

Cardiovascular **RISK ASSESSMENT**



PHO Performance Programme

New indicators announced

DHBNZ has announced the new performance indicators for the PHO performance management programme. Implementation of indicators is from 1 July 2008, with measurement of targets to begin on the 1 January 2009. These indicators have been developed in consultation with an expert advisory group and the PHO performance programme governance group.

The programme indicators are confirmed as:

- Breast cancer screening coverage
- Cervical cancer screening coverage
- Ischaemic cardiovascular disease detection
- Cardiovascular disease risk assessment
- Diabetes detection
- Diabetes follow up after detection
- 65 years + influenza vaccine coverage
- Age appropriate vaccinations for 2 year olds
- GP referred laboratory expenditure
- GP referred pharmaceutical expenditure

The indicators focusing on CVD and diabetes are new indicators for this phase of the programme. In this and future editions of the BPJ we'll be promoting practical strategies to support you in achieving the goals of the programme.

In this issue we begin looking at cardiovascular risk assessment.

The CVD risk assessment indicator focuses on ensuring people at risk of cardiovascular disease have had a CVD risk assessment and will be measured by comparing the number of people eligible against the number of people who have had their CVD risk recorded in the past five years.

Cardiovascular risk factors

- Family history of cardiovascular disease (father or brother CVD < 55 years old, mother or sister <65 years old)
- Family history of diabetes (parent or siblings with diabetes)
- Smoking (current smoker or have stopped smoking in the last 12 months)
- High blood pressure (prior blood pressure > 160/95 mmHg)
- Adverse lipid profile (especially low HDL, high triglycerides)
- Increased BMI and/or central obesity
- Diabetes or family history of diabetes or are at risk of developing diabetes (known impaired glucose tolerance or impaired fasting glucose)
- Polycystic ovary syndrome

Cardiovascular risk assessments – who should be screened?

	Males	Females
Māori, Pacific peoples and people from the Indian subcontinent	Age 35 years	Age 45 years
People with known cardiovascular risk factors or at high risk of developing diabetes	Age 35 years	Age 45 years
Asymptomatic people, without known cardiovascular risk factors	Age 45 years	Age 55 years

Age to begin cardiovascular risk assessment (NZGG, 2003)

GPs experiences of CVD risk assessment

Occasionally bpac^{nz} surveys primary care providers to help inform the development of our various programmes. One such recent survey asked GPs about their experiences undertaking cardiovascular risk assessments. This is of particular relevance to primary care with confirmation that the PHO Performance Programme will include ischaemic CVD detection and CVD risk assessment as performance indicators.

The results of the survey showed that 90% of respondents currently offer CVD risk assessments. While the benefits of CVD risk assessments were widely accepted, the ability to undertake them was often limited by the demands of day-to-day practice. Time and patient priorities were the most commonly cited barriers.

“ I try to! Time is always a barrier, and I sometimes feel that my patients think I am not addressing their presenting concerns when I start talking about CVD if it is unrelated to their presentation. ”

Patient priorities were also seen as a key issue in engaging the so called “hard to reach” patients. Many respondents commented that these patients appeared to lack interest in, or did not prioritise preventative healthcare.

“ Preventative health care is not in the patient’s top ten list of priorities in their lives. ”

This is understandable, because for most people, accessing healthcare is associated with experiencing symptoms, and many of the factors which contribute to cardiovascular risk are “silent”.

There were also a number of comments on the barriers to accessing primary care such as cost and accessibility during working hours. These barriers, along with the fact that practices are always busy, raises the question as to what extent some people are “hard to reach” as opposed to primary care services being difficult for some people to access.

The ability to engage patients in managing their cardiovascular risk was a concern for a number of respondents. Again competing priorities were cited as the most common barrier. This is a problem worldwide and the literature in this area suggests that the most significant contributing factors are a poor understanding by patients of the condition and difficulty in contextualising the risk.

