Advanced Illness Care Program (AICP) Utilizing a 'Five Cornerstone' Approach in California

Submitted by: AC Care Alliance

Overview

Research confirms that there are numerous benefits to utilizing care navigators in health care interventions, especially for Black people diagnosed with a serious illness. The AC Care Alliance created the Advanced Illness Care Program (AICP) to address the unique needs of this population, addressing serious illness care disparities in communities of color and advancing equity. The program builds on the confidence and trust that the African American church has won in communities of color that are often distrustful of the health care system. Developed in 2013 with input from pastors, congregants, health systems, community groups, and national organizations, the AICP addresses the advanced illness care needs of diverse community members in alignment with their spiritual and religious values and preferences. In this model, care navigators are members of the communities they serve, trained in community outreach and holistic advanced illness care wrap around support.

Acknowledging that a serious illness diagnosis affects the totality of a person, the AICP model uses a Five Cornerstone approach, which includes: 1) spiritual needs 2) health needs 3) planning for advance care 4) social needs and 5) caregiving needs. Care navigators build trusting relationships with program participants who have advanced illnesses, and their caregivers. Through a series of meetings and phone calls over approximately six months, the care navigator helps participants meet their advanced illness care needs by providing trusted resources and referrals, as well as tools and training to promote participant empowerment and specific coping skills (e.g., communicating effectively with their primary care providers). Care navigators help participants improve their skills for accessing appropriate care, both within the health care system and from social/non-medical services in the community.

Impact/Data Outcomes

Per evaluation work led by the UC Davis Betty Irene Moore School of Nursing, implementation of the AICP led to:

- → 1,500 people served since 2016
- → 3.5 average referrals to social service providers by care navigators per participant
- → Caregiver needs addressed at 53% of visits
- → 55% of participants completed an advance directive (compared to 15% national average)
- → Trained care navigator workforce reporting high satisfaction in training and work

Full details of the program impact here: https://www.care-alliance.org/impact

Feasibility

Two main prerequisites for this program model are ensuring engagement with the community and trusting, bidirectional organizational partnerships:

- → Those who plan to implement a similar model must be committed to providing community support, conducting 'upreach' (not outreach) to community-based organizations, and deeply understanding both the gaps and assets of the target community.
- → Trust between faith-based organizations, community members, academic institutions and the health systems must exist for any such program to operate. Partnerships, particularly those between health care organizations and the faith community, are essential to the success of the program. A number of respected faith leaders are part of the planning, implementation and evaluation phases of the model. Also, there is health system engagement to ensure the medical/health component is comprehensive.

Scalability

The AC Care Alliance (ACCA) has worked with multiple funders to design and test the AICP model, with a lens towards scalability. The ACCA has been developing technical assistance and other resources (e.g., their care navigator curriculum and training program) to bring additional partners into its local network. IT/data expertise, access, and integration is also essential to support care coordination and ensure compliance with HIPAA and other requirements. To date, the program has successfully expanded to counties in Northern California, and leadership is working to scale and expand the model to reach more Black people and Latino communities nationally.

Sustainability

The AICP model has been largely funded through philanthropic support, but is beginning to develop experience identifying and connecting with local payers.

Key Advice

- → Meaningful trusting collaboration, particularly centering the voices and expertise of others, is the crux of this model. If developed from the faith community, strong pastoral and congregational leadership is essential.
- → Community leaders, health partners, faith leaders, and academia should all be deeply committed and passionate about collaboration for the greater good.
- → Telling stories is powerful. Using both "storytelling" and "story listening" helps care navigators to build trusting relationships, learning participants concerns and tailoring the AICP to meet their needs.

Project Team

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