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Tackling Hypertension in the Workplace: A Comprehensive Approach for Employers

March 20, 2025

AGENDA

- **Welcome - HealthCareTN**
- **Cardiovascular Health- "A real-life Experience"**
  - **Lori Sepich**
- **Benefit Design to Support Hypertension Management**
  - **Neil Goldfarb**, Senior Advisor – National Alliance of Healthcare Purchasers
- **Latest Innovations in Cardiovascular Treatment Options**
  - **Dawn Waddell,** PharmD, BCPS, System Clinical Pharmacy Director - Baptist
- **Closing Comments - HealthCareTN**

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Cardiovascular Health - “A real-life Experience”

Lori Sepich

LORI SEPICH

- Heart Survivor
- Co-Founder of ***HeartQuest***
- Founder of "*Your Heart Rocks*" Project
- 2023 AHA Woman of Impact recipient

American Heart Association.

American Heart Association. Go Red for women.

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Benefit Design to Support Hypertension Management

Neil Goldfarb

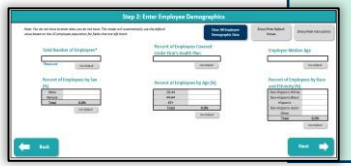
A Few Economic Metrics to Get us Started

- Employees with hypertension (HTN) have costs that are roughly $3,500 per year greater than those employees without HTN. This equates to roughly 44% higher costs.
- 30% of people with HTN do not know they have HTN, and of those who know they have HTN, 35% are uncontrolled
- People with uncontrolled HTN have more than double the lost work time due to health issues
- At least 50% of people with HTN have at least one other chronic condition or cardiac risk factor such as high cholesterol

The Budget Impact Model (BIM) allows employers and communities to **easily estimate the impact** of hypertension on a specific employee population or a broader region.

Step 1. Decide Analysis Population to Estimate Impact of Hypertension

- An entire workforce or regional population
- Stratified groups in the workforce or job function
- Key takeaway: Analysis can account for up to 5 subgroups across industry sectors or job functions or demographics – critical for large employers or regions with various industry, which have different costs or prevalence

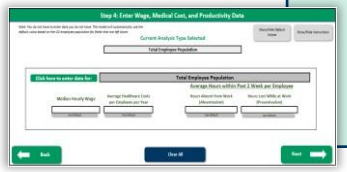


Step 2. Enter Demographic Characteristics

- Total target population; Proportion by age, sex, race, covered under health plan
- Key takeaway: Customize the results by the demographic breakdown of a specific region or employer population

Step 3. Enter Hypertension Prevalence Data (if available)

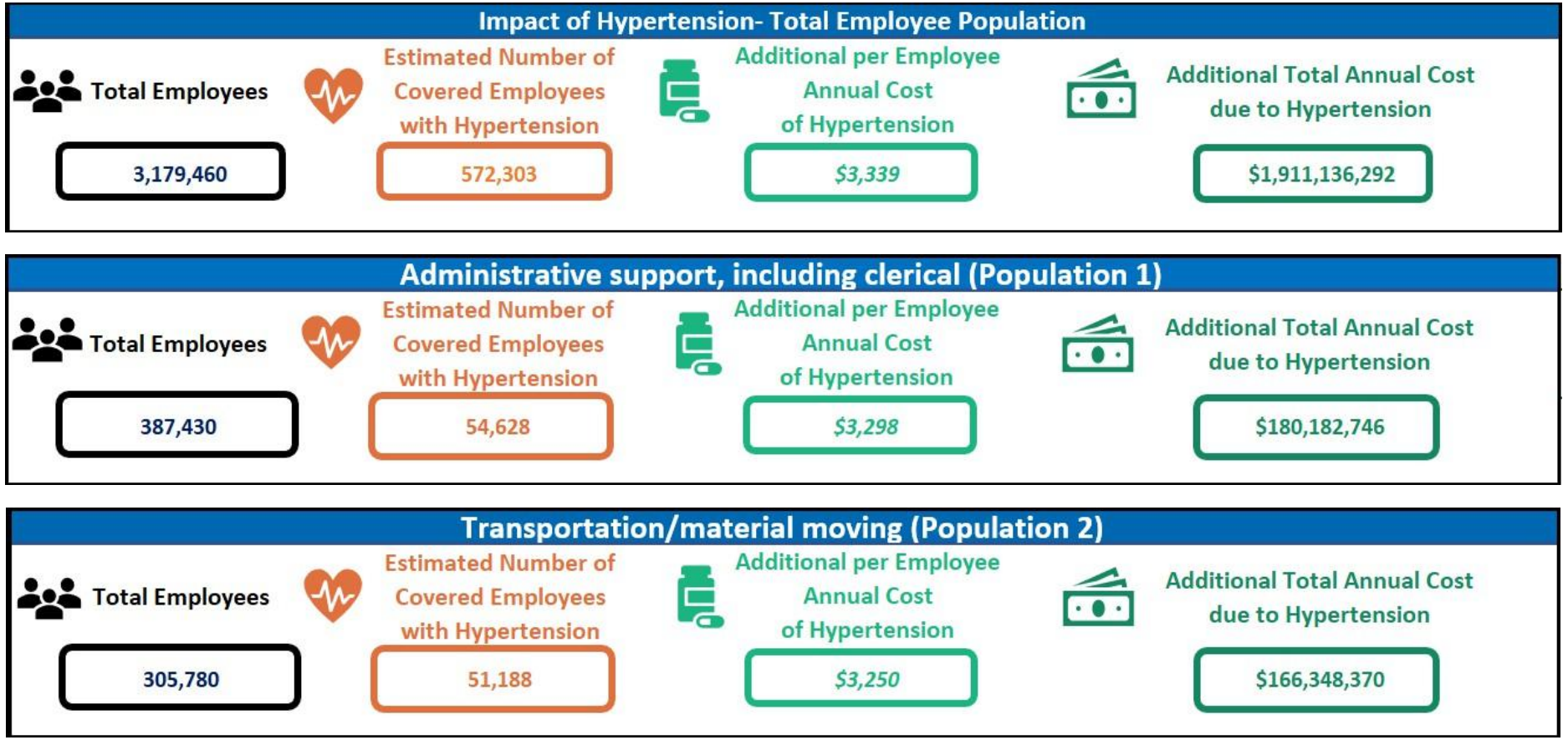
- If data are not available, use industry or job sector specific prevalence rates built into the model.
- Key takeaway: Prevalence rates vary by industry and job function and the analysis can take this into account



Step 4: Enter Average Wage and Hours Worked

- Use default values if data are not available
- Key takeaway: Customize the productivity loss cost estimates based on specific population or subgroups

