Physician-Focused Payment Model  
Technical Advisory Committee

Listening Session on Issues Related to Population-Based TCOC Models

Presenters:

Subject Matter Experts
• Sherry Glied, PhD, Dean, Robert F. Wagner Graduate School of Public Service, New York University
• Karen E. Holt, Vice President, South Region, Collaborative Health Systems
• Valinda Rutledge, MBA, MSN, Chief Corporate Affairs Officer, UpStream
• Christina Severin, MPH, President and CEO, Community Care Cooperative

Previous Submitter
• Jon Broyles, MSc, Chief Executive Officer, Coalition to Transform Advanced Care (C-TAC);
  Gary Bacher, JD, MPA, Chief of Strategy, Policy, & Legal Affairs, Capital Caring Health; and
  Torrie Fields, MPH, Chief Executive Officer, Votive Health
  • Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model proposal
Presentation: 
*Reducing Cost of Care While Maintaining or Improving Health Outcomes*

Sherry Glied, PhD
Dean, Robert F. Wagner Graduate School of Public Service, New York University
PTAC Public Meeting

Sherry Glied, PhD
Dean and Professor of Public Service
NYU Wagner
Goals

• Reduce cost of care while maintaining or improving health outcomes
• How?
  – reduce duplication, unnecessary care
  – monitor and connect people to care more effectively to avoid increases in severity
  – increase prevention efforts to avoid future care
• (Note: discussion is focused on Medicare program where prices are set – this would look different in a setting where prices are negotiated)
FFS as the Problem

• All of these actions are disincentivized under FFS payment

• The more you do, the more you are paid – whether the care is necessary or could have been avoided
  – Rationale for APM
    • A capitated/bundled/flat payment structure creates incentives to reduce costs
But…

FFS payment has many very useful properties
– easily monitor performance
  • payment clearly tied to a patient and process
– allows maximal choice of provider by patients
  • highly valued by patients
– automatically risk adjusts
  • patients who use more services generate greater payments
– in normal times (except in once in a hundred years pandemics), provider faces little risk
  • output generates payment
How many of these 9 countries use primarily fee-for-service to pay outpatient providers?

- Canada
- France
- Germany
- Italy
- Netherlands
- Sweden
- Switzerland
- UK
How many of these 9 countries use primarily global budgets to pay hospitals?

- Australia
- Canada
- France
- Germany
- Italy
- Netherlands
- Sweden
- Switzerland
- UK
APM Challenges (I)

• Shifts away from FFS toward APMs that include a capitated/bundled/flat payment component generate new sets of problems
  – Higher burden of monitoring
    • theoretically better to measure value than volume – but a lot harder to do!
  – Must assign patients to providers somehow
    • creates incentive for providers to offload work and costs to others
      – for example, behavioral health carve-outs shift from talk therapy (covered under capitation) to pharmacotherapy (drugs not in the contract)
      – bundled payment for post-acute care may shift burden of care to families, informal care
APM Challenges (II)

– Need some way to risk adjust so providers are not incentivized to avoid the sickest patients
  • risk adjustment systems can create perverse incentives to over-diagnose
  • pervasive across the system
– Need to address provider risk (even with risk adjustment)
  • voluntary participation
  • multiplicity of models
    – given inherent variability in costs and structures of provider organizations, each organization can select the model that brings it the most revenue relative to cost
    – organization can capture savings that would otherwise accrue to Medicare
– It is really hard to accurately assess performance of many APMs because of these selection problems at the patient and program level
The Underlying Problem is Tough!

• Research suggests the level of “inefficiency” in healthcare is comparable to that across the economy and probably smaller in the US than elsewhere.
  • lots of reasons to improve processes (as everywhere)
  • but these problems are not more pervasive in health care

• This means that it is easier to generate positive financial results by manipulating incentives etc. than by doing the hard work that might improve care
Total Cost of Care

• Key feature: unit of analysis is very broad
  • best-established is Maryland
  • other models at employer level
    – Population is not discretionary/assigned/etc.
    – Very crude risk adjustment (age/sex) is enough – and hard to manipulate
    – Ideally – measure all aspects of the cost of care
      • including all services paid for by Medicare
      • and all beneficiary out-of-pocket payments
      • and all informal care etc.
Examples

