The Bree Collaborative
Draft Blood Pressure Control Equity Charter and Roster

Problem Statement

High blood pressure or hypertension (HTN), which can lead to heart disease and/or stroke, impacts about half of American adults.[1] However, only 16.1% of those adults have their high blood pressure under control through medication and lifestyle changes, with disparities based on race, ethnicity, education, income, living in an urban or rural setting, and other social drivers of health.[2,3,4] Blood pressure control rates are lower for non-Hispanic (NH) Black persons, Asian American persons, and Hispanic person when compared to NH White persons, and NH Black and Hispanic individuals.[5] Native communities in Washington state also experience significant disparities in hypertension and cardiovascular health.[6] Social drivers of health significantly influence disparities in blood pressure control; for example, food insecurity has been associated with 14-77% increase in hypertension risk.[7] Healthcare access including insurance coverage influences attendance at appointments and acquiring and taking medication. Washingtonians do not receive the same standard of care across the state (e.g., multiple medications, accurate dose titration) with variation in therapy selection and care delivery models.[8,9,10,11] Improving blood pressure control quality metrics stratified by social drivers of health has promise to reduce inequities in morbidity and mortality related to HTN.

Aim

To decrease inequities and improve overall blood pressure control in Washington state.

Purpose

To propose evidence-informed guidelines to the full Bree Collaborative on practical methods to reduce inequities and the total burden of hypertension in Washington state, including:

- Improve trust between health delivery systems and communities, and cultural congruence and responsiveness of providers/delivery systems
- Leverage and operationalize community health workers (and other similar professional groups)
- Improved reimbursement for team-based care and non-physician led teams, and increase number and geographic spread of non-physician led clinics
- Address barriers to improving the connection between delivery systems and community resources
- Improve access to and funding for home blood pressure monitoring programs
- Best practices for enhancing self-efficacy of patients and their support systems
- Review current & upcoming updated hypertension treatment guidelines
- Identify strategies to address barriers causing gaps in care and inequities in blood pressure control
- As able, increase diversity of healthcare workforce in Washington state
- Other areas, as indicated

Out of Scope

- As indicated by the workgroup

Duties & Functions

The workgroup will:

- Research evidence- and expert-opinion-informed guidelines and best practices (emerging and established).
- Identify care caps with a focus on SDOH leading to disparities in specific communities
- Identify incentives to improve care (e.g., HEDIS, CMS)

- Identify current barriers and future opportunities for implementing interventions.
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report(s) on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and guidelines in a report.
- Recommend data-driven and practical implementation strategies including metrics or a process for measurement. *(may be included in the evaluation framework)*
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.

Meetings

Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

The workgroup will hold meetings as necessary. Bree Collaborative staff will conduct meetings, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members may be added at the discretion of the Bree Collaborative director.

Workgroup Members

Name	Title	Organization
Norris Kamo, MD, MPP (chair)	Section Head, Adult Primary Care	Virginia Mason Medical Center
Jake Berman, MD, MPH (vice chair)	Medical Director for Population Health Integration	UW Medicine, UWM Primary Care and Population Health
Mia Wise, MD	Chief Medical Officer	Kinwell Health
Albert Tsai, MD	VP	AHA Puget Sound
Elhami Hannan, MD	Nephrologist	Kadlec Medical Center
Nicholas P Koenig, MD Elizabeth C Slye, RN	Internal Medicine Registered Nurse	KP
Kimberly Parrish	Director, Clinical Excellence	WSHA
Josephine Young, MD	Medical Director, Commercial Markets	Premera
Laura Hanson, PharmD Nicole Treanor, MS, RD, CDCES	Pharmacist Registered Dietician	Virginia Mason
Jordan Despain, MD	Family Medicine	Confluence
Kristina Petsas, MD	Market Chief Medical Officer, PNW, AK and HI	UnitedHealthcare
Theresa Kreiser, MS	Senior Improvement Advisor	Comagine
Katrina Gangsaas,	Community Health Supervisor	YMCA

Mary Beth McAteer	Librarian	Virginia Mason
Molly Parker, MD, MPH	Population Health	Jefferson Healthcare
Jessica Beach, MPH, MPA	Health Equity Director	Molina Healthcare
Leo Morales, MD	Assistant Dean for Healthcare Equity and Quality | Co-director Latino Center for Health	UW School of Medicine | University of Washington
Chris Longnecker, MD Eugene Yang, MD	Cardiologist, Clinical Professor of Medicine, Division of Cardiology	University of Washington
Dionna Washington	Peer Navigator	Harborview Adult Medicine Clinic
Jonathan Liu, MD Jason Tzau, PharmD	Principal, Health Strategy Sr Mgr, US Health Plans	Amazon (Global Benefits)

[1] Centers for Disease Control and Prevention. (2025, January 3). High blood pressure facts. https://www.cdc.gov/high-blood-pressure/data-research/facts-stats/index.html

[2] https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/heart-disease-and-stroke/increase-control-high-blood-pressure-adults-hds-05/data?group=Obesity%20status%20(20%20years%20and%20over)&from=2017&to=2020&state=United%20States&populations=#edit-submit

[3] Vogel MT, Petrescu-Prahova M, Steinman L, et al. Partnerships for Blood Pressure Control in Washington State, December 2016-July 2017. *Health Promot Pract*. 2021;22(1):52-62. doi:10.1177/1524839919853819

[4] Fryar CD, Ostchega Y, Hales CM, Zhang G, Kruszon-Moran D. Hypertension Prevalence and Control Among Adults: United States, 2015-2016. *NCHS Data Brief*. 2017;(289):1-8.

[5] Abrahamowicz, A. A., Ebinger, J., & Whelton, S. P. (2023). Racial and ethnic disparities in hypertension: Barriers and opportunities to improve blood pressure control. Current Cardiology Reports, 25(1), 1–10. https://doi.org/10.1007/s11886-022-01826-x

[6] Parker T, Kelley A, Cooeyate N, Tsosie N. Tribal Perspectives on Hypertension: Results From the Center for Native American Health Native-CHART Needs Assessment. J Prim Care Community Health. 2022 Jan-Dec;13:21501319221144269. doi: 10.1177/21501319221144269. PMID: 36524696; PMCID: PMC9761798.

[7] Te Vazquez J, Feng SN, Orr CJ, Berkowitz SA. Food insecurity and cardiometabolic conditions: a review of recent research. Curr Nutr Rep. 2021;10(4):243–54. https://doi.org/10.1007/s13668-021-00364-2.

[8] Brownstein JN, Chowdhury FM, Norris SL, et al. Effectiveness of Community Health Workers in the Care of People with Hypertension. *Am J Prev Med*. 2007;32(5):435-447. doi:10.1016/j.amepre.2007.01.011

[9] Vogel MT, Petrescu-Prahova M, Steinman L, et al. Partnerships for Blood Pressure Control in Washington State, December 2016-July 2017. Health Promot Pract. 2021;22(1):52-62. doi:10.1177/1524839919853819

[10] Ostchega Y, Fryar CD, Nwankwo T, Nguyen DT. Hypertension Prevalence Among Adults Aged 18 and Over: United States, 2017-2018. *NCHS Data Brief*. 2020;(364):1-8.

[11] Schoenthaler, EdD A, Lancaster, PhD K, Midberry, Mph S, et al. The FAITH Trial: Baseline Characteristics of a Church-based Trial to Improve Blood Pressure Control in Blacks. *Ethn Dis*. 2015;25(3):337. doi:10.18865/ed.25.3.337