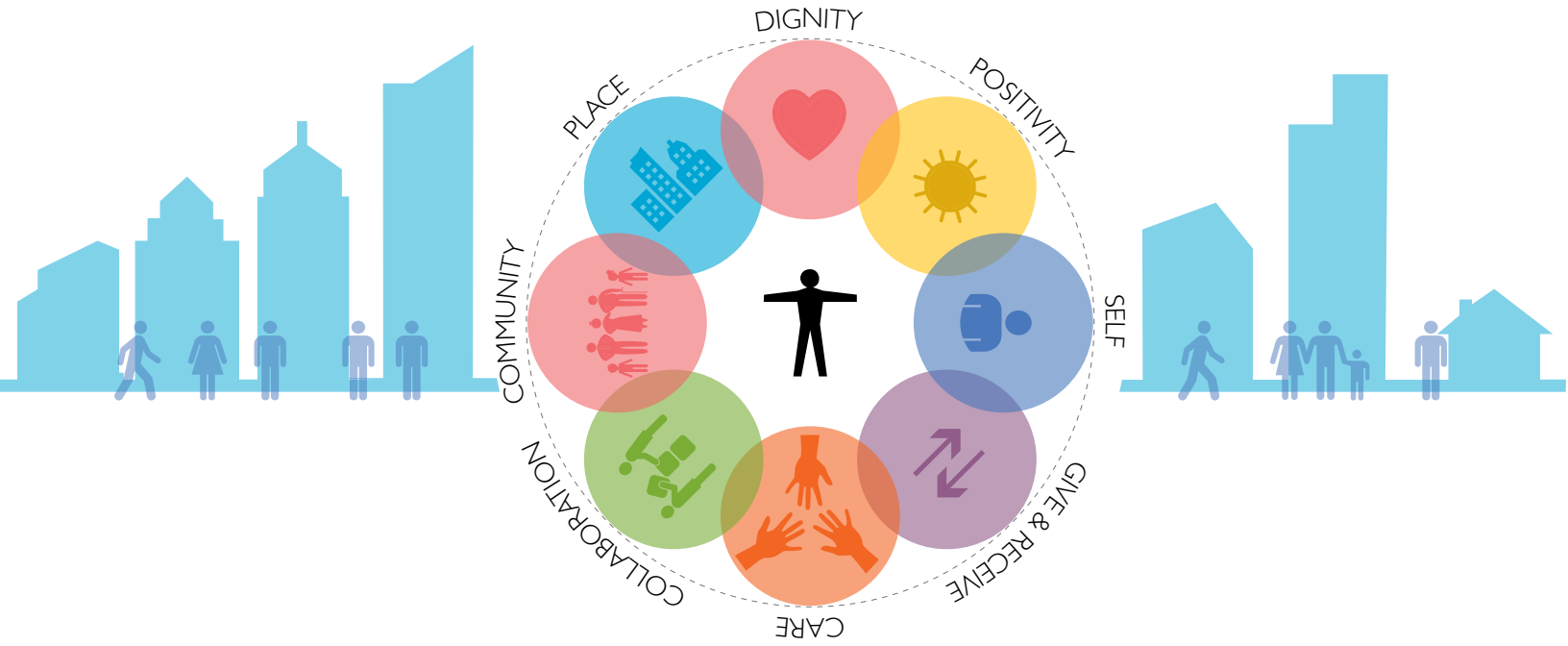

DIGNITY
POSITIVITY
SELF
GIVE & RECEIVE
CARE
COLLABORATION
COMMUNITY
PLACE

Chapter 2

Contents

> **The real act of discovery consists not in finding new lands but seeing with new eyes.**
>
> **- Marcel Proust**

Philosophy towards Change

Providing Information **Prompting Inspiration**

We are pleased to present Chapter 2 of the Living Story Book, the unfolding story of community working together to design a model of well-being focused on wrap around care services in the city of New Haven. The project has hit its 9-month mark. As such, much has been done and there is still much more to do. The information presented in this document should be understood as a launching point for visioning and not a comprehensive evaluation. We will continue to collect data as the project unfolds.

This chapter is primarily an **evaluation of data, strengths, needs, and opportunities** as they relate to the Community Living Model in New Haven, CT, spoken of through the voices of community members and partners. These voices provide permission for inspiration and bold dreams in a way that propels us to action. They were collected during appreciative inquiry interviews and focus groups. Themes that emerged from the collective voices are called powers in this book. We call them powers as they are, well, quite powerful and serve as values and guiding principles for the project. Quantitative and case study data are also presented to complement the powers. All data is supported by scholarship.