• Maryland – Medicare beneficiaries
• States – cost-growth benchmarks
  – Massachusetts
  – Connecticut
  – Oregon
    • Nevada
    • New Jersey
    • Washington
TCOC is a Management Tool

• TCOC avoids:
  – Selection of patients
  – Risk adjustment
  – Assignment of patients

• But it is not an incentive program – it is a monitoring and management tool
  – Incentives sit within TCOC monitoring
Presentation:

Making Care Primary Again: Partnering on the Path to Value Based Care

Karen E. Holt
Vice President, South Region, Collaborative Health Systems
MAKING CARE PRIMARY AGAIN

Partnering on the Path to Value Based Care

Opportunities for Improving PCP Care Coordination
Proven Performance & Outcomes

In PY2020, 160K Medicare beneficiaries cared for across the country by CHS partner providers

Since 2012*

$475M Total net savings to Medicare Trust Fund
$300M Total earned shared savings

Patient Impact in PY20

✓ 97% Average quality score
✓ 19% Reduction in Hospitalization
✓ 26% Reduction in SNF utilization

Financial Impact

$91M Total new savings to the Medicare Trust Fund in PY20

Total Earned Shared Savings from recent PYs:

PY18: $34M  PY19: $51M  PY20: $66M

*2012 is the first year of the program, generated by CHS Partner Shared Savings Program (MSSP) ACOs
Navigating An Evolving Industry
Administrative and clinical activities are overwhelming providers

<table>
<thead>
<tr>
<th>Industry Trends</th>
<th>Implications for Providers</th>
<th>CHS Value Proposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migration from Fee-for-Service to Risk</td>
<td></td>
<td><strong>Empower Providers to Run Efficiently</strong></td>
</tr>
<tr>
<td>Shift to PCP, SDOH &amp; Prevention</td>
<td></td>
<td>- Provide state-of-the-art tools which focus efforts on critical actions and eliminate waste</td>
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<tr>
<td>Exploding Tech and Admin Requirements</td>
<td></td>
<td><strong>Preserve Independence</strong></td>
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<tr>
<td>Increasing Vertical and Horizontal Integration</td>
<td></td>
<td>- Reduce the financial and administrative burdens which force acquisition from outside</td>
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<td></td>
<td><strong>Increasing Financial Pressure</strong></td>
<td><strong>Enhance Transition to Value-Based Care</strong></td>
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<tr>
<td></td>
<td>- Margin compression across value chain</td>
<td>- Collaborate with providers to deploy critical infrastructure for success in VBC and risk programs</td>
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<tr>
<td></td>
<td>- Reimbursement tied to quality</td>
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<td></td>
<td>- Cash flow problems due to slow/under/non-payments</td>
<td><strong>Clinical Program Implementation</strong></td>
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<td>- Rising operating costs and investment in new technology</td>
<td>- ADT messaging at the point of care</td>
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<td>- Federal budget uncertainty</td>
<td>- Health Systems and Emergency Departments</td>
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<td>- Readmission and Discharge Placement</td>
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<td></td>
<td><strong>Disparate Technology and Data Systems</strong></td>
<td>- Community Based Organizations</td>
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<tr>
<td></td>
<td>- Multi-platform data integration</td>
<td>- Community Health Worker</td>
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<td></td>
<td>- Implementing EMR/analytics tools</td>
<td>- Transitional Care Management</td>
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<td></td>
<td>- Ability to keep current and deploy new technology</td>
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<td></td>
<td>- Patient/beneficiary mobile health platforms</td>
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<td></td>
<td><strong>Declining Autonomy</strong></td>
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<tr>
<td></td>
<td>- Increasing administrative burden/reporting requirements</td>
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<td></td>
<td>- Pressure on balance sheet &amp; community needs</td>
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<tr>
<td></td>
<td>- Maintaining independence</td>
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</tbody>
</table>
Population Health Management

Population health management requires timely data for care coordination and beneficiaries to collaborate more effectively for improved care and lower costs.

