Hypertension Management in 2025

Guideline Updates and Local Results

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Disclosures

- Advisory Board and Speaker, Medtronic and ReCor Medical
- Speaker Edwards Lifesciences

Objectives

- Establish the prevalence of hypertension and its impact
- Review diagnosis and treatment of hypertension
- Highlight key 2025 Hypertension Guideline updates
- Overview hypertension management efforts and improvement at Cone Health

HTN Definition

Table 4. Categories of Blood Pressure in Adults*

	SBP		DBP
BP Category			
Normal	<120 mm Hg	and	<80 mm Hg
Elevated	120 to 129 mm Hg	and	<80 mm Hg
Hypertension			
Stage 1	130 to 139 mm Hg	or	80 to 89 mm Hg
Stage 2	≥140 mm Hg	or	≥90 mm Hg

BP indicates blood pressure (based on an average of ≥2 careful readings obtained on ≥2 occasions, as detailed in Section 3 ("Evaluation and Diagnosis"); DBP, diastolic blood pressure; and SBP, systolic blood pressure.

*Adults with SBP and DBP in 2 categories should be designated to the higher BP category. This table excludes individuals who are pregnant (see Section 11.5, "Hypertension and Pregnancy"). Adapted with permission from Whelton et al.[5] Copyright 2018 American College of Cardiology Foundation and American Heart Association, Inc.

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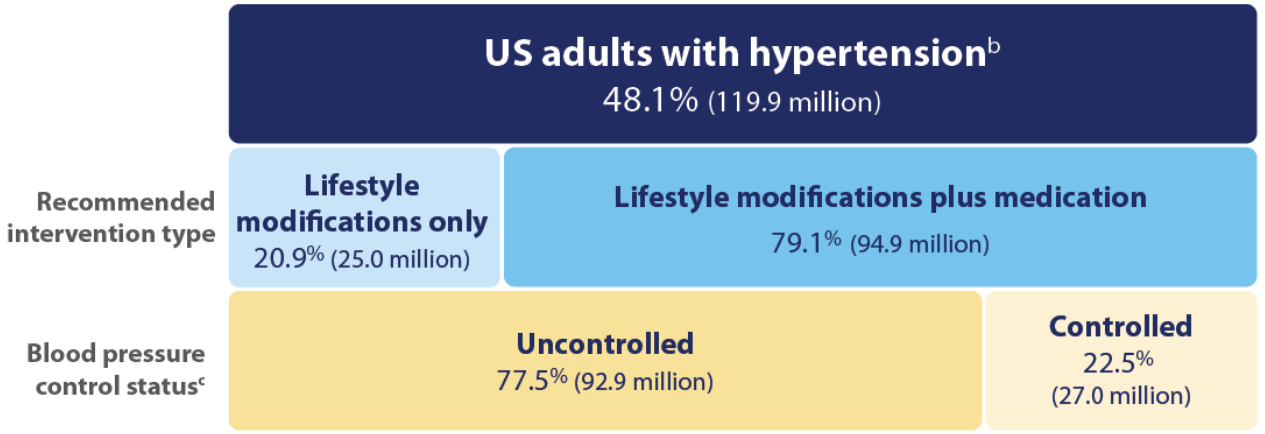
Jones, et al. Circulation 2025; 152

Prevalence of Hypertension in the US

Estimated Hypertension Prevalence, Treatment, and Control (Blood Pressure <130/80 mm Hg) Among US Adults[a]

Applying the criteria from the American College of Cardiology and American Heart Association's (ACC/AHA) 2017 Hypertension Clinical Practice Guideline - NHANES 2017- March 2020



Data source: National Center for Health Statistics, Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey (NHANES) 2017-March 2020. Definitions: ACC/AHA criteria adapted from Ritchey MD, Gillespie C, Wozniak G, et al. Potential need for expanded pharmacologic treatment and lifestyle modification services under the 2017 ACC/AHA Hypertension Guideline. *J Clin Hypertens*. 2018; 1377-1391. https://doi.org/10.1111/jch.13364

[a] Among adults aged 18 years and older; estimates may not equal 100% due to rounding.
[b] Blood pressure ≥130/80 mm Hg or currently using prescription to lower blood pressure.
[c] Controlled is defined as having a blood pressure <130/80 mm Hg. All adults recommended lifestyle modifications only are considered uncontrolled as their blood pressure is above the threshold.

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Centers for Disease Control and Prevention, National Center for Health Statistics. (2020)

Hypertension Prevalence, Awareness, and Control

Table 5. Prevalence of Hypertension* Among US Adults Aged 18 to 80 Years, 2017 to 2020

Demographic group	Prevalence	
	Men	Women
Overall	49.5% (59.0 million)	43.9% (56.3 million)
Age groups, y		
18-29	20.3%	9.0%
30-44	39.6%	23.7%
45-59	57.4%	52.5%
60-74	70.7%	71.4%
75-80	83.7%	84.8%
Racial and ethnic groups (age-adjusted)		
NH White	47.0%	39.0%
NH Black	56.8%	56.7%
NH Asian	49.8%	39.1%
Hispanic	50.4%	36.3%
Other	50.7%	47.9%

*Hypertension defined as diagnosed hypertension, BP ≥130/80 mm Hg, or receiving antihypertensive therapy. Derived from NHANES.[9]

BP indicates blood pressure; and NH, non-Hispanic.

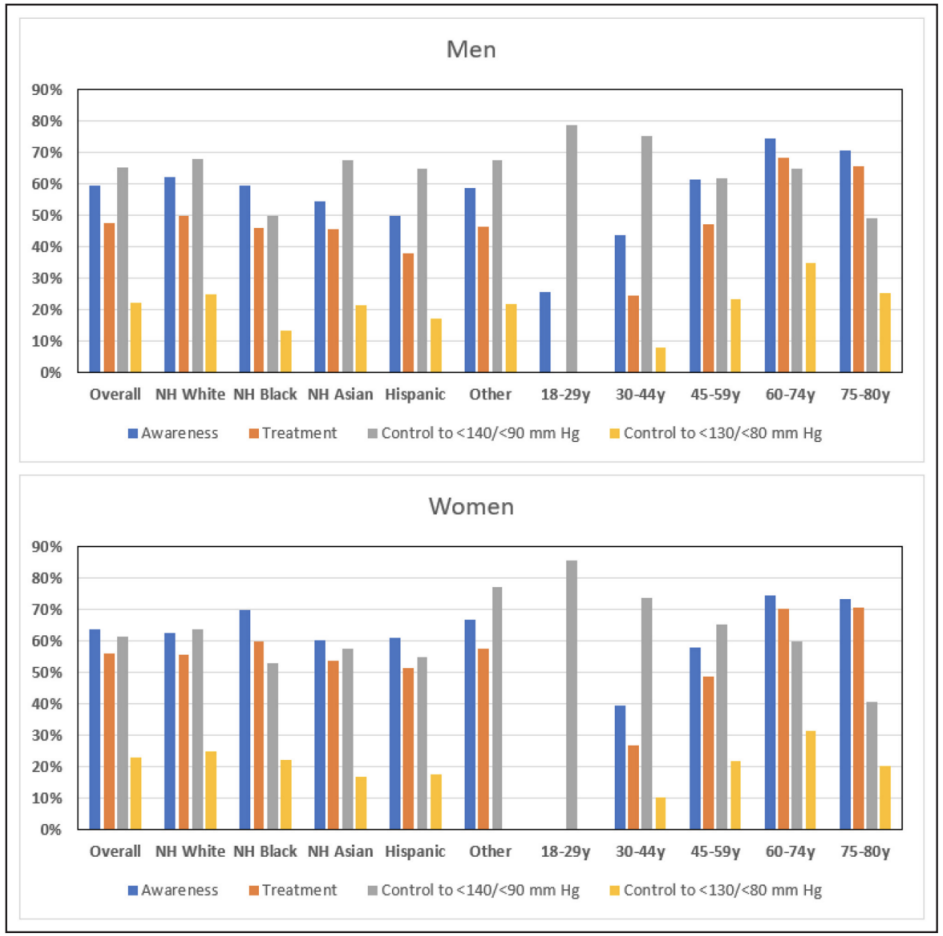

Figure 1. Rates of Awareness, Treatment, and Control of Hypertension Among US Adults Aged 18 to 80 Years, 2017 to 2020*.
*Missing data points indicate uncertain estimates due to small sample sizes for that subgroup. NH indicates non-Hispanic. Derived from NHANES.[9]

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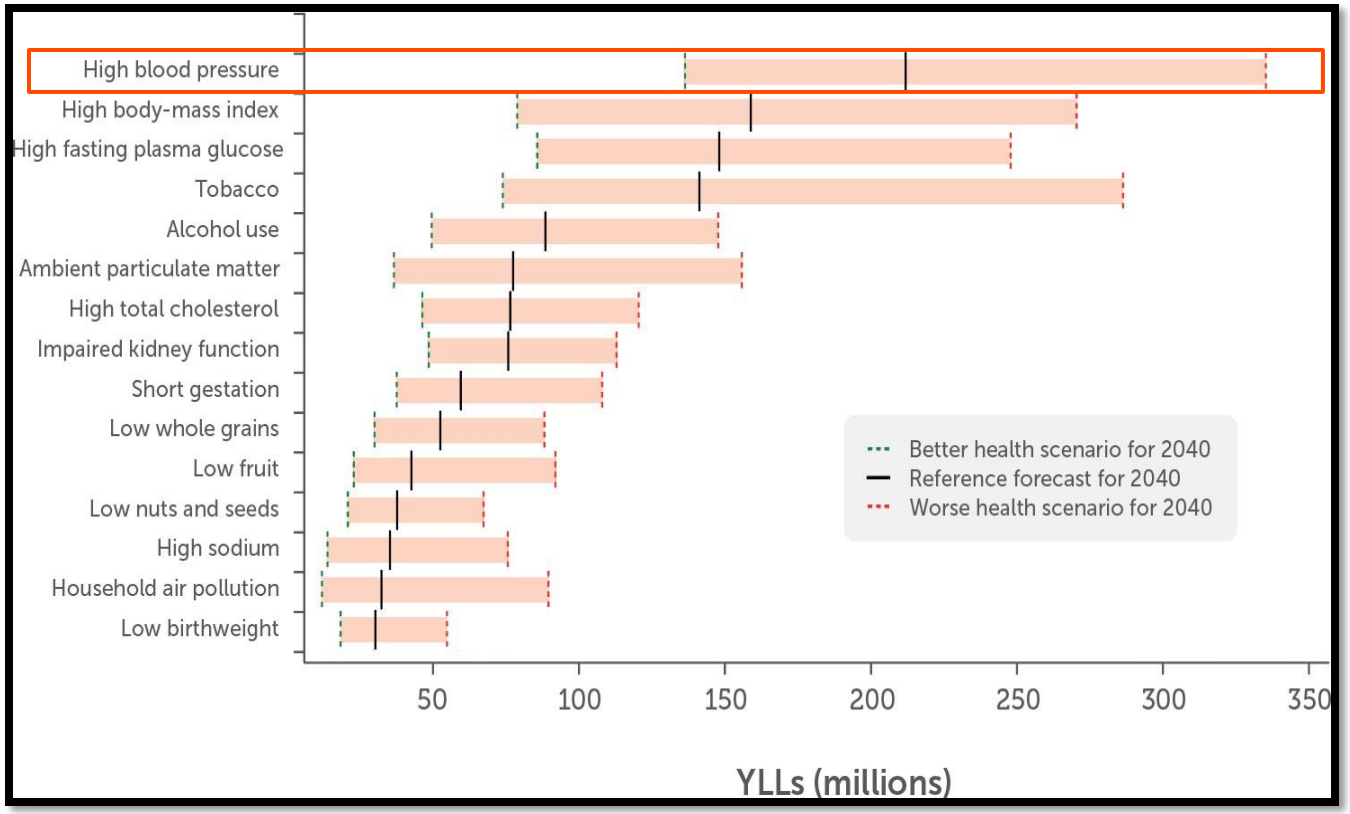
Hypertension is the #1 Cause of Global Disease Burden

