Council on Health of the Public

Friday, April 10, 2026
2:30 – 4:30 p.m.
Location: Kalahari Resort, Room Kalahari G
Zoom information:
https://us02web.zoom.us/j/87200344664?pwd=19pYxfUPBzIV3ZowRvzB8ZqyzlMLtp.1
Meeting ID: 872 0034 4664
Passcode: 898295

AGENDA

2:30	Call to order by Chair Li-Yu Mitchell, MD and introductions
2:38	Approval of report from November 13, 2025
2:40	Announcement: Member Assembly with Council Forums this evening with refreshments at 6:15 p.m. Includes a presentation from CPAN and PeriPAN.
2:45	Guest Dr. Zach Sartor to present on The Waco Guide
3:00	Update on Physician Well-Being Task Force
3:15	Discussion and vote on blood pressure resolution introduced at November 2025 meeting
3:35	Discussion on possible topics for possible environmental health CME topics
3:45	Discussion – What are you doing in clinic to get patients vaccinated?
4:00	Other business
4:15	Adjourn

Samantha White and Jessica Miley are the staff liaisons for this council.

COUNCIL ON HEALTH OF THE PUBLIC REPORT

Author: Samantha White
Meeting date: November 13, 2025

The following members attended the meeting in person: Li-Yu Mitchell, Lesca Hadley, Sarah Ashitey, Richel Avery, Karen Smith, Astrud Villareal, Judy Kim, Austin Plumlee, Susan Overstreet, Shadi Edalati, Sarah Toates, James Mobley,

The following members attended the meeting on Zoom: Kimberly Ellis-Garris, Sarah Samreen, Joaquin Villegas, Vyas Sarabu, Constanza Morales, and Rebecca Hart.

The following staff and guests attended the meeting: Samantha White (staff), Jessica Miley (staff), Tom Banning (staff), Rashmi Rode, Terrance Hines, Emily Briggs, Allison Tobola, Matthew Dufrene, Tricia Elliott, Janet Hurley, Jessica Yao, Adrian Billings, Eduardo Sanchez, Drew Mills, Mayver Gonzalez, Lindsay Botsford, Kenneth Barning, Vidya Sinha, Jen Nordhauser, Athulya Johnson, Tatiana Cordova, and Micah Nishigaki.

MINUTES

1. The meeting was called to order by Li-Yu Mitchell, MD, chair.
2. The council report from April 4, 2025 was approved.
3. Matthew Dufrene, MBA, Vice President of Texas Health, gave a presentation on Fort Worth's Blue Zones Project.
4. TAFP member Micah Nishigaki, MD, gave a presentation on the climate crisis and the many ways it impacts health. Nishigaki asked the council to recommend environmental health CME to TAFP's CME Planning Committee.
5. TAFP member Eduardo Sanchez, MD, MPH, Chief Medical Officer for Prevention at the American Heart Association, presented a draft resolution for the council to consider. The resolution would entail TAFP endorsing a new guideline for the prevention, detection, evaluation, and management of high blood pressure in adults. The council voted to table discussion on this resolution and pick it back up at the spring meeting.
6. TAFP member Allison Tobola, MD, presented a draft resolution for the council to consider on organ donation. The council voted to approve the resolution and pass it on to the board.
7. The council briefly discussed the results from the spring 2025 public health priority survey of TAFP members.
8. The meeting was adjourned.

TAFP
TEXAS ACADEMY OF FAMILY PHYSICIANS
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MEMO

To: Council on Health of the Public

From: Task Force on Physician Well-Being

CC:

Date: 4/1/2026

Re: Recent work from the task force

The Task Force on Physician Well-Being was created in 2025 by the Council on Workforce and Member Engagement.

The task force conducted a survey of the broader TAFP membership in late 2025 with 276 total responses. The group has reviewed the survey results and is currently forming subcommittees to develop targeted support in the areas where TAFP members expressed greatest need.

Related to the work of the task force, the TAFP Foundation received a generous donation from member Chrisette Dharma, MD, to support annual well-being lectures. The first lecture will be given by member Sarah Ashitey, MD, at TAFP's Annual Session and Primary Care Summit held this November in The Woodlands. A portion of this funding will be allocated each year to ensure long-term sustainability.

High Blood Pressure in Texas

TAFP Annual Session and Primary Care Summit

November 13, 2025

Eduardo Sanchez, MD, MPH, FAHA, FAAFP
Chief Medical Officer for Prevention
American Heart Association

Disclosures

None to disclose

- **High blood pressure is the most prevalent and modifiable risk factor for the development of cardiovascular diseases,** including coronary artery disease, heart failure, atrial fibrillation, stroke, dementia, chronic kidney disease, and all-cause mortality.

- The overarching blood pressure treatment goal is **< 130/80 mm Hg for all adults,** with additional considerations for those who require institutional care, have a limited predicted lifespan, or are pregnant.

Source: Jones et al. 2025, *Circulation*

Prevalence of Hypertension US Now (2013-2016) and Later

- **108 million (45%) of adults in US with hypertension** (**≥130mm/80mm**) or taking blood pressure medications
  - 21 million (8.75%; est.) with Type 1 hypertension
  - 87 million (36.25%; est.) with Type 2 hypertension

- Prevalence of hypertension in the US is projected to increase from **51.2% in 2020 to 61.0% in 2050**.

Source: CDC. Hypertension Cascade: Hypertension Prevalence, Treatment and Control Estimates Among US Adults Aged 18 Years and Older Applying the Criteria From the ACC/AHA 2017 Hypertension Guideline—NHANES 2013–2016. Atlanta, GA: US DHHS; 2019.
Source: Joynt Maddox et al. 2024; Circulation

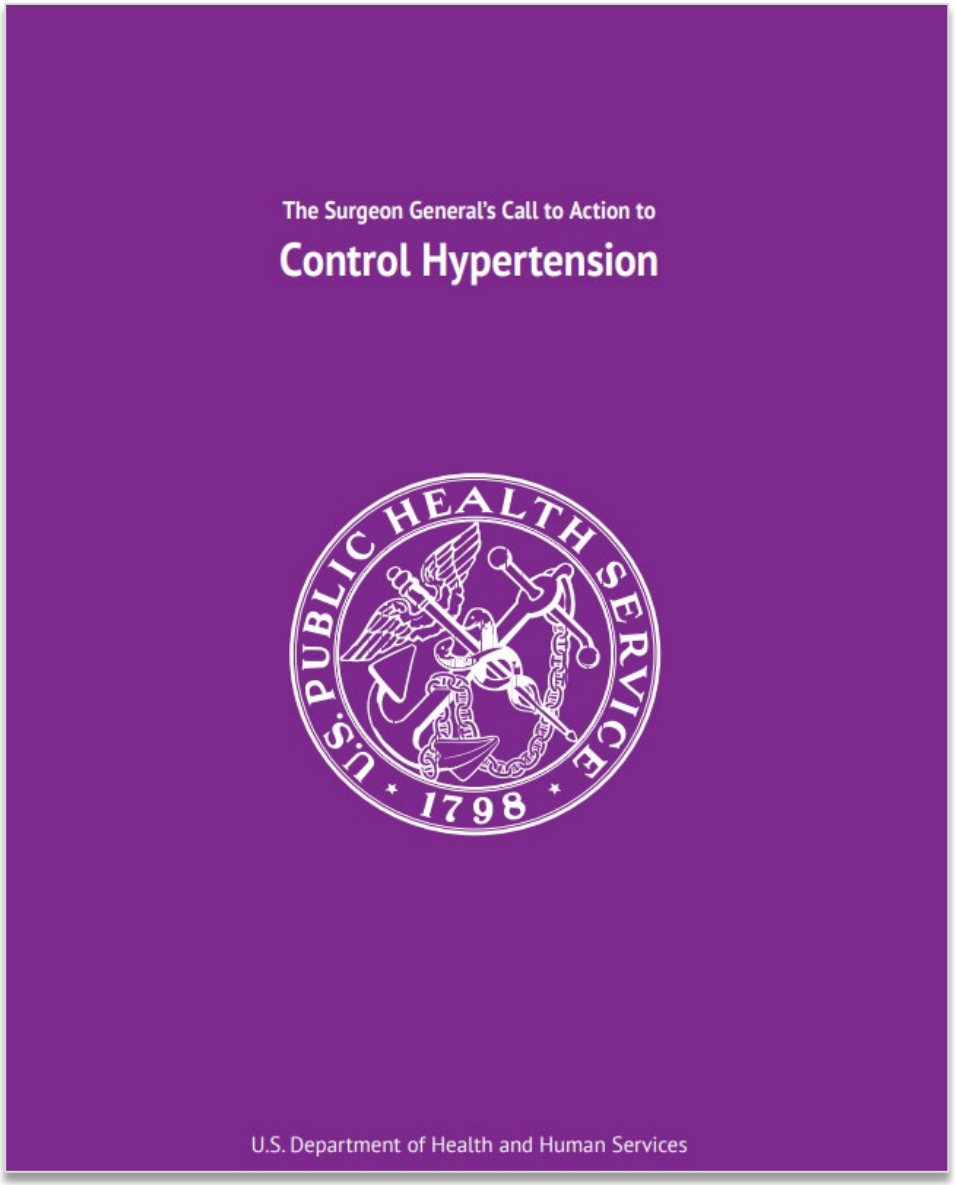
Leading Causes of Death in the US

Provisional Causes of Death (2024)

