

Hypertension Management Guidelines

DEPARTMENT: Utilization Management Physician Practice Guidelines

EFFECTIVE DATE: 01/06

DATE LAST REVIEWED: 12/21

SOURCES: 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee
2015 American College of Physicians Hypertension Guidelines
American College of Cardiology: 2017 Guide for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults

RECOMMENDED GUIDELINES:

- 1) Hypertension is a major health problem in America.
 - a) While hypertension is very common, it is important to establish the diagnosis with multiple readings unless the initial reading is dangerously high.
 - b) Many BP readings are inaccurate, either because of poor technique or because of inadequate equipment. The physician should recheck any high readings.
 - c) If a reading obtained later in the visit is lower, it is essential that the lower reading is entered into the EMR so that it does not appear that hypertension is being ignored.
 - d) "White coat hypertension" is real. It is important that the pressure be monitored by the patient outside of the office. The accuracy of the home device should be checked by the physician when possible.
- 2) The "Report from the Panel Members Appointed to the Eighth Joint National Committee" provides a guideline for hypertension prevention and management.
- 3) Key indicators of effective management of patients with hypertension:
 - a) Documented blood pressure readings at each visit. Blood pressure should be documented at least every 3 months until controlled, then at least yearly.
 - b) All cardiovascular risk factors are assessed and documented in the medical record. Cardiovascular risk factors include:
 - i) Hypertension
 - ii) Cigarette smoking
 - iii) Obesity (BMI >30 kg/m²)
 - iv) Physical inactivity
 - v) Dyslipidemia
 - vi) Diabetes mellitus
 - vii) Chronic kidney disease
 - viii) Age (>55 for men, >65 for women)
 - ix) Family history of premature CVD (men age <55, women age <65)

- c) Lifestyle modification issues are discussed with patient and documented in the medical record, including:
- DASH (Dietary Approaches to Stop Hypertension) diet: Rich in fruits, vegetables and low-fat dairy foods, reduced in overall fat
 - Dietary sodium restriction
 - Regular aerobic activity at least 30 minutes per day, most days of the week
 - Moderation of alcohol (no more than 2 drinks/day for men and 1 drink/day for women)
 - Smoking cessation
 - Weight reduction with documented goal
- d) Medications: As per current guidelines based on disease state.

Detection of White Coat Hypertension or Masked Hypertension in Patients Not on Drug Therapy

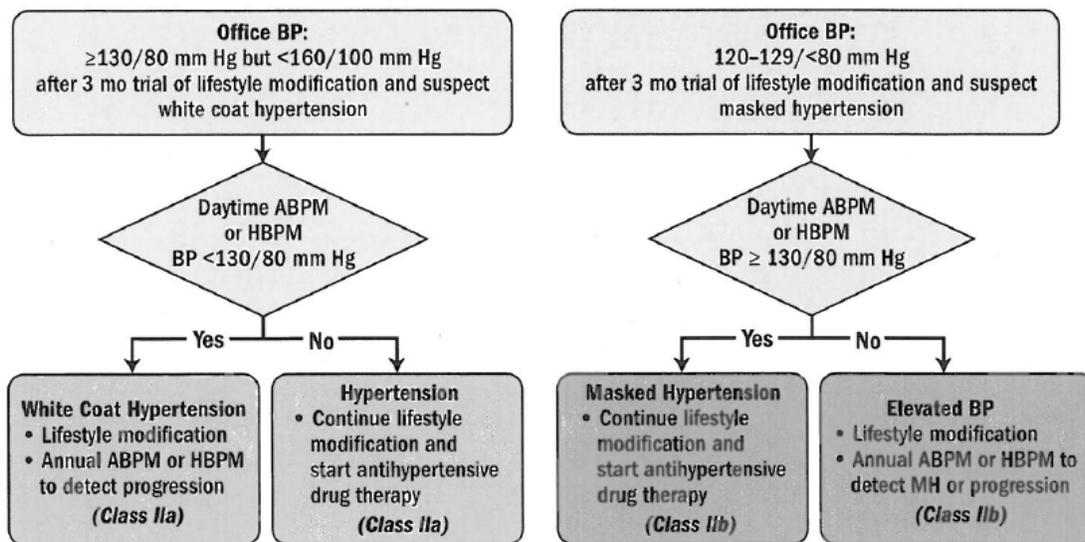


Figure 1

Detection of White Coat Hypertension or Masked Hypertension in Patients on Drug Therapy

