Improving Diabetes Outcomes for Pasifika & Maori Communities

Ioana Viliamu-Amusia
Clinical Coordinator
Porirua Union Community Health Service (PUCHS) General Practice
Cannons Creek Porirua East
Wellington

MOH conference February 2019
Te Papa, Wellington

Project team: Team Suka!

Project lead:

- Ioana

Lead GP and GP Diabetes interest

- Dr B Betty and Dr N Kuiper

Clinical Pharmacist

- Dr L Bryant

Diabetes Nurse Champion

- Ma'u Pauta (Nurse led clinics)

Community health worker

- Teau Marama

Medical care assistant

- Demelza Thomas

Diagnose the problem – data

Wellington 3 DHB data:

diabetes can be prevented or delayed by lifestyle changes[viii] and reducing obesity,[iii] the ability to achieve these changes

connectivity have been found to be associated with high body mass index (BMI) in New Zealand.[ix]

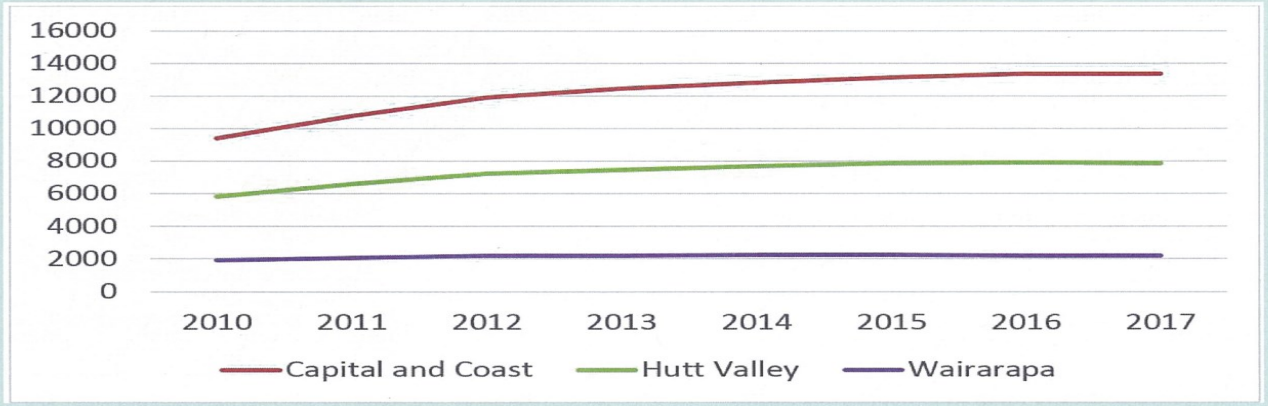
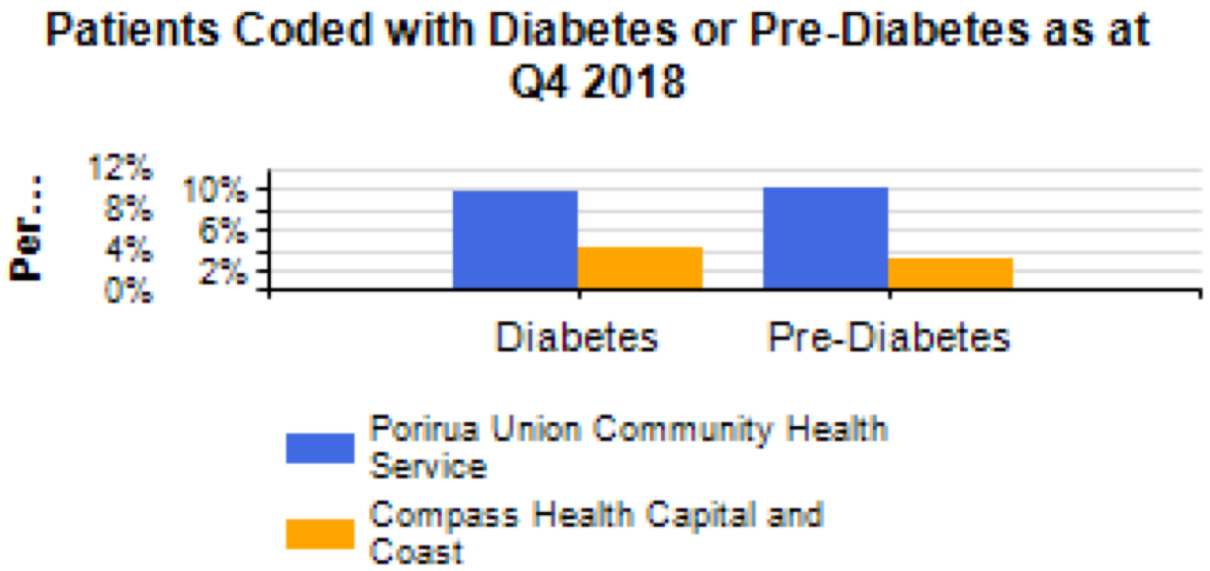


Figure 1. Number of people with diabetes, by DHB residence, 2010-2017
Source: Virtual Diabetes Register data on MoH web page

PHO data:
This tool shows PUCHS with one of the highest Diabetes data within the Compass Health PHO



.