Risk Factors Contributing to the Global Difference in Risk-Attributable Years of Life Lost (YLLs)[1]



1.39

Billion people worldwide[2]

31%

Of adults have hypertension[2]

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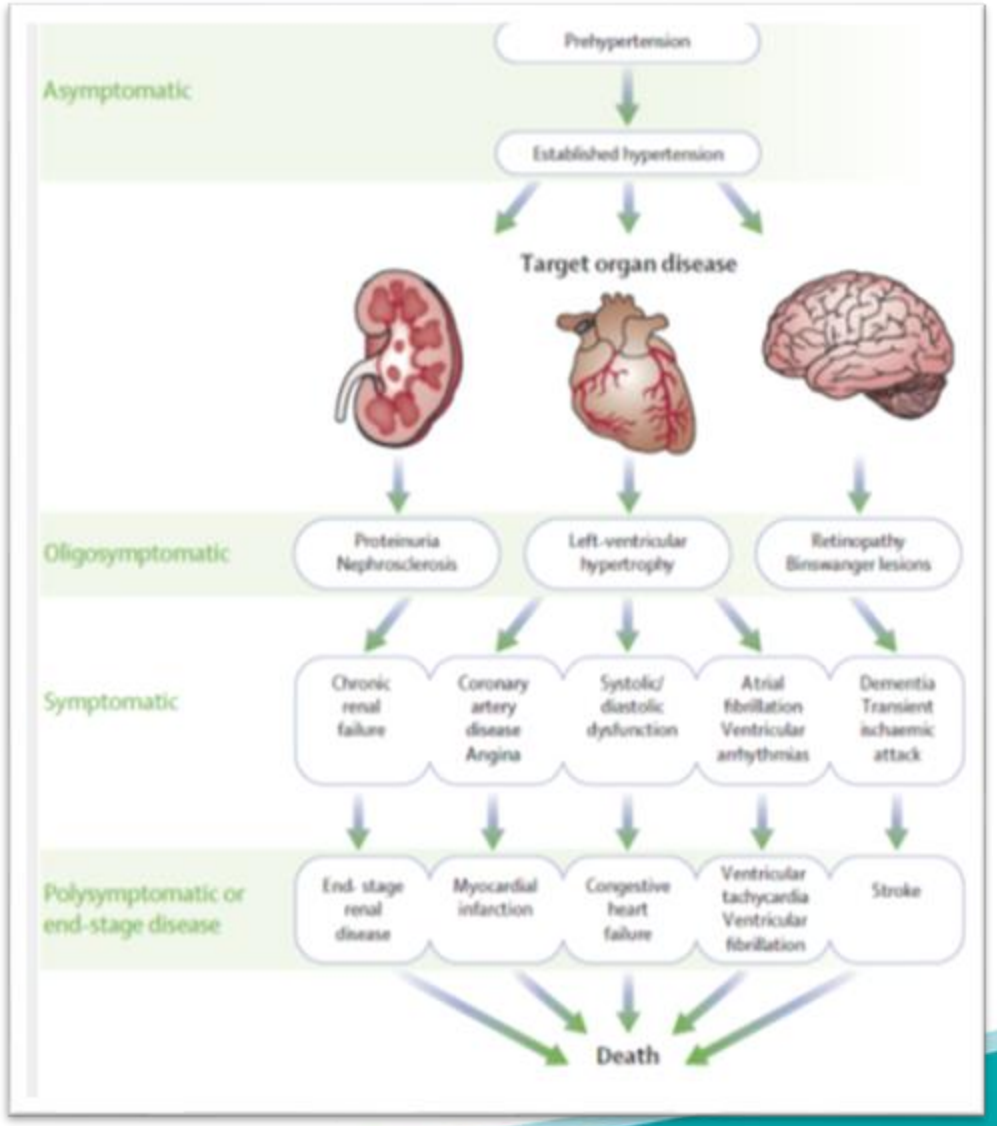
1. Foreman et al. *Lancet.* 2018 Nov 10;392(10159):2052-2090.
2. Mills et al. *Nat Rev Nephrol*. 2020 Apr;16(4):223-237.

Hypertension Affects Multiple Organs

- Changes occur before you feel any differences
- Hypertension is the “silent killer”
- Uncontrolled hypertension contributes to kidney failure, heart disease, vision loss, dementia and death



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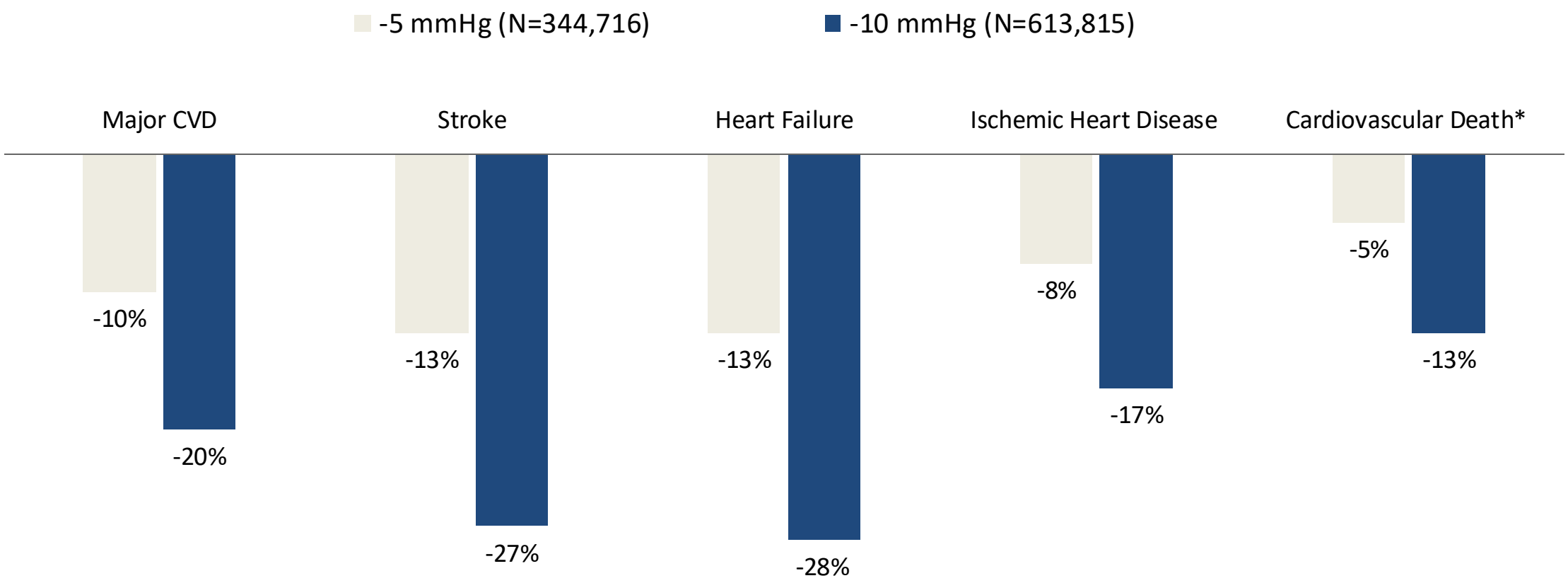
Messerli FH, et al. *Lancet*. 2007;370:591-603

Relative CV Risk Reduction with SBP reduction



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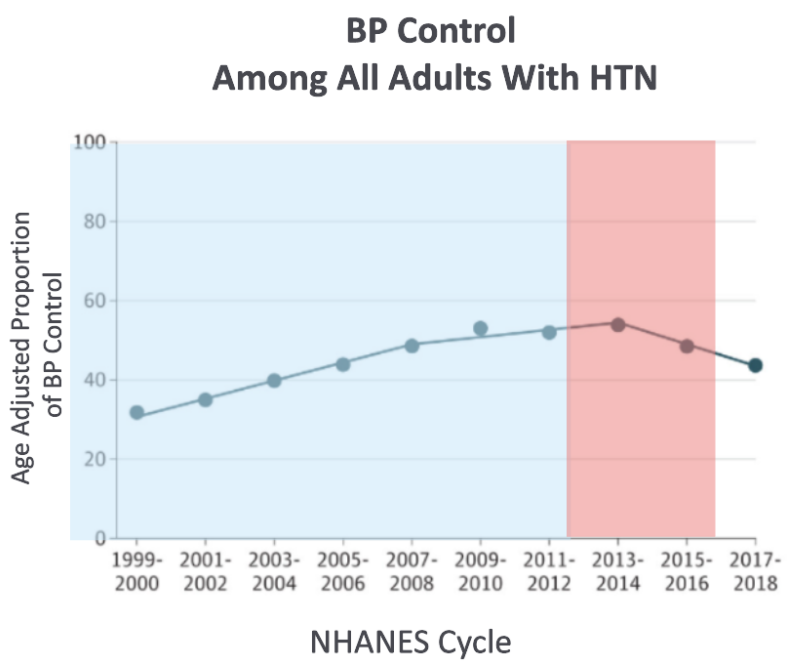
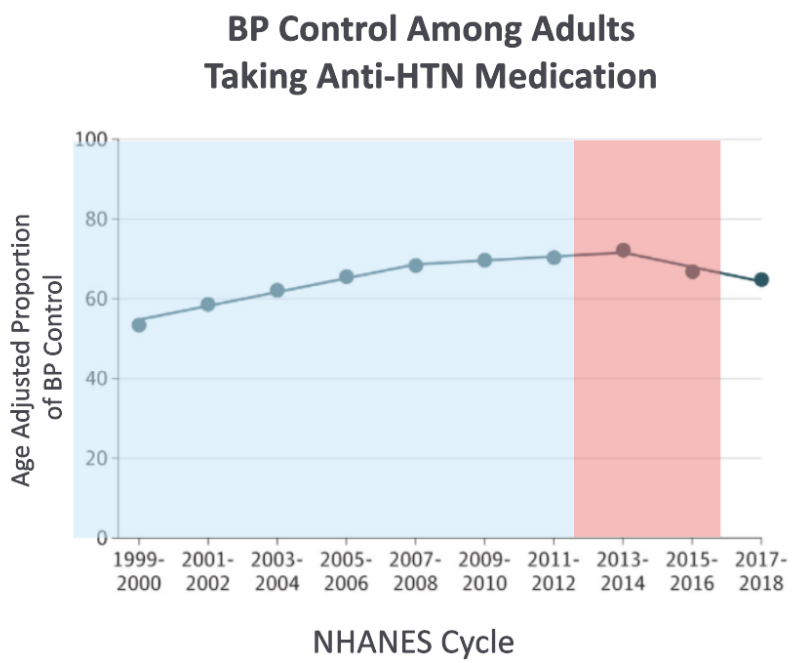
[1] Blood Pressure Lowering Treatment Trialists' Collaboration. Lancet. 2021;397(10285):1625-36.
[2] Ettehad D, et al. *Lancet*. 2016;387(10022):957-67.