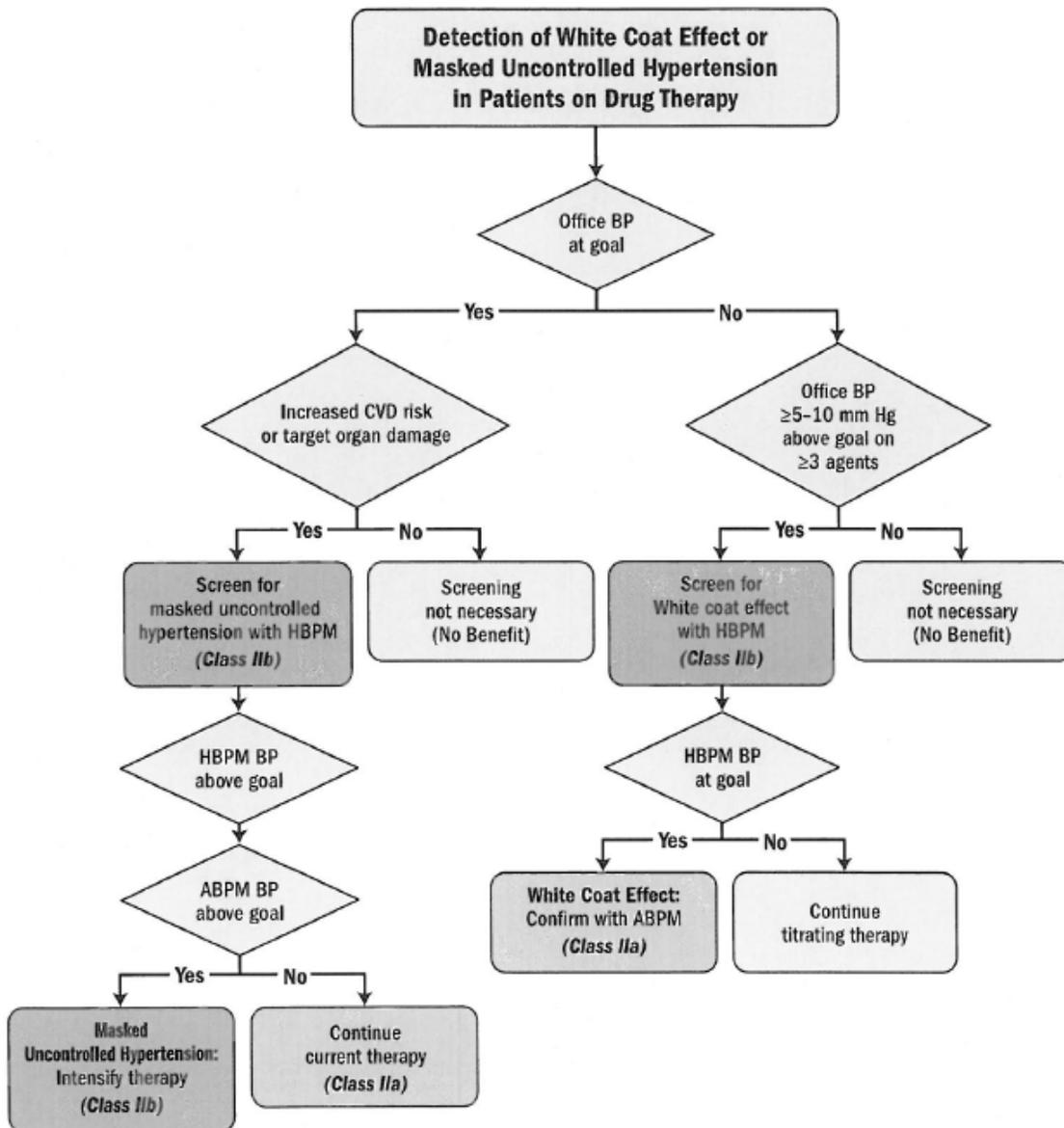


Figure 2

Screening for Secondary Hypertension

New Onset or Uncontrolled Hypertension in Adults

Conditions

- Drug-resistant/induced hypertension;
- Abrupt onset of hypertension;
- Onset of hypertension at <30 y;
- Exacerbation of previously controlled hypertension;
- Disproportionate TOD for degree of hypertension;
- Accelerated/malignant hypertension
- Onset of diastolic hypertension in older adults (≥ 65 y)
- Unprovoked or excessive hypokalemia

