Center for Diabetes - Kbh

Intervention catalogue

Diabetes and cardiac rehabilitation in the City of Copenhagen

September 2020

Preface

The purpose of the intervention catalogue
This catalogue contains a description of all interventions aimed at citizens in Copenhagen with type 2 diabetes and/or heart disease, who have been referred to a rehabilitation programme at the Centre for Diabetes. The catalogue serves as a joint professional reference document for all staff working at the Centre. The catalogue serves as an introduction for new staff members and may be shared with external partners requesting information from Centre for Diabetes.

What does the intervention catalogue feature?
The descriptions in the intervention catalogue encompass all the rehabilitation activities in the Centre for Diabetes; that is on-going interventions, new interventions that are being tested and activities in connection with development and research projects.

The rehabilitation programme is based on the disease management programmes for type 2 diabetes[i] and heart disease[ii] and the technical guidelines of the Danish Board of Health[iii];[iv];[v]. The health pedagogical framework is based on the work by Bjarne Bruun Jensen.[vi]

The first part of the intervention catalogue contains a general description of the person-centred approach in the Centre for Diabetes, our principles, and the health pedagogical foundation.

The second part of the intervention catalogue contains a description of each intervention that the citizens may be offered as part of their rehabilitation programme at the Centre for Diabetes, which is provided at Vesterbrogade or in the outreach unit in Tingbjerg. Each intervention is described under the following headers:

- Who can be assigned the intervention?
- The purpose of the intervention
- Objectives
- Method
- The framework of the intervention
- A description of the intervention
- Handling of the intervention
- References

In the appendices, you will find definitions and explanations of the various terms used in the intervention catalogue, detailed descriptions of how interventions at the Centre are conducted (with links for separate scenarios), templates for documentation, and new interventions and references.

Revision of the intervention catalogue
The intervention catalogue is alternated annually in January by the development team at the Centre for Diabetes and the health professionals responsible. The management approves all changes at the Centre for Diabetes.

Description of new interventions
New interventions under development, which are being tested at the Centre, are described in the template (see Appendix 6) and sent to the management at the Centre for Diabetes.

This is a translated version of the document *Indsatskatalog Center for Diabetes 2020* which is available in Danish on our website www.diabetes.kk.dk.

Last updated in September 2020

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1 Rehabilitation at the Centre for Diabetes

1.1 Rehabilitation programmes at the Centre for Diabetes

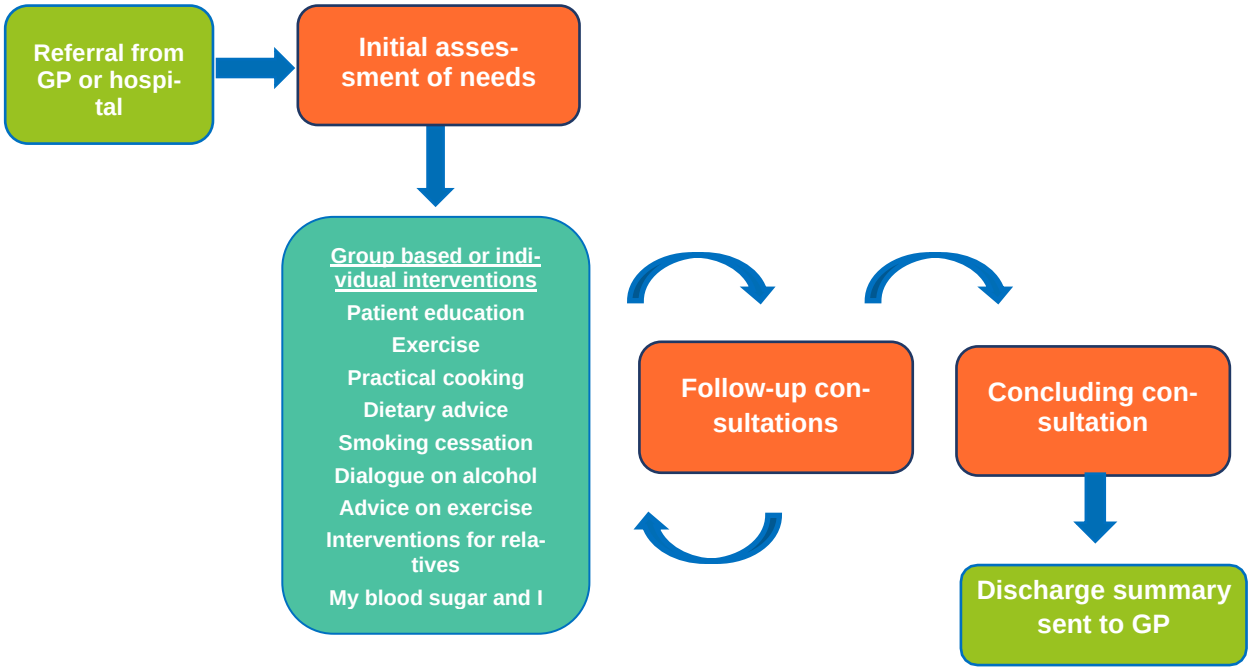
Centre for Diabetes offers rehabilitation programmes to citizens in the City of Copenhagen with type 2 diabetes and/or heart disease who are referred to the Centre by their GP or hospital outpatient department. The Centre offers rehabilitation programmes designed around individual needs; interventions include patient education, physical exercise, nutritional interventions, practical cooking classes, smoking cessation and dialogues about alcohol. For citizens with type 2 diabetes, the programme may include blood sugar measurement and digital guidance. The intervention of patient education will in this document be termed *Live your life with heart disease and type 2 diabetes* respectively. Relatives may participate in parts of the programme if the citizen requests it.

The rehabilitation programme for the citizen is initiated, followed up and concluded with an individual consultation with a contact person, who follows the citizen during the programme (see figure 1). Health care interventions are offered during day and evening times and in different languages, in order to include citizens with different ethnic minority backgrounds. In addition to Danish, languages frequently offered are Arabic, Urdu and Turkish. Interventions may take place with the help of an interpreter. Additionally, the Centre of Diabetes offers interventions separately for both genders.

Purpose

The overall purpose of the rehabilitation programme is to promote self-care skillsself-care skills and enable participants to manage daily life with their disease. Specifically, interventions should strengthen the self-care of participants, empowering them to make healthy choices and facilitate their physical and mental health. (read more in Appendix 1a).

Figure 1: Rehabilitation programmes at Centre for Diabetes



Basic principles for the work at the Centre for Diabetes

At the Centre for Diabetes, we work based on the following principles:

1. **We work with person-centred and differentiated approaches** so that individual needs, motivation, and preferences inform how rehabilitation programmes are designed.
2. **We aim to create lasting changes and embed the new experiences in the everyday life of participants.** We do this by preparing participants to maintain a healthy life following the programme.
3. **We apply evidence-based knowledge and practice** and continuously test new interventions to accommodate the needs of the individual.
4. **We include users** to gain more extensive knowledge about, and an understanding of, their individual needs.
5. **We strive to be a centre of excellence** in the area of rehabilitation for diabetes and heart disease. Our collaborating partners include other sectors in the health care system, patients' associations, civil society organisations and research institutions.

1.2 A learning organisation

At the Centre for Diabetes, it is our ambition to be a learning organisation, which entails a change of culture over time within all the employees. We work at three levels – values, competences, and tools – as shown in the figure below. There is a continuous flow between the three levels, which are all critical for the way we meet our citizens.

Figure 2 The learning organisation[vii]

Values (værdier – green base layer of the model)
Our value foundation is the technical and theoretical point of departure for meeting the needs of the individual. The *person-centred and differentiated approach* entails cooperation between the participant and the health professional, who incorporates the priorities, values, preferences and needs of the individual when planning the rehabilitation programme and interventions. *Self-management* means that we use the citizen's potential and opportunities as our starting point rather than shortcomings and weaknesses. We utilise a *flourishing mindset* and furthermore work based on the model which in Danish is termed "the Double KRAM (HUG)", which comprise a broad working foundation for physical and mental health promotion and prevention (see Appendix 1).[viii]

Competences (kompetencer – blue middle layer of the model)
The competence element is about the health care professional having the right skills to facilitate interventions. *Active listening* may be utilised in communication to promote dialogue-based consultation and teaching. *Patient literacy* focuses on the skills and competences that the health care professionals must possess and use in the meeting with participants, to give them the best possible interventions. Patient literacy also comprises the health professionals meeting the citizens on their linguistic terms, understanding their perspective and wishes. Furthermore, it is crucial to be able to 'juggle' between four health pedagogical roles: the Embracer, the Facilitator, the Translator and the Entrepreneur[ix] (see Appendix 1b). The health care professional must be able to juggle between roles, to inspire, motivate and empower participants to make healthy choices.

Tools (værktøjer – pink top layer of the model)
The work at the Centre for Diabetes takes its starting point in several tools, which may be utilised individually or in groups. At the time of writing, the tools used at the Centre are:

- A national PRO questionnaire is focusing on the critical issues for the individual to talk about and handle. PRO is an abbreviation: *patient reported outcomes*.
- A personal *Aim and Plan tool*, where the participant, together with the contact person, set specific aims for the rehabilitation programme at the Centre (see Appendix 1c).

- The Model for improvement and associated tools and methods, e.g. PDSA and driver diagramme.
- Feedback, where health care professionals train their competences giving and receiving feedback.

All the tools are tested and adjusted on an ongoing basis.

1.3 The health pedagogical framework

The health pedagogical framework creates the foundation for the interventions offered at the Centre for Diabetes, embedded in activities that create learning, change and development for the individual. This entails the concerned target group or citizen developing ideas, making decisions, and acting. To achieve this, we work according to five health pedagogical core terms.

A. Health: positively and broadly defined

WHO defines health as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*. Health is about the positive aspects of daily life, and the things are creating values in the life of a citizen. When working with the term health in its broadest sense, in addition to the absence of illness, we also include quality of life, since we believe that citizens must have the opportunity to live a good life with, and sometimes, despite the chronic disease. This entails citizens gaining knowledge about how to take care of themselves and learning how to handle their thoughts, feelings, and actions, enabling their body and mind to function in the best possible way. Interventions are planned with a focus on the citizens' own experience, feelings and needs rather than a theoretical understand of illness.

B. Self-care skills and action

Self-care skills entail five components, which altogether comprise the degree of the competence to act within an individual: insight, commitment, visions, acting experience and critical sense.

With a health pedagogical starting point, it is possible to increase the self-care skills of the participant by taking a point of departure in the citizen's own experience and allow the citizen to reflect on the consequences of his or her actions. Action and competence to act are not the same things. The participants may be competent to act, but circumstances in their life may prevent the action from happening. Therefore, the health professional together with the citizen may try to open up for "action rooms", e.g. through methods as dialogue, dialogue tools, picture cards etc., so that the individual citizen is supported in finding ways and methods to make the wanted action possible.

C. Participation and dialogue

A citizen experiencing ownership of the interventions he or she participates in is a requisite for lasting changes.

It can take place through participation and dialogue. Participation is not equivalent to the citizen running

the process, but through participation, the collaboration – the dialogue– between the citizen and the health professional is also emphasised. The knowledge, the skills and the professional competency thus have a pivotal and crucial significance. It is the responsibility of the health professional to involve the citizen. That can take place by inviting the citizen to reflect and articulate, set and prioritise aims, gain knowledge, and use his or her senses.

D. Knowledge
The citizen gets the opportunity to obtain knowledge, insight and understanding of his or her disease and living conditions, which have directly or indirectly significance for the development of illness or quality of life. The knowledge and the insight that the citizen receives must be relevant in terms of improving acting competences, initiate and maintain lifestyle changes and build up healthy mental robustness.

E. Setting
Health in a setting perspective revolves around looking at the settings and relations, in which the citizen enters, and how these settings can support the citizen in creating health-promoting changes for himself or herself. In doing so, the rehabilitation intervention becomes holistic and implicates daily life, work-life, and spare time. The interventions being initiated at the Centre for Diabetes must, therefore address the daily life of the citizen.

The five health pedagogical core terms should not be separately understood; they comprise each other's requisites and thus are closely related.

The subsequent chapters contain descriptions of the interventions at Centre for Diabetes. In Chapter 2, one-on-one consultations are described, Chapter 3 revolves around group lessons, in Chapter 4, the physical exercise interventions described, and in Chapter 5, other interventions are dealt with. Comprehensive descriptions of the interventions, including the health professional and theoretical foundation, can be found in the appendices.

2. One-on-one consultations

2.1 Initial assessment of needs

Who can be assigned the intervention?	Citizens in the City of Copenhagen with type 2 diabetes and/or heart disease referred to a rehabilitation programme at the Centre for Diabetes.
The purpose of the intervention	• To clarify personal motivation and challenges in the daily life of the citizen who lives with diabetes and/or heart disease. • That the healthcare professional and the citizen obtain a mutual understanding of expectations, needs and possibilities regarding prevention and rehabilitation offers presented to the citizen. • To plan a programme for the citizen at the Centre for Diabetes based on the wishes, needs and challenges identified from the citizen. The aim of the first consultation is to motivate the citizen to initiate or maintain changes that contributes to a better quality of life for the individual and subsidize to the citizen achieving increased health related competences and their health care skills related to their diabetes and/or heart disease. The ambition is to support a trustful space and relationship, where the citizen has the possibility to tell the healthcare professional about things that matter for the citizen. The healthcare professional will cooperate with the citizen in the planning of a programme and make sure that the citizen's needs, motivation and opportunities are part of the planning.
Objectives	• To create an opportunity for the citizen to describe what the most essential is for the citizen personally and what creates quality in their daily life. • To let the citizen describe their own perception of his or her own (physical and mental) health and readiness to change his or her behaviour. • To be introduced to the relevant offers at the Centre for Diabetes. • To receive support to compile individual goals and focus areas.
Method	The consultation builds upon the health pedagogical framework for rehabilitation interventions described in Chapter 1.4 and the recommendations of the Danish Health Authority for need assessment during the initial consultation.

The framework of the intervention	• The initial needs assessment takes place in an consultation room and takes up to an hour. • Relatives are encouraged to participate if the citizen wants them to. • If needed, an interpreter may be utilised. The interpreter is booked before the consultation through the secretariat. • The healthcare professional, who attends the consultation, will automatically become the contact person of the citizen. • The citizen will be handed date(s) for the start-up of the intervention(s) and a new date for the next consultation (programme dialogue). This also applies
	if the citizen is booked for digital guidance through Liva (see Chapter 6.1). • If needed, an individual consultation with another healthcare professional with another health profession than the contact person, may be booked. • After the consultation, 15 minutes of documentation has been allotted. • Read more about the framework for the intervention in the Procedure description for Centre for Diabetes.
A description of the intervention	The consultation is organised in four parts: 1. Establishment of a trustful relation (contact) 2. Matching of expectations (contract) 3. Uncovering of motivation, readiness, and ambivalence (catalysis) 4. Planning of a realistic plan for the programme (concretise) The consultation is centred around the things, which are most important for the citizen. Information collected through the questionnaire (CURA, PRO) are included in the consultation based on the professional assessment of the healthcare professional. A personal aim and plan is compiled for each citizen. Read more about aim and plan in Appendix 1c. Read more about the method and the approach for the initial assessment of needs in Appendix 2a.
Handling of the intervention	All professions.
References	• Sundhedsstyrelsen. Anbefalinger for behovsvurdering i den afklarende samtale. 2019 • Ammentorp, Bassett, Dinesen og Lau. Den gode patientsamtale. 2016

2.2 Follow-up consultation

Who can be assigned the intervention?	Citizens in the City of Copenhagen with type 2 diabetes and/or heart disease, who have been through a initial consultation.
The purpose of the intervention	• To follow up on how the citizen and the status of his or her programme at the Centre for Diabetes. • To clarify if the interventions in which the citizen has participated have contributed to the aims and agreements that were agreed upon at the initial consultation. • To clarify if new interventions should be offered or changed in the original plan. • To disclose the motivation of the citizen to maintain lifestyle changes.
Objectives	• That the citizen gets the opportunity to reflect on the process of the changes, which were talked about during the initial consultation. • That the citizen gets the opportunity to share minor milestones, good experience, victories, and insights since the initial consultation. • That the citizen gets the opportunity to discuss issues and challenges occurring during the programme; e.g. lack of motivation, lack of progress, and if there are things during the programme at the Centre for Diabetes, which can be changed, and if there is a need for additional interventions. • That the citizen sets up new goals/subsidiary goals and focuses areas if relevant according to the status of Aim and Plan.
Method	The consultation is based on the health pedagogical framework for the rehabilitation interventions described in Chapter 1.4 and on the principles described in the Recommendations of needs assessment by the Danish Health Authority during the initial needs assessment.
The framework of the intervention	• The follow-up consultation takes place in a consultation room and lasts half an hour. • After the consultation, 15 minutes are allotted for documentation. Ideally the follow-up consultation is conducted by the contact person. • Relatives may participate if the citizen wishes. • If needed, an interpreter may be utilised. The interpreter is booked before the consultation through the secretariat. • If needed, further programme consultations may be agreed upon. • Read more about the framework for the intervention in the Procedure description for Centre for Diabetes.

A description of the intervention	• Follow-up on the general well-being of the citizen and how the programme is progressing. • The consultations are, among other things, based on the focus areas from the initial consultation. • The Aim and Plan will be examined to decide if further steps should be initiated, or if the citizen is well on his or her way to achieve his or her goals. • A programme consultation can be changed to a finishing consultation, • if it is assessed that the citizen does not need more interventions at the Centre for Diabetes.
Handling of the intervention	All professions.
References	• Ammentorp, Bassett, Dinesen og Lau. Den gode patientsamtale. 2016 • Sundhedsstyrelsen. Anbefalinger for behovsvurdering i den • afklarende samtale, 2019

2.2 The concluding consultation

Who can be assigned the intervention?	Citizens in the City of Copenhagen with type 2 diabetes and/or a heart disease, who have had a programme at the Centre for Diabetes.
The purpose of the intervention.	• To round off the programme of the citizen at the Centre for Diabetes and assess the total output. • To ensure clarity and aims over the citizen's further programme and daily life, including contact with his or her doctor and other parts of the health service, and participation in possible networks or activities, which can strengthen the maintenance of the new habits.
Objectives	• To reflect on the changes which have occurred during the programme and the plans to maintain the changes in daily life after the programme has finished. • To relate to the fact if the aims and focus areas that the citizen has set in the Aim and Plan have been achieved and what the citizen wants to work on in the future. • To set new aims for maintenance of the achieved changes. • A citizen is well-informed about the opportunities to continue in the network and exercise offers, participate in cafe events in the afternoon, exercise groups, etc. • That the citizen recognises him/herself in the aims and focus areas that the contact person suggests passing on to the citizen's doctor.
Method.	The consultation is based on the health pedagogical framework for the rehabilitation interventions described in Chapter 1.4 and on the principles described in the Recommendations of a needs assessment of by the Danish Health Authority during the initial needs assessment.
The framework of the intervention	• The concluding consultation takes place in an consultation room and lasts up to 45 minutes. • The contact person conducts the consultation. • Fifteen minutes are being allotted for documentation after the consultation. • Relatives may participate if the citizen wants them to. • If needed, an interpreter may be utilised. The interpreter is booked before the consultation through the secretariat. • Read more about the framework for the work in the Procedure description for the Centre for Diabetes

A description of the intervention	• Follow-up on the general well-being of the citizen. • The status for the Aim and Plan of the citizen, including the future focus areas and to uncover the motivation of the citizen, including potential barriers for maintaining the new habits. • Along with the citizen plan for maintaining the new habits and lifestyle changes. • Collection and documentation of the relevant data. • Preparation of Epikrise, which should summarise the citizen's programme at the Centre for Diabetes, incl. Aim and Plan. • Read more in the Procedure description for the Centre for Diabetes.
Handling of the intervention	All professions.
References	• Ammentorp, Bassett, Dinesen og Lau. Den gode patientsamtale, 2016 • Sundhedsstyrelsen. Anbefalinger for behovsvurdering i den afklarende samtale, 2019

2.3 A consultation about diabetes and heart disease

Who can be assigned the intervention?	Citizens in the City of Copenhagen with type 2 diabetes and/or heart disease referred to a rehabilitation programme at the Centre for Diabetes. The intervention is an alternative to the citizens, who are not able to participate in a group-based training programme. The reasons for this may vary, e.g. that the citizen: • Needs to build more mental and social resources, before they optimally can be included in a group association. • Speaks a language of which there are not enough citizens to form a group. • Cannot participate in a group session due to temporal reasons.
The purpose of the intervention.	To strengthen the citizen's ability to cope with the chronic disease in everyday life coping, to support self-care skills to live a good life with his or her disease. By doing so, the citizen will improve his or her opportunities for building physical or mental health and living a life with social and emotional well-being.
Objectives	The consultation takes its point of departure in the needs of the citizen and the nursing professional and may, e.g. include: • To obtain an understanding of the history of the disease and programme and a basic understanding of the things happening in the body when you have type 2 diabetes and/or heart disease. • To obtain an understanding of what the citizen himself or herself about influence and acting possibilities for preventing sequela/other disease and build up mental health. • To obtain an understanding of the fact that disease is developed based on more complex reasons and by doing so, reducing possible feelings of guilt and shame. • To obtain a greater extent of self-care and increased acting competence in terms of living with a chronic disease. • To obtain greater control over the sickness by creating learning and get the tools to handle the disease. Furthermore, see the objectives for patient education described in Chapters 3.1, 3.2, and 3.3.