Decline in BP Control Over Time

Prevalence of Controlled BP Has Decreased Over Time





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Muntner et al. 26 May 2022. *Hypertension*. 2022;79:1971–1980

Who Should Be Treated with Medicine?

5.2.2. BP Treatment Threshold and the Use of CVD Risk Estimation to Guide Drug Treatment of Hypertension

Recommendations for BP Treatment Threshold and the Use of CVD Risk Estimation to Guide Drug Treatment of Hypertension
Referenced studies that support the recommendations are summarized in the Evidence Table.

COR	LOE	Recommendations
1	A	1. In all adults with hypertension, initiation of medications to lower BP is recommended when average SBP is ≥140 mm Hg to reduce the risk of cardiovascular events and total mortality.[1–6]
1	A	2. In all adults with hypertension, initiation of medications to lower BP is recommended when average DBP is ≥90 mm Hg to reduce the risk of cardiovascular events and total mortality.[1–6]
1	A	3. In adults with hypertension and clinical CVD, initiation of medications to lower BP is recommended when average SBP is ≥130 mm Hg to reduce the risk of cardiovascular events and total mortality.[5–8]
1	C-LD	4. In adults with hypertension and clinical CVD, initiation of medications to lower BP is recommended when average DBP is ≥80 mm Hg to reduce the risk of cardiovascular events and total mortality.[5–8]

Recommendations for BP Treatment Threshold and the Use of CVD Risk Estimation to Guide Drug Treatment of Hypertension (Continued)

COR	LOE	Recommendations
1	A	5. In adults with hypertension without clinical CVD but with diabetes or CKD or at increased short-term CVD risk (ie, estimated 10-year CVD risk ≥7.5% based on PREVENT*), initiation of medications to lower BP is recommended when average SBP is ≥130 mm Hg to reduce the risk of CVD events and total mortality.[5–10]
1	C-LD	6. In adults with hypertension without clinical CVD but with diabetes or CKD or at increased 10-year CVD risk (ie, ≥7.5% based on PREVENT*), initiation of medications to lower BP is recommended when average DBP is ≥80 mm Hg to reduce the risk of CVD events and total mortality.[5–10]
1	B-R	7. In adults with hypertension without clinical CVD and with estimated 10-year CVD risk <7.5% based on PREVENT,* initiation of medications to lower BP is recommended if average SBP remains ≥130 mm Hg after a 3- to 6-month trial of lifestyle intervention to prevent target organ damage and mitigate further rise in BP.[7,9,10]
1	B-R	8. In adults with hypertension without clinical CVD and with estimated 10-year CVD risk <7.5% based on PREVENT,* initiation of medications to lower BP is recommended if average DBP ≥80 mm Hg after a 3- to 6-month trial of lifestyle intervention to prevent target organ damage and mitigate further rise in BP.[7,9,10]

*Increased short-term or 10-year risk is defined as a 10-year predicted risk for CVD events of ≥7.5% based on PREVENT (Predicting Risk of cardiovascular disease EVENTs).

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Jones, et al. Circulation 2025; 152

PCE vs. PREVENT Risk Calculators

Pooled Cohort Equation

- Participants (25,000)
  - 20,338 White, 4,288 Black
- Baseline exam 1960s-1990s
- Risk estimates: ASCVD (MI, CVA)
- Age Group: 40-79
- Inputs: Age, race, gender, DM, BP, HDL, LDL, smoking status
- Cons: Over-predicts risk

PREVENT Calculator

- Participants (3.2 million)
  - 80% White, 10% Black, 6% Hispanic, 2% Asian)
- Baseline exam 1992-2022
- Risk estimates: MI, CVA, HF
- Age group: 30-79
- Inputs: PCE + BMI, eGFR, UACR, Hgb A1c, SDI
- Cons: More challenging to implement

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Khan S, et al. Circulation Vol 149

Recommended Testing

3.1.2. Patient Evaluation, Including Laboratory Tests and Other Diagnostic Procedures

Recommendation for Laboratory Tests and Other Diagnostic Procedures		
COR	**LOE**	**Recommendation**
1	**C-EO**	1. For adults who are diagnosed with hypertension, laboratory tests (ie, complete blood count, serum electrolytes, serum creatinine, lipid profile, glucose or hemoglobin A1c [HbA1c], thyroid-stimulating hormone, urinalysis, and urine albumin-to-creatinine ratio) and diagnostic procedures (12-lead ECG) should be performed to optimize management.

3.2.3. Secondary Forms of Hypertension

Recommendations for Secondary Forms of Hypertension References that support recommendations are summarized in the Evidence Table.		
COR	**LOE**	**Recommendations**
1	**C-EO**	1. In adults with hypertension, screening for specific forms of secondary hypertension is recommended when clinical suspicion is present (Table 10, Figure 5) to increase rates of detection, diagnosis, and specific targeted therapy.
1	**B-NR**	2. In adults with resistant hypertension, screening for primary aldosteronism is recommended regardless of whether hypokalemia is present to increase rates of detection, diagnosis, and specific targeted therapy.[1,2]
2a	**C-EO**	3. In adults who have a positive screening test for a form of secondary hypertension, referral to a clinician who has expertise in that form of hypertension is reasonable for diagnostic confirmation and treatment.

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When to consider secondary causes?

- Stage 2 HTN
- Treatment resistant HTN
- Sudden onset HTN
- Sudden increase in BP when previously controlled
- Age <30
- High DBP in older adults

- Common Causes:
  - OSA (25-50%)
  - CKD (14%)
  - Hyperaldosteronism (5-25%)
  - Drug/EtOH (2-20%)
  - Renovascular (0.1-5%)
- Uncommon Causes (<1%):
  - Hyper/hypothyroidism
  - Pheochromocytoma
  - Aortic coarctation
  - Cushing syndrome
  - Hyperparathyroidism

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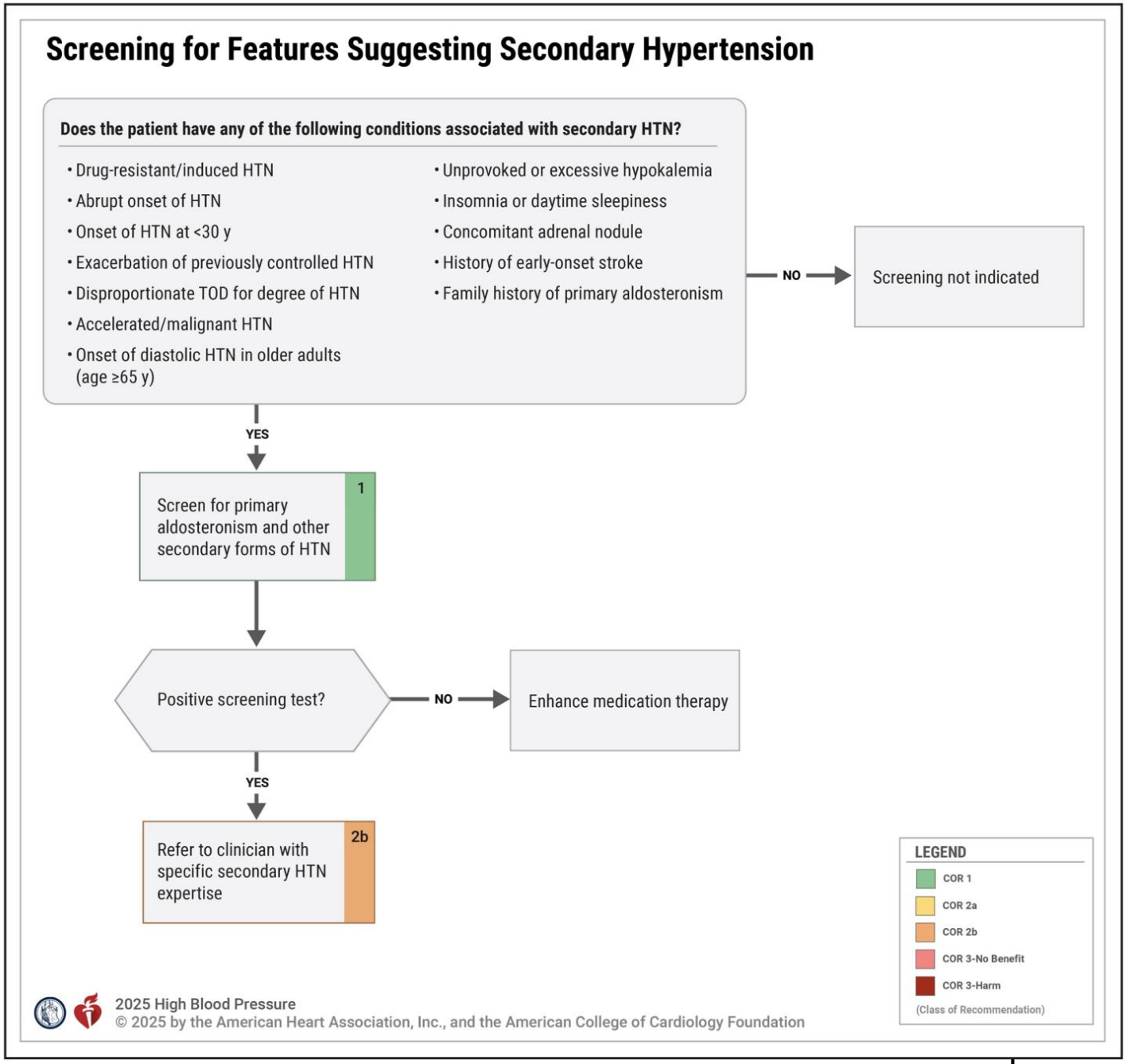

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How Do We Fix It?

