardee's action plan and the expected outcome measures of the award.

DHHS staff will monitor awards and assure that all awardees comply with federal and state statutes/regulations/policies. If an awardee (1) fails to comply with federal and state statutes/regulations/policies and/or (2) fails to perform its obligations of the award in a timely or proper manner, DHHS has the right to temporarily withhold payments pending the correction of any deficiency; disallow all or part of the cost of an activity or action not in compliance; wholly or partly suspend or terminate the award; or take any other remedies that may be legally available and necessary.

For an estimated payment summary, please refer to the "Funding Summary for One Clinic" section below.

Site Visits

Sub awardee may be selected for a site visit from DHHS staff during the duration of their work period. This visit will be to monitor award progress and allow for firsthand assessment of current practices.

Funding Summary for One Clinic

CAAPIE Framework Phase	Deliverable/ Documentation	Deliverable Frequency and Timeline	Payment
Capture	General Info and Outcomes tabs of the Scan and Plan Tool	One time during the application period	*$0.00 or N/A* **This is part of the required application process*
Assess			
• **Pre-Assessment**	SDOH, EHR Utilization, TBC, and SMBP tabs of the Scan and Plan Tool	One time during the application period	*$0.00 or N/A* **This is part of the required application process*
• **Post-Assessment**	Evaluation of clinic practices adopted during original 18-month project period, HTN control rate report, SDOH screening and referral report, and SMBP participant report.	One time. 1 full year post 18-month project period	One payment of $2,000
Action Plan	Action Planning tab of the Scan and Plan Tool	One time during the application period	*$0.00 or N/A* **This is part of the required application process*
Implement	Check-in Meetings and Six Progress Reports: 1. Progress reports for each project period that provide a description/reflection of progress towards Action Plan activities for each of the four interventions: SDOH, EHR Utilization, TBC, and SMBP. The reports may also include requested data and other supporting documentation such as awardee-created workflows, policies, and patient education materials. 2. SMBP or SDOH policy drafts addressing requirements from "deliverable" documents 3. Updated HTN control report, and # of patients screened for SDOH and any positive findings and/or # of patients participating in SMBP 4. Participation in check-in meetings with DHHS.	1. Submitted at the end of each of the four project periods. 2. Every 6 weeks (or as requested)	Required Interventions: • EHR Utilization • SDOH: Must meet required criteria on policy • TBC • SMBP: Must meet required criteria on policy Per Progress Report Total: $5,000 six payments of $5,000 for a total of $30,000 *Please note that if progress is not noted on each intervention participant may receive a pro-rated payment.
Evaluate	Evaluation Activities: 1. Participate in all evaluation activities requested by DHHS, including a 30 min. meeting in which the awardee evaluates DHHS's facilitation of this award opportunity. 2. Write a minimum of one final success statement per intervention.	1. As requested by DHHS	Two payments of $1,750 (one following Period 3 and one following Period 6) for a total of $3,500.

		2. One time in Progress Report 4	

TOTAL AVAILABLE FUNDING $35,500

Award Requirements and Expectations

This is an outcomes-driven award. Awardees must implement evidence-based interventions and demonstrate action towards sustained organization-level change around high blood pressure control and high blood cholesterol management. To support the work, awardees will:

- Designate a staff member to serve as the point of contact to DHHS (for Health System applicants, each Clinic must designate a staff member).
- Create a team of staff dedicated to completing the award work.
- Maintain clear and timely communication with DHHS.
- Participate in check-in meetings with DHHS every 4-6 weeks or as requested.
- Submit timely and robust deliverables that demonstrate continued progress with each intervention.
    - At its discretion, CDPCP may change reporting and submission requirements in order to support outcome achievement.
- Use required reporting templates and tools provided by DHHS.
- Share information about partnerships and innovative practices with DHHS.
- As needed, accept technical assistance from DHHS or partner organizations.
- Participate in all evaluation activities that DHHS requests. Activities may include, but are not limited to, formal documentation, surveys, and focused conversations.

As part of the application process, applicants will sign and return the “Participation Commitment” expressing agreement to the above requirements and expectations. Each clinic will sign a “Participation Commitment.” In the application package, Health systems must provide a brief description of their role versus the role of the individual clinics in completing the award work.

