Innovation and Translation

Diversity Conceptual Model for aged care: Person-centred and difference-oriented and connective with a focus on benefit, disadvantage and equity

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Aim: This project aimed to develop a Diversity Conceptual Model to support the aged care sector to identify diversity characteristics and associated benefits and disadvantages in order to consider greater equity in policy and practice.

Methods: A multi-method approach was used to develop the Diversity Conceptual Model using a literature review, organisation-wide consultation using a questionnaire, focus groups and interviews with key stakeholders.

Results: A Diversity Conceptual Model was developed as a visual ‘tool’, made up of numerous components, with a focus on diversity characteristics that may be creating benefits and disadvantages for a consumer to participate in their health care. Continuous quality improvements and equity are presented as essential overarching components of the Model.

Conclusion: The Diversity Conceptual Model has many potential applications for aged care. The author proposes that its wider adoption would increase confidence, skills and knowledge, enabling the aged care sector to influence greater equity in policy and care practice.

Key words: aged care, diversity, disadvantage, equity, policy.

Background

Australians enjoy the highest levels of health and well-being in the world [1]. The life expectancy of Australians is 79.5 years for men and 84 years for women. Eighty-two per cent of Australians are satisfied with their quality of life [1]. There are, however, subgroups within Australia’s population who have significantly poorer health and well-being compared to the rest of the nation. For example, the life expectancy of Aboriginal and Torres Strait Islander people is 12 years shorter than other Australians [1]. People who are socioeconomically disadvantaged are twice as likely as those who are least disadvantaged to have a long-term health condition [2]. The low levels of health literacy in Australia [3] also influence how successfully one can interact with the health-care system and manage one’s health: 59% of Australians are assessed as having below the minimum standard of health literacy, which increases to 83% for Australians aged 65–74 years [4]. The increased physical and mental health risks for older lesbian, gay, bisexual, transgender and intersex (LGBTI) people, together with lower rates of access to health care by these populations, are being increasingly acknowledged as major drivers of health inequity in Australia [5].

The National Health and Hospitals Reform Commission (2009) considered that significant reform is needed to the aged care system if it is to meet the challenges of an older and increasingly diverse Australian population. The Australian Government is progressively implementing a range of aged care reforms so that the aged care system can aim to be sustainable and affordable, and be the best possible system for all Australians [6,7].

Diversity is a policy priority for the Australian Government-initiated reforms across the aged care sector [8–11]. Guidance for providers and organisations regarding incorporating diversity in their policy and care delivery is required [12].

This paper will discuss and define diversity. A description of the development of a Diversity Conceptual Model, that can be systematically used by the aged care sector to make connections between diversity as a source of benefit or disadvantage is provided. Considerations for greater equity in policy, will be discussed.

A proposed definition of diversity

Interpretations of the term ‘diversity’ vary between individuals and groups, and these can change over time as a result of many interconnected factors over individual lives, with influence from ever-changing social and political settings. Diversity differentiates and individualises while also connecting people with groups and communities. In order to deal with all kinds of differences and similarities effectively, aged care service providers and their workforces need to focus not only on one, but on all, of the often overlapping layers of diversity [13].

For the purpose of developing the model, the following definition was used: diversity is about what makes a person unique and different and includes identity, life experience and beliefs. At the same time it is about the shared characteristics and values that connects a person to groups and communities, for example, connection to country for
Aboriginal people, connection to country of birth and language for culturally and linguistically diverse (CALD) people and a connection to community for LGBTI people. This definition was developed from a review of literature, informed by an organisation-wide consultation, focus groups and interviews with internal staff and external community aged care service providers (external service providers) regarding their perceptions of diversity.

**Diversity conceptual model**
A large national provider of nursing and aged care services (national service provider) in people’s homes and residential aged care facilities identified the need to develop a tool to support the organisation with diversity policy and practice. During the development phase of the Diversity Conceptual Model, no tools or any type of practical guidance emerged from the literature to support the aged care sector in this regard.