The framework of the intervention	• By default, the offer lasts 60 minutes for Danish speaking citizens and 75 minutes for non-Danish speaking citizens. This includes the documentation. • A programme typically lasts three times after which the citizen is concluded or booked for other interventions. In case there is a need for further lessons, this can be arranged. • Relatives are welcome to join if the citizen wants it. • If needed, an interpreter may be utilised. The interpreter is booked before the consultation through the secretariat. • Read more in the Procedure description for the Centre for Diabetes.
A description of the intervention	Before the consultation, the health professional talks to the contact person of the citizen about the needs of the person in question. This information must be documented in CURA. After initial the knowledge and learning needs of the citizen, the citizen, and the health professional jointly figure out, which topics should be taught. It may take its point of departure in the modules being offered in the heart and diabetes classes, respectively. See detailed descriptions in Chapters 3.1, 3.2, 3.3. Finally, it is possible to refer to other interventions if needed. This happens in dialogue with the citizens and the contact person.
Handling of the intervention	Nurse.
References	• Sundhedsstyrelsen. Anbefalinger for forebyggelsestilbud til borgere med kronisk sygdom, 2016. • Peter Thybo. Det dobbelte KRAM: Et tværfagligt arbejdsgrundlag for mental sundhed, helbred og trivsel, 2016 • SDCC. I balance med kronisk sygdom - Sundhedspædagogisk værktøjskasse til patientuddannelse, 2012 • SDCC. Guide til sundhedspædagogiske værktøjer - undervis- • ning af sårbare personer med kronisk sygdom, 2015
Method.	The dialogue is based on the health pedagogical framework for the rehabilitation interventions described in Chapter 1.4. • We change between presentations from the instructor and exercises for the citizen based on professional considerations about the content and user involving needs. The consultations make extensive use of the ”Steno-boxes”, several health pedagogical tools developed by Steno Diabetes Centre Copenhagen.

2.4 A consultation about food

Who can be assigned the intervention?	Citizens in the City of Copenhagen with type 2 diabetes and/or heart disease referred to a rehabilitation programme at the Centre for Diabetes. The intervention is an offer for citizens, who have food and meal habits, which may aggravate the citizen's disease and increase the risk of new food-related lifestyle diseases.
The purpose of the intervention.	The purpose of the intervention is to strengthen the self-care and acting competences of the citizen to improve his or her opportunity to create health-promoting lifestyle changes and live a good life with a chronic disease. In individual diet instruction by: • Giving the citizen the understanding of how he or she – through a change in food or health habits – e.g. may obtain an improved lipid profile, blood pressure, and blood sugar regulation. That should contribute to increased acting competence in terms of taking better care of himself or herself and prevent sequelae/other diseases. • To offer support to weight loss if the citizen is overweight (BMI >25). • To guide through nutritional therapy in case of unintended weight loss (>1 kg). • To support the citizen in prioritising and setting goals for his or her interventions concerning food and meal habits. • To obtain an understanding of the fact that disease is developed based on more complex reasons and by doing so, e.g. reducing possible feelings of guilt and shame. • That the citizen is guided according to the guidelines in force within heart disease and diabetes. • To support the citizen maintaining the achieved changes in food and meal habits.
Objectives	• To achieve increased acting competences and self-care regarding food and food habits and potentially achieve better regulation of his or her blood sugar. Cholesterol values and blood pressure and weight loss and weight increase.
Method.	The dialogue is based on the health pedagogical framework for the rehabilitation interventions described in Chapter 1.4. • We change between exercises and presentations from the instructor based on professional considerations about content and user involvement needs.

The framework of the intervention	The intervention typically consists of: • Initial diet guidance lasting up to an hour. • Follow-up consultations planned according to the need of the citizen lasting up to 60 minutes. • Relatives may participate if the citizen wants them to. • An interpreter is utilised if needed. The interpreter is booked before the consultation through the secretariat. • Read more about the framework for the work in the Procedure description for the Centre for Diabetes
A description of the intervention	The first consultation: • The intervention takes its point of departure in information from the reference, the medical chart notes of the contact person, the Aim and Plan of the citizen, and the stated need of the citizen. • During the first consultation, the eating habit and food and meal patterns of the citizen are gone through and together, the nutritionist and the citizen assess, how the meals and the diet is composed in the best way possible based on needs. • Weight and/or waist measurement is measured if the citizen wants it done. • Nutritional screening may be performed, which entails a calculation and assessment of BMI and weight change. • We guide in the diet principles in force for type 2 diabetes and heart disease, respectively, cf. the national food handbook. • The intervention is documented in the professional model NCP (see Appendix 5). • If relevant, the Aim and Plan is composed/adjusted. Follow-up consultation(s): • Agreements, which were made at the previous meeting, are followed up upon and with a basis on the current need of the citizen. • Follow-up in other relevant areas, including whether the citizen can benefit from other diet-related interventions in cooperation with the citizen's contact person. • Potentially weight checks if this is relevant during the programme.
Handling of the intervention	Clinical nutritionist.

References	• Nutrition Care Process (NCP) - proces og model til vejledning i ernæring og diætbehandling • Sundhedsstyrelsen. Anbefalinger for forebyggelsestilbud for borgere med kronisk sygdom, 2016 • Kost & Ernæringsforbundet. Den Nationale Kosthåndbog, 2016

2.5 A consultation about exercise

Who can be assigned the intervention?	Citizens in the City of Copenhagen with type 2 diabetes and/or heart disease referred to a rehabilitation programme at the Centre for Diabetes. • When during the initial consultation, it has been unclear, how the physical exercise can be part of a citizen's every day. There might be various challenges physically and exercise-wise that must be clarified for the citizen at the consultation about exercise. • Citizens who do not want/cannot exercise in classes at the Centre for Diabetes, however, need guidance regarding their exercise. • Citizens, who exercise on their own, but needs inspiration and support to continue exercising. The allocation takes place based on a health professional and health pedagogical assessment made by the individual health professional.
The purpose of the intervention.	• To clarify physical functional capacity with the citizen and how exercise may be integrated into daily life. • To declare which type of exercise the citizen should be allocated at the Centre for Diabetes. • That the citizen reflects on how he or she becomes more physically active and gains a more excellent quality of life. • To motivate the citizen to maintain exercising after an end programme at the Centre for Diabetes.
Objectives	• That the citizen becomes more aware of his or her preferences about exercise and physical activity. • To find the right exercise offer for the citizen in cooperation with an exercise guide. • To obtain a greater awareness about the effects of exercising.
Method.	The dialogue builds upon the health pedagogical framework for rehabilitation interventions described in Chapter 1.4. Focus on the guidance and motivation of the citizen regarding Aim and plan regarding physical exercise.
The framework of the intervention	• A consultation after exercise takes place in an consultation room and lasts 30-60 minutes. • Relatives may participate if the citizen wants them to. • If needed, an interpreter may be utilised. The interpreter is booked before the consultation through the secretariat. • Read more about the framework for the work in the Procedure description for the Centre for Diabetes

	• For a consultation programme, where the citizen does not need physical exercise at the Centre for Diabetes, but only wishes guidance during a given period. • To follow-up on an exercise programme, where the citizen, after completed exercise programme, has not found the right kind of exercise to go on with.
A description of the intervention	A consultation about exercise may be utilised in different contexts. • For the short clarification, where the focus is to clarify the motivation of the citizen in connection with physical exercise and which exercise classes will fit the citizen.
Handling of the intervention	Exercise instructor.
References	• Sundhedsstyrelsen. Fysisk aktivitet - en håndbog om forebyggelse og behandling, 2011

2.6 Dialogue about alcohol

Who can be assigned the intervention?	Citizens in the City of Copenhagen with type 2 diabetes and/or heart disease referred to a rehabilitation programme at the Centre for Diabetes.: • If alcohol consumption significantly exceeds the drinks limits of max seven drinks per week for women and maximum 14 for men and more than five drinks at a time. • Who wishes to change their alcohol habits with support and guidance? *Brief dialogue about alcohol* (Very Brief Advice) and *talk about alcohol* can be allocated at the initial consultation or during the citizen.
The purpose of the intervention.	• To increase the citizen's insight into the importance of alcohol consumption for daily life. • To strengthen the options of the citizen regarding a change of his or her alcohol habits. This happens through knowledge about tools, which can be utilised independently or through offers in the area, such as, e.g. a dialogue about alcohol.
Objectives	• That the citizen is motivated to reduce his or her alcohol consumption so that it remains within the frames of the recommendations of the Danish Health Authority: Max seven drinks a week for women. Max 14 drinks a week for men. No more than five drinks at a time and low damaging consumption. • That the citizen obtains a more excellent knowledge about alcohols influence on the health with a focus on diabetes and the surroundings (family, friends, children, job, colleagues, etc.). • That the citizen reaches his or her own stipulated aim about a reduction of alcohol consumption. • That the citizen is motivated to proceed within another framework, if the addiction is comprehensive enough to require other forms of treatment.
Method.	We work according to the TERAPI method. Read more in Appendix 2b. *Brief dialogue about alcohol* and *Dialogue about alcohol* is based on the health pedagogical framework for rehabilitation interventions described in Chapter 1.4 and on the principles described in the Danish Health Authority's Recommendations for the assessment of needs in the initial consultation.

The framework of the intervention	*Brief dialogue about alcohol* is a dialogue lasting between 5-15 minutes. Talk *about alcohol* may contain up to four individual consultations with the citizen lasting between 10-15 minutes (in exceptional cases up to 30 minutes). *The following applies for both interventions:* • Relatives may participate if the citizen wants them to. • If needed, an interpreter may be utilised. The interpreter is booked before the consultation through the secretariat. • Read more about the framework for the intervention in the Procedure description for Centre for Diabetes.
A description of the intervention	*The intervention can be engineered if the citizen scores five or more points in the part of the CURA questionnaire concerning alcohol (audit C).* *Brief dialogue about alcohol may be conducted in the open space, via text messaging and behind closed doors.* *Dialogue about alcohol may be conducted in various ways, through several consultations (e.g. by using picture cards/dialogue cards, etc.).* *Read more about how we conduct alcohol dialogues in Appendix 2b.*
Handling of the intervention	*The consultation is managed by a health professional educated to handle this type of consultations.*
References	• *Sundheds- og Omsorgsforvaltningen. Faglig vejledning: Forebyggende samtale om alkohol, 2017* • *Dansk Selskab for Almen Medicin. Screening med Alcohol Use Disorder Test (AUDIT).* • *Prochaska JO, Diclemente CC. Stages and Processes of Self-Change of Smoking: towards an Integrative Model of Change. J consult clin. Psychol. 1983;51(3):390-395* • *Miller W Rollnick S. Motivational consultationing. Preparing People to change Addicitive Behaviour. 2. edition Guilford Press, 2002* • *Bart T, Børveit T, Prescott P. Endringsfokuseret Rådgivning. Oslo Gyldendal Norsk forlag, 2001*

2.7 Individual smoking cessation

Individual smoking cessation programmes are offered if this is the most appropriate step about the needs of the citizens. The intervention is described in Chapter 3.7.

3 Group lessons

3.2 Patient education - Live your life with type 2 diabetes, classes in Danish

Who can be assigned the intervention?	The citizens in the City of Copenhagen with type 2 diabetes referred to a rehabilitation programme at the Centre for Diabetes. Criteria: • Must speak and understand Danish. • Have a need and be motivated for gaining knowledge about life with diabetes. • Be motivated to follow the entire training programme. • Be able to engage in a group context; be motivated to actively participate and interact with other citizens and the instructor.
The purpose of the intervention.	• To strengthen the citizen's illness and life coping, self-care, self-care skills, and acting competences to live a good life with type 2 diabetes. • To improve the citizen's opportunities for building physical and mental health and living a life with social and emotional well-being.
Objectives	• To gain the opportunity to build relations and network. • To obtain an understanding of type 2 diabetes, the programme, and the treatment of diabetes. • To gain insight into the relations, which are essential to prevent the progression of type 2 diabetes, working with self-motivation and wanting to see changes. • To gain insight and acting competences concerning physical and mental health, social support and building of cognitive resources. • That the citizen work on maintaining the wanted changes and coping ability and be strengthened in the correlation and communication with health professionals.
Method.	The lessons are built on the health pedagogical framework for rehabilitation interventions, as described in Chapter 1.4. • We change between presentations from the instructor and exercises for the citizens based on professional considerations about the content and user involving needs. • The instructor must master the "juggler role" (cf. Appendix 1b) to include and motivate the citizens. • The lessons will make wide use of ”Steno boxes”, a several health pedagogical tools developed by Steno Diabetes Centre Copenhagen.

The framework of the intervention	• The lessons take place at the Centre for Diabetes. • There are six modules each lasting two hours. • The classes take place once a week in different time spans for the various classes, so the citizen can choose a team that fits into his or her everyday life – morning, noon, or evening. • Class size is 12-16 citizens, with a minimum of 6 people enrolled. • Relatives may participate if the citizen wants them to. • Read more about the framework for the work in Appendix 3a and the Procedure description for the Centre for Diabetes.
A description of the intervention	The citizen participates in a complete teaching programme containing the following six modules: 1. Introduction to diabetes. 2. Sequelae, mental resources, and social support. 3. Food affecting my diabetes. 4. Exercising and training. 5. Food affecting my heart. 6. The progression of the disease, the medical treatment and recapitulation. A rolling plan for the work can be found in Appendix 3b. After an end teaching programme, an endnote is written about all the citizens. Read more in the Procedure description for Centre for Diabetes.
Contraindications	If the citizen has competing issues and needs to build up more mental and social resources until it is optimal to enter a group association, individual classes may be offered. See Chapter 2.4.
Handling of the intervention	Nurse, clinical nutritionist, and exercise guide.
References	• Sundhedsstyrelsen. Anbefalinger for forebyggelsestilbud til borgere med kronisk sygdom, 2016. • Forløbsprogram for type 2-diabetes. For hospitaler, kommuner og almen praksis i Region Hovedstaden, 2019. • Peter Thybo. Det dobbelte KRAM: Et tværfagligt arbejdsgrundlag for mental sundhed, helbred og trivsel, 2016 • SDCC. I balance med kronisk sygdom - Sundhedspædagogisk værktøjskasse til patientuddannelse, 2012 • SDCC. Guide til sundhedspædagogiske værktøjer - under- • visning af sårbare personer med kronisk sygdom, 2015

3.3 Patient education - Live your life with type 2 diabetes, for ethnic minorities

Who can be assigned the intervention?	Citizens in the City of Copenhagen with type 2 diabetes referred to a rehabilitation programme at the Centre for Diabetes, who do not have Danish language skills making it possible to follow the classes in Danish. Classes in Urdu, Arabic and Turkish is offered regularly. When a smaller group of a minimum of four people speaking other languages, e.g. Albanian and Somalian, classes may also be provided in other languages. Criteria: • Have a need and be motivated for gaining knowledge about life with diabetes. • Be motivated to follow the entire training programme. • Be able to engage in a group context; be motivated to actively participate and interact with other citizens and the instructor.
The purpose of the intervention.	• To strengthen the citizen's illness and life coping, self-care, self-care skills, and acting competences to live a good life with type 2 diabetes. • To improve the citizen's possibilities to make health-promoting lifestyle changes, build up physical and mental robustness and to live a life with psychological, social and emotional well-being.
Objectives	• To gain the opportunity to build relations and network. • To obtain an understanding of type 2 diabetes, the programme, and the treatment of diabetes. • To gain insight into the relations, which are essential to prevent the progression of type 2 diabetes, working with self-motivation and wanting to see changes. • To gain insight and acting competences concerning physical and mental health, social support and building of cognitive resources. • That the citizen works to maintain the wanted changes and coping skills and be strengthened in cooperation and communication with health professionals.
Method.	The lessons are built on the health pedagogical framework for rehabilitation interventions, as described in Chapter 1.4. • We teach based on a health pedagogical concept for diabetes education of non-Western ethnic minority groups. The idea is called CUSTOM (Culturally Sensitive Tools and Methods). The classes follow the manual,

	developed for CUSTOM. In the manual, the six modules and associated modules are described. • We change between presentations from the instructor and exercises for the citizens based on professional considerations about the content and user involving needs. • The instructor must master the "juggler role" (cf. Appendix 1b) to include and motivate the citizens. • So far, it is possible, a health communicator will be present to help with the cultural translation and understanding for the citizens. In addition to the CUSTOM-box tools from will be included from corresponding ”Steno-boxes”, several health pedagogical tools developed by SDCC for utilisation in the educations of patients.
Interpreter	• An interpreter is present during these classes. It should be the same interpreter during all six modules. • The interpreter is booked through the secretariat.
The framework of the intervention	• The classes take place at the Centre for Diabetes. • Six modules each lasting two hours has been allocated. • The classes take place twice a week. • Class size is up to 10 citizens, including relatives. • The instructor must make time after each module since there are typically many questions after each time. • Relatives may participate if the citizen wants them to. • Read more about the framework for the work in Appendix 3a and the Procedure description for the Centre for Diabetes.
A description of the intervention	The citizen participates in a complete teaching programme containing the following six modules: 1. Introduction to diabetes and matching of expectations. 2. Sequelae, mental resources, and social support. 3. Food affecting my blood sugar. 4. Exercising and training. 5. Food affecting my heart. 6. Medical treatment, excellent consultation and recapitulation. A rolling plan for the work can be found in Appendix 3c. After an end teaching programme, an endnote is written about all the citizens. Read more in the Procedure description for Centre for Diabetes.

Contraindications	If the citizen has competing issues and needs to build up more mental and social resources until it is optimal to enter a group association, individual classes may be offered. See Chapter 2.4.

