CVD CARE PACKAGE

MODULES 1-9

Version 2. November 2013.

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

Module 1: Assessment and tests

Introduction

Health workers should think about the diagnosis of cardiovascular disease (CVD), hypertension and type 2 diabetes in all adults who attend the health clinic. It is especially important to consider these diagnoses in men and women over 50 years. Assessment should include asking the patient questions, examining the patient and performing appropriate tests to help to make a diagnosis.

Session objectives

By the end of this session you will be able to:

- make an assessment of a patient attending a health facility or outpatient department;
- understand how to diagnose CVD, hypertension and diabetes; and
- understand which tests to choose and be able to interpret the results of the tests.

Assessment of cardiovascular disease

Refer to pages 6-7 in the case management desk guide

Take time to read through the 'Assessment of cardiovascular disease (CVD), Type 2 diabetes and hypertension', *(pages 6 – 7).*

Remember to explore each symptom that the patient tells you and compare with the lists on *page 6* of the case management desk guide.

It is important that when a patient mentions a relevant symptom, you ask about related symptoms, previous symptoms and current medication that the patient is taking.

If the patient presents with a symptom that does not fall into the diagnosis of cardiovascular disease (CVD) or diabetes, use your country clinical guidelines or the Integrated Management of Adolescent Adult Illness (IMAI) to help make an alternative diagnosis. Do not forget to look for other common important diseases such as HIV and TB.

All patients should be asked questions, examined and managed according to their diagnosis.

Diagnosis of CVD

If the patient has any of the symptoms of current cardiovascular disease (CVD) or severe CVD, you will need to decide whether they need to be referred to a hospital for further assessment and tests *(see page 6)* for signs and symptoms of severe illness and when to refer to hospital).

You will then need to examine the patient for signs of critical illness. This can help you to decide whether the patient needs urgent referral.

If the patient is stable and does not require urgent referral, use the desk guide to assess them for hypertension *(page 8)* or diabetes *(page 14)*

Role play 1

Ask the facilitator if you have any questions.

Diagnosis of Hypertension

Refer to *page 8* in the case management desk guide

Many patients with raised blood pressure will not present with symptoms. Raised blood pressure (BP) increases the chance of developing cardiovascular disease and contribute to the complications due to type 2 diabetes.

If the patient is >50 years then it is important to take a blood pressure reading.

Taking a blood pressure reading

It is important that the blood pressure is taken with the patient after they have been sitting for 5 minutes.

Make sure you have the correct equipment:

- A stethoscope
- A sphygmomanometer (blood pressure machine)
- The correct sized blood pressure cuff

Make sure the patient is sitting with their feet flat on the floor and their arm out at heart height, resting on a table.

Make sure the arm cuff is properly deflated before placing it around the patient's upper arm.

Ensure that the cuff is the correct size for the patient. If required use a smaller or larger cuff.

Wrap the cuff tightly around the upper arm, ensuring the whole cuff is above the elbow.

On the same arm as the cuff, with the palm turned upwards, feel in the inside curve of the elbow on the little finger side of the elbow for the brachial pulse. Place your stethoscope over the pulse (see figure 1)

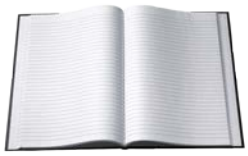
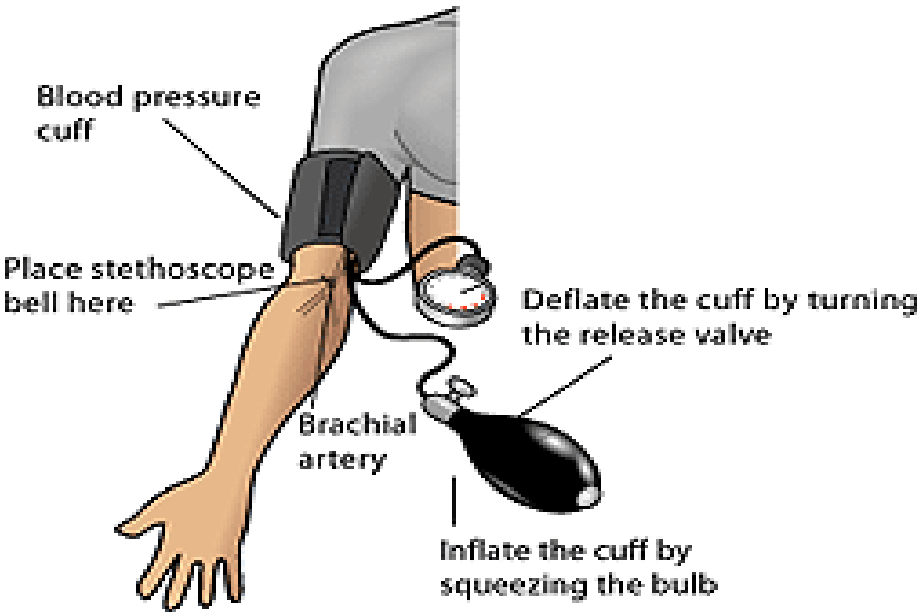


Figure 1:



Slowly inflate the cuff of the BP machine until you can no longer hear the blood flow through the artery.