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The Kaiser Effect

- Registry of 650,000 patients
- 140/90 goal
- 44% control in 2001
- Achieved 90% control rates by 2013
- Rate of MI reduced by 24%
- Death from stroke reduced by 42%

Keys to Success

- System-wide commitment
- Integrated care delivery
- Registry to ID and track patients with HTN
- System-wide treatment algorithms
- Follow up with MAs with no co-pay
- Combination pills
- Quality reporting
  - Clinic feedback
  - Best practices

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Jaffee, et al. JAMA. 301;2013:699-705

Where We Started

Cone Health True North Metric

Race

Race	% Passing	Opportunities	# Passing	Total Patients
White or Caucasian	✓ 73.02%	758	2,051	2,809
Black or African American	✗ 64.05%	500	891	1,391
Other or two or more races	✗ 62.91%	56	95	151
Asian	✗ 63.64%	20	35	55
Unavailable	✓ 75.76%	8	25	33
American Indian or Alaska Native	✗ 66.67%	3	6	9
	✓ 100.00%	0	1	1

Hypertension Control for Black or African American as of March 2023

Health Equity Gap of 8.97%

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How to Bridge the Gap: True North Metric Insights

- Awareness
  - Patient
  - Provider
- Alignment: Shared Goals
  - BP target
  - Lifestyle to limit medication when possible
- Empowerment
  - Ability to track BP
  - Affordability and ease of medication administration
  - *Partnering for meaningful change*

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Awareness: Patient

- Over 30% of hypertensive adults don’t know they have HTN
- Screenings
- Direct patient outreach by PharmD team
- MyChart education
- Think outside the provider’s office
- We ALL own this problem

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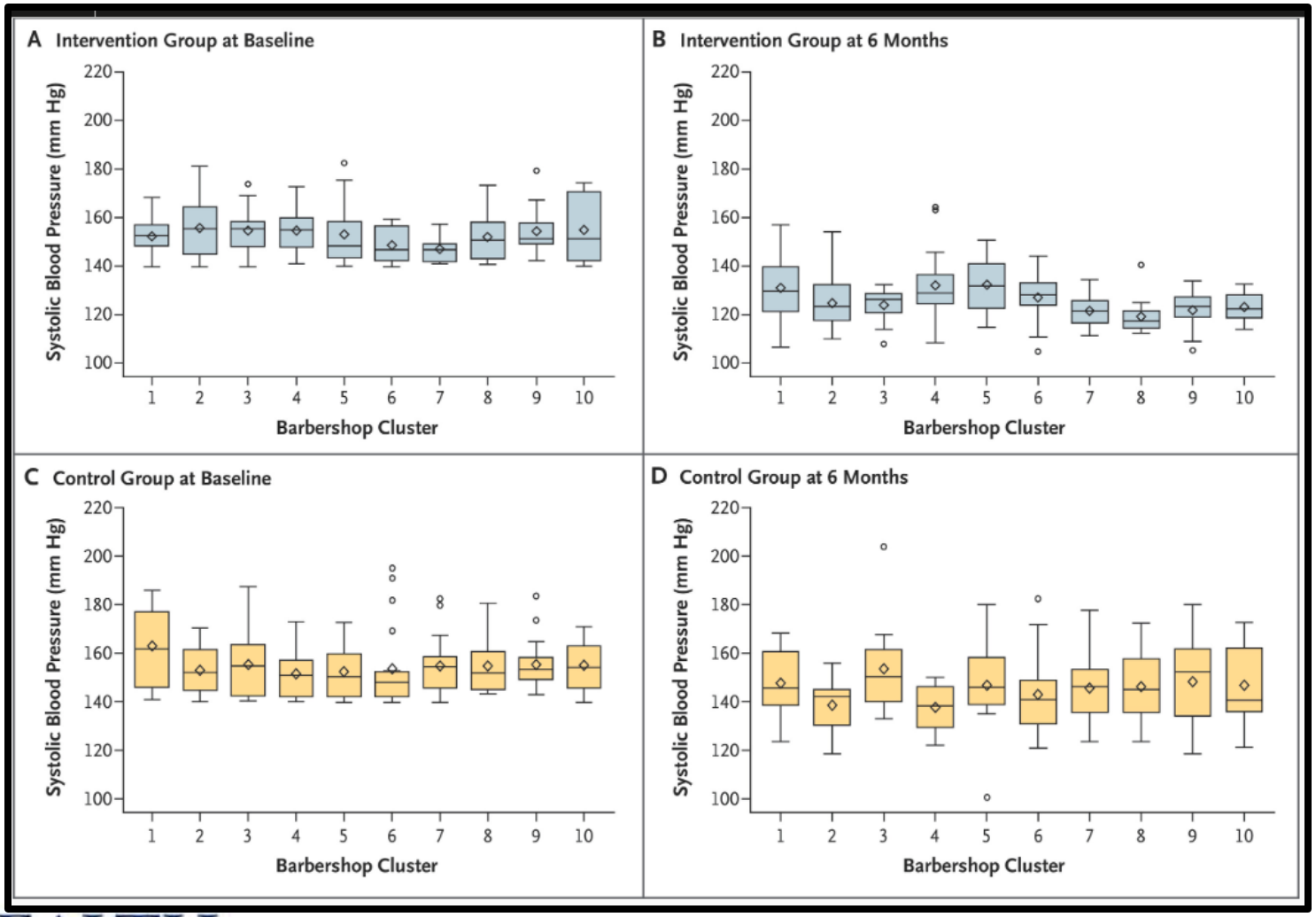
Hypertension Barbershop Study



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Victor RG, et al. **N Engl J Med 2018;378:1291-1301**

Awareness: Provider

- Check BP properly at every encounter
- Repeat BP if >140/90 and document appropriately
- Specialists: Assess and connect to care
- Stress the importance of high BP to the patient

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Proper Blood Pressure Measurement

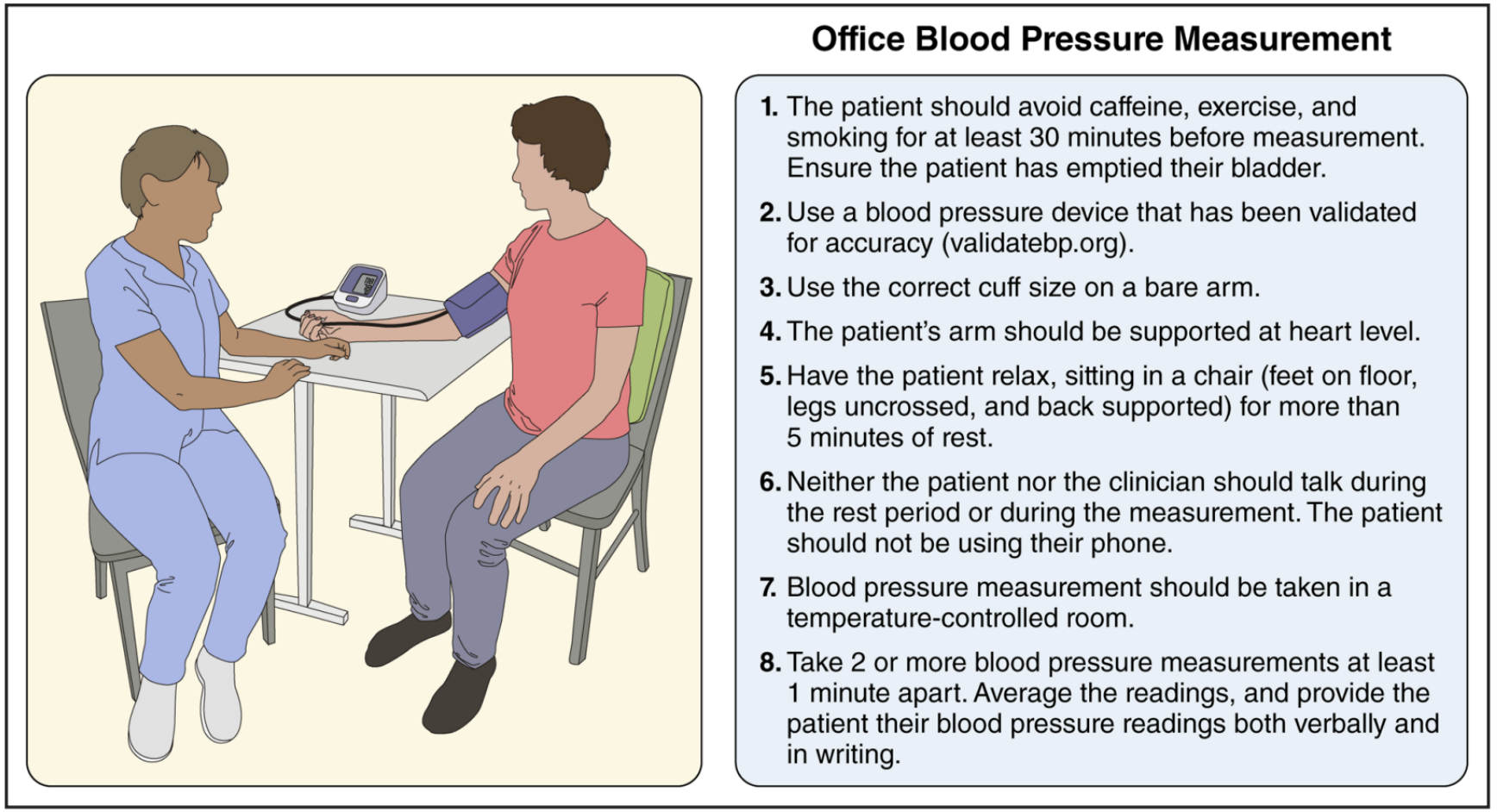

Figure 3. Checklist for Accurate Office Blood Pressure Measurement.