Handling of the intervention	Nurse, clinical nutritionist, exercise guide and health communicator.
References	• Centre for Diabetes, City of Copenhagen and SDCC. CUSTOM: A concept for education aimed at ethnic minorities with type 2 diabetes, 2019. • The Danish Health Authority. Recommendations for offers of prevention for citizens with a chronic disease, 2016. • Programme program for type 2 diabetes. For hospitals, municipalities, and general practice in the Capital Region of Denmark, 2019. • Peter Thybo. The double HUG: A interdisciplinary work basis for mental health, health, and well-being, 2016 • SDCC. In balance with a chronicle disease - A health pedagogical toolbox for the education of patients, 2012 • SDCC. A guide for health pedagogical tools - the teaching of vulnerable people with a chronicle disease, 2015

3.4 Patient education - Live your life with a heart disease

Who can be assigned the intervention?	Citizens in the City of Copenhagen with heart disease included in the programme program for the rehabilitation of heart disease referred to a rehabilitation programme at the Centre for Diabetes. Criteria: • Must speak and understand Danish. • Have a need and be motivated for gaining knowledge about living with heart disease. • Be motivated to follow the entire training programme. • Be able to engage in a group context; be motivated to actively participate and interact with other citizens and the instructor.
The purpose of the intervention.	• To strengthen the citizen's illness and life coping, self-care, self-care skills, and acting competences to live a good life with heart disease. • To improve the citizen's opportunities for building physical and mental health and living a life with social and emotional well-being.
Objectives	• To gain the opportunity to build relations and network. • To obtain an understanding of his or her heart disease, self-care skills regarding symptoms and the impact of medical treatment in daily life. • To gain insight into the relations, which are essential to prevent the progression of heart disease, working with self-motivation and wanting to see changes. • To gain insight and learn about self-care, in relation to physical and mental health, social support and building of cognitive resources. • To work on maintaining the wanted changed and coping ability and be strengthened in the cooperation and communication with health professionals.
Method.	The classes are built on the health pedagogical framework for rehabilitation interventions, as described in Chapter 1.4. • We change between presentations from the instructor and exercises for the citizens based on professional considerations about the content and user involving needs. • The instructor must master the "juggler role" (cf. Appendix 1b) to include and motivate the citizens. The classes will make wide use of ”Steno boxes”, a number of health pedagogical tools developed by Steno Diabetes Centre Copenhagen.

The framework of the intervention	• The classes take place at the Centre for Diabetes.
	• Five modules each lasting two hours, hereof a single programme of 2,5 hour. • The classes take place once a week in different periods, so the citizen can choose a team that fits into his or her everyday life – morning, noon, or evening. • Class size is 12-16 citizens, with a minimum of 6 people enrolled. • Relatives do not participate in the heart lessons. Relatives may participate in a separate meeting just for relatives for citizens with heart disease for 1,5 hours. This meeting time is placed after the five modules aimed at the citizens. A rolling plan for the work can be found in Appendix 3f.
A description of the intervention	The citizen participates in a complete teaching programme containing the following five modules: 1. <u>What is in your heart</u>: Presentation, what has a strong presence in daily life with heart disease, requested changes. 2. <u>My heart disease in daily life</u>: Heart diseases, handling of symptoms and medicine. 3. <u>Improved health behaviour</u> : Circumstances impacting the health and prevention, options for change, Aim and Plan. 4. <u>My mental health:</u> Mental health, mental resource, and social support. 5. <u>Balance in daily life</u>: Maintaining changes and cooperation with health professionals. As a point of departure, the sequence of the modules is followed, as described. However, modules 2-4 may be placed in the series that the instructor from a professional point of view assesses makes sense based on the specific needs of the group. This is evaluated in connection with the first module. Placement of the module lasting 2.5 hours is also assessed at this time. A rolling plan for the work can be found in Appendix 3e. Read more about the framework for the work in Appendix 2b and the Procedure description for the Centre for Diabetes.
Contraindications	If the citizen has competing issues and needs to build up more mental and social resources until it is optimal to enter a group association, in individual classes may be offered. See Chapter 2.4.

Handling of the intervention	Nurse.
References	• Sundhedsstyrelsen. Anbefalinger for forebyggelsestilbud til borgere med kronisk sygdom, 2016. • Region Hovedstaden. Forløbsprogram for rehabilitering af hjertesygdom, 2019 • Peter Thybo. Det dobbelte KRAM: Et tværfagligt arbejdsgrundlag for mental sundhed, helbred og trivsel, 2016 • SDCC. I balance med kronisk sygdom - Sundhedspædagogisk værktøjskasse til patientuddannelse, 2012 • SDCC. Guide til sundhedspædagogiske værktøjer - undervisning af sårbare personer med kronisk sygdom, 2015 • DEFACTUM, Hjerteforeningen. Livet som pårørende til hjertesyge, 2019

3.5 Healthy in nature

Who can be assigned the intervention?	Citizens in the City of Copenhagen with type 2 diabetes and/or heart disease referred to rehabilitation programme at the Centre for Diabetes. The intervention concerns all citizens who: • Wants to spend time outside or are motivated to do it. • Can walk approx. 500 meters.
The purpose of the intervention.	• To strengthen the citizen's illness and life coping, self-care, self-care skills, and acting competences to live a good life with type 2 diabetes and/or heart disease. • To change one's possibilities of doing health-promoting lifestyle changes, build up physical and mental robustness and live a life with psychological, social, and emotional well-being. • To sustain the citizen in his or her new active habits - in nature.
Objectives	• To focus on mental and physical well-being. Cf. Chapter 3.1 • To gain insight and coping skills to use nature to build up physical and mental resources. • To gain the opportunity to build relations and network in nature. • The citizen continues/is happy to utilise nature in his or her everyday life and continues to use it in the citizen's daily life regarding peace, physical activity, cooking, or networking. Furthermore, see the objectives for patient education for diabetes and heart described in Chapters 3.1, 3.2, and 3.3.
Method.	The lessons are built on the health pedagogical framework for rehabilitation interventions, as described in Chapter 1.4. The approach for the various exercises/interventions takes place through exercising, where physical activity will be utilised as a primary learning method. Since the intervention takes place outside, more elements from nature will be included, such as bonfires among other things.
The framework of the intervention	• Five meetings have been allocated, typically Mondays from 10.00-14.00 • The intervention is run one to two times a years from March to October. • We strive towards all classes having 12-16 citizens, but at least six people enrolled. • For all classes, health care professionals must be present: A nurse, a nutritionist, and an exercise instructor. • As a point of departure, the work takes place in Søndermarken and in the Natur- og fritidshytten, which is leased by Frederiksberg Municipality. Read more about the framework for the intervention in the

	Procedure description for Centre for Diabetes.
A description of the intervention	Healthy in nature is an intervention taking place outside. It integrates outdoor life and the joy from nature with lessons and cooking and focuses on, how the participants achieve and maintains healthy habits. The intervention is based on: • Nature. • Creativity. • Playing. • Exercise. The aim is to increase the citizen's knowledge about diabetes and heart disease, food, mental health etc. The increased knowledge is created through different activities where questions of reflection emerge that the participating citizens can gather around. After a finished programme, the citizen will receive a certificate/diploma for completing the programme.
Contraindications and special precautions	There is no opportunity to: • Use facilities for driving or walking. • Use an interpreter, which is why the citizen must be able to understand and speak passable Danish.
Instructors	Since interdisciplinarity is a fundamental element in Healthy in Nature, three instructors will be affiliated each time. One form each profession
References	• Wengel, Ishøj, Andkær. SDU. Naturen kan noget særligt – • kvalitativ evaluering af projekt sund i naturen, 2020 • Friluftsrådet. Sund i naturen: kvantitativ evaluering af Sund i Naturen - indsatserne 2017-2020, 2020 • Sundhedsstyrelsen. Anbefalinger for forebyggelsestilbud til borgere med kronisk sygdom, 2016 • SDCC. Undervisning af sårbare personer med kronisk sygdom, 2015 • SDCC. I balance med kronisk sygdom. Sundhedspædagogisk værktøjskasse til patientuddannelse, 2012

3.6 My blood sugar and I

Who can be assigned the intervention?	The citizens in the City of Copenhagen with type 2 diabetes referred to a rehabilitation programme at the Centre for Diabetes, who needs a more profound understanding of variable blood sugar, blood sugar regulation and so on. Criteria: • A class is offered for Danish-speaking and one for citizens, who do not speak Danish. • All citizens can participate no matter which type of medication they are on. • Four-eight citizens in the Danish-speaking classes and max five in the non-Danish-speaking classes. • It is essential that the citizen are literate since home assignments are included and require a certain level of reading and writing abilities. The citizen is offered the intervention if the other measures (education, exercising, consultations) shows a need for further knowledge about blood sugar. During the lessons, the citizens may ask about the following: • Do you have any knowledge about the symptoms of high and low blood sugar? • Meal patterns– how often/what do you eat? • Do you take your medication?
The purpose of the intervention.	• To increase the knowledge and understanding of blood sugar values. • To allow the citizen to build up acting competences regarding obtaining better regulation of the blood sugar. • That the citizen gets a clarification of his or her need for using blood sugar measuring for self-regulation and by doing so, get better at coping the illness of the citizen.
Objectives	• To receive instruction in the correct measuring of blood sugar according to clinical recommendations. • To gain an understanding of the recommendations for blood sugar values. • To gain knowledge about circumstances affecting the blood sugar, such as, e.g. food, exercise, and medicine. • To gain knowledge about how blood sugar measurement may be included in self-regulation of diabetes. • To gain an understanding of how blood sugar measuring may be utilised in relations to his or her disease, understand the difference between one's blood sugar measuring and measuring long-term blood sugar at the GP.

Method.	The lessons are based on the health pedagogical framework for the rehabilitation interventions described in Chapter 1.4. • We change between presentations from the instructor and exercises for the citizens based on professional considerations about the content and user involving needs. • The instructor must be able to handle the "juggler role" (cf. Chapter 1b) regarding inclusion and motivation of the citizen and be ready to be twisting the content of the lessons without losing perspective.
	The blood sugar measurement must follow the procedures described in the clinical guidelines of the administration: https://www.varportal.dk/portal/proce- dure/9655/13 .
The framework of the intervention	• The lessons take place at the Centre for Diabetes. • There will be two modules each lasting two hours in the Danish-speaking classes and two modules each lasting 2.5 hours in the non-Danish-speaking classes. If you need an interpreter, one must be booked through the secretariat. • In between the two classes, a piece of homework must be carried out by the citizen. • One clinical nutritionist and one nurse handle the classes. • The classes take place every two weeks. • Relatives may participate if the citizen wants them to. • Read more about the framework for the work in Appendix 2b and the Procedure description for the Centre for Diabetes.
A description of the intervention	Read more about the detailed content of each module in Appendix 2d.
Handling of the intervention	Nurse and clinical nutritionist.
References	• Endokrinologisk selskabs retningslinjer for behandling og kontrol af type 2-diabetes • Kliniske retningslinjer for blodglukosemåling: https://www.varportal.dk/portal/procedure/9655/13 • Diabetesforeningen. Type 2 diabetes, 2017

3.7 Practical cooking and food inspiration

Who can be assigned the intervention?	Citizens in the City of Copenhagen with type 2 diabetes and/or heart disease referred to a rehabilitation programme at the Centre for Diabetes. Relatives are welcome to participate.
The purpose of the intervention	• To initiate an understanding of the importance of food to promote the health and health situation of the citizen. • To initiate an exposure and strengthen the citizen's motivation and self-care skills regarding food and meal habits. • To initiate a reflection of one's food and meal habits concerning the facts, one's values, goals, and opportunities regarding realistic changes. • To gain practical skills to cook health food together with others.
Objectives	• To learn how the diet principles for diabetes and heart disease can be transformed into practice. • To gain an understanding of why dietary fibres and wholemeal are essential. Additionally, to acquire awareness regarding reducing sugar content, salt and saturated fat in the food and gain an understanding of appropriate portion sizes and the optimal meal frequency. • To gain an understanding of the impact that food has on the regulation and prevention of disease and how this can be transferred to everyday life at home. • To gain inspiration for cooking and combination of appropriate meals with a point of departure in the diagnosis and the state of nutrition.
Method.	Dialogue based education containing presentations, exercises, and exchange of experience between the participants, and practice learning through cooking of meals in the on-site kitchen.
The framework of the intervention	• The programme takes place in the on-site kitchen at the Centre for Diabetes. • Diabetes: three lessons each lasting 3 hours once a week. • Heart disease: First time: 1½ hours, subsequently: 2 lessons each lasting 3 hours once a week. • The classes may have up to 10 citizens, including relatives. • Read more about the framework for the work in the Procedure description for the Centre for Diabetes
A description of the intervention	• Food inspiration (for citizens with heart disease) and Practical cooking (for citizens with type 2 diabetes)

	is based on dialogue and exchange of experience, where the participants gain insight into their challenges related to food, gain the opportunity to challenge ambivalence and insight into working with change. Furthermore, the programme consists of practical lessons, where the participants will be in the kitchen to be inspired and supported in transforming the theory for the diet principles in practice. • Focus is on meals with a high content of dietary fibres, wholemeal, vegetables, reduced content of salt and sugar. Focus on portion sizes, plate model and meal frequency concerning type 2 diabetes and heart disease. • There will be a specialist presentation and dialogue as a supplement for the practical lessons. Here the focus will, among other things be on the utilisation of a shopping guide, exposition of sweetener and fat, the Whole Grain logo and the Keyhole Label when using dummies. Read more about the content in the Rolling plan for Food inspiration for citizens with heart disease and Practical cooking for citizens with type 2 diabetes in Appendix 3g and 3h. Manual for Food inspiration for citizens with a heart disease contains a detailed description of the course.
Handling of the intervention	Clinical nutritionist(s) and potentially a nurse. If there are more than eight citizens, two instructors must be present.

3.8 Smoking cessation

Who can be assigned the intervention?	Citizens in the City of Copenhagen with type 2 diabetes and/or heart disease, who utilises tobacco products daily or occasionally.
The purpose of the intervention.	• To motivate and help the citizens with all kinds of smoking cessation. • To give the citizens increased life quality, lower risk of sequelae, better chances of survival and results of treatment.
Objectives	• To gain knowledge about smoking, addiction, and withdrawal symptoms. • To gain awareness of motivation and ambivalence. • To gain knowledge about the health advantages of smoking cessation. • To gain insight into disease risk when continuing to smoke. • To gain knowledge about psychological addiction. • To gain knowledge about weight and smoking cessation. • To be aware of the utilisation of smoking cessation medicine.
Method.	• All the smoking cessation counsellors teach according to the common smoking cessation concept from the "Smoking cessation consultants" chosen by the City of Copenhagen. The intervention has been described in the professional guide "Smoking cessation", and the same intervention is across all units in the City of Copenhagen. • The *KVIT and FIT concept* is a group-based offer at the Centre for Diabetes. In the KVIT and FIT concepts, the purpose is smoking cessation together with an increased focus on physical activity. <u>Recruitment for smoking cessation programme</u> • VBA (very brief advice) is a simple and effective tool, which can be utilised by all employees in all sorts of contacts with citizens, who smoke. • The VBA method consists of three steps: 1) Ask if the citizen smokes, 2) advice about the free offer from the Stoplinien and 3) refer to the Stoplinien with a calling card. The citizen only must send a text message to the number, and the Stoplinien will call him or her back.

The framework of the intervention	• Smoking cessation programmes may take place in groups or as an individual programme. • For a group-based programme, up to 15 citizens may participate. The KVIT and FIT concept runs for six weeks, six classes each lasting one hour and 45 minutes. • An individual programme consists of up to five meetings, which runs for 1½ month. The first meeting lasts max 1½ hour, and the subsequent sessions (potentially on the phone) lasts up to 30 minutes. • Relatives may participate if the citizen wants them to. • If needed, an interpreter may be utilised. The interpreter is booked before the consultation through the secretariat. • Read more about the framework for the intervention in the Procedure description for Centre for Diabetes.
A description of the intervention	The intervention is offered as an integrated part of the programme at the Centre for Diabetes. Recruitment of the citizen happens as a part of the dialogue, which is already taking place between the citizen and the health professional, e.g. at the initial consultation or during the programme consultations. Both individual and group-based programme are offered containing the following topics during the smoking cessation intervention: • Smoking, dependency, and withdrawal symptoms. • Motivation and ambivalence. • Health advantages to smoking cessation. • A health risk to continued smoking. • The psychological addiction. • Weight and smoking cessation. • Use of smoking cessation medicine. There is no limit to how many smoking cessations programmes a citizen may follow. Stoplinien follows up on the programme participants six months after the cessation date entered the smoking cessation database. All smoking cessation programmes must, therefore, be recorded in the smoking cessation database. Read more in the specialist guide.
Handling of the intervention	Smoking cessation counsellor

References	• Undervisningsmateriale findes på www.rygestopkonsulenterne.dk • Sundheds- og omsorgsforvaltningen. Faglig vejledning "Rygestop", 2017 • www.henvis.nu (on the VBA-method) • Sundhedsstyrelsen. Fakta om rygning, 2015. • FCFS. Sundhedsprofil for region og kommuner, 2017

4. Physical exercise

4.1 Exercise programmes – general introduction

Who can be assigned the intervention?	Interventions regarding physical exercise are allocated the citizens in the City of Copenhagen with type 2 diabetes and/or heart disease referred to a rehabilitation programme at the Centre for Diabetes. Criteria for participating in the exercise is that the citizen must: • Be able to walk 500 meters because of potential exercise in the immediate environment. • Be self-moving. That means that the citizens must have some degree of mobility to participate in the exercise. • Be motivated for exercising and continued physical activity. • Be able to engage in a group context. • Be able to follow simple instructions. In cases of contraindications (see below) the citizen must either be evaluated professionally at the Centre for Diabetes or sent for also diagnosing at his or her doctor.
The purpose of the intervention.	• Physical activity programmes should a means to cope with life with type 2 diabetes and/or heart disease. • To increase the citizen's physical ability to function and initiate health improvement, including lowering the blood pressure and stabilising HbA1c, a modification of the fat composition in the blood, and improvement of the physical fitness and muscle strength in the citizen. This will be done through supervised exercise programmes, where the focus will be on increasing the heart rate, as per clinical recommendations. • That physical activity becomes a part of daily life for the citizen and giving him or her increased knowledge about physical activity as an active means to prevent the consequences and impairment of diabetes and/or heart disease. A basic principle of the intervention is that it aims to support network and that the citizen should gain a positive feeling when participating in the exercise programme. Different kinds of networks may help motivate and make the citizen stick to physical activity. Furthermore, citizens with type 2 diabetes and/or heart disease may use the network to find support to handle life with the disease, among others with the same disease.

Objectives	• To gain a better understanding of how exercise and moving benefits daily life. • To gain a positive feeing from exercising. • To gain experience of their physical abilities and safety from being physically active. • To get motivation and inspiration to stick to an active life-style after the end of the programme through participation in, e.g. association activities or exercise networks at the Centre for Diabetes.
Method	During the exercise/lessons, we work according to a health pedagogical approach where, e.g. user involvement and knowledge about type 2 diabetes and/or heart disease are central elements. The methods/tools below are utilised during exercise: • Aim and Plan. • Supervised exercise to boost the citizen through aerobic and functional exercise. • A focus on adherence after the programme has ended. • Health pedagogical principles. • Different exercise tools such as heart rate monitor, borg scale etc. Read more about physical exercise in Appendix 3a, 3b and 3c.
The framework of the intervention	The exercise takes place at the training facilities at the Centre for Diabetes, outside or with other partners in Copenhagen. <u>For citizens with type 2 diabetes</u> • Three months' exercise programmes, twice a week, each lasting 1½ hour. Exercise will be conducted inside once a week and outside once a week (as far as possible). • There will be a regular intake of citizens in classes distributed twice a month. The last exercise will be on the previous exercise class three months after start-up. • Each month, there is a new intake in the class, so that the programme continually consists of a group of experienced and a group of newly arrived citizens. The intake includes eight citizens per month per class. • There will be exercise classes morning, noon, and evening and for men and women. • Once a month, class exercise guidance will take place (see Appendix 3c). • There is no general classification of levels in the exercise classes. In the evening class, the ground is prepared for the functional level to be higher, and the motivation is for the intensity to be increased. However, everyone is welcome in

	case they are not able to participate in a day class. • Relatives do not participate in the exercise. • We encourage individual exercise once a week, such as taking a walk. <u>For citizens with heart disease</u> • Six or 12 weeks programme according to the fact if the citizen has been referred to a partial or full rehabilitation programme in the municipality.
	• The exercise will be conducted twice a week each time lasting 1½ hour. Training will be conducted inside once a week and outside once a week (as far as possible). • Cf. The programme programme for the rehabilitation of heart disease is the goal that citizens reach an increased work capacity of at least 10% during six minutes walking test. Six minutes' walking test Partial programme- hospital/municipality: • Start test at the hospital • End test at CfD • Excluding citizens with atrial fibrillation, where both tests are conducted in CfD. Full programme- municipality: • Start and end test at CfD Instructions for conducting six minutes' walking test: link to be inserted. The settings for conducting six minutes' walking test is currently being clarified. Read more about the framework for the intervention in the Procedure description for Centre for Diabetes.
A description of the intervention	The training programmes are divided into general focus areas according to a standard rolling plan (see Appendix 4b). The standard manual template is taken as a point of departure to ensure uniformity, increased quality, and fulfilment of the objectives. However, there will always be a few changes according to the classes utilising the manual. The manual can be found here: LINK The general focus areas are: <u>For citizens with type 2 diabetes</u> 1. Focus – Welcome, expectations and introduction to the exercises. 2. Focus – Measuring.