Now slowly deflate the cuff and listen for when the sound of the pulse returns.

Note the value of the mmHg on the machine - this is the systolic blood pressure.

Continue deflating the cuff until you can no longer hear the pulse.

Note the value of mmHg on the machine – this is the diastolic blood pressure.

Use *page 8* of the guide to help you decide whether you need to repeat the reading. If the blood pressure reading is very high > 200mmHG systolic or >120mmHG diastolic, then it is important that you send the patient to the *hospital* urgently for further assessment and tests.

Practical exercise A

Using the desk guide and the information above, take turns to measure blood pressure in a group of 3.

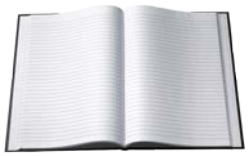
Record your findings and discuss what you would do next. Look at *pages 8-11* to help you.

Practical exercise B

Mossam has attended the clinic. You know him well he often attends as he has a history of anxiety and depression. You notice looking at his records that he has recently turned 50.

Questions:

1. After you have discussed *Mossam*'s anxiety what else should you consider doing?



You decide to measure his waist circumference and take his blood pressure.

Waist: 104cm
Blood pressure 138/88 mmHg
2. What do you tell *Mossam* and what would you do next? Look at pages 2 to 5 to help you decide.
Acknowledge that it can be difficult to make a lot the lifestyle changes at one time, but emphasise how important it is for his health. Offer support and referral to a *health educator* if appropriate.

Diagnosis of Type 2 Diabetes

Refer to *pages 14* in the case management desk guide

If the patient presents with symptoms that could be related to type 2 diabetes you will need to also consider testing for HIV.

If the patient's symptoms could be diabetes then you will need to perform a blood glucose test.

If a patient is over the age of 50 and has a high waist circumference (see page 14) or has a family history of diabetes you will also need to consider a test for diabetes.

You will need to ask/ examine the patient for symptoms/ signs of pregnancy or critical illness to help you decide if they need an urgent referral to hospital (page 14)

Refer to page 12 and complete role play 2

There are 3 types of blood glucose test available. When interpreting the results you must know which type was done in order to interpret the result correctly.

Random Blood Glucose (RBG):

This can be taken at any time. It does not take into account what the patient has been eating or drinking. It is therefore less sensitive than the other tests. However,

it is the easiest to perform. Diabetes can be diagnosed on the basis of two RBG results if necessary.

Fasting Blood Glucose (FBG):

Before taking the blood test, the patient must have fasted for at least 8 hours. The easiest way to do this is to arrange an appointment for the patient to have the blood test first thing in the morning. They should fast overnight and must not have anything to eat until after the test.

Oral Glucose Tolerance Test (OGTT):

This is the most accurate way of assessing how a patient metabolises glucose:

Take fasting blood glucose (FBG) in the morning. Give a glucose drink (75g of glucose or approximately 400ml of a regular coca cola). Take blood glucose 2 hours later. It is difficult to do because it requires 2 tests in the same day and the patient has to wait at the clinic for 2 hours.

Refer to *page 16* in the case management desk guide

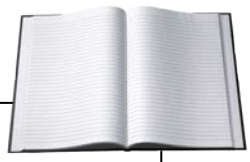
You have already learnt how to identify patients for screening. The first stage is to check random blood glucose on all these patients. Depending on the result of this first test you may need to repeat the test or consider another blood glucose test.

Always clearly explain why tests are being done and give appointments for review.Work through the exercise referring to the desk guide page 15.

Practical exercise C

You are the health worker. *Hadija* came to the clinic with recurrent infections, thirst and urine frequency. You suspected diabetes and sent her for a random blood glucose test immediately after the consultation.

You have now received the following blood result from the laboratory:



Patient ID: *Hadija Akubari* **DOB:** 12/04/1956
Date of sample: 05/01/2012

Random Blood Glucose: 10.4mmol/l (187 mg/dl)

Questions:

1. Can the patient be diagnosed with diabetes based on this blood test?

2. What further action is required to make a diagnosis?

You decide to arrange another blood test for *Hadija* to confirm the diagnosis. She has little money and has to travel a long way to the clinic. She is unable to come first thing in the morning and wait for two hours because she needs to attend to her family.

Questions:

3. Which second blood glucose test would best suit *Hadija*?

You now have two blood glucose results for Hadija:
05/01/12 RBG: 10.4 mmol/l (187mg/dl) ()
28/01/12 RBG: 11.8 mmol/(l214mg/dl) ()

Questions

4. Can you confirm the diagnosis of diabetes in Hadija?

5. Discuss what you will do next? Look at page 15 - 19 of the desk guide to help you.

Key considerations include:
Treatment and treatment adherence
Patient education
Treatment supporters

Module 2: Complications and referral

Introduction

Patients with uncomplicated diabetes and hypertension can be managed in the health facility by regular clinic appointments with the health worker. If patients have complications from diabetes and hypertension then you may need to consider referring them to a *hospital* for more tests and treatment.