Rank	Cause	Number
1	**Heart Disease**	**683,037**
2	Cancer	619,812
3	Unintentional injury	196,488
4	**Stroke**	**166,783**
5	Chronic lower respiratory disease	145,612
6	**Alzheimer's disease**	**116,016**
7	Diabetes	95,382
8	**Kidney disease**	**55,070**
9	Chronic liver disease and cirrhosis	52,259
10	COVID-19	48,683

Source: Vital Statistics Rapid Release, Number 039 (September 2025); Accessed 9/16/25

2020


The Surgeon General's Call to Action to
Control Hypertension
U.S. PUBLIC HEALTH SERVICE
1798
U.S. Department of Health and Human Services

2025


Global report on hypertension 2025
High stakes – turning evidence into action
World Health Organization

Blood Pressure Control (≤140/90) Among Adults with Hypertension in the US (2021-2023) Sociodemographic Factors

Characteristic	Control Rate (%) – With Hypertension	Control Rate (%) – With Hypertension and on Medication
Overall Control Rate	51.1%	**68.3%**
Female	52.3%	**69.3%**
Male	**51.3%**	**68.4%**
Non-Hispanic White	51.8%	**69.3%**
Non-Hispanic Black	49.6%	**62.6%**
Non-Hispanic Asian	53.5%	**71.0%**
Hispanic	**48.8%**	**66.4%**

Source: Hardy, AJH, 2024.

Blood Pressure Control (≤140/90) Among Adults with Hypertension in the US (2021-2023) - Sociodemographic Factors

Characteristic	Control Rate (%) – With Hypertension	Control Rate (%) – With Hypertension and on Medication
Less than high school graduation	**45.0%**	**60.7%**
High school and some college	51.3%	**67.6%**
College graduation	53.4%	**73.7%**
Income/Poverty <1	**43.0%**	**58.4%**
Income/Poverty 1 - <2	50.0%	**62.6%**
Income/Poverty 2 - <4	49.5%	**67.3%**
Income/Poverty 4+	54.6%	**76.5%**
Private health insurance	44.4%	**58.5%**
Medicare	59.2%	**69.2%**
Medicaid	NSR	**NSR**
Uninsured	45.2%	**NSR**
Routine place for care	53.1%	**68.9%**
No routine place for care	**23.3%**	**52.6%**
No healthcare in past 12 months	NA	**NA**

Source: Hardy, AJH, 2024.

NSR – Not Statistically Reliable
NA – Not Available

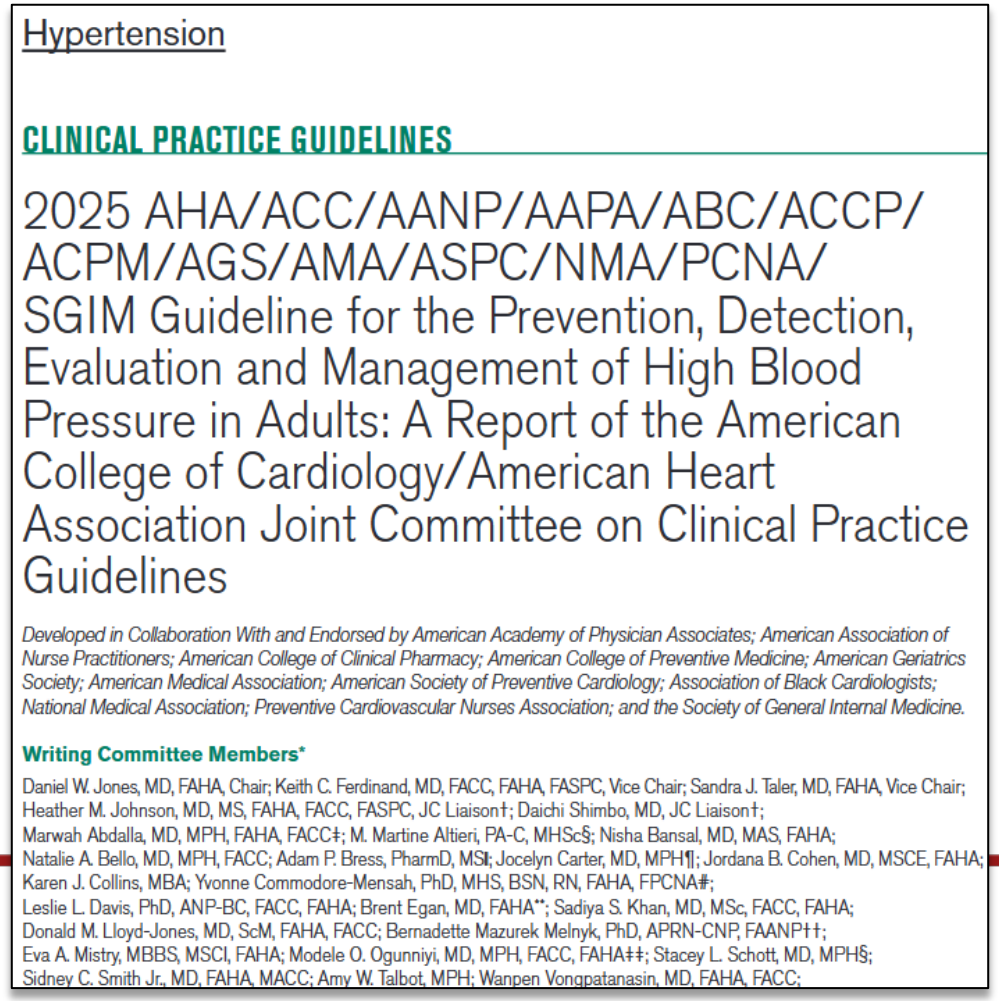
Blood Pressure Control (≤130/80) Among Adults with Hypertension in the US (2021-2023)

	2013-2014	2013-2014	2013-2014	2013-2014
Prevalence of Hypertension	45.1%	46.1%	46.7%	46.2%
Control rate with hypertension	26.5%	23.3%	24.3%	23.0%
Control rate with hypertension and on Medication	46.6%	43.4%	43.4%	39.9%

Source: Hardy, AJH, 2024.

2025 Update

Released August 2025



Hypertension

CLINICAL PRACTICE GUIDELINES

2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

Developed in Collaboration With and Endorsed by American Academy of Physician Associates; American Association of Nurse Practitioners; American College of Clinical Pharmacy; American College of Preventive Medicine; American Geriatrics Society; American Medical Association; American Society of Preventive Cardiology; Association of Black Cardiologists; National Medical Association; Preventive Cardiovascular Nurses Association; and the Society of General Internal Medicine.

Writing Committee Members*

Daniel W. Jones, MD, FAHA, Chair; Keith C. Ferdinand, MD, FACC, FAHA, FASPC, Vice Chair; Sandra J. Taler, MD, FAHA, Vice Chair; Heather M. Johnson, MD, MS, FAHA, FACC, FASPC, JC Liaison†; Daichi Shimbo, MD, JC Liaison†; Marwah Abdalla, MD, MPH, FAHA, FACC‡; M. Martine Altieri, PA-C, MHSc§; Nisha Bansal, MD, MAS, FAHA; Natalie A. Bello, MD, MPH, FACC; Adam P. Bress, PharmD, MSǁ; Jocelyn Carter, MD, MPH¶; Jordana B. Cohen, MD, MSCE, FAHA; Karen J. Collins, MBA; Yvonne Commodore-Mensah, PhD, MHS, BSN, RN, FAHA, FPCNA#; Leslie L. Davis, PhD, ANP-BC, FACC, FAHA; Brent Egan, MD, FAHA**; Sadiya S. Khan, MD, MSc, FACC, FAHA; Donald M. Lloyd-Jones, MD, ScM, FAHA, FACC; Bernadette Mazurek Melnyk, PhD, APRN-CNP, FAANP††; Eva A. Mistry, MBBS, MSCI, FAHA; Modele O. Ogunniyi, MD, MPH, FACC, FAHA‡‡; Stacey L. Schott, MD, MPH§; Sidney C. Smith Jr., MD, FAHA, MACC; Amy W. Talbot, MPH; Wanpen Vongpatanasin, MD, FAHA, FACC;