	3. Focus – Interval training, training, strength training and mental training. 4. Focus – Adherence and network visit. 5. Focus – Recapitulation (only relevant when a fifth week occurs during the month). The women's class runs according to an individual manual, as there are other reservations for this group of citizens. <u>For citizens with heart disease</u> 1. Focus – Welcome, expectations, test, and introduction to the exercises. 2. Focus – Physical fitness and interval exercises. 3. Focus – Adherence and network visit. 4. Focus – Strength training and staying power. 5. Focus – Games and play/Body and mind. 6. Focus – Adherence and network visit/Test.
Contraindications and special circumstances	Exercise is advised against when: <u>For citizens with type 2 diabetes</u> • Blood sugar over 17 mmol/l and for users of insulin with a blood sugar below seven mmol/l. Read more about the approach with high blood sugar values in Appendix 3. • Foot ulcers and neuropathy (no weight-carrying activities are recommended) • Systolic or diastolic blood pressure over 180 mm Hg and 105 mm Hg, respectively. • NYHA IV. <u>For citizens with heart disease:</u> Applicable for citizens with ischaemic heart disease, heart failure, cardiac valve disease, and persistent atrial fibrillation, exercise is advised against when the person has: • Respiratory distress when resting or impairment of breath. • Systolic or diastolic blood pressure over 180 mm Hg and 105 mm Hg, respectively. • A weight gain over 1.8 kg for 1-3 days. • Dizziness or falling in systolic blood pressure when stressed. • Chest pain/signs of oxygen deficiency to the heart. • A resting heart rate over 100. • Dysregulated atrial fibrillation (a heart rate over 110 when starting the test).

Handling of the intervention	• Two instructors will be affiliated each time. • The exercise instructor in the class will, as a rule, be responsible for the exercises. Still, the planning will be a cooperation between the instructors regarding relevant topics during the exercising, such as, e.g. food, sequela, symptoms etc. • We strive towards having a regular nurse weekly in all classes.
References	• Forløbsprogram for rehabilitering af hjertesygdom (2019) og type 2-diabetes (2016) • Sundhedsstyrelsen. Fysisk aktivitet – håndbog om forebyggelse og behandling. 2011 • Region Hovedstaden. Anbefalinger til superviseret fysisk træning af mennesker med type 2 diabetes, KOL og hjerte-kar-sygdom, 2013 • Dansk Cardiologisk Selskab. Hjerterehabilitering, 2019 • Sundhedsstyrelsen. Anbefalinger for forebyggelsestilbud til borgere med kronisk sygdom, 2016 • SDCC. I balance med kronisk sygdom - Sundhedspædagogisk værktøjskasse til patientuddannelse. 2012toolbox for patient education. 2012

4.2 Mini classes

Who can be assigned the intervention	Citizens in the City of Copenhagen with type 2 diabetes and/or heart disease referred to a rehabilitation programme at the Centre for Diabetes. An exercise instructor assesses participation in the class. When conducting the initial consultation with other professions, Consultation about exercise is offered. Criteria for participation in the exercise class, the citizen must: • Have a reduced functional impairment, either physically, psychologically, or cognitive. • Have independent standing and walking ability with or without walking tool. • Be motivated for exercising and continued physical activity. • Be able to engage in a group context. • Be able to follow simple instructions. If seeing improvements in functioning levels the exercise instructor assesses in cooperation with the citizen's contact person, if the citizen can be transferred to a more extensive exercise class.
The purpose of the intervention.	• To offer exercise to and improve the functional level with citizens with an impaired level of functioning, who needs to exercise in smaller classes - that is, a more individualised offer. Participation in this class may prepare the citizen for the involvement in the other exercise classes. See Chapter 4.1. Exercise programmes – general introduction.
Objectives	See Chapter 4.1. Exercise programmes – general introduction.
Method.	See Chapter 4.1. Exercise programmes – general introduction.
The framework of the intervention	• The training takes place at the Centre for Diabetes twice a week, each time lasting 1.5 hours up to 12 weeks. If the functional level is improved, the citizen may start in a regular exercise class, until the programme is finished. • Number of citizens in a class: max 8. The class continuously take in new participants. • The exercise takes place during the day. • The class is for both women and men. • Relatives do not participate in the exercise. • If there is a need for driving at the beginning of the exercise class, the need is continually assessed by the exercise instructor as the citizen's work capacity is improved. • Read more about the framework in the Procedure description for the Centre for Diabetes.

A description of the intervention	The intervention is focused on: • Strength training. • Balance training. • Fitness training. The primary focus is on strength and balance training.
	The time will be distributed so that one hour will be spent on exercise, 15 minutes will be spent on recapitulation and dialogue with the training responsible and 15 minutes will be spent on social interaction and development of networks We aim at conducting the exercise outside every other time. We encourage individual exercise once a week, such as taking a walk. Rolling plan for the intervention is adjusted to the functional level of the citizens. It can be found here: link will be inserted
Contraindications and special precautions	See Chapter 4.1.Training programmes in general.
Handling of the intervention	• Two instructors will be affiliated each time. • The training instructor is responsible for the training. • The planning takes places in cooperation with another health professional instructor - training instructor/nurse regarding relevant topics in training, such as side effects of the medication, handling of symptoms, food, sequelae etc.
References	See Chapter 4.1 Training programmes in general.

4.3 Yoga

Who can be assigned the intervention?	In addition to the general criteria for the exercise described in Chapter 4.1, the requirements for this class are that the citizen: • Must be able to get down on the floor and get back up. • Must be able to lie down and do the exercises. • Must be motivated for exercising and/or try the exercise type yoga. • Is interested in finding silence within
The purpose of the intervention	• That the citizen starts a lifestyle change in daily life, where yoga and stress relief becomes a measure for increased quality of life. • To increase the citizen's physical ability to function and the consequent positive effects. • That the intervention strengthens the mental health for the citizen. A basic principle of the intervention is that it aims to support network and that the citizen should gain a positive feeling when participating in the exercise programme.
Objectives	• That the citizen gains increased knowledge about and understanding of the positive effects of exercise/training/yoga on the health and the opportunities to adhere.
Method	Predominantly deductive. However, the citizen will be included in the planning of the training and individual needs, and requests will be taken into consideration.
The framework of the intervention	• The training will take place once a week, each time lasting 1½ hour for two months. • We encourage supplementing the yoga training with circulation training. • There is room for eight to 10 citizens in the class. • The training takes place in the small gym on the 4th floor. • Read more about the framework in the Procedure description for the Centre for Diabetes.
A description of the intervention	• Contains physical yoga exercises, breathing exercises, stress relief and mindfulness. • Is conducted with low intensity by which the parasympathetic nervous system is activated, and the blood pressure and the feeling of being stressed are reduced. • Contains exercises, which maintains/increases muscle strength (including the five essential exercises from the physical training (see Appendix 3)), flexibility, balance, and coordination. • Ends with approx. 20 minutes of relaxation.
Handling of the intervention	Health professional instructor.

References	• www.diabetes.dk • Timothy McCall. Yoga as medicine, 2007 • Erling Petersen. YOGA – De klassiske stillinger Åndedræts – og koncentrationsøvelser, 1994 • Inge Schöps. Yoga – Teori og Praksis for begyndere og øvede, 2012 • Derudover generelle referencer beskrevet i afsnit 4.1.

5 Other interventions

5.1 Digital guide – LIVA

Who can be assigned the intervention?	All citizens in the City of Copenhagen with type 2 diabetes and/or heart disease, who are motivated to receive help for behavioural changes with digital guidance, who can utilise and have access to a smartphone/tablet/computer.
The purpose of the intervention	• To motivate the citizen to initiate or maintain a change, which contributes to a better quality of life for the individual and contributes to improving the citizens' self-care skills and ability to cope with his or her disease. • To give the citizens guidance regarding the specific challenges they are facing, whether it concerns food, exercise, or life in general with type 2 diabetes and/or heart disease. The citizen will get biological measuring done when starting up the LIVA intervention and again after six and 12 months (HbA1c, waist measurement, weight). In addition to work as indicators of the effectiveness of the intervention, these measures should also contribute to motivating the citizen to the chosen lifestyle changes.
Objectives	• That the citizen obtains a greater extent of self-care, increased acting competence and a better understanding of what the intervention they can make to live a life with psychological social and emotional well-being. • That the adherence of the improved behaviour and the motivation for the citizen's own aim becomes more comfortable with contact to a health professional. By giving the citizen the knowledge and the tools to act on their illness, the aim is for them to achieve greater control over their disease.
Method	Digital guidance staggered in time. Based on a professional assessment by a clinical nutritionist, physiotherapist and a nurse, as described on the way in the intervention catalogue, the citizen is guided according to his or her own needs and goals. As a main rule, the citizens are guided digitally once a week during the first three months; then every other week for three months and finally once a month for six months. However, it is always based on a professional assessment of the individual citizen needs a differentiated guidance frequency. As a rule, the citizen is offered a 12-month programme. However, this can be extended if requested/needed.

The framework of the intervention	• Four LIVA counsellors are trained in guiding citizens. • All LIVA counsellors can be booked for a LIVA start-up consultation (approx. one consultation per week per councillor), and also, between one and four hours for guidance per week per employee is allocated (depending on the number of citizens).
	Read more about the framework for the work in the Procedure description for the Centre for Diabetes
A description of the intervention	LIVA applies to several target groups and can, therefore, be utilised in different ways: • LIVA can be used as an independent intervention for citizens, who does not visit the Centre for Diabetes very often. That could be socioeconomically advantaged citizens with a busy everyday life or citizens, who do not have the surplus energy to visit the centre physically. • LIVA can be utilised as an add-on to the existing interventions to support the intervention of maintenance and lasting change. LIVA can be offered during or after the citizen has finished a current programme. • The LIVA programme starts with a LIVA consultation lasting approx. Forty-five minutes, where the citizen, together with the LIVA counsellor sets the aims for the things, the citizen wishes to change or maintain in his or her lifestyle. • Then the citizen has his or her Hba1c, weight, hips-waist measurement and blood pressure measured by his or her LIVA councillor. Before the LIVA consultation, the citizen has received a questionnaire that he or she should fill in. At the six- and 12-month follow-up, a questionnaire is also sent. • One of the components in LIVA is an action plan that the citizen and the LIVA councillor compile together. Here, the citizen's individual goals within several topics are specified, such as, e.g. food, exercise, blood sugar, sleep, blood pressure and cholesterol. • The citizen will continuously record information about behaviour and values related to these aims. The LIVA counsellors monitor the citizen's data at scheduled times and guide the citizen regarding obtaining the chosen aims. At the weekly/monthly counselling, the LIVA councillor follows up on the records and aims. The counselling takes place in staggered time via text or video. • The LIVA team (consisting of the four LIVA counsellors) has developed the teaching material, which consists of

	short one-two pages information sheets available as general advice in LIVA. These teaching resources are sent to the citizen continually, as a separate guide or as a supplement for the guide. This is done to ensure a more health professional guide and to extend the benefit of the LIVA from "only" being a guide/feedback to also be a platform for teaching.
Handling of the intervention	The interdisciplinary team of the professions nurse, physiotherapist and clinical nutritionist.
References	• Sustained Weight Loss during 20 Months using a Personal- ized Interactive Internet Based Dietician Advice Program in a General Practice; International Journal on Advances in Life Sciences, vol 3 no 1 & 2, 2011 • Anna Sherrington. Evaluation of an internet based weight loss intervention. Ph.D. Thesis, 2015

5.2 Cafe afternoons

Who can be assigned the intervention?	The cafe afternoons is a free intervention for citizens, who have or have had a programme at the Centre for Diabetes, their relatives, or others, who want to share experiences or expand their network. All citizens are welcome, including motivation groups and others who have an interest in sharing their experiences and expand their network.
The purpose of the intervention.	• To frame the communication of topics related to living with diabetes and/or heart disease. • To strengthen the cooperation with volunteers, patient associations and NGOs • To provide the opportunity for sharing of experiences in an informal setting where the citizens help set the frame There is a focus on sharing of experiences and development of a network with a point of departure in a relevant professional presentation.
Objectives	• That the citizens gain insight into a specific topic related to their illness scenario. • That the citizens gain the opportunity to network through informal meetings with like-minded. • To gain knowledge and relation to the NGOs.
Method	The cafe is primarily run by a group of volunteers who oversee the practical deduction and who are the prime forces of planning of content at the cafe meetings. The method varies between a brief professional presentation and a facilitated open discussion, where the citizens bring their own experiences and knowledge into play. The meetings are planned for six months at a time. The participants suggest, which topics they would like to hear about, and these are passed on to the contact person at the Centre for Diabetes.

The framework of the intervention	• The cafe is conducted on the first Monday of each month in the afternoon. • A poster of topics for the cafe afternoons is stuck to the pin-up board on the ground floor at the Centre for Diabetes. • The cafe takes place on the ground floor of the municipal health centre.
	• Coffee and tea are served; the participants are encouraged to bring a snack or a packed lunch. Read more about the cafe afternoons in the Procedure description for Centre for Diabetes
A description of the intervention	The cafe will typically be initiated with a special presentation, which can be done by one or more employees from the Centre for Diabetes, citizens with exceptional experiences or knowledge or external resource persons/introductory speaker. After the presentation, it is time for questions and dialogue between the citizens. The cafe is concluded with a brief evaluation, where the citizens get the opportunity to make requests for future topics to discuss at the cafe. Topics which have previously been on the agenda in the cafe: • Medicine and diabetes • From everyday food to diabetes food • Exercise and diabetes • Late complications • Lose weight in January • Sleep and diabetes • To be a relative Each year there is a Ramadan cafe. The intervention has been developed for citizens with a Muslim background/persuasion and their relatives. A description of the theme meeting can be found here.
Handling of the intervention	The responsibility of the cafe is shared between a group of volunteers (deeply rooted in the motivation group of The Danish Diabetes Association) and the Centre for Diabetes, who vouches for the professional content.

5.3 Developing Life Skills

Who can be assigned the intervention	Developing Life Skills is an intervention for citizens in the City of Copenhagen with type 2 diabetes and/or heart disease referred to a rehabilitation programme at the Centre for Diabetes. This intervention is relevant where the other interventions do not provide the wanted changes regarding coping and self-care. The citizen must: • Be Danish-speaking. • Be motivated to work with home assignments between the four consultations.
The purpose of the intervention.	• To clarify the circumstances of the citizen and get motivation and new ideas to change the things, the individual citizen wants to change. • To make it easier to solve issues, which has so far been difficult. • To get a higher quality of life. Developing life skills is particularly useful in long-term conditions or complicated situation, where it is difficult for the citizen to move on in handling the disease. This may apply to the citizen and their relatives, but also for the health professionals, who want to support the citizen but has a difficult time finding useful solutions. With Developing Life Skills, it is possible to find new ways and mobilise a potential for change, which has not been seen before. Developing Life Skills is an alternative to the regular nursing dialogues.
Objectives	• That the adherence of improved health behaviour and the motivation for the citizen's own goal becomes easier with contact to a health professional. By giving the citizen the knowledge and the tools to act on their disease, the goal is for them to achieve greater control of their disease. • To find new ways for the citizen to handle the issues and challenges, he or she may have. • For the citizen to obtain a more significant deal of self-care, increased acting competence and to better understand how they can try to live a healthy life in the future. • For the citizen to achieve greater control of their disease by passing on knowledge and tools to act on their disease. • To learn how to set individual aims, which will be adjusted in cooperation with the councillor.

Method	Developing Life Skills is a dialogue technique, which is based on the theories about self-management and grounded theory. The technique was originally developed within complex diabetes to overcome barriers
	preventing self-managementself-management in the relation between the patient and the professional. Developing Life Skills has since been adjusted to several chronic or long-term diseases.
The framework of the intervention	A Guided own decision dialogue last for one hour. Four meetings are offered during a programme. • Relatives are welcome to join if the citizen wants it. • After the consultation, 15 minutes of documentation has been allotted. • The intervention is handled by health professionals authorised in Developing Life Skills. Read more about the framework for the intervention in the Procedure description for Centre for Diabetes.
A description of the intervention	Developing Life Skills is a dialogue between the citizen and the health professional based on several reflection sheets filled in at home by the citizen as preparation for talks with the health professional. In doing so, the citizen will gain insight into his or her reactions and be able to express what is complicated or challenging in daily life with the disease. That increases the attention on one's values and mobilises new opportunities to accomplish a wanted change. Developing Life Skills is flexible and easy to dose for the individual need. The advantage of the Developing Life Skills method is a combination of a reflection sheet and advanced professional communication, who guides the citizen and the health staff through joint decision-making. The programme focus on what is essential for the individual citizen in the way the person handles a chronic condition. The use of reflection sheet allows the citizen to acknowledge and express needs. The four dialogues are based on the following modules: 1. Cooperative agreement and your life right now. 2. Life quality between ideal and reality. 3. Change work. 4. Change work (new strategies and a long-term plan.
Handling of the intervention	Nurse certified in the method.
References	• Zoffmann, At uddanne til livet med diabetes. i Diabetes: sygdom, behandling og organisation. 1. udg, Munksgård Danmark, Kbh, 2007

5.4 Together on diabetes – diabetes buddy programme

Who can be assigned the intervention	Together about diabetes is an intervention for citizens with type 2 diabetes, who needs support in their everyday life. The citizen does not have to be referred to or in the middle of a programme at the Centre for Diabetes. The arrangement is a peer-to-peer intervention, where volunteers with diabetes put themselves at disposal for another person with diabetes in daily life. They become diabetes buddies. The arrangement is development cooperation between the Centre for Diabetes, University of Copenhagen, and The Danish Diabetes Association. Target group criteria include: - People with type 2 diabetes - Primarily men over 45 years - more diagnosis/diseases (comorbidity) - a low association to the labour market - A short education or no education - Predominantly lives alone - No association to the Centre for Diabetes or the Danish Diabetes Association - Lives in a rented accommodation - Poorly regulated blood sugar
The purpose of the intervention.	The arrangement should, in the long term contribute to the buddies getting: • Better achievement of health outcomes • Strengthened health competence • Strengthened social relations • Increased self-management and self-care skills • Increased well-being and quality of life
Objectives	Through structured and joyous time together with a peer, the buddy arrangement contributes to: • the building of positive relations • increased faith in one's competences • strengthen the possibilities of acting to the benefit of one's health

Method	Peer to peer approach where the voluntary buddies participate in a two-day preparation programme ahead of the "match" with a buddy. Also, they will continuously participate in supervision and network meetings. Match meeting: The buddy programme starts with a match meeting, where the project manager meets with the two buddies. Here cooperation, programme and shape are agreed upon, and two parties agree to start a programme. Activities: Social, practical or network establishing activities between the two buddies approx. every two weeks for six months. From one occasion to the next, it is agreed when the meeting will take place and what the sessions should contain.
	Completion of programme: Here, the buddy programme is rounded off and evaluated.
The framework of the intervention	The programme lasts for six months, where the buddies meet approx. every two weeks.
A description of the intervention	It is up to the individual buddy team to plan the content of the programme. Activities usually fall into these categories: 1) Social: walking, drinking coffee, cooking together 2) Practical: calling the doctor, preparation or follow-up of consultations or doing shopping together. 3) Bridge-building: Either for the health system (companion at the doctors, out-patient clinic) or the in the local area (participate in local social or health-promoting activities in the area).
Handling of the intervention	Voluntary diabetes buddies, who typically are recruited at the Centre for Diabetes. A project manager runs the arrangement with support from a nurse who can help to clear illness-specific issues in advance and underway in the buddy programme?
References	www.sammenomdiabetes.kk.dk SAMMEN OM DIABETES - En håndbog for diabetesmakkere, Centre for Diabetes 2019

Appendix 1. Definitions and explanations of terms

1a. Clarification of concepts

In the intervention catalogue, several technical terms are utilised, which are briefly described here.

