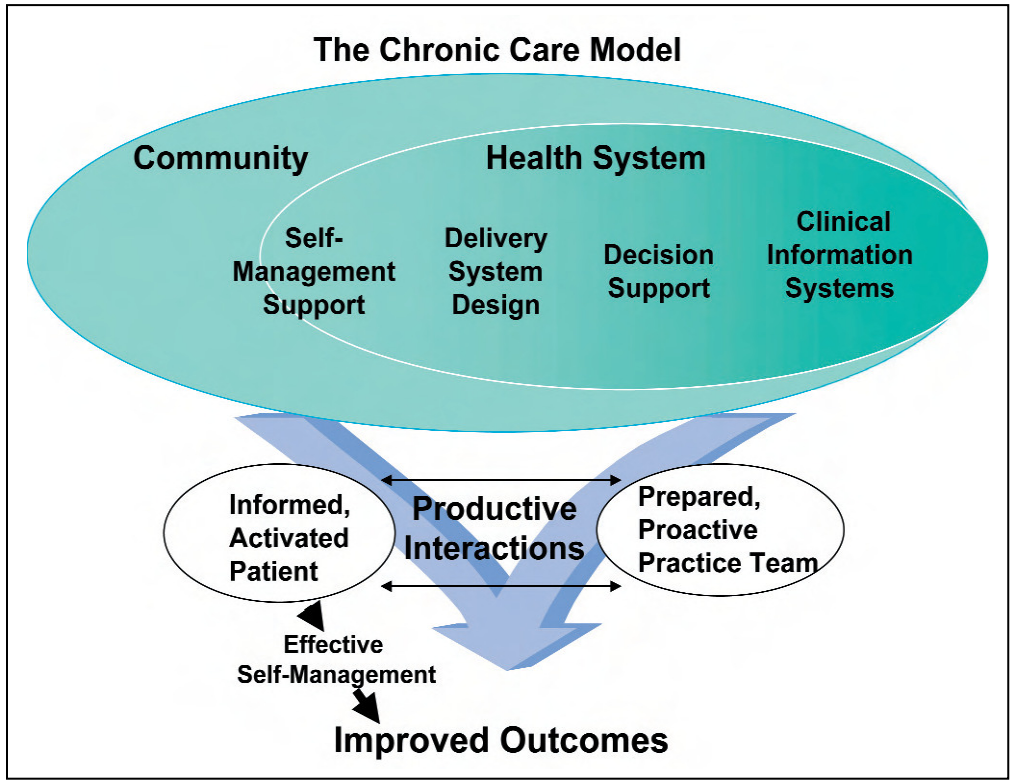
The Wagner Chronic Care Model with an 'equity lens'

Recognising the diverse needs of individuals and populations is a core component of providing good quality care, yet with the best intentions we may still fail to meet the needs of people and communities with the greatest health issues. This tool is designed to assist you to deliver an accessible, inclusive and equitable chronic disease programs.

What is 'equity'? Equity is a term which describes fairness and justice in health outcomes. It is not about the equal delivery of services or distribution of resources, but about recognising diversity and disadvantage, and directing resources and services towards those most in need, to ensure equal outcomes for all[i].

What is an 'equity lens'? The concept of an 'equity lens' suggests a magnifying glass to identify avoidable, unnecessary or unintentional barriers, exclusions and lack of opportunities to achieving good health. It prompts services to consider factors like gender, age, socioeconomic status, disability, culture, sexual preference and geography when planning, implementing and evaluating a service or program. It also encourages services to consider the impact of discrimination, social cohesion or isolation, levels of support, and control over life choices.



The Wagner Chronic Care model identifies the essential elements of a health care agency or system that encourages high quality chronic disease care. The elements are interdependent components, building upon one another.

To ensure we are directing chronic disease resources and services towards those most in need, to ensure equal outcomes for all, we have overlaid equity based questions on the various elements of the chronic care model for consideration in service development and review.

The Wagner Chronic Care Model with an 'equity lens'

Wagner Chronic Care Model	Definition	Prompt questions to assist you to design and deliver an accessible, inclusive and equitable service.
Health System Organisation of Healthcare	Program planning includes measurable goals for better care of chronic illness	**Program Planning (see also capacity building)** ☐ Have you involved a *diverse* range of people & services in your planning including the people for whom the service or program is intended e.g. people from low socio-economic backgrounds, specific cultural groups? We are inclined to develop programs that would suit people like ourselves and may 'miss the mark' for other specific groups. ☐ Will your services and programs include *targeted* initiatives to reach specific population groups or individuals with the greatest need? ☐ What else may you need to consider to ensure that your service has the *capacity* to address equity principles and practices (e.g. staff development, strengthened relationships with specific community/population groups, further consultation)? ☐ Do you regularly discuss how your own/your organisations *values, biases and assumptions* affect your planning, implementation and evaluation processes? ☐ Where required, will resources be *reallocated* to reach those with greatest needs? ☐ Have you considered the diversity of the workforce and whether it reflects the diversity of the population you are working with? **Barriers to accessing services** ☐ Have you ensured that any potentially avoidable, unfair, or unnecessary barriers that inhibit *access*, (e.g.cost, operating times and physical layout, location, transport, lack of childcare or respite care) have been addressed[ii]? ☐ Does your plan address men and women and their *particular circumstances* (e.g. income status, care responsibilities, impact and experience of violence, gender roles)?[iii]
Self-Management Support	Emphasis on the importance of the central role that patients have in managing their own care	**Program Promotion** ☐ Will the information and promotion of programs and services reflect the diverse ways people like to receive information and consider varying literacy levels? **Service delivery** ☐ Are clients encouraged and supported to attend with a family member or support worker[iv]. ☐ Does the service adopts each client's definition of 'family' which may include, but not be limited to, significant others, relatives by blood, same-sex partners, or spouses[v]? ☐ Were clients able to inform you about their strengths and resources as well as their needs, when designing their self management program? ☐ Does the organisation ensures that all written information is developed using Easy English[vi] (and translated as required) to cater for a range of literacy levels, abilities/disabilities and communication styles? ☐ Do staff have opportunities to reflect on the potential impact that the *power differential*, inherent in a practitioner/client relationship, has on your endeavours to *transfer power* to the client for effective self management? ☐ Do staff consider the power base within individuals, families, or communities that may impact on a clients capacity to self manage?(e.g. a client with chronic illness may not have financial power, therefore access to resources such as medication and healthy foods to assist with self management may be restricted or withheld, if those with the financial power do not deem them a high priority). ☐ Are specific processes and systems in place that transfer power, autonomy, and decision making to a community or