- Care Coordination and Connectivity
  - Timely data for all patients and all health plans
  - Stronger regulations to support ACOs, and IPAs ADT feeds

- Care Settings
  - Post Acute Facilities (SNFS, LTAC, IRFs, etc.)
  - Home Health Providers
  - Hospitals
  - Specialty care providers
  - Diagnostic services
  - Transportation services

- Care Management
  - Health risk assessments and stratification
  - Transitions of care and follow-up
  - Care plan definition, management, tracking

- Patient Engagement
  - Timely outreach to patients for education and support
CHS Core Care Model

- Educates providers around risk adjustment practices and reviews for accuracy
- Develop partnerships with providers, facilities and ancillary services to collaborate and coordinate beneficiary care
- Review Utilization reports to identify actionable opportunities

- Monthly programs review: Home Health, Skilled Nursing Facilities, Transitions of Care and ER Utilization
- Monthly practice scorecard and gap review
- Review of accurate diagnosis documentation education

- Collaboration/Coordination of community resources to meet beneficiary needs
- Communicates care needs with Primary Care Physician and coordinates care based on provider direction
- Beneficiary education to entitlements

- Referrals for behavioral health and social issues
- Beneficiary education: Annual Wellness Visits, age/gender/disease specific preventive services, and appropriate care
- Assist in access to care
QUESTIONS?
Let’s Collaborate

For general questions & to determine if you qualify to participate, call 877-808-5643 or visit our website to schedule a time for a representative to call you.

For contract or model specific questions, reach out to our team:

Karen E. Holt, Regional Vice President
Karen.Holt@collaborativehs.com

Michael Barrett, Vice President, Strategy & Business Development
Michael.Barrett@collaborativehs.com
Presentation:  
*Healthcare is a State of Independence*

Valinda Rutledge, MBA, MSN  
Chief Corporate Affairs Officer,  
UpStream
Healthcare is a state of independence
UpStream’s Innovations

A Global Value-based Risk Organization

Physically embedded clinical care teams

- Highly trained prescribing pharmacists and coordination nurses physically in the office working with patients
- Systematic resolution of quality and care gaps with consistent follow-up over time to therapeutic goals
- Extended services such as fully integrated pharmacy dispensing with home delivery

Risk-free physician participation in value-based care

- Upfront, irrevocable guaranteed advance payments for quality (GAP-Q™) during the performance year
- Elimination of uncertainty for physicians with greatly improved cash flow
- Based on underlying full-risk contracts with traditional Medicare and Medicare Advantage insurers
- UpStream takes all contract risk through substantial capital investment

Most powerful technology platform in primary care

- Industry-leading population analytics and data science capabilities to proactively identify risk
- Combined with embedded teams, delivers dramatic reductions in downstream utilization within months
- Significant improvements in patient outcomes and satisfaction
BARRIERS TO PHYSICIAN ADOPTION IN TCOC

1. Financial Risk – Risk averse to “betting farm”

2. FFS reimbursement is main stay for clinical encounters but ill-designed for integrated team delivery

3. Inability to connect the dots between coordination of care (CCM) codes for integrated team care

4. Difficulty in independently applying technology and clinical resources at point of care including home
SOLUTIONS

Increase Incentives
• Support development of more provider groups (tax or financial provisions)
• Engage patients as partners – a develop compacts with patients
• Reduce regulatory requirements
• Funds to address SDOH

Minimize Risk
• Benchmark modified for high performers (less discount, more geographic weight)
• Education and Technical Assistance programs to help groups including central repository.
• Financial support to develop/buy analytics tools

Overcome Inertia
• Lower FFS schedule
• Strengthen architecture of MIPS – i.e. Minimize ability to use “uncontrollable” circumstances, maintain 5% AAPM bonus
Presentation: Community Care Cooperative: Moving FQHCs to VBC

Christina Severin, MPH
President and CEO, Community Care Cooperative
Community Care Cooperative: Moving FQHCs to VBC

PTAC Public Meeting on Population-Based Total Cost of Care
March 8, 2022
Background on Health Centers & on C3
Our Story

Early 2016
Nine health center leaders created Community Care Cooperative to play a leading role in a redesigned Medicaid program, facing stiff opposition.