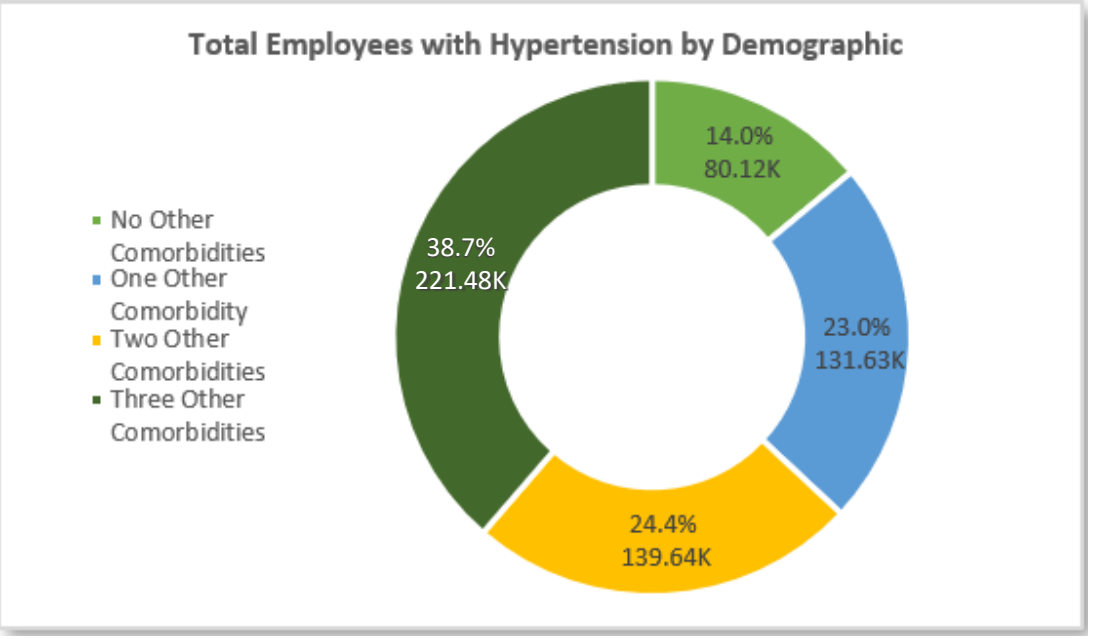
The BIM estimates the incremental costs of hypertension for a specific employer or region **overall and by sub-populations**.

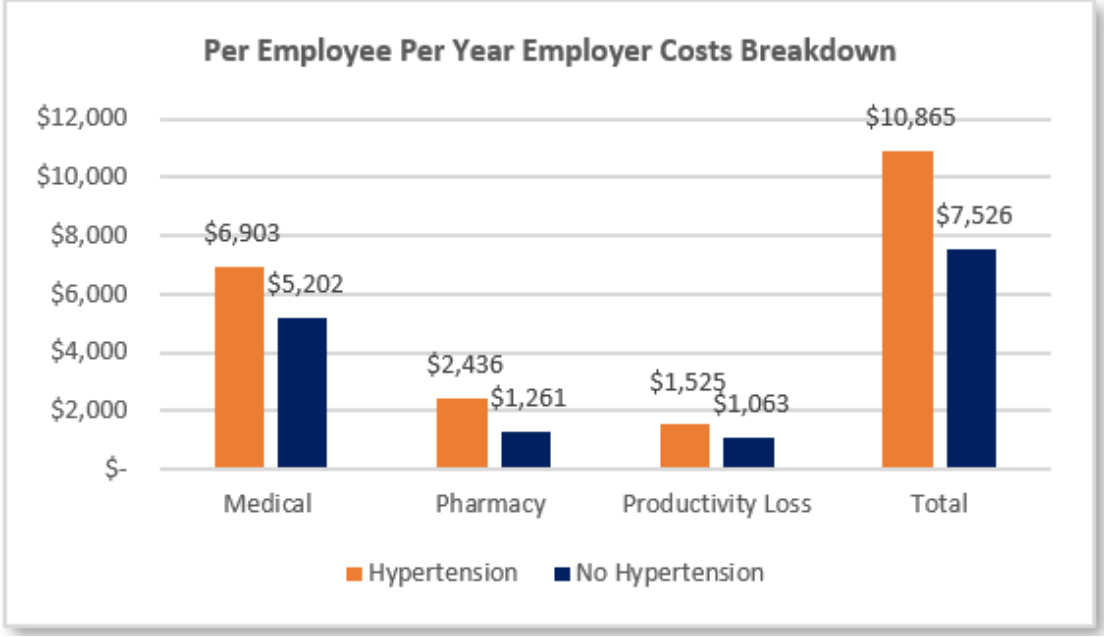


Example dashboard based on Houston with an employed population of 3,179,460. Two subpopulations were analyzed separately.

<u>Key takeaway</u>: The dashboard shows, at a glance, the overall as well as the differential per person and total impact of hypertension for each sub-population.

The BIM generates **detailed health and cost impact results** for the total population and each sub-population.



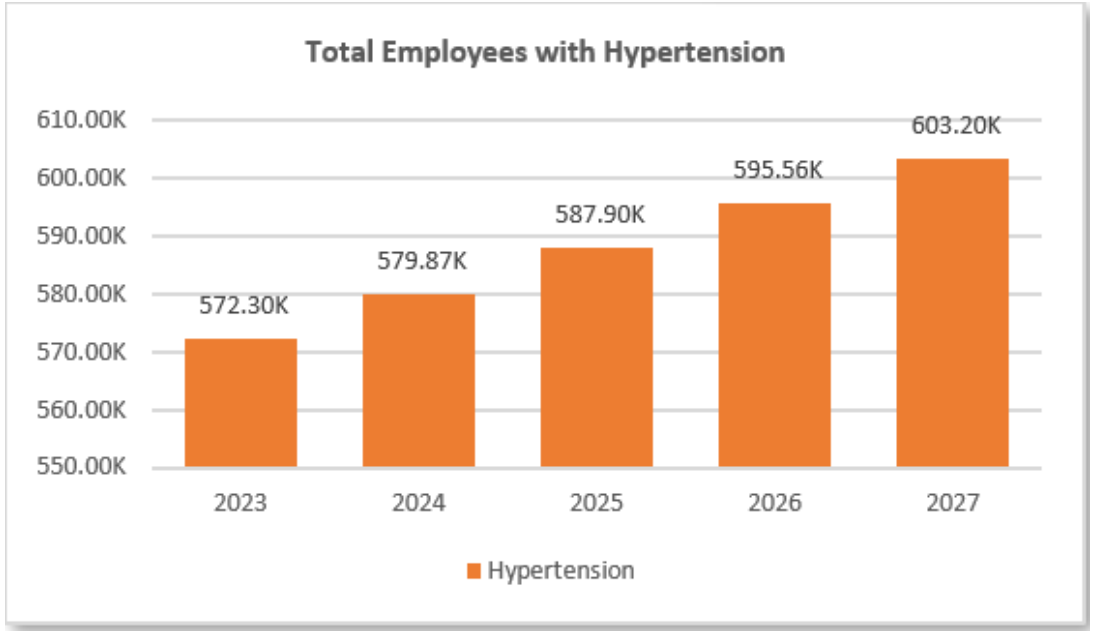


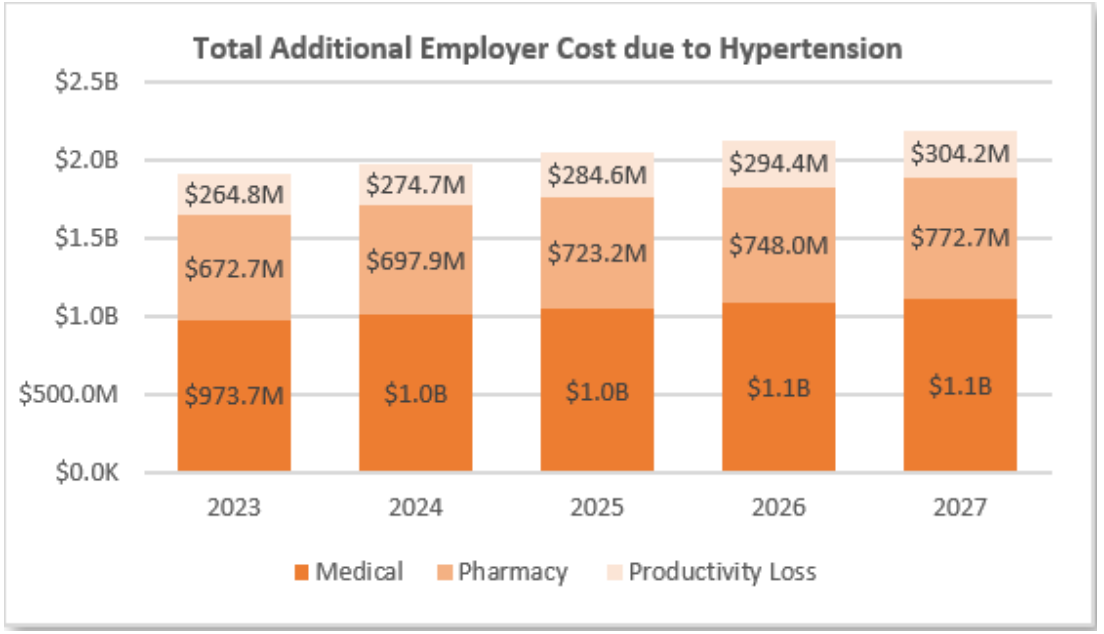
Example dashboard based on Houston with an employed population of 3,179,460. Two subpopulations were analyzed separately. For this example, default parameters based on the U.S. were used for demographic variables (age, sex, race) and were applied to Houston workforce populations.