Finally almost three quarters of respondents indicated they would like extra tools and resources to help them undertake CVD risk assessments, communicate risk and engage their patients in managing their risk of cardiovascular disease.

In the following articles we explore what we hope are practical strategies for helping to communicate risk and engage patients. We hope to explore this issue further in the future and so would be interested in your feedback, in particular strategies, tools and interventions you have found work well in daily practice.

What approach to CVD risk screening is best for your practice?

To decide which approach to CVD screening is best for your practice, consider your patient demographics, unmet needs and the resources your practice can make available to meet these needs.

Practices may use one, or a combination, of the following approaches:

Opportunistic assessment

- Initiate risk assessment when someone attends for any reason.
- Consider using a decision support tool.
- Previous (within last 12 months) cholesterol and HDL measurements can be used.
- Non-fasting cholesterol and HDL levels can also be used (e.g. point-of-care testing).
- Consider setting up an alert on your patient management system to remind yourself that the patient is due for an assessment when they next attend for an appointment.

Formal assessment

- Schedule an appointment dedicated to a cardiovascular risk assessment.
- Use fasting blood tests.
- Consider using formal assessment if opportunistic testing or estimates from clinical records show a patient is at high risk of cardiovascular disease.

Estimate of risk from clinical records

- Initial estimate from clinical records with those estimated to be at high risk called in for formal cardiovascular risk assessment.
- Consider using a decision support tool to enter values and calculate risk.

Resources for calculating cardiovascular risk

- Risk tables (found in BNF, NZGG, MIMS etc)
- Decision support tools
- Online calculators e.g.
 - www.riskscore.org.uk
 - www2.everybody.co.nz/Heart/Risk-Calculator/index.htm
 - <http://cvrisk.mvm.ed.ac.uk/calculator/framingham.htm>



Communicating cardiovascular risk

– getting your message across

Key concepts

- The effectiveness with which the results of CVD risk assessment are communicated can have a significant impact on how likely a patient is to make lifestyle changes and accept treatment to reduce their risk.
- Use simple words to explain risk
- Put the risk into context for individual patients - using analogies can be effective
- Visual aids can increase understanding and are a good tool for efficient explanation
- Decide carefully how to frame the risk - risk can be expressed as positive or negative, a loss or a gain
- Check that the patient has understood

Health professionals tell us some patients do not seem interested in knowing their CVD risk and once they do know, they are often not motivated to make changes. Patients, on the other hand, tell us some health professionals suggest substantial changes to their lifestyle for reasons that they do not understand.

Cardiovascular risk assessments are promoted to clinicians and patients as a way of reducing the morbidity and mortality associated with cardiovascular disease. While lifestyle changes and pharmaceuticals can reduce risk, the effectiveness with which the results of the risk assessment are communicated, can have a significant impact on the patient's understanding and motivation to make changes and accept treatment.



communicating

What is the role of risk explanation?

It is useful to consider what we are trying to achieve when explaining cardiovascular risk to a patient. Is it simply an understanding of the probabilities, providing sufficient information to make an informed choice, or is it persuading a patient of the benefits of making lifestyle changes and beginning medication?

Health professionals need to balance the responsibility of assisting the patient to make an informed choice against practical considerations such as the time available for explanations.

A number of factors can impact on a patient's understanding of the concept of cardiovascular risk and the benefits of treatment. These include the use of technical language, low levels of statistical literacy, effects of framing (see over page) and the beliefs and experiences of patients. Understanding these barriers helps health professionals to improve the effectiveness of their risk communication.

What do patients understand by the term “cardiovascular event”?

Although most people will be familiar with the words ‘heart attack’ and ‘stroke’, many people are surprised by the consequences associated with these. Often heart attacks and strokes are associated with death. For many

people this may be considered as a reasonably acceptable manner of dying, so they may not be concerned about their risk of such an event or they may not think they can alter the outcome.

Many people are unaware of the considerable morbidity associated with cardiovascular events; therefore it may be useful to discuss the realities of living with the consequences of a heart attack or stroke, as well as the risk of death.