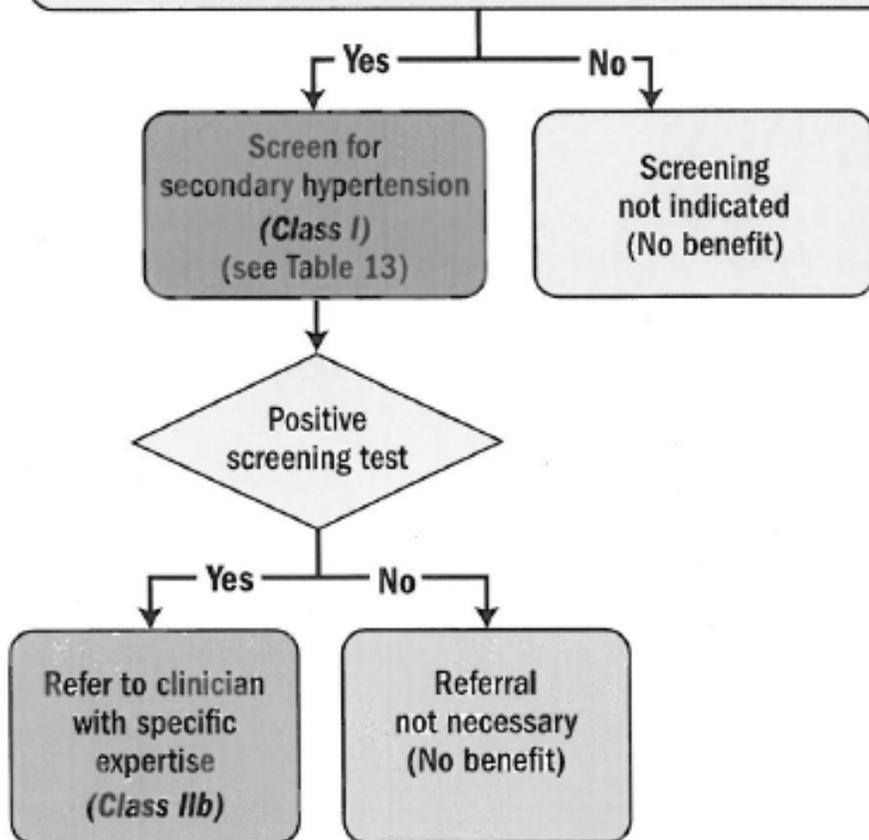


Figure 3

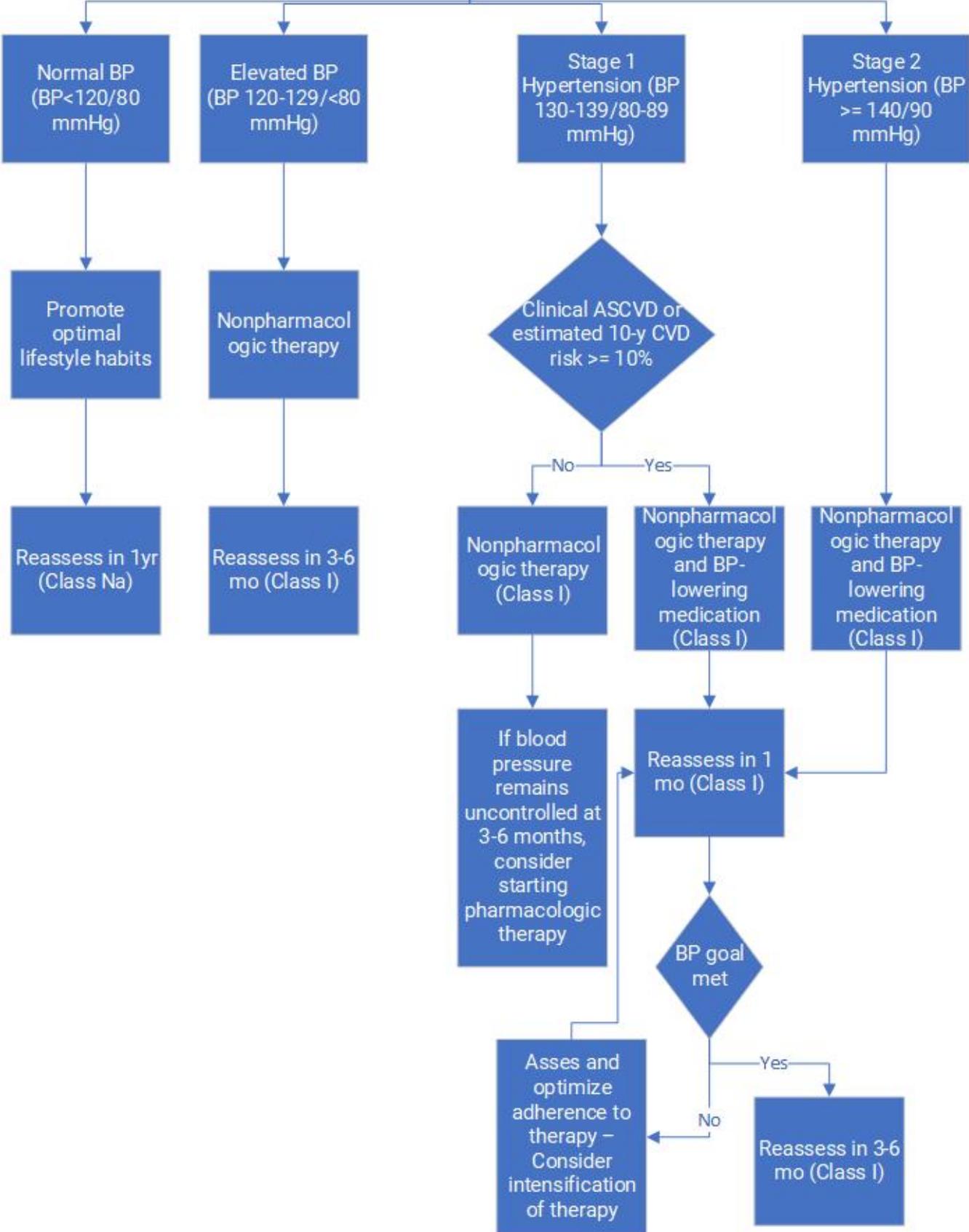
Basic and Optional Laboratory Tests for Primary Hypertension

Basic Testing	Fasting blood glucose*
	Complete blood count
	Lipid profile
	Serum creatinine with eGFR*
	Serum sodium, potassium, calcium*
	Thyroid-stimulating hormone
	Urinalysis
	Electrocardiogram
Optional Testing	Echocardiogram
	Uric acid
	Urinary albumin to creatinine ratio