As we move towards action, our aim is to deepen collaboration with and among community stakeholders through the visioning sessions with 5 actions groups outlined in this chapter on page 39. Our first visioning session will be focused on embedding a wrap around care management team within existing programs/services. Using a multidisciplinary care team approach, patients and their caregivers in the home setting will be supported to achieve and maximize their health and well-being. The team will aim to foster sustainable improvements through the creation of a person-directed healthy living plan that integrates both medical and social needs. Evidence suggests that this team-based approach can optimize health with improved adherence and mental health outcomes.

Wrap around care management will be designed and implemented through two planning phases: 1) Program Collaboration and 2) Service Integration.

During the **Program Collaboration Phase**, we will work to coordinate multidisciplinary care interventions across the continuum of care in coordination with community stakeholders supporting health and well-being. The stakeholder providers and groups will be referred to as PODS, or Places Offering Dynamic Services. The PODS will share guiding principles and explore ways to intentionally integrate program and services through technology, data analytics, training, and awareness building. Leaders and care coordination staff will work towards seamless hand-off's and a consistent high touch consumer experience.

The **Service Integration Phase** involves designing a place where medical and social care is provided with seamless access to services under one roof. Through Service Integration, a "Place of Well-being" (POW) will be designed as a "one stop shop" for personalized health and wellness services. Here we will consider how key staff from PODS may be located in the same place as they strive to enhance communication and integration of services. The importance of staff sharing what they are learning on a daily basis will assist with the practice of continuous improvement that we are looking to promote across community partners.

In both phases, we will solve for the importance of evaluating the time in between medical intervention and the opportunities to improve life in community through the lens and focus on the social determinants for change. A hub and spoke methodology, **the PODS and POW, will provide a systematic infrastructure** to enhance services and supports that will expand choice to remain in the home environment. Through shared guiding principles and integrated programs and services, our hope is to foster a consistent philosophy of continuous learning no matter where the patient/client is served. Programs implemented will be evidence-based and centered on the concepts of experiential learning, health literacy, coaching, peer support, and role modeling. Through PODS and POW, a learning community of individuals and organizations will align and support the execution of DSS state programs, No Wrong Door and Community First Choice (see appendix titled "Leeway- Alignment with State of Connecticut Initiatives" for more detail). Both programs are central to our work and essential to program sustainability.

Phase I
Living Storybook Chs 1 and 2
(Assessment of Strengths and Needs)

Phase II
Places of Dynamic Services
(Program Collaboration)

Phase III
Place of Well-being
(Service Integration)

Through the development of a Community Living Model, Leeway will expand its mission and caring reach for individuals who live with HIV/AIDS. The funding also necessitates and affords Leeway the opportunity to diversify services to all patients requiring high acuity, community-based care. Leeway's founder and supporting pioneers were committed to solving for a significant gap and to filling the need for specialized care and services. With that same spirit in mind, Leeway looks forward to the co-creation of this model and moving the concepts and information provided to action. As the City Transformation Plan has described it, as we work towards a shared goal of placing New Haven on the map as a city of well-being, we do so by finding our lanes and moving together in the same direction. By giving and receiving, we disrupt the current state and move toward a more desired end state.

Stakeholder Engagement

The Community Living Model project is made possible through the participation of a diverse range of stakeholders who are working together to co-create personalized positive change for individuals living with multiple chronic illnesses by transforming the way care management services are delivered and how health and wellness services are integrated in the community. Innovative cross-sector partnerships are both increasing in the United States and are necessary to "strategically align investments, replicate and scale efforts, and maximize collective impact" thereby supporting healthy behaviors and improving neighborhoods. The following is a summary of meetings, interviews, focus groups, and involved organizations to date. We look forward to seeing these numbers grow as more individuals and organizations come on board.