For example stroke is the leading cause of disability in the New Zealand adult population. Of the approximately 8000 New Zealanders who suffer strokes annually, one-third die within the first year after the stroke. For those that survive there is a 70 per cent chance of long term disability. The degree of disability varies from minor inconvenience, to being fully dependent upon others, for all day to day needs.

The morbidity associated with a non-fatal heart attack is also significant including an increased risk of depression, heart failure, further heart attacks, and financial hardship if the patient is unable to return to work.

Effective strategies for communicating cardiovascular risk

Use simple words

While it is common in medicine to use technical words to ensure accuracy, most people are more likely to understand common words and phrases (e.g. heart) than technical terms (e.g. cardiovascular).

Be cautious with quantitative explanations of risk

Patients often prefer quantitative to qualitative explanations of risk, possibly associating numbers with a greater degree of certainty. However quantitative explanations rely on numeracy skills and if these are limited, statistical estimates of risk are often misinterpreted.

“You have a 15% risk of having a heart attack.” could be interpreted as you will have a heart attack but it will only be a mild one (i.e. a 15% heart attack).

If numeracy is an issue, consider avoiding numbers altogether, and instead present the level of risk in terms of the action required.

“Your risk has reached a level where we need to do something about it.”

Put the risk into context by comparing to familiar events

Simple descriptions of cardiovascular risk such as high and low can be helpful if put into context by comparing the cardiovascular risk to situations or risks with which patients are familiar. Analogies can be used to explain risk in terms of a patient's existing knowledge base. They should be tailored to each patient; the more familiar the

situation described in the analogy the more effective it will be.

“Running across a four lane motorway is much riskier than running over a country road; there's more chance of being hit by a car. Likewise, running your life with lots of risky behaviours (not exercising, eating poorly and being overweight) makes it more likely you will be hit by a heart attack.”

“If you are baking a cake and find you don't have all the ingredients, you can often substitute one and it will turn out okay. But if you start leaving out key ingredients (like eggs and baking powder) the end result probably will not be very nice. Heart health is the same and most of us know the recipe for good health (eat well, don't smoke, exercise). But if we start changing the ingredients to things such as bad eating, smoking and not exercising, we can't expect the recipe to turn out well.”

Whānau concepts may also be useful as a means of explaining the risk. For example, use the concept of a Marae to emphasise what the result of a 15% risk could mean. If the Kaikaranga (caller), the kaikorero (speaker) and ringawera (cooks) had a heart attack, how would this impact on the ability of the Marae to welcome, cook and care for visitors. Would there be others with the skills and experience to take their place?

Use visual aids

Using visual aids can increase understanding and enhance the time efficiency of a consultation. A range of visual aids should be on hand in order to match the patient's circumstances. These could include professionally produced diagrams and charts, interactive online risk tables or simply drawing a diagram for a patient on a piece of paper (your own art work is often highly memorable).

Framing

Framing is the expression of equivalent information in different ways.

Framing can be positive or negative, e.g., a 15% chance of a cardiovascular event (negative framing) or an 85% chance of not having a cardiovascular event (positive framing). Clearly negative framing is more likely to encourage patients to take up an intervention and patients may use positive framing to justify inaction.

Framing can also be expressed in terms of loss or gain and this approach may be more relevant to communicating

clinical risks. Loss framing considers the potential losses, from not undertaking an intervention such as loss of health, longevity, and relationships. Gain framing considers the gains from undertaking an intervention such as maintenance or improvement of health

In a similar manner to framing, risk can be presented as either absolute or relative risk; e.g., if an intervention reduces risk from 10% to 5%, this can be represented as 5% decrease (absolute risk) or a 50% decrease (relative risk). Clearly patients are more impressed by the relative risk decrease however this presentation does raise concerns with respect to informed consent.