<u>Key takeaway</u>: The BIM shows drivers of hypertension cost impacts (medical, pharmacy, and productivity loss) and the incremental costs, useful to decision-makers and those responsible for programs for assessing the current status and impact of hypertension.

The BIM generates **projected costs by cost type** and shows that without intervention, they will continue to increase.

These metrics show the cost of standing still and the benefits to gain from intervention.





Example dashboard based on Houston with an employed population of 3,179,460. Two subpopulations were analyzed separately. For this example, default parameters based on the U.S. were used for demographic variables (age, sex, race) and were applied to Houston workforce populations.

<u>Key takeaway</u>: The BIM provides data and transparency for your business and community in terms of opportunity costs and future costs with no additional intervention.

The Claims Analysis Guide was developed to help **employers ask questions and obtain data** to **understand drivers and inform interventions** and insurance benefit decision-making.

Question 1: How many employees have hypertension?

- Provides data points for decision making including current number of employees with hypertension and number of employees newly diagnosed.

Question 2: What are the costs related to hypertension?

- Provides detailed insights on hypertension-related direct medical costs broken out by various categories such as age group, race/ethnicity, type of care (e.g., inpatient hospitalization, physician office visit), treatment category, and neighborhood characteristics as measured by the Social Deprivation Index (SDI).

Question 3: How many employees are treated with medication for hypertension?

- Provides data on hypertension treatment and adherence as measured by proportion days covered (PDC).

1. “Health Insurance Claims Analysis Guide for Employers,” FTI Consulting (2023). Note: Developed for the CDC Foundation by FTI Consulting's Center for Healthcare Economics and Policy.

To Access the BIM and Claims Analysis Guide on the FTI Consulting Website:

https://www.ftichep.com/hypertensiontools/

Note: these resources are free; registration is required

Comprehensive Benefit Design for Hypertension

7 Strategies for prevention, screening, and management

Employers are encouraged to view the strategies as a **checklist of key interventions** to implement for reducing the impact of hypertension: both by **reducing the number of individuals with hypertension** and **helping to control blood pressure for those diagnosed** with this chronic condition.

View the guide here: https://hypertensioncontrol.org/wp-content/uploads/2023/11/Comprehensive-Benefit-Design-for-Hypertension.pdfenefits Design for Hypertension

September 2023

Comprehensive Benefit Design for Hypertension
Employer Recommendations for Action

Hypertension (high blood pressure) affects nearly 50% of working-age adults in the U.S., resulting in significant impacts on health and well-being (e.g., cognitive decline, kidney disease), direct costs of care (e.g., hospitalization, physician visits), and indirect costs (absenteeism and presenteeism). This Comprehensive Benefit Design for Hypertension is intended to help employers, as purchasers of health benefits, and stewards of population health, develop and implement well-being and benefit design strategies to prevent, control, and manage the impact of hypertension.

The Comprehensive Benefit Design for Hypertension draws on a wide variety of resources from the U.S. Centers for Disease Control and Prevention, the American Heart Association, and similar organizations that are committed to improving population health and blood pressure control. These, and other resources are listed toward the end of this guide.

How Employers Can Use this Comprehensive Benefit Design for Hypertension

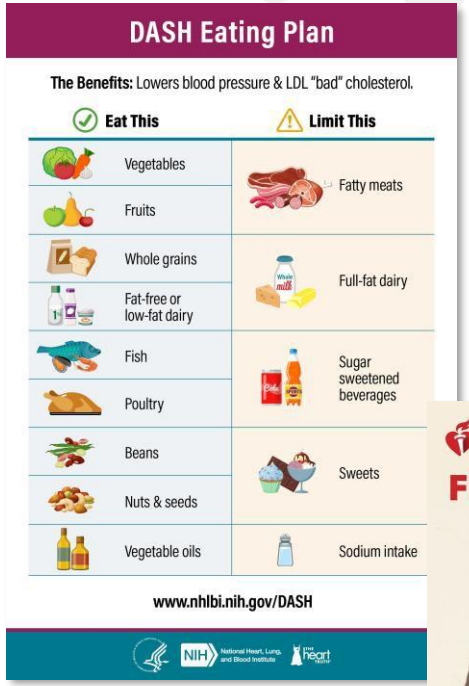
Employers are encouraged to view the following strategies as a checklist of key interventions to implement for reducing the impact of hypertension: both by reducing the number of individuals with hypertension, and helping to control blood pressure for those diagnosed with this chronic condition. These strategies are intended to improve the health of the workforce and the community, and lower healthcare costs. The Resource List provides additional information and tools to assist employers in implementing these seven strategies.

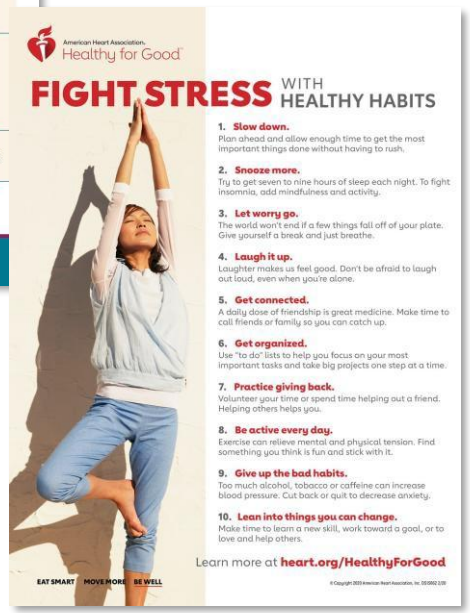
GPBCH Greater Philadelphia Business Coalition on Health
DRIVING INNOVATION AND VALUE IN HEALTHCARE

