

The logo for Pacific Perspectives, featuring a stylized geometric pattern of triangles and lines in shades of blue and white, positioned to the left of the text.

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Tofa Saili: Pacific Case Studies

Pacific Perspectives Limited

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Introduction

This document presents three case studies. The first case study discusses cardiovascular disease (CVD), a significant area of health disparity for Pacific peoples.

The second and third case studies have been chosen to show how services are responding to the complex interplay between social, economic and community resources and health and social needs that impacts on the health and wellbeing of Pacific peoples in areas with high concentrations of Pacific peoples. The case studies are about Pacific integrated care services in different settings, one a support service in a large tertiary hospital and the second a Pacific community not-for-profit organisation.

The themes which emerge from the service case studies are:

- Service contexts matter. The services are located in areas with high numbers of Pacific peoples, where there is a concentration of poverty and communities lack many of the supports and services available in wealthier suburbs and often have higher numbers of liquor, fast food and convenience stores;
- Integrated care approaches are required. This involves designing navigation and coordination of the range of health and social services required by patients and their families with high and complex health and social needs;
- The fundamental importance of healing relationships. Delivery is based on Pacific values and strengths based approaches by Pacific staff with a range of skills, knowledge and qualifications;
- The challenge of resourcing and delivering services focused on equity for Pacific peoples in health system contexts primarily based on the needs of the majority population.

Cardiovascular disease: a case study in Pacific health

CVD is the single most important contributor to the life expectancy gap between Pacific and non-Māori non-Pacific people (NMNP), contributing 1.7 years to the lower life expectancy in Pacific men and 1.3 years in Pacific women (Walsh & Grey, 2019). Risk factors for CVD include smoking, high blood pressure and diabetes, which are all more common in Pacific peoples compared to NMNP (Grey et al., 2010). Subsequently, Pacific peoples are more likely to develop CVD, including coronary disease (heart attacks and angina) (Grey et al., 2018) and stroke (Feigin et al., 2015).

Research has shown that although Pacific and Māori people have the highest rates of CVD deaths in NZ, their rates of CVD hospitalisation, although high, are not proportional to their rate of death, suggesting that there are important issues with access to acute CVD care for these groups. For every Pacific person that dies from coronary disease, for example, approximately three or four Pacific people are hospitalised with the disease. In contrast, for every NZ European that dies from coronary disease, five or six are hospitalised and for every Asian that dies, seven or eight are hospitalised (Grey et al., 2018). This is consistent with research that has demonstrated significantly higher death rates for Pacific peoples compared to NMNP, both before and after hospitalisation for a heart attack (Grey, Jackson, Wells, Marshall, et al., 2016; Grey, Jackson, Wells, Marshall, et al., 2014).

The reasons for these higher death rates in Pacific peoples are complex, but are likely due to a combination of factors related to the severity of disease, the presence of comorbid conditions that can worsen prognosis (e.g. diabetes and renal failure), and differential access to timely primary, paramedic and secondary care. Research has shown that, compared to NMNP, Pacific peoples are less likely to be maintained on evidence-based medications following hospitalisation for coronary disease (Grey et al., 2014). They are also less likely to receive revascularisation (mostly stenting) following a heart attack (Grey et al., 2016; Kerr et al., 2014; Sandiford, Bramley, El-Jack,

& Scott, 2015), although most (but not all) of the differences are accounted for by the type of coronary disease or the presence of comorbid conditions that preclude people from receiving intervention (Sandiford, El-Jack, Scott, Crengle, & Bramley, 2015). Thus, the management of these comorbid conditions (and in particular, achieving good diabetes control) and the prevention of CVD through optimal management of risk factors, particularly in primary care, is essential.

