Cardiovascular disease, Type 2 diabetes and hypertension in adults

HEALTH EDUCATOR DESK GUIDE

for lifestyle change and adherence

Version 2. September 2013

This is a desk guide for health educators to use in healthcare centres. It contains information to help change the behaviours and key lifestyle risk factors of adults at risk of cardiovascular disease (CVD), particularly in adults in low resource settings. The guide also contains information on treatment support, including adherence to clinic appointments and medication.

This guide has been designed for those patients identified as high risk individuals through assessment by a clinician in a rural health care facility. It should be used for all patients with:

- CVD
- Hypertension
- Diabetes type 2
- Pre-diabetes

These guidelines must be adapted to the local health service context in country by the Ministry of Health and NGO partners by using a technical working group process. This process should assess available resources and staff before piloting, evaluation and scale-up of this guide in country.

This desk guide is a concise ‘quick reference’ for health educators. The objectives are to effectively facilitate behaviour change, focusing on the key risk factors for CVD, diabetes and hypertension and to discuss adherence strategies with the patient. This guide should be used in health service settings as part of a package of tools, including the health workers ‘case management desk guide’ for CVD in adults.

This guide provides a systematic approach to identifying and assessing lifestyle risk factors, assessing motivation for behaviour change, and suggestions on how to support and encourage behaviour change in individuals using recognised techniques. It includes information on adherence strategies to discuss with the patient in conjunction with the patient education leaflet.

The text in blue highlights points which are likely to need adapting to the country context.

These materials are intended as a guide for clinical use and incorporate the best current evidence and recommendations, but are not comprehensive. Users and planners should adapt this guide to their country context. They should be aware that all decisions remain with the clinicians using them. The materials cannot be reproduced for sale.

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Contents

How to use this guide: instructions for health educators

A patient will be referred to you following initial assessment, diagnosis and management by a health worker. The health care worker should briefly discuss with you the key messages related to lifestyle change, disease education and adherence to clinic appointments and medication for the patient.

Work through this booklet with the patient and their treatment supporter.

This guide is divided into 2 sections:
1. Patient adherence
2. Lifestyle assessment

Discuss both sections of the guide with the patient and their treatment supporter. This guide will help you deliver key educational messages and develop action plans with the patient.

Use the education leaflet as a prompt.

Review progress at each appointment, and encourage all efforts to change behaviour, re-emphasise key messages, and discuss whether the patient is ready to target other behaviours. If they are ready, give the patient the necessary help and guidance. Review all individual goals and revise them to reflect the patient's progress.

Always make a follow-up appointment.

Patient adherence

Using the education leaflet as a prompt:

Explain to the patient the importance of attending clinic appointments and taking prescribed medication.

Sign the treatment contract.

Discuss the importance of a treatment supporter.

Tell the patient that if they miss an appointment a reminder will be sent or an attempt to contact them will be made.

A treatment supporter

Explain to patient why a treatment supporter is important:

- Treatment is life-long, support is essential.
- It can be difficult to remember to take tablets regularly, but it is vital to continue treatment.
- A treatment supporter is someone they can talk to easily and who will encourage them.
- It is their choice who will be their treatment supporter. They will be called if the patient cannot be contacted or if there is a problem.

Discuss who would be the best treatment supporter; it must be someone concerned, trusted and committed to providing support.

Help the patient choose someone e.g. family member, friend or community volunteer. If patient cannot decide, suggest someone. It would be helpful if this could be someone who has had similar problems and has successfully changed their behaviour.

Record name, address and mobile phone number of patient and treatment supporter on the patient's treatment card.

Ask the patient to bring treatment supporter with them for all clinic visits, to learn about the illness, treatment and their role.

Advise the treatment supporter to**:**

- Meet with the patient often, try to make this a enjoyable time. If possible, meet at the time the patient takes their tablets to see them taking the tablets as prescribed.
- Look at tablet pack to check the patient is taking tablets correctly.
- Inform health worker if the patient stops taking the tablets.
- Encourage the patient to be active, eat healthily, stop smoking as needed and attend all appointments.
- If this is someone with similar experiences they can demonstrate how they changed their behaviour or overcame any difficulties.