2018
We launched our MassHealth ACO with 15 health centers and 110,000 members following a one-year ACO Pilot.

2019
We grew to 17 health centers serving 125,000 Medicaid members in the largest ACO in Massachusetts.

2022
We are 18 FQHCs serving 170,000 members in 3 risk contracts; our BCBS and Medicare DC contracts have a primary care capitation.

We have launched pharmacy and IT (Epic) services subsidiaries.

We will welcome 2+ new FQHCs in 2023.
Current Vision, Mission and Strategy

• Vision
  • Transforming the health of underserved communities

• Mission
  • To leverage the collective strengths of federally qualified health centers to improve the health and wellness of the people we serve

• Strategy
  • We unite federally qualified health centers at scale to advance primary care, improve financial performance, and advance racial justice

• Core values
  ![Social Justice]
  ![Integrity]
  ![Learning]
  ![Respect]
  ![Optimism]
  ![Results]
Health Centers Provide *Better* Care for Patients Than Other Forms of Primary Care

*Health Centers Achieve Higher Rates of Hypertension and Diabetes Control than the National Average, Despite Serving Higher Need Population*

- Health centers provide more accessible and satisfying care
  - 96% of low-income patients satisfied with FQHC hours vs. 37% nationally
  - 98% of low-income patients satisfied with FQHC care vs. 87% nationally

Source: NACHC Community Health Center Chartbook, January 2019
Health Centers Provide More Economic Value Than Other Forms of Primary Care

Health centers deliver **24% lower** total health care spending than non-health center based care...

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**TABLE 2—Use and Expense for Health Center Patients Compared With Matched Non–Health Center Patients: United States, 2009**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-Health Center (n = 144,075), Estimate (95% CI)</th>
<th>Health Center (n = 144,075), Estimate (95% CI)</th>
<th>Difference, % (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits, no.</td>
<td>8.2 (8.2, 8.3)</td>
<td>7.6 (7.6, 7.7)</td>
<td>-7 [-8, -7]</td>
</tr>
<tr>
<td>Spending, $</td>
<td>1845 (1815, 1876)</td>
<td>1430 (1418, 1442)</td>
<td>-23 [-24, -21]</td>
</tr>
<tr>
<td><strong>Other outpatient care</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Visits, no.</td>
<td>15.7 (15.5, 15.9)</td>
<td>12.2 (12.0, 12.4)</td>
<td>-22 [-24, -21]</td>
</tr>
<tr>
<td>Spending, $</td>
<td>2948 (2900, 2996)</td>
<td>1964 (1930, 2000)</td>
<td>-33 [-35, -32]</td>
</tr>
<tr>
<td>Prescription drug spending, $</td>
<td>2704 (2664, 2744)</td>
<td>2324 (2296, 2352)</td>
<td>-14 [-16, -12]</td>
</tr>
<tr>
<td><strong>Emergency department</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits, no.</td>
<td>1.3 (1.3, 1.4)</td>
<td>1.2 (1.2, 1.2)</td>
<td>-11 [-13, -10]</td>
</tr>
<tr>
<td>Spending, $</td>
<td>244 (240, 247)</td>
<td>216 (213, 219)</td>
<td>-24 [-22, -26]</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions, no.</td>
<td>0.25 (0.25, 0.26)</td>
<td>0.19 (0.19, 0.20)</td>
<td>-25 [-27, -22]</td>
</tr>
<tr>
<td>Length of stay, d</td>
<td>1.1 (1.1, 1.2)</td>
<td>0.8 (0.8, 0.9)</td>
<td>-26 [-29, -23]</td>
</tr>
<tr>
<td>Spending, $</td>
<td>2047 (1987, 2114)</td>
<td>1496 (1446, 1548)</td>
<td>-21 [-20, -22]</td>
</tr>
<tr>
<td><strong>Total spending, $</strong></td>
<td>9889 (9784, 9996)</td>
<td>7518 (7440, 7597)</td>
<td>-24 [-25, -23]</td>
</tr>
</tbody>
</table>

Source: Nocon et al, Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings, Am J Public Health 2016
How We Started the Company
Developing and Executing a Strategy for an ACO: Operating Platform