Lifestyle interventions (e.g. smoking cessation, good diabetes management, and support for maintaining a healthy weight) and, where appropriate, medications, can prevent CVD in people at high risk of disease (Chew et al., 2016; Ministry of Health, 2013, 2018). The use of medications is informed by CVD risk assessment, mostly undertaken in primary care, which involves the use of a well-established tool to estimate a person's risk of developing CVD in the next five years (Ministry of Health, 2018). Information needed to complete a CVD risk assessment includes a person's blood pressure, weight, cholesterol levels, smoking status, age and ethnicity. Pacific, Māori and Indian people are all considered to be at higher risk of CVD than other ethnic groups in NZ, so guidelines recommend that risk assessment starts in these groups 15 years earlier than for the rest of the population, at 30 for men and at 40 for women (Ministry of Health, 2018).

The purpose of CVD risk assessment is to ensure that people at moderate (10-15%) to high risk ($\geq 15\%$) receive appropriate advice on treatment and lifestyle changes. For those at high risk, treatment with blood pressure- and cholesterol-lowering medications is often necessary. For people who already have CVD, these two medications, plus aspirin, are necessary. These medications have been shown to reduce a person's risk of CVD death, but to be effective, must be taken on a long-term basis (Ministry of Health, 2013).

In 2012, the Ministry of Health made the completion of CVD risk assessments in 90% of the eligible adult population a key target (Ministry of Health, 2011), and this was achieved in all DHBs in September 2016



(Allen and Clarke, 2016). As the target focused on the completion of CVD *risk assessments*, rather than the extent of *appropriate CVD management*, it was unclear whether this had led to a reduction in CVD risk for different population groups, particularly those at high risk of CVD (including Pacific peoples). A recent analysis for Procure, the Primary Health Organisation with the highest number of Pacific enrolees (almost 110,000) in NZ, reported that, as a group, a lower proportion of Pacific, Māori and those living deprivation quintile 5 were receiving appropriate CVD management compared to the rest of the population (Wells, 2018).

An evaluation of the impact of the health target was conducted in 2016. It found that the greater attention on CVD and diabetes risk, and communication of that risk to individuals, had helped to make the public more aware of their CVD risk and how to manage it. However, it also found that communicating CVD risk was difficult, time consuming and not always well-understood by patients, and lifestyle changes were infrequently sustained over time (Allen and Clarke, 2016).

The communication of risk is particularly difficult when there are mismatches in the language and cultural beliefs of healthcare providers and Pacific patients. As part of her doctoral research, Dr Tua Su'a interviewed seven practice nurses and 16 Samoan people who had received a CVD risk assessment in primary care. She found that low health literacy, a limited command of the English language, inadequate appointment times and follow-up care, lack of appropriate resources in the Samoan language, ambiguity of information provided and lack of continuity of community programmes all served to limit Samoan people's knowledge and understanding of CVD, the implications of the CVD risk assessment process, and the steps that they needed to take to reduce their risk. The majority of participants felt there was no true value gained from completing CVD risk assessment (Su'a, 2017).

A number of recommendations were made to make the process more meaningful and increase the uptake of CVD management for Samoans (and Pacific peoples more generally). These included: the use of interpreters and Pacific language-speaking health professionals; longer and more flexible appointment times to allow time for questions and meaningful discussion; the development of appropriate written and other resources in Pacific languages that clearly explain what CVD is, what CVD risk means, and actions that people

can take to reduce risk; and the implementation of community programmes that are inclusive of cultural and spiritual values and include the whole family (Su'a, 2017). These recommendations are also highly applicable to the acute care setting.

These recommendations, taken up systematically and at scale, particularly in areas with large Pacific populations, would facilitate more meaningful CVD risk assessment for a group at particularly high risk of CVD. This could form part of a multi-tiered approach to the reduction of CVD in Pacific populations, which would also focus on improved management of comorbid conditions, increased awareness of CVD in the community, greater attention to the social and health needs of Pacific families and the removal of financial and other barriers to care.