Box 1: Making risk communication more effective

Cite basic risk data in general terms

Add estimated probabilities for positive and negative outcomes to descriptive terms such as “low risk”

Reinforce effectiveness of your explanations by using visual aids to help show risks in perspective

Express encouragement and hope. Reassure patient by detailing all the help that is available.

Increasingly
effective risk
communication
and deepening
doctor-patient
relationship

Paling J. Strategies to help patients understand risks. BMJ 2003;327:745-48.

Check what the patient has understood

Asking if the patient understands or has any questions will not differentiate between patients with a good understanding and those with such a poor understanding they do not know what to ask. The best approach is direct questioning such as “When your partner asks what I said, what will you say?”

Reinforce your explanation with written material to take away. This not only provides the patient with a reference but also provides a useful tool for them to use when discussing the risk assessment with family.



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Motivational interviewing

Motivational interviewing includes a range of techniques to help people make changes in their behaviour. It has been shown to be effective in the primary care setting with smoking cessation, hazardous drinking, physical activity, nutrition and chronic disease. This article provides an overview of motivational interviewing. Recommendations for further reading can be found at the end of the article.

Motivational interviewing is based on the presumption that our behaviours are a product of our thoughts (what I know) and our feelings (what I believe). For instance, knowing that something is bad for their health does not necessarily cause a person to change their behaviour. For example, only 50% of smokers quit smoking after an myocardial infarction. To change health behaviour we need to change feelings too.

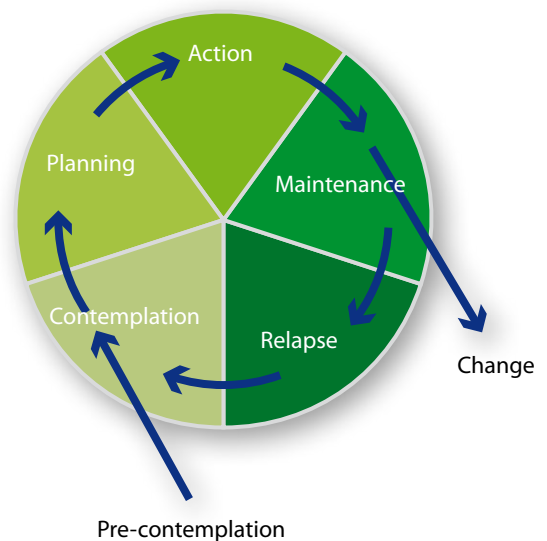
Cycle of Change

Motivational interviewing helps people become motivated to change, moving through a cycle of change from belief that a change is needed through to a belief in their ability to make change and stick to it.¹

The components of the cycle of change are:

- Pre-contemplation: before thinking about change (Problem. What problem?)
- Contemplation: favourably disposed to change but have not made concrete plans (I'd like to, but...)

- Planning: strategies selected but not yet used (I have decided what to do.)
- Action: e.g. attempts made to stop smoking, lose weight, (I'm making changes.)
- Maintenance: sticking to it



Individuals can lapse at any stage and it is unusual to achieve permanent change in an ingrained behaviour at the first attempt. Most people rotate through this cycle many times.

Motivational interviewing strategies

Motivational interviewing is about helping the patient make the decisions. It involves systematically directing the patient towards motivation to change through empathic

reflection, appropriate feedback and advice. The aim is to increase the patients own internal conflict around the health related behaviour and their wish to change: “I want to” versus “I don’t want to”.

Patients become motivated to change if they can see the benefits of change and that the costs of remaining the same are high.

Empathic reflection

Motivational interviewing avoids confrontation and making judgements which tend to increase resistance to change. It accepts that patients have their own reasons for choosing their behaviours and that there are costs and benefits which can be highlighted to the patient. Its starts with listening and expressing understanding, acceptance and interest.

Appropriate feedback and increasing internal conflict

Motivational interviewing lets the patient decide how much of a problem they have by selectively reinforcing the patients own self motivational statements around problem recognition e.g. “I notice that you say everything is fine with your drinking but that you say that it causes problems” and reinforcing the patients intention to change, “It seems that you would like to try and change.” The aim is to highlight the patient’s own conflict between their statements. It is often helpful to let the patient make the connection.

