

## Communicating cardiovascular risk effectively

Patients and health professionals often think differently about cardiovascular risk and may arrive at different conclusions regarding cardiovascular health. Following a cardiovascular risk assessment, information should be presented and discussed in ways that patients understand, and a shared decision-making approach taken to formulate a management plan. This engages patients in their own health and makes it more likely that they will adhere to the agreed treatment regimen and be satisfied with their care.

**Cardiovascular tools are a prompt for discussions about cardiovascular risk.** The New Zealand Heart Foundation has provided two online tools, one for health professionals and one for the general public (see: [www.heartfoundation.org.nz](http://www.heartfoundation.org.nz)). Both tools are designed to communicate, rather than calculate, cardiovascular risk.

**Present risks as frequency statements, rather than single event probabilities.** For example, if the patient has a five-year cardiovascular risk of 15%, this can be explained as 15 out of 100 patients like them will experience a cardiovascular event over the next five years. Avoid descriptive terms, e.g. high-risk, which may have different meanings for different people and provide examples with a consistent denominator where possible.

**Present information in the form of absolute risk to increase patient understanding,** although this may mean that patients are less likely to take action to reduce their risk. Presenting the benefits of an intervention in terms of relative risk reduction may be more motivating for patients, but increases the risk of misinterpretation.

**Balance the framing of the benefits of interventions,** e.g. "If you give up smoking you could live an extra five years and be much less likely to be disabled by a stroke." Framing the benefits of an intervention as both short-term and long-term also broadens the appeal of the message.

**Lifestyle interventions can be presented as an alternative to medicines,** e.g. "If you lost a few kilograms by September I don't think there would be a need for you to start taking pills for hypertension." This approach can motivate patients who may view beginning long-term treatment as a negative milestone in their life.

**Present information graphically to patients to overcome denominator neglect.** This occurs when people pay more

attention to the number of times an event happens and less attention to the number of opportunities it had to happen.

**Cardiovascular interventions should improve aspects of life that are important to the patient.** Asking patients "what makes you smile?" is a good way to find out what they enjoy. Use this answer as a focus for interventions.

**When discussing options, the status quo, i.e. no change, is also a possibility.** This fits well with the process of informed consent and may strengthen the relationship with the patient, enabling the health professional to help the patient make healthier decisions about their life at a later date.

Do not overwhelm patients with information. Ask the patient what they will tell their family/whānau as a simple way to check what message the patient is taking away from the consultation.

### Peer group discussion points:

1. In your experience, how well do patients understand their calculated CVD risk?
2. What methods do you use to explain CVD risk?
3. What are some of the more challenging concepts for patients to understand? What are some of the most common misconceptions?
4. What are the factors that you find most useful to motivate patients to make lifestyle changes?
5. Do you find the current New Zealand recommendations for CVD targets realistic and achievable for patients? E.g. lipid levels, blood pressure levels