The Fanau Ola Pacific service at Counties Manukau Health

Meeting the high demand for hospital services in clinically and financially sustainable ways within current capacity and models of care is the context in which Counties Manukau Health (CMH) have developed the Fanau Ola service.

CMH data shows the challenges and the need for Pacific tailored responses:

- In 2018, there were 118,100 emergency department admissions (CMH, 2019). Pacific peoples are overrepresented, accounting for 33% of presentations to the emergency department.
- CMH has the second highest number of 'Acute Hospital Bed Days' (AHBDs) among DHBs in NZ. A feature of the high level of AHBDs is the proportion associated with people with LTCs which at 37.5% is the highest among all DHBs.
- Pacific peoples have the highest rates of AHBDs at CMH, more than double the rate for other groups (741 per 1000 compared with 366 per 1000).
- Pacific peoples are also more likely to be readmitted to hospital than NMNP at CMH.

CMH has concluded that the needs of the Pacific population and the way services are currently designed demand a targeted, multi-faceted response. CMH have developed a service that works to integrate current service models around the needs of Pacific patients and their families identified through secondary care data as high service users. The service is designed to make the connection between the health and social needs of patients, and the influence of ethnicity, culture, language and the family context.

CMH has been exploring service models that account for this complexity of service need for over a decade. These services have evolved considerably with a progressive escalation in the intensity, systematisation and integration of health and social service support. The organisation's objective for the services has been to reduce the utilisation and cost pressures on hospital services, particularly emergency department and

hospital admissions. In response, the Fanau Ola team have developed a broader vision based on the concept of Pasifika Fanau Ola, which is a comprehensive strength-based approach to understanding family health and wellbeing that acknowledges the spirit, heart, mana and inherent dignity of Pacific families and communities. This approach recognises that comprehensive approaches for family, need to take account of the family's future goals, family and social relationships, cultures and languages, physical, mental, and emotional health and each family's unique context. Central to the model is the cultivation of trust-based partnerships between CMH staff and Pacific patients and families.

Fanau Ola has operated in its current form since 2017. A team of senior Pacific staff including management, nurses and social workers are co-located to provide case management for Pacific patients and their families. The multidisciplinary case management approach is designed to address complex and often interrelated health, social and economic issues that affect the capability of Pacific families to self-manage.

The Fanau Ola team works on behalf of patients and their families - with hospital based clinical services, primary care services and social services - in order to identify service gaps. The Fanau Ola team also advocate for patients and facilitate connections to a full range of services required to meet the needs of the whole family. This approach is consistent with the Welfare Expert Working Groups finding that people in need often do not know which agencies are responsible for providing the different services they need (Welfare Expert Advisory Group, 2019). Furthermore, the agencies did not have this information or assist people with getting the services they required from other agencies.

The Fanau Ola approach requires staff who are highly qualified and are grounded in Pacific cultural values, knowledge and relationships. They must have an in-depth knowledge of health in primary and secondary care as well as knowledge of the plethora of social



services in the community – which is characterised by a constant dynamic of change driven by initiatives from many government departments and community entrepreneurship. Most Fanau Ola staff have postgraduate qualifications and a wide mix of clinical and social work expertise and experience. The majority of nurses in the Fanau Ola service have masters level qualifications achieved through the Ministry of Health’s Aniva Leadership Development Programme, which has focused on applied leadership and personal and professional development.

The Fanau Ola service provides case management services and opportunistic health assessments to around 1400 patients and families each year. Around half of all cases are closed within 6 and 22 weeks with almost all discharged within 12 months. Evaluations show that there has been a 40% reduction in hospital admissions and presentations to the Emergency Department service for patients under the Fanau Ola service.¹

Patient/Family experience

In-depth interviews with patients and families were undertaken by an external Pacific researcher as part of an independent evaluation of the Fanau Ola service (Pacific Perspectives Ltd, 2019). The following section provides a summary of themes from this research.