Connections Made

286

Individual Voices

(from interviews, focus groups & meetings)

73

Organizations

Categories of Community Partners

(2) Addiction Services
(5) Arts and Recreation
(5) Elder Care
(7) Food and Nutrition
(4) Government
(6) Health and Wellness
(15) Healthcare
(1) Holistic Services
(5) Housing
(1) Insurance
(3) Research
(6) Social Support
(6) Spirituality
(2) Transportation
(5) University

Participating Organizations

- 211
- AIDS CT
- AIDS Project New Haven
- All About You Home Care
- American Medical Response
- APT Foundation
- Area Agency on Aging
- Art Space New Haven
- Arts Council of Gr New Haven
- Atwater Senior Center
- BHCare
- CARE (Community Alliance for Research and Engagement)
- Central CT Coast YMCA
- Christian Community Action Inc.
- City of New Haven
- City Seed
- Clifford Beers Clinic
- Collective Consciousness Theatre
- Columbus House
- Community Action Agency of New Haven
- Community Dining Room
- Community Health Network of CT
- Community Health Van
- Continuum of Care Inc.
- Cornell Scott-Hill Health Center
- Council of Churches of Gr Bridgeport
- County Health Rankings & Roadmaps
- CT Coalition to End Homelessness
- CT Mental Health Center
- DataHaven
- Dixwell/Newhallville Senior Center
- Downtown Community Soup Kitchen
- Downtown Evening Soup Kitchen
- East Shore Senior Center
- Easter Seals Goodwill
- Elm City YMCA
- Fair Haven Community Health Center
- Fellowship Place
- FISH
- Gateway Community College
- Gr New Haven Chamber of Commerce
- Gr New Haven Clergy Association
- Hispanic Health Council
- HomeHaven
- Interfaith Volunteer Caregivers of Gr New Haven
- Junta for Progressive Action
- Liberty Community Services
- MAAS (Multi-Cultural Ambulatory Addiction Services)
- Marrakech, Inc.
- Mary Wade
- New Freedom Baptist Church
- New Haven Board of Alders
- New Haven Farms
- New Haven Housing Authority
- New Reach
- PACT-Physician Alliance of CT
- Power House Temple of Deliverance Ministries
- Quinnipiac University
- Reitman Personnel
- Revive Wellness Centre
- Southern CT State University
- Springs of Life-Giving Water Church
- State of CT DMHAS
- State of CT DSS
- Stetson Library
- Sunrise Cafe
- United Way
- University of New Haven
- VA CT Healthcare System
- VNA of South Central CT
- Yale New Haven Health
- Yale New Haven Hospital
- Yale University

Guiding Principles

Introduction to our method, **Appreciative Inquiry**

The common approach to social change is based on a deficit theory of change. Identify a problem, conduct a root cause analysis, brainstorm and analyze possibilities, and develop a plan of action. The metaphor here is that organizations and systems are problems to be solved. Consequences of this model include fragmentation, stifled images of possibility, a re-confirmation of hierarchy under the "experts must know" philosophy, a spiraling effect of deficit language, breakdown in relationships, closed door meetings, and fear.

An appreciative view of individuals and organizations involves appreciating the best of what is working, imagining and dreaming big, designing what could be and creating what will be. It is a fundamental shift in the way we think of ourselves in the world and the role of organizations. Kim Cameron discusses positively deviant organizational performance as successful performance that dramatically exceeds the norm in a positive direction. Positive deviance "investigates affirmative dynamics, or an orientation toward strengths rather than weaknesses and abundance rather than deficits in organizations". It focuses on the best of the human condition and that which we consider good.

Deficit Machine Metaphor: Organizations are problems to be solved

- Identify problem
- Conduct root cause analysis
- Brainstorm solutions & analyze
- Develop treatment - action plans

Mystery Metaphor: Organizations alive, living systems, and webs of infinite strengths

- Appreciate "Best of what is"
- Imagine "What might be"
- Design "What should be"
- Create "What will be"