www.GPBCH.org

Strategy 1: Primary Prevention/Lifestyle Support

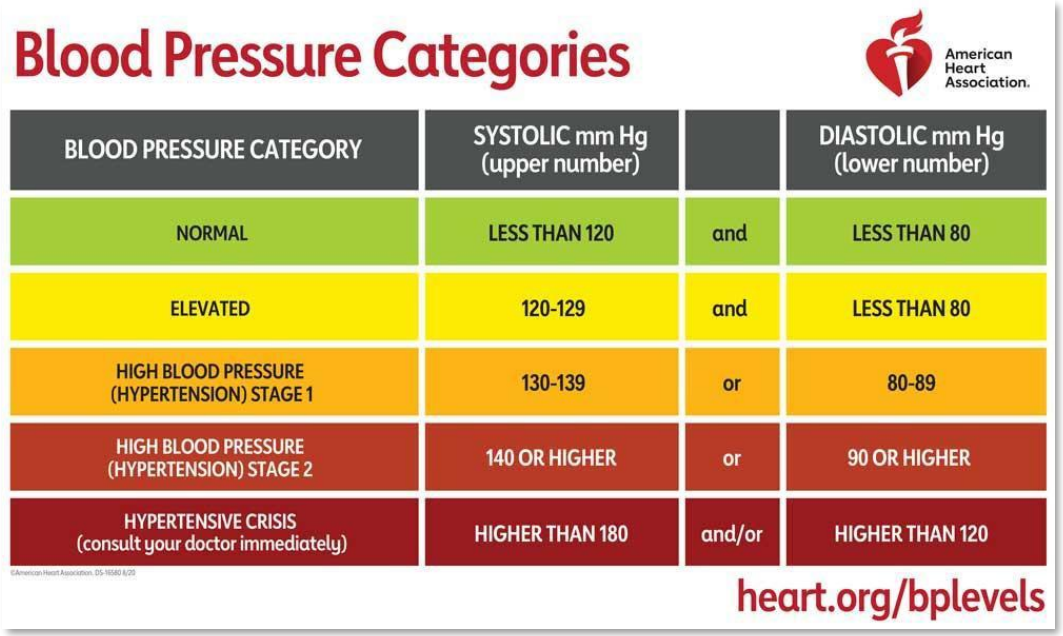
- ❑ Healthy eating and physical activity programs
- ❑ Availability of healthy foods, including low-sodium options
- ❑ Promote smoke-free campus and smoking cessation
- ❑ Education and resources to limit alcohol intake
- ❑ Education and resources to promote healthy sleep
- ❑ Promote healthy weight: lifestyle, Rx benefit, surgical benefit
- ❑ Promote access to mental health resources, including EAP





Strategy 2: Screening &Detection

- ❑ Promote primary care relationships
- ❑ Incorporate blood pressure (BP) measurement into health fairs and other events
- ❑ HRA's should include family history, and self-reported BP, or biometric measurement
- ❑ Determine how high BP findings will be referred/followed-up



Blood Pressure Categories

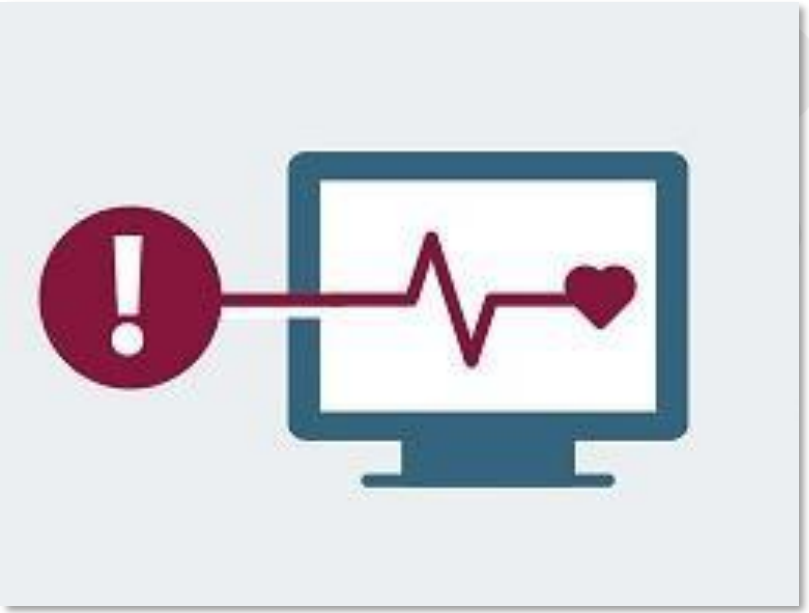
American Heart Association.

BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (upper number)		DIASTOLIC mm Hg (lower number)
NORMAL	LESS THAN 120	and	LESS THAN 80
ELEVATED	120-129	and	LESS THAN 80
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 1	130-139	or	80-89
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 2	140 OR HIGHER	or	90 OR HIGHER
HYPERTENSIVE CRISIS (consult your doctor immediately)	HIGHER THAN 180	and/or	HIGHER THAN 120

heart.org/bplevels

Strategy 3: Know YOUR Data

- ❑ Ask health plans and vendors to provide information on:
  - **Population prevalence of hypertension**
  - **Subgroup differences: age, gender, race/ethnicity, co-morbidities…**
  - **Percent (%) of population with HTN has a primary care relationship**
  - **Percent (%) of population with HTN on pharmacotherapy**
    - For those on pharmacotherapy, what is the adherence rate
- ❑ Ask and learn how each of these indicators are measured
- ❑ Track progress over time, looking at both prevalence and cost



https://www.cdc.gov/dhdsp/materials_for_professionals.htm

3b: Additional Questions for Health Plans

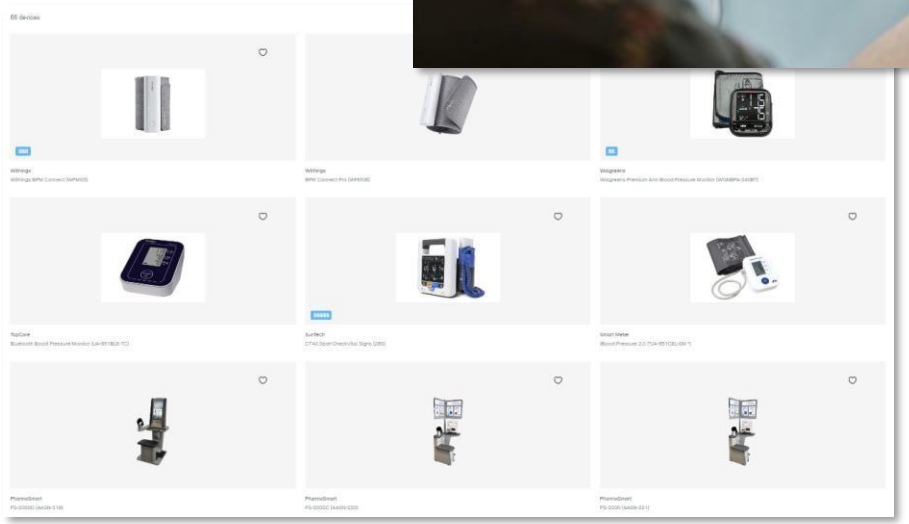
- ❑ What are your commercial HEDIS rates for the hypertension measures?
- ❑ What programs are you offering to manage hypertension?
- ❑ Is it possible to capture blood pressure in claims data?
- ❑ How are you trying to foster primary care relationships, especially for people with hypertension?

Controlling High Blood Pressure

Measure Year	Commerical HMO	Commercial PPO	Medicaid HMO	Medicare HMO	Medicare PPO
2021	60.3	50.8	58.6	70.4	70.1

Strategy 4: Benefit Design Considerations

- Value-based insurance design (V-BID)for HTN medications
- Coverage of self-monitoring BP cuffs (validated)
  - **Check out ValidateBP.org** (American Medical Association)
- Pharmacist review of formulary