Any patient referred to a *hospital* should also continue to attend the health facility to make sure that they are not lost from follow up. You will learn more about follow up in module 8.

Session objectives

By the end of this session, you will:

- understand the common complications of diabetes and hypertension;
- know when patients may need to be referred for specialist care; and
- know how to record this information and how to make sure that patients are not lost to follow up.

Management and complications

Refer to the following pages:
Management and complications of hypertension *page **10***
Management and complications of diabetes *page **16 - 20***

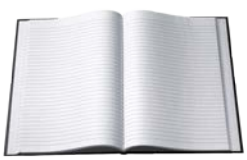
Remember that patients with uncomplicated diabetes and hypertension can be managed in the health facility. Complications can often be prevented by good adherence to medication and lifestyle changes. In the following role plays, use the pages in the desk guide to decide whether you need to refer the patient for specialist care.

Complete role play 1 using pages 12-13

Complete role play 2 using pages 18-20

Practical exercise A

Using the information in your role play with *Hadija*, update the treatment card and complete a referral form.



Module 3: Register and treatment card

Introduction

Recording and reporting information on individual patients is a crucial method of monitoring both individual and health facility progress. The tools to be completed to assist in this process are the treatment card, annual diabetes treatment card and the patient register.

Session objectives

By the end of the session, you will be able to:

- understand the importance of completing the treatment card and the patient register;
- complete the relevant sections of the treatment card; and
- complete the relevant sections of the patient register.

Recording information on the treatment card

See *page 26* of the case management desk guide

All patients seen at the health clinic who are assessed for cardiovascular disease and have possible hypertension or diabetes should have a treatment card.

It is important that the details about the patient are recorded on this card at their first visit. This includes details such as name, address, contact telephone number and date of birth. It is also important that the health worker records details of any symptoms, examination results, tests performed and medication started.

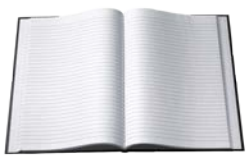
The card should be completed as you assess and manage the patient in the consultation.

The treatment card will be used at each appointment.

The treatment card will be given to the patient to take home with them.

Practical exercise A

You are the health worker. *Hadija* came to the clinic with recurrent infections, thirst and urine frequency on 5th January 2012. You suspected diabetes and sent her for a random blood glucose test immediately after the consultation.



You have now received the following blood result from the laboratory:

Patient ID: *Hadija Akubari* **DOB:** 12/04/1956 Date of sample: 05/01/2012 Random Blood Glucose: 10.4mmol/l *(187 mg/dl)*

Fill out a treatment card for *Hadija*.

You will learn about the treatment contract in module 6.

Questions:

What other information would you need to ask her to complete the treatment card?

Recording patients with a new diagnosis in the register

See diabetes/hypertension/CVD register – *page 26*

When any results of tests are received and a diagnosis can be made, you should record these patients in the *chronic disease (diabetes/hypertension/CVD etc.) register*.

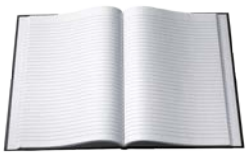
The date of the patient's next appointment should be added to the second page of register, above the dotted line on the row allocated for that patient. Each time a patient attends the health facility, the date should be entered on the register, underneath the dotted line. This enables patient attendance to be effectively monitored.

If a patient fails to attend an appointment then the reason, if known, should be recorded instead of the date of the missed appointment. An attempt should be made to contact the patient. You will learn more about follow up in module 6.

There are three possible outcomes:
1. Lost to follow up means that any attempt to contact the patient or treatment supporter has failed (3 attempts) and the patient is no longer attending (missed 3 appointments).
2. If the patient has died then enter this in the corresponding appointment.
3. If the patient has been transferred to another health care facility, then enter TOUT.

Recording these details on the patient register enables better monitoring and evaluation of CVD services in the health facility. The patient register will be sent to the district office so that they are able to see the numbers of patients assessed and diagnosed by the health facility.

Practical exercise B



You have arranged a second blood test for *Hadija* and confirmed the diagnosis of diabetes. Hadija attended this most recent appointment two days later than it was scheduled.

You now have two blood glucose results for *Hadija:*
05/01/12 RBG: 10.4mmol/l (187mg/dl) ()
28/01/12 RBG: 11.8mmol/l (214mg/dl) ()

Update the treatment card from the previous exercise and add *Hadija* to the diabetes/hypertension/CVD register.

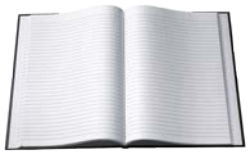
Recording information on the annual review diabetes treatment card.

See *page 27* of the case management desk guide

All patients with a confirmed diagnosis of diabetes will need an appointment for an annual review. The annual review is an opportunity for a more detailed assessment of the patient. It should be used to look for any complications of diabetes, in particular in the eyes, feet and peripheries.

It is important that the additional tests performed and any results available are recorded on the annual review card.

The annual review card also has space for the details of the patient and the treatment supporter. This should also be completed by the health worker. It is important that the details about the patient are the same on the treatment card and annual review card i.e. DOB and unique patient number.



