

Blood Pressure Control Public Comments

1. Do you have general comments about the stakeholder guidelines?
 - a. **Patient and Family:** I would like to emphasize the frequent training for those who measure blood pressure. As a patient and nurse, it is a rare day when my blood pressure is measured accurately in clinics. MA's take your blood pressure through layers of clothing including sweaters, take the measurement the second you arrive, use the wrong size cuffs, don't support your arm during the measurement, ask you questions during the measurement, etc. I also want to emphasize your point of having clinics use validated measuring devices.
 - b. **Community Health Worker:** Yes, all the programs look great, but we need to invest in blood pressure monitors to give away to anybody who gets into the preventive programs. Programs themselves don't have the full capabilities when trying to work with real clients/patients and implement these strategies if we don't support them with their basic equipment and other SDOH.
 - c. **Public Health:** Very well done overall! One thing...hypertensive crisis is mentioned 4 times (pages 20, 24, 47, and 51) however, this term has been thankfully eliminated per the 2025 HTN ACC/AHH GL so it would be a good idea to replace crisis with "emergency". If needed, you may have to explain, as you did on page 24 that BP without acute ToD is not an emergency, when the term appears or put this in the Glossary as a specific defined term.
2. Do you have feedback on the report's Executive Summary and/or focus areas?
 - a. **Primary Care Provider:**

Referral to primary care within 2 weeks for BP \geq 130/80 would be quite challenging to do and a more nuanced approach would take into account the risk the person has. But a more nuanced approach would also bring its challenges.

Re: SBP target:

I wouldn't argue against a more aggressive BP target approach (e.g., SBP < 130 vs. < 140, or other target) in many patients which I think has been supported since the SPRINT trial. But I do worry that the intervention is weaker than we would like, and I think it's plausible that the more impactful approach for the population would be to get more people to <140 vs. getting some people to <130. Having a greater BP control rate, with a less aggressive target, in large swaths of disadvantaged pts might thus be a smarter goal. This could be the forte' of the Bree—to think about the

whole population and the relative importance of targets and actions.

Take the data in table 2 of the Whelton 2024 paper. They calculated the number needed to harm to support [the idea that](#) the risk of harm is low. I wish they had done the same on the benefit size.

For CV mortality, the hazard ratio of 0.73 is an important number. But, in the table below, where I have calculated the ARR and NNT, the NNT is, to me, pretty unimpressive. Same for HF.

Absolute risk calculations

Whelton et al 2024

CV mortality HR 0.73

Absolute numbers

SBP < 130: $414/35815 = 0.0116$

SBP \geq 130: $561/35060 = 0.0160$

ARR = $0.0160 - 0.0116 = 0.0044$; NNT = 227

HF HR 0.69

Absolute numbers

SBP < 130: $258/34314 = 0.0075$

SBP \geq 130: $358/33541 = 0.0107$

ARR = $0.0107 - 0.0075 = 0.0032$; NNT = 312

3. Do you have guidelines for State Agencies?

a. **Public Health:** I have a few thoughts that could improve clarity in the HCA section, especially for folks looking at the guidelines in the future.

i. When the report states: "Promote value-based payment that includes stratified blood pressure control metrics." It seems a little unclear what type of stratification is intended. I gather that the intent is to stratify

blood pressure control metrics by race, ethnicity, and language. If so, it may be more understandable to state: Promote value-based payment that includes stratified blood pressure control metrics stratified by race, ethnicity and language.

- ii. When the report states: “Include single pill combination medication on single preferred drug list when possible.” I am not sure what we mean and wonder if we could word it differently. I assume we mean a combo antihypertensive such as lisinopril/hctz should be on the preferred drug list so people can take those drugs in a combo pill rather than two separate pills. I think what is throwing me off is the second time “single” is used in the sentence. The second “single” is confusing, also likely a typo and should be removed.
 - iii. There is a sentence in the HCA section on page 17 that is confusing to me and may contain a typo: “Consider aggregating HEDIS CBP measure by geographic location (e.g., RURA) to identify disparities in rural and urban populations”. I do not know if the term RURA is an acronym related to GIS mapping, but it seems like it should say “rural”. Also, I know that CBP means controlling blood pressure, but I think it would be beneficial to spell it out.
4. Do you have feedback for the guidelines for Community Pharmacies?
 - a. **Public Health:** No. Glad to see collaborative practice agreements mentioned!
 5. Do you have feedback for the guidelines for Dental Clinics/Dentists?
 - a. **Patient and Family:** They often use wrist monitors and slap it on the second you get in the chair.
 6. Do you have feedback for any section under Evidence Review (Blood Pressure Control in Context, Towards Universal Blood Pressure Screening, Blood Pressure Self-Management, Team-Based Care, Access to Validated Blood Pressure Cuffs, Health Information Exchange, or Alternative Payment Mechanisms...)? Please indicate which section in your response.
 - a. **Primary Care Provider:**

Re: the idea that BP should be “screened” at every opportunity. That does not match the USPSTF and would lead to a lot of BP measurements that are not valuable. Of course, at least in many health systems, BP is already checked at every visit (in most sites), so we do that—but it strikes me as a low value activity for pts who have already had BP screening and it was < 120/80. In my ideal world, the EHR would tell the MA they can skip it in this case. The Bree could make a statement supporting this higher value approach.

Here is what the USPSTF says about screening intervals.

Available evidence on optimal screening intervals for hypertension remains limited. The USPSTF suggests annual screening for hypertension in adults 40 years or older and for adults at increased risk for hypertension (such as Black persons, persons with high-normal blood pressure, or persons who are overweight or obese). Screening less frequently (i.e., every 3 to 5 years) is appropriate for adults aged 18 to 39 years not at increased risk for hypertension and with a prior normal blood pressure reading

7. Do you have feedback for the following sections: Measurement, Washington State Initiatives? Please indicate which section in your response.
 - a. **Primary Care Provider:** As an editorial suggestion, there are several points where $> 140/90$ should be $\geq 140/90$ (e.g., pages 32) or $> 130/80$ should be $\geq 130/80$ (e.g., pages 10, 11, 19, 24, 32), or similar inconsistencies.