Stakeholders & Communication

brief details of our stakeholder analysis and communication plan:

2018 four focus groups and three telephone interviews were undertaken to explore the views of our Maori and Pacific populations about our delivery of services for people with diabetes, we asked 4 questions to help us with improving diabetes services.

What was helpful at the time of the diagnosis

- What was not helpful
- What improvements could be made
- What barriers are present for engaging and managing diabetes successfully

The interviews/focus groups were facilitated in multiple languages including Samoan, Tongan, Cook Island Maori, Tokelauan and English.

People with various duration of diabetes were invited, and their whanau /Aiga.

- Co design group work

understanding the concerns and wishes of our community.

Youthful population.

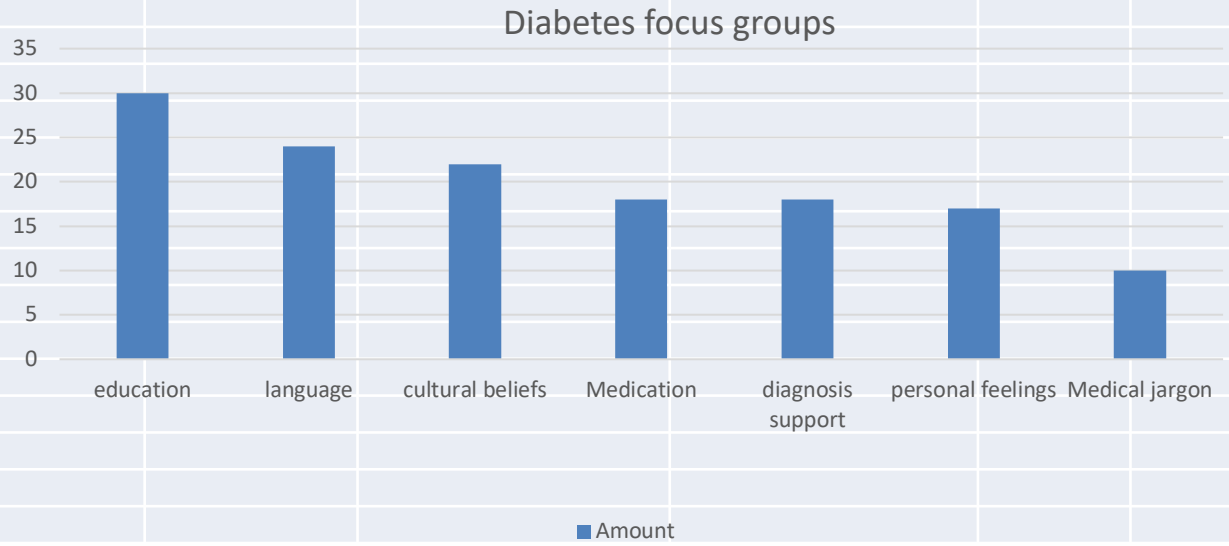
develop a service that met the needs of individuals, community, ethnic and different cultural approaches.

Capturing the Patient Experience

Pareto chart: Diabetes focus groups

Improving Diabetes for Pacifica people@PUCHS.

contributing factor	Amount	contributing amount	contributing %
education	30	30	22%
language	24	54	39%
cultural beliefs	22	76	55%
Medication	18	94	68%
diagnosis support	18	112	81%
personal feelings	17	129	93%
Medical jargon	10	139	100%
	139		



Voice of the Customer

Value how we feel who we are, what we do!

Dr's 'always right', so hard to respond in the right way … say 'yes' all the time (but may not understand)

Exercise and eating is important – choose the right words to talk about these … not the word exercise, but e.g. "move and sweat more"

Not 'diet' and not 'diabetes' – just healthy food we should all eat [language]

Medical – only looking through one lens

Need to have a better understanding e.g. what is borderline

Hard to find healthy food – pies are cheap ($1) and readily available when hungry at lunchtime

Hard to admit to not understand

Stories from people who are on this journey – share stories; including share with children now rather than later

Psychological support / counselling (mindfulness; stress management) – everyday coping skills required – how to cope with bad days, as well and good days