Practical exercise C

Hadija has been attending appointments for 1 year since her first appointment and it is time for her annual review. She is pregnant and you have referred her to the *hospital*. Complete the Diabetes Annual Review card. As part of the exercise, compare the register, the treatment card and the annual review card to ensure all of *Hadija*'s information is the same.

Module 4: Disease specific education

Introduction

Once a patient has been diagnosed with a chronic condition such as hypertension or diabetes, it is essential that you take the time to educate the patient on their diagnosis, the importance of adhering to medication, potential complications and ways they can manage their condition. As you may only have a small amount of time, the information included in the desk guide has been limited to the key messages.

Session Objectives

By the end of this session, you will be able to:

- understand how to communicate effectively with the patient;
- provide key educational messages on diabetes, hypertension and cardiovascular disease; and
- remind the patient of the importance of adherence to medication.

Disease specific education

Refer to the following pages in the case management desk guide
Hypertension patient education - *page 12 - 13*
Diabetes patient education - *page 19*

Take time to read through these pages.

If you have any questions at this stage, please ask the facilitator.

Be aware that the patient has just been told they have diabetes, hypertension or CVD. This is likely to be quite difficult for them. Some patients may prefer to deny reality, and choose not to acknowledge that they have this condition. There may be social stigma, with negative social consequences for patients and their families, especially for women.

It is important to ask the patient about their existing knowledge, and explore any misunderstandings. It is unlikely that the patient will remember all the information you provide at one visit, so refer to these pages during each appointment.

Diabetes, hypertension and CVD are long-term illnesses and adherence to medication and appointments is essential for preventing long term complications. At each appointment the key messages on adherence to medication should be reinforced.

It is important to make sure the patient understands the information and checking understanding should be part of the consultations (see page 18 - 20).

At each appointment, give the patient an opportunity to share their concerns about their illness and ask any questions.

Complete role play 1

Complete role play 2

Module 5: Lifestyle advice

Introduction

A healthy lifestyle is important for the prevention of diseases such as hypertension, diabetes and CVD. Addressing key lifestyle risk factors; smoking, alcohol, weight, poor diet, and physical inactivity can greatly reduce the risk of complications and improve quality of life .

If adopted, lifestyle advice can remove the need for a patient to start or increase medication. It is important that advice on lifestyle is given as soon as a risk factor is identified or condition diagnosed.

The chronic care pathway on *page 2* of the desk guide emphasises the importance of promoting lifestyle changes to patients. These should be discussed before prescribing medication and the positive impact of such changes it should be made clear.

Lifestyle advice should be given to all patients with pre-diabetes, diabetes, hypertension and cardiovascular disease so that they can begin to make changes that will help to manage or improve their condition.

This advice should also be given to patients who are overweight or who smoke, even if they have not been diagnosed with a specific condition.

Session Objectives

By the end of this session you will be able to:

- Deliver and effectively communicate to patients key lifestyle advice for smoking, alcohol, weight, healthy eating and physical activity;
- Understand the importance of the education leaflet; and
- Understand who to *refer to the health educator* for further discussion on these lifestyle risk factors.

Lifestyle advice

Refer to *pages 13, 20* in the case management desk guide

Some people may not be aware of the link between their lifestyle and their diagnosis. It is important to explain that behaviours such as smoking, drinking too much alcohol, poor diet, lack of physical activity and weight gain may have contributed to their diagnosis and changing them is an important part of their treatment. Throughout the consultation patients should be encouraged to ask questions

Using *page 2* of the desk guide, you must communicate all the key lifestyle advice, discussing each of them if needed. If the patient is not overweight or does not smoke, you obviously do not need to communicate these specific messages. These messages should be briefly repeated at each consultation as the patient is unlikely to remember all of them after the first appointment.

All patients should receive an education leaflet. For patients who have previously been diagnosed, check that they have received a leaflet.

After delivering the key messages, it is important that patients with hypertension, diabetes or CVD are referred to the health educator. At each subsequent visit to see the health worker, the patient should also attend an appointment with the *health educator* to discuss lifestyle changes and adherence strategies in more detail.

Complete role play 1

Complete role play 2

Module 6: Medication and patient adherence

Introduction

Diabetes, hypertension and cardiovascular disease are chronic conditions that require long term management and medication. It is important to prescribe appropriate drugs for patients and promptly recognise and manage side effects as they occur.

Patient adherence to medication and clinic appointments is essential if their condition is to be managed effectively. It is advised that all patients have a treatment supporter, a friend or family member, who will remind them to take their tablets and who will attend all appointments with the health worker and health educator. It is also recommended that each patient diagnosed with a chronic disease, signs a treatment contract, along with the health worker. If patients do not attend appointments or do not adhere to treatment there should be clear procedures outlined to follow-up these individuals.