		individual[vii]? **Service evaluation** ☐ Will you ensure that feedback from clients and communities is gathered in a variety of ways which consider varying literacy levels and communication styles? ☐ Will your evaluation tell you if you reached everyone you wanted to, and if not, why not? ☐ Do you regularly obtain feedback from clients about issues of access, inclusion and respect for diversity etc?
Decision Support	Integration of evidence based guidelines into daily clinical practice	**Evidence Based Guidelines** ☐ Have you investigated evidence about best practice for specific population groups or individuals with the greatest needs, in addition to generic best practice models and frameworks? ☐ Have you incorporated *local evidence* of what works and what doesn't, particularly for specific population groups?
Delivery System Design	Focus on teamwork and an expanded scope of practice for team members to support chronic care	**Capacity Building** ☐ Does your service have staff with the skills and support to engage diverse groups including under-represented groups? ☐ Are there regular opportunities to maintain and enhance training in relation to equity, diversity, culture, and community development[viii]? ☐ Is training available for people involved in the program from reception and intake and do policies and procedures support service inclusion[ix]? **Service delivery** ☐ Does the organisation ensures that consumer rights documents and processes are developed using Easy English (and translated as required) and cater for a range of literacy levels, abilities/disabilities and communication styles?
Clinical Information Systems	Developing information systems based on patient populations to provide relevant client data	☐ Have you considered whether the expected measures and outcomes are appropriate for specific population groups? ☐ Will you document the important steps and processes (separate from outcomes) undertaken to effectively engage with individuals, groups and communities with specific needs, and will you share this with others?
Community Resources and Policies	Developing partnerships with community organizations that support and meet patients' needs	☐ Have you considered the underlying issues that determine the health of individuals and populations (social determinants of health[x]) and determined if you are able to address these in your work? ☐ Have you considered the reciprocal transfer of skills and knowledge between your agency and specific population groups, such as Indigenous and CALD communities, and the disability sector[xi]? ☐ Have you built in worker time, resources, and documentation processes for relationship development, partnerships and collaborative work?

Ideas for Action[xii] Change doesn't happen overnight. Please reflect on your discussions, and using the framework suggested below, keep a record of the actions you might take to bring about short, medium and long term change.

STEP 1: Identify any important issues to address in relation to:

Health System Organisation of Healthcare

Self-Management Support

Decision Support

Delivery System Design

Clinical Information Systems

Community Resources and Policies

STEP 2. Identify those actions which you see as possible to implement:

In the next 6 weeks…

In the next 6 months…

In the next year…

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[i] Adapted from Dyson, S (2001) Gender and Diversity Workbook
[ii] Adapted from Whitehead, M. The concepts and principles of equity and health, WHO, p8; The Equity Triangle Tool, VicHealth (2008)
[iii] Gender and Diversity Lens, DHS 2008,
[iv] Working with Aboriginal people and communities Health and Community services Audit, from Making Two Worlds Work Resource Kit, Mungabareena Aboriginal Corporation & Women's Health Goulburn North East, 2008 www.whealth.com.au
[v] Sexual Diversity Health Services Audit produced by Gay and Lesbian Health Victoria, available at www.glhv.org.au
[vi] Easy English means using clear, simple words to make written information easy to understand, with visual information such as photos or logos to explain information
[vii] Hearn, S & Wise, M Health Promotion: a framework for Indigenous health improvements in Australia in Hands on Health Promotion (2004). Moodie, R & Hulme, A Eds IP Communications, Melbourne
[viii] Adapted from The Equity Triangle Tool, VicHealth 2008
[ix] Adapted from The Equity Triangle Tool, VicHealth 2008
[x] Social Determinants of health are: income and social status, employment status, education, social environment, physical environment, healthy child development, personal health practices and coping skills, health services, social support networks, biology and genetic endowerment, gender, culture , from Health Canada Women's Health Strategy, 1999
[xi] Hearn, S & Wise, M Health Promotion: a framework for Indigenous health improvements in Australia in Hands on Health Promotion (2004). Moodie, R & Hulme, A Eds IP Communications, Melbourne
[xii]The 'ideas for action' concept is adapted from the Sexual Diversity Health Services Audit produced by Gay and Lesbian Health Victoria, available at www.glhv.org.au
and Working with Aboriginal people and communities Audit from Making Two Worlds Work Resource Kit, Mungabareena Aboriginal Corporation & Women's Health Goulburn North East, 2008
www.whealth.com.au

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