Acting competence	Development of the acting competence includes the individual sets up and realises his or her personal goals or subsidiary goals in partly unpredictable situations. The preconditions to unfold the acting competencies are: • That you have the necessary abilities, knowledge, and skills. • That there are sufficient opportunities and resources present in the surroundings (both the close and broader surroundings). • That you are motivated. *Patient education– a medical technology assessment'. The Danish Health Authorities, Monitoring & Medical Technology assessment; 2009*
Coping/self-management	Coping and self-management mean reinforcement and the approach includes the approach interventioned to the citizen based on the potential of the citizens instead of the shortage and weaknesses. The scope is to develop the citizen's inherent strengths and acting abilities through supportive and encouraging dialogue. *Hopen L, Vifladt E Helsepedagogikk – samhandling om læring og mestring. Oslo: The national competence Centre for learning and coping with chronical illness; 2004*
Self-care	Self-care is a health activity that the citizens exercise to prevent illness and promote his or her health. It is a broad term that may cover many interventions, e.g. physical activity and exercise smoking cessation, monitoring of numbers and values, maintenance of social networks, leisure activities, and compliance for the prescribed treatment (if you have a chronic disease). Self-care can be strengthened through three general means: • Theoretical knowledge and theoretical health professional knowledge. • Practice knowledge: training of specific skills. • Experienced based knowledge: Situation specific knowledge based on competences and experience that enables the citizen to make choices contributing to a healthier life. *Self-care: a unique perspective on prevention and health promotion. Willemann og Lolk Hanak. The Danish Health Authority 2006*

Self-care skills	Self-care skills is a person's faith in his or her own ability to act in a certain way. The expectation for which affect the specific actions will have, make up the motivation for the action Both the self-care skills and motivation areas such crucial to the fact if a person completes a given behaviour or act. The different sources for self-care skills include: Own experiences, Observed experiences, Linguistic persuasion/belief, Experienced feelings, and surroundings A person's self-care skills can be strengthened in more than one way, but the different sources of self-care skills are not equally useful. For instance, one's own experience has a a strong influence on a person's self-care skills, while observed experiences and linguistic persuasion has a weaker influence. Self-care skills: The Exercise of Control. Bandura 1997
The Double KRAM (HUG)	The KRAM factors contain elements, which may affect an individual's physical health. KRAM is the abbreviation in Danish for Food, Smoking, Alcohol, Exercise. The superstructure (the double KRAM) says something about mental health and how an individual can work with the ability to handle resistance and stress in life. The superstructure consists of the terms Competences, Relations, Accept and Coping. When using the Double Kram we have chosen to expand the KRAM factors with S, which stands for sleep, stress, and sexual health. Kost (food) Kompetence (competence) Rygning (smoking) Relationer (relations) Alkohol (alcohol) Accept (accept) Motion (exercise) Mestring (coping) (Sleep, Stress, Sexual health) The double KRAM (means: HUG): A interdisciplinary work basis for mental health, health, and well-being. Peter Thybo, 2018.
Flourishing	A flourishing mindset does not only strive to prevent decline and achieve conditions away from the negative; however, it also to helps the citizens building, promoting, and grow positive emotional well-being. With a focus on flourishing, we want to move the citizen towards growth and well-being based on the thought that we can continue to learn, grow, and develop towards healthy mental robustness and physical vitality - despite chronic illness. Flourish: Positive Psychology and Positive Interventions. Martin Seligman 2010

1b. The health pedagogical juggler

At the Centre for Diabetes, we want the interaction between the citizen and the health professional to be based on the citizen's wishes and needs. That means that the health professional must be ready for spontaneous turning in the interaction without losing perspective and be able to maintain the professional framework in the interaction of the citizen. The health professional must, therefore, be able to juggle with more than one role, so that the citizen is seen and heard, inspired, and motivated and competent to act in a health-promoting way. That requires that the health professionals master the four different roles: *The Embracer - the facilitator - the translator - the motivator*

The Embracer
The embracer is the empathetic instructor tying the group together. The embracer creates confidence and security and demonstrates openness and broadness. One point of attention is that the embracer becomes emotionally involved and has a difficult time embracing everyone.

The facilitator
The facilitator listens, asks relevant questions and creates a constructive dialogue between the citizens. The facilitator feels like controlling and introducing challenging topics. Furthermore, the facilitator dares to interrupt the citizens or the talks to give space to another citizen or to ensure a positive dialogue. This part of the facilitator role can be a challenge for many instructors since it can be challenging to break the social politeness norms of communication.

The translator
The role of a translator is about passing on health professional knowledge to the citizens, which must be adjusted to the individual citizen and at the same time, be based on both planned and spontaneous input. The passing on of health professional knowledge must happen in a way, which inspire the citizens to act aim-oriented.

The motivator/entrepreneur
The entrepreneur must motivate the citizen to act and make new changes and helps the citizens to find solutions and start thoughts and ideas. Try it can be a challenge for the entrepreneur to have ambitions on behalf of the citizen and let go of the belief of knowing better. The entrepreneur must learn how to include the citizen in the solutions and not come up with the answers himself.

Reference: Gitte Engelund, Ulla Møller Hansen, Jane Rohde Voigt. Den sundhedspædagogiske jonglør: kompetenceudviklingsmodel for patientuddannelse på tværs af diagnoser. Steno Centre for Sundheds- fremme, 2011

1c. Aim and plan

During all individual dialogues, the tool Aim and Plan must be included. Aim and Plan is a tool where the citizens get help working with both long, short and ultra-short goals for their lives based on the situation the citizen is in according to the experiences the citizen have already acquired in life with a chronic disease.

The tool is utilised since research has shown that it strengthens the self-care skills with the citizen when the compliance of SMARTE aims (Specific, Measurable, Attractive, Realistic, Dated, Evaluative). Aims that are set during the initial consultation can easily be changed at the programme dialogue if the citizen's goals have been fulfilled or demand adjustment. Aim and Plan, therefore, becomes a living document, which is continuously evaluated and adjusted together with the citizen in the dialogues, so that the fulfilled goals can be celebrated, and new goals or subsidiary goals can be set. Aim and Plan also becomes a sort of logbook guiding both the citizen as well as the health professionals in their joint wish of striving towards a better life despite the chronic disease.

Aims and Plan is hence a reference tool for the citizen all through the citizen's programme at the Centre for Diabetes and can also be utilised by the citizen after a completed programme.

Aim and Plan consist of six questions, which the citizen and the health professional fill in together at the initial consultation. The six questions are as follows:

- I really want to ...
- What will I do now ...?
- How will I do it?
- Who will support me?
- What can make it easier/more challenging to reach my goal?
- How sure am I to reach my goal? (on a scale from 1-10)

It requires a certain level of reflecting on filling in Aim and Plan. Not all citizens will be able to fill in Aim and Plan at the initial consultation. However, the contact person must introduce the tool to the citizen so that he or she knows what the Aim and Plan is and gets the opportunity to reflect on possible amendments for the next consultation.

Practical utilisation of Aim and Plan
The filling in of the Aim and Plan happens during the consultation, which is why the health professional must remember to bring the paper for the consultation. When the Aim and Plan are revisited in the following dialogues and interventions, it creates a greater likelihood for achieving the set goals and giving ownership to both the citizen and the health professional.

To support the tool Aim and Plan and help the citizen achieve these, tools such as e.g. "Life wheel" and "Your life in one, five, ten years" be utilised. The tools create a reflection with the citizen, who can help to make the basis for larger life goals, shorter goals for the programme at the Centre for Diabetes, and subsidiary goals on the way to the target.

The citizen mustn't become too ambitious and unrealistic in setting his or her goals. The focus must therefore be on fulfilment of the-goals instead of the objective. An essential part of fulfilling the goal

is to focus on smaller and short-term goals. The Aim and Plan tool must, therefore, make the citizen define, which focus area(s) the citizen should work with and a plan for this should be made. A focus area can be "my negative thoughts" or "eat more vegetables". Subsequently, a strategy or plan can be made on how the citizen can work with his or her focus area towards a specific goal of eating x gram vegetables per day. By adding subsidiary goals, which are the smallest possible steps in the Aim and Plan, it is more likely that the building of the coping ability and the faith in one's skills to create change will succeed (self-care skills).

- The dialogue about the Aim and Plan is completed if possible with the health professional and the citizen together set up specific goals for the citizen, e.g. certain changes in the food, increased physical activity and a detailed and realistic plan for how and when these goals can be achieved.

Appendix 2. The individual consultations

2a. Initial assessment of needs

This overview contains a:

1. A detailed evaluation of the building and structure of the initial needs assessment.
2. A description of the professional foundation for conduction of consultation at the Centre for Diabetes.

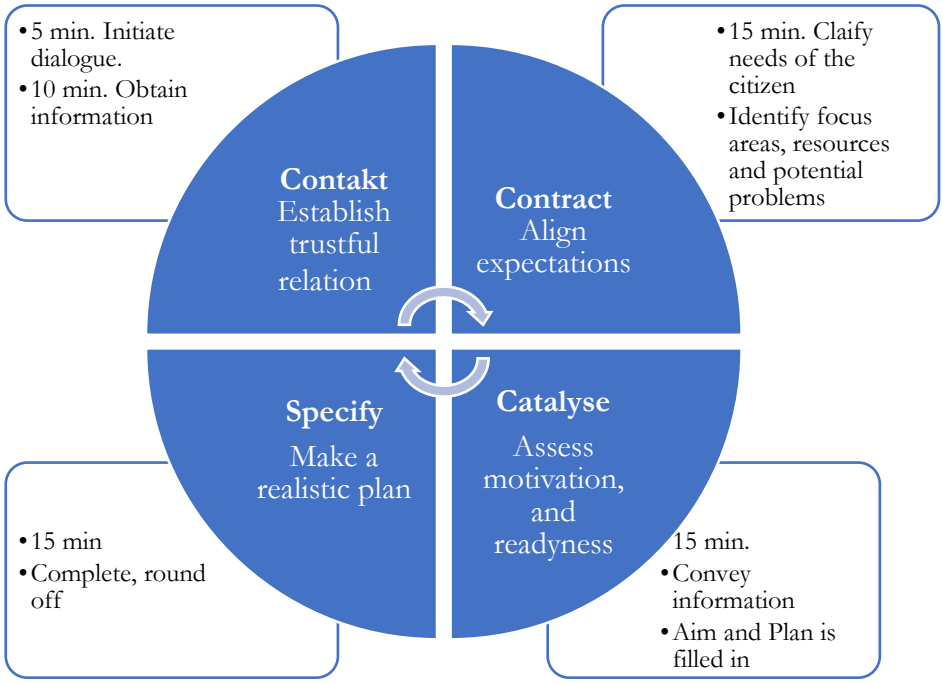
The initial consultation is the first meeting between the citizen and a health professional at the Centre for Diabetes. The consultation lasts an hour in addition to the filling in of the questionnaire and the documentation. During this meeting, the citizen's need, resources, and motivation are uncovered. The consultation results in the citizen and the health professional together plans for the citizen's programme at the centre.

1. The building and framework of the consultation

As described in the recommendations of the Danish Health Authority for needs assessment during the initial consultation, the consultation is structured in four parts:

1. Establishment of a trustful relation (contact)
2. Matching of expectations (contract)
3. Uncovering of motivation, readiness, and ambivalence (catalysis)
4. Planning of a realistic plan for the programme (concretize)

The four bullets can be seen in the figure below and are further unfolded in the table on the following page:



Content and time perspective during the initial consultation

Preparation 10 minutes	• Read referral from doctor/hospital. • CURA-/PRO questionnaire is reviewed, and the focus area is identified (what matters to the citizen).
Contact Five minutes Initiating the consultation Gather information for 10 minutes.	• Say welcome, introduce oneself (including the contact person), say hello to the citizen - ensure the identity. • Set the frame. • Consent. • The overall content of the consultation. • The purpose of the consultation: including the introduction of Aim and Plan. • If relatives participate initial their role. CURA-/PRO questionnaire – knowledge from here: - What is essential for you to talk about today – which focus areas should we concentrate on? - The Double KRAM (HUG) - Everyday life, well-being, resources, social relations. - Risk factors. Furthermore: - Assessment of functioning. - The illness scenario. - Medicine.
Contract 15 minutes	• Initial the citizen's need; potentially using "My day". • Cooperating on a well-functioning solution. • Identifying the focus areas that the citizen wants to discuss – ask openly/directly. • Confirm, summarize strengths, resources, and potential challenges and potentially screen for further ones. • Negotiate a common agenda, the needs of the citizen and the health professional are included.
Catalyse 15 minutes	• Communicate information. • The health professional expresses his or her considerations; potentially elaborating of his or her choices. • Ensuring accordance between the preferences and the opportunities of the citizen in CfD. • Aim and Plan are filled in.
Specify 15 minutes	• Uncover the motivation (potentially the scale 1-10). • Check with the citizen if the plan is accepted/ concerns/challenges. • Agree on the next step for the citizen and the health professional – who will do what? (start-up of group classes, booking of the programme dialogue, etc.). • Safety net: What happens if the citizen does not show up for the dialogue/class/training. Can I call you? • Finish by summarising (preferably by the citizen) of the consultation. • Aim and Plan are copied and handed out to the citizen. • Final check: have we forgotten anything?

Documentation 15 minutes	• The documentation/medical record-keeping can take place in connection with the consultation or continuation hereof.

2b. Alcohol

Below appears the two consultations "A brief consultation about alcohol" and "Consultation about alcohol".

Headline/Topic	A brief consultation about alcohol
Professional basis of the consultation	**A description of the professional basis for conducting the alcohol consultations** *A brief consultation about alcohol* (Very Brief Advice) and *Consultation about alcohol* can be allocated during the initial consultation or the citizen's programme. It will be the wishes and needs of the citizen combined with a health professional and a health pedagogical assessment plus the information in the referral that controls if the intervention will be initiated. Both consultations are a part of the "stepped-care"-understanding. That means that it is a graduated intervention depended on the need of the citizen and in interaction with the treatment area and *Consultation about Alcohol*. See the figure below. For both consultations, it applies that we work according to the TER-API method below: • **T**ilbagemelding (feedback) about the personal risk of the behaviour and the challenges of the change. • **E**mpati (empathy) in the shape of understanding and recognition of, e.g. feelings. • **R**åd (advice) in the shape of a clear and direct recommendation about changing the lifestyle. • **A**nsvaret (responsibility) for change must remain with the citizen. • **P**ositive (positive) changes in coping the change must be strengthened. • **I**ndividuelt (individually) adjusted approaches, including goal and actions.
A brief intervention about Alcohol	The conversation can be completed in the open space, through text messages and behind closed doors. Initially, there will be a short matching of expectations about the duration of the consultation, what the content should be and what should happen subsequently. Topics to discuss could be: • When does the citizen drink alcohol? • How does alcohol affect a citizen's daily life? • Which interventions exist in the alcohol-related field? • Other things that the citizen wishes to discuss.

Intervention about alcohol	The dialogue can be completed in more than one way and over several talks (e.g. using picture cards/dialogue cards, etc.) and may contain the following topics regarding the citizen's : • Expectations of the dialogue. • The alcohol consumption based on a screening using AUDIT C questions that the citizen answers in connection with the initial consultation. • Motivation for and experience with the change of behaviour. • The view on one's alcohol habits and the role alcohol plays in one's life. • The view on one's alcohol habit's influence on the surroundings (spouse, children, friends, colleagues, etc.). • Health risk based on alcohol consumption, the citizen's age, and health. • Goals and actions for changing alcohol habits are written in an action plan. • Recording of daily alcohol consumption. • A belief in the fact that it is possible to change one's alcohol habits. • During the dialogues, potential medicine and drug abuse may be covered. If it is assessed that the citizen has a drug abuse, it may be profitable to refer the citizen to the Centre for Drug treatment.

Appendix 3. Group lessons

3a. Framework for Living your life with type 2 diabetes and heart disease

Generally, for all lesson programmes
The first time the citizens meet the framework of the teaching is set, and there will be a joint discussion of what it takes to create an adequate education space. E.g.: • A confidential space (confidentiality). • Turn off the cell phone. • Make it a priority to show up every time. • All questions are welcome. • To speak based on one's own experiences. • Introduce the kitchenette and toilets.
Each lesson start by:
• Introducing the instructor(s). • Go through the questions from the last lesson, which are particularly relevant to today's lesson. It is clarified whether new questions have approached since last time. • Welcome new citizens. • Outline the rules of the game agreed upon during the first lesson. • Bear in mind to facilitate network and group dynamic. It does not just happen spontaneously; as health professionals, we must help create it through exercises and interactions.
Each lesson ends by:
• Reflection on: *What is the most important thing you will take with you today? Have you found the answer to some of the questions you had?* Potentially talk to each other in pairs. • A round, where those who want to, can talk. Possible follow-up by the instructor. • Round-off, and goodbye.

3b. Live your life with type 2 diabetes - classes in Danish

The six teaching modules are introduced in separate boxes below.

Headline/Topic	**1) Introduction to type 2 diabetes**
The purpose of the lessons	To give the citizen an understanding of the history and programme of the disease and basic knowledge of the things that happen in the body, when you have type 2 diabetes.
Objectives	To create the cornerstone for a network of other citizens with type 2 diabetes and having received a fundamental understanding of type 2 diabetes.
Today's presentation and exercises	Introduction and presentation, cf. Appendix 2a. Introduction of the six modules: 1. 1) Introduction to type 2 diabetes 2. Sequalae 3. Food affecting my diabetes. 4. Exercising and training. 5. Food affecting my heart. 6. The medical treatment and standard recapitulation. The three stations: To give the instructors an overview of the things that have a strong presence in the minds of the citizens, the exercise "The three stations" is introduced. It is an exercise, where the citizens must list their wishes/expectations for the coming lessons in the areas "Food and type 2 diabetes", "Exercise and type 2 diabetes" and "daily life with type 2 diabetes". That is also the headline of the associated posters. When the citizens state their wishes and expectations, the exercise becomes a guide to the instructors about which topics should be included in the classes and matching of expectations for the citizens. The filled-in posters can be included again for the following modules so that the citizens can watch that their wishes for the classes have been covered. A quiz about diabetes for the citizens. QuestionsAnswer can be found here. A survey of What is type 2 diabetes Here the movie from The Danish Diabetes Association about type 2 diabetes can be shown with an advantage: https://diabetes.dk/diabetes-2/fakta-om-diabetes-2.aspx • Heredity and lifestyle. A survey of What happens in the body • Insulin resistance (keyholes). • The programme of the illness. • The treatment triangle. • Blood sugar and hyper/hypoglycaemia. Exercise: Mention three things that you do, which are right for you and your

	type 2 diabetes.
	The citizen speaks together in groups of four about what they do, which is good for them and type 2 diabetes. Then these things are written on the blackboard for mutual inspiration.
Extra exercises	Welcome exercise/hello (choose an activity) • Who am I? (Steno) or My mood today? (Steno) Same cards for the exercises. The number of years with type 2 diabetes – line. When is it difficult? (the same as in ethnical classes) Myths (Can also be utilised for sequelae).
Supporting materials	Bring along the modules where it is relevant: • Steno box og Family box. • Blood sugar value laminated. • How to take good care of your feet. • Infographics, The Danish Diabetes Association: "How a blood clot develops. • Movie from Hjerteforeningen about the effect of smoking on the heart. • Handing out copies for the citizens about the chosen exercises. • "The man with the blood vessels". Teaching resources Several teaching resources, which can be utilised during the lessons. E.g. an outline of the game rules, laminated organs and different types of medicine, blood sugar values etc. They can be found in the nurse drawer in the classroom.
Handling of the intervention	Nurse, exercise councillor and clinical nutritionist.
Reference	Type 2-diabetes. Diabetesforeningen. Side 6-10 og 43-49.