For patients and their families, the service’s value centres around relational aspects of care. When talking about Fanau Ola, patients and families consistently return to some common themes - staff are ‘like family’, compassionate, approachable and able to be trusted. They make them feel respected, safe, understood and listened to. Taking time and maintaining regular contact (even after ‘official’ Fanau Ola support has ended), demonstrates for patients and families that Fanau Ola staff care for them and are committed to their health and wellbeing. For families whose collective contact with the health system has so often been marred by negative, intimidating or disempowering experiences, the emotional and cultural dimensions of these relationships, alongside clinical expertise and experience, become hugely important. Genuine and meaningful relationships provide the foundation for all subsequent support and activity.

Patient and family interviews illustrate the comprehensive understanding of family circumstances and need, which the service has developed through inclusive, family-centred approaches. For example, providing Pacific language support, can relieve the burden on family members to translate and interpret complex medical information about health conditions or medications. Direct contact with a GP with explanation of family context, key needs and issues, can reset the terms of the care relationship after long periods of disengagement. It also results in more timely support, arriving for patients and families at critical points in their care journey or at times of particular vulnerability and urgency.

Patients and family recount examples of support ranging from practical support (providing transport, sending reminders to take medicines); to more complex functions of facilitation (coordinating health and social services, encouraging families to be actively involved in their care); navigation (completing paperwork for housing, income, home help entitlements); negotiation (addressing cost barriers for prescription medication); and advocacy (accompanying patients to meetings and appointments). Communication of accessible, easy to understand information about conditions, medications and lifestyle factors, meets patients and family where they were at, builds skills, confidence and knowledge, and frequently goes beyond expectations of patients and family.

The Way Forward

The service appears to effectively address the complex and interrelated needs of Pacific families identified through frequent presentation to secondary services. However it faces significant challenges including scalability of the service in relation to the level of potential need, as well as the challenges of converting multiple datasets into meaningful information for measuring and monitoring impacts on Pacific health outcomes. The success of the team in working with patients and families that require intensive interventions can lead other pressured hospital services to abdicate to the Fanau Ola team, their direct role with these patients and families.

1. Hospital and ED utilisation data was compared for the period of 6 months prior to and 6 months after engagement with the Fanau Ola team.



Resource intensive interventions require effective demand management through highly refined criteria for acceptance in to the service. This is an area of work that is ongoing. The case management team is made up of 7 full-time staff supported by an administrator. This level of resource has to be rationed in relation to potential demand – an estimated 21,640 Pacific people with one or more long-term conditions; the rate of AHBDs for Pacific peoples being twice that of other groups; and almost 40,000 Pacific people using CMH’s emergency department each year.

The service needs to significantly invest in suitable information systems in order to support effective measurement and monitoring.

The Fanau Ola service is tailoring an integrated service to the highly complex health and social conditions experienced by Pacific peoples with multiple LTCs and social needs in Counties Manukau. This service has an adaptive and evaluative approach to service improvement. Key to its initial successes are the staff who have a broad knowledge of the health and social systems, demonstrate respectful interactions with the patients, families and communities, and have the skills to credibly engage with health managers and senior clinicians to effect change.

Vaka Tautua: ‘for Pacific by Pacific’ community services

Reviews of health and social services have identified that a subset of patients and their families with needs that are not aligned with standard service requirements have unmet needs and experience suboptimal services. The NZ Productivity Commission’s review of social services estimated that 3% of New Zealand service users and their families with complex needs required tailored services that were not met by existing service approaches. The Mental Health Enquiry Pacific Report and the Welfare Expert Working Group Review (WEAG) identified that Pacific families with disability or mental health conditions made up a significant proportion of the groups facing challenges in navigating and using services to support improved health and wellbeing.

The WEAG report (2019) discusses the important role of community organisations in supporting patients and their families to get the services they need, while also contributing to building community infrastructure.

