



Summary of key points

Module Three: Managing Care Plans with disease-specific Elements

Section 1 - Diabetes

Best practice guidelines:

- Clinical guidelines point you in the right direction but most are written for a single disease
- Moreover, the best evidence comes from randomised controlled trials that exclude older adults with multiple chronic conditions
- Best practice guidelines are regularly updated so you should always check you have the latest version. Best practice guidelines can be found at:
 - [Diabetes Australia](#)
 - [Royal Australian College of General Practitioners](#).

The **role of the CVC care coordinator will vary**, depending on whether the care coordinator is based in general practice or in a community nursing setting. Where the care coordinator is a:

- practice nurse or Aboriginal health worker, that person will be involved in undertaking the needs assessment and will contribute to the development of a comprehensive Care Plan and patient friendly version of the Care Plan.
- community nurse from a DVA-contracted community nursing provider, the GP will complete the needs assessment and Care Plan and will forward a copy of the Care Plan and referral to the community nursing provider. Coordination of care, monitoring of veterans' health, coaching and provision of regular feedback to GPs are core responsibilities of the care coordinator, irrespective of the practice setting.

The **roles and responsibilities of general practice and community nurses** are described in more detail in the [Coordinated Veterans' Care Program A Guide for General Practice](#)

Diabetes education is a lifelong goal so it is important that the care coordinator recognises that the veteran may not understand all of the aspects of the disease and how to manage the condition. Reflective listening is an important skill to use in supporting the veteran.

The care coordinator needs to be up to date with best practice in diabetes management as he or she may have an important role in coaching the veteran to initiate and maintain lifestyle changes that will slow the progression of the disease and optimise quality of life.

There are **minimum requirements for Care Plans for CVC participants**. These are outlined in the [Coordinated Veterans' Care Program A Guide for General Practice](#)

There are specific criteria for Care Plans for CVC participants and the GP must finalise the Care Plan. Both the comprehensive and patient friendly version of the Care Plan must include information about 'red flags', or symptoms that indicate the need for medical review. For a patient with diabetes who is prescribed a sulphonylurea, recognition and prompt management of hypoglycaemia may help to avoid hospitalisation. An action plan may assist patients to recognise and respond appropriately to signs of deterioration in their condition. These plans can be developed from information on the [Diabetes Australia](#) website.

Lifestyle interventions appropriate for diabetes include diet and nutrition, exercise, alcohol intake and psychosocial programs. Consideration should be given to psychosocial intervention, as a cross-sectional study of veterans with diabetes and aged over 65 years found that 25% had comorbid depression, as defined by anti-depressant use ([Caughey et al 2010](#)).

Section 2 - Congestive heart failure

- Heart failure is a disabling condition that requires complex management and treatment protocols
- Heart failure is often accompanied by important comorbid conditions that require specific intervention
- The typical trajectory of heart failure is cyclical (with around one-third of patients hospitalised each year) and progressive
- Many patients fail to recognise the serious nature of heart failure
- Patients can limit worsening of symptoms if they understand the basic principles of heart failure management and learn to monitor daily the symptoms and signs of deterioration
- Fluid management is an important part of heart failure symptom monitoring and control
- Self-management can lead to better health outcomes for heart failure patients
- Lifestyle, medical issues and psychosocial issues should all be discussed with patients
- Regular physical activity tailored to the individual is now strongly recommended for patients with heart failure. Clinically stable patients should be encouraged to keep as active as possible.

Section 3 – Pneumonia

- Veterans living in the community may have many risk factors which predispose them to the type of pneumonia known as CAP
- Pneumonia presentation in an older veteran can be quite atypical when compared to their younger counterpart
- Early symptom recognition by the veteran, carer and GP is the first step to successful CAP treatment
- In veterans predisposed to pneumonia, it is important for their Care Plan to contain details on how it's best prevented and treated in accordance with the veteran's preferences.

Section 4 – Coronary artery disease

Best practice guidelines are regularly updated and summarise current thinking about new technologies and established practices. Organisations such as the Heart Foundation have resources for health professionals and patients.

Current terminology for coronary artery disease (CAD). Patients with symptoms of myocardial ischaemia are classified as having stable angina or acute coronary syndromes (ACS). Stable angina represents coronary artery obstruction arising from a stable atherosclerotic plaque. A diagnosis of ACS signifies an accelerated pattern of symptoms where plaque rupture is then complicated by thrombus formation and vasospasm, which may ultimately lead to myocardial infarction ([Veterans' MATES 2010](#)).

Warning signs of acute coronary syndromes (ACS). Chest discomfort at rest or for a prolonged period (more than 10 minutes, not relieved by sublingual nitrates), recurrent chest discomfort, or discomfort associated with syncope or acute heart failure are considered medical emergencies. Other presentations of ACS may include back, neck, arm or epigastric pain, chest tightness, dyspnoea,

diaphoresis, nausea and vomiting. Very atypical pain, including sharp and pleuritic pain, is more common in women, people with diabetes and older people (Aroney et al. 2006) .