Areas of discrepancy may be helpfully summarised with a decision balance tool. This can be used to explore the patient’s beliefs and motivation to change. Write down the patients likes and dislikes of the behaviour and the good and bad aspects of changing:



Advice and encouragement

Work with the patient to plan small achievable goals by asking, “How can I help you?”

Summary

Throughout the process it is important to continually affirm the patient’s freedom of choice and self-direction. Motivational interviewing is not about “making” people change but about motivating them to do so. We can provide facts, offer advice and encouragement, a listening and empathic ear, and help explore their reasons for changing or not. Motivational interviewing is a tool to use in the right circumstances to help people get closer to making permanent changes. We do not fail if our patients do not make changes now.

Further reading

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Engaging patients in managing cardiovascular risk

Key concepts

- Effective and positive communication helps motivate patients to make lifestyle changes to modify their cardiovascular risk.
- Lifestyle modification is usually best approached by making small changes over time and setting realistic health goals.
- Involve whānau in treatment decisions and lifestyle changes.

Modifying risk factors

Once a patient understands that they have a higher risk of a cardiovascular event occurring, the next step is to engage them in participating in their healthcare and making lifestyle changes to reduce this risk.

Treatment needs to be tailored to the individual taking into account their beliefs and attitude towards modifying their cardiovascular risk.

The guidelines recommend:

- Drug therapy and lifestyle modification initiated simultaneously for people whose CVD risk is greater than 20%
- Lifestyle modification initiated three to six months prior to initiating drug treatment for patients whose CVD risk is 15–20%

However for some patients with less than 20% risk it may be appropriate to initiate drug treatment simultaneously with lifestyle interventions if you consider outcomes will be better, for example if they are unlikely to undertake lifestyle measures or the addition of a prescription is likely to better engage them in addressing their cardiovascular risk.

Agree on realistic patient-centred health goals

It is unrealistic to expect patients to make all lifestyle changes at once. Changes are more likely to occur if each patient prioritises lifestyle changes and sets realistic targets.

All health targets should be **S.M.A.R.T.**²

Specific – a specific target would be: “I’m going to go for a 30-minute walk everyday in my lunch break”, rather than: “I’m going to exercise more”.

Measurable – targets must be able to be measured. The target above of a 30-minute walk every lunch time is able to be measured, it is clear if it has been done or not.

Achievable – do not set unrealistic targets. For example setting a target weight loss of 20 kg in two months is unrealistic and will most likely fail and reduce the patient’s confidence. Setting a lower target such as 500 g a week is more achievable and if exceeded, will increase the patient’s confidence.

Rewarding – targets that are rewarding increase confidence in ability to achieve goals.

Time bound – goals are more likely to be carried out if a specific time to achieve them has been agreed in advance.

All people who smoke should be advised and supported to stop

Smoking increases the risk of coronary, cerebral and peripheral arterial disease.³ This effect is dependent on the lifetime exposure to tobacco smoke i.e. the amount of tobacco smoked daily and the duration of smoking.⁴

The risk of cardiovascular disease declines rapidly after smoking is stopped.

Assess current behaviour: How many cigarettes does the patient smoke? Do they want to stop?

Advise about the benefits of changing behaviour: The latest New Zealand guidelines for smoking cessation suggest advising every patient who smokes, about the benefits of stopping smoking, at least once a year.

Advise that it is never too late to stop and tell patients that the benefits of smoking cessation include:

- Within two days of quitting your ability to smell and taste improves
- Within three months of quitting your circulation improves
- You will save money
- You will set a good example for your children

Agree on patient-centred goals to change behaviour: A first step to engaging patients in reducing or stopping smoking may be to encourage a smoke-free house and car.