Vaka Tautua is a national ‘for Pacific by Pacific’ provider of support services for health. The not-for-profit NGO was established in 2007. The service provides a comprehensive approach to working with Pacific families, providing a dynamic range of services that respond to community priorities.

Vaka Tautua holds a number of contracts with different agencies which are delivered in integrated ways:

- based on Pacific cultural values and strengths based approaches;
- delivered by a workforce that includes people with lived experience of disability or mental health;
- staffed by Pacific peoples with passion for their communities, many have community leadership roles and demonstrate compassion and strong networks with people and organisations in the communities they serve;
- that meet industry standards. VT has quality accreditation; and
- VT has accreditation as a Living Wage employer.

■ The range of services include:

Disability Information Advice and Support Services

Mental Health

- Community support
- Peer support
- Like Minds Like Mine
- Mental health navigation

Older peoples programmes

- Weekly education, health promotion and activities
- Elder abuse response service

Financial Support programmes

- Financial literacy for families with disability
- Community Finance, providing low or no interest loans through partnership with Good Shepherd, BNZ Bank and the Ministry of Social Development.

Clients and their families experiences of services

Interviews with Vaka Tautua clients and their families show the central importance of relationships with staff. Engagement can occur over long periods of time during the trajectories of illness and disability which are marked by periods of relapse and more intense need interspersed with remission and improvement. Clients described trusting relationships that were based on regular and intensive contact, knowing that staff would ‘go the extra mile’ for them. Examples of this commitment included visits after work hours and for one client a visit on Christmas Day when he was alone.

The service’s philosophy is to promote self-reliance and independence while providing flexible and responsive support at times of need. The scope of support for clients with mental illness after periods of hospitalisation included practical support such



as finding accommodation, re-establishing daily routines, seeking employment, managing household cleaning, and dealing with finances. Holistic support was provided for the burden of treatment, for example, facilitating appointments with health services, managing medications; promoting healthy behaviours; as well as encouraging cultural, spiritual and creative interests and creating opportunities for social interactions and developing networks. The extent of this support is powerfully expressed by the following client with a 17 year history of mental illness and frequent periods of hospitalisation:

“I know these days there’s a lot of – even in churches – it’s quite sad because there’s a lot of care but not affection and that’s what’s missing – the affection with the care that comes with it. It holds a lot of value, because when you feel loved, you feel a sense of worth... you feel a sense of nourishment and you feel more awake, alert, aware... because I’ve been places in my mind, real dungeon mentalities, real dark places... when someone hits you with that level of care and the honesty with sincerity and to support – it just really hits home and you just feel that sense of worth...”

Interviews with clients with disability and their families similarly showed support provided over long periods for ongoing and diverse needs. Clients’ needs ranged from access to and managing carers, to getting equipment and modification of homes. Accessing and using these services often required navigating complicated bureaucratic processes that were time consuming for families, particularly for people with English as a second language. The approaches taken by Vaka Tautua staff included informing families about services and allowances they were eligible for, advocacy with services on behalf of families, communicating with families in their preferred language and maintaining contact to ensure that referrals to other services were followed through and the outcomes that mattered to families were achieved. The interviews showed that the wellbeing and empowerment of families was as important as the services that were provided to meet the client’s needs. An indication of the trusting relationships that were developed was one family members’ statement that Vaka Tuatua staff were “like a second family”.

Summary

Vaka Tautua is providing a comprehensive range of services to Pacific clients and their families with complex, long term and ongoing needs. The dynamic range of services demonstrate responsiveness to family needs and community priorities. The service quality and effectiveness is judged by their clients and the testimonies included in this report are an example of the transformational changes that result for families.

This not-for-profit organisation provides an example of the broader role of community organisations that serve Pacific peoples, whereby they model community values in their organisation and service delivery. Employing service users who have lived experience, paying a living wage to staff and enabling community access to finance; demonstrate how community infrastructure can be supported by health providers. Vaka Tautua provides an example of a wellbeing approach for Pacific peoples.

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