

Partners in Care co-design case study

Improving access to diabetes care for Māori and Pacific people in the Western Bay of Plenty

Western Bay of Plenty Primary Health Organisation New Zealand

The Doctors Bayfair and The Doctors Papamoa

Context

Type 2 diabetes is a significant health risk for Māori and Pacific people and is commonly associated with increased risk of heart and renal disease. It is well known that type 2 diabetes can either be prevented or at least managed to reduce or prevent associated complications when people follow recommended management guidelines (Ministry of Health 2021).

Within our practice population we have 418 enrolled patients with type 2 diabetes. Of these, 14.35 percent (60) are Māori and 4.06 percent (7) are Pacific people. Currently we have a lower number of Māori and Pacific people accessing diabetes care than other enrolled populations, and some of these people also have poorer diabetes control.

We are undertaking this work to understand the experiences of living with diabetes for Māori and Pacific people who are enrolled in The Doctors Bayfair and The Doctors Papamoa practices and to co-design solutions that better meet their needs, especially focusing on how they can access services.

The location of this study is across two urban practices within the Western Bay of Plenty in New Zealand.

Our overall practice enrolment hovers around 10,800, of which 1,810 are Māori and 219 are Pacific peoples. Western Bay of Plenty ethnicity statistics indicate that 19.5 percent identify as Māori and 2.9 percent as Pacific peoples (Stats NZ, 2020). Our patient population shows 16.3 percent Māori and 1.95 percent Pacific peoples.

The Ministry of Health's *Quality Standards for Diabetes Care 2020* state that all people with diabetes:

will be offered, as a minimum, an annual assessment for the presence and future risk of cardiovascular disease and diabetes-related complications. They will be provided with the outcome of the risk assessment and should participate in making their own care plans. They should set agreed and documented goals/targets with their health care team, including a specific target for glycaemic control.

Attending an annual diabetes review has been identified as best practice because it allows for assessment of glycaemic control and earlier detection of, and intervention for, diabetes-related complications (Best Practice Advocacy Centre New Zealand (bpac), 2015).

Early in 2021, PHARMAC launched newly funded oral diabetes medications. The advantage of these is their ability to significantly reduce cardiovascular and renal disease. It is understood that these medications could have an important role in reducing diabetes complications for Māori and Pacific people. However, people with diabetes will need to see their health care providers to gain access to them.

We want to ensure our Māori and Pacific people have the opportunity to receive the best diabetes care available, and by working closely with Māori and Pacific people with diabetes we will understand how to achieve that.

Problem statement

At both our practices the numbers of Māori and Pacific patients attending annual diabetes appointments and reviews are lower than other populations. This provides a signal to us that there is an inequity in access to care for these peoples (Table 1).

We are attempting to understand the experience of Māori and Pacific people living with diabetes so that we can enhance our diabetes service to provide the best appropriate support and care and reduce inequity.

Equity aim

Our current data illustrates that Māori and Pacific people are less likely to be able to participate in an annual review of their diabetes than others in our two practices. This means that they are not able to receive the care and support they need, which is likely to result in them having greater health risks than others. We aim to engage with Māori and Pacific people to understand how we can develop diabetes services that will enable them to access diabetes care, including the new medications mentioned earlier. We anticipate that this will provide an opportunity to reduce diabetes-related complications for Māori and Pacific people and improve their quality of life for them as individuals and for their whānau.

Start up

Our team

Our practice co-design team includes members from our clinical, management and reception teams together with Māori and Pacific consumer members. This combination of expertise enables a wide range of perspectives to be shared and included in the work.

Routinely collected baseline data

Our attendance figures for annual diabetic reviews show that in September 2020, 62 percent of Māori and 41 percent of Pacific patients were overdue, whereas the rate for other ethnicities was 19 percent (See Table 1).

