

ongoing quality improvement initiatives.¹⁷ Multifaceted approaches studied to date include: 1) application of hypertension screening algorithms to EHR databases to identify at-risk patients; 2) contacting at-risk patients to schedule BP measurements; 3) monthly feedback to clinicians about at-risk patients who have yet to complete a BP measurement; and 4) electronic prompts for BP measurements whenever at-risk patients visit the clinic. The role of the EHR is paramount in supporting interventions in primary care and to maximize hypertension management in under-represented racial and ethnic groups. Some clinical interventions implementing clinical decision support systems and best practice alert applications in primary care clinics show promising results.¹⁵

7. RCTs and meta-analyses of RCTs of telehealth interventions demonstrate greater office SBP and DBP reductions^{18-26,65} and a larger proportion of patients achieving hypertension control compared with individuals receiving usual clinic-based care without telehealth interventions, but results are mixed on improving medication adherence.^{19-21,23-26,42,46,47} Telehealth interventions, including out-of-office BP monitoring using HBPM (Section 3.1.4, “ABPM and HBPM”) with remote BP data transfer between the patient and health care staff, lifestyle education, and/or medication management, demonstrated greater BP lowering compared with usual clinic care alone.^{19,22,48,66} Trial results are inconsistent for interventions solely using mobile apps, but a growing number of studies demonstrate significant BP reduction based on strengthening patients’ self-management skills.^{46,67,68} Limited telehealth RCTs have focused on under-represented racial and ethnic populations, with some demonstrating reduced BP among Black and Hispanic populations.^{25,46} Hypertension telehealth interventions demonstrated significant BP reduction in patients with comorbid conditions (eg, diabetes, stroke); however, there are insufficient data on reduction of MACE.⁴⁶ Even as there is increasing use of hypertension telehealth interventions, significant barriers remain for equitable access to telehealth services, including patient internet access, digital literacy, equipment/infrastructure costs, clinical staffing/workflow, and integration with EHRs.^{46,47} Additional studies are needed, particularly among high-risk underrepresented racial and ethnic populations.^{46,47,69}

5.5. Hypertension and Pregnancy

Recommendations for Individuals With Hypertension and Pregnancy*
Referenced studies that support the recommendations are summarized in the Evidence Table.

COR	LOE	RECOMMENDATIONS
1	A	1. For individuals with hypertension who are planning a pregnancy or who become pregnant, labetalol and extended-release nifedipine are preferred agents to treat hypertension and minimize fetal risk. ¹
1	B-R	2. Individuals with hypertension who are planning a pregnancy or who become pregnant should be counseled about the benefits of low-dose (81 mg/day) aspirin to reduce the risk of preeclampsia and its sequelae. ²
1	B-R	3. Pregnant individuals with SBP $\geq$ 160 mm Hg or DBP $\geq$ 110 mm Hg confirmed on repeat measurement within 15 minutes should receive antihypertensive medication (Table 23) to lower BP to <160/<110 mm Hg within 30 to 60 minutes to prevent adverse events. ³⁻⁷
1	B-R	4. Pregnant individuals with chronic† hypertension (defined as prepregnancy hypertension or SBP 140 to 159 mm Hg and/or DBP 90 to 109 mm Hg prior to 20 weeks’ gestation) should receive antihypertensive therapy to achieve BP <140/90 mm Hg to prevent maternal and perinatal morbidity and mortality. ^{1,8,9}
3: Harm	C-LD	5. Individuals with hypertension who are planning a pregnancy or who become pregnant should not be treated with atenolol, ACEi, ARB, direct renin inhibitors, nitroprusside, or MRA to avoid fetal harm. ¹⁰⁻¹⁴

*ACOG diagnostic criteria and classification of hypertensive disorders of pregnancy are found in Tables 22 and 23. †Chronic hypertension in pregnancy is defined as a preexisting diagnosis of hypertension or SBP $\geq$ 140 mm Hg and/or DBP $\geq$ 90 mm Hg on 2 occasions at least 4 hours apart before 20 weeks’ gestation.