Clinical Practice Guideline: **Hypertension (High Blood Pressure) Management**

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GUIDELINES

In the context of American Specialty Health – Specialty (ASH) best practices, screening all adult patients for hypertension by measuring their blood pressure is considered necessary. Within this same context, providing a referral intervention (e.g., to their medical physician) and/or a direct intervention (e.g., lifestyle and/or dietary changes) commensurate with the practitioner's expertise and scope, are recommended for adult patients with elevated blood pressure measurement during office blood pressure screening.

It is the practitioner's responsibility to monitor any patient identified with hypertension, even if co-managed. In patients identified with hypertension, practitioners should check blood pressure at every visit. This is especially important if the patient is exercising in the clinic setting. It is imperative for the practitioner to monitor blood pressure response to exercise by checking it pre, post, and during exercise. All values should be documented within the medical record for that visit. Hypertension history, blood pressure levels, and any health care practitioner recommendations for exercise should be taken into account when developing home exercise programs.

INTRODUCTION

High blood pressure affects millions of Americans. Prevalence is higher among non-Hispanic black adults and the elderly. Frequently hypertension is also responsible for a significant percentage of serious health conditions such as myocardial infarctions, strokes, episodes of heart failure, and premature deaths in the U.S. The risk of stroke, myocardial infarction, heart failure, and peripheral vascular disease is two to four (2-4) times greater for those with hypertension than those with normal blood pressure (BP). End-stage renal disease, retinopathy, and aortic aneurysm are also complications related to hypertension.

According to the ACC/AHA (2025), The causes of hypertension are a mix of genetics, lifestyle choices, and chronic stress. People with a genetic predisposition toward high blood pressure can help treat and prevent hypertension with healthy lifestyle behaviors.

Hypertension (high blood pressure or high BP) has been defined by the Joint National Committee (JNC 7, 8) for adults as systolic blood pressure of 140 mm Hg or higher, or diastolic blood pressure of 90 mm Hg or higher. In patients 60years of age or older, a systolic blood pressure level of 150 or greater is used instead of 140. In November 2017, the American Heart Association (AHA) and American College of Cardiology (ACC) published hypertension guidelines that lowered blood pressure thresholds of previously accepted guidelines. These guidelines also provided specific steps on how to accurately measure and interpret blood pressure. This change resulted in more people being identified as "hypertensive." In 2025, the ACC/AHA released an updated guideline for blood pressure levels.

The changes and comparison to other guidelines are shown in the table below:

AHA/ACC 2025 Hypertension Classifications		**Previous Hypertension Classifications (JNC 7, 8)**	
Category	**Systolic/Diastolic BP**	**Category**	**Systolic/Diastolic BP**
Normal	Less than 120/80 mm Hg	**Normal**	Less than 120/80 mm Hg
Elevated	120 - 129/less than 80 mm Hg	**Pre-Hypertension**	120 – 139/80 – 89 mm Hg
Hypertension - Stage 1	130 - 139/80 - 89 mm Hg	**Hypertension - Stage 1**	140 – 159/90 – 99 mg Hg
Hypertension - Stage 2	Greater than or equal to 140/90 mm Hg	**Hypertension - Stage 2**	Greater than 160/100 mm Hg
Critical	Greater than 180/120 mm Hg	**Critical**	Greater than 180/110 mm Hg

ASH will continue to closely monitor with internal and external experts any updated information regarding the guidelines.

SCREENING RECOMMENDATIONS

Population	Recommendation	Grade
Adults 18 years or older without known hypertension	The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A
Asymptomatic pregnant persons	The USPSTF recommends screening for hypertensive disorders in pregnant persons with blood pressure measurements throughout pregnancy.	B
Children and adolescents	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for high blood pressure in children and adolescents	I

The USPSTF recommendation, published in 2021, is consistent with the previous 2015 recommendations. Although evidence on optimal screening intervals is limited, reasonable options include:

- Screening for hypertension every year in adults 40 years or older and in adults at increased risk for hypertension (e.g., Black persons, persons with high-normal blood pressure, or persons who have overweight or obesity)
- Screening less frequently (i.e., every 3 to 5 years) as appropriate for adults aged 18 to 39 years not at increased risk for hypertension and with a prior normal blood pressure reading.

Screening for hypertension in the office setting can be done with automated or manual sphygmomanometry using an appropriately sized arm cuff. The patient is to be in a seated position with their arm at the level of the right atrium for the most accurate reading. The mean of two blood pressure measurements should be used. It is recommended that the patient be in the office for at least five minutes before the blood pressure is measured.

Blood pressure readings can be influenced by multiple common factors, such as emotional status, stress, pain, physical activity, caffeine use, tobacco use, time of day and medications. High blood pressure that only occurs in a medical setting and/or in the presence of medical personnel may occur in 15-30% of the population. People with this

'white coat hypertension' may have lower blood pressure outside of the office. If blood pressure is only measured in an office setting, diagnostic accuracy may be affected by procedural errors, the limited number of measurements that can be easily taken over time with multiple visits, and the possible presence of white coat hypertension.