Source: Jones et al. 2025, *Circulation*

Definition and Classification of Blood Pressure

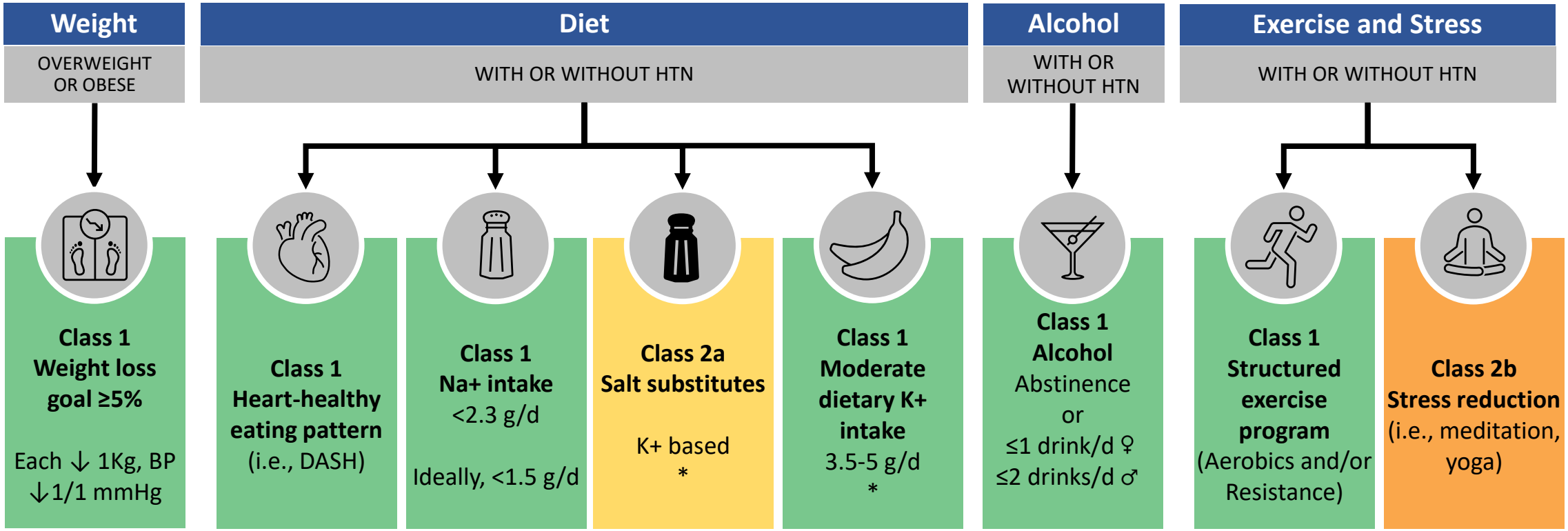
Blood Pressure Category	SBP		DBP
Normal	< 120 mmHg	and	< 80 mmHg
Elevated	120 to 129 mmHg	and	< 80 mmHg
Hypertension			
Stage 1 Hypertension	130 to 139 mmHg	or	80 to 89 mmHg
Stage 2 Hypertension	≥ 140 mmHg	or	≥ 90 mmHg

COR	RECOMMENDATIONS
1	In adults, BP should be categorized as normal, elevated, or stage 1 or stage 2 hypertension to prevent and treat high BP.

Abbreviations: BP indicates blood pressure; DBP, diastolic blood pressure; and SBP, systolic blood pressure.

Jones, D.W., et al. (2025). 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.*Circulation*.

Blood pressure management: Lifestyle and psychosocial approaches



***Monitor potassium in those at risk for hyperkalemia**

Abbreviations: BP indicates blook pressure; DASH, Dietary Approaches to Stop Hypertension diet Kg, kilograms; and HTN, hypertension.

Jones, D.W., et al. (2025). 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.*Circulation*.

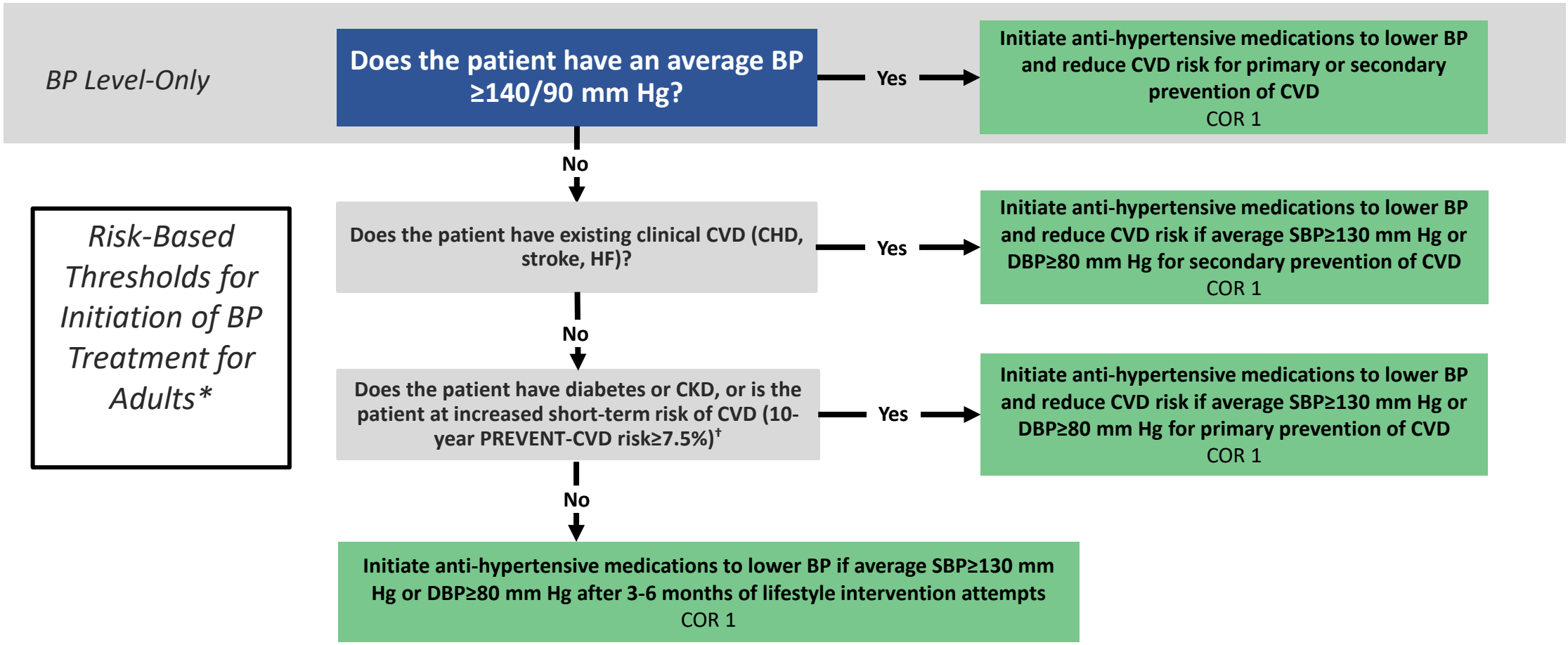
From Clinic to Home: Blood Pressure Monitoring

COR	RECOMMENDATIONS
1	In adults with suspected hypertension, out-of-office BP measurements by either ABPM or HBPM are recommended to confirm the diagnosis of hypertension.
1	In adults who are taking antihypertensive medication, HBPM is recommended for monitoring the titration of BP-lowering medication, along with co-interventions such as patient education, telehealth counseling, and clinical interventions.
3: No Benefit	In adults, the use of cuffless BP devices is not recommended for the diagnosis or management of high BP.

Abbreviations: ABPM indicates ambulatory blood pressure monitoring; BP, blood pressure; and HBPM, home blood pressure monitoring.

Jones, D.W., et al. (2025). 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.*Circulation*.