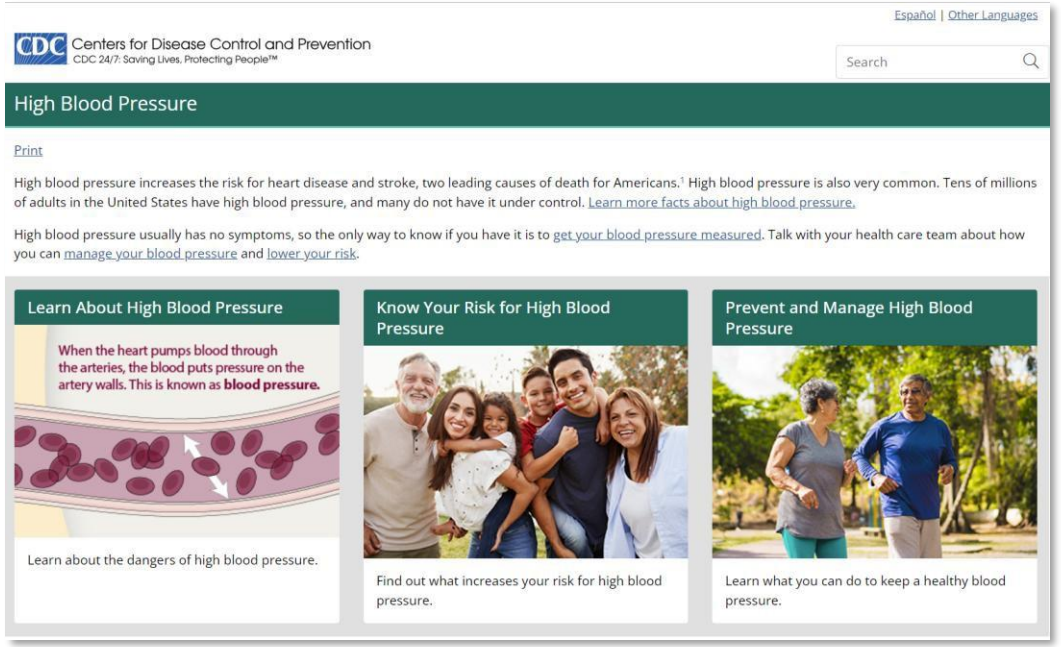
https://www.validatebp.org/

Strategy 5: Promoting Appropriate Care Management

- ❑ Ensure that all people with diagnosed HTN have a PCP
- ❑ Assess health plan programs and resources to support patient education and high-quality care
- ❑ Implement MTM or CMM (pharmacist review) for those with co-morbidities
- ❑ Consider outsourcing to a HTN management vendor, or providing access to self-management apps
- ❑ Ensure appropriate follow-up for hospitalizations related to HTN

Strategy 6: Promote a Supported Workforce with Resources

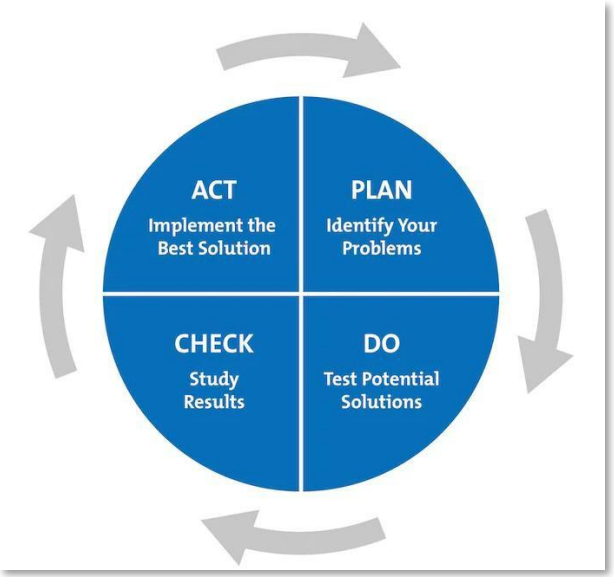
- ❑ Link to resources from AHA, CDC, and other organizations
- ❑ Easy access (including $) to educational tools and programs
- ❑ Identify existing resources for individual counseling (e.g., registered dietitian), and consider adding services
- ❑ Recognize impact of Social Determinants of Health; identify and address inequities
- ❑ Consider fostering patient resource groups



https://www.cdc.gov/bloodpressure/index.htm#print

Strategy 7: Evaluate and Continuously Improve Your Efforts

- Refer back to strategy 3: Know your data
- At least annually, track these key metrics:
  - **Hypertension prevalence**
  - **Hypertension control**
  - **Obesity prevalence**
  - **Incidence rates and costs for HTN-related events (cardiac and cerebrovascular)**
  - **Overall trends in direct cost for total population, and HTN sub-group**



https://www.mindtools.com/as2l5i1/pdca-plan-do-check-act

Takeaways from GPBCH Employer Collaborative on Hypertension

- Few employers had a HTN strategy in place (prior to the project)
- Employers recognize "cardiovascular disease" as a cost driver, but don't necessarily develop preventive strategies for risk factors such as HTN or hyperlipidemia
- Employers were not aware of what their benefit designs covered with regard to HTN, e.g. blood pressure monitors, HTN medication out-of-pockets
- Employers were very interested in asking health plans and consultants to look at HTN prevalence, links to primary care utilization, and Rx adherence for HTN medications
- Employers were going to look at the link between HTN as a co-morbidity, and costs and utilization for common and costly chronic conditions such as diabetes

Contact Information

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Latest Innovations in Cardiovascular Treatment Options

Dawn M. Waddell, PharmD, BCPS
System Clinical Pharmacy Director

Overview

- Cardiovascular disease
- Disease management
- Medication adherence
- Workplace wellness programs

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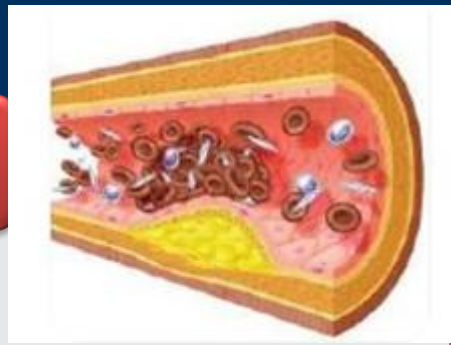
Cardiovascular Disease (CVD)



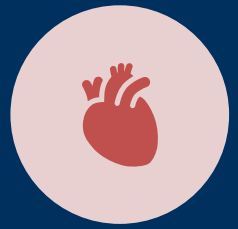
Atherosclerotic CVD (ASCVD)

- **Coronary heart disease** (heart attacks)
- Cerebrovascular disease (stroke)
- Peripheral artery disease (pain/claudication)
- Aortic atherosclerosis / aortic aneurysm

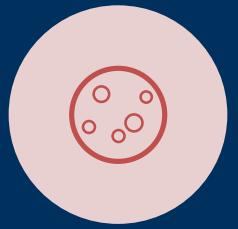
Additional cardiac diseases

- Heart failure
- Arrhythmia
- Heart valve problems

Key CVD Risk Factors



HYPERTENSION



DYSLIPIDEMIA

GLUCOSE INTOLERANCE / DIABETES

OBESITY

SMOKING

PHYSICAL INACTIVITY

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HYPERTENSION

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Hypertension (HTN)

Normal BP	< 120 / < 80
Elevated	120-129 / < 80
Stage 1 HTN:	130-139 / 80-89
Stage 2 HTN:	≥ 140 / ≥ 90

- 46% of adults have HTN
- 76% with HTN if age ≥ 65
- <50% HTN patients controlled

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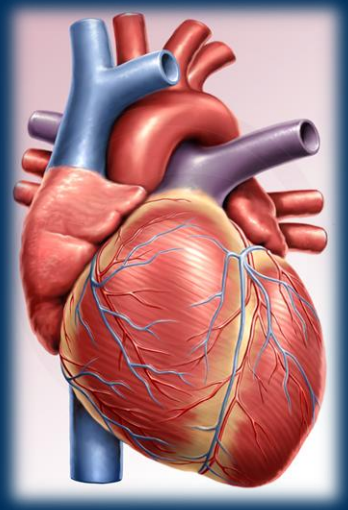
Increased BP = Increased Health Risk

Every 20 mmHg systolic BP (or 10 mmHg diastolic BP) above normal = 2x risk of death from heart disease or stroke



HTN damages small blood vessels in the kidneys, damaged kidneys are not able to regulate BP as well leading to harmful cycle of HTN and kidney damage

