Bree Collaborative | Blood Pressure Control Equity
April 10th, 2025| 3-4:30PM
Hybrid

MEMBERS PRESENT VIRTUALLY

Norris Kamo, MD, MPP, VM (chair)
Jake Berman, MD, MPH, UW Medicine (vice chair)
Albert Tsai, MD (AHA Puget Sound)
Asher Strauss, PsyD, Kinwell Health
Laura Hanson, PharmD, VM
Josephine Young, MD, Premera
Mary Beth McAteer, MLIS, VM
Molly Parker, MD, Jefferson Healthcaer
Mia Wise, Kinwell Health
Kimberly Parrish, MHA, RN, WSHA
Kristina Petsas, MD, UnitedHealthcare
Theresa Krieser, MS, Comagine Health
Elizabeth Slye, RN (Kaiser Permanente)
Kristina Petsas, MD, UnitedHealthcare
Mary Beth McAteer, Virginia Mason
Jonathan Liu, MD, Amazon (Global Benefits)
Chris Longenecker, MD, UW Medicine
Nicholas Koenig, MD, Kaiser Permanente

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GDip, Bree Collaborative
Phil Levy, MD, Wayne Medical

WELCOME

Beth Bojkov, Bree Collaborative, welcomed everyone to the Bree Blood Pressure Control Equity Workgroup April meeting.

- **Action**: March workgroup minutes approved

MOBILE MEDICAL UNITS

Beth invited Dr. Phil Levy to share the Wayne Mobile Health Unit Program. The Mobile Health Unit Program is derived from Wayne Medical in Detroit Michigan.

- Disparities in life expectancy lower, city of Detroit has some census tracts where it's anywhere from 5-15 years younger than state average. Many young people in Detroit experience mortality from heart disease.
- Started to implement screening programs in the ER to catch things like high blood pressure
- PHOENIX project – population health outcomes information exchange – created to pull together many different data points to identify areas of higher risk and lower risk – based off early HIV work that looked at community viral load for a sense of how well controlled HIV was in that community. PHOENIX adopted that for blood pressure, showing a mean blood pressure reading for a specific census tract based on ER blood pressure readings.
- Started to incorporate social determinants to understand what else was going on with the community (poverty level, unemployment, uninsurance rate, etc
- Then COVID-19 pandemic began – began layering COVID data on top of the information exchange to start targeting areas to set up drive through COVID-19 testing sites.
- Worked with Ford to get a couple vans to take the testing on the road – some of the biggest traffic was going to employers who tested wide swatches of employees.

- State of Michigan developed racial disparities task force to understand why people from BIPOC communities were experiencing worse COVID-19 outcomes – Michigan state provided funds to the mobile program to continue and expand their work
- Designed a mobile unit that could deliver high throughput mobile testing – two lanes of traffic, hired diverse workforce field staff represented the communities their serving
- Now done almost 100,000 encounters – somewhere between 500-1000 people per month
- Portable population health
    - Once started doing COVID-19 antibody blood draws, why don't we start taking lipids/other blood studies, taking blood pressures, social driver assessments, patient navigation services, etc
    - Amongst the most important is measuring BP
    - Added CHW support in the field to do this, front seat of the vehicle is an ideal spot to measure BP.
- Starting routinely doing BP and lab tests, have a philanthropic partner to do testing and charges $14 to do several basic lab tests
- Started using the data exchange network to indicate where to deploy mobile units
- Started partner with payors. Molina was an early partner – bundled screening rates, lots of preventive screenings like BP, lipid, depression screening, etc. The Molina provided information about where their nonengaged patients were so the mobile units could target those areas.
- Started a women's health mobile unit
- Started to partner with local businesses as well – plenty of people that have insurance and especially in manufacturing industry would not take time off to get their BP screening. Provide services onsite to get BP screened and checked.
- Vast majority of care for people under 65 is covered by private insurance. More people will be reached by going to places of employment and working with employers.
- Worked with employers to make a:
    - up front bundled screening package – includes a health risk assessment (questionnaire, assessment of current health status, personalized feedback about steps to reduce risks, maintain health and prevent disease) age appropriate comprehensive history, triplicate blood pressure management, and lab testing for kidney disease/electrolye abnormalities/liver function/high cholesterol/diabetes
    - backend follow up care management per employee per month rate for:
        - team-based care model with remote and MHU based engagement
        - monthly plan focused on blood pressure, diabetes (noninsulin dependent) high cholesterol, smoking cessation, obesity add on
        - onsite lab testing and prescription dispensing
        - items included in PMPM package: monthly for anyone who screens positive for 1 tof the following – elevated BP, high cholesterol, diabetes (NIDD), kidney disease, weight control, smoking cessation
            - remote patient monitoring of BP, blood sugar, scale for weight
            - onsite patient monitoring
            - lab testing
            - prescriptions (specific formulary focused on conditions addressing)
- Moving towards nonphysician led care, no physicians are on site with screening. Going to a doctors office doesn't work. Pharmacists, CHW and team-based approaches are the most effective for lowering BP over time.
- Primarily Medicare patients that are eligible for RPM. Figure out what the best way to get margin on what they're doing.