Use of Risk Based Thresholds for Initiation of BP Treatment

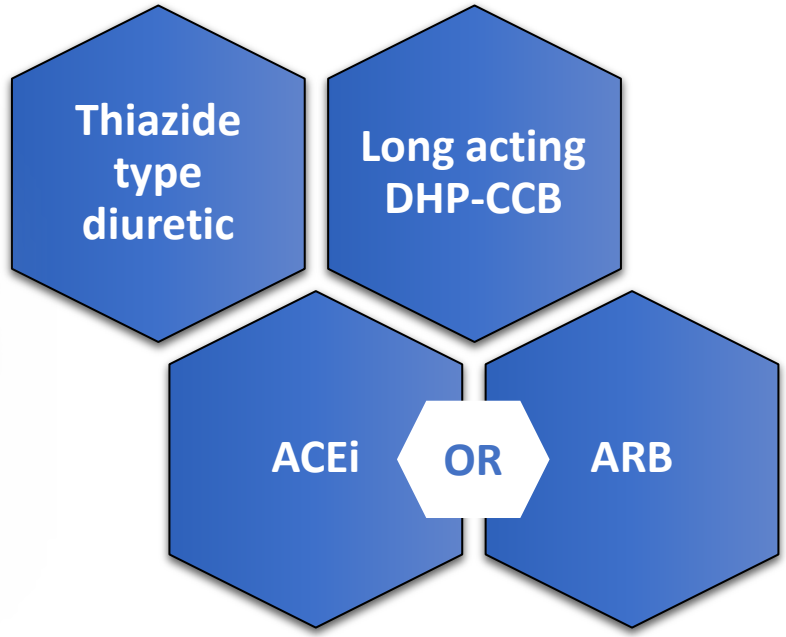


Abbreviations: BP indicates blood pressure; CHD, coronary heart disease; CKD, chronic kidney disease; CVD, cardiovascular disease; DBP, diastolic blood pressure; HF, heart failure; PREVENT, Predicting Risk of CVD EVENTs; and SBP, systolic blood pressure.

Jones, D.W., et al. (2025). 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.*Circulation*.

Initial Medication Selection for Treatment of Primary HTN

COR	RECOMMENDATIONS
1	For adults initiating antihypertensive drug therapy, thiazide-type diuretics, long-acting dihydropyridine CCBs, and ACEi or ARBs are recommended as first-line therapy to prevent CVD.



Abbreviations: ACEi indicates Angiotensin Converting Enzyme inhibitors; ARB, Angiotensin Receptor Blocker; CVD, cardiovascular disease; and LA DHP-CCB, Dihydropyridine Calcium Channel Blocker.

Jones, D.W., et al. (2025). 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.*Circulation*.

Choice of initial combination drug therapy vs monotherapy

Stage 1 HTN*
Class 2a

SBP 130-139 mmHg
DBP 80-89 mmHg

Initiation of <u>a single</u> 1st line agent is reasonable.

Dosing titration and sequential addition of other agents as needed.

Stage 2 HTN*
Class 1

SBP ≥140 mmHg
DBP ≥90 mmHg

Some high-risk patients with stage 1 HTN.

Initiation of <u>two</u> 1st line agents of different classes.

Ideally, in a single pill combination to improve adherence.

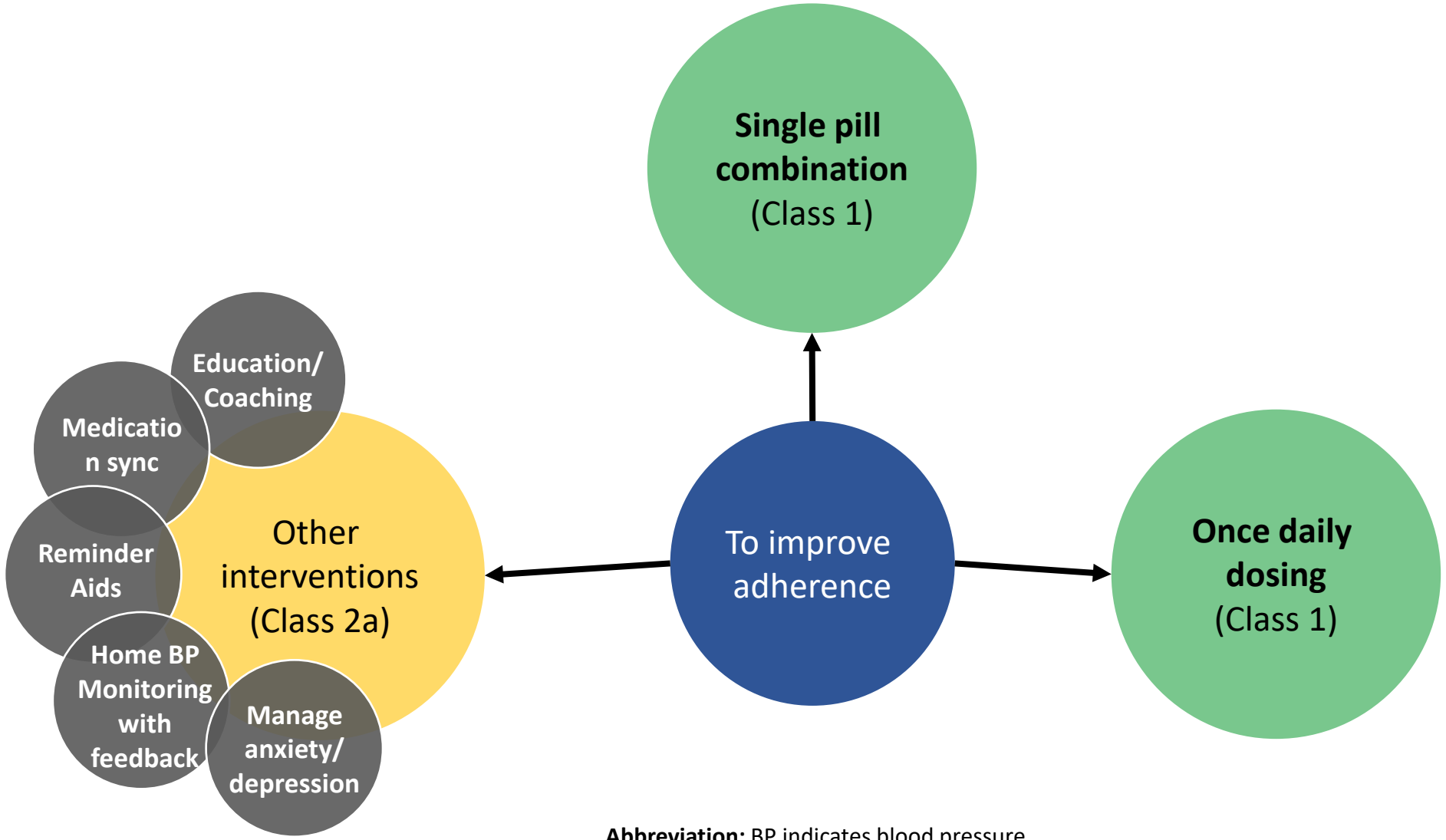
Any stage HTN
Class 3: Harm

<u>Don't</u> combine ACEi, ARBs and/or renin inhibitors.

Abbreviations: ACEi indicates Angiotensin Converting Enzyme inhibitors; ARB, Angiotensin Receptor Blocker; and HTN, hypertension.

Jones, D.W., et al. (2025). 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.*Circulation*.

Antihypertension medication adherence strategies



Abbreviation: BP indicates blood pressure

Jones, D.W., et al. (2025). 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.*Circulation*.

Plan of Care for Adults with Uncontrolled HTN

COR	RECOMMENDATIONS
1	Team-based care approach is recommended.
1	Evidence-based care plan utilizing HBPM and team-based care that is responsive to addressing adverse SDOH is recommended.
1	An integrated treatment model that includes accurate BP measurement, prompt treatment, patient engagement, and ongoing review of HBPM is recommended to improve BP control.

Abbreviation: BP indicates blood pressure; HBPM, home blood pressure monitoring; HTN, hypertension; and SDOH, social determinants of health.

Jones, D.W., et al. (2025). 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.*Circulation*.

Plan of Care for Adults with Uncontrolled HTN

COR	RECOMMENDATIONS
1	Health information technology is beneficial in improving BP control, access to care, and adherence to standards of care.
1	Use of electronic health record and patient registries is beneficial for screening and identification of hypertension to focus on those who need additional care.
2a	Telehealth interventions can be useful to reduce BP and improve office BP control.
1	Adults with uncontrolled hypertension placed on new or intensified medical therapy should have follow-up evaluations for medication adherence and response to treatment at monthly intervals until control is achieved.

Abbreviation: BP indicates blood pressure; and HTN, hypertension.

Jones, D.W., et al. (2025). 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.*Circulation*.