**Methods**
A multi-method approach was used to develop the Diversity Conceptual Model using a literature review, organisation-wide consultation using a questionnaire, focus groups with key stakeholders from a national service provider, and interviews with internal and external stakeholders.

This project was approved for implementation by the national service provider’s Clinical Governance Committee.

**Participants**
Participants were external service providers in Victoria working with and representing people from CALD backgrounds, LGBTI people, people with dementia and Indigenous Australians. In addition, staff of a national service provider that worked with diverse consumer populations in Victoria also participated.

**Literature review**
A literature search was conducted using PubMed and MEDLINE databases, and the following key words and their variants were used as search terms: diversity, equity, continuous improvements, policy, aged care, health inequalities, illness narratives, culture, consumer participation and social determinants of health.

Unpublished (grey) literature on the topic was sought using the same terms in searches of the Australian Government Department of Social Services website and websites of aged care providers and international organisations such as the World Health Organisation (WHO).

**Organisation-wide consultation using a questionnaire**
An internal organisation-wide consultation process using a questionnaire was developed from the findings of the literature review. An invitation to participate was emailed to all staff, across jurisdictions, service types and work roles, and was voluntary in nature.

**Focus groups**
Internal staff participated in the first focus group discussion. The organisation’s Clinical Governance Committee, which is made up of Executive General Managers and General Managers of departments across the organisation, participated in a second focus group.

**Interviews with key internal and external stakeholders**
Internal staff and external service providers participated in the interviews.

The focus groups and interviews were based on a set of four themes and related prompt questions that were informed by the literature review and the outcomes of the internal organisation-wide questionnaire.

**Results**
Within the national service provider, 29 staff agreed to participate, which consisted of 15 written submissions and 14 agreeing to participate in a focus group and face-to-face interview. All eight Clinical Governance Committee members and two of the organisation’s Board members participated in the second focus group. From the 22 invitations to the external service providers, 12 agreed to participate in interviews.

**Literature review**
During the consultation process, there were three iterations of the Diversity Conceptual Model. The first iteration was informed by the literature and focused on the following components:

**Connection to culture**
The literature revealed the connection between culture and illness. Kleinman argues that ‘culture shapes clinical reality’ [14]. As a result of the mounting evidence of inequality of health status and the relationship between culture and illness, cultural group (self-identity) must be the central diversity characteristic from which all other diversity characteristics are considered for planning and providing person-centred care.

**Diversity characteristics**
In the Diversity Conceptual Model, diversity is underpinned by recognition that diversity characteristics create benefit or disadvantage for some people and impact on their health status and consequently their ability to participate in their care.

The first iteration of the Diversity Conceptual Model included 12 diversity characteristics common to and
shared by older people. These characteristics were informed by the WHO’s work with social determinants of health [15], special needs groups identified in the Aged Care Act 1997 [16] and a human rights approach for ageing and health [17].

Recognising differences and disadvantages

The Diversity Conceptual Model promotes a difference-oriented approach focusing on all kinds of differences and disadvantages [18]. There are existing tools to measure disadvantage, such as the Australian Bureau of Statistics Socio-Economic Indexes for Areas, but these have not been designed for aged care providers to easily use and as a result will not be discussed in this paper. Current government policy focus is on individual population groups defined by a shared diversity characteristic, such as Indigenous Australians or CALD people. Many peak Australian organisations are funded to provide resources and education to the aged care sector. While this is valuable in improving awareness of the needs of populations with a shared diversity characteristic, it is increasingly evident that our community consists of people with multiple person-specific diversity characteristics that impact on equity of service access and care. Many aged care service providers consider that they are good at providing services to a diverse population because they practice a ‘we treat everyone the same’ policy [19]. The service belief of treating everyone the same may be contributing to greater inequity in policy and service provision, as it may not fully recognise the multiple diversity characteristics that are contributing to disadvantage.

Equity in systems

Equity must be mainstreamed in all relevant strategic and organisational management instruments [20]. Cattacin et al. present the following five key standards for the creation of equity in organisations [21]:

- equity in policy;
- equity in access;
- equity in quality of care;
- equity in participation; and
- promotion of equity within an organisation.