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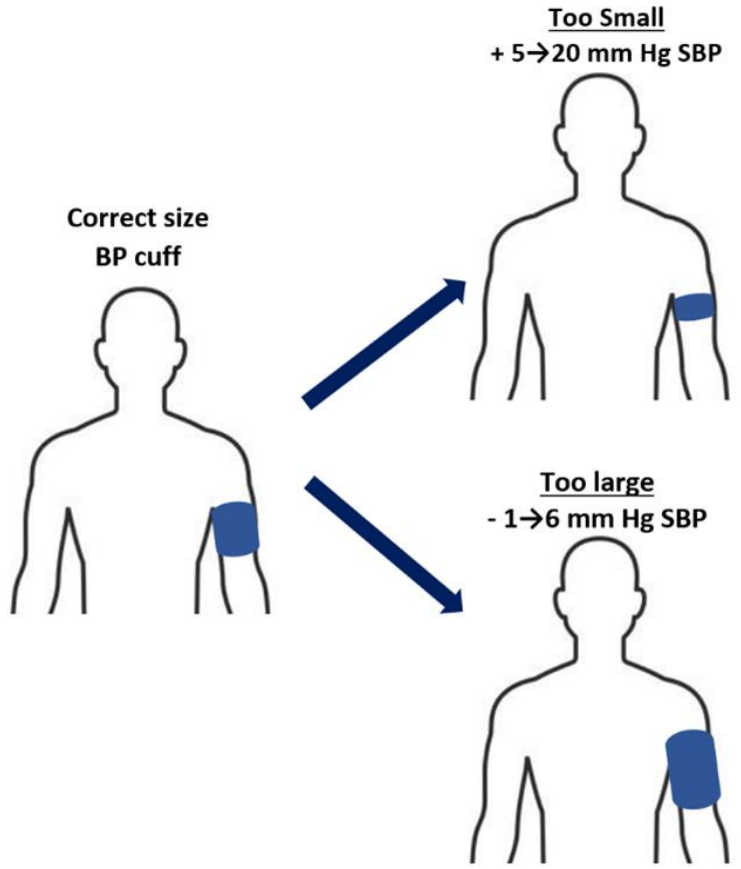
Why We MUST Measure Correctly

Table 1: Best Practices and Common Pitfalls That Can Impact Accurate BP Measurement. *Courtesy of Whelton S, Ebinger J, Yang E.*

Best Practices for BP Measurement	Common Measurement Pitfalls	Impact of Improper Practice on SBP (mm Hg)
Use appropriate cuff size	Cuff too small	+ 5-20
	Cuff too large	- 1-6
Rest for 5 min before measurement	No rest period	+ 10-20
Sit quietly	Talking or texting during measurement	+ 10-15
Avoid caffeine for 30 min before measurement	Drinking coffee before measurement	+ 5-8
Have an empty bladder	Full bladder	+10-15
Avoid alcohol consumption	Excess alcohol consumption	+ 5-8
Sit with back supported	Sitting upright on examination table	+ 5-15
Keep both feet flat on floor	Crossing legs, legs dangling from examination table	+ 5-8
BP cuff should be placed on bare arm	Measurement over clothing	± 10-50



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Alignment: Shared Goals

- Know the appropriate target BP
  - <130/80 if known ASCVD, 10 year ASCVD risk >10%, CKD, DM or African American (or other high risk ethnic group)
  - <140/90 if none of the above or otherwise advised (prior guidelines)
- Medication algorithm
- Minimize pill burden and cost
- Identify barriers
- *Lifestyle coaching*

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Alignment: SPRINT

- 9361 participants
- Randomized to SBP target <120 mmHg or <140 mmHg
- Inclusion: Age ≥ 50; SBP 130-180 mmHg and increased CVD risk
- Exclusion: DM or prior stroke
- Outcomes:
  - Primary: Composite of MI, ACS, stroke, heart failure or CV death
  - Secondary: All-cause mortality

Wright, et al. NEJM. 387;(2015):435-443

Alignment: SPRINT

Mean BP 121 mmHg (intensive) vs. 136 mmHg (standard)

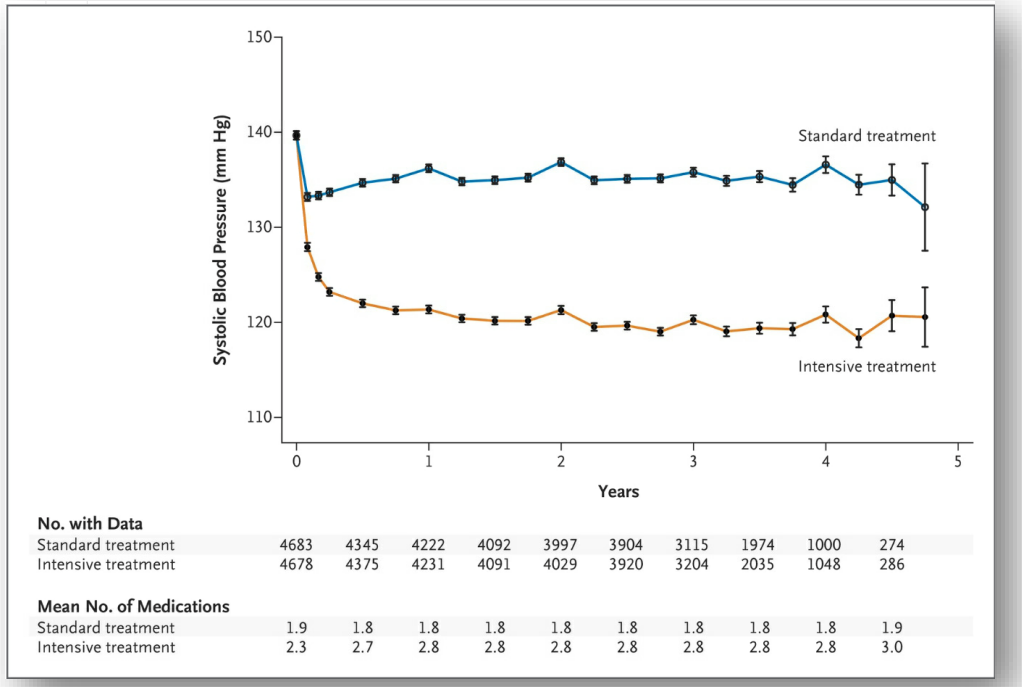

Table 2. Primary and Secondary Outcomes and Renal Outcomes.*

Outcome	Intensive Treatment		Standard Treatment		Hazard Ratio (95% CI)	P Value
	no. of patients (%)	*% per year*	*no. of patients (%)*	*% per year*		
All participants	**(N=4678)**		**(N=4683)**			
Primary outcome†	243 (5.2)	1.65	319 (6.8)	2.19	0.75 (0.64–0.89)	<0.001
Secondary outcomes						
Myocardial infarction	97 (2.1)	0.65	116 (2.5)	0.78	0.83 (0.64–1.09)	0.19
Acute coronary syndrome	40 (0.9)	0.27	40 (0.9)	0.27	1.00 (0.64–1.55)	0.99
Stroke	62 (1.3)	0.41	70 (1.5)	0.47	0.89 (0.63–1.25)	0.50
Heart failure	62 (1.3)	0.41	100 (2.1)	0.67	0.62 (0.45–0.84)	0.002
Death from cardiovascular causes	37 (0.8)	0.25	65 (1.4)	0.43	0.57 (0.38–0.85)	0.005
Death from any cause	155 (3.3)	1.03	210 (4.5)	1.40	0.73 (0.60–0.90)	0.003
Primary outcome or death	332 (7.1)	2.25	423 (9.0)	2.90	0.78 (0.67–0.90)	<0.001
Participants with CKD at baseline	**(N=1330)**		**(N=1316)**			
Composite renal outcome‡	14 (1.1)	0.33	15 (1.1)	0.36	0.89 (0.42–1.87)	0.76
≥50% reduction in estimated GFR§	10 (0.8)	0.23	11 (0.8)	0.26	0.87 (0.36–2.07)	0.75
Long-term dialysis	6 (0.5)	0.14	10 (0.8)	0.24	0.57 (0.19–1.54)	0.27
Kidney transplantation	0		0			
Incident albuminuria¶	49/526 (9.3)	3.02	59/500 (11.8)	3.90	0.72 (0.48–1.07)	0.11
Participants without CKD at baseline‖	**(N=3332)**		**(N=3345)**			
≥30% reduction in estimated GFR to <60 ml/min/1.73 m^2§	127 (3.8)	1.21	37 (1.1)	0.35	3.49 (2.44–5.10)	<0.001
Incident albuminuria¶	110/1769 (6.2)	2.00	135/1831 (7.4)	2.41	0.81 (0.63–1.04)	0.10

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Wright, et al. NEJM. 387;(2015):435-443

SPRINT Trial

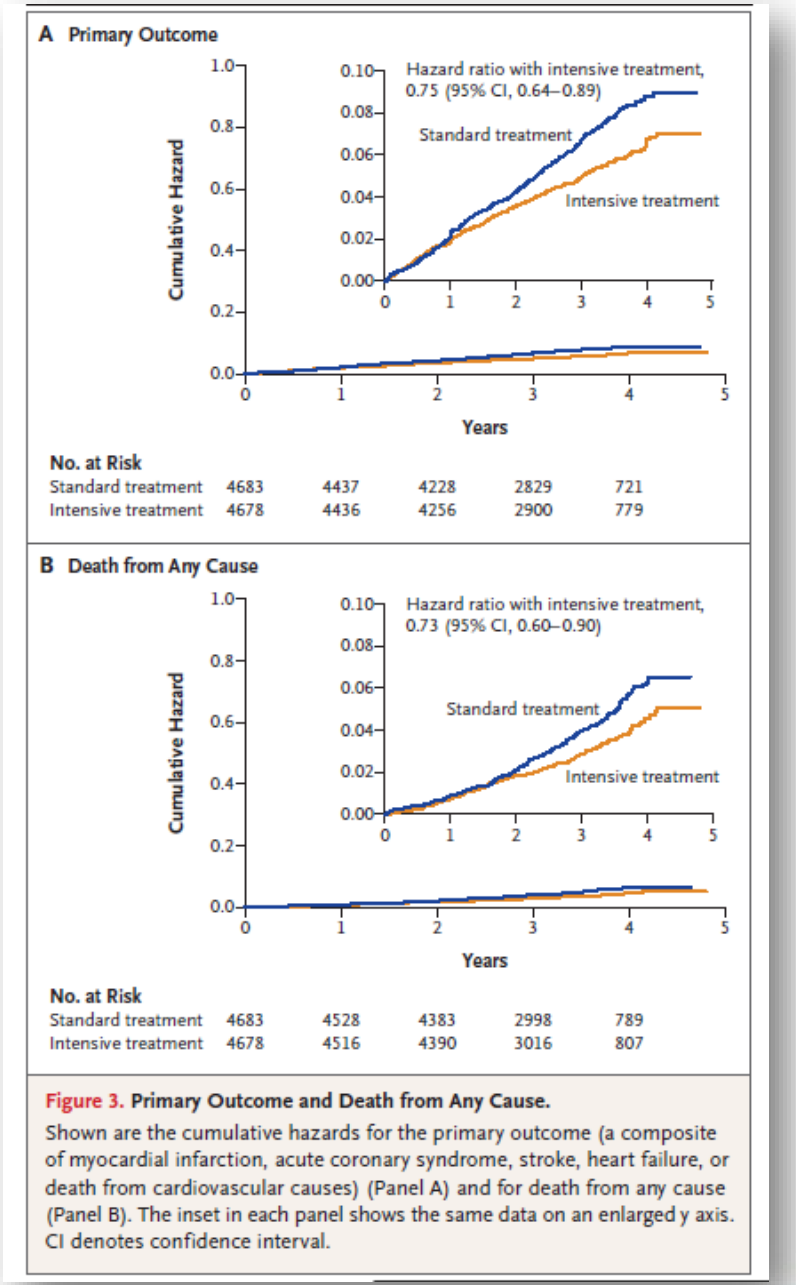

Figure 3. Primary Outcome and Death from Any Cause.