• To take on TCOC two-sided risk, an ACO must have a strategy to harvest multiple data streams into a harmonized enterprise data warehouse (EDW)

• The EDW becomes the engine of virtually all aspects of the operating model, including:
  o Rules-based approach to workflow automation
  o Universe for performance analysis, actuarial, financial reporting, KPIs
  o Research database
Systems and Data Flows

FQHCS/EMRS

HOSPITALS

PAYERS

MassHealth

Diagnostics

LabCorp

Quest Diagnostics

LabCorp

OTHER DATA

Beacon

Dartmouth

Findhelp

EDW

Analytics Engine

Arcadia

Performance

Usage

Patients

Risk

Operations

CMT VPN
Developing and Executing a Strategy for an ACO: How We Used a Portfolio Strategy for Risk Distribution

Max Exposure: 14.3
Excess loss insurance: -4.9
FQHC share of risk: -5.5
Misc other risk sharing: -1.1
Remaining ACO risk: 2.7
The C3 Model of Care

**Our Model of Care:**

- Builds on existing capabilities and strengths at our Health Centers
- Integrates new MoC programs at the provider level (Health Center or Hospital)
- Improves quality of care for patients
- Brings targeted and tailored care to the entire population
How It’s Been Going
Our Total Cost of Care Performance Has Been Favorable Every Year and Market Leading

C3 vs. Market - Percent Favorable/Unfavorable

<table>
<thead>
<tr>
<th></th>
<th>C3</th>
<th>Market</th>
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<tbody>
<tr>
<td>2018</td>
<td>2.7</td>
<td>-3.5</td>
</tr>
<tr>
<td>2019</td>
<td>0.1</td>
<td>-10.5</td>
</tr>
<tr>
<td>2020E</td>
<td>2.3</td>
<td>0.1</td>
</tr>
<tr>
<td>2021E</td>
<td>2.6</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Note: Market is the sum of the largest 10 ACOs required to report to the state on their performance.
Source: “4B” regulatory reporting obtained under FOIA; MassHealth/Mercer rate setting and performance reports.
Growth in Balance Sheet Strength

Unrestricted Net Working Capital


$M

$196k  ($706k)  4.2  14.1  35.0  47.5  55.0

Unrestricted Net Working Capital
Growth

170,000 Members
19 FQHCs + APPs

Health Centers
Membership
Business Diversification: 2 New Subsidiaries

• Community Technology Cooperative (CTC)
  o Licensed Epic and converting 12 FQHCs to this EHR

• Community Pharmacy Cooperative (CPC)
  o Working with FQHCs to have them regain ownership of 340B and retail pharmacy licenses and supporting them with MSO services to run the business
What’s Coming Next
Move to Primary Care Capitation

Primary Care Capitation

- For the last several years, we have had a policy agenda of getting off of the Fee-for-Service chassis and into prospective, enhanced primary care capitation
- Primary Care Capitation will be included in the next 1115 MassHealth Medicaid Waiver
- By moving away from the need to focus on volume-driven health care, we have re-tooled our model of care based on this system of prospective payment
Goal is >70% in Primary Care Capitation

Percent of Visits Capitated vs. FFS, by FQHC, 1/1/2023

- Goal: >70% in Primary Care Capitation

<table>
<thead>
<tr>
<th>FQHC</th>
<th>Capitation</th>
<th>FFS</th>
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<tbody>
<tr>
<td>CHCC</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td>HHC</td>
<td>81%</td>
<td></td>
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<tr>
<td>HSH</td>
<td>80%</td>
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<tr>
<td>UCHC</td>
<td>83%</td>
<td></td>
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<tr>
<td>FHCW</td>
<td>78%</td>
<td></td>
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<tr>
<td>BNHC</td>
<td>59%</td>
<td></td>
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<tr>
<td>LCHC</td>
<td>57%</td>
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<tr>
<td>NSCH</td>
<td>54%</td>
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<tr>
<td>IHC</td>
<td>53%</td>
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<tr>
<td>EMK</td>
<td>49%</td>
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<tr>
<td>CRCH</td>
<td>49%</td>
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<tr>
<td>HCHC</td>
<td>48%</td>
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<tr>
<td>CHCFC</td>
<td>45%</td>
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<tr>
<td>Dimock</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>EBNHC</td>
<td>45%</td>
<td></td>
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<tr>
<td>CHC-F</td>
<td>31%</td>
<td></td>
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<tr>
<td>Fenway</td>
<td>18%</td>
<td></td>
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<tr>
<td>NEWH</td>
<td>18%</td>
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In Summary

• We believe that the opportunity to transform primary care that health centers have been waiting for, is upon us – and this is very exciting!