Teach me and my children – share family information

Look at the family situation, who can learn together

Our food, our culture

The feeling of being judged by the clinical team

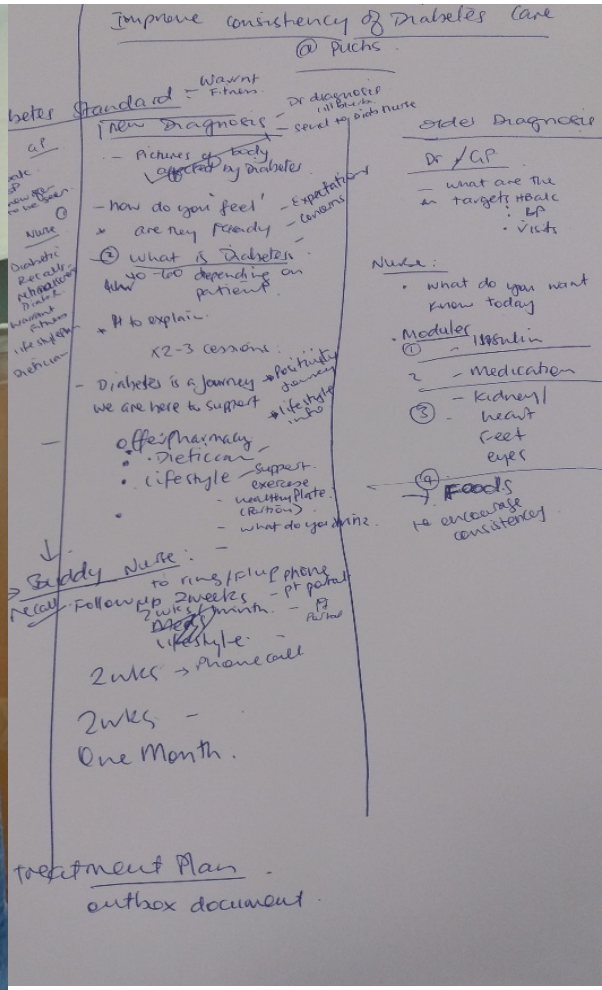
Need to know more about the medicines – to <u>understand</u> them

Ask us (patient) what we want to know first at this point – what is important to me?

*Set goals – **mine** and yours, that I know*

Having a deeper connection with the team is important "Sustenance of food for chiefs is connection' …. Builds trust and connection with people; understand me and connect with me; shared experiences help; personal stories are more powerful

Encouraging Staff input and view



Measuring to monitor & Tracking

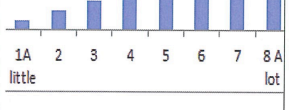
MY STRENGTHS, NEEDS AND WORRIES (First Session) **NAME:**.....

Facilitator Names: XXXXXXXX

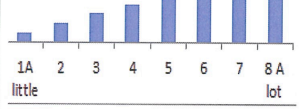
Date: XXXXXXXX

Please circle the level that applies to you on the graph!
(1= a little; 8= a lot)

Q.1 How much do I know about my health condition?



Q.2 How much do I know about my medicines and treatment ?



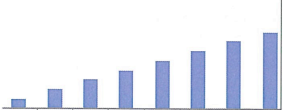
Q.3 Do you take your medications regularly as prescribed by your doctor

Q.4 I feel confident that I am listened to when I go to visit my doctor?

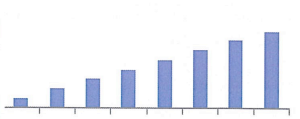
Q.5 Do you feel your culture is respected when you visit your doctor?

Q.6 Do you attend your appointments?

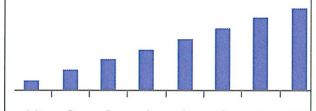
Q.7 How well do you recognise when you are getting sick?



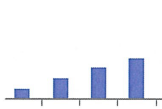
Q.8 Do you know what to do when symptoms arise?



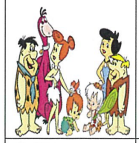
Q.9 Are you able to move around easily and do the things you like doing?

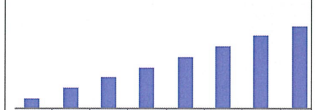


Q.10 Do you cope with how your health affects your feelings?

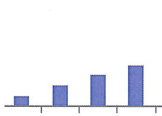


Q.11 Can you easily visit your family and friends?

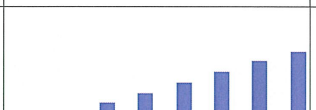




Q.12 Overall, do you lead a healthy life?



Q.13 How confident do you feel at the moment about making changes in your life to better manage your health?



COMMENTS

Do you worry about your long term condition/health problem? **YES/NO (circle one)**	**If yes, what is it you worry abou**
Do you have a goal(s) for the next six months to improve your health? **YES/NO (circle one)**	**If yes, what is the goal?**

What next:

- Whats new at PUCHS:
- Diabetes standards for new diabetes patients and the established diabetic patient.
- Developing the Pre Diabetic standards
- Improved support resources\tools for clinical staff: (better efficient care)
  - Preliminary testing of use of the ‘metal pipe/s’ analogy & rainbow Hba1c indicator chart in our education to clients and whanau.
- Use of the electronic diabetes folder and/ hardcopy folder for ease of access to clinical staff –
- Ability to transfer the learnings of the tools used and information gathered for use in other long term condition projects.
- Individual careplans (PUCHS participates with Health Care Home)
- Feedback and write up of findings: important to give back to patients and the community as requested.