Appointment reminders

If an individual fails to attend a review appointment, take action.

- **Phone** patient and encourage them to return.
- **Phone** treatment supporter and ask them to remind patient.
- **Send** reminder letter to patient if you cannot contact them.
- **Ask** someone e.g. CHW to home visit if patient does not return.

If patient is not adhering to treatment or attending clinic appointments:

- Do not criticise.
- Praise or reward patient for what they are doing well.
- Discuss any concerns or difficulties using open questions.
- Encourage the patient and treatment supporter
- Remind patient of treatment contract and the importance of continued medication.
- Use case studies to provide positive examples of how other patients have overcome difficulties. For example this could be by relying on treatment supporters or using cues for medication such as mealtimes.
- Make an appointment for them to see the health worker.

Lifestyle assessment

Ask the patient whether they are aware of any link between their current condition and their lifestyle (i.e. what they eat/drink).

Inform the patient that changing their lifestyle will improve their health and disease prognosis.

Tell the patient that there are 4 main behaviours that could be addressed:

1. Physical activity
2. Healthy eating
3. Reducing alcohol intake
4. Stopping smoking

Discuss the patient's current status or ask if not known:

- Does the patient do regular physical activity?
- Is the patient drinking above the advised limit?
- Does the patient eat healthily?
- Does the patient smoke, have they ever smoked?

Ask the patient to choose 1 behaviour that they could change.

If the patient is not willing to change any behaviour:

- **Ask** the patient what they think would happen if they don't change their behaviour.
- **Make sure** the patient has an education leaflet.
- **Ask** patient to return for follow-up appointment.
  If they are still not motivated to change at the next appointment, **repeat** education information and invite them to return if they decide to change.

If the patient identifies a behaviour to change:

- **Ask** the patient how they feel about this behaviour. Is changing the behaviour important for the patient?

If changing behaviour is not a priority for patient:

- **Discuss** the key messages for this behaviour.
- **Make sure** the patient has an education leaflet.
- **Ask** the patient to return for follow up appointment.

If changing behaviour is a priority for the patient:

- **Ask** if the patient feels they are able to change the behaviour they have identified?

All patients **make a plan** (see appropriate lifestyle page)

- **Ask** the patient to involve their treatment supporter.
- Ask the patient who else needs to be involved to make their change successful. This could be the support of family members or close friends.
- **Complete** their treatment card and ask them to sign a 'contract' (included in the treatment card or as a separate sheet) agreeing to actions outlined in the plan.
- **Ask** patient to return for follow-up appointment.
- **Encourage** all efforts and success.
- Introduce simple self rewards for success and build on these at each stage (see appropriate lifestyle page) to help increase motivation. These will be different for each patient. Discuss what will keep them motivated, but avoid using food as a reward.
- Consider getting groups of patients together to encourage support and motivation, if appropriate. For example exercise groups or smoking cessation support groups
- Encourage the patient to use self – encouragement and positive statements to help motivation ("I can …).

If the patient has previously tried or is lacking confidence in how to change their behaviour, discuss potential barriers, encourage all efforts and make a plan for change (see appropriate lifestyle change page for information).

Once a patient has successfully changed a behaviour, set a future date for longer term follow up and review progress. Encourage them to identify risky situations that may cause a relapse and plan for these.

Patients that successfully change behaviours (and good adherence to medications) should be invited to become peer educators and supporters for those at the beginning of the change process.

Healthy eating

Using the education leaflet as a prompt:

Key messages

- Changing your diet can improve your health and wellbeing.
- Eating unhealthy food can cause heart disease and strokes.

Help the patient make a plan, write this into their behaviour change contract:

- Identify barriers to improving their diet and plan ways to overcome them.
- Identify a specific, measurable and realistic goal and discuss a plan to achieve this. Ask the patient to identify when, where and how they might achieve their goals.
- Start with simple achievable goals and increase levels at each meeting until the target behaviour is achieved.
- Encourage them to monitor their progress i.e. food diary.
- Ask the patient to remind themselves of all the reasons why they want to eat healthily.
- Encourage them to involve the whole family in healthy eating changes.
- Encourage use of rewards to aid motivation, this could include an activity enjoyed by the patient such as watching a favourite TV programme.

