Bree Collaborative | Blood Pressure Control Equity
October 9th | 3-4:30PM
Hybrid

MEMBERS PRESENT VIRTUALLY

Jake Berman, MD, MPH, UW (chair)
Norris Kamo, MD, MPP, VMFH (chair)
Asher Strauss, PsyD, Kinwell Health
Kristina Petsas, MD, United Healthcare
Kimberly Parrish, MHA, RN, WSHA
Elizabeth Slye, RN, Kaiser Permanente
Tonja Nichols, RN, HCA
Al Tsai, MD, Puget Sound AHA
Jordan Despain, MD, Confluence
Laura Hanson, PharmD, VMFH
Katrina Gangsaas, YMCA
Chris Longnecker, PhD, UW
Elizabeth Slye, RN, Kaiser Permanente
Theresa Kreiser, Comagine

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Karie Nicholas, MA, GDip, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative

WELCOME

Beth Bojkov, Bree Collaborative, welcomed everyone to the Bree Blood Pressure Control Equity Workgroup October meeting. Quorum was not reached so minutes will be approved at the November meeting.

BP GOAL STATEMENTS

Beth transitioned the meeting to return to the discussion from the previous meeting around BP treatment targets, and dissonance between different guideline writing organizations.

- **Discussion of Updated Blood Pressure Guidelines:** 2025 AHA/ACC guidelines have been endorsed by a multitude of organizations, but some other orgs (AAFP) have not caught up to them yet.
    - Some trials on aggressive BP targets for older adults did not result in an increase in adverse events, but did increase side effects like dizziness and fatigue.
    - The group emphasized individualization of care and BP treatment targets as being important to distinguish from population level health metrics
    - Process measures and narrative guidance may be more pragmatic than rigid numeric targets
- **Blood Pressure Screening and Referral Protocols:** The team developed consensus on blood pressure thresholds for referral from community screening events, the role of patient education, and the need for clear protocols for follow-up and escalation.
    - **Referral Thresholds:** The group agreed that individuals with blood pressure readings of 130/80 mmHg or higher at community screening events should be referred to clinical care, while those with readings between 120-129 mmHg should receive educational materials and be encouraged to monitor their blood pressure at home. Also mentioned were hypertensive emergency protocols.
    - **Patient Education Materials:** the group discussed the importance of providing reliable, multilingual educational materials at screening events, with an emphasis on

encouraging follow-up with healthcare providers and proper home monitoring techniques.
    - **Wallet Cards:** the group suggested the use of wallet cards or similar tools for patients to record their blood pressure readings and follow-up steps, promoting adherence and continuity of care.
- **Validation of Home Blood Pressure Devices:** The workgroup discussed the importance of validating home blood pressure monitors as soon as possible, ideally during first follow up visit, the challenges of ensuring device accuracy, and the need for structured validation visits and staff training on measurement technique and device validation. Also mentioned important to provide an utilize logs and document home BP readings in a structured spot.

REVIEW OF DRAFT GUIDELINES

Beth transitioned the workgroup to reviewing and drafting guideline statements together, with discussion including the following:

- **Process and Outcome Measures:** The group addressed the integration of process and outcome measures into guidelines and reports, focusing on how to evaluate the effectiveness of blood pressure control initiatives at both the provider and system levels.
    - **Standardized Documentation of BP Goals:** The workgroup discussed the importance of standardized documentation of individualized blood pressure goals and risk assessments in electronic health records to facilitate measurement and quality improvement.
- **Shared Decision-Making and Treatment Escalation:** The workgroup discussed the recommended timeline for lifestyle interventions, the importance of shared decision-making regarding medication initiation, and strategies to avoid therapeutic inertia in hypertension management.
    - **Lifestyle Intervention Timeline:** The group recommended to reinforce after 3-6 months of unsuccessful lifestyle intervention to engage in a structured conversation about medication initiation should occur, in line with current guidelines.
    - **Avoiding Therapeutic Inertia:** the workgroup stressed the need to set clear expectations with patients from the outset, ensuring that treatment escalation is not indefinitely delayed and that shared decision-making is prioritized.

CLOSING & NEXT STEPS

Beth thanked all for attending, providing time for public comment and reviewed upcoming events. The next workgroup meeting will be held **November13th 3-4:30PM**