The Diversity Conceptual Model is informed by these equity standards.

Client narratives

The telling of stories about oneself and others is universal [22]. Understanding the illness experience can create better understandings between the consumer and aged care worker, and can assist service providers to respond to all of the consumer’s needs [23]. A particular self is created and presented through these narratives, and the community aged care workforce is the listener who questions and comments [22].

Questionnaire, focus groups and interviews

The second and final iterations of the Diversity Conceptual Model were informed by outcomes of the organisation-wide questionnaire and then the focus groups and interviews with staff and face-to-face interviews with external community service providers. Thematic analysis was used to group the data. The following themes were identified as essential factors to further inform the development of the Diversity Conceptual Model.

Reason for referral

The need to acknowledge and consider the reason for referral came out of the focus group discussions. Focus group participants had a great knowledge of the aged care system and felt that a referral is the starting point for understanding consumers entering the aged care system.

Cultural identity

Focus group participants expressed concerns about the potential neglect of cultural identity, given that there are so many diversity characteristics possible. As a result of the mounting evidence of patterns of inequality of health status for specific population groups such as Aboriginal and CALD and the relationship between culture and illness, cultural group identity was perceived as the central diversity characteristic of consumers, from which all other diversity characteristics can be considered for planning and providing care. Focus group participants agreed that culture is inclusive of heritage, ancestry and ethnicity. It was also agreed that a self-identity approach should be used, whereby the consumer chooses to identify with one or more cultural group. Sample responses can be: Macedonian; Vietnamese Australian; Australian Scottish, Aborigi- nal, Italian and so on. By identifying a connection to a cultural group, the person is only indicating a link or shared value. The level of commitment or adherence to the culture(s) can range from total, uncompromising, through to complete non-concern and/or non-practising association. Early recognition of this connection to cultural group can assist aged care providers to better understand the needs, choices and health behaviour of a consumer.

Diversity characteristics common to and shared by older people

The organisation-wide questionnaire confirmed a number of characteristics common to and shared by older people in addition to those identified in the literature, including: refugee experience, poor literacy, socially isolated, health beliefs and habits, health condition, torture and/or trauma, disability condition, relationships, people who are dying, continence, stigma and discrimination, age, and carers.

Focus group participants, as a result of their experience in the sector, stated that some very vulnerable groups needed to be included, such as asylum seekers and people who hoard. Further, some diversity characteristics were
renamed; for example, ‘disability condition’ was renamed ‘disability’. Focus group consensus led to the removal of diversity characteristics originally listed in the questionnaire; for example, ‘relationships’, as they argued that these could become part of already listed diversity characteristics.

Focus on research and continuous quality improvements
Feedback from the questionnaires, focus groups and interviews had a strong focus on the need for more systemic approaches to recognising disadvantage as a result of diversity. Further, the organisation as a whole has numerous quality and accreditation requirements, and works with an evidence-based and continuous quality improvement approach. The final iteration of the Diversity Conceptual Model contains all these elements.

Use of client narratives
Focus groups and interviews identified client narratives as an integral part of identifying and understanding diversity. Focus group participants strongly agreed that aged care workers use a wide variety of skills to elicit life stories including listening, assessment, relationship and trust building skills. There was preference that the narratives be formed from real stories told by clients, their families and carers as to how they perceive, live with and respond to their illness. It was agreed that client narratives could be used together with the Diversity Conceptual Model to support concept learning for aged care workers. This can help aged care workers to identify, understand and classify a consumer’s diversity characteristics which can be critically analysed for connection and disadvantage, and applied to assessment and care planning practices.

The diversity conceptual model
After collating the above information, the following five themes were identified as essential to inform the development of the Diversity Conceptual Model:
1. Acknowledge and consider reason for referral
2. Cultural group identity to be the central diversity characteristic
3. Identification of diversity characteristics common to and shared by older people
4. Focus on research and continuous quality improvements for greater equity in policy
5. Use of client narratives to support the Diversity Conceptual Model.

