
Bree Collaborative | Blood Pressure Control Equity

May 8th, 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 Healthcare
Mia Wise, Kinwell Health
Kimberly Parrish, MHA, RN, WSHA
Kristina Petsas, MD, UnitedHealthcare

Theresa Krieser, MS, Comagine Health
Elizabeth Slye, RN (Kaiser Permanente) *in person*
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
Tonja Nichols, RN, Washington HCA
Leo Morales, MD, UW

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Karie Nicholas, MA, GDip, Bree Collaborative
Brandon Smith, ND, Family Health Centers
Mistie Taylor, RN, Family Health Centers

WELCOME

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

- **Action:** April workgroup minutes approved

FAMILY HEALTH CENTERS – SELF MONITORING BLOOD PRESSURE PROGRAM

Beth invited Dr. Brendan Smith and Mistie Taylor from Family Health Centers in Okanogan to share their successful SMBP program. Dr. Smith provided an overview of the program and its components, contributions to its success. Their lessons learned were:

1. Identify roles/positions within the team able to support/educate patients in hypertension self management
 - a. Their program began with a PDSA cycle during the pandemic, with the goals of:
 - i. Lowering barriers for monitors and home monitoring
 - ii. Engage non-physician team members for team-based care
 - iii. Provide effective patient education and goal setting
 - iv. Develop ways to monitor success and decrease time in spreadsheets
 - v. Spread and support SMBP program by building competency and coordinated within teams
 - b. Multiple team members can identify and add patient to the SMBP program
 - c. Patient training is provide by the RN, MA, or CHW/educator as available
 - d. Enrolled patients are assigned to a care manager, and follow up delegated to a trained CHW

- e.
2. Recognize tools and resources to train staff and ensure competency
 - a. Developed a way to chart BP Home monitoring in the EHR
 - i. 20 minute health education with CHW
 - ii. Covisit with provider if performed in the same day (pre-visit prep)
 - iii. Teach back – patient can demonstrate correct BP collection techniques and report results
 - iv. Education with learning materials/handouts (posted to intranet)
 - v. Document handouts provided at the visit or mailed
 - vi. Set at least one SMART goal in the HER and enroll in SMBP program with care manager
 - vii. Follow up phone call to evaluate success and ensure documentation of BP
 - viii. Schedule in person BP check at 4 months with the provider
 - b. Utilized AHA resources for SMBP program – used intranet to build resource page and store links to the videos needed
 - c. Included training materials in English and Spanish
 - d. Incorporated public facing materials to promote their free BP machines
 - e. Use a validated BP monitor – prefer not to use wrist monitors on patients with hypertension
3. Apply health-related social needs and quality initiatives to launch a hypertension self-management program
 - a. When developing SMART goals, identify things that are relevant for the patient’s life, not just hypertension related
 - b. This program started tracking things in excel, and then they created a registry for reports in the EHR
 - c. Registry identifies not just the BP meds the patient is on, but also any identified HRSN needs
 - d. Team tracks the program participants and follows up with patients, while organization tracks the teams care of patients with hypertension and offers care to more patients
 - e. Braiding of funding and advocating for patient education/support and advancement of CHWs in clinics is valuable

Questions

- They do have telehealth but majority of their patients appreciate in person visits
- Employers are a consideration for financial support but not broken into that yet
- Do not track other outcomes like ED utilization or hospitalization, just HRSN currently
- SDM is around setting goals in this sense – what makes sense for you? Lifestyle change? Incremental steps? How often can you check your BP?
- Getting someone to check their BP 2-4 times a day is very difficult

BLOOD PRESSURE SCREENING

Dr. Kamo transitioned the group to discuss blood pressure screening, revisiting out draft guidelines

- Want to envision the funnel of people that will get eventually everyone in Washington state to have their blood pressure screening annually, and then how do we effectively connect them to care?
 - Don’t want perfect to be the enemy of the good, so widespread campaigns around blood pressure

- As we get further down the funnel, HCPs are trained in accurate BP screening and diagnosis to avoid inappropriate treatment
- KP exploring if BP checks can be done at community events, where there's lots of AAPI community members – summer in Seattle is a huge opportunity when people are outside
- Idea: a card to fill out for everyone in Washington with essential vitals, and biometrics
- YMCA is trying to get blood pressure kiosks off the ground – trying to get kiosks in more locations just as a touch point recently
- What is the role of all our audiences in reaching this lofty goal of universal screening?
 - Dental visits can screen BP and refer to PCP
 - Specialty clinics –
 - Employer role – employers might be able to identify members or populations that are not getting screening done, target care coordination and education potentially
 - MCOs provide member reward programs for preventive screening
- Might be helpful to have the state produce maps with more micro-level data to show where there's uncontrolled hypertension – would be interesting to know
 - CDC places has most currently available data from BRFSS , navigable online
 - Would be good to have a tool for systems to identify who in their service area has higher blood pressure or worse control
 - HCA to look into the kinds of data they can get – would be different than the MCO side of the house, but potentially county level
 - Is there a way to overlay Area Deprivation Index with the HTN map from CSC places
- Protocol for connection to care after screening?
 - From Leo's clinic:
 - Initial blood pressure, then second one
 - If someone screens high, three different categories of referral
 - ER
 - Leo's team follows up/Partner clinic in the area for close follow up
 - General follow up
 - Don't know to the extent that people go to those follow up appointments – actively investigating that.
 - Warmer handoff the better – if you can walk people over same day for an appointment that is a good example of success
 - Different size cuffs are important

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, June 12th 3-4:30PM. Upcoming events were shared.