

**Recommendation-Specific Supportive Text**

1. The hypertension care team may include primary care clinicians, specialists, nurses, pharmacists, dietitians, community health workers, or social workers (Table 19). RCTs and meta-analyses of RCTs of team-based hypertension care involving nurse or pharmacist intervention demonstrated reductions in SBP and DBP and/or greater achievement of BP goals when compared with usual care.<sup>1-4,31,34,53-56</sup> Systematic reviews of team-based care, including a review of studies that included nurses, pharmacists, and community health workers, showed reductions in SBP and DBP and improvements in BP control, appointment keeping, and hypertension medication adherence compared with usual care.<sup>1,31,35,53,57</sup> Team-based care interventions that include medication titration by a nonphysician health care clinician or titration by a physician had the greatest reduction in SBP (−7.1 and −6.2 mm Hg) compared with other implementation strategies.<sup>56</sup>
2. Studies demonstrate that implementing an evidence-based care plan for hypertension can lead to sustained reduction of BP and attainment of BP targets.<sup>43,45</sup> The care plan should take into account the local environment,<sup>6</sup> patient preferences, SDOH, and readiness for behavioral change,<sup>58,59</sup> with resources matched to the needs of each patient to promote health equity. Several RCTs have evaluated the effectiveness of team-based care on changes in BP and hypertension control for up to 12 months with case management provided by nurses or pharmacists.<sup>43,44</sup> These studies demonstrate that case management utilizing strategies such as individualized training and education,<sup>44,60-62</sup> home BP monitoring,<sup>43</sup> telenursing, and home visits<sup>63</sup> can improve hypertension control. Given that hypertension is a chronic disease requiring ongoing long-term care to prevent or delay complications,<sup>43,61</sup> consideration should be given to implementing longitudinal case management strategies to assist in health promotion, support medication adherence, foster and support behavioral change, and address comorbidities that impact BP control.<sup>44,63</sup> As HBPM is incorporated into the care plan, it is important to facilitate active collaboration<sup>40</sup> and relay of BP data back to the care team so that appropriate and timely advice can be provided to the patient.
3. A clinical framework including accurate BP measurement, timely initiation of pharmacotherapy, regular interval follow-up and therapeutic intensification for uncontrolled BP, active engagement and support of adults with hypertension, and ongoing data monitoring and reporting enables rapid and sustained improvement in hypertension control.<sup>64</sup> Using this approach, improvement in hypertension control has been observed in historically under-resourced groups,<sup>7-10</sup> including those receiving care in resource-limited care settings.<sup>8-10</sup>
4. The addition of new medications or intensified dosing of current medications requires follow-up to monitor BP response and the potential for adverse effects. High-quality RCTs have successfully and safely developed strategies for follow-up, monitoring, and reassessment for management of BP from which recommendations can be made (Figure 7). Components of the follow-up evaluation should include assessment in the office, and when possible, outside of the office (eg, telehealth), for BP control, including evaluation for OH, adverse drug effects, adherence to medication and lifestyle therapy, need for additional therapeutic intensification of medication dosing, and indicated laboratory testing (eg, electrolytes, renal function, target organ damage).
5. The implementation of HIT improves hypertension control and adherence to guidelines using clinical decision support pathways.<sup>15,17</sup> Hypertension control to lower home BP targets (<135/85 mm Hg) has shown to be greater after intervention via self-monitoring and telemonitoring (HBPM or ABPM, Section 3.1.3, “Out-of-Office BP Monitoring”) compared with standard office-based care.<sup>14-16</sup> Self-monitoring is recommended for the ongoing management of hypertension in all patients willing to use it, and clinicians should consider readings obtained from self-monitoring in titrating medications and ruling out white-coat hypertension and masked hypertension.<sup>48</sup> In an RCT, SBP was lower in both self-monitoring and telemonitoring intervention groups compared with usual care with no difference between the self-monitoring and telemonitoring groups. Enhanced self-monitoring of BP paired with an advanced application was not shown to be superior to standard self-monitoring in BP control.<sup>16</sup> Further, additional medications were prescribed to individuals using self-monitoring or telemonitoring in the titration of antihypertensive medications.<sup>14</sup>
6. Health systems are developing and using patient registries and EHRs for large-scale queries to support population health management strategies by identifying undiagnosed or uncontrolled hypertension as