NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Michelle Morse, MD, MPH
Acting Health Commissioner

JAMES V. McDONALD, MD, MPH
Commissioner

2025 Health Advisory #27:
2025 ACC/AHA Joint Committee Updates Adult Hypertension Guidelines to No Longer Include Race-Based Criteria

Please distribute to clinical staff in cardiology, internal medicine, family medicine, primary care, nephrology, obstetrics & gynecology, endocrinology, emergency departments, pharmacy, local health departments.

- The American College of Cardiology (ACC) and American Heart Association (AHA) Joint Committee published a guideline update in August 2025 regarding the prevention, detection, evaluation, and management of hypertension.
- These guidelines no longer recommend race as a factor to consider for treatment. Instead:
  - An individualized approach is preferred to ensure successful medication management and blood pressure control, mitigate racial hypertension inequities, and reduce morbidity and mortality.
  - For adults initiating antihypertensive drug therapy, thiazide-type diuretics, long-acting dihydropyridine calcium channel blockers (CCB), angiotensin-converting enzyme inhibitors (ACEi), or angiotensin II receptor blockers (ARBs) are recommended as a first-line therapy to prevent cardiovascular disease, depending on risk score and presence of comorbidities, not race.
  - Health care team members taking blood pressure measurements should adhere to best practices to mitigate error.
- To facilitate system level adoption of these guidelines and removal of race as a factor in clinical decision-making, refer to the Digital Medicine Society toolkit, created in collaboration with New York City (NYC) Health Department Coalition to End Racism in Clinical Algorithms and The Senior Care Action Network (SCAN) Foundation.

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The New York State and New York City Departments of Health are elevating recent, key guideline changes to the management of hypertension in adults. In August 2025, the AHA/ACC Joint Committee published new recommendations building on the 2023 AHA Predicted Risk of Cardiovascular EVENTS (PREVENT) equations and revised the 2017 guidelines.

Removal of Race-based Prescribing in Hypertension Management and Updated Guideline Take-aways

The 2025 updated hypertension (HTN) management guidelines no longer include race as a factor for consideration in determining initial treatment for individuals. This change recognizes previously held practices of using race as a risk factor to determine therapy, which was based on erroneous, harmful practices of race-based differential biology, did not improve HTN control and associated racial health inequities, and revealed the inadequacy of monotherapy in many people, including members of the Black population.

The 2025 ACC/AHA HTN Guidelines uses the PREVENT risk calculator, estimating an individual's 10 and 30-year risk of cardiovascular disease (CVD), including myocardial infarction, stroke, and heart failure. The 2023 PREVENT calculator does not include race but rather considers risk factors such as sex, cholesterol, blood pressure, body mass index, estimated glomerular filtration rate (eGFR), and comorbidities (e.g., type 2 diabetes, smoking status). For a more personalized approach, hemoglobin A1C, urinary albumin-to-creatinine ratio (uACR), and a patient's zip code can be entered to factor in geographic disadvantages.

The PREVENT score utilizes a Social Deprivation Index (SDI), which can be included to refine an individual's 10- and 30-year CVD risk estimates. This index is determined by the individual's zip code, which serves as an agent for a range of socioeconomic factors that can influence health outcomes such as education, income, employment, transportation, or housing conditions. This approach provides a more in-depth view into the various social and environmental factors that may influence an individual's ability to adequately manage their hypertension. *Blood pressure management is therefore based on an individual's calculated PREVENT score, blood pressure measurement, and identifiable risk factors, not whether one identifies themselves as a member of the Black or white race or is racialized as such.*

The New York State Department of Health and New York City Department of Health therefore explicitly call for all health care systems and providers to end race-based prescribing of antihypertensive therapies and transition to recognizing the importance of race-consciousness in clinical practice to mitigate health inequities and manage blood pressure more effectively.

Updated Treatment Guidelines

Stage 1 Hypertension (SBP 130-139 mmHg or DBP 80-89 mmHg)

- **Low CVD score** (<7.5% 10-year risk):
    - 3–6-month period of lifestyle modifications, including weight loss, exercise, and/or heart-healthy diet modifications such as the DASH (Dietary Approaches to Stop Hypertension) eating plan.
    - If persistent and blood pressure remains ≥130/80 mmHg, one first-line medication [ACEi/ARB/CCB/Thiazide-like diuretic] should be initiated.

- **A high CVD score** (≥7.5% 10-year risk), **diabetes**, or **chronic kidney disease (CKD)**:
    - One first-line medication [ACEi/ARB/CCB/Thiazide-like diuretic] should be utilized in conjunction with lifestyle changes.