Arrange follow-up and support: Make a follow up appointment to ask about current smoking status. Support involves prescribing medicines including nicotine replacement therapy which is now able to be prescribed by all GPs and practice nurses.



All Māori who smoke should be encouraged and supported to stop

Māori are equally as motivated and just as likely as non-Māori to have made a quit attempt in the past year. Māori can be encouraged to quit smoking using nicotine replacement therapy (NRT) and programmes such as Aukati Kai Paipa, a smoking cessation support programme delivered by Māori for Māori that takes a whānau based approach to smoking cessation. The programme reports that quit rates for Maori are significantly better for Aukati Kai Paipa than conventional programmes.

Aukati Kai Papa: www.auahikore.org.nz

Encourage weight loss for those who are overweight

Obesity, particularly abdominal obesity, increases cardiovascular risk.

Weight reduction results in lower blood pressure, lower LDL cholesterol and triglycerides, and higher HDL cholesterol.

An initial goal may be a small change in weight over a set time, achieved by introducing changes in diet and physical activity.

A healthy diet is good for the heart and can modify other risk factors. A diet rich in fruit and vegetables and low in saturated fat is beneficial for preventing and managing cardiovascular disease.

Key targets for dietary modification

- Limit dietary intake of fat, particularly saturated fat
- Replace saturated fats with unsaturated fats
- Increase the intake of fresh fruit and vegetables to at least five portions a day

- Regularly eat fish (at least two servings per week)
- Limit intake of salt
- Limit alcohol to less than 21 units per week for men or less than 14 units per week for women

Dietary changes, while recommended for an individual, often need to be adopted by a whole whānau in order for change to take place, therefore expectations of this change need to be realistic and culturally acceptable.

Approach dietary modification in a step wise manner; a recommended approach is:

Assess current behaviour: what does the patient currently eat? For example, find out the components of a patient's diet that may be contributing the most fat.

Advise about the benefits of changing behaviour: Advise patients about the key targets for dietary modification listed above but provide some suggestions. Encourage any healthy suggestions the patient makes for changing their diet.

Agree on patient centred goals to change behaviour. Initial goals may be to replace some foods with healthier alternatives. For example:

- Replace white bread with grain bread
- Replace butter with margarine
- Replace fruit juices or soft drinks with water, or low fat milk
- Replace full fat milk ('blue top milk') with lower fat milk ('light blue' or 'green' top milk)

Or provide some food cooking and preparation tips:

- Cut fat off meat
- Grill instead of frying

Arrange follow-up and support. Make a follow up appointment to assess changes in diet. Provide simple written material to reinforce messages when a patient gets home. Material that is personalised can be shared with whānau.

Encourage an increase in physical activity

A sedentary lifestyle is associated with an increased risk of cardiovascular disease.³ Being physically active can also modify other risk factors, for example, reduce weight, lower blood pressure and increase the level of protective HDL cholesterol.

Provide advice about physical activity that is patient centred, achievable and measurable; a recommended approach is:

Assess current behaviour: Ask about current levels of activity including activities that the patient may not associate with exercise. For example, ask about method of getting to work or time each week spent gardening or gathering kaimoana (seafood).

Advise about the benefits of changing behaviour: Advise patients that physical activity can be accumulated throughout the day. Three ten minute bouts of exercise per day are equivalent to one 30 minute session. Activities that can be incorporated into everyday life, such as brisk walking, using stairs and cycling, are recommended as people may be more likely to participate in these activities.

Agree on patient-centred goals to change behaviour: An initial goal may be a small but agreed and measurable increase in exercise, for example these activities may be done at least three times per week:

- Walk to school or shops
- Get off the bus one stop earlier than usual
- Use the stairs instead of the lift
- Park a block away from work and walk

Group activities may encourage some people to engage in physical activity because the social aspect can be enjoyable.

Arrange follow-up and support: Set measurable goals that can be evaluated at follow-up.



Consider issuing a Green Prescription or referring patients to a local sports trust.