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HTN Medication Therapy

Medication Class	Example	Additional Benefit
ACE-I ARB	Lisinopril (Zestril) Losartan (Cozaar)	Heart failure Kidney disease Diabetes
Calcium channel blocker	Amlodipine (Norvasc)	
Thiazide/TZD-like diuretic	Hydrochlorothiazide (HCTZ) Chlorthalidone (Thalitone)	
Mineralocorticoid	Spironolactone (Aldactone)	Heart failure Kidney disease
Beta blocker	Carvedilol (Coreg) Metoprolol (Lopressor, Toprol)	Post-heart attack Heart failure Arrhythmia
SGLT2-I	Empagliflozin (Jardiance) Dapagliflozin (Farxiga)	Diabetes Heart failure Kidney disease

Various classes often used in combination

10 mmHg reduction in BP = ↓20% risk of CV events

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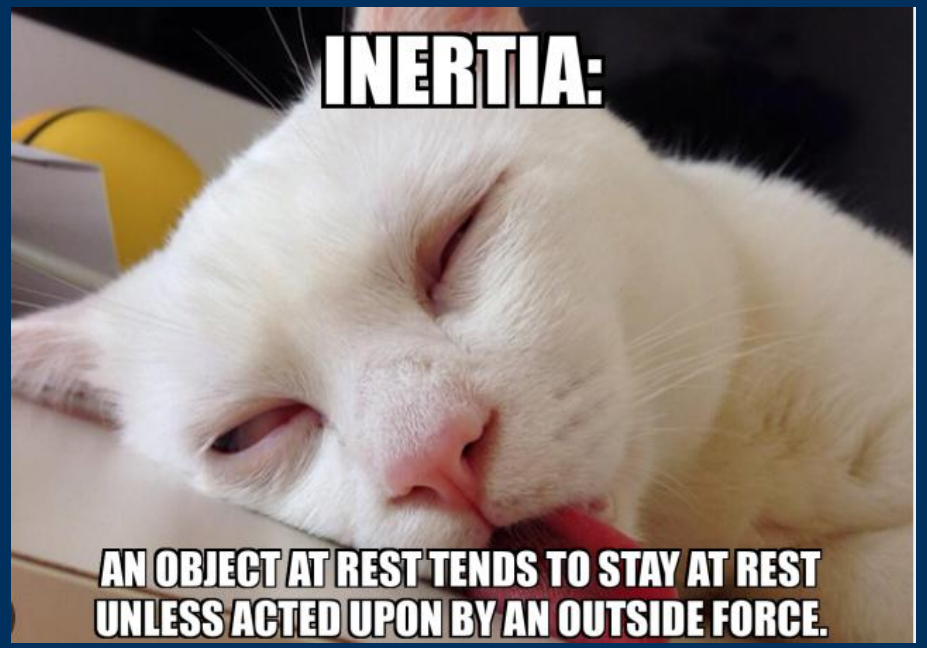

Avoid Therapeutic Inertia!

40% of patients with uncontrolled HTN are only on ***1 medication***

Patients should be evaluated every 2-4 weeks until BP at goal

Once BP at goal, evaluate every 3-6 months

Visits can be in-person or via telehealth

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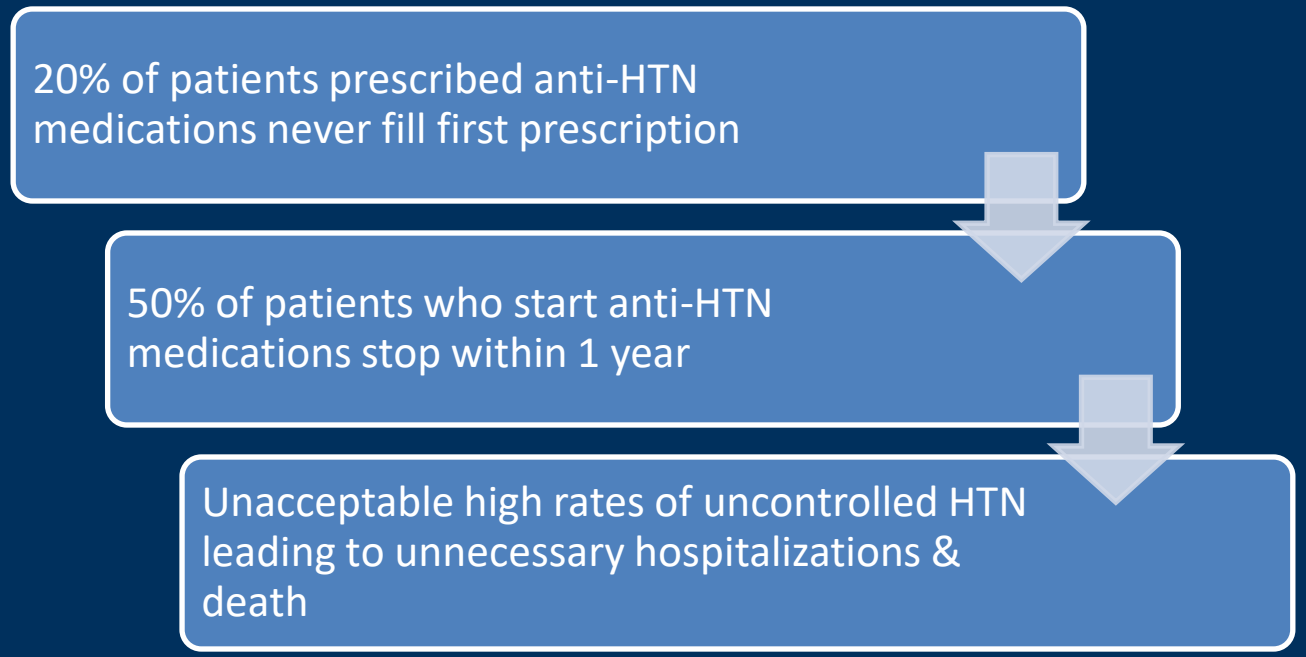
Non-Adherence



Pharmacist Tips:

- Long-acting medications / once-daily dosing
- Combination pills
- Synchronize prescriptions for fewer trips to the pharmacy for refills
- Incorporate mail-order pharmacy services
- **Counsel patients!**

Fischer MA et al. Am J Med 2011; 124:1081
Vrijens B et al. BMJ 2008; 336:1114

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Hypertensive Emergencies

Heart attack

Stroke

Eye damage

Kidney failure

- Symptoms
  - Chest pain or pain in upper back or between shoulders
  - Difficulty breathing
  - Nausea or vomiting
  - Severe headache
  - Confusion
  - Passing out / seizures
  - Weakness on 1 side of body, or 1 arm or leg
  - Difficulty talking
  - Blurry vision/ vision changes
  - Brown or bloody urine
- Seek urgent medical help

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DYSLIPIDEMIA

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Cholesterol

Key ingredient for your body to make new cells

Made in the liver and comes from diet

Different lipid types:

- Triglycerides: most common type of fat in body
- HDL: “good cholesterol”
- LDL: “bad cholesterol”
  - Leads to plaque build-up in arteries contributing to increased heart attack and stroke risk
  - Goal <100 mg/dL

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Cholesterol-Lowering Medications

- Providers evaluate LDL levels and CV risk to consider lipid lowering medications
- 1st-line = Statins:
  - ↓ LDL by 25-55% and **↓ relative CVD risk by 30%**
  - Atorvastatin (Lipitor) or Rosuvastatin (Crestor) often preferred due to larger reductions in LDL and CV risk
  - Diabetes patients should also be prescribed statins
- Additional medications:
  - Ezetimibe (Zetia)
  - Bempedoic acid (Nexletol)
  - Colesevelam (Welchol)
  - Alirocumab (Praluent), Evolocumab (Repatha)

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GLUCOSE & DIABETES MANAGEMENT

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Glucose & Insulin Resistance