Relationship between coronary artery disease and heart failure. The most important risk factors for heart failure are coronary artery disease (CAD) and high blood pressure. CAD and prior myocardial infarction account for approximately two-thirds of systolic heart failure cases and hypertension is present in about two-thirds of new cases (NHFA & CSANZ 2011). The co-occurrence of multiple diseases in an individual can make the diagnosis of separate diseases, such as heart failure, more difficult.

Mental health issues. A 2005 study found that Korean War veterans were five or six times more likely to have post-traumatic stress disorder (PTSD), anxiety or depression compared with a group of similarly aged Australian men who did not serve in that conflict. Up to 33% of Korean War veterans met criteria for PTSD, 31% met criteria for anxiety and 24% met criteria for depression (Sim et al. 2005).

Coronary artery disease, depression and anxiety frequently coexist and all patients with CAD should be assessed for depression and treated if indicated. Cognitive-behavioural therapy has been shown to be efficacious in the management of depression (NHFA & CSANZ 2007).

Antidepressants. The SSRI class of antidepressants has been shown to be safe and efficacious in the management of depression with comorbid CAD. However caution is required for veterans who are prescribed warfarin as there can be a potential SSRI drug interaction with warfarin. These are all issues that Dr Geoff will consider when he has his consultation with David.

VVCS – Veterans and Veterans Families Counselling Service provides counselling and group programs to Australian veterans, peacekeepers and their families. It is a specialised, free and confidential Australia-wide service.

Section 5 – Chronic obstructive pulmonary disease

Best practice guidelines are regularly updated and summarise current thinking about new technologies and established practices. Organisations such as The [Australian Lung Foundation](#) have resources for health professionals and patients.

Exacerbations of COPD cause:

- accelerated deterioration in lung function
- increased morbidity and progressive loss of independence
- increased mortality rates
- hospitalisation.

Annual influenza vaccination reduces by about 50% the development of severe respiratory complications and hospitalisation or death from both respiratory disease and all causes. Pneumococcal vaccination is also recommended for patients with COPD (McKenzie et al. 2010).

Inhaled bronchodilators provide symptom relief and may increase exercise capacity ([McKenzie et al. 2010](#)).

Veterans need to be provided with the **knowledge and skills to use their inhaler devices safely** and effectively. It is estimated that up to 70% of patients have poor inhaler technique. The veteran community is particularly vulnerable to problems with medicines, as many older veterans have poor eyesight, tremor, and coordination difficulties. A yearly Home Medicines Review (HMR) presents an opportunity to critically assess inhaler technique and to work with the veteran or carer to teach appropriate inhaler technique when required. This should be supplemented by additional review at each medical and pharmacist consultation and at the time of any acute exacerbation or evidence of disease destabilisation. HMRs are an effective means of educating veterans in the use of their respiratory medicine devices and should be considered for all patients ([Veterans' MATES 2006](#)).

HMRs can be requested more frequently than every 12 months if there is a medical need, for example, post hospitalisation or when a new condition is diagnosed.

Antibiotics and glucocorticoids. Current guidelines do not support long-term antibiotic use to prevent exacerbations in patients with COPD (McKenzie et al. 2010 p49). The COPD-X guidelines state: Exacerbations with clinical signs of infection (increased volume and change in colour of sputum and/or fever, leukocytosis) benefit from antibiotic therapy [evidence level II] (McKenzie et al. 2010 p63). Inhaled glucocorticoids should be considered in patients with moderate to severe COPD and frequent exacerbations [evidence level 1] (McKenzie et al. 2010 p31). Long term use of systemic glucocorticoids is not recommended and caution is warranted in older patients due to potential toxicity [evidence level 1] (McKenzie et al. 2010 p30).

Smoking cessation or a significant decrease in smoking does not lead to recovery of lung function; however, it does cause the accelerated annual rate of decline in forced expiratory volume in one second (FEV1) to revert toward that of a non-smoking subject, and it reduces mortality (McKenzie et al. 2010 p16). Smoking cessation is the most successful intervention for slowing the progression of COPD.

Mental health issues. People with COPD are vulnerable to developing symptoms of anxiety and depression which then worsen quality of life and disability (McKenzie et al. 2010 p34). The prevalence of panic disorder in patients with COPD is up to 10 times greater than the overall population prevalence of 1.5-3.5% ([Livermore et al. 2010](#)). There is promising evidence that cognitive behaviour therapy (CBT) can treat anxiety and depressive symptoms in COPD and prevent the development of panic attacks and panic disorders. Some pharmacological treatments for anxiety and mood disorders may cause respiratory depression or have inherent risks for older patients including dependence, cognitive impairment and falls (McKenzie et al. 2010).

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Optimising patient outcomes. Pulmonary rehabilitation reduces dyspnoea, fatigue, anxiety and depression, improves exercise capacity, emotional function and health-related quality of life and enhances patients' sense of control over their condition. Pulmonary rehabilitation reduces hospitalisation and has been shown to be cost-effective (McKenzie et al. 2010).