As shown in Figure 1, the final Diversity Conceptual Model contains a central diversity characteristic – cultural group (self-identity) and 27 other diversity characteristics.
common to and shared by older people. These are: age, refugee/asylum seeker; abuse/neglect; bariatric; disease or illness; co-morbidity; country of birth; end-of-life; stigma and discrimination; homeless or at risk of homelessness; religion/spirituality; hoarding; Aboriginal and/or Torres Strait Islander; disability; LGBTI; financial disadvantage; torture or trauma; English not primary language; rural or remote setting; health beliefs, practices and habits; low health literacy in English or another language; dementia; carer; gender; veteran; no social support; and drugs or alcohol. It should be noted that this is not an exhaustive list.

Diversity conceptual model visual representation
Very early in the development process, it became clear that a visual representation of the Diversity Conceptual Model was required. A focus group participant suggested that it be presented as a visual ‘coat hanger’, upon which the numerous identified components can hang. Given that there were many characteristics of diversity, a circular model was developed to depict these aspects.

Rather than simply considering the reason for referral, the Diversity Conceptual Model encourages a focus on all diversity characteristics that may be creating benefit or disadvantage for a consumer in participating in their health care. As evidence, quality improvement and equity in policy are essential as overarching components of the Diversity Conceptual Model, these were used as the outer ring of the model.

Discussion
Cultural planning has been the priority of the Australian and State Departments of Health and Ageing in the last two decades. Migration, culture and improving services to people who originate from non-English speaking countries have been the focus. Diversity is now a policy priority for the Australian Government initiated reforms across the aged care sector [8,9,11,24]. Aged care service providers need to accommodate all categories of difference and acknowledge the realities of people disadvantaged by more than one diversity characteristic. Cattacin et al. confirm that organisations face important challenges in accommodating differences among their users [24]. They describe equity standards as the answer for aged care service providers that are willing to respond to differences between people. These equity standards underpin the Diversity Conceptual Model.

Central diversity characteristics – cultural group (self-identity) and 27 other diversity characteristics – are identified in the Diversity Conceptual Model. One may ask which of these diversity characteristics is most important to influence an intervention or improve a policy. Syme argues that diversity characteristics are all important and that we must intervene on all the diversity characteristics that cause health problems [24]. The author proposes that concentrating on the worse-off maximises the benefits of greater equity in policy for all consumers.

What are the next steps for the Diversity Conceptual Model?
The Diversity Conceptual Model was largely developed and evaluated by a national service provider with some input from external service providers. The author recommends wider consultation and testing of the model to ensure that it is relevant to other aged care service providers. The author acknowledges that a limitation of the model is that consumers (in particular older people and service users) were not directly involved in the design of the model. Any future work to validate the model needs to include consumers in particular older people and service users as well as aged care service providers. Once validated, the author believes that the Diversity Conceptual Model could have many potential applications for policy and practice.

The Diversity Conceptual Model can be used as a tool:
• To inform the design and development of consumer information;
• To support My Aged Care and Regional Assessment Services with assessing consumer needs.
• For the professional development of the aged care workforce;
• To inform policy development and more inclusive service pathways.

Conclusion
The Diversity Conceptual Model has been developed as a result of an identified lack of practical guidance to support the aged care sector to understand and resolve problems associated with diversity and associated benefit or disadvantage in policy and practice. The author proposes that a wider adoption of the Diversity Conceptual Model should increase the confidence, skills and knowledge of the aged care workforce to use client narratives to reveal connections between diversity and disadvantage and consider greater equity in service provision. In addition, the Diversity Conceptual Model may be applicable to fields outside the community aged care sector.

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Key Points

• This paper presents a new Diversity Conceptual Model to guide the aged care sector to better understand and respond to consumers who are disadvantaged by their diversity.
• The visual tool assists the workforce to identify diversity characteristics that may be impacting on the ability of consumers to participate in their wellness.
• The Diversity Conceptual Model can be used with client narratives to support consideration for greater equity in aged care policy design and implementation.

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