Question

- How did you determine not to do SDOH in privately insured populations?
    - Plenty of businesses where people have some social needs, but we don't want people to pay for something that they don't want. Can add it on as the employer wants.
- Have you done comparative effectiveness or cost-effectiveness work?
    - Part of our grant work now – gravitate towards can you deliver care to meet cost effectiveness threshold (e.g., $2500) what's the price point that payors are willing to pay and providers are willing to accept
    - How can you implement this at scale and sustainable as a business? As a standalone business how do you go about this, we continue to have philanthropy support.
    - What are your pain points as payors? HEDIS metrics that they can't hit – turned into part of the bundle.
- Have you looked at rural-urban differences in your data? Does your mobile program go out to these rural areas and how do you balance the reduced population density/cost to get our to rural areas?
    - Team goes statewide, but what we're trying to get new programs in areas that are further from Detroit for a reason. Pushing payment reform to make these sustainable.
    - Might be a better solution for more rural environments than urban, more for neighborhoods that have primary care deserts and low engagement.
- Right now talking to companies with large factories to come onsite and screen all employees. If we're going to engage people, we need to have easiest backend pathway to get connected to care – really important to not conflate this with ACOs. This is instead saying who's not engaged, lets come up with a way to fish for those people and once you find them, find a way to give backend care that they need.
- Have you seen variance in engagement in employer based or community based sites?
    - Challenges with Medicaid population – advertising has to get approved through the state – no semblance of coercion
    - Hard to get that uptake unless we have collaboration with the state – employers don't have that requirement
    - 60-70% employer population comes out when events are done, its during work and they are paid to do it. That signals that the employer cares about you.
    - Now trying to get businesses to get contracts.
- Health plans should allow place of service codes outside a brick and mortar building, and bundled rates for these preventive services. Will decrease overall cost on the backend because its cheaper than you would get it elsewhere.
- Have you had any success in doing warm handoffs to primary care or not?
    - Have a linked physician group, but do handoffs all the time to other practices.
    - Tying all of this to Michigan health information exchange.
    - Standardize intake process in mobile health settings – open-source EHR that we're developing.
    - Very simple intake of data, document testing that we did, and push into the information exchange.
    - Most interested parties is payor, can get that information from the exchange.
    - Going to take burden off the clinicians now and improve engagement, but also reimagine prevention as being community based – new layer of healthcare.
- What would you recommend in a state that has a budget deficit?
    - There's money in Medicaid and insurer population
    - How can we think about money is better spent on other care delivery.

    - If you get the volume, you can fully absorb the cost of an uninsured patient once you get to thousands of people cared for.
    - Mobile care is a fixed cost – just have to cover cost at the end of the day.
    - How can we reimagine what we're paying for for healthcare.

BARRIERS TO SCREENING

Beth invited the group to review the barriers for screening from the March workgroup brainstorm and discuss next steps for screening focus area.

- Thinking about blood pressure screening, how do we envision a system where everyone has their BP screened within the past year. How do we walk backwards from that?
- Barriers – good blood pressures – all the different ways that we take a good and accurate blood pressure reading.
- How do we make this a cohesive system where people are not ping-ponged around the system – is it employer driven? Is it plan driven? Not sure. Dr. Levy's program is within his own practice, but outside that warm handoffs break down the communication pathway.
- Trying to set up self-monitored blood pressure program – train the trainer – how well we can scale that?
    - How can we leverage something like AHA to be able to validate technique amongst folks in the community
- One thing so striking about the story of Dr. Levy – they started with a product/chassis in the pandemic that was repurposed for other clinical points of focus. Without having that sort of product at this point, what sort of products or bundles of services do we have that could fill this need? Where are we in that process in our own engagement?
    - What are the core things we can achieve? Backend integration with health system has been a priority but clearly there's some integration with referral to primary care which is the low end fruit
    - There often is only one provider in rural spaces so its not congested with multiple providers
    - In the absence of a health information exchange, can we at least get a paper card like at the beginning of COVID
- Comagine ran a pilot for patients with diabetes who were missing A1c screening, in English and in Spanish with different methods of outreach – marketing is important
- Potential idea: universal form for referral to health systems
- Virtual care could fill the gap between community screening and connection to care – not sure how many people will start going to the doctor just because they have high blood pressure
    - See the patient in person at first, validate their technique, then transition to virtual visits with home BP monitoring
    - Clinic buys the cuffs, shows return on investment to the insurance company
- Like the idea of a bundled payment for preventive screening, example across all insurance providers to make it sustainable.
    - WA Medicaid offers $200 per year per member for preventive screening paid to the member
    - Examples: Molina, Coordinated Care
    - Could advertise that in mobile clinics?
- TRAX work is currently ongoing, not being used currently for hypertension but still in the beginnings of governance. Could be a good opportunity

PUBLIC COMMENT AND GOOD OF THE ORDER

Beth invited final comments or public comments, then thanked all for attending. A reminder to group members to submit OPMA training and conflict of interest forms to bree@qualityhealth.org or ebojkov@qualityhealth.org. The next meeting will be on Thursday, May 8th 3-4:30PM. Upcoming events were shared by Emily Nudelman, DNP.