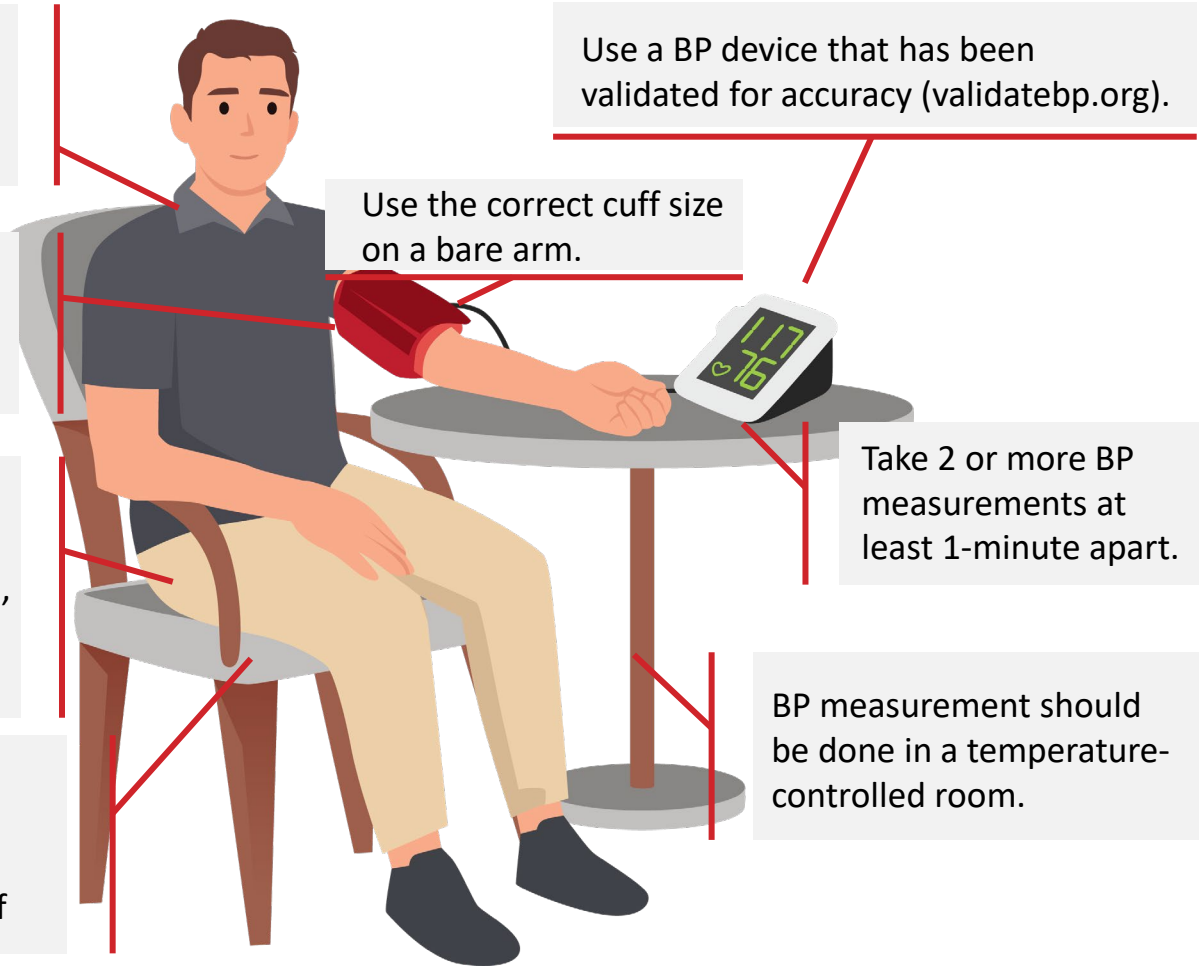
The Right Technique with the Right Equipment: Best Practices for Accurate In-Office Blood Pressure Measurement

Avoid caffeine, exercise, and smoking for at least 30 minutes before.

The patient's arm should be supported at heart level.

Patient should be relaxed, sitting in a chair (feet flat, legs uncrossed, and back supported) for at least 5 minutes.

Neither patient nor clinician should talk during the rest or measurement. No use of phones.



Use a BP device that has been validated for accuracy (validatebp.org).

Use the correct cuff size on a bare arm.

Take 2 or more BP measurements at least 1-minute apart.

BP measurement should be done in a temperature-controlled room.

COR	RECOMMENDATIONS
1	When diagnosing and managing high BP in adults, standardized methods are recommended for the accurate measurement and documentation of in-office BP.
2a	When measuring in-office BP in adults, it is reasonable to use the oscillometric method with an automated device over the auscultatory method.

Abbreviation: BP indicates blood pressure.

Jones, D.W., et al. (2025). 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.*Circulation*.

Acknowledgments – Numerous Previous Slides Adapted From:

Many thanks to our Guideline Ambassadors who were guided by Dr. Elliott Antman in developing this translational learning product in support of the **2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.**

Dr. Olu Akinrimisi
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Dr. Chaitanya Rojulpote
Dr. Tayyab Shah

The American Heart Association requests this electronic slide deck be cited as follows:
Akinrimisi, O., Aguilar Nunez, F., Oribabor, J., Rojulpote, C., Shah, T., Reyna, G.G., Bezanson, J. L., & Antman, E. M. (2025). AHA Clinical Update; Adapted from: [PowerPoint slides]. Retrieved from the 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults. https://professional.heart.org/en/science-news .

Therefore, be it resolved…
From “Affirmation of Value” to “Endorsement”

- Therefore, be it resolved that the Texas Academy of Family physicians recommends that the American Academy of Family Physicians **endorse** the **2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults.**

American Heart Association.

Jones, D.W., et al. (2025). 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.*Circulation*.

Thank You

Acknowledgements:
Drew Mills (AHA) & Angela Agens (AHA)

National Hypertension Control Initiative (NHCI) Performance and QI Insights

Purpose & Scope

- Improve hypertension control
- Use evidence-based interventions, including SMBP monitoring

Federally Qualified Heath Centers

- Eligible with control rates <58.9% in 2019
- Goal of offering SMBP devices to majority of patients with uncontrolled BP
- Funded $60M for 350 community health centers (CHCs) over 3 years (2021-23)

American Heart Association

- Provide technical assistance and training
- Support community outreach, patient/ public education, and evaluation
- Funded $32M over 3 years (2021-23)

Results

19.2% relative improvement in BP control from 2020-2023 in NHCI CHCs

VS

11.4% improvement in BP control from 2020-2023 in non-NHCI CHCs

13.5% improvement in BP control from 2020-2023 in all HRSA CHCs

Texas FQHC's in National Hypertension Program Achieve Significant BP Control Over 3 Years

Luis Arellano, Eduardo Sanchez, M.D., M.P.H., FAHA, Katherine Sanchez, Ph.D., LCSW, Gary Harmon, Ph.D.

INTRODUCTION

- Cardiovascular disease and stroke remain among the **leading causes of death** in the U.S, accounting for more than **940,000** deaths in 2022.[1] Despite advancements in hypertension management, blood pressure (BP) control rates remain suboptimal, necessitating targeted interventions to improve outcomes.[2]
- The U.S. Department of Health and Human Services launched the **National Hypertension Control Initiative (NHCI) through a cooperative agreement with the AHA**. With **$32 million** in funding, **AHA** aimed to improve BP control in **350 Federally Qualified Health Centers (FQHCs)** across the U.S. with BP control rates below 58.9% by **providing clinical training and technical assistance focused** on the AMA MAP™ framework and implementation of self-measured blood pressure monitoring.[3]
- **This study focuses on Texas because of its unique demographic and healthcare landscape.** Texas is one of the most **racially and ethnically diverse states and** has one of the **highest uninsured rates in the nation**, groups that are disproportionately affected by hypertension. Studying the impact of NHCI in Texas provides insight into how these programs perform in a setting with significant healthcare access barriers and a diverse patient population.
- This study assesses NHCI's impact on BP control in Texas NHCI FQHCs from 2020 to 2023 by comparing trends with national data and evaluating changes over time. These findings provide insight into NHCI's effectiveness and inform future efforts to improve hypertension management nationwide.

HYPOTHESIS

- We hypothesize that **BP control rates in Texas NHCI FQHCs will be lower than national NHCI FQHCs** due to Texas' **higher uninsured rate and diverse population**, both of which are linked to greater hypertension disparities. These factors may **pose greater challenges to improving BP control compared to the national average**.

FIGURES

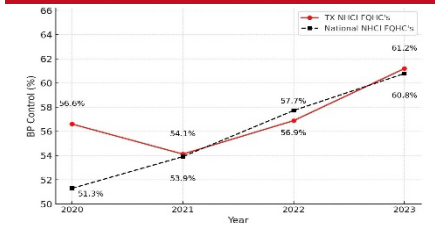

Figure 1. BP Control Rates for TX NHCI FQHCs and National NHCI FQHCs (2020–2023)

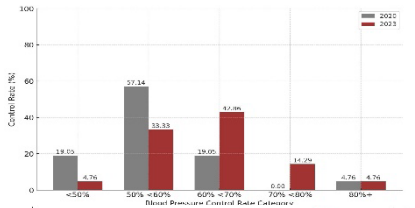

Figure 2. Change in BP Control Rate Categories Among TX NHCI FQHCs (2020–2023)

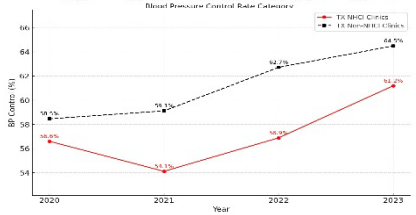

Figure 3. Comparison of BP Control Rates Between TX NHCI and TX Non-NHCI FQHC's (2020–2023)

METHODS

- This study analyzed **BP control trends (2020–2023)** in Texas NHCI FQHCs, comparing them to national NHCI FQHCs. **BP Control Rate (%)** was measured as the proportion of patients with hypertension with BP ≤140/90 mmHg.
- The data for this study was obtained from the Health Resources and Services Administration's (HRSA) Uniform Data System (UDS). Identifiers indicating participation in the NHCI were sourced from official HRSA program documents.
- **Descriptive, trend, and comparative analyses** were conducted to assess BP control rates (2020–2023), assess year-over-year changes, and evaluate whether Texas NHCI FQHCs followed national improvement patterns.

