Both the Toolset and Motivation Are Needed for Lasting Change

Sandra J. Taler

A fter 50 years of pharmacological treatment options and 7 expert guideline reports, hypertension control rates in the United States remain disappointing. With a plethora of salt-laden, calorie-dense, supersized foods that are widely marketed and regularly consumed by the American public, combined with the mechanical conveniences of modern life, it is no surprise that obesity is spreading, and this salt- and weight-sensitive disease of hypertension remains uncontrolled. Are we as healthcare providers offering the right amounts and types of counseling and feedback to assist our patients in reforming their choices and successfully reducing their sodium intake and their weight? If not, would additional lifestyle coaching be effective in improving hypertension control rates?

In this issue of Hypertension, Svetkey et al describe a Herculean effort to modify blood pressure (BP) control rates by interventions directed at 32 physicians and \( \approx 600 \) patients over an 18-month time period. This prospective, randomized trial evaluated the success of physician interventions within a practice, intervention efforts addressed directly to patients, and the combination, randomized within 8 primary care practices in community practice settings. The physician interventions included Internet-based learning, self-monitoring, and review of quarterly feedback reports. For the patients, the intervention included 20 weekly group sessions over 6 months, followed by 12 monthly telephone counseling contacts.

Enrollment rates were excellent, with 56% of screened patients randomized. Outcome results were available for 91.0% at 6 months and for 88.5% at 18 months. The primary outcome of systolic BP change after 6 months was promising, with a 9.7-mm Hg lower systolic BP in the dual intervention group, which was significantly greater than the 6.7-, 5.3-, and 7.1-mm Hg fall in those receiving neither, physician-alone, or patient-alone interventions, respectively. The percentage of patients achieving goal systolic BP increased at 6 months, followed by 12 monthly telephone counseling contacts.

Outcome results were available for 91.0% at 6 months and for 88.5% at 18 months. The primary outcome of systolic BP change after 6 months was promising, with a 9.7-mm Hg lower systolic BP in the dual intervention group, which was significantly greater than the 6.7-, 5.3-, and 7.1-mm Hg fall in those receiving neither, physician-alone, or patient-alone interventions, respectively. The percentage of patients achieving goal systolic BP increased at 6 months, followed by 12 monthly telephone counseling contacts.

Enrollment rates were excellent, with 56% of screened patients randomized. Outcome results were available for 91.0% at 6 months and for 88.5% at 18 months. The primary outcome of systolic BP change after 6 months was promising, with a 9.7-mm Hg lower systolic BP in the dual intervention group, which was significantly greater than the 6.7-, 5.3-, and 7.1-mm Hg fall in those receiving neither, physician-alone, or patient-alone interventions, respectively. The percentage of patients achieving goal systolic BP increased at 6 months, followed by 12 monthly telephone counseling contacts.

Both the Toolset and Motivation Are Needed for Lasting Change

Sandra J. Taler

© 2009 American Heart Association, Inc.

The opinions expressed in this editorial are not necessarily those of the editors or of the American Heart Association.

Correspondence to Sandra J. Taler, Division of Nephrology and Hypertension, Mayo Clinic, 200 First St SW, Rochester, MN 55905. E-mail taler.sandra@mayo.edu

Hypertension is available at http://hyper.ahajournals.org

DOI: 10.1161/HYPERTENSIONAHA.109.139584
mined, and in Roumie et al., weight, dietary changes, and urinary metabolite excretion were not reported.

This study has additional weaknesses, including the designation of CKD on the basis of patient self-report, likely to greatly underestimate CKD prevalence rates. The use of physician self-reporting to indicate whether lifestyle modification counseling was provided at each visit would also seem unreliable. On a practical level, these interventions were costly and time intensive and, thus, difficult to continue outside of a research setting. The drain on the physicians participating was substantial related to the intervention and the required completion of a data form with every patient study visit.

In summary, this was an important study in an area of high significance addressed at key questions. Can we change the eating and exercise habits of a patient cohort? What types of efforts are successful and who should provide them? There are few studies that have evaluated the efficacy of a multi-level approach to BP control in hypertensive patients. Even after successful change, the patients were unable to maintain their positive results. We might conclude that success requires the right toolset and the motivation. Without the first, energy is present but undirected, and without the second, the tools stay on the shelf. We need the tools and the drive to begin and continue efforts to help our patients change. Svetkey et al.1 shared the tools, but their study cohort was perhaps less motivated and the effort was not successful over time. Realizing this, we need to try again to apply these techniques in a motivated population.

Disclosures
None.

References
Both the Toolset and Motivation Are Needed for Lasting Change
Sandra J. Taler

Hypertension. 2009;54:1202-1203
doi: 10.1161/HYPERTENSIONAHA.109.139584
Hypertension is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2009 American Heart Association, Inc. All rights reserved.
Print ISSN: 0194-911X. Online ISSN: 1524-4563

The online version of this article, along with updated information and services, is located on the
World Wide Web at:
http://hyper.ahajournals.org/content/54/6/1202

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published
in Hypertension can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial
Office. Once the online version of the published article for which permission is being requested is located,
click Request Permissions in the middle column of the Web page under Services. Further information about
this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Hypertension is online at:
http://hyper.ahajournals.org//subscriptions/