Complete Summary

GUIDELINE TITLE

Screening for high blood pressure: recommendations and rationale.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Screening for high blood pressure: recommendations and rationale. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003 Jul 14. 12 p. [46 references]

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

- High blood pressure (hypertension)
- Cardiovascular disease events, such as myocardial infarction, heart failure, and stroke

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the current U.S. Preventive Services Task Force recommendations on screening for high blood pressure and the supporting evidence
- To update the 1996 recommendations contained in the Guide to Clinical Preventive Services, Second Edition

TARGET POPULATION

Children, adolescents and adults seen in primary care settings

INTERVENTIONS AND PRACTICES CONSIDERED

Blood pressure measurement (office and/or ambulatory) with sphygmomanometer

NOTE: Treatment of high blood pressure with pharmacological agents and nonpharmacological therapies, such as dietary sodium intake reduction, potassium supplementation, increased physical activity, weight loss, stress management, and alcohol intake reduction, was considered.

MAJOR OUTCOMES CONSIDERED

Key Question No. 1: Does screening and early treatment of hypertension reduce cardiovascular disease and mortality compared with usual care?

Key Question No. 2: What are the most effective means to identify patients with hypertension for whom treatment will be beneficial?

Key Question No. 3: How effective is the treatment of hypertension (pharmacological or nonpharmacological) in reducing cardiovascular disease events and mortality?

Key Question No. 4: What are the adverse effects of screening and treatment for hypertension?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Research Triangle Institute (RTI) International - University of North Carolina at Chapel Hill (RTI-UNC) Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Search Strategy

EPC staff used the 1996 Guide to Clinical Preventive Services and searches of MEDLINE, DARE, or the COCHRANE Collaboration Library for systematic reviews published since 1995 and focused searches of MEDLINE to identify new evidence on the benefits of detecting and treating hypertension. When a good quality, recent systematic review was available, EPC staff used it to summarize previous research and searched MEDLINE only for more recent articles. When such a review was not available, EPC staff identified English-language articles from comprehensive searches of the MEDLINE database between January 1966 and January 2002 and used manual searches of relevant articles and personal libraries, as well as peer review, to ensure that all appropriate articles were included.

Inclusion Criteria for Admissible Evidence

EPC staff included recent systematic reviews and individual observational studies or randomized controlled trials that examined the following topics: the epidemiology of hypertension; the accuracy and reliability of screening; the benefits of pharmacologic and nonpharmacological treatment of elevated blood pressure; and the adverse effects of screening or treatment for hypertension.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Research Triangle Institute (RTI) International - University of North Carolina at Chapel Hill (RTI-UNC)Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Data Extraction and Synthesis

Two EPC staff members reviewed abstracts of potentially relevant articles to determine if they should be included. When the reviewers disagreed, EPC staff obtained the full articles and resolved the disagreements by consensus. For each topic for which EPC staff performed a comprehensive review (e.g., the prognostic ability of home blood pressure monitoring, the prognostic ability of ambulatory blood pressure monitoring, and the adverse effects of screening for hypertension), a single reviewer extracted data from the included studies and created evidence tables. Using the guidelines developed for the USPSTF reviews, EPC staff evaluated the internal and external validity of each study.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF´s 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The Task Force grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [this service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole USPSTF before final recommendations are confirmed.

Recommendation of Others. Recommendations for screening for high blood pressure from the following groups were discussed: the Joint National Committee (JNC) VI; the American Heart Association; the Canadian Task Force on Preventive Health Care; the American Academy of Family Physicians; the American College of Obstetricians and Gynecologists; the American Academy of Pediatrics; the National Heart, Lung, and Blood Institute and the American Medical Association.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

The USPSTF strongly recommends that clinicians screen adults aged 18 and older for high blood pressure. A recommendation.

The USPSTF found good evidence that blood pressure measurement can identify adults at increased risk for cardiovascular disease due to high blood pressure, and good evidence that treatment of high blood pressure substantially decreases the incidence of cardiovascular disease and causes few major harms. The USPSTF concludes the benefits of screening for, and treating, high blood pressure in adults substantially outweigh the harms.

The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for high blood pressure in children and adolescents to reduce the risk of cardiovascular disease. I recommendation.