RESULTS

- BP control rates in Texas NHCI FQHCs improved from 56.6% in 2020 to 61.2% in 2023, closely following national trends (51.3% to 60.8%).
- Texas clinics saw a major shift toward higher BP control rates
  - Clinics with **<50% BP control** decreased from **19.05% to 4.76%**.
  - Clinics with **60%-<70% BP control** increased from **19.05% to 42.86%**.
  - Clinics achieving **70%-<80%** control increased from 0% to **14.29%**.
- Results suggest NHCI participation contributed to significant BP control improvements in Texas NHCI FQHCs, mirroring national progress.
- From **2020 to 2023**, BP control rates improved in **TX NHCI clinics (+4.6%)** and **TX Non-NHCI clinics (+6.0%)**, with NHCI clinics rising from **54.1% in 2021 to 61.2% in 2023 (+7.1%)**, after decreasing from 56.6% in 2020

CONCLUSION

- This study provides evidence that NHCI interventions improved BP control in Texas FQHCs from 2020 to 2023 comparable to improvements nationally.
- The observed increase in BP control rates and the growing number of clinics achieving higher control thresholds suggest that these programs might improve hypertension management in participating health centers.
- These findings could help guide use of training and technical assistance in implementing effective BP control protocols and could guide future clinical funding and policy decisions to expand NHCI participation and improve hypertension outcomes nationwide.

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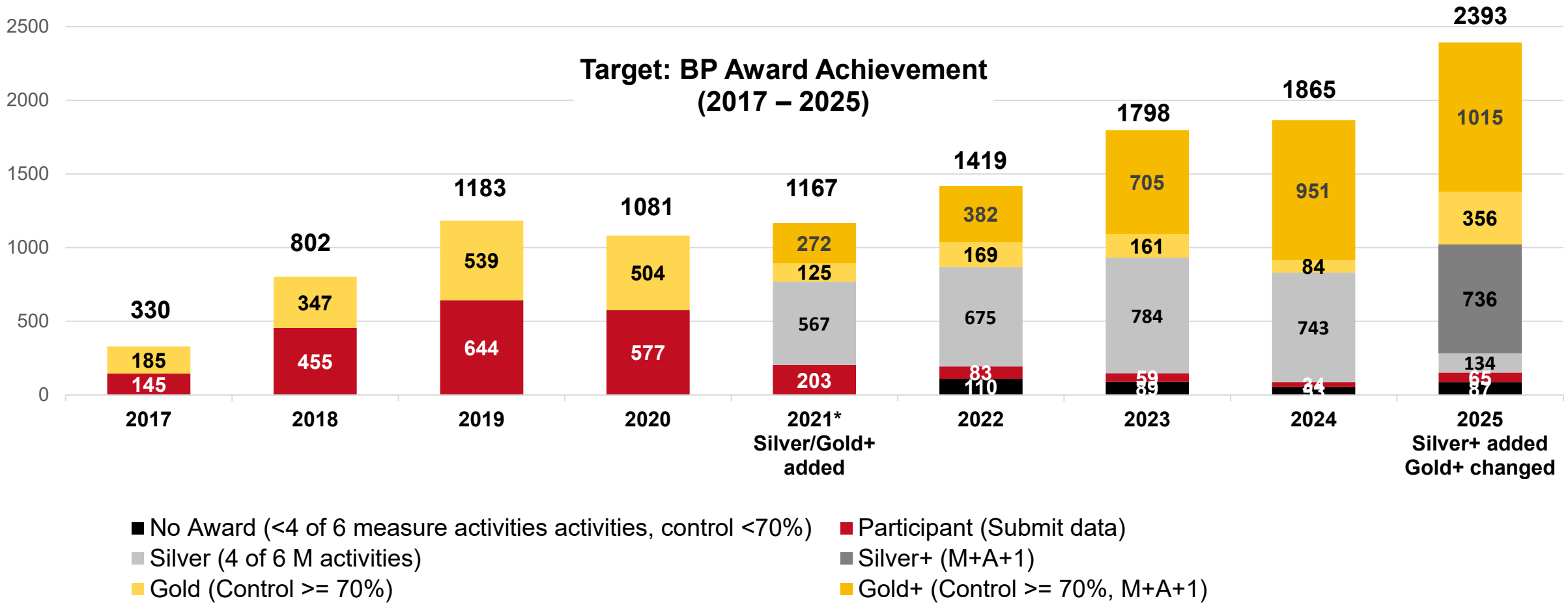
Target: BP Awards

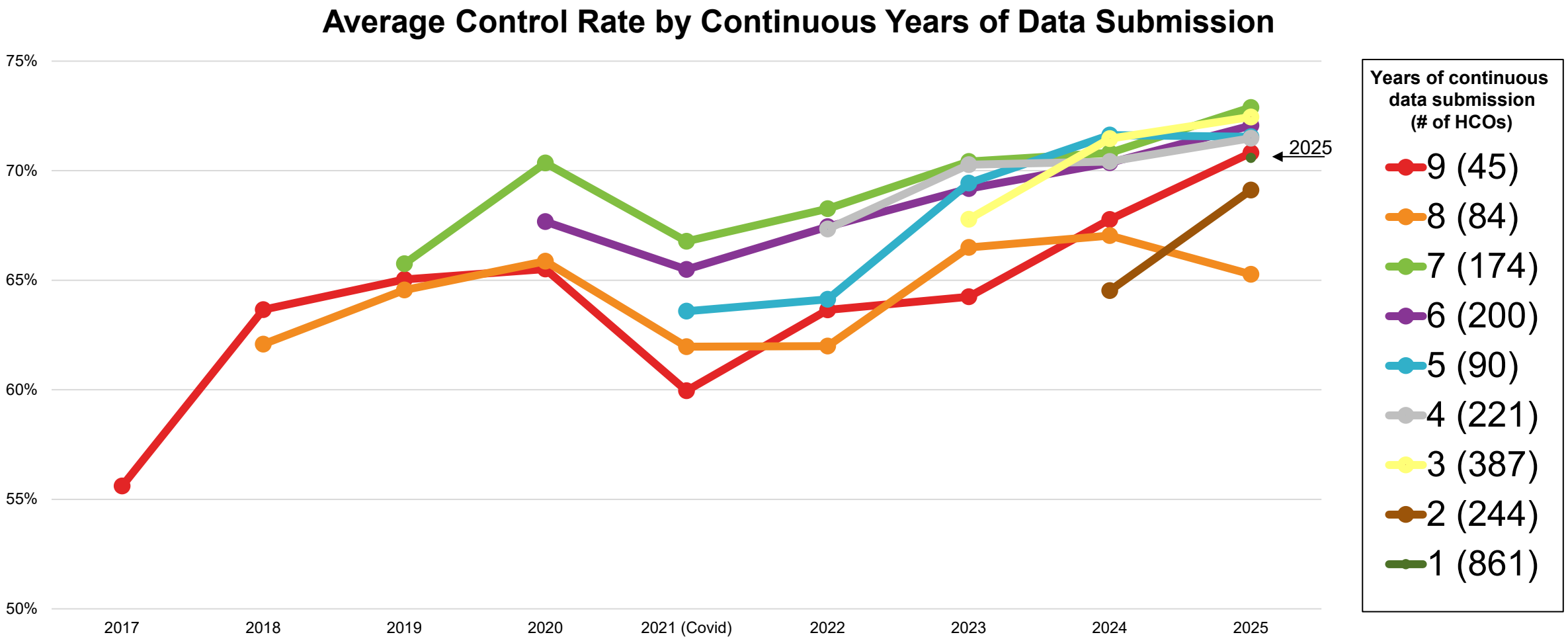
From 2017-2025, overall participation grew from 330 to 2393 organizations, caring for **10.5 million patients with hypertension**. **In 2024**, 1,371 organizations reported BP control rates ≥70 percent and 1,885 reported the adoption of ≥4 of 6 evidence-based BP activities.