If selected for this award opportunity, the awardee is required to sign the legal subaward and agree to the Terms and Assurances, which will be provided after notification of award.

Attachments

Applicants will submit the following attachments with the application. Please reference the attachments for further instructions.

Complete Applications Include
A. Clinic Application Document
B. Clinic Application Questionnaire
C. Participation Commitment

Further information can be found in the attached documents

1. Scan and Plan Tool
2. Scan and Plan Tool Demo Video
3. SDOH and SBMP Quarterly Deliverable Documents (QDD)
4. SDOH and SMBP QDD Video
5. Resource Guide.

Contact Information

For any questions, please contact DHHS at the following email address:
sara.lawless@nebraska.gov

Acknowledgement

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Appendix A:

Key Terminology

Action Plan: A detailed plan outlining action steps needed to reach one or more goals.

Action Step: The specific activity(s) an organization performs to achieve one or more goals.

Adults

Patients for Blood Pressure Control: Ages 18-85
Patients for Blood Cholesterol Management: Ages 20+

Atherosclerotic Cardiovascular Disease (ASCVD): Includes acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke or transient ischemic attack (TIA), and peripheral arterial disease of atherosclerotic origin (CMS, 2019). Find the American College of Cardiology's ASCVD Risk Estimator here.

Controlled Blood Pressure: Systolic blood pressure below 140 mm Hg and diastolic blood pressure below 90 mm Hg among patients ages 18-85 with diagnosed hypertension. If multiple readings were taken in one visit, the average of all readings should be used to obtain the final blood pressure value. Exclusions may include all patients: 1) with evidence of end-stage renal disease on or prior to the end of the measurement year; 2) with a diagnosis of a pregnancy during the measurement year; or 3) who had an admission to a non-acute inpatient setting during the measurement year.

Dyslipidemia: Elevated total or low-density lipoprotein (LDL) cholesterol levels, or low levels of high-density lipoprotein (HDL) cholesterol (ICD-10: E78.00, E78.01, E78.2, E78.4, E78.5, and E78.6).

High Blood Cholesterol/Hyperlipidemia: Total cholesterol greater than 200 mg/dL with an LDL greater than 100 mg/dL (National Cholesterol Education Program, 2001) with a diagnosis of dyslipidemia (ICD-10 codes E78.00, E78.1, E78.2, E78.4, E78.5 or E78.6) or with a high risk of cardiovascular events (based on CMS criteria) among patients ages 21+.
High Blood Pressure (HBP)/Hypertension: Systolic blood pressure (SBP) of 140 mmHg or higher or diastolic blood pressure (DBP) of 90 mm Hg or higher with a diagnosis of hypertension (ICD 10 codes I.10 - I15.8) among patients ages 18-85.

Managed Blood Cholesterol: High blood cholesterol among patients ages 21+ treated with statin medications.

Priority Population: A disparate (see disparate population definition) population for whom interventions will be targeted.

Self-Measured Blood Pressure (SMBP) with Clinical Support: A patient's regular use of personal blood pressure monitoring devices to assess and record blood pressure across different points in time outside of a clinical, community, or public setting, typically at home. When combined with clinical support (e.g., one-on-one counseling, web-based or telephonic support tools, education), this intervention can enhance the quality and accessibility of care for people with high blood pressure and improve blood pressure control.

Team-Based Care (TBC): A multi-disciplinary approach to patient care that utilizes the expertise of the patient, of the primary care provider, and of other non-physician team members such as nurses, pharmacists, dieticians, social workers, patient navigators, and/or community health workers to achieve coordinated, high-quality care. Principles of TBC include: (1) Shared goals; (2) Clear roles; (3) Mutual trust; (4) Effective communication; (5) Measurable processes and outcomes. Non-physician team members augment the work of the primary care provider in the form of process support and shared responsibilities of care in areas such as: medication adherence, support, and education; medication management; patient follow up and adherence; self-management support and education; community resources connections; dietary, physical activity, and weight loss counseling; and diagnosis and disease processes education.

Appendix B

Resources

Please take some time to explore the resources below as they are intended to assist applicants in understanding the interventions and in formulating action steps and work plans for this award.