Table 1: People with diabetes who are enrolled at The Doctors Bayfair and The Doctors Papamoa, by ethnicity (September 2020)

Ethnicity	People with diabetes	Overdue for diabetes annual review	% overdue for diabetes annual review
Māori	60	37	62%
Pacific	17	7	41%
Others	341	64	19%

Our diabetes glycated haemoglobin (HbA1c) statistics for Māori and Pacific people show:

- 30 percent (23) have not had an HbA1c blood test in the 12-month period between September 2019 and September 2020
- of the total 57 people in the practice with an HbA1c > 75 mmol, 19 (33 percent) are Māori and Pacific people.

This means 33 percent of patients with HbA1c measures showing poorly controlled diabetes are Māori and Pacific people and therefore at greater risk of significant associated complications.

Engage

We invited two community representatives to be involved in our co-design project. They attended our first co-design hui (meeting) as part of our team.

These two people were known to our practice team and identified as people who would be likely to feel comfortable speaking in a large group. One is a Niuean woman with diabetes and the other is a confident Māori woman competent in te reo (Māori language) and tikanga (Māori customs and traditional values). In order to engage with other patients, we developed an elevator pitch together. This enabled us to consistently describe the project in a succinct way to other patients. The elevator pitch was initially discussed at the hui and then further refined by the group after the hui.

Elevator pitch

Kia ora. My name is _____. I work at The Doctors (Bayfair/Papamoa), and we want to know more about how people cope with their diabetes. We know sometimes it's a struggle and would like to understand your experience of having diabetes and how we could help to make managing your diabetes easier. This will then help us to provide the best care and support to you and others like you with type 2 diabetes.

We are thinking about bringing a few patients with diabetes and their whānau (family) together to talk about this or having some one-on-one conversations with patients and whānau. Would you be interested in helping us by coming to a meeting or having a conversation about what works for you and what's difficult for you?

Capture

Two main methods were used for capturing data. Using our elevator pitch, we invited people to either participate in a face-to-face interview or a focus group hui. The invitations were delivered by phone and email.

- 1. Face-to-face interviews.** Seven participants completed interviews, which were guided by a set of questions to prompt people to share their experiences of living with diabetes (see Box 1). All participants agreed to have their interviews recorded and signed a consent form. The interviews were later transcribed to establish themes. The interviews were completed by the practice diabetes nurse specialist.

Box 1: Prompt questions and notes used within face-to-face interviews with diabetes patients

Introductions and reinforcement of the purpose of the discussion.

- How do you feel about living with diabetes? (The interviewer should listen for any signs of whakamā (shame or embarrassment) that may lead a person to avoid going to a doctor, for example.)
- What helps you manage your diabetes?
- What challenges do you face living with diabetes?
- Do you have any whānau diabetes memories that influence your thinking about diabetes? Are these thoughts helpful or unhelpful?
- Tell me about your diabetes journey so far.
 - When were you diagnosed?
 - What treatments have you used?
 - What information or education have you received, by whom, and where?

- 2. Focus group.** We held a focus group hui with eight people (five female patients and one male patient with diabetes, a diabetes nurse, and a practice receptionist who also has diabetes) and facilitated a discussion around their experience of coming to the practice.

To do this we identified six touch points (different stages of the journey; see Box 2) relating to their experience of coming into the practice for an appointment or requesting a prescription, and we asked several prompt questions at each touch point (see Appendix).

Box 2: Six touch points related to the experience of going to the general practitioner (GP)

1. Booking appointments and getting prescriptions
2. Reception greeting on arrival
3. Waiting for the appointment
4. The consultation
5. Communication
6. Outcomes and take-home messages

As the discussion progressed, participants were able to place sticky notes onto large sheets of newsprint flip-chart paper detailing the specific touch points where there were highs or positive feelings, lows or negative feelings, and any comments and suggestions for improvement.

This effectively created a storyboard of participants' emotions or comments based on their experience at the six touch points of the diabetes care journey. The focus group hui was well received by the participants, and they were very keen for the opportunity to share their personal diabetes journeys, feelings and experiences.