Target: BP Participation and Reach

Recognition Summary	2017	2018	2019	2020	2021*	2022**	*2023*	2024	2025***
Population with hypertension served and participating HCOs									
Total Population with hypertension served by HCOs submitting data	3.4M	8.8M	8.2M	8.9M	7.9M	8.4M	8.6M	9.02M	**10.5M**
Total HCOs submitting data	330	802	1183	1081	1167	1,416	1806	1,869	**2,393**
Average control rate	66.3%	65.5%	67.0%	66.9%	63.5%	65.6%	68.6%	69.2%	**71.0%**
# (%) HCOs repeating submission from prior year	-	220 (67%)	607 (76%)	626 (53%)	863 (80%)	978 (84%)	1,224 (86%)	1,493 (83%)	**1,227 (82.2%)**

Continuous engagement and improvement



Recognition Summary	2017	2018	2019	2020	2021*	2022**	*2023*	2024	2025***
Awards earned by participating HCOs									
Total Awards	330	802	1183	1081	1167	1,309	1709	1,812	**2,306**
Participant - Attested to fewer than 4 of 6 criteria Reported < 70% BP control rate	145	455	644	577	203	83	59	34	**65**
Silver - Attested to at least 4 of 6 evidence-based activities Reported < 70% BP control rate	-	-	-	-	567	675	784	743	**134**
Silver + Attested to at least 4 of 6 evidence-based activities – M+A+1; Reported < 70% BP control rate	-	-	-	-	-	-	-	-	**736**
Gold - Attested to fewer than 4 of 6 evidence-based activities Achieve ≥ 70% BP control rate	185	347	539	504	125	169	161	84	**356**
Gold+ - Attested to at least 4 of 6 evidence-based activities - (M 2021-2024) (M+A+1 2025); Achieve ≥ 70% BP control rate	-	-	-	-	272	382	705	951	**1,015**
HCOs attesting to evidence-based activities (BP Measurement) and reporting control rates ≥70%									
Total HCOs attesting to at least 4 of 6 evidence-based activities - M (Silver, Silver+, and Gold+ with ≥4 activities)	-	-	-	-	839	1057	1,489	1,694	**1,885**
Total HCOs attesting to at least 4 of 6 evidence-based activities – M+A+1 (Silver+ and Gold+)	-	-	-	-	-	-	-	-	**1,751**
Total HCOs reporting control rates ≥ 70% (Gold + Gold+)	185	347	539	504	397	551	866	1,035	**1,371**

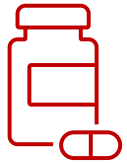
* 2021 was the first year that Silver/Gold+ were offered

** 2022 was the first year that only 1st-time submitters were eligible for a Participant Award, making some prior data submitters ineligible for an award.

*** 2025 was the first year the Silver+ was added and the criteria for Gold+ changed. Both require ≥4 of 6 evidence-based activities for M+A+1 pillar.

What is the best strategy to increase BP control rates?

Considering the relative effect of increasing medication adherence, shortening visit interval, and increasing medication intensification rates, a simulation study compared the effect of these parameters on BP control rates.



BP Control Model simulation study:	PATIENT Increase medication adherence	ENCOUNTER Increase visit frequency	**CLINICIAN** **Intensify medication prescription**
Usual rate	57% adherence	13.8 weeks	13.0-33.3% intensification
Simulated rate	100%	1 week	62%
Potential BP control rate achievable with simulated rate	57% BP control Rate	67% BP Control Rate	**≥80%** **BP Control Rate**

TARGET: BP™ | American Heart Association. | AMA AMERICAN MEDICAL ASSOCIATION

Bellows, et al DOI: 10.1161/CIRCOUTCOMES.119.005624 Council on Health of the Public, IS 2026, 36

Tracking Blood Pressure Control and Process Metrics: The PCORnet Blood Pressure Control Laboratory

Standardized electronic health record (EHR) data collected from 25 health systems from January 2017 to March 2020 - ~1,738,000 patients

- 62% BP control (<140/90 mm Hg) overall (44% - 74% range)
- In only 12% of cases where BP was uncontrolled did medication intensification occur (a new class of antihypertensive medication prescribed)
- When medication intensification occurred, there was a large decrease in systolic blood pressure (15 mm Hg reduction)

Source: Cooper-Dehoff RM, et al. JAHA, October 2021.

Draft TAFP Blood Pressure Control Resolution

Whereas hypertension is a highly prevalent medical condition in the United States; and

Whereas hypertension is the most modifiable risk factor for the prevention of cardiovascular disease and myriad other diseases; and

Whereas blood pressure control among persons with hypertension reduces myocardial infractions, stroke, heart failure, and chronic kidney disease and slows dementia; and

Whereas blood pressure control among persons with hypertension can be improved; and

Whereas the **2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults (the 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM BP Guideline)** was published in August 2025; and

Whereas hypertension categories were well defined in **the Guideline**; and

Whereas primary care providers manage 70 % of hypertension in the US; and

Whereas physicians and other clinicians can be confused by differing blood pressure control recommendations from different guidelines from different organizations; and

Whereas patients can get confused by different blood pressure control recommendations; and

Whereas the **Guideline** comprises specific, clear, and unambiguous recommendations that are applicable to family medicine settings; and

Whereas the overall quality of the **Guideline** ranks as good; and

Whereas the **Guideline** is based on a systematic review conducted with sound methodology; and

Whereas the “strong”, key recommendations are supported by high quality evidence; and

Whereas fewer than 50% of the members of the Guideline panel had significant conflicts of interest and the panel chair was conflict-free.; and

Whereas any conflicts of interest were recorded and addressed appropriately; and

Whereas the content of **Guideline** is not influenced by the funding bodies; and

Whereas the mission of the Texas Academy of Family Physicians is to promote the health of all Texans by serving the needs of members and advancing the specialty of family medicine;

Therefore, be it resolved that the Texas Academy of Family physicians recommends that the American Academy of Family Physicians endorse the **2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults.**

Dear Dr. Mitchell:

Thank you for having me at your meeting and giving me time to make the case for a TAFP resolution recommending a full endorsement of the 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM **Guideline** for the prevention, detection, evaluation, and management of high blood pressure in adults: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Hypertension*. 2025;82:e212–e316. doi: 10.1161/HYP.0000000000000249.

During my presentation, I noted a table with errors. I apologize. I have attached a corrected PowerPoint document and attached the corrected table by itself.

One of the committee members cited JNC8 – more than a decade old.

Whereas, the 2025 ACC/AHA GL states that the overarching blood pressure treatment goal is **<130/80 mm Hg** for **all** adults, with additional considerations for those who require institutional care, have a limited predicted lifespan, or are pregnant; the JNC recommendation is that in the general population of adults 60 years and older, patients should be treated to a target systolic pressure of less than 150 mm Hg and a target diastolic pressure of less than 90 mm Hg, and in the general population younger than 60 years ,the target systolic pressure is less than 140 mm Hg, and the target diastolic pressure is less than 90 mm Hg.

These are very different recommendations.

The rationale for the AAFP decision to elect to express “affirmation of value” was also referenced in the meeting.

The AAFP's decision to affirm value of the ACC/AHA blood pressure guideline was based, it appears, on concerns about its 1) methodological rigor, 2) conflicts of interest, and 3) lack of consideration for harms.

I want to address the concerns and a few other things.

In addition to the American College of Cardiology and American Heart Association, the Guideline included participation and endorsement of American Academy of Physician Associates, American Association of Nurse Practitioners, American College of Clinical Pharmacy, American College of Preventive Medicine, American Geriatrics Society, American Medical Association, American Society of Preventive Cardiology, Association of

Black Cardiologists, National Medical Association, Preventive Cardiovascular Nurses Association, and the Society of General Internal Medicine.

The perspectives and contributions of primary care physicians and other primary care providers, albeit not AAFP, are incorporated in the guideline including American Academy of Physician Associates, American Association of Nurse Practitioners, American College of Preventive Medicine, American Geriatrics Society, American Medical Association, National Medical Association, and the Society of General Internal Medicine.

STRUCTURE: The focus of this clinical practice guideline is to create a living, working document updating current knowledge in the field of high blood pressure aimed at all practicing **primary care** and specialty clinicians who manage patients with hypertension.

In addition, I want to address each of the concerns that AAFP cited in its decision to elect "affirmation of value":

1. methodological rigor – the methods are described in the Guideline as shown below:

METHODS: A comprehensive literature search was conducted from December 2023 to June 2024 to identify clinical studies, reviews, and other evidence performed on human subjects that were published since February 2015 in English from MEDLINE (through PubMed), EMBASE, the Cochrane Library, the Agency for Healthcare Research and Quality, and other selected databases relevant to this guideline.