Headline/Topic	**2) Sequelae**
The purpose of the lessons	That the citizen obtains an understanding of the correlation between high blood sugar, BT, cholesterol, and sequelae. Also, the purpose is to trigger a dialogue about the mental/psychological challenges that might be connected with a chronic disease.
Objectives	After the end of the classes, the citizen should have learned about sequelae and what the citizen can do to prevent the progression. In addition, the citizen should have learned about the recommended preventive controls.

Today's presentation and exercises	The citizen should learn about his or her acting possibilities regarding prevention of sequelae. Focus on flourishing (in particular, that the citizens are praised for all the little things that they are already doing well) and not blaming the victim. What are the discomforts of the sequelae, and what can they do themselves? <u>Sequelae which must be gone over</u> The man on the blackboard – can be drawn in with a free hand or found as a template in the EMMA box. - Neuropathy. - Brain. - Heart (BT, cholesterol, smoke).
	- Feet (skin, healing). - Kidneys. - Eyes. - Sex (remember the sex box and the film) (The group is only divided if it makes sense). - The mental. - Teeth (periodontitis, infection). - Sleep. The evaluation of the various sequelae mustn't be on too high a level. The important part is that the citizens understand that they need to remember their check-ups and why and that they cannot physiologically explain why. A joint discussion of how we take good care of ourselves during the evaluation of the sequelae and a reminder of booking the check-ups they are not attending. Home assignment: Fill in the schedule for changes of one thing for next time. Follow-up of the modifications done for today.
Extra exercises	Other sequelae, which may be gone through if relevant for the citizens: - Gastroparesis. - Intestine. - Hearing. - Dementia.
Handling of the intervention	Nurse.
Reference	Type 2-diabetes. Diabetesforeningen. Side 50-63

Headline/Topic	3) Food with a focus on carbohydrates
The purpose of the lessons	• To learn and gain knowledge about the importance of the food regarding type 2 diabetes: particularly regarding carbohydrates. • To obtain an understanding of how the citizens can each change their habits in a health-promoting way. • To obtain acting competences by being able to assess each of the food and based on this, make better choices in a health-promoting perspective.
Objectives	That the citizen gains insight into the fact what carbohydrates are, and how both carbohydrates and food in general affect type 2 diabetes. Furthermore, the citizens have obtained an understanding of how they can help regulate their blood sugar through the food.
Today's presentation and exercises	Carbohydrates and their effect on the blood sugar and type 2 diabetes, the optimal meal distribution, and its impact regarding the regulation of blood sugar and the plate model. General subdivision of food in the four boxes. A survey of carbohydrates in the three groups – how they affect the blood sugar. Plate model Portion size Meal frequency Shopping card The Keyhole label and the Whole Grain label <u>Home assignment</u>: Fill in the schedule for changes of one thing for next time. Follow-up of the changes done for today. Remind that the motivation group will come at end class.
Extra exercises	Carbohydrate quiz pools coupon Sweeteners: frequency/amount (show with dummies)
Supporting materials	• Product dummies, with a focus on carbohydrates. • Blood sugar value laminated. • "Pools coupon about food". • Shopping guide from the Danish Diabetes Association. • Pictures of plate models. • The Keyhole model. • Balance card from The Danish Diabetes Association or the Steno box. • Healthy snacks
Handling of the intervention	Clinical nutritionist.

Reference	Type 2-diabetes. Diabetesforeningen. Side 25-37
NB	The motivation group from the Danish Diabetes Association will be present to introduce the group at the end of the class.
Headline/Topic	**4) Exercising and training.**
The purpose of the lessons	• That the citizen understands the effect and impact of exercise in daily life. • To create an understanding of how to regulate the blood sugar just by moving. • That the citizen has a forward-looking plan created for increased movement in daily life.
Objectives	• To have the cornerstone created to signal the difference between exercise/training and movement. • To obtain a fundament understanding of how simple movement can impact blood sugar. • That the citizen has planned for the changes, he or she can make to increase their movement in daily life.
Today's presentation and exercises	**Presentation of today's program (5 minutes)** A) Measuring of blood sugar - a walk - measuring of blood sugar B) Why move? C) How much does it take? D) What can I do? **A) Practical exercise with BS measuring (40 minutes)** Measuring of blood sugar noted on flip-over Walking approx. one kilometre or 15-20 minutes. The class may be divided into two if there is a big difference of level in the class. The ones who have the most prominent walking disabilities can walk rounds around the block, together with the nurse. The participants must be instr. in interval walking. If walking around the block, it may be a fast walk on the long side and a slow walk on the short side. On the walk around the local area, the intervals can take place between benches, lamp posts, etc. Or by using apps if some of the participants have experience with that. Measuring of blood sugar after the walk, which is also noted on flip-over. **B) Why move (15 minutes)** Joint talk about BS-values and the changes by physical activity – what are the roots of it. The citizen must mention other reasons to move, preferably according to his or her own experiences. Subsequently, talk about the effect/reward of movement, **Break (10 minutes)** **C) How much does it take? (10 minutes)** • The recommendations from the Danish Health Authority (30 minutes daily exercise with moderate to high intensity+ 2 x 20 minutes with high intensity per week). **D) What can I do? (10 minutes)** <u>Intro for the citizen:</u>

	The recommendations from the Danish Health Authority are based on large groups of people and applies to the broad public. It has been examined what it takes to lower the risk of illness and early death. The importance of emphasising the fact that work in the entrance, the house, and the garden is also accepted as an exercise type. Sedentary work increases the risk of 3x for death than for those who do not sit down. For citizens with diabetes, it is even more critical. Here, the citizens were asked to move every
	half-hour with four exercises/time. Had a positive effect on blood sugar and the production of insulin. Fat in the blood, physical fitness, the waist measurement is also measured, and all show a positive effect by interrupting the sedentary time. **Exercise:** *Fill in the schedule of how much you sit still on a typical day and state the time in hours or minutes. You must think about the time where you are continuously sitting still. E.g. watching tv, sitting by the PC, reading, knitting or similar. You also must state how long you sleep, but NOT include it in the total time spent. You will have five minutes.* Material: My day (insert link). *"Now, in groups of three, you have to go to the blackboard and tell each other about your day and* *help each other with good ideas on how to reduce the time. An example could be."* (here you will take two-three examples from the Tips and Tricks not, so the participants understand what it potentially could be). "*Write three ideas on the blackboard so that all the good ideas can inspire the rest. You will have 10 minutes*". NB! The groups must be relatively homogeneous. So if the citizens are sitting, so that it is evident that the resources will not be equal in the groups, it might be a good idea to count 1, 2, 3 instead of making the groups based on how they are sitting. Going through the good ideas from the groups, standing in the groups or sitting at the table. *"What have you come up with?"* The participants must now, individually, fill in the blue box on the schedule "what will I do different tomorrow". Material: Subsequently, the sheet with the Tips and Tricks can be handed out. Round-off: • Check that all the questions from the first time have been covered (Exercise and type 2 diabetes). • Check if there are any unanswered questions form the citizen.
Supporting materials	Aim and plan, if the citizens wish to have their new goals specified in detail for increased activity in daily life. Material about strength training, fitness training, and the impact of the exercise on the blood sugar.
Handling of the	Exercise councillor + nurse.

intervention	
Reference	Type 2-diabetes. Diabetesforeningen. Side 16-24

Headline/Topic	**5) Food with a focus on fat**
The purpose of the lessons	• To learn and gain knowledge about the importance of the food regarding type 2 diabetes: particularly regarding fat. That the citizen obtains an understanding of how he or she can each change their habits in a health-promoting way. • To obtain acting competences by being able to assess individual food and based on this, make better choices in a health-promoting perspective.
Objectives	• To gain insight into what fat and proteins are, and how both proteins and food generally impact type 2 diabetes. Furthermore, the citizen has obtained an understanding of how he or she can help regulate his or her blood sugar through the food.
Today's presentation and exercises	Summary from last time – E.g. with the carbohydrate quiz. Follow-up on the citizen's personal Aim and Plan Fat types and – quality (dummies) Meal distribution Healthy snacks Por- tion sizes Plate models Alcohol Salt Sweeteners - if it was not gone through the time be- fore the shopping guide Cholesterol Quiz about fat Home assignment: Fill in the schedule for changes of food for next time. Follow-up of the changes done for today.

Supporting materials	• Product dummies with a focus on fat, sweeteners and Seltin. • Blood sugar value laminated. • Pictures of healthy and unhealthy sources of fat, the hidden salt. • "Pools coupon about food". • Shopping guide from the Danish Diabetes Association. • Pictures of plate models. • The Keyhole model. • Balance card from The Danish Diabetes Association or the Steno box. • Find five fat sources healthy for the heart – quiz. • ”Food with unhealthy fat”. • ”Food with healthy fat”. • "The man with the blood vessels". • Healthy snacks
Handling of the intervention	Clinical nutritionist
Reference	Type 2-diabetes. Diabetesforeningen. Side 25-37

Headline/Topic	**6) The progress of the disease and the medical treatment**
The purpose of the lessons	• To get an understanding of the progress in type 2 diabetes and the treatment of this. • To get an understanding of the purpose of the check-ups, the citizen must go to. • To learn how the medication can regulate the progress of the disease and how necessary the medicine is. • To learn about several acting opportunities, which can increase the citizen's self-care after the end of the lessons.
Objectives	• To learn about the progression of the illness and understand how the illness should be treated. • To learn what they can do in the future to control their illness. • To learn who to go to for help if they run into challenges. • That the citizen, after the end of the lesson, understands their action plan.
Today’s presentation and exercises	Focus on an increased need for treatment over time. The pathological picture may change. Guilt and shame. Why are lifelong check-ups necessary? That type 2 diabetes is a chronic disease and that it is important to do the various check-ups. Learn how to follow the progress of the disease and regulate the medication and lifestyle to get the best programme of the disease as possible. Draw the development line for the choice of medication (the physiological development must be included). Focus on objections against medication, challenges posed for taking medication, the effect of the drug on the blood sugar, finances concerning the medication, normalise the amount of medicine. Exercise: agree/do not agree with cards from the Steno box and EMMA Quotes about medication that the citizens must assess if they agree/do not

	agree with. The Diabetes quiz – repeated from the first time. Follow-up from the first lesson with the three stations: - 'Me and type 2 diabetes.' - 'Food and type 2 diabetes.' - 'Exercise and type 2 diabetes.' Make sure all the topics have been covered. Ask if the citizens feel clarified in every way. Brief coverage of the home assignments with changes from time to time. Talk to the person next to you about what they have achieved in six weeks. Inform about the network groups. Evaluation • To what extend to do you feel that the lessons have met your expectations? What have you been exceedingly satisfied with, and which parts require improvement? • To what extent do you expect to be able to live according to the advice and the guidance you have received? What will be particularly challenging?
Extra exercises	Exercise from PIFT: The Family line – how much of a strong presence is type 2 diabetes for my family and me? How well equipped do you feel about going into the world with your type 2 diabetes? Exercise: My challenges The Treatment Triangle
	Test study– show it, e.g. when being fearful of injection technique – how often change, injection place, size of the needle Shown on the computer: Minmedicin.dk E-journal.dk Pharmacy, finances, medicine check at the pharmacy, subsidies
Handling of the intervention	Nurse during the first class. Nurse, physiotherapist, and nutritionist (if possible) during the last class.
Reference	Type 2-diabetes. Diabetesforeningen. Side 64-78

3c. Live your life with type 2 diabetes - classes for ethnic minorities

Generally, for all lesson programmes

The first time the citizens meet the framework of the teaching is set, and there will be a joint discussion of what it takes to create an adequate education space. E.g.:

- A safe and confidential space.
- Turn off the cell phone.
- Make it a priority to show up every time.
- All questions are welcome.
- To speak based on one's own experiences.
- Introduce the kitchenette and toilets.

Preparation

The folder

From the beginning, everyone gets handed a folder the folder will be in the storage room and contains:

- The program (My diabetes education)
- When is it difficult for me to have type 2 diabetes?
- My symptoms: High and low blood sugar.
- Food affecting my blood sugar (with animals).
- Blood sugar values.
- T-plate.
- Exercise– my biggest temptation.
- Five training exercises.
- Home assignment.
- (Shopping guide in four languages).
- Shopping guide.
- Balance card.
- Lampoon over the Centre for Diabetes.

Each lesson start by:

- Introducing the instructor(s).
- Go through the questions from the last lesson, which are particularly relevant to today's lesson. It is clarified whether new questions have approached since last time.
- Welcome new citizens.
- Outline the rules of the game agreed upon during the first lesson.
- Bear in mind to facilitate network and group dynamic. It does not just happen spontaneously; as health professionals, we must help create it through exercises and interactions.

Each lesson ends by:

- Reflection on: *What is the most important thing you will take with you today? Have you found the answer to some of the questions you had?* Potentially talk to each other in pairs.
- A round, where those who want to, can talk. Possible follow-up by the instructor.
- Round-off, and goodbye.

Particularly for instructors in ethnical minority classes

- Having acquainted oneself with the CUSTOM tools before the classes.
- Be aware of the cultural beliefs and show respect, e.g. how to welcome them, offer praying rooms and if the citizens should get the coffee themselves etc.

- New employees must be trained by experienced employees since a different approach is necessary for teaching than in the Danish-speaking classes.
- An interpreter is utilised during these classes. It should be the same interpreter during all six modules.
- Fifteen minutes must be allocated before and after classes for matching of expectations with the interpreter; it is most important the first time. It is a good idea to go through today's program, technical terms, or cultural beliefs with the interpreter.
- It is essential to speak in brief sentences so that the interpreter can translate correctly.
- Remember to tell the interpreter that it is essential if he or she interrupts to be able to translate.

Health communicator

It is essential to clarify before the class starts if the health communicator will participate during all classes. It makes no sense only to participate during some classes. If the health communicator participates during classes, she must also be invited to the preliminary meeting.

The health communicator can, with advantage take over the classes about Ramadan. It can be agreed upon internally if there are other exercises that the health communicator should handle; otherwise, it is the primary health professionals, who handle the specialist content.

Calling of citizens before the health communicator handles the classes. That gives a higher attendance.

An essential part of the health communicators role is the informal talk with the citizens during the breaks. Here she is often told, where the citizens live and can refer them to network groups in the respective areas.

General citizen addressed prevention, such as, e.g. including everyone in the family, individual smoking cessation in another language

etc. is also a large part of the health communicator's task during the lesson plan.

The six modules

1. 1) Introduction to type 2 diabetes
2. Sequalae
3. Food affecting my diabetes.
4. Exercising and training.
5. Food affecting my heart.
6. The medical treatment and familiar recapitulation. Below, the individual classes are gone through in details.

Headline/Topic	**1) Introduction to type 2 diabetes**
The purpose of the Education	• To establish a foundation for the creation of relationships between the citizens. • To express personal challenges with diseases. • To obtain an understanding of the history of the disease and programme and basic knowledge of the things happening in the body, when you have type 2 diabetes.
Objectives	To create the cornerstone for a network of other citizens with type 2 diabetes and having received a fundamental understanding of type 2 diabetes.
Introduction	Everyone writes nameplates and gets help to do it if they cannot do it themselves. Introduction of the instructors. Game rules. Introduction for the program for the six modules ("Diabetes education" from Steno, doc. 1 in the folder). Distribution of folders. An important point here is the fact that the classes are dialogue-based and not a monologue. The language must have a low readability index. When is it difficult for me to have type 2 diabetes? (doc 2 in the folder). Must allocate 10 minutes for discussion in pairs and then have a general discussion in the class. Introduce an energizer, so that everyone gets up and says hello to someone, they have not talked to before. A health professional summarises while another writes on the flip-over. <u>What is type 2 diabetes</u> • Heredity and lifestyle. • Exercise 8.1 – Family case. - Here the focus should be on talking type 2 diabetes into the family. <u>What happens in the body?</u> • Insulin resistance. • Blood sugar and hyper/hyperglycaemia (doc. 3+4 in the folder). <u>Exercise: Mention three things that you do, which are right for you and your type 2 diabetes (or your health).</u> The citizens talk in pairs about what they do that is good for them and type 2 diabetes/health. Subsequently, these things are written on the blackboard for inspiration for each other and as a reminder for the next class.
Handling of the intervention	Nurse exercise instructor, clinical nutritionist, health communicator.
The book	Reference side 6-10 og 43-49

Headline/Topic	**2. Sequelae, mental resources, and social support**
The purpose of the education	• That the citizen obtains an understanding of the correlation between high blood sugar, BT, cholesterol, and sequelae. Furthermore, the purpose is to provoke a dialogue about the metal/psychical challenges potentially connected when living with a chronic disease.
Objectives	• After the end of the classes, the citizen should have learned about sequelae and what the citizen can do to prevent the progression. In addition, the citizen should have learned about the recommended check-ups.
Today's presentation and exercises	The citizen should learn about his or her acting possibilities regarding the prevention of sequelae. Remove the focus from blaming the victim. What are the discomforts of the sequelae, and what can they do themselves? A joint introduction to the day and recapitulation from last time. <u>Sequelae which must be gone over</u> Exercise: What do I do to take care of myself (from the EMMA box). - Neuropathy. - Brain. - Heart (BT, cholesterol, smoke). - Feet (skin, healing). - Kidneys. - Eyes. - Sex (remember the sex box and the film) (The group is only divided if it makes sense). - The mental. - Teeth (periodontitis, infection). Ten minutes where they find cards in pairs. Afterwards, they put the cards on the man, and the sequelae are gone over. A joint discussion of how we take good care of ourselves and the evaluation of the sequelae and a reminder of booking the check-ups the citizens are not attending. A large majority of the citizens from ethnic minorities do not follow their check-ups, so it is essential to focus on if there is a need to help book the check-ups.
Preparation	The exercise with the sequela from the EMMA box.
Handling of the intervention	Nurse exercise instructor, clinical nutritionist, health communicator.
Reference	Type 2-diabetes. Diabetesforeningen. Side 50-63

Headline/Topic	**3) Food affecting my diabetes.**
The purpose of the lessons	• To learn and gain knowledge about the importance of the food regarding type 2 diabetes: particularly regarding carbohydrates. • That the citizen obtains an understanding of how he or she can each change their habits in a health-promoting way. • To obtain acting competences by being able to assess each of the food and based on this, make better choices in a health-promoting perspective.
Objectives	• That the citizen gains insight into the fact what carbohydrates are, and how both carbohydrates and food in general affect type 2 diabetes. Furthermore, the citizen has obtained an understanding of how he or she can help regulate his or her blood sugar through the food.
Today's presentation and exercises	Carbohydrates and their effect on the blood sugar and type 2 diabetes, the optimal meal distribution, and its impact regarding the regulation of blood sugar and the plate model. Summary from last time and introduction for today's program. Overall subdivision of food in the four groups (carbohydrates, fat, protein, alcohol). Exercise 5 CUSTOM: Food affecting my blood sugar (doc. 5 in the folder). A survey of carbohydrates in the three groups – how they affect the blood sugar. Please base it one "my biggest temptation". <u>Topics which should be covered</u> Plate model Portion size Meal frequency Keyhole logo and Whole Meal logo (do not spend too much time on that) Exercise: Talk about the colour/animal category the food they eat belong to. <u>Follow-up on the day</u> Potentially select a temptation that they want to work on for next time.
Preparation	Exercises from CUSTOM
Handling of the intervention	Nurse exercise instructor, clinical nutritionist, health communicator.
Reference	Type 2-diabetes. Diabetesforeningen. Side 25-37

Headline/Topic	**4) Exercise and training.**
The purpose of the lessons	• To get a comprehensive insight into the significance of sizes and intensity of the training in everyday life and how this can be implemented in the citizen's own life. • To work with one's own motivation regarding exercising and movement and which interventions will benefit and gratify them the most. The classes are divided into a practical part (walking) and a more theoretical part. The purpose of walking is for the citizen <u>to experience</u> the impact of physical activity's influence on the blood sugar and in this way obtain an understanding of how this can be utilised in one's regulation of the blood sugar.
Objectives	• That the citizen obtains increased acting competence through more excellent knowledge and understanding of training and movement's beneficial effects on life with type 2 diabetes. • That the citizen obtains awareness of his or her own need for a more active lifestyle and the opportunity to maintain this lifestyle.
Today's presentation and exercises	<u>Summary from last time and introduction for today's program.</u> <u>1.</u> <u>class: walking+ dialogue about BS values</u> • Blood sugar measuring before walking. Their pre-measuring is written on a flip-over. Those who do not have type 2 diabetes are also allowed to have their BS measured. • The citizen will guess if they think their BS will increase, fall, or remain unchanged. • The citizens are instructed to alternating walk in a slow and quick pace. • BS is measured again and noted on a flip-over. Dialogue about the results. Joint discussion about blood sugar. • The physiological explanation of why it is vital to exercise. - Show the triangle again with Food-Exercise-Medicine <u>2.</u> <u>class: Clearing of motivation for exercise/anchorage.</u> Focus on amounts and intensity, how little or how much it takes to achieve a given effect. The dialogue is supported by Borg 15's intervention scale and the recommendations by the Danish Health Authority for physical activity. Our focus will be on the citizen's own experiences and wishes for training and exercising. Which steps should the citizen take to implement more exercise in his or her everyday life? Exercise 5 CUSTOM: My biggest temptation – exercise. The nurse talks about the home assignment with measuring of BS revolving training and food. Recapitulation of the day.
Preparation	Recipes. Blood sugar device.