Shown are the cumulative hazards for the primary outcome (a composite of myocardial infarction, acute coronary syndrome, stroke, heart failure, or death from cardiovascular causes) (Panel A) and for death from any cause (Panel B). The inset in each panel shows the same data on an enlarged y axis. CI denotes confidence interval.

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Wright, et al. NEJM. 387;(2015):435-443

BP Goal for Patients with Hypertension

Recommendations for BP Goal for Patients With Hypertension
Referenced studies that support recommendations are summarized in the Evidence Table.

COR	LOE	Recommendations
1	A	1. In adults with confirmed hypertension who are at increased risk* for CVD, an SBP goal of at least <130 mm Hg, with encouragement to achieve SBP <120 mm Hg, is recommended to reduce the risk of cardiovascular events and total mortality.[1–4]
2b	B-NR	2. In adults with confirmed hypertension who are not at increased risk* for CVD, an SBP goal of <130 mm Hg, with encouragement to achieve SBP <120 mm Hg, may be reasonable to reduce risk of further elevation of BP.[5]
1	B-R	3. In adults with confirmed hypertension who are at increased risk* for CVD, a DBP target of <80 mm Hg is recommended to reduce the risk of cardiovascular events and total mortality.[6]
2b	B-NR	4. In adults with confirmed hypertension who are not at increased risk* for CVD, a DBP target of <80 mm Hg may be reasonable to reduce the risk of cardiovascular events.[5]

*Increased risk is defined as a 10-year predicted risk for CVD events of ≥7.5% using PREVENT.

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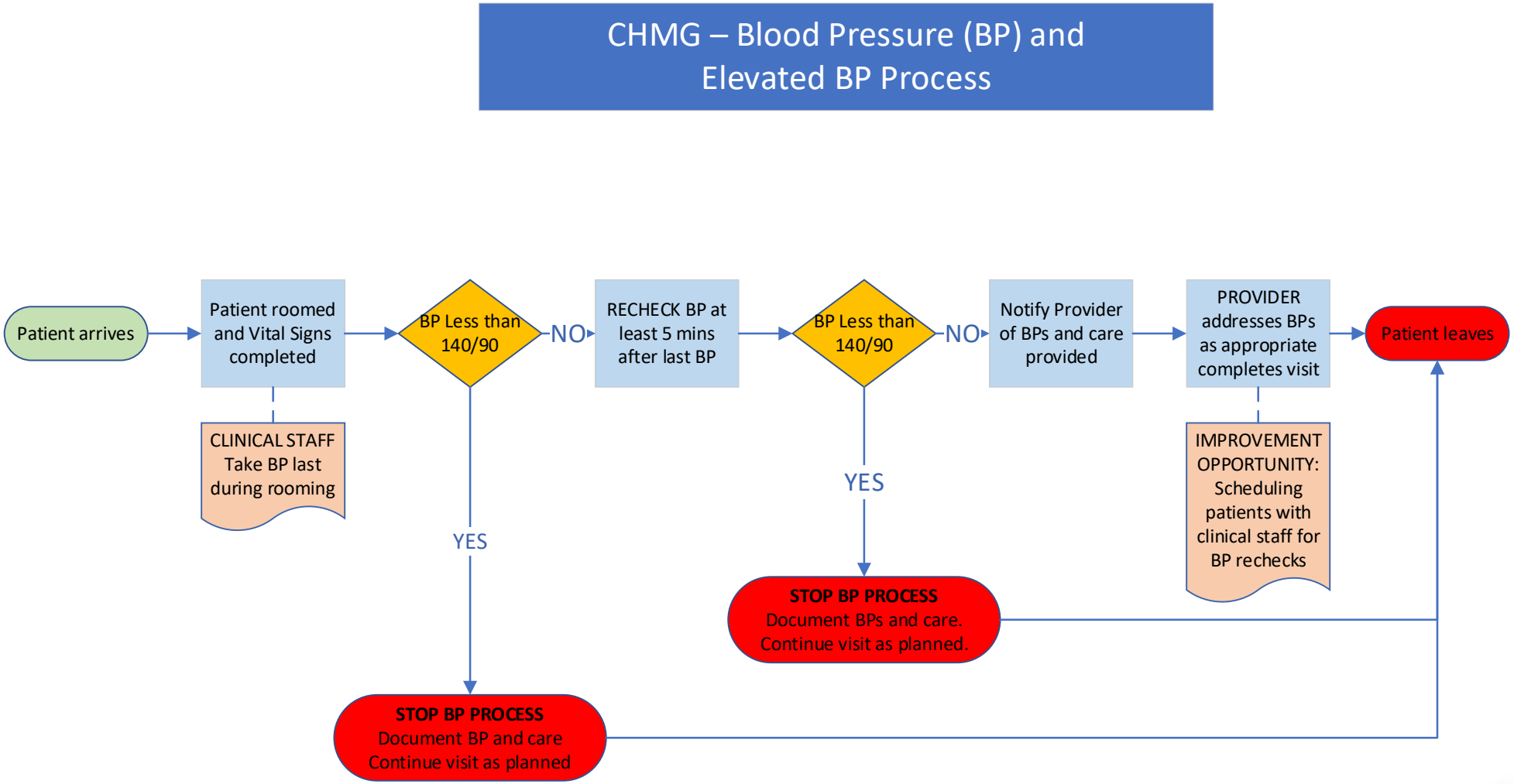
BP Assessment and Follow Up Process



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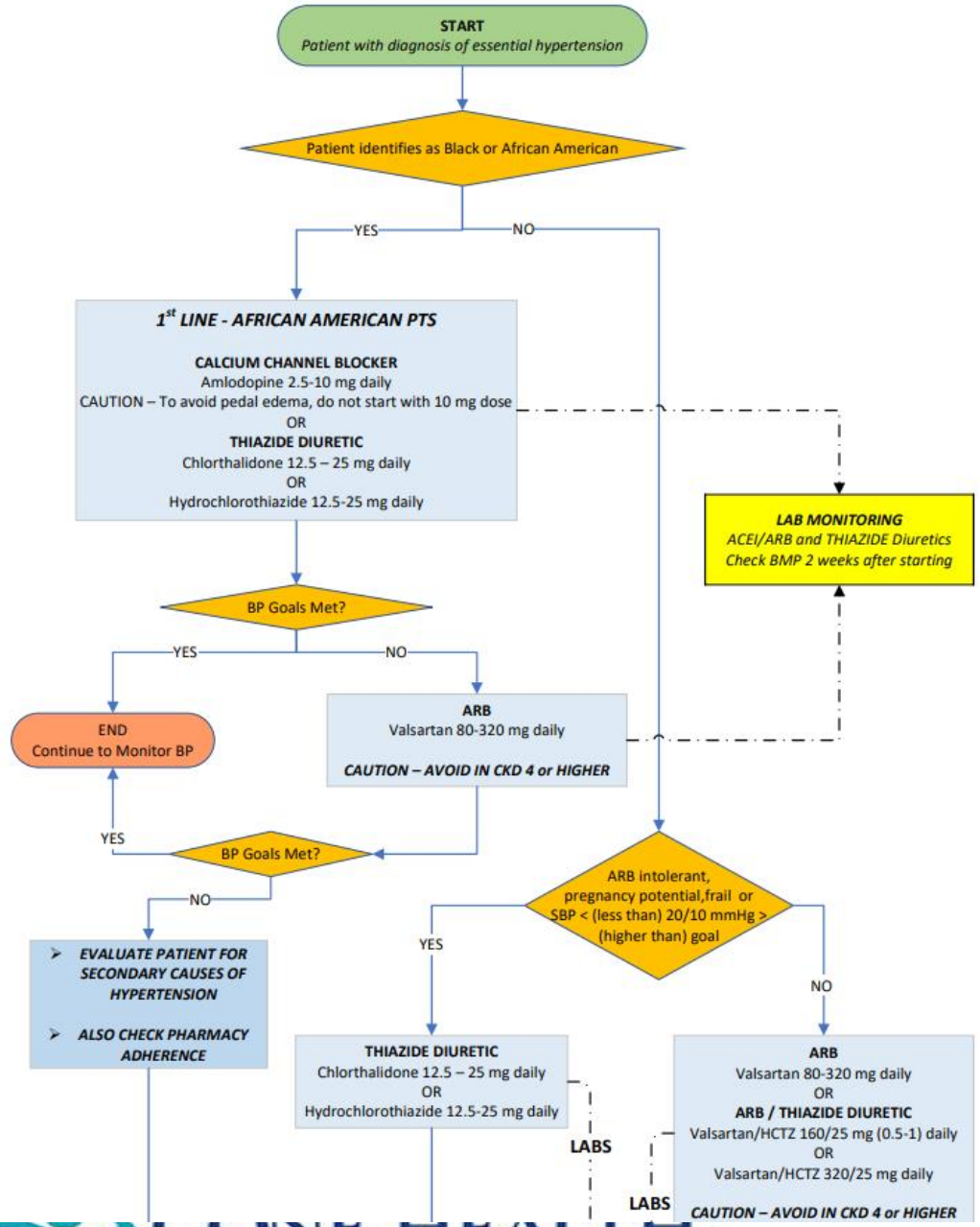

Treatment Algorithm

- Evidence-based medication algorithm
- Focus on combination therapy and low-cost medication
- Recommend medications with greater efficacy & lower risk of side effects in patients who identify as Black or African American
- Integrate into the Electronic Medical Record for easy reference during patient visits

Medication Management

5.2.3. Initial Medication Selection for Treatment of Primary Hypertension

Recommendation for Initial Medication Selection for Treatment of Primary Hypertension
Referenced studies that support the recommendation are summarized in the Evidence Table.

COR	LOE	Recommendation
1	A	1. For adults initiating antihypertensive drug therapy, thiazide-type diuretics, long-acting dihydropyridine CCB, and ACEi or ARB are recommended as first-line therapy to prevent CVD.[1,2]

5.2.4. Choice of Initial Monotherapy Versus Initial Combination Drug Therapy

Recommendations for Choice of Initial Monotherapy Versus Initial Combination Drug Therapy
Referenced studies that support the recommendations are summarized in the Evidence Table.