Evidence Review and Evidence Review Committees

In developing recommendations, the writing committee uses evidence-based methodologies that are based on all available data. Literature searches focus on randomized controlled trials (RCTs) but also include registries, nonrandomized comparative and descriptive studies, case series, cohort studies, systematic reviews, and expert opinion. Only key references are cited. An independent evidence review committee is commissioned when there are ≥1 questions deemed of utmost clinical importance that merit formal systematic review to determine which patients are most likely to benefit from a drug, device, or treatment strategy, and to what degree. Criteria for commissioning an evidence review committee and formal systematic review include absence of a current authoritative systematic review, feasibility of defining the benefit and risk in a time frame consistent with the writing of a guideline, relevance to a substantial number of patients, and likelihood that the findings can be translated into actionable recommendations. Evidence review committee members may include methodologists, epidemiologists, clinicians, and biostatisticians. Recommendations developed by the writing committee on the basis of the systematic review are marked "SR".

Class of Recommendations and Level of Evidence

The Class of Recommendation (COR) indicates the strength of recommendation, encompassing the estimated magnitude and certainty of benefit in proportion to risk. The Level of Evidence (LOE) rates the quality of scientific evidence supporting the intervention on the basis of the type, quantity, and consistency of data from clinical trials and other sources (Table 3).

2. conflicts of interest are described below:

Relationships With Industry and Other Entities

The ACC and AHA have rigorous policies and methods to ensure that documents are developed without bias or improper influence. The complete policy on relationships with industry and other entities (RWI) can be found online (ACCF Relationship With Industry (RWI) and Other Entities: Policies and Procedures for the Development of Guidelines and Other Clinical Documents) . Appendix 1 of the guideline lists writing committee members' comprehensive and relevant RWI.

Specifically:

2.1.3. Writing Committee Balance Chair: **The Chair must have no relevant RWI**.* The writing committee chair is selected mainly for the competency to effectively manage the writing group and develop consensus on the text and any suggestions for clinical practice. A general knowledge of the topic of the scientific publication is also necessary, but the chair need not have expertise in the topic. The chair must be free of RWI and other relationships or biases that could undermine the integrity or credibility of the work. Vice Chair: A vice chair may be appointed to add content expertise. Vice chairs may have relevant RWI but may not have a significant relationship (as defined in Section 2.1.4) in the ownership category as defined in 2.1.2 above. Committee: **The Chair and at least half the writing committee members (at least 51%) must be free of relevant RWI*.** The MOC monitors writing committee composition for RWI and other potential sources of bias, such as intellectual perspectives or organizational relationships, and approve each writing committee before scientific publication development commences. Once chosen, authors are requested to avoid relevant RWI throughout the writing effort until publication. Author RWI is verified every 90 days from start-up call through publication. *In conjunction with the writing committee Chair, the MOC may prospectively define relevance to the topic when the content addressed in the scientific publication is non-clinical or non-prescriptive in nature and, therefore, where disease- or procedure-based definitions do not apply. Based upon the agreed-upon definitions, certain relationships may be deemed irrelevant to the scientific publication. These may include, but are not limited to, specified

institutional/organizational and government/nonprofit relationships. Such special determinations must be approved by the organizational leadership of the AHA.

By my count, 9 of 31 writing group members disclosed relevant relationships with industry. That is less than 30%.

3. lack of consideration for harms.

In Figure 6 of the GL - *In older adults who may be frail or have a limited life expectancy, a clinician-patient assessment of potential benefits and harms of BP lowering should be pursued to align care with patient goals.

In reference to use of single pill combination medications: However, BP-lowering medications should be carefully initiated and monitored in older patients because hypotension or orthostatic hypotension (OH) may develop. In most cases, SPCs are a cost-effective alternative to multiple pill combination therapy, and longer follow-up intervals extend the time for intensification of each medication and addition of the next medication in stepped-care treatment.

In reference to plan of care: 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).

There is a section dedicated to **COMPLICATIONS OF MANAGEMENT**

6.1. Management of Orthostatic Hypotension (OH)

Recommendations for Management of OH - Referenced studies that support the recommendations are

summarized in the Evidence Table.

COR LOE Recommendations

Strong - 1 A 1. In adults with hypertension, **improved BP control is recommended to reduce the risk for OH.**

Not so strong

2a A 2. In adults receiving intensive BP-lowering therapy with asymptomatic OH, treatment with a goal of SBP <130 mm Hg is reasonable due to increased CVD and mortality benefit.3,5

2a B-R 3. In adults with hypertension initiating treatment or adding medication with a goal of SBP <130 mm Hg, assessment for symptomatic OH is reasonable

In the text - In adults with hypertension and clinical CVD (coronary heart disease, stroke, HF), data from 3 RCTs that evaluated different BP treatment goals provide the evidence base to support initiation of antihypertensive treatment at a lower BP threshold of ≥130/80 mm Hg. The SPRINT trial, which enrolled patients aged ≥50 years with high cardiovascular risk and an SBP >130 mm Hg, included 17% of participants with baseline CVD. In the subgroup with CVD, intensive SBP lowering to <120 mm Hg versus standard treatment targeting <140 mm Hg reduced the incidence of the primary outcome to a similar extent of those without CVD. In the STEP (Strategy of Blood Pressure Intervention in the Elderly Hypertensive Patients) trial, which randomized adults aged 60 to 80 years to an SBP target of 110 to 130 mm Hg compared with 130 to 150 mm Hg, 6% of participants had a history of CVD, with similar findings. In the ESPRIT (Effects of Intensive Systolic Blood Pressure Lowering Treatment in Reducing Risk of Vascular Events) study of 11 255 patients (including 4359 with diabetes and 3022 with a history of stroke), randomization to intensive treatment targeting office SBP <120 mm Hg was associated with better CVD

outcomes compared with standard treatment (hazard ratio [HR]: 0.88 [95% CI: 0.78-0.99]) with no heterogeneity of treatment effect by comorbid diabetes or stroke history. **In aggregate, these data indicate that the benefit of treatment clearly outweighs the potential harm at a threshold of ≥130 mm Hg for SBP for secondary prevention of CVD.**

I hope it is not too late to put this information in front of you and the committee. Please carefully review the **2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the prevention, detection, evaluation, and management of high blood pressure in adults** and compare to the criteria for AAFP endorsement.

Respectfully submitted,

Eduardo Sanchez MD, MPH, FAAFP, FAHA

Council member comments on BP resolution

I would leave the management of hypertension of their patients to the clinician. It is a fact that BP readings are very much affected by multiple factors, stress, lack of sleep, driving to appointments, white coat syndrome. I do not want FP's to be dinged for this unnecessarily and affect metrics.

We are advocates for our patients. We don't blindly follow recommendations, we evaluate them and see if it applies to our patients.

As for the hypertension one, this is a tough one. I am sure the AAFP commission on Health of the Public and Science (of which I was formerly chair) will receive many recommendations from the states on this one and will have a thorough discussion. They are a huge committee, not sure how many, but it must be at least 25 of the best people and scientists we have around the states who take their reviews very seriously.

This debate has so many implications, but the 2 I see as major would be hypotension risk, and the problem of guideline following by primary care and the "dings" we receive when we can't meet them with our difficult populations that we serve.

First hypotension. I am acutely aware of this after going to the ER twice this year for hypotensive episodes with my husband and pleading with his doctors to decrease his medicine. Once I truly thought he was dead. This is very impactful! Finally they stopped one of his meds and he seems stable now. But hypotension DOES happen, even to the husband of a physician.

So I'm quite biased on that point.

Secondly,

On the issue of how we are judged in primary care keeping the BP under control - and as I recall in my last position that the last BP of the year was the only one counted, so there was a lot of gaming of the system happening, by doing home or video visits, etc trying to get the best BP possible to make the right score for Medicare or the ACO, in order to get a bonus. How nuts is that? But we all know it is reality. So if we push the standard to even lower BP, we are doomed to fail even worse. To me it's just wrong to pit a physician's payment against individual BP management for a patient. We all know that we keep some

patients a little higher for a reason. Will those patients be counted differently in the new guidelines? Maybe yes, but that is also up for debate. It's very complex.

So what's a doctor to do? Should we approve this and send it up for AAFP to grapple with? Or keep it and discuss more in Spring when we've had more time to think. Or just table it and not send it anywhere. I can guarantee you that the AAFP Commission on Health of the Public and Science WILL debate this guideline very seriously.

If AAFP disagrees, it is a very strong statement. You saw how many medical groups agreed, and many times groups become sheep and vote yeah to stay the course of others.

Please let us not be sheep but accountable physicians and think this through. Is it really the best for the patients? Can all patients follow this guideline? Can all physicians?

My vote is to table it for now and allow all of us to study this matter and discuss with our colleagues before a vote.