Blood Pressure and Cholesterol Patient Education

What is High Blood Pressure?

Available in English and Spanish

Source: Target: BP

2 page overview of blood pressure and how to understand a blood pressure reading.

How Do I Manage My Medicines?

Source: Target: BP

2 page guide with tips for adherence and a sample form to use for at-home documentation.

Make the most of your appointment with a health care professional

Source: American Medical Association/American Heart Association

1 page template for patients to review and document their current health habits and most recent blood pressure in preparation for discussion with their provider.

What is High Blood Pressure Medicine?

Source: Target: BP

2 page overview of common medications and their side effects and tips for adherence.

Heart Guide

Source: Mended Hearts

105 page guide developed by patients for patients with cardiovascular disease and their caregivers.

7 Steps to a Healthy Heart

Source: Association of Black Cardiologists

32 page guide designed to teach patients how to choose a healthy lifestyle to prevent chronic disease. This guide can be grouped with the Heart and Soul cookbook. The cookbook comes in a magazine-like format and contains simple, delicious, plant-based recipes. Click here to order a free box of 25 of these cookbooks.

Hypertension Control Tools for Clinical Staff

Hypertension Control Change Package

Source: Centers for Disease Control and Prevention/Million Hearts

This is an excellent resource for brainstorming your clinics action steps. The guide includes change concepts, change ideas, and evidence- or practice-based tools and resources.

BP Connect: Improving Follow-up After High Blood Pressures Toolkit

Source: HIPxChange

BP Connect is a protocol where nurses or medical assistants during vitals assessment are prompted by EHR alerts to provide patient counseling and to create a follow-up order. This toolkit provides multiple resources that guide implementation of this protocol and that guide education to staff about the protocol. Among these resources is a step-by-step guide for building the protocol into the EHR. Users will need to create a free account with HIPxChange to access this resource.

Medication Adherence

Source: Preventative Cardiovascular Nurses Association

4 page guide on methods for improving medication adherence. The guide also includes a sample medication tracking form.

MAP BP

Source: American Medical Association

A free evidence-based quality improvement program named for its three key elements: Measure accurately, Act rapidly, Partner with patients. The AMA provides expert coaching and support with developing blood pressure dashboards for those who request the program.

Team-Based Care (TBC)

Team-Based Care to Improve Blood Pressure Control
Source: Centers for Disease Control and Prevention

Webpage that defines TBC and provides guidance for its implementation.

Technical Package for Cardiovascular Disease Management in Primary Health Care: Team-Based Care
Source: World Health Organization

36-page guide that overviews the advantages and disadvantages of TBC, steps for implementing TBC, and sample workflows. There are tables starting on page 15 that provide ideas for tasks that can be assigned to different members of the care team.

Creating Patient-Centered Team-Based Primary Care
Source: Agency for Healthcare Research and Quality

Article that discusses the need for team-based care and outlines strategies for its implementation

Cardiovascular Disease: Team-Based Care to Improve Blood Pressure Control
Source: The Community Guide

Webpage that compiles supporting research for the use of TBC in high blood pressure control as well as guidelines and resources for implementing TBC.

Effectiveness and Cost-Effectiveness of Team-Based Care for Hypertension: A Meta-Analysis and Simulation Study
Source: American Heart Association Journals

A study examining the effectiveness and cost savings of team based care with non-physician titration.

Self-measured Blood Pressure (SMBP)

7-step SMBP Quick Guide
Source: American Medical Association

5 page guide on developing an SMBP program. Includes CPT codes and validated device resources.

Ambulatory and Home Blood Pressure Monitoring
Source: National Association of Community Health Centers/Million Hearts

9 page guide for providers and for patients about implementing ambulatory or home blood pressure monitoring.

An Economic Case for SMBP Monitoring
Source: Centers for Disease Control and Prevention/Million Hearts

1 page brief that outlines the case for reimbursement of SMBP education and device purchases. Incudes CPT codes.

SMBP Patient Training Checklist
Source: Target: BP

YouTube Video: SMBP Patient Training
Source: American Medical Association

3 mins 45 secs

Home Blood Pressure Recording Log
Source: Stride BP

Validated SMBP Devices Guidance

US Blood Pressure Validated Device Listing

Stride BP Validated Blood Pressure Monitors Listing

Target BP Purchasing and Managing Devices Recommendations
Includes a sample loaner device agreement form and device inventory form.