The USPSTF found poor evidence that routine blood pressure measurement accurately identifies children and adolescents at increased risk for cardiovascular disease, and poor evidence to determine whether treatment of elevated blood pressure in children or adolescents decreases the incidence of cardiovascular

disease. As a result, the USPSTF could not determine the balance of benefits and harms of routine screening for high blood pressure in children and adolescents.

Clinical Considerations

- Office measurement of blood pressure is most commonly done with a sphygmomanometer. High blood pressure (hypertension) is usually defined in adults as a systolic blood pressure (SBP) of 140 mm Hg or higher, or a diastolic blood pressure (DBP) of 90 mm Hg or higher. Due to variability in individual blood pressure measurements (occurring as a result of instrument, observer, and patient factors), it is recommended that hypertension be diagnosed only after 2 or more elevated readings are obtained on at least 2 visits over a period of 1 to several weeks.
- There are some data to suggest that ambulatory blood pressure measurement (that provides a measure of the average blood pressure over 24 hours) may be a better predictor of clinical cardiovascular outcome than clinic-based approaches; however, ambulatory blood pressure measurement is subject to many of the same errors as office blood pressure measurement.
- The relationship between SBP and DBP and cardiovascular risk is continuous and graded. The actual level of blood pressure elevation should not be the sole factor in determining treatment. Clinicians should consider the patient's overall cardiovascular risk profile, including smoking, diabetes, abnormal blood lipids, age, sex, sedentary lifestyle, and obesity, in making treatment decisions.
- Hypertension in children has been defined as blood pressure above the 95th percentile for age, sex, and height. Up to 28% of children have secondary hypertension, ie, high blood pressure due to causes such as coarctation of the aorta, renal parenchymal disease, renal artery stenosis, and other congenital malformations. On the basis of expert opinion, several organizations, including the American Academy of Pediatrics (AAP), American Heart Association (AHA), and American Medical Association (AMA), recommend routine screening of asymptomatic adolescents and children during preventive care visits, based on the potential for identifying treatable causes of secondary hypertension, such as coarctation of aorta. However, there are limited data on the benefits or risks of screening and treating such underlying causes of hypertension in children. The decision to screen children and adolescents for hypertension remains a matter of clinical judgment.
- Evidence is lacking to recommend an optimal interval for screening adults for high blood pressure. The sixth report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC VI) recommends screening every 2 years for persons with SBP and DBP below 130 mm Hg and 85 mm Hg, respectively, and more frequent intervals for screening those with blood pressure at higher levels.
- A variety of pharmacological agents are available to treat high blood pressure. JNC VI guidelines for treatment of high blood pressure can be accessed at www.nhlbi.nih.gov/guidelines/hypertension/jncintro.htm. The JNC VI-recommended goal of treatment is to achieve and maintain SBP below 140 mm Hg and DBP below 90 mm Hg, and lower if tolerated. Evidence indicates that reducing DBP to below 80 mm Hg appears to be beneficial for patients with hypertension and diabetes. In considering the effectiveness of treatment for hypertension, it must be noted that a given treatment's ability to lower

blood pressure may not correspond directly to its ability to reduce cardiovascular events.

- Nonpharmacological therapies, such as reducing dietary sodium intake, potassium supplementation, increased physical activity, weight loss, stress management, and reducing alcohol intake, are associated with a reduction in blood pressure, but their impact on cardiovascular outcomes has not been studied. For those who consume large amounts of alcohol (more than 20 drinks in a week), studies have shown that reduced drinking decreases blood pressure. There is insufficient evidence to recommend single or multiple interventions or to guide the clinician in selecting among nonpharmacological therapies.

Definitions

Strength of Recommendations

The Task Force grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

Strength of Evidence

The USPSTF grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Screening and treatment for adults

The U.S. Preventive Services Task Force (USPSTF) found good evidence that blood pressure measurement can identify adults at increased risk for cardiovascular disease due to high blood pressure, and good evidence that treatment of high blood pressure substantially decreases the incidence of cardiovascular disease and causes few major harms. The USPSTF concludes the benefits of screening for, and treating, high blood pressure in adults substantially outweigh the harms.

Screening and treatment for children

The USPSTF found poor evidence that routine blood pressure measurement accurately identifies children and adolescents at increased risk for cardiovascular disease, and poor evidence to determine whether treatment of elevated blood pressure in children or adolescents decreases the incidence of cardiovascular disease. As a result, the USPSTF could not determine the balance of benefits and harms of routine screening for high blood pressure in children and adolescents.