*May be included in a comprehensive metabolic panel

Table 17

BP Thresholds and Recommendations for Treatment and Follow-Up

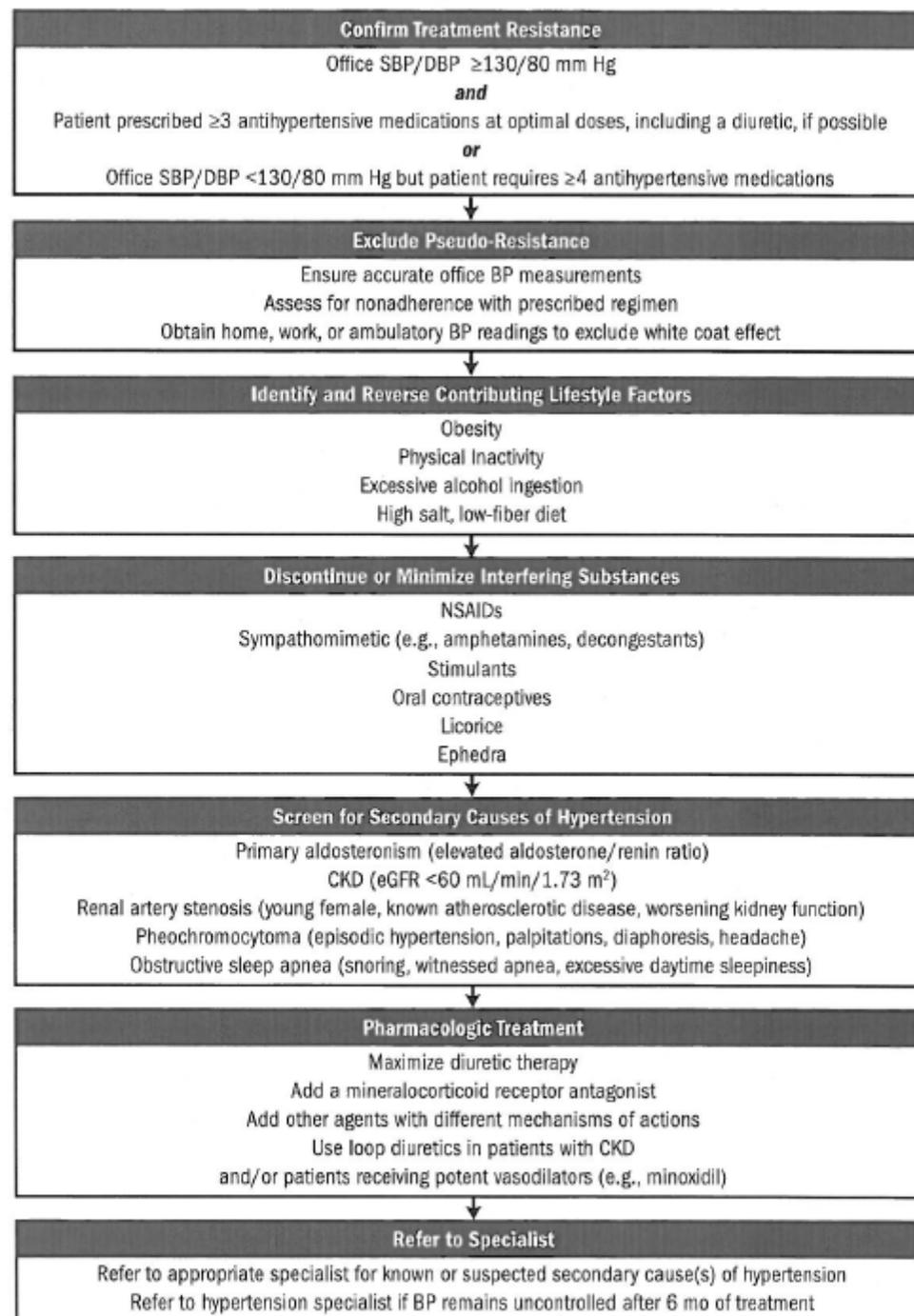


**BP Thresholds for and Goals of Pharmacologic Therapy
in Patients with Hypertension According to Clinical Conditions**

Clinical Condition (s)	BP Threshold mm Hg	BP Goal mm Hg
General		
Clinical CVD or 10 year ASCVD risk \geq 10%	\geq 130/80	<130/80
No clinical CVD and 10 year ASCVD risk <10%	\geq 140/90	<130/80
Older persons (\geq 65 years of age; non-institutionalized, ambulatory, community-living adults)	\geq 130 (SBP)	<130 (SBP)
Specific Comorbidities		
Diabetes mellitus	\geq 130/80	<130/80
Chronic kidney disease	\geq 130/80	<130/80
Chronic kidney disease post-renal transplantation	\geq 130/80	<130/80
Heart failure	\geq 130/80	<130/80
Stable ischemic heart disease	\geq 130/80	<130/80
Secondary stroke prevention	\geq 140/90	<130/80
Secondary stroke prevention (lacunar)	\geq 130/80	<130/80
Peripheral arterial disease	\geq 130/80	<130/80

Table 23

Resistant Hypertension: Diagnosis, Evaluation, and Treatment



Adapted with permission from Calhoun DA, Jones D, Textor S, et al. Resistant hypertension: diagnosis, evaluation, and treatment. A scientific statement from the American Heart Association Professional Education Committee of the Council for High Blood Pressure Research. Hypertension. 2008; 51:1403-19

Figure 10



AMERICAN
COLLEGE of
CARDIOLOGY