Advise:

- Eat locally available healthy food and less refined food.
- Eat 3 regularly spaced meals throughout the day.
- Drink water in place of tea and sugary drinks.

Fats

Reduce total daily fat and saturated fat intake i.e. animal fat, ghee

- Use vegetable oil for cooking <1 tablespoon/day
- Grill or boil food; avoid fried food.
- Eat fish and chicken rather than red meat, remove visible fat.

Salt

- Add less salt when cooking.
- Avoid ready made or street food, as is unhealthy with a lot of fat and salt, home cooked is better.

Fruit and Vegetables

- Eat at least **5** fruit or vegetables every day.

Give this advice but don't expect the patient to make all these changes at once. Instead aim for one or two changes at each meeting and review goals as they meet each one.

Physical activity

Using the education leaflet as a prompt:

Encourage existing activity and advise 30 mins/day of physical activity, which makes them feel out of breath.

Key messages:

- Increasing physical activity will help to keep your heart healthy.
- A lack of physical activity will increase your chance of having a stroke, heart attack and dying prematurely.

Help the patient make a plan**:**

- Identify barriers to increasing physical activity and plan ways to overcome them.
- Identify a specific, measurable and realistic goal and discuss a plan achieve this. Ask the patient to identify when, where and how they might achieve their goals. Start with simple goals and increase difficulty at each meeting until the target behaviour is achieved.
- Encourage them to monitor their progress i.e. exercise diary.
- Ask the patient to remind themselves of all the reasons they want to increase their physical activity.
- Ask patient to inform family and friends and ask for their support.
- Encourage use of rewards to aid motivation, for example every time they do 30 minutes of physical activity they could put a small amount of money in a jar. At the end of the week they can reward themselves with a preferred treat.

Advise:

Daily physical activity for at least 30 minutes, that will make them out of breath i.e.

- Manual work e.g. farming or gardening
- Fast walking
- Cycling
- Use stairs rather than the lift
- Sports

Consider activities that the patient enjoys and how these can be incorporated into their daily routine. Ask if they can make this a family or community activity (for example starting or joining a walking group). This will make it more fun and increase motivation.

Reducing alcohol intake

Using the education leaflet as a prompt:

Advise individuals to drink less than 1.5 pints of beer, 1 large glass of wine, 75ml of spirits per day (3 units).

Key messages:

- Long term alcohol intake will cause heart disease, stroke and liver disease.
- If patient has diabetes, alcohol can make them very ill with low blood sugar (especially if on insulin or sulphonylurea tablets)

Help the patient to make a plan:

- Identify barriers to reducing alcohol intake and plan ways to overcome them. This can include identifying stressful or high risk situations.
- Identify a specific, realistic goal and discuss a plan to achieve this. Start with simple goals and increase difficulty at each meeting until the target behaviour is achieved.
- Encourage them to monitor their progress i.e. alcohol diary.
- Ask the patient to remind themselves of all the reasons they want to reduce their alcohol intake.

Encourage rewards for positive changes:

- Encourage patient to put aside money usually spent on alcohol to spend on treating themselves or their families.
- Discuss with the patient what kind of rewards may be most likely to motivate them.
- Examples could include beauty treatments, going out for a meal or new clothes.

Stopping smoking

Using the education leaflet as a prompt:

Advise all smokers to stop smoking.

Advise individuals who use other forms of tobacco to quit.

Key messages:

- Giving up smoking is the most important thing you can do to protect your heart and health.
- If you continue to smoke, you are more likely to have heart attacks, strokes, cancer, kidney disease, disease of the blood vessels and impotence (men).