• We think it is critical for FQHCs across the country to figure out how to get the support that is needed to enable them to responsibly move into Advanced Payment Models because they are THE BEST positioned to get it right from a quality, outcomes, equity and cost perspective.
Thank You

Questions?

@C3aco
Community Care Cooperative
www.communitycarecooperative.org
Previous PTAC Proposal Submitter

Presentation: 

*Coalition to Transform Advanced Care (C-TAC): Voice of the Patient and Family*

Jon Broyles, MSc  
Chief Executive Officer, Coalition to Transform Advanced Care (C-TAC)

Gary Bacher, JD, MPA  
Chief of Strategy, Policy, & Legal Affairs, Capital Caring Health

Torrie Fields, MPH  
Chief Executive Officer, Votive Health

*Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model* proposal
Coalition to Transform Advanced Care (C-TAC)
| Voice of the Patient and Family

• **Vision:** All Americans experiencing serious illness, especially those who are underserved and under-resourced, have a high quality of life – on their own terms.

• **Our Approach:** Convene and Advocate based on Core Principles for Care

• **Our Members:** Alliance of all sectors of healthcare (170+ organizations), including:
  
  • Health systems (Kaiser Permanente, Optum, Health Partners), health plans (Humana, Cigna, etc), Area Agencies on Aging, Hospice and Palliative Care Providers, Home-Based Primary Care Providers, etc
  
  • 14+ State Coalitions developing / implementing care models (e.g., Arizona - see Appendix)
  
  • 100+ faith leaders developing new models (Alameda Co Care Alliance – see Appendix)
Background

• C-TAC submitted the “Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model” proposal to PTAC in 2017.

• The ACM focused on using a population health management approach for delivery of palliative care services to Medicare beneficiaries who are in the last 12 months of life.

• The proposal was recommended to the Secretary of HHS for Limited-Scale Testing.
Priorities to Explore Today

1. **Systematically identify and assess** populations with serious illnesses and their caregivers

2. Support CBO Infrastructure

3. **Explore payment options and support for high-value CBO services** that could be adopted across payer contexts

Shirley Roberson lived with serious illness for over 14 years
Appendix – Innovative CBO Models (examples from our membership)

• Arizona Coalition model
  • Care Model developed after 18 months of coalition building w/ 40+ orgs
  • Needs: Payment model design and pilot

• Alameda County Care Alliance (ACCA) Advanced Illness Care Program
  • Pilot underway with Kaiser Permanente serving 400 people
  • Needs: Capacity Building
The Arizona Coalition Model

[Diagram with text and icons]

azhha.org/az_model
**ACCA Advanced Illness Care Program™**

**Five Cornerstones**

Series of 5-12 meetings between the Care Navigator and Person Needing Care or Caregiver over approximately 6 months

Program is personalized to individual participants’ needs

<table>
<thead>
<tr>
<th>Spiritual Needs</th>
<th>Health Needs</th>
</tr>
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<tbody>
<tr>
<td>Prayer, meditation, and faith community support</td>
<td>provider communication, physical and emotional support</td>
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<table>
<thead>
<tr>
<th>Planning for Advance Care</th>
<th>Social Needs</th>
</tr>
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<tbody>
<tr>
<td>Understanding, choosing and documenting advance care choices</td>
<td>Transportation, meals, housing, socialization, financial/legal</td>
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<table>
<thead>
<tr>
<th>Caregiving Needs</th>
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<tbody>
<tr>
<td>Respite care, support groups, support for caregivers</td>
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</table>

- Identify needs, provide trusted referrals/resources, empower individuals with tools & training