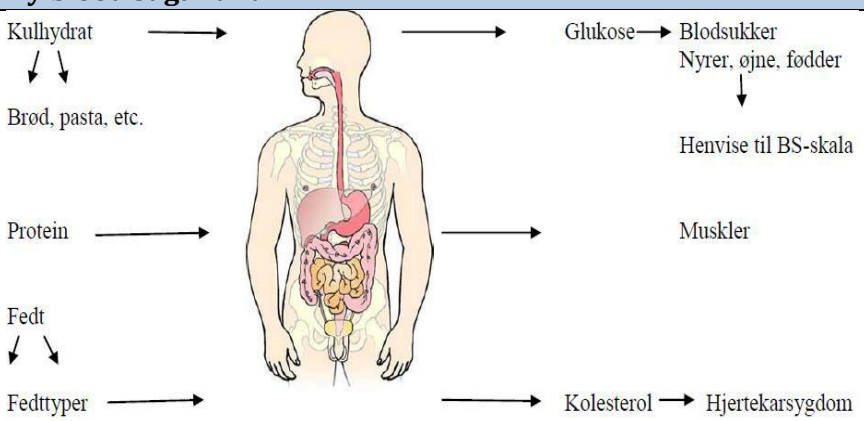
Handling of the intervention	Nurse exercise instructor, clinical nutritionist, health communicator.
Reference	Type 2-diabetes. Diabetesforeningen. Side 16-24

Headline/Topic	**5) Food affecting my heart.**
The purpose of the lessons	• To learn and gain knowledge about the importance of the food regarding type 2 diabetes: particularly regarding fat. That the citizen obtains an understanding of how he or she can each change their habits in a health-promoting way. • To obtain acting competences by being able to assess each of the food and based on this, make better choices in a health-promoting perspective.
Objectives	• To learn and gain knowledge about the importance of the food regarding type 2 diabetes. • To obtain an understanding of how they can each change their habits in a health-promoting way. • To obtain acting competences by being able to assess individual food and based on this make better choices in a health-promoting perspective.
Today's presentation and exercises	Summary from last time and introduction for today's program. Exercise 6 CUSTOM: Food affecting my heart. The citizens must understand what is beneficial for their hear and what is less beneficial for their heart. Introduce "my temptations" about fat. <u>Topics to be discussed:</u> - Fat types and – quality (dummies). - Cholesterol - Meal distribution. - Healthy snacks. - Amounts of portions. - Salt. - The shopping guide. Recapitulation of the day.
Preparation	The exercise from CUSTOM.
Handling of the intervention	Nurse exercise instructor, clinical nutritionist, health communicator.
Reference	Type 2-diabetes. Diabetesforeningen. Side 25-37

Headline/Topic	6) The progress of the disease and the medical treatment
The purpose of the lessons	• To get an understanding of the progress in type 2 diabetes and the treatment of this. • To get an understanding of the purpose of the check-ups, the citizen must go to. • To learn how the medication can help regulate the progress of the disease and how necessary the medicine is. • To learn about several acting opportunities, which can increase the citizen's self-care after the end of the lessons.
Objectives	• To learn about the progression of the illness and understand how the illness should be treated. • To learn what they can do in the future to control their illness. • To learn who to ask for help if they experience challenges and that they receive the best possible treatment.
Today's presentation and exercises	Summary from last time and introduction for today's program. Introduced to the programme of the illness. Draw the development line for the choice of medication (the physiological development must be included). Exercise: my challenges from EMMA. Everyone chooses a picture card, and we talk about the challenges they can have against medication. Focus on objections against medication, challenges posed for taking medication, the effect of the drug on the blood sugar, finances concerning the medication, normalise the amount of medicine. Focus on an increased need for treatment over time. The pathological picture may change. Guilt and shame. Why are lifelong check-ups necessary? That type 2 diabetes is a chronic disease and that it is important to do the various check-ups. Learn how to follow the progress of the disease and regulate the medication and lifestyle to get the best programme of the disease as possible. The triangle is introduced again with Food-Exercise- Medicine After the medication, and the home assign- ment is gone over. Evaluation • What did you gain from it? • What will you continue with? Take your point of departure in Exercise 10: Agreement with myself (doc 2 in the folder) Summarise what they have done previously.
Handling of the intervention	Nurse exercise instructor, clinical nutritionist, health communicator.
Reference	Type 2-diabetes. Diabetesforeningen. Side 64-78

3d. My blood sugar and I

Headline	My blood sugar and I
1. module	**Opening (15 minutes)** • Welcome. • Introduction of the instructors. • The two meetings – content. • Set up frames for the class. • Confidentiality. • Speaking time for everyone/no interruptions. • Mobile phone silent/turned off. • Make room for diversity. • Show up on time. • Are there additions from the class? • Name round. **Exercise: training in measuring of blood sugar (35 minutes)** The blood sugar device is handed out, and the procedures are gone over. The citizens measure the blood sugar, and the result is written on the blackboard (we ask permission to write on the blackboard). Why should we measure blood sugar? Who should measure their blood sugar? Explanation of blood sugar numbers: • Own blood sugar measuring values. • HbA1c values. • How they correspond to each other. Break (10 minutes) **Quick repetition** – introduction from the basic package by the laminated man and blood sugar value scale. What happens in the body when we eat? • Sources of carbohydrates. • Carbohydrate quality affects blood sugar in different ways. **Exercise:** Ask the citizens to choose a picture card or dummies on food, that gives a fast-respective slow blood sugar increase. What happens in the body when we eat? Time (45 minutes)

Headline	My blood sugar and I
	 **Presentation of home assignment (10 minutes)** Hand out sheets with home assignments: Citizens must make blood sugar profiles: - Before and after breakfast. - Before and after dinner. - Before and after 20 minutes movement, potentially a walk (minimum 20 minutes). **Summary– round off** Potentially, what am I bringing home today?

2. module	After two weeks **Intro** My mood today from Steno. Or thoughts from last time. **The home assignment (50 min)** Going through the home assignment. Each home assignment will be gone over at plenary**.** How do we interpret the numbers - what do we need it for? **Break (10 minutes)** **Exercise (45 min)** Talk together in pairs. Why should we measure blood sugar, and what do we need it for? **Summary in plenary and review of:** • When and how much should I measure? • Who should measure their blood sugar? How does it feel to have respectively hyper and hyperglycaemia? What are the acting options based on both conditions? Citizens buzz for five minutes – experiences are shared in plenary. Rules about the application for shred, lancets. Potentially help for filling in the application. Cooperates with a health professional, one's doctor, outpatient department.

Headline	**My blood sugar and I**
	Summary (15 minutes) Recap of questions for the citizens; ask the citizen to write on a post-it: "Mention one thing that you have made out today." Collect the post-its. **Round-off.**

Supporting materials for both modules.	Bring along for the classes: • Whiteboard and markers, pen. • Laminated A3 ”blood sugar value scale”. • Laminated A3 sheet ”The Man”. • Blood sugar box; container for needles, needles for finger perforating, disinfection, shreds, device, cotton wool, gloves, kitchen roll. • Dummies/pictures of food for exercise about fast/slow blood sugar increase. The citizen will be handed out: • BS devise and strips. • Copy of blood sugar value scale. • Value card. • A5 copy hypo and hyperglycaemia drawings. • Home assignment sheets for blood sugar measuring.
Handling of the intervention	Nurse and clinical nutritionist

3e. Live your life with a heart disease

Headline/Topic	**1) What's in your heart**
The purpose of the module	• To establish a basis for relations and networking, gain an increased awareness of what has a strong presence in everyday life with heart disease and the wanted changes. For the instructor, the purpose is to get an overall impression of the group of citizens; including hearing how the individual citizen talks about his life situation with the disease to facilitate, juggle and plan the collected lesson plan based on the need of the group.
Objectives	• To get to know each other to establish a foundation for increased group dynamic and reflection. • To gain increased attention to the fact of what has a strong presence in life with heart disease and the wanted changes.
Lesson 1 Introduction to the programme.	• Welcome and introduction of the instructor. - Nameplates, introduction to the folder. - The overall purpose of the programme+ short description of the content of the modules - Methodical and professional approach (the broad health term, The Double Kram, active participation, change between exchange of experience, dissemination of information and exercises). - Game rules/frames for the classes/absence. - Accepting each other/room for everyone's feelings.
Introduction to today's topic Presentation	• Going through the objectives. • An overall presentation concerning the citizens' heart diseases and programme. Is run by the instructor with questions in plenary. • Intro for the exercise: *"Who am I":* Presentation based on the Steno card. Who am I, and what is crucial for me? Summary in plenary

Lesson 2 What has a strong presence concerning today's topic	• Intro for exercise: "The pedagogical sun". What has a strong presence/thought regarding life with heart disease? Is written on a flip-over. • Intro for exercise: "How am I doing". Sheets are handed out. 1.: How strong a presence does heart disease, have in terms of the wanted life? Reflect and mark on a line (has a small presence - has a strong presence). 2.: Buzz with the person next to him her/in plenary regarding how much/what has a strong presence. 3.: Recapitulation in plenary. Introduction for reflection that the citizen can give more thought. Which dreams and changes are wanted (and what is standing in the way). What does it take to achieve the desired changes? Own faith in handling challenges and wanted changes.
The coming modules	• The modules are reviewed with a focus on emphasizing the common thread in the modules. The order of module 2-4 is professionally estimated according to the specific need of the group (pedagogical sun and exercise).
Matching of expectations	• Match the expectations of the citizens. Do the expectations match the topics in the programme?
Summary and round-off	• Summary of today's topics. Focus on next time. Which reflections do the citizens take with them?
Supporting materials	A3 pictures: The purpose of the programme and Objectives, puzzle heart, mountain climber, health tray, bar chart active participation, "can one get a word in edgeways", The double KRAM (HUG), future programme times. Film: "It's about living as regularly as possible (grab life). Pictures, exercises and potential presentation can be found in the toolbox here.
Material for hand out	Folder (programme overview, objectives, notepaper, today's exercise).
Handling of the intervention	Nurse
Reference	I balance med kronisk sygdom: s. 57: - Øvelse "Hvem er jeg"

Headline/Topic	**2) My heart disease in daily life**

The purpose of the module	• To gain an understanding of one's heart disease, symptoms, and medication for strengthening self-care and acting competences.
Objectives	• To increase the understanding of one's heart disease and life with a chronic illness. • To strengthen one's acting opportunities concerning symptoms. • To get tools to handle medical treatment in everyday life.
Lesson 1 Introduction to today's topic What has a strong presence concerning today's topic Heart disease	• Going through the objectives. - A presentation of general/general thoughts and questions concerning heart disease, the experience of symptoms and medical treatment. • What has a strong presence concerning heart disease, symptoms, and medication? Is utilised as a base of dissemination of information and weighting of topics. - The three topics are written on a flip-over. Buzz in pairs/individual reflection with post-its. Plenary summary. • Dissemination of information about heart disease and illness progression based on the citizens' heart disease and programme. - Linking to the citizens' own experiences on the way.
Lesson 2 Symptoms Medicine Summary and round-off	• Dissemination of information about symptoms and handling. - Include the citizens' own experience of symptoms and handling on the way Focus on acting competence and when it can be difficult to distinguish between immediate/moderate/easy symptoms or anxiety. Exchange of experience. • Dissemination of information about general medical treatment/drugs. - Possible changes, e.g. remember the medication, counterfeit drugs, side effects, resistance, finances, subsidies, travelling, recommendations by the Danish Health Authority - Include the citizens' own experience about the medicine on the way. - Steno card "My illness and I" (focus on medicine questions) can be utilised. - Information about useful apps (a comprehensive list is also handed out during the last programme). • Summary of today's topics. Focus on next time. Which reflections do the citizens take with them?

Supporting materials	- *A3 Pictures*: Circulation, universal constriction of arteries, development of constriction of arteries, angioplasty before/after, stent, bypass surgery, reduced pumping function, atrial fibrillation -EKG, cardiac valve disease, symptoms, situations with an immense oxygen need, nitro-glycerine before/after, medicine- main groups, medicine glasses/boxes. -Heart model, vessel model. -Film: The average heart and cardiovascular disease, heart failure, cardiac valve disease, atrial fibrillation, treatment, and patient experiences. - Pools coupon-The Heart (focus on ischaemic heart disease). - Medicine boxes/glasses (show the content matter contra drug name). -Apps: 112 with a GPS, Medicin tjek, Min medicin, Medicinkortet, Medicin Husker. Pictures, exercises and potential presentation can be found in the toolbox here.
Material for hand out	Hjertebogen, Livet med hjertesvigt, øvrige relevante pjecer fra Hjerteforeningen (atrieflimren, hjerteklapsygdom, forhøjet blodtryk, Kolesterol, ballonudvidelse, bypassoperation), "Når hjertet flimrer "(SIG-atrieflimren).
Handling of the intervention	Nurse
Reference	I balance med kronisk sygdom: s. 78 – Øvelse "min sygdom og mig". Udsagn om medicin generelt. Kort som vedrører diabetes udtages.

Headline/Topic	**3) Improved health behaviour**
The purpose of the module	• That the citizens gain insight into the physical circumstances, which are essential for the health and focus on one's own wishes about change and acting opportunities.
Objectives	• To gain an understanding of which circumstances affect health and are essential for the development of heart disease. • To obtain acting opportunities and gain more extensive insight into one's own wishes regarding change related to living the best possible life with heart disease.
Lesson 1 Introduction to today's topic What has a strong presence concerning today's topic Dissemination of information about physical circumstances essential to the health/risk factors	• Going through the objectives. • Uncover the citizens' understanding of the physical circumstances there are essential, the need for knowledge and acting opportunities. Reduce guilt and shame. Important circumstances/risk factors in writing on the flip-over. • Intro to exercise: Susceptible/non-susceptible factors. The citizens work individually. - Recapitulation in plenary based on one-two examples. How do you work, or does the citizen want to work with this change? - Exchange of experiences in plenary.

	- Focus on what you would like to achieve and do more of (flourishing). The instructor is generally aware of "how little knowledge" there is a need to make changes. Citizens' knowledge is included in communication and how to look for further knowledge.
Lesson 2 To make changes Working with goals/ Aim and Plan Self-care skills Recapitulation and round-off Other interventions in CfD	• Communication about natural phases and barriers in processes of change. - Going through the phases of the wheel of change, the inclusion of the citizens' experiences. - How "pitfalls" can be planned (when X occurs, I will do X). • Communication about the method "small steps" and "smart aims". - Intro to the exercise "Small steps" and "Aim and Plan" (that some people know from the initial consultation). Both can be linked together (work more at home). - Recapitulation in plenary, with examples. To be revisited during the last class. • Communication about the faith in having the strength, the abilities, and the resources to create positive change with small steps. Exercise: ”Importance– and line of faith”. • Summary of today's topics. Focus on next time. Which reflections do the citizens take with them? • Information about offers food inspiration, physical training, smoking cessation, alcohol dialogues.
Supporting materials	-A3 Pictures: The Double KRAM (HUG), photos from Food inspiration, urge/aversion diagram, mountain climber, health tray, the wheels of change, the wheel of change with smoking, small steps, smart goals. -Film: You can do a lot yourself (Grab life). -Exercises: The wheel of change, The advantage and Disadvantage Box, Line of Importance and Faith. -Worksheet: Physical-mental-lifestyle factors, values for BT, the necessary support during the different phases in the Wheel of change.
Material for hand out	The road to heart-healthy lifestyle, New habits get a good start - inspiration for you who wishes to change your lifestyle, Hjerteforeningen- communicated to the citizen that this can be found on the website (a lot of reading material). Other relevant pamphlets from Hjerteforeningen, appropriate folders about interventions in SH. Pictures, exercises and potential presentation can be found in the toolbox here.

Handling of the intervention	Nurse
Reference	I balance med kronisk sygdom: s. 111 – Øvelse ”Mål og Plan”, s. 108 - ”Fo ulempe- boksen”, s. 105 – Betydning – og tiltros linje
Headline/Topic	**4) My mental health**
The purpose of the module	• That the citizens gain an understanding of the importance of the mental health for the heart disease and gain insight into the acting competencies related to one’s mental health and building of mental resources.
Objectives	• To be aware of one’s mental health. • To gain an understanding of mental circumstances necessary to the health. • To gain insight into the importance of building one’s mental resources. • To get knowledge about support and help opportunities.
Lesson 1 Introduction to today's topic	• Going through the objectives. • A presentation about common reactions following heart disease. Do the citizens recognise it?
What has a strong presence concerning today's topic	• Intro to exercise: ”Balance card”/”My mood today”. Summary in plenary
Thematization	• Topics from the exercise are being thematised (flip-over) and utilised as a basis for dissemination of information and exchange of experiences.
Lesson 2	
Dissemination of information regarding challenges/themes	• Dissemination of information is adjusted based on the topics, which occupies the group (e.g. anxiety, stress, sleep, social relations/support, sexuality, married life, loneliness). NB on the topics that the citizens do not mention; however, which can still be communicated (e.g. sexuality, loneliness).
Mental handling	• Communicate the importance of building mental resources and resistibility, what is crucial for me, accept, self-care, social support, communication with a potential partner, "No – Nevermind– Help”. Experiences from the citizens are implicated. Further about this topic in the last module.
Further support and helping opportunities	• Communicate about: intervention in KK, including ”open and calm”, referral to a psychologist through PL, Hjerteforeningen's counselling centre and telephone counselling, Hjerteforeningen's psychologist.
Summary and round-off	• Summary of today's topics. Focus on next time. Which reflections do the citizens take with them?