Te Hotu Manawa Māori provides Māori specific resources for lifestyle intervention www.tehotumanawa.org.nz

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Engaging Māori

In general, Māori like other indigenous cultures, place great emphasis on the spoken word and eloquence is traditionally valued. Be careful when using medical jargon (e.g. myocardial infarction for heart attack) and ordinary words that have a specialised meaning in a medical context (e.g. 'the patient is complaining of a headache' can be taken by the patient to mean the GP does not believe them).

Māori are less likely to question a GP so it is important to check on their understanding in different ways. Open questions and the involvement of whānau can assist with this. Everyone, regardless of background has a preference for receiving information in a particular way. Information may need to be delivered in a number of ways to check that the patient has understood what is being communicated.

When discussing cardiovascular risk and the actions that can be taken to reduce the risk, it may be appropriate to include other whānau members. Rather than just educating the patient there are benefits in investing time in educating all members of the whānau. Any actions or changes will be most successful if they are understood and adopted by the entire whānau.

Although these education sessions may take a bit longer than the average consultation it can be an excellent investment of time and energy. Not only may the patients CVD risk be lowered, but other whānau members can similarly benefit.

Best health outcomes for Māori: Practice Implications. Available from:

www.mcnz.org.nz – look under "Publications"

Patients understanding of cholesterol

GPs regularly discuss healthy diets with their patients and perform blood tests to determine “cholesterol” levels. However a recent study raises questions about how much people actually understand about cholesterol and its effect on health.

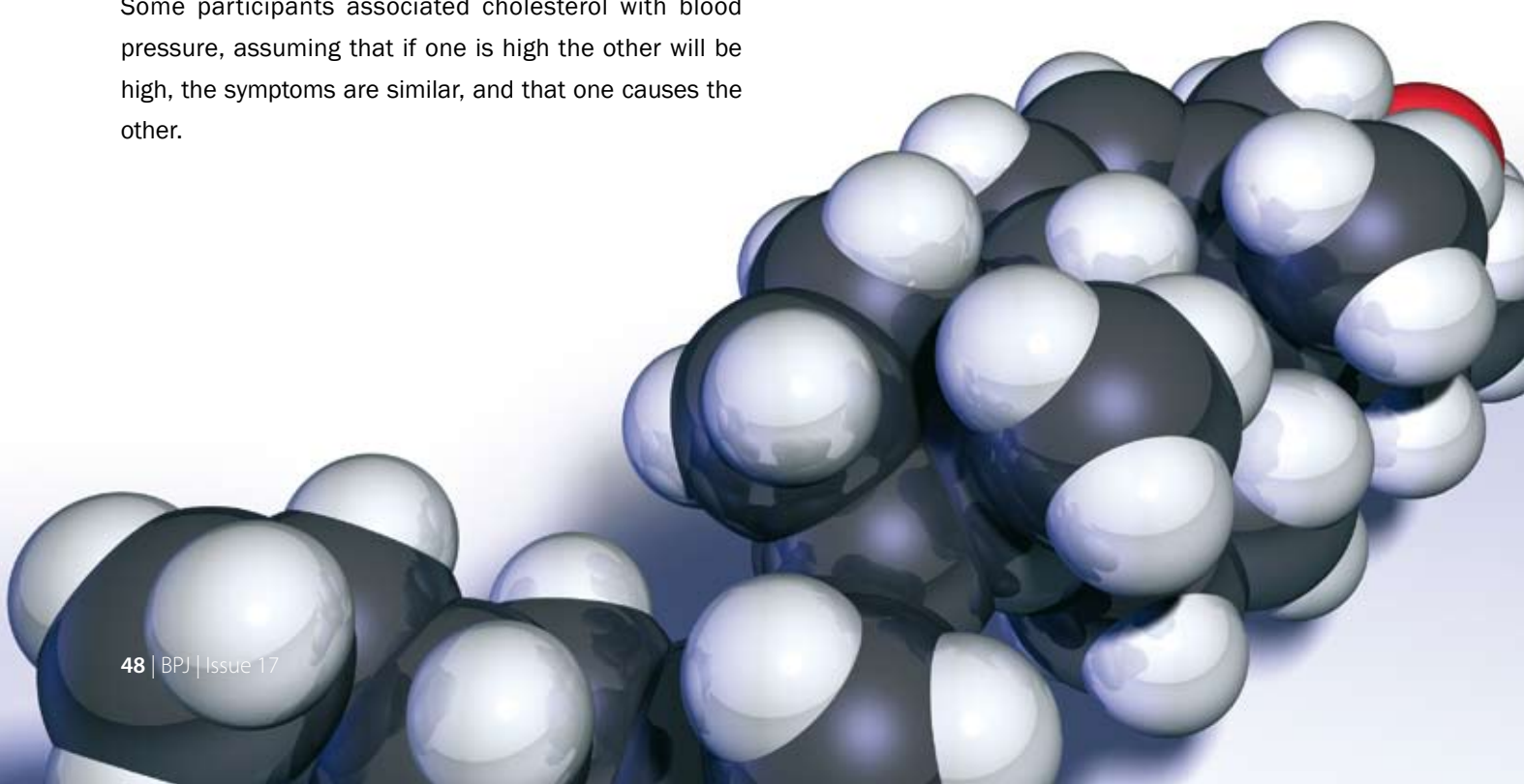
In a series of focus group meetings,¹ people were asked about their knowledge of cholesterol. Overall, participants assumed that:

- Doctors test cholesterol as part of having a blood test
- High cholesterol levels have an adverse effect on health
- High cholesterol was a newly discovered health problem
- Doctors had only recently become concerned about cholesterol

Some participants associated cholesterol with blood pressure, assuming that if one is high the other will be high, the symptoms are similar, and that one causes the other.

Many believed high cholesterol levels were caused by being overweight but they were frustrated by shifting health messages regarding diet and were reluctant to believe dietary recommendations. Many participants told stories about a sibling or friend who eats “whatever they want” and has a normal cholesterol, whereas others who eat a healthy diet have high cholesterol values. Nevertheless, despite prevailing doubts about the accuracy of dietary recommendations, most participants acknowledged some association of diet with high cholesterol levels.

Few participants were familiar with the terms “HDL” (high-density lipoprotein) and “LDL” (low-density lipoprotein), though many had heard of “good” and “bad” cholesterol. Some understood that one type should be high and the other low. This resulted in general confusion about cholesterol being both good and bad, with goals for high and low numbers.





How understanding affects perception of CVD risk

A common theme identified from the focus groups was inadequate knowledge and awareness about cholesterol and its association with CVD risk. Participants said that cholesterol numbers were not an effective way to understand their CVD risk. They expressed surprise that they knew so little about cholesterol.

Most viewed high cholesterol levels as less serious than high blood pressure because they thought that cholesterol can be managed while blood pressure cannot, blood pressure leads more directly to a heart attack, they have known about high blood pressure for longer, and they continue to hear more from physicians about blood pressure. Patients had much less understanding of cholesterol compared to blood pressure. Some prioritised taking blood pressure medication over cholesterol-lowering medication.

Giving patients more medical information may be confusing. There is a current trend towards increasingly

complex explanations (that include total, HDL, LDL, triglycerides, and ratios) which may not lead to optimal understanding of cholesterol.

GP comment

"It can be confusing trying to explain cholesterol. I find using terms such as 'good' and 'bad' cholesterol is helpful and yet I know when I am talking to them I am losing them. It is also confusing to try to explain to patients where cholesterol comes from and that it is not all from their diet."

"I often find patients are not too concerned about the actual numbers, but just want to know what they can do."

Reference

Goldman RE, Parker DR, Eaton CB, et al. Patients' Perceptions of Cholesterol, Cardiovascular Disease Risk, and Risk Communication Strategies. *Ann Fam Med* 2006;4:205-212