Body breaks down food -> converts to glucose

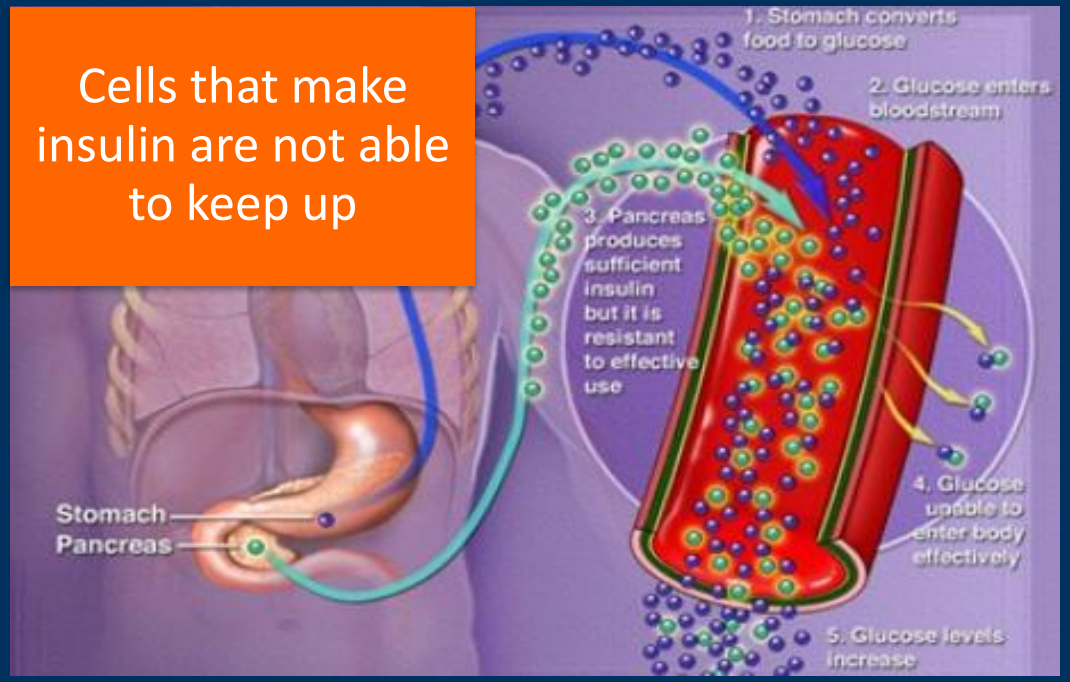
Glucose enters blood stream

Insulin helps glucose enter cells to use for energy

Body unable to use insulin efficiently -> insulin resistance

Cells that make insulin are not able to keep up

Leads to high glucose levels in bloodstream -> Diabetes



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Type 2 Diabetes Mellitus (DM2)

- Obesity = #1 risk factor
- ↑ risk of heart attacks, stroke, kidney disease, neuropathy, eye damage, poor wound healing, vascular issues leading to amputations
- Most common diagnoses methods:
  - A1C = measures average BG over past 2-3 months
  - Fasting glucose test = measures BG when patient has not had anything to eat or drink for ~8 hours

	Normal	Pre-Diabetes/↑Risk	Diabetes
A1C	4-5.6%	5.7-6.4%	≥6.5%
Fasting glucose	<100 mg/dL	100-125 mg/dL	≥126 mg/dL

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DM2 Treatment

Medications	Medication Names	Possible side effects	Additional
Metformin	Metformin (generic)	GI side effects	Oral, inexpensive
SGLT2-I	Dapagliflozin (Farxiga) Empagliflozin (Jardiance)	UTIs, genital infections	Oral, $$
GLP-1	Semaglutide (Ozempic) Tirzepatide (Mounjaro)	GI side effects	Injection, $$$$
Insulin	Glargine (Lantus, Levemir) Aspart (Humalog, Novolog)	Hypoglycemia, weight gain	Injection, $$
Various	--	--	--

- Additional
  - Control HTN
  - Lipid therapy (Statin)
  - Consider Aspirin
  - DM education
  - Get to goal!

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OBESITY

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Obesity Overview

Classification	BMI
Normal	18.5-24.9 kg/m2
Overweight	25-29.9 kg/m2
Class I Obesity	30-34.9 kg/m2
Class 2 Obesity	35-39.9 kg/m2
Class 3 Obesity	≥ 40 kg/m2

- Prevalence in US adults (2020)
  - BMI ≥ 30: ~42%
  - BMI ≥ 40: ~9%
- ↑ Annual medical costs per person (2019 $'s)
  - BMI ≥ 30: $1861
  - BMI ≥ 40: $3097

↑ Health risks:

- DM2, HTN, dyslipidemia, heart disease, stroke, cancer, osteoarthritis, kidney/liver disease, sleep apnea, depression, gout, infertility, immobility…

BMI ≥ 40: ↓ lifespan by average 8-10 years

↑ BMI associated with ↑ all-cause and cardiovascular mortality

Ward et al. PLoS One 2021; 16(3)

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Obesity as a Disease instead of Stigma

- Estimated energy imbalance leading to ↑ obesity prevalence:
  - Only ~100 kcals/day (1 ½ Oreos)
- Additional adipose (fat) tissue sets off cascade of inflammatory responses
- Chronic inflammation of obesity affects metabolism
  Contributes to insulin resistance and CV disease
- Diet influences gut microbiome
  Imbalance can increase appetite, fat storage, and inflammation

Metabolic derangements of obesity can lead to more weight gain!

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Rx Weight Loss Medications: GLP-1s

Tirzepatide (**Zepbound**, Mounjaro) & Semaglutide (**Wegovy**, Ozempic)

- Weekly injections

FDA approved indications:

- BMI ≥ 30 kg/m2
- BMI ≥ 27 kg/m2 with comorbidity (CV disease, DM2, HTN, HLD, OSA)
- Improve glycemic control in DM2
- Reduce CV/kidney disease risk in DM2 (Wegovy)
- Obstructive sleep apnea (OSA) with obesity (Zepbound)

Slow digestion, feel full more quickly, ↑ insulin release after eating

- Side effects: Nausea, vomiting, diarrhea, constipation

$$$$$ ~12,000 per year

- Need to continue treatment to maintain weight loss

BAPTIST

Costs vs. Benefits: Study 1

- 3,346 commercially insured members
  - New GLP-1 therapy 1/1/2021-12/31/2021
  - No DM diagnosis and BMI ≥ 30 kg/m2
- Compared to matched control group of 8,343 patients
- Average age: 46 years old; Pre-DM: 14%; 81% Female
- Analyzed pharmacy & medical claims/Total care costs (TCC)
  - Pre-period (12 months prior to GLP-1 claim)
  - Post-period (2 years from index GLP-1 claim)