COR	LOE	Recommendations
1	B-R	1. In adults with stage 2 hypertension (SBP ≥ 140 mm Hg and DBP ≥90 mm Hg), initiation of antihypertensive drug therapy with 2 first-line agents of different classes, ideally in a single-pill combination (SPC), is recommended to improve BP control and adherence.[1–6]
2a	C-EO	2. In adults with stage 1 hypertension (SBP 130-139 mm Hg and DBP 80-89 mm Hg), initiation of antihypertensive drug therapy with a single first-line antihypertensive drug is reasonable, with dosage titration and sequential addition of other agents as needed to achieve BP control.
3: Harm	A	3. In adults with hypertension, simultaneous use of an ACEi, ARB, and/or renin inhibitor in combination is not recommended due to the potential for harm.[7–9]

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Alignment: Understand Barriers to BP Control

- Social and Economic Factors
- Therapy-Related Factors
- Patient-Related Factors
- Condition-Related Factors
- Health System-Factors
- Prevalence of non-adherence is high (37%)
- Assess and Intervene Where Possible

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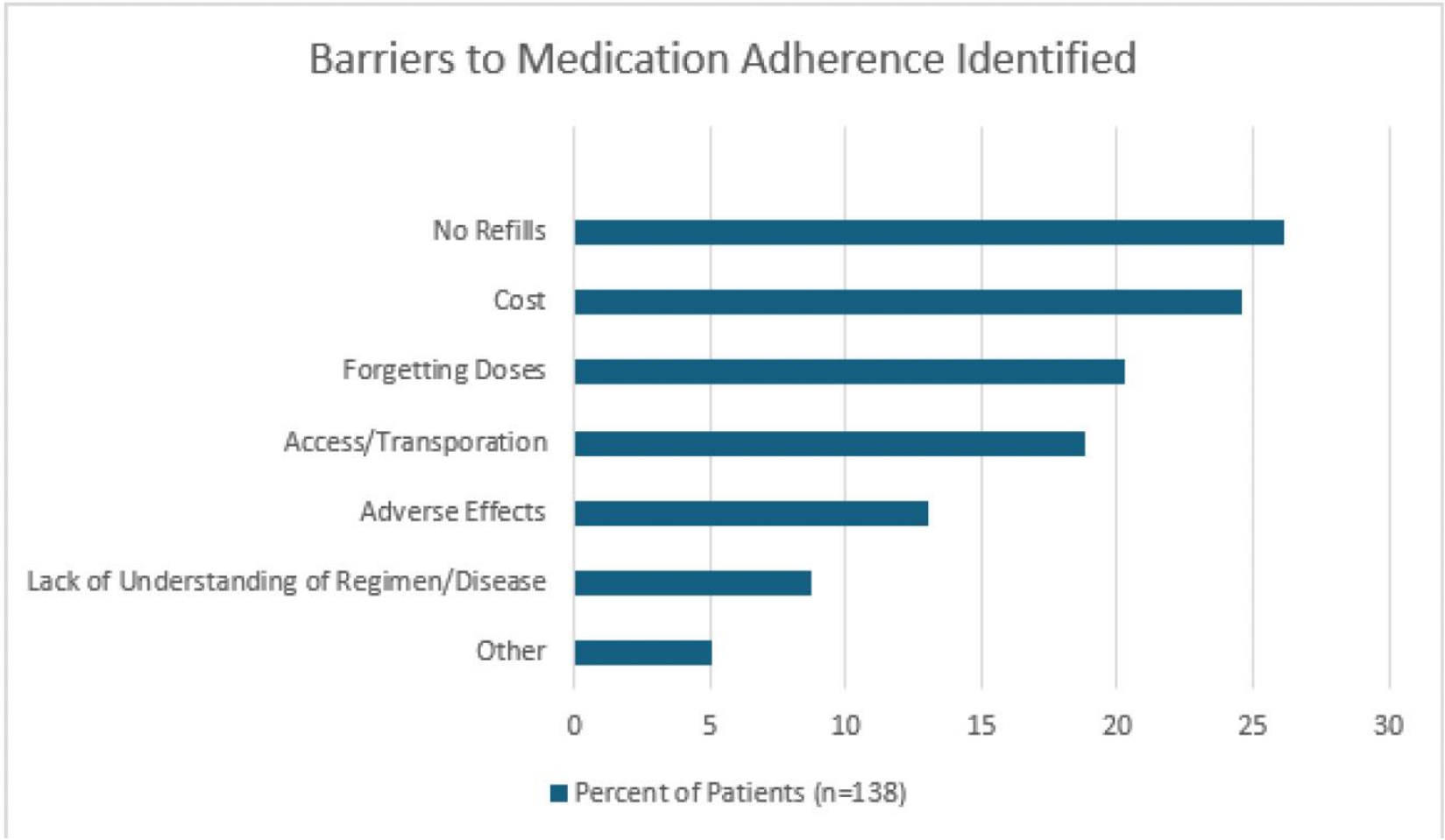
Bourque G, et al. Am J Hypertens. 2023 Jun 15;36(7):394-403

Barriers Identified in True North Metric



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Cone Health, Tyson Award Documentation

Strategies to Improve Adherence

Table 15. Evidence-Based Strategies for Improving Antihypertensive Medication Adherence

Evidence-Based Strategies for Improving Antihypertensive Medication Adherence
Dose consolidation
Single pill combination rather than separate pills
Education/coaching by pharmacists and other health professionals
Electronic/home blood pressure monitoring and feedback
Integration of patient preferences and values/shared decision-making into management plan
Medication synchronization and reminder aids
Mindfulness-based stress reduction or counseling for high stress, anxiety, and/or depression
Self-management interventions

Modified with permission from Choudhry et al.[21] Copyright 2022 American Heart Association Inc.

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Jones, et al. Circulation 2025; 152

Empowerment

3.1.4. ABPM and HBPM

Recommendations for ABPM and HBPM Referenced studies that support the recommendations are summarized in the Evidence Table.		
COR	**LOE**	**Recommendations**
1	A	1. In adults with suspected hypertension, out-of-office BP measurements by either ABPM or HBPM are recommended to confirm the diagnosis of hypertension.[1,2]
1	A	2. In adults who are taking antihypertensive medication, HBPM is recommended for monitoring the titration of BP-lowering medication, along with cointerventions such as patient education, telehealth counseling, and clinical interventions.[2–6]

- Know how to check blood pressure properly at home
- Know BP target
- Know all medications and why they take them
- Know what factors they can control that affect blood pressure:
  - Alcohol, stress, exercise, caffeine, NSAIDs, etc.

Jones, et al. Circulation 2025; 152

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Empowerment: Impact of Lifestyle Changes

Lifestyle Change	Intervention	Recommendation	Expected Decrease in SBP
Weight Loss	Weight/body fat reduction	Ideal Body Weight. Expect 1mmHg reduction in BP for every 1kg reduction in body weight	5 mmHg
Healthy Diet	DASH diet	Consume a diet rich in fruits, vegetables, whole grains, low-fat dairy products, reduced saturated fat	11 mmHg
Reduced Sodium Intake	Reduce Dietary Sodium	Optimal goal is <1500 mg/day. Aim for at least 1000 mg/day reduction.	5-6 mmHg
Increased Dietary Potassium	Increase Dietary Potassium	3500-5000 mg/day. Diet rich in potassium.	4-5 mmHg
Physical Activity	Aerobic	150 min/week	5-8 mmHg
	Resistance	90-150 min/week	4 mmHg
Moderation in alcohol intake	Reduce alcohol consumption	In individuals who drink alcohol, reduce alcohol to : ≤2 drinks daily for men, ≤1 drink daily for women	4 mmHg

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Whelton, et al. Hypertension. 71;2017:e12-e115

Steps to Success

Standardize Blood Pressure Assessment

- Guideline-based office blood pressure assessment
- Changes to blood pressure medications based on inaccurate BP measurement can cause unexpected changes (increases/decreases) in BP

Targeted Pharmacy Outreach

- Pilot with pharmacy students checking BP at Cone Pharmacies
- MyChart pre-visit adherence and adherence barriers interventions

Primary Care Education

- Appropriate technique for BP check
- Repeat and document pressure if first value is elevated
- Cardiology hypertension medication algorithm
- Referral to Advanced Hypertension Clinic

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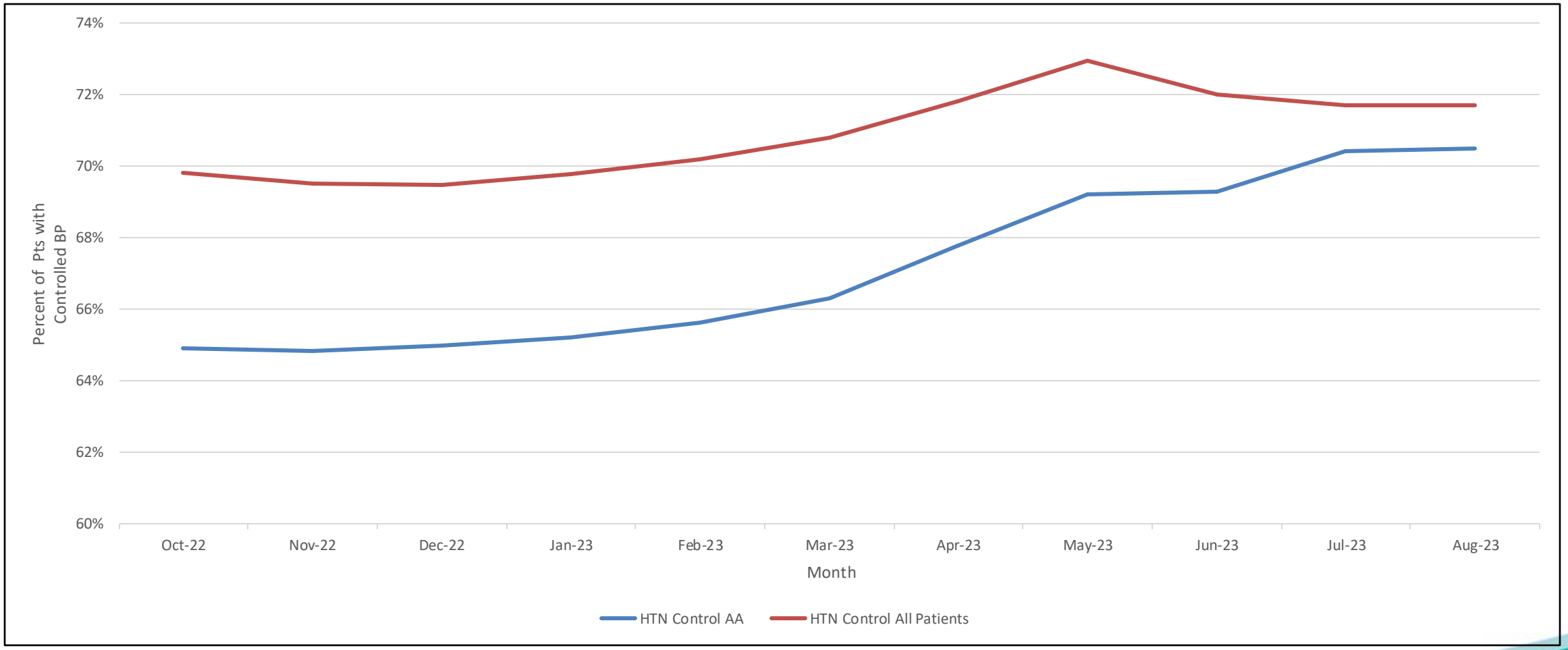
Health Equity Gap - HTN Control (All vs AA)