Help the patient make a plan to quit:

- Set quit date.
- Ask the patient to monitor smoking for a week before the quit date to become aware of their triggers (times, places, activities, people) to smoke.
- Ask patient to inform family and friends, ask for their support.
- Advise patient to remove cigarettes/tobacco/objects that remind them of smoking.
- Explain that the patient may experience withdrawal signs i.e. tiredness, sleeplessness and becoming irritable - this is normal and will become easier the longer they do not smoke.
- Advise the patient to not smoke even one cigarette and to record their progress.
- Ask the patient to remind themselves of all the reasons they want to be a non smoker.
- Reinforce success and praise positive steps towards quitting.

Encourage rewards for positive changes:

- Encourage patient to put aside money usually spent on cigarettes to spend on treating themselves or their families.
- Discuss with the patient what kind of rewards may be most likely to

motivate them.

- Examples could include beauty treatments, going out for a meal or new clothes

If patient is not successful, begin the process again, with more frequent follow up and seek more support from family and friends.

If there is a specific smoking cessation clinic locally, refer to this.

APPENDIX

Education leaflet

If you have hypertension, diabetes and cardiovascular disease improving your health is still important.

Hypertension is when your blood is at a higher pressure than normal.

You cannot give hypertension to someone else.

It is a lifelong condition that can be treated with medication and lifestyle changes.

If it is not treated, it can cause stroke, heart attack, kidney failure and death.

Type 2 Diabetes is when the body cannot use the food you eat, especially sugar.

You cannot give diabetes to someone else.

It is a lifelong condition that can be treated with medication and lifestyle changes.

If it is not controlled, it can cause blindness, kidney failure, heart disease, disease of your blood vessels, poor erections and leg ulcers.

High blood sugars in pregnancy can damage your unborn baby.

Patients with diabetes can develop hypertension and the other way round, especially if overweight.

Attending the clinic and taking medication

It is important that you attend your appointments at the health clinic to see the doctor and the health educator.

Take a friend or family member (treatment supporter) with you to all your appointments.

It is important that you take your medication as given by the doctor, even if you feel well.

Do not miss doses of your tablets.

If you miss a dose do not take a double dose.

Do not share your tablets with other people.

If you think you are experiencing side effects, contact the health clinic.

If you have any questions about how to improve the way you live or the illnesses in this leaflet, please contact your local health facility.
Address:
Telephone no.:
Doctor/Health educator:

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How to live a healthy life

A healthy diet, increased physical activity, not smoking and less alcohol are essential to improve your health and to prevent diseases like hypertension and diabetes

There are many ways that you can improve your health

Stopping smoking

Giving up smoking is the most important thing you can do to protect your heart and health.

If you smoke, you are more likely to have heart attacks, strokes, kidney disease, peripheral vascular disease and poor erections.

Other forms of tobacco are also bad for your health.

Smoking in the home can be harmful to your family.

If you want to quit smoking, it is important that you have support from your doctor and family.

Eating healthy food

Improving your diet can improve your health.

Eating unhealthy food can cause heart disease and strokes.

Try to:

- Eat locally available healthy food.
- Eat 3 regularly spaced meals per day.
- Drink water instead of tea or sugary drinks.
- Eat less fat i.e ghee.
- Use vegetable oil for cooking <1 tablespoon/day.
- Grill or boil food; avoid fried food.
- Eat fish and chicken rather than red meat, remove visible fat.
- Eat at least **5** fruit or vegetables every day.
- Add less salt when cooking.
- Avoid ready made or street food, home cooked is better.

Being active

Increasing physical activity will help keep your heart healthy.

A lack of physical activity increases your chance of having a stroke, heart attack and dying.

Try to do 30 mins/day of activity that makes you out of breath:

- Manual work e.g. farming
- Fast walking
- Cycling
- Use stairs rather than the lift
- Sports

Reducing alcohol intake

Reducing the amount of alcohol you drink will reduce the chance of developing heart disease.

Long term alcohol intake will cause heart disease, stroke and liver disease.

It is important to try to drink less than 3 units each day (1.5 pints of beer, 1 large glass of wine, 75ml of spirits).

If you have diabetes, alcohol can make you very ill with low blood sugar (especially if you are on insulin or sulphonylurea tablets).

If you want to change any of the behaviours discussed then please talk to your doctor.