* Team-based care strategies (e.g., huddles, care management meetings, high-risk patient panel review) are consistently used through co-located or integrated models.
* Teams screen blood pressure according to USPSTF evidence-based guidelines (e.g., higher frequency for those at higher risk for hypertension)
  + **~~Annually~~**~~for people 40+ and others at risk for hypertension e.g., demographic factors, persons with high-normal blood pressure, persons who are overweight or obese)~~
  + **~~Less frequently~~**~~(e.g., 3-5 years) as appropriate for adults 18-39 years not at increased risk for hypertension and with a prior normal blood pressure reading~~
* Triage of positive screening results for blood pressure in, including protocols ranging from elevated blood pressure to hypertensive emergency and follow up plans for previously undiagnosed individuals
  + Elevated blood pressure (SBP120-129/DBP up to 80): repeat screen in X weeks/months?
  + Hypertension stage 1 & 2 (SBP 130+/DBP 81+): consider out of office BP measurement to confirm hypertension diagnosis
* Accurate, guideline driven diagnosis of hypertension, based on an average of 2+ careful readings on 2+ occasions.
* Screening for comorbid health conditions for people with elevated blood pressure (e.g., kidney disease, atherosclerosis)
* Annual screening for non-medical drivers of health (e.g., food insecurity, transportation difficulties), clear documentation of results and connection to resources as available to address nonmedical drivers of health
* Guideline-directed services for people at risk for and with hypertension that address the whole person are regularly offered, including:
  + Behavioral health support for people with hypertension
  + Guideline directed medication management, reconciliation and titration
  + Self-measured blood pressure monitoring program (in-house or referred) and self-management counseling
  + Patient education and management support for hypertension including lifestyle interventions, medication and behavioral health interventions
  + Active management of co-occurring conditions (e.g, kidney disease, diabetes, etc.)
  + Additional supports for patients with uncontrolled hypertension (e.g., intensive case management, home visits with community health workers)
* Treatment goals are developed through a shared decision-making process to determine patient-directed goals taking into consideration nonmedical drivers of health
* Clear criteria and pathway for patient graduation to self-management of blood pressure
* Convenient and flexible care options to allow easy access to the care in the right setting
  + Alternative to traditional physical and behavioral health office visits (e.g., e-visits, phone visits, group visits, home visits, alternate locations)
  + As able, offer expanded hours for visits (e.g., early morning, evening, weekend)
* Language accessibility resources (translation, interpretation, patient materials such as pamphlets) that meet the needs of the populations served
* Health information technology  that supports management of patients with hypertension at the population level, including the following capabilities:
  + Identification of variation between populations in hypertension control rates
  + Monitoring of patients at risk for or with hypertension, including if able ability to communicate through blue-tooth or other methods of directly uploading blood pressure readings from home blood pressure monitors
  + Interoperability with the broader healthcare ecosystem, such as through health information exchanges to support longitudinal patient-centric records