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

MEMBERS PRESENT VIRTUALLY

Norris Kamo, MD, MPP, VM (chair)
Asher Strauss, PsyD, Kinwell Health
Josephine Young, MD, Premera
Jordan Despain, M.D., Confluence Health
Katrina Gangsaas, YMCA
Nicole Treanor, MS, RD, CD, CDCES, Virginia Mason
Leo Morales, MD, UW Latino Center for Health and UW Medicine
Laura Hanson, PharmD, Virginia Mason
Jake Berman, MD, MPH, UW Medicine (vice chair)
Molly Parker, MD, Jefferson Healthcare
Kimberly Parrish, MHA, RN, WSHA
Theresa Krieser, MS, Comagine Health
Elizabeth Slye, RN, Kaiser Permanente
Tonja Nichols, RN, HCA
Al Tsai, MD, Puget Sound AHA
Jon Liu, MD, Amazon

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Karie Nicholas, MA, GDip, Bree Collaborative
Corey Gardner, MD, Optum

WELCOME

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

BP CONTROL QUALITY INITIATIVES

Beth transitioned the meeting to Dr. Corey Gardner from Optum to share their hypertension quality improvement work for people with hypertension.

- Dr. Gardner shared about Optum's Hypertension Control initiative
    - Goals were to achieve HEDIS and Medicare targets within 4-8 weeks, reducing polypharmacy and creating a scalable workflow for all clinics. Integration of pharmacists and remote monitoring services is critical.
    - Optum devised three pathways for hypertension control
        - Pharmacy management: embedded pharmacists who manage complex patients, including those with polypharmacy and high-risk conditions. Pharmacists can conduct on-site visits, educate patients, and adjust medications as needed
        - Care companions: developed by the Mayo Clinic, is a 12-week remote monitoring program for engaged patients. It includes home blood pressure monitoring, patient education, and follow-up with nurses to ensure effective hypertension management.
        - Team-based care with nurses and medical assistants: follow up with patients through MyChart messages or phone calls. This pathway ensures regular monitoring and timely medication adjustments, reducing the burden on providers
    - Care companion program involves 12 week remote monitoring service developed by the Mayo Clinic including patient education, home blood pressure monitoring, and follow-up with nurses.

        - Enrollment – patients receive a BP cuff and other monitoring tools, required to check BP daily and report readings through MyChart, ensuring continuous engagement and monitoring
        - Nurse follow up with enrolled patients to review their BP readings, provide education and make necessary adjustments to their care plan
    - Challenges and Solutions
        - Health literacy: proper use of BP cuffs requires time to provide education
        - Equipment access: access to BP cuffs is a challenge, make sure every person the companion level or above has a BP cuff machine
        - Provider Resistance: resistance to team-based care lessened with shown reduction in workload and improved patient outcomes
        - Flexibility: need to adapt workflows to meet the needs of different patient populations and ensuring all team members work effectively
- UW Medicine Hypertension Quality Improvement
    - Dr. Berman presented UW Medicine's hypertension initiative, aiming to improve BP control rates through team-based care, updated guidelines, and IT interventions; The intervention involved medical assistants, APP teams, and panel navigators
        - Goals: improve HTN control rates by implementing team- based care, updating clinical guidelines and leveraging IT interventions to support patient management
        - Team-based care: involved medical assistants, APPs, panel navigators to ensure consistent follow up and support
        - Updated Guidelines: clinical guidelines for hypertension management updated to reflect latest evidence based practices, standardized protocols for BP measurement, medication titration and patient follow up
        - IT interventions: Track My Health Tool in EPIC was implemented to facilitate home BP monitoring and streamline data entry
    - Results: improvement in BP control rates, next steps include better data accessibility (performance data more transparent, easily accessible and allow for better tracking and management of HTN control efforts), integration of clinical pharmacists and community based resources

QUALITY IMPROVEMENT FRAMEWORK

Beth provided a brief overview of an equity focused quality improvement framework that team-based care effectiveness in hypertension control and improving hypertension equity. (IHI framework)

- **IHI Health Equity Framework:** includes recommendations for making health equity a strategic priority, collecting and analyzing data, and tailoring efforts to meet the needs of specific populations.
- **Feedback and Discussion:** The team provided feedback on the health equity framework and discussed the importance of marketing and patient engagement in hypertension control. They also considered the role of health plans in addressing coverage lapses and supporting community-based events.

Discussion:

- Marketing and patient engagement in hypertension control is critical and often forgotten about
- Health plans have a role in addressing coverage lapses and supporting community based events for SMBP

CLOSING & NEXT STEPS

Beth thanked all for attending, providing time for public comment and reviewed upcoming events. The next workgroup meeting will be held **August 14th 3-4:30PM**