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Missed Opportunities? Improving the Care of Patients With High Blood Pressure

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Hypertension is the most prevalent and modifiable cardiovascular disease risk factor in the United States. In light of data suggesting that the prevalence rate of hypertension is increasing, concerted efforts to control high blood pressure are indicated.¹ Helping hypertensive patients adopt healthier lifestyles is part of a comprehensive approach to achieving adequate blood pressure control. Physicians have an important role in helping patients engage in healthy behaviors and counseling is effective in motivating behavior change.²

In the current issue of the *American Journal of Hypertension*, Lopez *et al.* examine the frequency with which physicians counsel patients to modify their lifestyle and explore whether receipt of advice varies by patient characteristics.³ In this population-based study (NHANES 1999–2004), lifestyle counseling was high (84% received advice); however, there was considerable variability across groups. Hypertensive adults who were overweight or obese, diabetic, or had high cholesterol were more likely to receive lifestyle modification advice as were blacks, males, and adults with Medicare insurance. The findings by Lopez *et al.* are intriguing and consistent with a study that found that hypertensive adults with two cardiovascular comorbidities were more likely to receive lifestyle modification advice than hypertensive adults with just one or no additional cardiovascular medical concerns.⁴

In one respect, these findings are encouraging—lifestyle modification counseling is high, particularly for those who are medically complex. These data, however, also raise an important question: Do physicians routinely miss opportunities to counsel lower-risk patients? The pattern of more counseling for higher-risk patients is robust. This has also been demonstrated in smokers and in overweight/obese adults (i.e., smoking cessation and weight loss advice, respectively, is more common in patients with comorbidities).

The higher rate of counseling in high-risk patients may merely reflect health-care utilization patterns (e.g., high-risk patients have more physician visits and thus, more opportunities to receive counseling). Interestingly, a recent study supports this hypothesis. When just one physician visit per hypertensive patient was considered, rates of lifestyle counseling did not differ in low vs. high-risk patients.⁵ Alternatively, variability in physician counseling may reflect physician attitudes—counseling may be viewed as having greater benefit to the high-risk patient, and accordingly, low-risk patients are not counseled. With the documented gaps in lifestyle counseling, studies should explore the factors that underlie physician practice patterns.

We must also remain cognizant of how we think about lifestyle counseling. This single phrase has been applied widely to behaviors that in fact are very different (e.g., a single recommendation to alter behavior vs. a structured discussion that includes behavior change principles). A common vernacular is needed. Attention must also be paid to the quality of lifestyle counseling. Setting behavioral goals, assessing barriers and facilitators to behavior change, assessing patient motivation and confidence, and planning for follow-up visits to assess progress toward behavioral goals are quality indicators recently assessed in a study of hypertension-related visits.⁶ This framework which includes evidence-based behavior change principles can serve as a model for lifestyle counseling.

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