Supporting materials	-A3- pictures: Reactions to disease, crisis reaction, what is anxiety, the human brain/the reptile brain, the upper and lower part of the body, a self-perpetuating circle of anxiety, monster drawings, Charlie Brown and Snoopy, balance weight. -Film: When heart disease strikes the mind (Hjerteforeningen), Sexuality and married life, Sex medicine and intimacy (Helbredsprofilen), Sexuality and heart illness (The City of Copenhagen). -Exercises: The pedagogical sun, My social relations, breathing exercise in plenary, Case about sexuality. - Apps: iBreathe, Åben og rolig.
Material for hand out	Hjerteforeningen's handbook - You are not alone, pamphlet- Sleep well, pamphlet – about sexuality, stress Other relevant pamphlets. Pictures, exercises and potential presentation can be found in the toolbox here.
Handling of the intervention	Nurse
Reference	I balance med kronisk sygdom: s. 72-74 - "Balancekort – at tale om ubalancer, udfordringer og muligheder", s. 60 - "Mit humør i dag"

Headline/Topic	**5) Balancing everyday life**
The purpose of the module	• That the citizen reflects on maintaining the wanted changes, what it takes to create balance in everyday life and be strengthened in the cooperation with the health professionals.
Objectives	• To be strengthened in the continued work with the wanted changes and adherence. • To focus more on how to create balance in daily life and build up mental resources and resistibility. • To be strengthened in the cooperation with the health professionals and meet the system.
Lesson 1 Introduction to today's topic What has a strong presence concerning today's topic Changes and maintenance	• Going through the objectives. • The three areas can be written on a flip-over with the purpose of the citizens' thoughts (maintenance, balancing daily life, meeting the system). • Recapitulation and dissemination of information of topics needing elaboration • How is it going "Aim and Plan"/"small steps"? - Self-care skills and linking to the exercise "Importance and line of faith".

Balancing everyday life Coping resources	- Ideas on what to do to maintain the changes. In pairs/plenary. Write on flip-over. E.g. planning, preparation, structure, meeting/talking to someone. • A presentation on how life with heart disease can create imbalances in daily life because of more demands and fewer resources. - Draw the imbalance-regain the balance fraction on the blackboard. - Include the challenges the citizens have articulated during the programme. - What can create balance? What is essential for the citizen? Buzzing in pairs. • How can coping resources be built? Plenary and potentially a flip-over. Recapitulation. Examples of questions of reflection: - How can you take better care of yourself? - How can emotional life be "digested" in an appropriate way? - Does one have an optimistic thinking style (or pessimistic)? - How does one think about oneself and one's life? - Is there another way to look at things? - What can you do more of instead of avoiding something?
Lesson 2 The cooperation with the health professionals and the system Future control Other interventions + apps Recapitulation and round-off of the lesson plan	• Intro to exercise: "My meeting with the health professionals" - or ask questions in plenary based on the Steno Card. What are the experiences of the citizens? • Ideas and good advice for a good dialogue during the meeting with the health professionals - in plenary. • How can you prepare for an consultation - the instructor supplements the ideas of the citizens? Hand out sheets with good questions for preparation. • Information about control at the PL in the future. Control of blood tests and BT. • Other interventions and opportunities: information about the website of the City of Copenhagen – Use the city. • Information about relevant patient associations, including the Hjerteforeningen (counselling, website, Hjertenyt). • Hand out sheets with all apps and website links mentioned in the class. • Recapitulation of today's topics and the programme in general. What/which reflections do the citizens take with them? Evaluation of the entire lesson plan. Did the programme live up to the expectations? What do the citizens take with them from the complete programme?

Supporting materials	-A3 pictures: The circle of change, battery, balance weight, monster drawing. -Film: En god behandling begynder med en god dialog.
	-Exercises: Potentially revisit the Pedagogical sun, how am I doing, my meeting with the health professionals, Balance card, Imbalance-regain the balance fraction. -Apps, websites: Sundhed.dk, Min læge, kk.dk/brug byen. Information about the patient's book- 10 good advice about the meeting with the health authorities.
Material for hand out	Hjerteforeningens local offers, an inspiration for the question ”Glad you ask”, Sheet with links, apps, and handbooks. Pictures, exercises and potentially a presentation and sheet for hand out can be found in the toolbox here.
Handling of the intervention	Nurse
Reference	I balance med kronisk sygdom: s. 87: - Øvelse ”Mit møde med sundhedsprofessionelle”

3f. Meeting for relatives of citizens with a heart disease

Headline/Topic	**Meeting for relatives - support for life as a relative**
Who can be allocated the intervention	Relatives of citizens with heart disease. Recruitment of relatives happens through citizens participating in the heart lessons and at the initial consultation and further interventions at the centre.
The purpose of the meeting and the objectives of the relatives	• To become aware of one's own needs as relatives. • To become aware of one's situation through the exchange of experiences and the experience of community with other relatives. • To get support to take care of oneself and build up coping resources. • To get knowledge about how you can get support and help as relative.
45 minutes Introduction Expectations Presentation and what is a strong presence	• Welcome, presentation of the instructor and nameplates. - The setting of frames and general introduction. - Going over objectives (also written on flip-over as preparation or show A3 laminated poster). - Confidentiality and accept/room for all emotions. • Do purposes make sense - are there other wishes/expectations? • What is the relation to the person struck by heart disease? - How does the illness affect the life and everyday life of the relatives? - Share my own experience of the programme and what is the most substantial presence.
45 minutes Dialogue and presentation Themes	• Presentations about being a relative (three general themes which can be linked to the challenges of relatives from the presentation - written on a flip-over). - Heart disease strikes the whole family/the social circle.

Handling everyday life The building of mental resources. Summary and round-off:	- When you are a resource as a relative. - The own needs of the relatives. If the relatives have a difficult time putting things into words, words of reflection can be: Which feelings have a strong presence with you? Mention the thing(s) that makes it more challenging to be a relative? Mention one thing that you have experienced being a help? What do you need? • A presentation of handling everyday life (three general themes with the inclusion of the experiences of the relatives about handling). - Meeting the health authorities - how can you prepare/cooperate. - Communication concerning each other as partners - Own needs - what is important to me, how do I get the surplus energy. • Examples of questions of reflection: - How can you take better care of yourself? - How can emotional life be "digested" in an appropriate way? - Does one have an optimistic thinking style (or pessimistic)? - What does one think about oneself, one's partner and one's life? - Is there perhaps another way to look at it? • Communication of further help and support (Learn how to handle, relative councillor, Hjerteforeningen, a psychologist via PL, the Danish National Centre for Grief). Summary of today's topics. • What have the relatives taken with them?
Supporting materials	A3 pictures: Mountain climber, battery, weight, imbalance/regain balance fraction, monster drawing.
Material for hand out	"To be a relative" from Hjerteforeningen, pamphlets about relative counselling and "Learn how to handle" from the City of Copenhagen.
Handling of the intervention	Nurse.

3g. Food inspiration for citizens with a heart disease

Headline	Me and my food
Overview of the lessons	Opening (20 minutes) • Welcome. • Introduction of the instructors. • The three meetings – content. • Set up frames for the class. • Confidentiality. • Speaking time for everyone/no interruptions. • Mobile phone silent/turned off.
	• Make room for diversity. • Show up on time. • Are there additions from the class? • Allergies? • Kitchen and hygiene rules. In the kitchen • A presentation of recipes and a little tour around the kitchen. Eating • Ask the citizens to set the table. • Ask the citizens to introduce the programme(s) they have made for each other and evaluate the programmes. • Potentially a professional presentation, going over the dummies, a shopping guide and the plate model. Organising. • Ask the citizens for help cleaning, wiping off the table etc. Conclusion
	Materials to bring: Instructor • Recipes adjusted to the number of citizens. • Pictures of plate models. • Dummies. • An overview of sweeteners. • Various remedies: Nameplates, a flip-over, blackboard, writing tools. • The citizens should be handed out • Recipes. • Shopping guide.

3h. Practical cooking for citizens with type 2 diabetes

Headline	Practical cooking
An outline of the programme	1. meeting: • Welcome, nameplates. • Introduction of the instructors. • The three meetings – content. • Frames for the programme, incl. confidentiality, speaking time for everyone, mobile phone silent/turned off, provide space for diversity, show up on time, are there additions from the class? • Introduction of the participants. • Expectations for the programme. • Insight into one's challenges related to food.
	• Challenge ambivalence. • A desire for change. 2. and third meeting: • Welcome, nameplates. • Follow-up from the last class. • Introduction to today's topic. • Exercise: Go into the store. • Going through the recipes. • Kitchen and hygiene rules. • Preparation of food. • Communal eating. • Clean-up. • Conclusion. Eating • Ask the citizens to set the table. • Ask the citizens to introduce the programme(s) they have made for each other and evaluate the programmes. • Potentially a professional presentation, going over the dummies, a shopping guide, and the plate model. Organising. • Ask the citizens for help cleaning, wiping off the table etc. Conclusion • Summary of today's topics. • The ”Small steps” schedule may be utilised.

	Materials to bring: <u>Instructor</u> • Recipes adjusted to the number of citizens. • Pictures of plate models. • Dummies. • An overview of sweeteners. • Various remedies: Nameplates, a flip-over, blackboard, writing tools. <u>The citizens should be handed out</u> • Recipes. • Shopping guide.

Appendix 4. Physical exercise

4a. General principles for physical exercising

Headline/Topic	General principles for physical training at the Centre for Diabetes.
Methodical approach to the training programme	The content in training is based on: • The Motivating Dialogue. • The deductive and inductive principle. • Peer to peer. • Inclusion of network and motivation groups and associational life.
Content in the training intervention	• The training contains both training/movement and lessons/theory. The citizens are included in the planning of the training, and they are continuously encouraged to be responsible for parts of the training. • We vary between to the citizens known and unknown activities, training methods and frames to create safety and development for the individual and the class. • Activities promoting social relations and networking, such as e.g. connection creating games, are prioritised. At the same time, we strive towards following the tendencies for training and exercising, trending in society. • We strive towards achieving as high intensity as possible.

Examples of content during the weekly training	Strength training • We work with five basic exercises in different constellations, both indoor/outdoor and with various tools. The five basic exercises are divided into 1) leg exercises 2) back exercises 3) stomach exercises, 4) pushing exercises and 5) pulling exercises. Fitness training. • Walking, running, cycling and interval training. • Combination of strength and fitness training. • Game and play, circle training and stairs. Prevention of damages • Warm-up, balance training and in case of guidance in PRICEM treatment. Mental health • Mindfulness, stress relief, body-consciousness and breathing techniques. Lessons • Illness and training related group exercise guidance and health competence. Facilitation of networking • Focus on social interprogramme with and network cafe according to the wishes and needs of the citizens.
Approach at blood sugar over limit value (Applying to citizens with diabetes)	When we measure a blood sugar over 17 mmol/mol 1. We recommend light exercising (walking/light cycling). No high intensity (neither strength nor fitness). 2. The blood sugar is measured again after 30 minutes. 3. We watch the citizen during the training. If worrying continues, the citizen is asked to contact his or her doctor.
	At blood sugar measuring under seven mmol/mol for insulin users 1. If the citizen has not just eaten, we provide some food in the shape of a piece of crispbread, half a piece of fruit or similar. 2. The blood sugar is measured again after 30 minutes. 3. The citizen joins the exercise if the blood sugar is increasing. 4. If it continues to fall, bullets 1, 2 and 3 are repeated. If worrying continues, the citizen is asked to contact his or her doctor.

Maintenance.	The Centre for Diabetes supports the meaningful communities that develop during the training interventions. The exercise communities contribute to the fact that they can keep meeting and exercise together, and everyone is open to new members and are free to participate in. Examples of current exercise communities are table tennis, floorball, walking in nature, outdoor life etc. Further info can be found here. We encourage everyone to participate in all the interventions and initiatives taking place outside the Centre for Diabetes, e.g. Boblberg.dk. Also, we visit and talk about voluntary exercise networks as a standing part of the monthly training.

4b. An outline of training sessions

Mentioned below is a rolling plan for class-based training.

4b.1. Rolling plan- Diabetes

WEEK	FOCUS	TRAINING	THEME
1	Welcome Expectations Intro for training	Muscle strength Fitness training Mindfulness exercise	Meals 3 x training per/week Rowing in daily life Citz scale
2	Measuring	Circle training Games and Play	Blood sugar measuring
		Cooper's test Waling in a calm pace Circle training	Fitness rating App for testing
3	Interval training Mentally	Superset 30-20-10 Game and play Stress relief	Yoga classes Open and calm Feet
		Superset 30-20-10 Waling in a calm pace	
4	Maintenance Network visits	Guide for group exercising - Takes place on the third floor at the Centre for Diabetes	
		Hill training 36 exercises	Visit networks
5	Recapitulation Only relevant when there is a fifth week in a month	Games and play 36 exercises	
		Games and play 36 exercises	

4b.2 Rolling plan- Heart

UGE	FOKUS	TRÆNING	TEMA
1	Velkomst Forventninger Intro til træning	Konditionstræning Styrketræning Mindfulnessøvelser	Konditionstræning- effekt på hjerte og kredsløb 3x træning ugentligt Borgskala Ro i hverdagen
2	Konditions- og intervaltræning	Cirkeltræning Spil og leg Muskeludholdenhed Mindfulnessøvelser	Intervaltræning Kondital
3	Fastholdelse og netværksbesøg	Gruppemotions-vejledning- undervisningslokale i Center for Diabetes Netværk Spil og leg Styrketræning	Træningsmuligheder i Københavns Kommune
4	Styrke og udholdenhed	Supersæt Cirkeltræning Mindfulnessøvelser	Styrketræning- effekt på hjerte og kredsløb Anbefalinger for træning
5	Spil og leg/ Krop og sind	Spil og leg Afspænding/Yoga	Introduktion til forskellige træningstyper
6	Fastholdelse og netværksbesøg	Træning i sal Gruppemotionsvejledning i multirum Konditionstræning Styrketræning	Opsamling

4c. Guide for group exercising

Mentioned below is a manual for class exercise guidance.

Headline/Topic	Group exercise in training classes
The purpose of the lessons	• That the citizens maintain or pick up good exercise and training habits. • That the citizens take examples from each other. • To increase the possibilities for the development of networks. • That all the citizens get a monthly plan.
Objectives	• To create a cornerstone for the network and community. • That the class have a basic understanding of the importance of maintaining exercise and training during and after the training programmes with others and/or on their own.
Must	The citizens meet in the usual place and go together to the classroom in CfD (remember to book the room). We put a note on the door to Gym 3 about the training class being on the 3. floor. Introduction to the topic and action plan.

	"At the CfD, we have decided that all exercising classes must receive exercise guidance once a month for the purpose of all of you getting a plan regarding exercise and training during and the exercise programme." Introduce the action plan. A presentation of today's program (written on the blackboard): - *The thoughts of the class.* - *Where and what can we exercise?* - *Introduce Together about diabetes.* - *We plan.* <u>*The thoughts of the class*</u> Talk to each other about the following questions, which have been put on the tables or written on the blackboard. • Why do we exercise? • What have we gotten from exercising? <u>*Case*</u> The citizens are informed about one or two places where they can exercise; either through a case or from a citizen, who has tried it, tells about it. Potentially vary between the options below from class to class: Motivational groups, Motivational networks, Liva, associations etc. <u>*Which type of exercise fits me?*</u> Divide the citizens into three categories: - Training on your own. - Training with a buddy. - Training in classes. We put laminated sheets on the floor with the headlines from the three categories with associated pictures, or the categories are written/hung on boards: The citizen will go to the category that is most appropriate for them. If more than four citizens stand next to a headline, they are divided into subgroups consisting of two to four people. <u>*Questions from Aim and Plan (bring for six groups)*</u> The groups are handed out A5 sheets with the following questions (inspired by the action plan) and talk about the questions: - *What will you do now ...?* What will you do first? - *How will you do it?* Which days, times and for how long? - *Who can support you?* Is it a family, a friend, and/or a class? - *What can make it easier to achieve your plan?* What are the advantages of doing it? - *What can make it easier to achieve your plan?* What is your biggest challenge? How do we fit it into a busy every day? What can we do as a minimum? - *How sure are you that you will get it done?* How big is your motivation to do it? (E.g. utilise 0-10 scale where 1=Not sure at all 10= Completely sure) <u>*Where can we exercise?*</u> There are computers and various flyers and pamphlets available. The instructors are aware of those who do not take any initiative and

	emphasises the good ideas.
	We plan for the next month All the participants are handed over the sheet "My plan", which should be filled in. They write down their plan and give it to the instructors, who take a copy. The participants will take home their plan and put the copy in the class folder. The plan is gone over. NB! On the backside of "My plan," the citizen can write down his or her results from Coopers test. Round-off and recapitulation.
Handling of the intervention	Two physiotherapists/educated in sports or physical therapists/educated in sports and a nurse.

Appendix 5. NCP – schedule for documentation for nutritionist interventions

The bullets below are used for documentation of the diet intervention in CURA.

Diagnosing of nutrition	
Reason for referral	
Anthropometrical measuring	
Biochemical data, medical testing, and examinations (if relevant)	
Citizen anamneses	
Food and nutrition-related anamneses	
Nutritional diagnosis	
P: Identifying the problem	
E: Determine ethology/reason	
S: State signs and symptoms	
(Nutritional diagnosis) related to (reason) and documented by (symptom/sign) E.G., *Excessive intake of fat-related to daily butter on four slices of bread and fat cold meat types recorded at food anamneses*	
Nutrition intervention	
Nutritional recommendations/ guided in	
Handed out materials	
Follow-up	
Monitoring of nutrition and evaluation	
E.G. weight, waist, blood pressure, blood sugar	

Appendix 6. Template for description of new interventions

Who can be assigned the intervention	
The purpose of the intervention.	
Objectives	
Method.	
The framework of the intervention	
A description of the intervention	
Handling of the intervention	
References	

Appendix 7. References

[i] Forløbsprogram for type 2-diabetes. For hospitaler, kommuner og almen praksis i Region Hovedstaden. 2019
[ii] Forløbsprogram for rehabilitering af hjertesygdomme. For hospitaler, kommuner og almen praksis i Region Hovedstaden. 2019
[iii] Anbefalinger for tværsektorielle forløb for mennesker med type-2 diabetes. Sundhedsstyrelsen 2017
[iv] Anbefalinger for tværsektorielle forløb for mennesker med hjertesygdom. Sundhedsstyrelsen 2018
[v] Anbefalinger for Forebyggelsestilbud til borgere med kroniske sygdom. Sundhedsstyrelsen 2016
[vi] Sundhedspædagogik og sundhedsfremme - Teori, forskning og praksis. Monica Carlsson, Bjarne Bruun Jensen & Venka Simovska. 2009
[vii] Erfaringsopsamling: Værktøjer og metoder til behovsvurdering. Steno Diabetes Centre Copenhagen. 2018
[viii] Det Dobbelte KRAM — et tværfagligt arbejdsgrundlag for mental sundhed, helbred og trivsel. Peter Thybo. 2016
[ix] Den sundhedspædagogiske jonglør: kompetenceudviklingsmodel for patientuddannelse på tværs af diagnoser. Gitte Engelund, Ulla Møller Hansen, Jane Rohde Voigt. Steno Centre for Sundhedsfremme. 2011