Stage 2 Hypertension (SBP ≥140 mmHg or DBP ≥90 mmHg):

- Two first-line agents [ACEi/ARB/CCB/Thiazide-like diuretic] from different classes should be considered, preferably as a single-pill combination to reduce pill burden and increase the potential for successful medication management, alongside possible lifestyle modifications.

<table>
<tr><th colspan="3">Special Populations</th></tr>
<tr><th>Comorbidities</th><th>Preferred Agent(s)</th><th>Additional Comments</th></tr>
<tr><td>Chronic Kidney Disease (CKD)
(eGFR <60 mL/min/1.73 m^2 or albuminuria ≥30 mg/g)</td><td>ACEi or ARBs</td><td>Beneficial in cases of albuminuria</td></tr>
<tr><td>Diabetes
(SBP ≥130 mmHg or DBP ≥80 mmHg)</td><td>Any of the first-line agents</td><td>ACEi or ARBs are recommended in the presence of CKD</td></tr>
<tr><td rowspan="3">Heart Failure (HFrEF)</td><td>ARNi or ACEi or ARBs</td><td rowspan="2">---</td></tr>
<tr><td>Beta blockers - bisoprolol, carvedilol, or metoprolol succinate</td></tr>
<tr><td>Aldosterone Antagonists - spironolactone or eplerenone</td><td>Preferred agents with symptomatic HFrEF, given:
eGFR >30 mL/min/1.73m^2 and K+ <5.0 mEq/L</td></tr>
<tr><td>Coronary Artery Disease</td><td>ACEi or ARBs + beta-blocker</td><td>If additional antihypertensives are required: CCB, thiazide-type diuretic, or aldosterone-antagonists</td></tr>
<tr><td>Overweight/Obesity</td><td>Any of the first-line agents
(+ GLP-1 receptor agonist as an adjunct)</td><td>If weight loss goals not met with nonpharmacological interventions, consider GLP-1 receptor agonist (BMI ≥27 kg/m^2) or bariatric surgery (BMI ≥35 kg/m^2)</td></tr>
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Pregnancy and Hypertension: For individuals with hypertension who are planning a pregnancy or who become pregnant, labetalol or extended-release nifedipine are preferred agents. These individuals should not be treated with atenolol, ACEi, ARB, direct renin inhibitors, nitroprusside, or mineralocorticoid receptor agonist (MRA) to avoid fetal harm. Refer to the 2025 ACC/AHA HTN Guidelines for more details about hypertension and pregnancy.

Positioning During Blood Pressure Measurement: In addition to this important guideline change, we want to remind our providers to ensure best practices for positioning a person during blood pressure measurement, in order to avoid inaccuracies. Please consider the following tips:

Best practices for patient positioning during blood pressure measurement			
No smoking, caffeine, alcohol, exercise, or decongestants 30 minutes prior.	Ensure patient's bladder is empty. (Full bladder adds 10 mm Hg)	Ensure patient sits upright with back supported, feet on floor and legs uncrossed. (Unsupported back and feet add 6 mm Hg; Crossed legs add 2-8 mm Hg)	Use a validated device with the correct cuff size. (Cuff too small adds 2-10 mm Hg)
Put cuff on bare arm. (Cuff over clothing adds 5-50 mm Hg)	Ensure patient sits quietly for 5 minutes and does not talk during measurement. (Talking or active listening adds 10 mm Hg)	Rest patient arm comfortably on a flat surface at heart level. (Unsupported arm adds 10 mm Hg)	Wait one minute, then take blood pressure again.

- NYC Health Department Patient Resource on How to Correctly Measure Blood Pressure at Home
- AMA In-Office BP Measurement Infographic

Resources

- 2025 ACC/AHA HTN Guidelines
  - Target: BP August 2025 Webinar Recording on 2025 AHA/ACC High Blood Pressure Guideline
- Removing harmful race-based clinical algorithms: A toolkit (2025)
  - Offers health systems and clinicians an extensive, practical step-by-step guide towards eliminating the misuse of race in clinical algorithms.
- Hidden in Plain Sight: Reconsidering the Use of Race Correction in Clinical Algorithms (2020)
- The Race-Correction Debates – Progress, Tensions, and Future Directions (2025)[1]

[1] Vyas, D. A., Eisenstein, L. G., & Jones, D. S. (2025). The Race-Correction Debates — Progress, Tensions, and Future Directions. New England Journal of Medicine, 393(10), 1029–1036. https://doi.org/10.1056/nejmms2506241