Session Objectives

By the end of this session, you will be able to:

- Understand and explain medication (part 1), specifically:

    - prescribe the correct medication to manage the patient's condition
    - adjust and alter medication and dosage for optimal management
    - monitor potential side effects

- Understand and explain patient adherence (part 2), specifically:

    - explain the importance of adherence to both clinic appointments and medication.
    - educate the patient about treatment support
    - explain the role of a treatment supporter
    - help the patient to identify an appropriate treatment supporter
    - manage patients who do not adhere to appointments or medication
    - supervise the treatment supporter
    - explain and complete the treatment contract
    - remind patients of their appointment through a number of different mechanisms

Part 1: Medication

Refer to the case management desk guide as appropriate;
Management of hypertension and anti-hypertensives - *page* ***10 - 11***
Management of diabetes and oral hypoglycaemics - *page* ***16 - 17***
Side effects and contraindications - *page* ***32 - 33***

Hypertension

Patients with uncomplicated high BP can initially be managed with lifestyle changes alone. If blood pressure is not controlled or if the patient has complications anti – hypertensives (medication to reduce blood pressure) should be prescribed. *Page 10* of the desk guide gives you further details on when to start blood pressure medication and how frequently patients should attend the clinic.

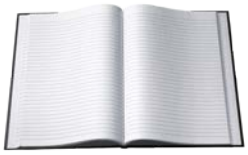
The drug of choice for the patient will depend on several factors and you should use the step by step approach *on page 10* of the desk guide to help you decide what drug to start and what dose. When prescribing new medication it is important to consider any contraindications see *page 32.*

Patients with hypertension and diabetes may need slightly different treatment and *page 16* will guide you on this.

The lowest dose should be started and then increased using a step by step approach to achieve control of the blood pressure. Medications should be recorded on the patient's treatment card and reviewed at every appointment. It is important to ask about possible side effects of each drug, these can be found on *page 31.*

Practical exercise A

You have been treating *Peter Mbaruku, a 37 year old man*, since his diagnosis. Unfortunately, as he does not always take his treatment, his blood pressure has not been well controlled. Today his blood pressure is 148/95. Using *page 8* of the desk guide, discuss what you would do now if *Peter* had already been started on *enalapril*.



Using the information in the desk guide answer the following:

1. Which drug would you consider adding?
2. What contraindications would you ask Peter about?
3. When would you arrange to see Peter again in the health facility?

At his next appointment Peter mentions that he has been getting some tiredness, nausea and vomiting.

4. Where would you look to see if these are side effects of the medication?
5. What other information would be important to tell Peter about taking his medication?

Diabetes

Blood glucose can be controlled with lifestyle changes and medication, known as hypoglycaemics. Patients with type 2 diabetes usually take oral medication (though may need insulin later). If the patient does not follow the prescribed course of treatment, blood glucose will remain high and complications such as blindness or kidney failure may develop (see page 16 for further information). Symptoms should improve when the blood glucose is controlled.

Page 14 of the desk guide will help you to decide when to start medication and how frequently to monitor blood glucose in the health facility. For the majority of patients the first drug is metformin. If the blood glucose is still not controlled after stepping up metformin to the maximum tolerated dose then a sulphonylurea (2nd step) should be added.

It is important to look at the contraindications on *page 32* before starting any of the drugs. If in doubt, refer to the *hospital* for advice and management. Patients who are breastfeeding, pregnant or planning pregnancy should be referred to hospital, as should patients with:

- kidney disease or liver disease,
- HIV on anti-retroviral treatment or
- TB on chemotherapy

The lowest dose of each drug should be started and recorded on the patient's treatment card. Drugs and possible side effects should be reviewed at each appointment.

The blood glucose of patients should be monitored and it is important to identify a target blood glucose. At each appointment the most recent blood glucose result should be compared to the target. It may be necessary to increase the dose of the medication to reach the target. When choosing a target remember that patients who are elderly or have multiple complications may be slower at reducing blood glucose levels and a less aggressive reduction may need to be chosen.

When prescribing or changing the dose of diabetes drugs, it is important to talk to the patient about the risk of hypoglycaemia (low blood sugar). You should make the patient and treatment supporter aware of the information on *page 21* of the desk guide.

If the maximum tolerated dose of 2-3 oral agents for 6 months fails to control blood glucose the patient should be *referred to the hospital who will assess whether insulin is required*. If a patient has been started on insulin by the *hospital* it is important that both the patient and the treatment supporter know the information on *page 21* of the desk guide.

Practical exercise B

Mossam is a 51 year old man. You have recently diagnosed him with diabetes and are keen to make sure he is given the correct medication. Using the information in the desk guide answer the following questions:

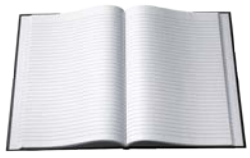
1. What drug and dose would you start *Mossam* on?
2. How often would you see *Mossam* in the health facility?

After 6 months you have increased the doses of Mossam's oral hypoglycaemic drugs but you find that his blood glucose is still not controlled. You are sure that Mossam has been taking his medication, but you are concerned that he may develop more complications if you do not control his diabetes.

3. What would you do now?

You decide to refer *Mossam* to the *hospital to consider starting insulin.*
At his next appointment *Mossam* tells you that he has been taking his insulin. He feels well but has had a few episodes when he has been feeling very shaky, dizzy and hungry. He is concerned about these and wants to know what to do.

