Bree Collaborative | Blood Pressure Control Equity
January 16th, 2025| 3-4:30PM
Hybrid

MEMBERS PRESENT VIRTUALLY

Norris Kamo, MD, MPP, VM (chair)
Jake Berman, MD, MPH, UWMedicine (vice chair)
Mia Wise, DO, Kinwell Health
Kimberly Parrish, WSHA
Josephine Young, MD, Premera
Laura Hanson, PharmD, Virginia Mason
Nicole Treanor, MS, RD, CDCES, Virginia Mason
Jordan Despain, MD, Family Medicine
Kristina Petsas, MD, UnitedHealthcare
Theresa Kreiser, MS, Comagine
Katrina Gangsaas, YMCA
Mary Beth McAteer, Virginia Mason
Molly Parker, MD, MPH, Jefferson Healthcare
Jessica Beach, MPH, MPA, Molina Healthcare
Chris Longnecker, MD, University of Washington
Eugene Yang, MD, University of Washington
Jonathan Liu, MD, Amazon (Global Benefits)

MEMBERS PRESENT IN PERSON

Albert Tsai, MD, AHA Puget Sound
Elizabeth C Slye, RN, KP

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GDip, Bree Collaborative
Cora Espina, ARNP, Foundation for Health Care Quality (Intern)

WELCOME

Beth Bojkov, Bree Collaborative, welcomed everyone to the first Bree Blood Pressure Control Equity Workgroup. Beth introduced the team and chair/vice chair for the workgroup.

DISCUSS: BREE BACKGROUND AND WORKGROUP PROCESS

Beth introduced the Bree and the workgroup process. The Bree Collaborative is a program of the Foundation for Health Care Quality. The Bree was established by the state legislature in 2011 in response to health care services with high variation and utilization that do not produce better outcomes. Each year, Bree members (drawn from public and private healthcare stakeholders) choose three to four topics to develop recommendations. Blood Pressure Control Equity is one of three topics for 2025.

The workgroup will meet monthly throughout 2025 to define the purpose and scope, identify focus areas, review existing guidelines, . The report will include recommendations for specific health care stakeholders and will be sent to the WA Health Care Authority. The workgroup must follow Open Public Meetings Act regulations. This includes workgroup member training and conflict of interest disclosure. Following the presentation, Beth opened the floor for comments, but there were no questions.

PRESENT& DISCUSS: WORKGROUP MEMBERS AND TOPIC SCOPE

Beth invited workgroup members to introduce themselves and opened the brainstorming conversation with a discussion on additional stakeholders to consider inviting to participate or speak:

- Some additional stakeholders to consider for participation or inviting to speak, including:
    - Patient/family partner
    - Behavioral Health Clinician
    - Community Health Worker
    - Tribal communities
    - WACH
    - Housing Authorities, other social service organizations

Beth then transitioned the group to provide an overview of the topic and proposed scope.

- **Topic Overview:** Hypertension is a major contributing cause to mortality and morbidity in the Untied States. Individualized blood pressure control often requires multiple medications, blood pressure monitoring and iterative dose titration which can be subject to clinical inertia. Several groups, including, rural communities, Black, Hispanic and American Indian and Alaska Native communities, are disproportionately impacted by hypertension. Meeting the 66th percentile of the HEDIS Controlling Blood Pressure (CBP) across all marketplaces could save over 110,000 lives annually.
- **Current Data:** In 2022, high blood pressure was a primary or contributing cause of 685,875 deaths in the United States, over 1 in 4 people in Washington have been told by their healthcare provider that they have hypertension. Nationally about 1 in 4 adults with high blood pressure have their blood pressure under control. Among those recommended to take blood pressure medication, blood pressure control is higher among non-Hispanic white adults (32%) than in Non-Hispanic Black adults (25%), non-Hispanic Asian adults (19%) or Hispanic adults. High blood pressure costs the United States about $131 billion each year.
- **Potential Evidence-Based Strategies:**
    - **Delivery systems:** implement team-based models of care, quality improvement initiatives focused on equity in hypertension control
    - **Plans**: Extend pharmacy benefit to assume dual and quad therapy, modify prior authorization processes to reduce barriers to anti-hypertensive medications, value-based purchasing linked to CBP HEDIS quality metrics
    - **Purchasers**: employee incentives and wellness benefits, onsite screening and connection to care
    - **Public Health**: outreach and engagement of underserved and marginalized Washington communities
- **Potential Impact**: Align multisector quality improvement initiatives around a common goal of improving blood pressure control and reducing inequities in Hypertension

Beth then transitioned the group to identify their main outcomes they hope to achieve by creating the report and guidelines, what is realistic and unique?

- **Evidence-Based vs. Evidence-Informed Programs:** workgroup members discussed the challenges of implementing evidence-based programs when they are not culturally aligned or adapted for underserved and marginalized communities, and the potential benefits of evidence-informed programs. Adapting evidence-based models to allow for better alignment with community needs and cultural contexts leads to greater success.
- **Community and Clinical Linkages:** The group emphasized the importance of improving connections between primary care providers and community resources, with a focus on community health workers and other liaisons. Workgroup members mentioned the need for guidance on operationalizing changes related to CHW reimbursement and integration into clinical workflows.

- **Home Blood Pressure Monitoring:** Members highlighted the need to improve access to home blood pressure monitors and self-monitoring programs, including reimbursement for these devices.
- **Non-Physician Led Hypertension Clinics:** The group discussed the importance of increasing the number and geographic distribution of non-physician led hypertension clinics, particularly those led by nurse practitioners and clinical pharmacists.
- **Trust and Cultural Competency:** Members emphasized the need for strategies to improve trust between the community and the healthcare system, including training for staff and providers and leveraging community health workers.

DISCUSSION: CHARTER

Beth then transitioned to reviewing the charter and updating the purpose. The following edits were made in red:

- 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

PUBLIC COMMENT AND GOOD OF THE ORDER

Beth invited final comments or public comments, then thanked all for attending. At the next workgroup meeting, the team will review comments made from the Bree member meeting on January 22nd meeting and continue the brainstorming discussion around potential focus areas for the report. The workgroup's next meeting will be on Thursday, February 13th from 3-4:30PM.