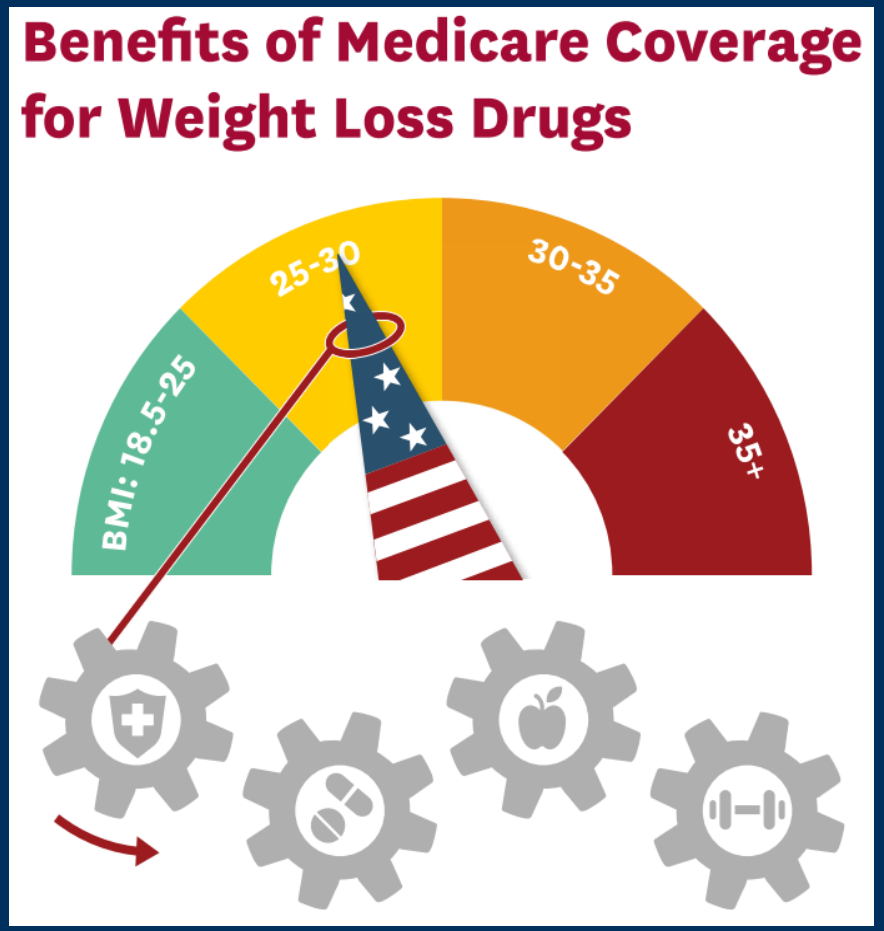
Avg TCC per person	Pre-period	Post-period year 1	Post-period year 2
GLP-1 group	$12,695	$20,165	$18,507
Control group	$11,406	$11,882	$13,012

- Low GLP-1 persistence and adherence to therapy
  - One year: 32% on therapy, 27% adherent (≥ 80% Rx fills)
  - Two year: 15% on therapy, 17% adherent

Gleason et al. Prime Therapeutics publication. Oct 2024

BAPTIST

Costs vs. Benefits: USC White Paper



- Medicare prohibited from covering obesity treatments due to failures of treatments in 1990s
- Cost analysis to evaluate reduced obesity and decreased incidence of obesity-related medical conditions

Ward A et al. Schaeffer Center for Health Policy and Economics. April 2023

BAPTIST

Costs vs. Benefits: USC White Paper

- Utilize models to simulate various obesity coverage scenarios
- US population aged ≥ 25 and older, simulated health and economic outcomes over next 30 years
- Treatment model: BMI reduction 20%, continuous lifelong therapy
- Analysis with Medicare only or Medicare + Private insurance coverage
- 30 years of Medicare + Private coverage -> $1.5 trillion costs savings (*does not include drug costs)

Table 3. Value to Medicare From Covering and Treating Obesity (Difference From Status Quo)

	10 Years		20 Years		30 Years	
	Medicare	Medicare & Private	Medicare	Medicare & Private	Medicare	Medicare & Private
Cumulative Cost Offsets						
Total Medicare cost offsets	$175.6B	$245.1B	$479.0B	$832.2B	$704.3B	$1,494.6B
Part A	$107.1B	$146.3B	$293.5B	$482.8B	$425.9B	$845.5B
Part B	$61.5B	$87.0B	$169.2B	$303.9B	$258.4B	$564.5B
Part D	$6.9B	$11.8B	$16.3B	$45.4B	$20.0B	$84.7B
Cumulative Health Benefits						
Value of Added QALYs ($150K/QALY)	$770B	$927B	$1,971B	$2,535B	$3,131B	$4,595B
Social benefit	$1,002B	$1,269B	$2,597B	$3,743B	$3,997B	$6,743B

Notes: Medicare population simulation results. Treatment costs are not included in benefit calculations. We assumed 100% uptake and adherence. Social value is measured as the sum of the value of QALYs, medical expenditure cost offsets and disability expenditure savings.

Ward A et al. Schaeffer Center for Health Policy and Economics. April 2023

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LET’S WRAP IT UP

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SMOKING CESSATION

- Keep Trying!
- Medication options:
  - Varenicline (Chantix)
  - Nicotine replacement therapies
  - Buproprion (Wellbutrin)

PHYSICAL INACTIVITY

- Sorry, no script available at the pharmacy!

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Additional Employer Strategies

Health Employees = Productive Employees

Employee Incentives

Provider Incentives

PBM/Contract negotiations for High-cost Medications

Additional criteria-based coverage for GLP-1s

- BMI ≥ 40 kg/m2
- BMI ≥ 35 kg/m2 with pre-diabetes

Employer-based Health Screenings

Utilize Pharmacy and Medical professional students for health fairs

Worksite BP measurement devices

Employer-based Health Education

Speakers, webinars, email & onsite health education

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omada

HC/TN HealthCareTN
One Voice. One Focus. Leading Employers.

Omada & HCTN Pilot Programs

→

Omada for Hypertension

Help your members reduce their risk of heart disease

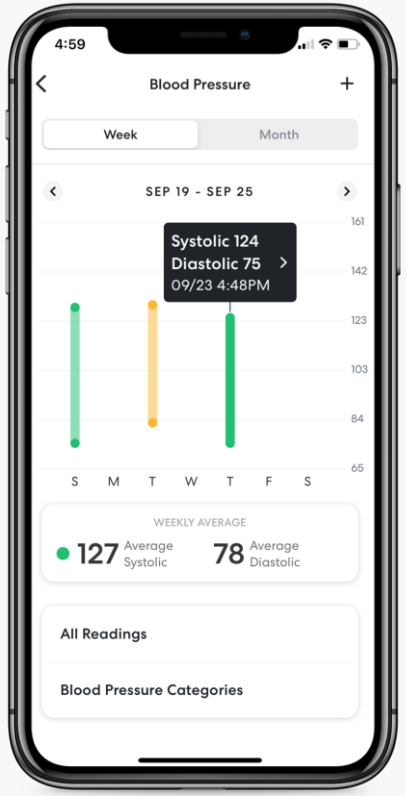
- Connected devices
- Hypertension Specialist
- Supportive Health Coach
- Hypertension-specific peer groups

10.3mmHg

Reduction in systolic BP (baseline stage 2)

14%

Increase in medication adherence



Education Lessons

Scale, Blood Pressure Cuff

Methodology and data from Omada BOB, or from Omada studies available at https://resourcecenter.omadahealth.com/peer-reviewed-studies

HCTN & Omada Health Pilot

HCTN & Omada celebrate pilot success as measured through Enrollment, Engagement & Outcomes trends.

Enrollment

- **Total Enrollments: 179**
  - Prevention: 35
  - Diabetes: 3
  - Hypertension: 141

Engagement & Outcomes

- **94% early program engagement,** highlighted by Connected Scale and Blood Pressure Monitor utilization rates
- **1,100 pounds lost and counting,** with 32% of participants reporting at least 5% weight loss at Month 12
- Significant blood pressure reduction, including **9 mmHg reduction in Systolic Blood Pressure (SBP)** and **4 mmHg reduction in Diastolic Blood Pressure (DBP)** for Stage 2 Hypertension participants.

Want to learn more?

Connect with HCTN & Omada:

- Become an HCTN Member today
- Request a business case
- Schedule a demo
- Take advantage of one of the two additional pilot opportunities available for 2025

Upcoming Events

- **High Cost Claims Meeting (in person) – Nashville**
  - April 2, 2025
- **Advanced Primary Care Webinar**
  - April 9 , 2025
- **Women's Health Webinar**
  - May 7, 2025
- **Mental Health Webinar**
  - May 14, 2025
- **Nashville Regional Conference**
  - June 4, 2025
- **Diabetes Webinar**
  - June 19, 2025

THANK YOU