Blood Pressure Control Guideline Checklist

Primary Care Settings & Professionals

Level 1

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The current state of the issue

Hypertension impacts about half of American adults, while only around a quarter have their hypertension under control.[i] Hypertension prevalence and control varies between subpopulations, and these inequities are rooted not only in contemporary social and economic barriers but also in a long history of systemic racism, structural discrimination, and inequitable access to conditions that promote health.[ii],[iii],[iv] This report and guidelines focuses on the healthcare ecosystems' role in addressing hypertension control and equity, including the identified strategies outlined in our focus areas. While our report aligns with most updated evidence and national guidelines on blood pressure control targets, the workgroup also emphasizes that the higher an individual's blood pressure, the higher their risk for adverse outcomes.

Screening and Diagnosis

- [ ] **Review Key Priorities in the Executive Summary**
- [ ] **Screen BP in all adults** at least annually per USPSTF guidelines using accurate methods. (see Target: BP)
  - [ ] Refer people with BP >/=130/80 for further primary care. The higher the blood pressure, the more time sensitive it is to complete further evaluation and management.
  - [ ] For those with BP >/=120/80 provide blood pressure management education materials
  - [ ] Train and certify staff in proper measurement techniques regularly
- [ ] **Annually screen for health-related social needs** and establish protocols to address them, integrating findings into care plans. Follow FHCQ's report on Social Need and Health Equity and other evidence-informed guidelines.
- [ ] **Screen for behavioral health needs** per current clinical recommendations using validated tools (e.g., PHQ-9, GAD-7)
- [ ] **Diagnose hypertension accurately** per national guidelines (e.g., AHA/ACC), confirming with multiple and out-of-office readings.

Individualized Blood Pressure Management

- [ ] After diagnosis, create and document a **patient-centered management plan** to achieve healthy blood pressure. Utilize shared decision-making to identify blood pressure goals and targets, and to discuss medication options as needed.
  - [ ] Calculate cardiovascular risk using tools like PREVENT and educate patient about their long term ASCVD risk
  - [ ] Customize plans for preferences, culture, and language; involve interpreters as needed.

- [ ] Leverage payor resources (CVD prevention programs, care coordination, etc.).
- [ ] Consider referral to specialty care (e.g., cardiology) for complex hypertension management as indicated

- [ ] **Nonpharmacological intervention**
  - [ ] Use culturally sensitive and tailored approach to all interventions
  - [ ] Assess available nutritional resources and tailor diet advice to what's feasible for each person. Recommend DASH diet with emphasis on fruits, vegetables, whole grains, low-fat dairy, and reduced sodium (<2,300 mg/day, ideally <1,500 mg/day). Use culturally adapted tools for guidance.
  - [ ] Set achievable physical activity targets, adjusting for personal circumstances; suggest 150+ minutes of moderate intensity aerobic exercise per week.
  - [ ] Discuss weight management in a non-stigmatizing, person-centered way, focusing on healthy behaviors rather than weight alone; prioritize sustainability.
  - [ ] Promote moderation or avoidance of alcohol and tobacco tailored to individual readiness and motivation. Provide cessation resources.
  - [ ] Encourage stress management and behavioral health care within overall lifestyle changes.
- [ ] **Pharmacological intervention**:
  - [ ] Recommend single-pill combination therapy for stage 2 hypertension when possible.
  - [ ] Prefer once-daily dosing if feasible.
  - [ ] Do not apply race-based medication guidelines
- [ ] **Address needs of people with comorbidities** (diabetes, kidney disease, overweight/obesity, cerebrovascular disease, etc.) and **screen for secondary hypertension causes** per latest evidence-based guidelines (**2025 AHA/ACC**). See **Appendix** for further details

Integrated Team-based Care

- [ ] **Distribute patient education materials** on hypertension and ensure resources are accessible in appropriate languages and cultures.

Resources

- The Bree Report on Blood Pressure Control is meant to supplement these resources.
- Full Bree Report on Blood Pressure Control
- AHA Home Blood Pressure measurement Instructions
- 2025 Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults by AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC /NMA/PCNA/SGIM
- Validated Device Listing

Read the full Bree Report Blood Pressure Control online by scanning the QR code:

Connect with the Bree Collaborative at bree@qualityhealth.org

References: [i] Centers for Disease Control and Prevention. (2025, January 28). High blood pressure facts & statistics. https://www.cdc.gov/high-blood-pressure/data-research/facts-stats/index.html [ii] Forde AT, Lewis TT, Kershaw KN, Bellamy SL, Diez Roux AV. Perceived Discrimination and Hypertension Risk Among Participants in the Multi-Ethnic Study of Atherosclerosis. J Am Heart Assoc. 2021 Feb;10(5):e019541. doi: 10.1161/JAHA.120.019541. Epub 2021 Feb 18. PMID: 33596667; PMCID: PMC8174295. [iii] Mohottige D, Davenport CA, Bhavsar N, et al. Residential Structural Racism and Prevalence of Chronic Health Conditions. JAMA Netw Open. 2023;6(12):e2348914. doi:10.1001/jamanetworkopen.2023.48914 [iv] Dolezsar CM, McGrath JJ, Herzig AJM, Miller SB. Perceived racial discrimination and hypertension: a comprehensive systematic review. Health Psychol. 2014 Jan;33(1):20-34. doi: 10.1037/a0033718. PMID: 24417692; PMCID: PMC5756074.

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