



Let's Beat Diabetes

**Primary Care
Action Area**

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**LBD Information Sharing Workshop
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Overview and lessons learnt from two Primary Care projects:

1. Community Nutrition Project

2. Diabetes Self Management Education

1. Community Nutrition Project



Community Nutrition Project

- Concept developed 2003, funding approval 2004, project commenced 2005 and ran for 2 years
- Train the trainer pilot project
- Weight and Lifestyle management
- Working with two Primary Health Organisations (PHOs) in Counties Manukau (one a Maori Provider)
- Trained twenty nurses and Community Health Workers (CHWs)
 - Twelve Maori trainees
 - Three Pacific Island trainees



CNP Project Aims

- To increase the capacity of PHOs to deliver culturally appropriate and safe overweight and obesity management programmes
- To determine if a 'train the trainer' model is an effective method of obesity management within Primary Care in Counties Manukau



CNP Course Results

- Evaluated by the School of Population Health (Auckland University)
- The programme rated highly
 - especially the hands-on sessions and teaching aids
 - recognition of cultural practices
- A steady loss of CNP trained workers (8 trainees left)
 - staff leaving the job
 - reduced interest
 - competing workload commitments



Health Worker Results

- **MANAGEMENT**

Need management support & commitment to implement what they learnt

- **COMMITMENT**

A belief in worth & applicability of CNP linked with perseverance

- **ADDRESSING OBESE INDIVIDUALS**

Difficulty in approaching and working with obese individuals
(health worker confidence and motivation)



Patient Results

- On reassessment at six months, average weight loss was 2.7kg
- Patients found their health worker influenced them to make the lifestyle changes
- Realised that personal effort was required to make health changes
- Families and immediate communities are both sources of support and willing recipients of health information



Implementation Results

- **The Practices**
 - increased practice workloads
 - time commitment not well understood
 - other work took priority
 - needed specialised equipment to measure obese individuals

- **The PHOs**
 - Not sufficiently engaged early on
 - DHB-PHO cultures differed
 - PHOs unclear of staff capabilities post training
 - PHOs required more feedback about how staff were progressing
 - Providers now actively involved in planning other projects with DHB
 - CNP is compatible with other programmes such as CCM



Implementation Results

- **Hinderers to programme success**
 - Time required
 - Management support
 - Communication issues
 - Project was scoped and developed at a very early stage in the evolution of PHOs
- **Enablers to success**
 - support given to health workers by the project manager
 - SIA funding to cover CHW expenses
 - Interest of trainees



Summary of Key Points

- The weight and BMI rates of participants reduced over the 6 months
- CNP has the ability to increase the capacity of PHO's to deliver safe weight management
- The nutrition knowledge of health workers was increased
- The findings suggest 'train the trainer' model may be an effective model for obesity management
- The importance of engaging the appropriate staff for training
- The amount of support required post training
- The impact of the CNP on the workloads of staff



2. Diabetes Self Management Education



Diabetes Self Management Education

- December 2005 - PHO Governance forum endorsed implementation of a district wide Self Management Education (SME) programme.
- The initial focus was on **Diabetes SME** for 2006/07
- The model based on a central Coordinator at DHB and number of Facilitators based at PHOs
- Additionally Maori (0.5) and Pacific (0.5) Facilitators based at the DHB
- Facilitator training programme, DSME manual and related resources developed May – October 2006



Recruitment and Training

- PHOs utilised their SIA monies to fund the employment of their own Facilitators.
- Training course (10 days) run as modules over one month.
- Trainee Facilitators were assessed on their knowledge, attitude, presentation and facilitation skills.
- Facilitators were trained during 2006 - 15 completed the training and assessment



Current Position

- 11 Facilitators employed by 4 PHOs and DHB
- To date, approximately 300 patients enrolled onto the group DSME programme.
- Groups run in community, primary care, Church and Marae settings (groups run in Pacific churches are delivered in Pacific languages).
- Facilitators meet on a regular basis for peer support, information sharing and skill and knowledge update sessions.



Evaluation

- DSME Programme being evaluated by School of Population Health
- No results available yet
- Trying to measure changes in Health behaviour, and attitude as well as biomedical indices
- Early learnings include issues relating to the collection of data via self administered tools



Learnings So Far

- **PHO LEADERSHIP**
Establishing a PHO-led Steering Group as the leadership group has proven to be effective.
- **COMMUNICATION**
Regular update meetings enabled positive working relationships plus sharing of expertise/skill between facilitators and across organisations.
- **GENERIC vs DISEASE-SPECIFIC SME**
Starting with Diabetes, how to leverage for other self care programmes?
- **COMMITMENT**
10 days training is only the start...
- **FLEXIBILITY**
One size does not fit all...



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**COMMUNITY PARTNERSHIPS AND
ACTION IN COUNTIES MANUKAU**

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