Understand

During this phase we brought data from the interviews and the focus group hui together and reviewed them to identify positive and less positive experiences and any suggestions for improvement.

Survey interview themes and comments

Living with diabetes

Participants shared responses that ranged from a sense of resignation that they had diabetes to feeling terrible about living with it.

‘I have had diabetes for a while, and one of the hardest things about living with diabetes is accepting that you have got it, knowing that you have got it and accepting that you have got it and talking openly with people about your diabetic self is something that I still find difficult to do even though I have had it for decades.’

‘A lot of people don’t know that I am a diabetic ’cause I don’t talk openly about that, so in answer to your question I don’t deal well with that, I don’t believe.’

‘It is terrible, I hate it, but I gotta deal with it, so it is very hard, yeah.’

‘It is no problem, not a problem, I mean, I could live without diabetes but if that’s what you get then that’s what you get.’

Managing diabetes well

The most common theme participants mentioned about what helps them manage their diabetes well was the support they had received. This included support from whānau and spouses and also from their diabetes nurse, whom they described as a person they had an established trusting constant relationship with. Comments from patients included;

‘I have a lot of support from my wife who I met when she was 14 and I was 16. If it wasn’t for her, I would have been just another fat Māori in jail. Because she is bossy, and I am a follower and not a leader.’

‘I think having somebody who knows what they are talking about and that you respect and trust and that is constant.’

‘It is having that constant reminder from somebody that I respect that actually this is your business and you have to take responsibility for it, but I’ll just keep telling you honestly and openly and you can say what you are doing is not right and not good for you. It is about having support from someone you trust.’

‘For me forward management of food stuffs, forward planning, which is what my wife tries to do – she organises a week’s worth of dinner meals, she shops for those meals. There are two good sides to that – one is I get to eat well, and the costs are lower.’

Challenges of living with diabetes

The challenges people faced living with diabetes were quite varied and personal to them. Participants had different experiences in their work environment. Some were supportive, but others less so. Those who were able to work regular hours found things less of a challenge compared to

those who travelled a lot and worked irregular hours. They mentioned lack of consistency in lifestyle as a difficulty. Of those people interviewed, financial issues were not a challenge, even though one person was receiving a state benefit. Comments from patients included;

‘The challenge is staying with the plan; it is a long-term plan. It is up and down, and I accept that, I guess for me is accepting it can be fixed and to keep going on it.’

‘Remembering to take my medicines when I am busy can be a challenge.’

‘Work related, constantly being on the move could be a challenge, but when I am in the zone I manage travel, including having to go to a dinner and think about my eating choices. You just have to try to manage, that’s what I have experienced anyway. I just don’t do it consistently, so the challenge then is being consistent.’

‘I mentioned when growing up is the amount of money and the type of food we could afford to buy, but that’s not a problem now, but it’s the habits I learnt then that I think could well be the challenge.’

Focus group experiences and suggestions for improvement

The focus group focused on six touch points (Box 2) relating to peoples’ experience of coming into the practice for an appointment. Participants identified highs or positive feelings, lows or negative feelings, and comments and suggestions for improvement. Their feedback is presented in Table 2.

Table 2: Feedback from the focus group

	Highs	Lows	Suggestions
Booking appointments	<ul style="list-style-type: none"> • Awesome reception • Receptionists here and at Bayfair are warm and patient when answering the phones 	<ul style="list-style-type: none"> • Difficulty accessing own GP • Barriers created from me not feeling well and feeling rushed on the phone • Lack of attention to detail with scripts leading to wrong numbers of drugs • Agency policies can create barriers for diabetics – eg, 48 hrs prescription time – but I needed it more urgently as I had an unusual situation 	<ul style="list-style-type: none"> • Need pleasant voice and helpful on end of phone • Having more GP availability for acute appointments • Increase patient knowledge on accessing GP triage appointments • Make reception and nurses aware that people with diabetes can’t run out of medications and need to facilitate timely access to medications whatever the situation.
Reception	<ul style="list-style-type: none"> • Receptive, respectful, warming, nice to be greeted in te reo • Nice to be recognised and known • Like that people know me and call me by name when I arrive 	<ul style="list-style-type: none"> • When phoning the Bayfair practice it gets answered at Papamoa by people who don’t know me 	<ul style="list-style-type: none"> • Change physical reception area at The Doctors Bayfair