4. What would you need to tell him?



Part 2: Patient Adherence

Refer to the case management desk guide as appropriate;
Patient adherence - *page **23***
Treatment card and contract – *page **26***

Take time to read through these pages. Review the session objectives outlined at the beginning of the module.

If you have any questions at this stage, please ask the facilitator.

As well as communicating the importance of adherence and treatment support, you must allow the patient to ask questions and to discuss any concerns they may have relating to attending appointments, adhering to medication or involving another individual as their treatment supporter. The next step is for you and the patient to sign the treatment contract, to encourage patients to commit to their appointments and medication.

Treatment supporter

It is your job to explain the role of a treatment supporter and help the patient to identify someone appropriate. Once a patient has chosen a treatment supporter, it is expected that they will attend all appointments with the individual. When the treatment supporter first attends, it is important that you discuss with them their role and responsibility, in order that there is a shared understanding by you, the patient and the treatment supporter.

Practice using the information in the case management desk guide to inform the patient and help them to choose a treatment supporter as guided by the role plays below.

Treatment contract

The treatment contract is in the top section of the patient treatment card. It is an agreement between you, to commit to providing care and medication, and the patient, to adhere to the recommended treatment and required appointments. Both you and the patient must sign the contact.

Only patients who have been diagnosed with CVD, hypertension and diabetes should sign a treatment contract. It should only be signed once **after** the patient has been educated about their condition and potential complications, encouraged and informed about changes they could make to their lifestyle and received instructions about their medication.

You should consider the following questions before asking the patient to sign the treatment contract.

1. Does the patient understand key facts about diabetes and its related illnesses including the importance of continuing treatment and keeping appointments?

2. Does the patient agree with their care plan including medication and lifestyle changes?

3. Is the patient clear how many tablets to take when?

3. Is the patient aware of potential side effects of their medication and what action to take?

4. Has the patient discussed their feelings, anxieties, misconceptions and traditional beliefs about their diagnosis?

5. Does the patient know the date of the next appointment?

If the patient is aware of all the necessary information, you should explain the treatment contract to them and sign it. Allow time to clarify any areas of uncertainty and repeat information if necessary.

Remember, if you notice at this stage that there is information missing on the treatment card, ask the patient and fill in the corresponding information.

Complete role play 1

Procedures for non-adherence to clinic appointments or medication

The case management desk guide clearly outlines different procedures for follow-up if a patient does not attend a clinic appointment.

Read through the section on *page 23* on appointment reminders.

If an individual is not adhering to treatment or has stopped medication, it is important that you do not criticise. Try to encourage the patient and discuss with them any concerns or difficulties. They may be experiencing side effects, or finding the long term nature of their condition discouraging.

Using the guidelines outlined in the case management desk guide and the role plays below, practice the procedures for patients who do not attend an appointment or adhere to treatment and how you would communicate with them.

Practical exercise C

Last time you saw *Peter Mbaruku*, you gave him information about hypertension and discussed the importance of taking medication regularly. However, he has failed to attend his last 2 appointments. You helped him to choose a treatment supporter, who is one of his friends. In your group, use the information on *page 23* of the desk guide to discuss what you could do next to remind *Peter* that he needs to return.

Module 7: Concerns and questions

Introduction

It is essential that you communicate effectively with the patient throughout their appointment, using 'W.E.L.L' principles (Welcome, Encourage, Look and Listen) as discussed at the beginning of these training modules. However, this module focuses specifically on the end of the patient's appointment where it is important to use these skills to clarify and discuss any concerns or questions that the patient may have. Refer to *page 2* in the case management desk guide to see where this fits within the chronic care pathway.

Session objectives

By the end of the session you should:

- understand the importance of inviting and allowing the patients to ask questions and tell you their concerns; and
- further develop your consultation skills using the W.E.L.L principles so that patients feel comfortable discussing their concerns and questions.

Concerns and questions

In their appointment with you, the patient will have been given a lot of information about their diagnosis, any medication they need to take, possible side effects as well as the importance of lifestyle changes, treatment support and choosing a treatment supporter. It is unlikely they will have remembered all the information you have told them, especially if they have just been diagnosed.

The patient will be able to read the education leaflet once they have left the health facility, however, it is very important that they have the opportunity to ask questions and to discuss their concerns during the appointment.

During repeat appointments, it is also very important to give time for the patient to ask questions. Even though they will have heard the information previously, the patient may have looked at the education leaflet since their last visit or discussed their diagnosis with their family, or realised the long-term implications of their condition and therefore have further questions.

Role play 1

Module 8: Follow-up appointment

Introduction

All patients with a chronic disease such as diabetes, hypertension and CVD should be given a follow-up appointment at the end of their consultation with you. This is illustrated in the diagram of the chronic care pathway on *page 2* of the desk guide.

Session Objectives

- understand the importance of making a follow-up appointment for all patients;
- understand the importance of continuing to monitor patients whilst they are under specialist care; and
- learn to set follow-up appointments of the appropriate length depending on the patient's current condition.