SMBP Device Accuracy Test
Source: Target: BP

1 page checklist for verifying that and SMBP device accurately measures blood pressure.

Choosing a Home Blood Pressure Monitor for Your Practice At-A-Glance-Comparison
Source: National Association of Community Health Centers

1 page chart that compares SMBP devices by cost, validation status, device features, and data/technology features.

Health Disparities Resources

Evaluating Strategies for Reducing Health Disparities By Addressing The Social Determinants Of Health
Source: Health Affairs

This article address how treatment recommendations and education might change to address certain health disparities.

Social Determinants of Cardiovascular Disease
Source: American Heart Association Journals

An article examining health inequities.

** Please reach out to the Heart Disease and Stroke Program Coordinator for full list of SDOH screening tools

Hypertension Control and Cholesterol Management Achievement Recognition Programs

Target: BP
The Target: BP Recognition Program celebrates physician practices and health systems who achieve blood pressure control rates at or above 70 percent within the populations they serve.

Million Hearts
The Million Hearts® Hospitals & Health Systems Recognition Program acknowledges institutions working to systematically improve the cardiovascular health of the population and communities they serve.

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2 page guide with tips for adherence and a sample form to use for at-home documentation.

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1 page template for patients to review and document their current health habits and most recent blood pressure in preparation for discussion with their provider.

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EMR Integration Resources

Electronic Alerts to Improve Heart Failure Therapy in Outpatient Practice: A Cluster Randomized Trial
Source: Journal of the American College of Cardiology

Additional Resources

10-year ASCVD Risk Calculator
Source: American College of Cardiology/American Heart Association

Journal Article: Improving hypertension control and cardiovascular health: An urgent call to action for nursing
Source: Worldviews on Evidence-Based Nursing Journal
Article published on Feb. 8, 2022 that poses actions for each nursing role (e.g. RN vs. APRN vs. QI/Population Health) to take in order to control hypertension and prevent CVD.

Improving Chronic Disease Self-Management Cardiovascular Disease Change Package
Source: Quality Innovation Network
14 page guide for community coalitions working to improve cardiovascular disease self-management. The guide includes a thorough explanation of Plan-Do-Study-Act (PDSA) cycle design and it includes an extensive list of additional resources.

American Heart Association (AHA) NE Chapter
The AHA offers one-on-one assistance to clinics who are working to improve hypertension control and cholesterol management and to clinics who are developing or improving their SMBP program. It also assists clinics with completing the American Heart Association's Target BP, Check. Change. Control. Cholesterol. and Target: Type 2 Diabetes programs and receiving recognition for the completion of those programs.

Infographics and CE courses for Staff

Free CME Course: Advancing Quality Care for Patients with Hypercholesterolemia
Source: Prime Continuing Medical Education

51 mins

Infographic: In-Office Blood Pressure Measurement
Source: Target: BP

Available in English and Spanish

Infographic that demonstrates 7 steps for getting an accurate blood pressure reading. Target BP encourages providers to display it in a public place. Providers may hang the infographic on bulletin boards, frame it in exam rooms, make it a computer screensaver, and laminate and hang it on the blood pressure pump stand. It is available in a poster size or as a folded 6x9 card.

Video: How to Check Blood Pressure Manually
Source: RegisteredNurseRN.com

5 minute 16 second YouTube video that reviews how to check blood pressure with a manual cuff.

Technique Quick Check
Source: Target: BP

Checklist for determining if a medical professional accurately and consistently measures blood pressure.

Free CME Course: Measuring Blood Pressure Accurately
Source: Target: BP

65 mins

Free eLearning Course: Taking an Accurate Blood Pressure Reading
Source: Metastar

35 mins

Free CME Course: How to Improve Hypertension Control Through Team-Based Care
Source: Target: BP

60 mins

Free eLearning Course: Patient Self-Measurement of Blood Pressure
Source: Metastar

35 mins

Free CME Course: Partnering with Patients Using Self-Measured Blood Pressure and Collaborative Communication
Source: Target: BP

58 mins

Free CME Course: Health Equity and Hypertension Treatment