	Highs	Lows	Suggestions
Waiting for appointments	<ul style="list-style-type: none"> • Like separate small waiting room at Bayfair 	<ul style="list-style-type: none"> • Longish waiting time to see GP • Waiting room at Bayfair too crowded 	<ul style="list-style-type: none"> • Change layout of waiting room at Bayfair • Fish tank for Papamoa
The consultation	<ul style="list-style-type: none"> • Positive people • Great during Covid liked the phone calls • Like the use of the healthy food plates that demonstrate food groups and portions 	<ul style="list-style-type: none"> • Varying levels of caring • Computers not working properly to have possible diabetes-related complications made clearer – eg, eye problems 	<ul style="list-style-type: none"> • Want more information on understanding results • How to use Manage My Health • More phone consultations • Ensure people are given all facts about the importance of their complications • To know more about phone triage • Everyone to be offered a food plate example if possible so we can see what to aim for

Improve

A second focus group hui was held to review the findings from the interviews and first focus group hui. Participants included two of the original Māori focus group members, our Māori receptionist, the diabetes nurse specialist and two practice nurses also involved with caring for our diabetes patients. We all had the opportunity to read the feedback from the focus group hui together with the survey interviews.

We agreed having support from whānau was a key factor for managing diabetes better.

Another significant factor is receiving continuity when accessing health care. People want to see the same health provider whom they know, trust and have a relationship with. This is a challenging factor for the practice. Although there is consistency in provision of care from the diabetes nurse specialist, there is a lack of employment longevity in GPs, which leads to less continuity in a person's lead health care provider.

To improve our diabetes service for Māori and Pacific people, some changes are being made to how and what we communicate with our patients.

- In the first instance we have maximised the use of our Māori reception/admin team member to make initial engagement by phone with Māori and Pacific diabetes non-responders and personally invite them for appointments.
- We are reviewing our written diabetes annual review invitation letter and will include an offer to bring whānau or a support person to the appointment.
- Still to be completed is an in-house training for reception on the importance of timely access medicines for people with diabetes when requesting repeat prescriptions.

The points above were chosen as initial improvements to our service because they were seen as achievable within a short timescale. It was acknowledged by the group that further changes towards improving equity are likely to be required.

Measure

We have reviewed the numbers of patients with diabetes who are enrolled in the practice, taking into consideration those who have left and those who have recently joined (May 2021). Currently, we have a total of 410 people with diabetes.

Our tracking of the number who have attended for their diabetes annual review has shown an increased attendance for all patients, with the largest increase being among Māori (Table 3).

Table 3: People with diabetes who are overdue for their diabetes annual review at The Doctors Bayfair and The Doctors Papamoa, by ethnicity (May 2021)

Ethnicity	People with diabetes		Overdue for diabetes annual review		% overdue for diabetes annual review	
	Sep 2020	April 2021	Sep 2020	April 2021	Sep 2020	May 2021
Māori	60	58	37	20	62%	34%
Pacific	17	19	7	6	41%	32%
Others	341	332	64	58	19%	17%

Conclusion

The team are very pleased that through this co-design project we have been able to better understand the needs of our diabetes patients, especially those who are Māori and Pacific.

So far, we have implemented one seemingly small change. However, since our Māori reception team member has been making individual contact with Māori and Pacific people who have previously not responded to invitations for check-ups, we have seen a positive increase in attendance for diabetes annual reviews, especially for Māori (Table 3).

This small change aligns with the concept of 'for Māori by Māori', tikanga, and manaakitanga (the process of showing respect, generosity and care for others).