Making follow-up appointments

It is essential that all patients who have pre-diabetes, diabetes, hypertension or cardiovascular disease are given a follow-up appointment at the end of their visit. This should be entered on both copies of the treatment card as a reminder to both you and the patient when they should next be attending. It should also be entered in the attendances section of the CVD, hypertension and diabetes *register*, above the dotted line on the row allocated to that patient. If a patient has been referred for specialist care, either urgently, or non-urgently, they should still be given a follow-up appointment to provide continuity of care and to prevent patients getting lost in the system during referral.

Refer to the following pages of the case management desk guide:
Management of hypertension: *page **10***
Management of diabetes: *page **15***

The length of follow-up is dependent upon the patient's diagnosis, whether their condition is stable, if they have complications or how long they have had the condition. It is essential that where possible, patients are monitored as often as the guidelines recommend.

Complete the following practical exercises;

Practical exercise A

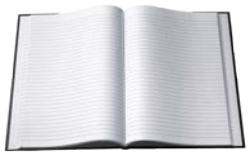
Peter has hypertension and has recently been diagnosed with diabetes. He is currently taking tablets for both conditions. At this appointment, his blood pressure is

145/80 and his most recent blood glucose is FBG 7.5 mmols/l (135 mg/dl). His target level is an FBG of <7 mmols/l (126 mg/dl). He is now more adherent to medication and seems to have accepted his diagnoses. He doesn't have any complications.

- Discuss when you would next see *Peter* at the health facility.
- How should you communicate the next appointment to the patient?

Peter has now returned to the health facility for his follow-up appointment. His repeat FBG is 6.9 mmols/l (124 mg/dl).

- Discuss what other tests are needed.
- Discuss when you would book his next appointment.



Practical exercise B

Salim has been attending the health facility to see both the health worker and the health educator for the last 6 months. He has managed to reduce the amount he is smoking, but not completely stop. His blood pressure has been well controlled. Today his reading is 135/85. When you talk to him, he tells you that he has started to get more chest pain. You decide to refer him again to see the specialist at the *hospital.*

- Discuss when you would make a follow-up appointment for *Salim.*
- How would you document this information and what forms would you fill in?

Module 9: Health educator

Refer to the health educator guide and education leaflet

Introduction

This module is designed to train all individuals who will fulfil the role of the health educator, as part of the management of CVD, diabetes and hypertension in primary care. It is important that all health workers have an understanding of the role of the health educator, so should also complete this module. If the health educator has not completed the previous modules they should read the introductory module to familiarise themselves with the course.

The health educator will discuss adherence to clinic appointments, medication, treatment support as well as facilitating behaviour change of key lifestyle risk factors; smoking, alcohol, poor diet and physical inactivity. All patients with pre-diabetes, diabetes, hypertension and CVD will be referred to the health educator following their appointment with the health worker.

Before starting this module you should look at again at the communication section in the introduction.

Session objectives

By the end of this session, you will be able to:

- Understand and explain adherence strategies (part 1), specifically:
  - explain the importance of adherence to both clinic appointments and medication
  - educate the patient about treatment support
  - explain the role of a treatment supporter
  - help the patient to identify an appropriate treatment supporter
  - explain and complete the treatment contract
  - manage patients who do not adhere to appointments or medication
  - supervise the treatment supporter
  - remind patients of their appointment through a number of different mechanisms

- Understand and explain lifestyle assessment (part 2), specifically:
  - identify and assess lifestyle risk factors with each patient
  - assess motivation for behaviour change in an individual
  - understand how to support and encourage behaviour change, applying appropriate techniques to specific individuals.
  - be able to support the patient to plan specific goals using the behaviour change contract

Health educator guide

Part 1: Adherence strategies

If you have already completed module 6 on adherence strategies, take time to familiarise yourself with the role of the health educator.

> Refer to the health educator desk guide - *pages 5-7*
> and education leaflet – *page 20*

Take time to read through these pages.

Patient adherence to medication and clinic appointments is essential if their condition is to be managed effectively. It is advised that all patients have a treatment supporter, a friend or family member, who will remind them to take their tablets and who will attend all appointments with the health worker and health educator. If patients do not attend appointments or do not adhere to treatment, it is important that there are clear procedures outlined to follow-up these individuals.

You need to communicate to each patient the importance of adherence and treatment support, allow the patient to ask questions and to discuss any concerns they may have relating to attending appointments, adhering to medication or involving another individual as their treatment supporter.

The patient may already have a treatment supporter and have signed their treatment contract, so it is important to check their treatment card see if the details are noted down and the contract is signed. If this has not been completed, you should sign the contract and fill in the contact details of the treatment supporter.

You will need to explain the role of a treatment supporter using the health educator desk guide and help the patient to identify someone appropriate. Once a patient has chosen a treatment supporter, it is expected that they will attend all appointments with the individual. When the treatment supporter first attends, it is important that you discuss with them their role and responsibility, in order that there is a shared understanding by you, the patient and the treatment supporter.

Practice using the information in the health educator desk guide to inform the patient and help them to choose a treatment supporter as guided by the role plays below.