Subgroups Most Likely to Benefit:

- Hypertension is more common in African Americans and the elderly than in other groups.
- Individuals with higher absolute risk for experiencing future cardiovascular events because of other coexisting risk factors (such as age, sex, lipid disorders, smoking, and diabetes) experience greater absolute benefit from blood pressure reduction than those at lower risk for future adverse cardiovascular events.

POTENTIAL HARMS

Screening

Initially, some studies suggested that screening and labeling individuals with hypertension may result in adverse psychological effects and transient increases in absenteeism. However, studies that have measured psychological well-being have found inconsistent effects of screening and diagnosis. Several cohort studies showed mixed effects on rates of absenteeism, and the causes of absenteeism were not well established. In children, too few studies have examined the potential harms of screening to draw conclusions.

Treatment

Potential adverse effects of drugs-some sufficiently bothersome to interfere with adherence to the medication regimen-are common, but serious adverse drug reactions are rare. Physicians should take adverse effects into consideration when deciding whether to treat and which treatment to use.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The U.S. Preventive Services Task Force recommendations are independent of the U.S. government. They do not represent the views of the Agency for Healthcare Research and Quality (AHRQ), the U.S. Department of Health and Human Services, or the U.S. Public Health Service.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Neither the resources nor the composition of the U.S. Preventive Services Task Force equip it to address these numerous implementation challenges, but a number of related efforts seek to increase the impact of future U.S. Preventive Services Task Force reports. The U.S. Preventive Services Task Force convened representatives from the various audiences for the Guide "Put Prevention Into Practice. A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach"--clinicians, consumers and policy makers from health plans, national organizations and Congressional staff--about how to modify the content and format of its products to address their needs. With funding from the Robert Wood Johnson Foundation, the U.S. Preventive Services Task Force and Community Guide effort have conducted an audience analysis to further explore implementation needs. The Put Prevention into Practice initiative at the Agency for Healthcare Research and Quality (AHRQ) has developed office tools such as patient booklets, posters, and handheld patient mini-records, and a new implementation guide for state health departments.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the third edition of the Guide to Clinical Preventive Services. Freed from having to serve as primary repository for all of U.S. Preventive Services Task Force work, the next Guide may be much slimmer than the almost 1000 pages of the second edition.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring

the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals and test results are not always centralized.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Screening for high blood pressure: recommendations and rationale. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003 Jul 14. 12 p. [46 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2003 Jul 14)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force Members: Alfred O. Berg, MD, MPH (Chair); Janet D. Allan, PhD, RN, CS (Vice-chair); Paul Frame, MD; Charles J. Homer, MD, MPH*; Mark S. Johnson, MD, MPH; Jonathan D. Klein, MD, MPH; Tracy A. Lieu, MD, MPH*; C. Tracy Orleans, PhD; Jeffrey F. Peipert, MD, MPH*; Nola J. Pender, PhD, RN*; Albert L. Siu, MD, MSPH; Steven M. Teutsch, MD, MPH; Carolyn Westhoff, MD, MSc; Steven H. Woolf, MD, MPH

*Members of the Task Force at the time this recommendation was finalized.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Screening for hypertension. In: Guide to clinical preventive services. 2nd ed; Baltimore (MD): Williams & Wilkins; 1996. p. 39-51.

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Review:

- Sheridan S, Pignone M, Donahue K. Screening for high blood pressure: A review of the evidence for the U.S. Preventive Services Task Force. Am J Prev Med. 2003. Jul;25:151-158.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt JS. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

Electronic copies: Available from U.S. Preventive Services Task Force (USPSTF) Web site.

The following is also available:

- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. 189 p. (Pub. No. APPIP01-0001). Electronic copies available from the AHRQ Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Preventive Services Selector, an application for Palm Pilots and other PDA's, is also available from the AHRQ Web site.

PATIENT RESOURCES

The following is available:

- The Pocket Guide to Good Health for Adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI on July 11, 2003.

COPYRIGHT STATEMENT

Requests regarding copyright should be sent to: Gerri M. Dyer, Electronic Dissemination Advisor, Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research), Center for Health Information Dissemination, Suite 501, Executive Office Center, 2101 East Jefferson Street, Rockville, MD 20852; Facsimile: 301-594-2286; E-mail: gdyer@ahrq.gov.

© 1998-2004 National Guideline Clearinghouse

Date Modified: 5/3/2004