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Current State

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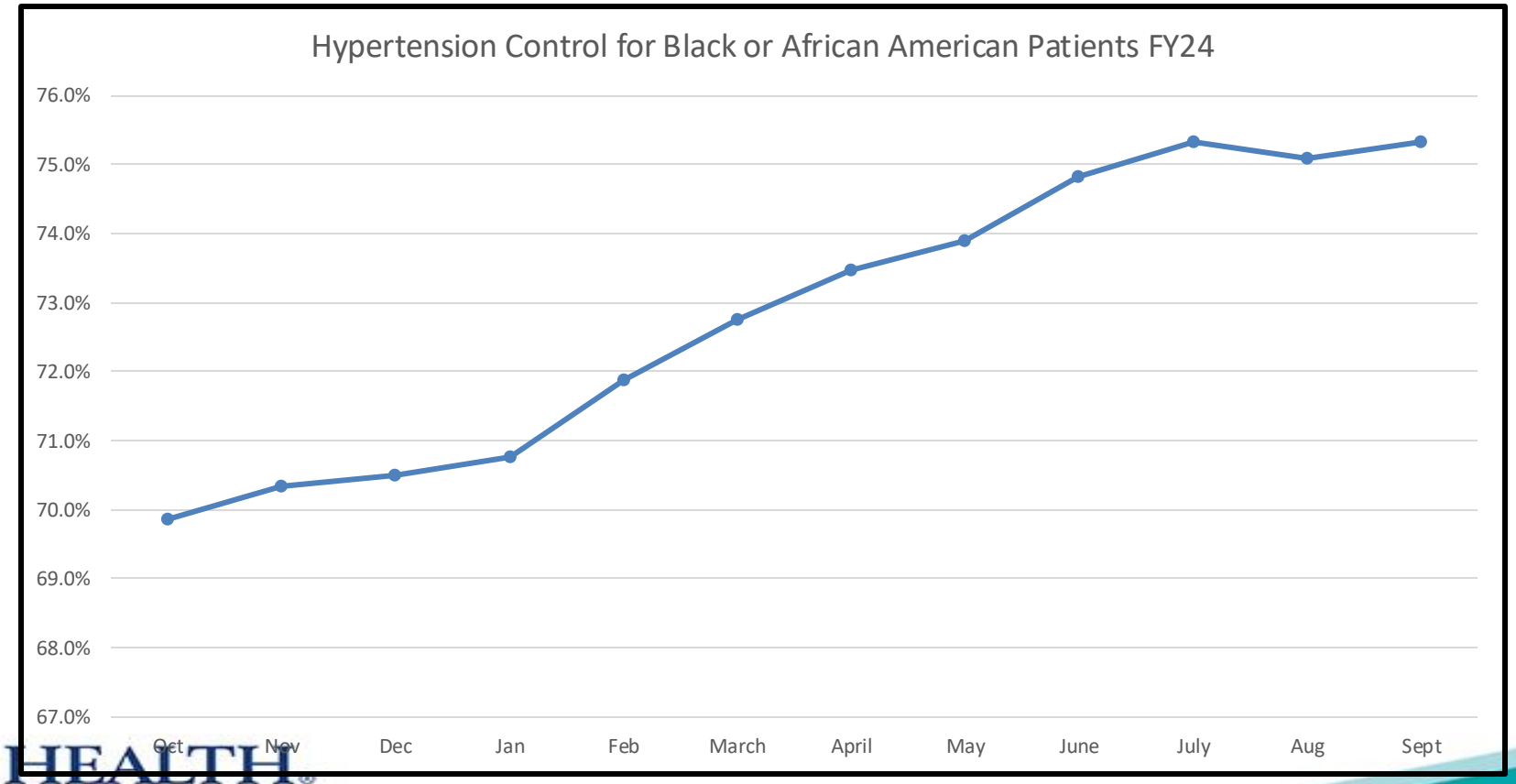
Analytic Data & Application Development

CHMG Quality Dashboard: Overview

Hypertension Control	75.33%	82.00% Target	4,399 Opportunities	13,435 # Passing	17,834 Total Patients



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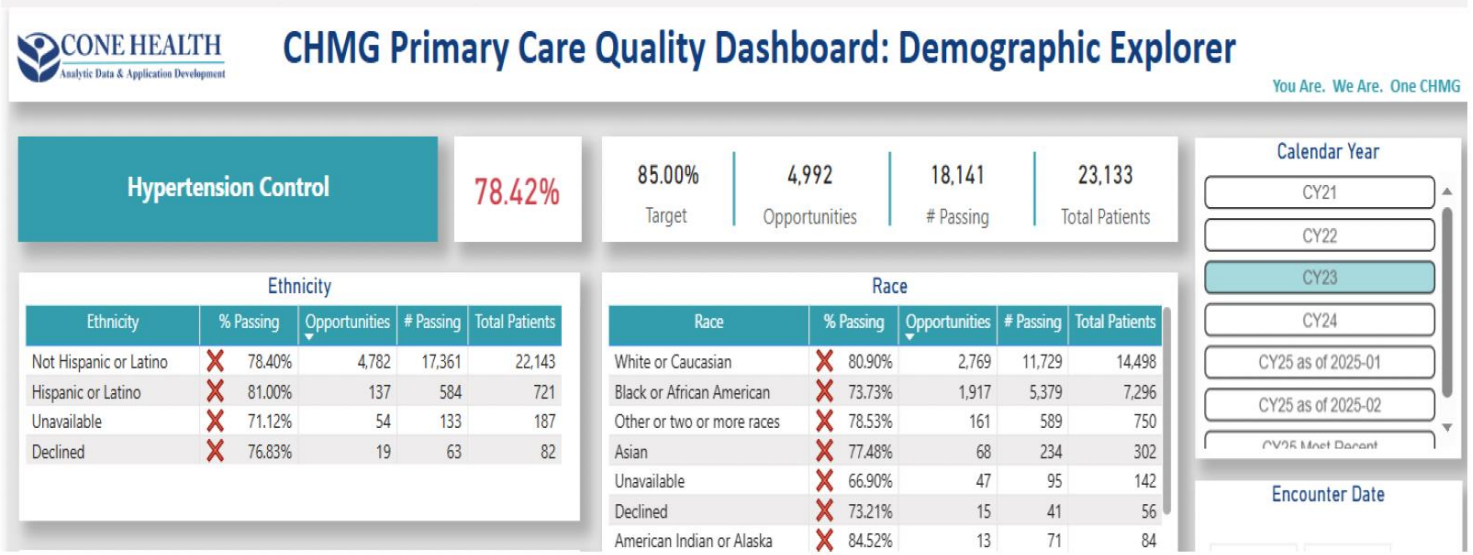
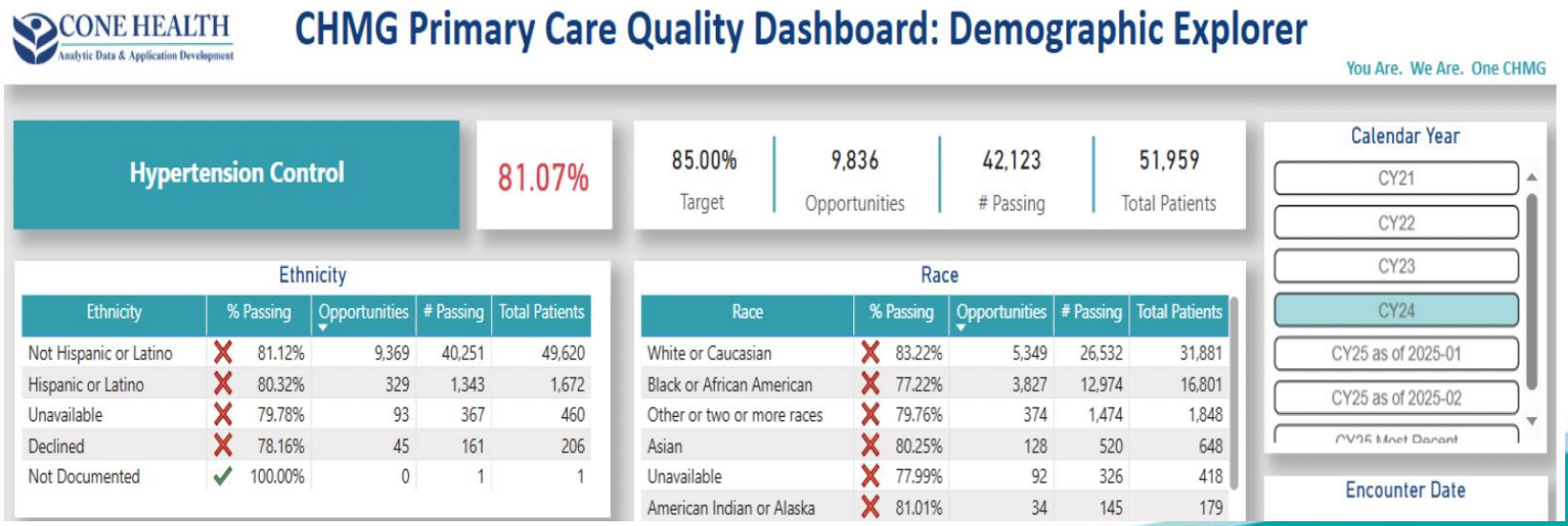
Dashboard showing the demographics and hypertension control for FY 23 and 24



2023

2024



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2025 Bernard J. Tyson Award

Cone Health Honored for Advancing Health Equity

9/17/2025

16 Like | Comment

What's new? Cone Health is proud to receive the **2025 Bernard J. Tyson Award for Pursuit of Healthcare Equity**. The award recognizes our program for closing a blood pressure control care gap for Black patients as well as significantly improving blood pressure control among all patients.

Presented by the Joint Commission and Kaiser Permanente, the Tyson Award honors health care organizations and their partners that lead a measurable, sustained reduction in one or more health care disparities.

Olu Jegede, MD, Chief Health Equity and Community Impact Officer of Cone Health, accepted the award earlier today at UNIFY 2025, the Joint Commission's inaugural health care leadership conference. Pictured left to right: Andrew Bindman, MD, Executive Vice President and Chief Medical Officer, Kaiser Permanente, Dr. Jegede and Jonathan B. Perlin, MD, PhD, President and CEO, Joint Commission.

We recognize Dr. Jegede and all the teams who contributed to this achievement. Your work to reduce disparities made this recognition possible.

Who is the award named after? Bernard J. Tyson, the late Chairman and Chief Executive Officer of Kaiser Permanente, who championed equity in health care. His legacy lives on through this honor, which aims to inspire other organizations to take action.

For more information on the Tyson Award, please visit the Tyson Award webpage.

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Key Takeaways

- Hypertension is incredibly common and is the greatest contributor to developing cardiovascular disease
- Most people should be treated to <130/80
- Small improvements in BP can have a huge impact
- Partner with patients to make sure they understand the importance of BP control and that you understand their barriers

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Thank You

- Cone Health Heart & Vascular
- Dr. Jake Hochrein
- Center for Health Equity
- Dr. Olu Jegede
- Stefannie Carrikier
- HTN True North Metric Team
- Advanced Hypertension Clinic and Research Teams

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