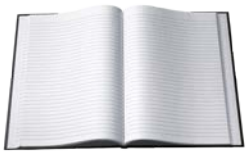
Role play 1

The health educator desk guide clearly outlines different procedures for follow-up if a patient does not attend a clinic appointment.

Read through the section on *page 8* on appointment reminders.

If an individual is not adhering to treatment or has stopped medication, it is important that you do not criticise. Try to encourage the patient and discuss with them any concerns or difficulties. They may be experiencing side effects, or finding the long term nature of their condition discouraging.

Using the guidelines outlined in the health educator desk guide and the role plays below, practice the procedures for patients who do not attend an appointment or adhere to treatment and how you would communicate with them.



Practical exercise A

Hadija was due to attend an appointment with the health educator today to discuss her progress with increasing her daily physical activity, but she has not arrived. In the last couple of times she's attended, she has been difficult to engage in discussions and less interested in changing her lifestyle.

- Discuss how you will contact her and what your next steps would be.

You managed to make contact with *Hadija* and she tells you that she was unable to come because two of her children were unwell. You make a further appointment with her, but she also fails to attend.

- Discuss what else you could do.

Part 2: Lifestyle assessment

Refer to the health educator desk guide *pages 9 - 11*
and education leaflet – *page 20*

A healthy lifestyle is very important in the prevention of hypertension, diabetes and CVD, as discussed in module 5. The health educator guide focuses on four key lifestyle risk factors; smoking, alcohol, poor diet and physical inactivity. The patient will have heard some of the key messages from the health worker during their routine appointment, however this will not necessarily lead to changes in their lifestyle. It is your responsibility to help the patient to change, but remember, it is not your responsibility to change the patient.

At the start of the appointment, you should check that the patient has a copy of the education leaflet. If they do not have one, give them a copy. You should use the education leaflet throughout the appointment, so that the patient is aware of what is included in the leaflet and can refer to it at home.

It is important to use the W.E.L.L principles for communication and use supportive communication techniques. If you did not read the introduction to the training modules, it is important you read this now.

You need to encourage the patient to talk. Make sure you look at them and listen to what they have to say. Use open questions, don't judge and encourage them to set their own goals.

Read through *pages 9-11* on lifestyle assessment, using the notes below to explain the process.

Step 1: Giving information

At the beginning of the lifestyle assessment, described on *page 9,* you need to establish what the patient already knows about their condition and their lifestyle. For example, the patient may already be aware that increasing their daily activity will help prevent complications of diabetes or hypertension or they may not know that there is any link between the two. At this stage, try not to give any detailed information, but follow the steps on *page 9.*

It is important to find out what the patient eats on a daily basis, how much alcohol they drink, if they smoke and how much physical activity they do regularly. Some of this information you should know as it may be recorded on their treatment card. Make sure you check this before asking the patient for this information.

It will be too overwhelming if a patient is asked to address their level of physical activity, what they eat, the amount they drink/smoke all at once, so you should look at one of the behaviours at a time. The patient should choose which behaviour they would like to try and change. If they choose a behaviour, they are more likely to make the changes necessary.

It may be that the patient does not yet understand the link between their condition and their lifestyle, or simply that they are not willing to change. If this is the case, ask them what would happen if they don't change their behaviour. If they do not know, use the education leaflet to explain some of the risks. If they are still not willing to change, make sure the patient has a leaflet and ask the patient to return on their next appointment at the facility.

Step 2: Supporting motivation to change

Most patients will identify one behaviour. *Refer to page 10.*

The next step is to ask some questions to work out if changing their behaviour is important to them.

If it is not important to them, it is important that you repeat the key messages for thebehaviour they have mentioned, which are clearly marked at the top of *pages 12 - 18* and are also included on the education leaflet on *page 20.*

If it is important, they are more likely to make the necessary changes.

Some patients may really want to change, but not have the confidence to make the changes that are necessary. It is important to ask whether they feel they are able to change the behaviour they have identified.

Use the 'make a plan' section on the lifestyle page for the behaviour the patient has identified. Focus only on this one. *See pages 12 - 18*. Help the patient complete a behaviour change contract and set some specific goals. . Encourage your patient to include their treatment supporter, families and friends in the changes they are making; this will make it easier for them

If the patient is not confident in changing their behaviour it is even more important to be encouraging, help them to overcome any barriers they may have to change and ensure the support of their treatment supporter, families and friends. When arranging a follow-up appointment, it may be suitable to see these patients more often

At all times, encourage the patient to talk, and make sure you look at and listen to the patient. Encourage and reward small steps towards achieving goals, no matter how small they seem, they are probably a big step for your patient. Remember to always use supportive communication as described in the introduction.

Consider setting up a patient support group for patients to meet and share positive stories and discuss barriers to change. It is important this is facilitated by someone who can provide encouragement and motivation.

Step 3: Maintaining new behaviours (*see page 11)*

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

Patients that successfully change behaviours should be invited to become role models or treatment supporters for those at the beginning of the change process.

Complete role plays 1-4 for this module.