The increased engagement with our Māori patients has enabled them to access diabetes care, which in turn has provided an opportunity for them to access medicines, education and support to improve their confidence and ability to live with and manage their diabetes well.

Working as a co-design team

Taking up the opportunity to be involved in a co-design project was a significant change in the way we work with our patients. Apart from getting their feedback via written surveys, this was a totally different approach to understanding their needs.

Learning about co-design and being involved in a small project has provided us with new skills that can be used in the future. It has been beneficial to have the opportunity to hear our patients' perspectives on a variety of areas, including the low and high points that can impact on their care.

We received helpful feedback and suggestions for changes to improve their diabetes journey. There were some surprises, including some grateful and welcomed comments together with positive feedback. In general, the experience of being involved with co-design has been a valuable

learning opportunity. From the beginning when gathering the initial data on this topic and now reviewing our current data, it is clear that using this tool and method of engagement could be replicated into other areas of the practice.

The project team

Name	Role
Parehuia Bishop	Practice Manager
Julie Cowley	Diabetes Nurse
Wendy Dillon	Regional Clinical Manager
Annie Gordon	Nurse Lead
Janey Horne	Māori Receptionist
Mary Latovai-Levi	Pacific patient

References

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Appendix

This appendix lists the prompt questions that were used for each of the six touch points (different stages of the journey) relating to participants' experiences coming into the practice for an appointment or requesting a prescription.

Touch points

1. Booking appointments and getting prescriptions

- Were you able to get an appointment with the person you needed when you needed it?
- Tell us about how you booked that appointment. What was good or easy about that? What was more difficult? Why? What works well and what does not?
- How far do you travel to get to the clinic? How long does that take? What do you think about the location of the clinic?
- Do you worry about the cost of seeing the doctor or nurse? What do you think would be an OK cost? If you had an overdue account, would this stop you coming to the practice?

2. Reception greeting on arrival

- Tell us what it's like when you come to the practice and get to the receptionist.
- How did this make you feel?
- What would make this better?

3. Waiting for your appointment

- How long did you have to wait to see the doctor or nurse?
- Do you think that was a short or long wait?
- How were you feeling during your wait time (okay, anxious etc)?
- What would make that better?

4. The consultation

- What was your time like when you were with the nurse or doctor? (Add prompts if the patient gets stuck. For example: Did you think they were caring, sympathetic, understanding, knowledgeable, or other?)
- How did this make you feel?
- What kind of information did you get? [Patients were shown common examples.]
- What did you think about that information, was it useful/understandable?
- What did you do with the information when you got home? [If they had a leaflet]
- What other type of resources and/or information would you prefer to get at the visit? (For example, easier to understand, more pictures rather than words, different language.)
- What do you need more help with when thinking about your diabetes?
- How often would you like to catch up with someone about your diabetes?
- What would you most like to talk to them about?
- What would make the consultation better?

5. Communication

- Apart from 'snail mail', how do you prefer to receive communication from the practice (for example, text, e-mail, Manage My Health)?
- I want to talk to you about different types of appointments now.
 - Did you know that we can help you through phone or video consultations? (Yes/No)
 - How would you feel about either of these ways of talking to a doctor or nurse?
- Have you got a computer or cell phone you can use to use for this type of appointment? (Yes/No)
- Does insufficient credit on your phone prevent you receiving or sending messages?
- Have you heard of our Manage My Health patient portal? (Yes/No)
(If they say 'no', you may need to describe it to them. If they say 'yes', you can go on to ask what they think they can do via the portal. Make a list of what they say as this will help you to know what they understand. Then ask the following questions.)
 - Does this interest you as an option for getting your results, ordering prescriptions and making appointments etc?
 - Would you be able to use the portal on your phone or another device?

6. Outcomes and take-home messages

- How were you feeling at the end of the consultation?
- Did you leave the practice with a clear understanding of what you need to do at home for your diabetes?
- If not, how could this have been made clearer?