Evidence Based Treatment for Excessive Alcohol Consumption and Concurrent Hypertension

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Purpose
Excessive alcohol consumption is one of the preventable risk factors for hypertension, heart disease, and stroke, which are the leading causes of death in the U.S. [1]. Though alcohol-related deaths number 88,000 annually in the U.S. [2], alcohol use has the lowest treatment rate of all behavioral health disorders at 10% [3]. The well-established link between excessive alcohol consumption and hypertension means that when primary care providers don’t treat alcohol abuse, their treatment of hypertension is compromised. This project aims to increase PCP and patient awareness of the connection between hypertension and excessive alcohol use and promote screening of excess alcohol consumption.

Methods
The protocol was developed with literature review and consultation with content experts. Patient education materials were developed to increase the primary care providers’ ease with addressing alcohol use objectively as it relates to hypertension. An in-person educational presentation was offered for providers about the evidence-based treatment protocol including the use of motivational interviewing. Post-presentation and follow-up surveys were collected and analyzed for practice change as evidenced by providers’ report of increased co-management of alcohol use and hypertension. Practice change associations relative to pre- and post-intervention were analyzed via descriptive statistics and themes were extracted through content analysis.

Results
Three presentations were given to twenty providers and nurses. Nineteen post-presentation surveys and seven follow-up surveys were returned (response rate of 95% and 35%). Seventy-nine percent of respondents (n=15) indicated they were likely to implement a practice change. Eighteen percent of respondents (n=4) liked this treatment approach focus on using the hypertension-alcohol link to discuss health risks without stigma. At 3-months follow-up, two providers reported appreciating the protocol not relying on medication. Three providers used the tracking log; blood pressure was reduced in at least two patients. Three of seven providers reported increased screening for alcohol use, one already screened all patients, two did not screen any patients.

Conclusions
A majority of providers were hesitant to broach alcohol use and patients were not regularly screened for alcohol consumption. Evidence-based tools were well received by participating PCPs. Without universal alcohol use screening in primary care, the treatment gap will persist, and the treatment of concurrent hypertension may continue to be compromised.

References