According to the 2025 ACC/AHA guidelines, the risk of cardiovascular disease (CVD) associated with white coat hypertension may only be increased among older adults who have a high baseline CVD risk. Therefore, it is reasonable to exclude white coat hypertension using out-of-office BP monitoring in adults with high office BP (i.e., SBP/DBP ≥130/80 mm Hg). One caveat is that adults with office SBP/DBP ≥160/100 mm Hg should be promptly treated, with antihypertensive medication doses titrated as necessary to control BP. The prevalence of white coat hypertension is low among those with office BP levels in this range. Compared with individuals who have sustained normotension, a higher proportion of individuals with white coat hypertension or masked hypertension develop sustained hypertension during follow-up. An additional study demonstrated that, compared with individuals with sustained normotension, a higher proportion of individuals with white coat hypertension had high out-of-office BP during follow-up. Therefore, it is reasonable to conduct out-of-office BP monitoring to exclude sustained hypertension among those initially identified with white coat hypertension or masked hypertension.

Ambulatory and home blood pressure monitoring can be used to confirm a diagnosis of hypertension after initial screening. The USPSTF reports that evidence supports ambulatory home blood pressure monitoring as the best method for diagnosing hypertension. During this procedure the patient wears a small portable device that can measure blood pressure at 20–30-minute intervals. Good quality evidence supports that home blood pressure monitoring may also be acceptable for diagnosing hypertension especially when ambulatory blood pressure monitoring is not available. Blood pressure readings that are more significantly elevated may require more immediate intervention during the current clinical encounter without waiting for ambulatory monitoring results.

Home blood pressure monitoring with in-clinic measurements is important. At this time, cuffless devices such as smartwatches have not demonstrated appropriate accuracy and should not be used for blood pressure monitoring.

ASH recommends the following guidelines for a patient with an elevated blood pressure reading during the practitioner's examination:

- Blood pressure within 140/90 to 159/99 range: needs follow up blood pressure measurement with practitioner or referral to physician
- Blood pressure within 160/100 to 179/109 range: refer the patient to their physician for follow up.

- Blood pressure within 180/110 to 199/119 range: discuss the severity of this reading with the patient and recommend immediate follow up with their physician (if possible, contact the patient's physician to discuss how to proceed regarding the blood pressure reading)
- Blood pressure at or above 200/120: contact emergency services (e.g., call 911) for immediate care for the patient

INTERVENTIONS

Effective interventions to reduce hypertension can be pharmacological or nonpharmacological.

Pharmacological

Pharmacotherapy has been found to be effective compared to placebo in numerous trials in reducing cardiovascular events by lowering blood pressure. Over two-thirds of people with hypertension will require more than one antihypertensive medication to adequately control their blood pressure. The 2025 ACC/AHA recommendations include starting appropriate people with hypertension on two medications from the outset, especially in a combination pill for improved adherence. Multiple classes of antihypertensives are available including diuretics, angiotensin receptor blockers (ARBs), angiotensin converting enzyme inhibitors (ACEIs), beta blockers (BBs), alpha blockers, and calcium channel blockers (CCBs).

Adverse effects of antihypertensives have been found to be very common, varying from 40-89% of participants, depending on the study and the particular medication. These effects include headache, upper respiratory infection, nasopharyngitis, ankle edema, constipation, facial flushing, hyperkalemia, dizziness, and erectile dysfunction. Serious adverse effects were found to be less common (4-11% of participants, depending on the study and the medication).

Practitioners should also be aware that patients may not be adhering to their medication regimens as prescribed. Practitioners should follow the above recommended guidelines for blood pressure ranges and encourage follow up with the prescribing physician as indicated for management of blood pressure and/or medication adherence issues.

Nonpharmacological

There is fair to good evidence for a reduction in cardiovascular events from the use of certain nonpharmacological interventions for patients with hypertension. These interventions include weight reduction in patients with overweight/obesity , tobacco cessation, increased physical activity, dietary sodium reduction, increased dietary potassium, decreased or no alcohol intake, and stress management. Reductions in systolic blood pressure ranged from 3-15 mm Hg, depending on the study and the intervention.

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education, training, and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a patient only if they are trained to competency, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the patient to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a patient's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is essential for the practitioner to refer the patient for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

PRACTITIONER RESOURCES

Publicly available resources can be found at:

- NHLBI (National Heart, Lung, and Blood Institute) Publications and Resources https://www.nhlbi.nih.gov/health/high-blood-pressure

SPANISH LANGUAGE RESOURCES

- Materials for the Hispanic/Latino Population (National Heart Lung and Blood Institute): https://www.nhlbi.nih.gov/health/educational/healthdisp/health-education-materials/hispanic-latino.htm

MEMBER RESOURCES

Publicly available resources can be found at:

- Blood Pressure Toolkit https://www.heart.org/en/health-topics/high-blood-pressure/high-blood-pressure-toolkit-resources

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