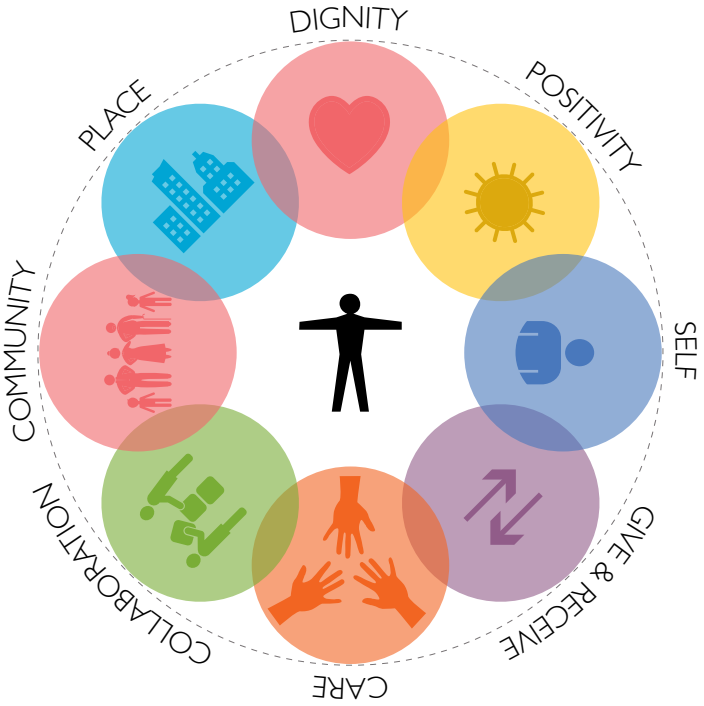
Ap-pre'ci-ate, v.,

1. Valuing …
   - The act of recognizing the best in people and the world around us;
   - Affirming past and present strengths, successes, and potentials;
   - To perceive those things that give life (health, vitality, and excellence) to living systems.

2. To increase in value, e.g. the economy has appreciated in value.
   - Synonyms: valuing, prizing, esteeming, and honoring.

In-quire', v.,

1. The act of exploration and discovery.
2. To ask questions; to be open to seeing new potentials and possibilities.
   - Synonyms: discovery, search, study and systematic exploration.



What we found...
8 Powers of New Haven

The powers are the roots from which the grass will grow. They represent values and guiding principles that may underlie the entire project.

From 286 collective voices, 8 powers emerged. During interviews and focus groups, participants shared high point stories of what works when things are working really well. Our main questions revolved around strengths of each partner organization, well-being, community and connections, and the dream of a Place of Well-Being (POW). Interviews were transcribed and then we identified powerful quotes. From these quotes, themes emerged. Like themes were clustered. These clusters are the powers listed on the subsequent pages.

We know that successful social change comes from direct and early engagement of all stakeholders. The powers are the voices of our community, the ideas and dreams of stakeholders, and the foundation upon which action groups will vision a plan for implementation.

Key Questions

Tell me about a time when you felt healthy and happy?

Who was a part of that experience? What did they contribute? How?

What do you believe contributes to your personal well-being?

What are some things you do to stay healthy and happy?

Tell me of a time when a person or group supported you to achieve a goal.

Tell me of a time when you helped someone or contributed to something. How did it make you feel?

Dream into the future and imagine the community of New Haven working together to support individuals living with multiple chronic illnesses to thrive. What does this look like?

What does collaboration look like when it works at its best?

How is information gathered and shared for mutual benefit?

What does the coordination of services look like when it flows seamlessly?

What does community mean to you?

If you could design a place where all services and supports were under one roof, what would that look like? How would it feel?


Themes
Powers
Being acknowledged
Being accepted
Being respected as an equal
Meet me where I am at
Belonging
Dignity
Optimism
Hope
Spirituality
Self-Esteem
Purpose
Positivity
Accountability
Empowerment
Choice
Goal Setting
Doing with, not for
Self
Peer support
Volunteering
Student Involvement
Family and Social Support
Give & Receive
Availability
Trust
Compassion
Person-directed
Care
Seamless service
Consistency and Continuity
Breaking down silos
Greater than the sum of our parts
Collaboration
Access and Awareness
Transparency
Data driven change
Grassroots solutions
Community
Continuous learning and growth
Social connectivity
Healing surroundings
Compassionate Support
Place

Dignity

As humans, we are inextricably bound up in each other. This recognition, it is thought, is vital to the development of a psychology of human strengths.

- Being acknowledged
- Being accepted
- Being respected as an equal
- Meet me where I am at
- Belonging

"I am who I am because of who you all are" is a way to express the essence of dignity. Together, we share in our human-ness and feel this most when we are recognized and respected. As humans, we are inextricably bound up in each other. This recognition, it is thought, is vital to the development of a psychology of human strengths.

The healthcare system is in the process of transitioning from an operational efficiency focus to a focus on the experience of the delivery of care. This shift is representative of how healthcare facilities will be paid, in lieu of the number of procedures or the number of people seen. In this shift, the subjective perception of the quality of care one receives becomes paramount. Perception of quality of care is dependent upon how one feels they were treated during the continuum of delivery of care. This includes the first phone call for an appointment, the greeter at the front desk, the trained medical provider, and all others along the continuum of care.

While there is a business case that serves as motivation for dignified treatment, there is also the healthcare system's function… to heal. "[H]ealing is a holistic, transformative process of repair and recovery in mind, body, and spirit resulting in positive change, finding meaning, and movement towards self-realization of wholeness, regardless of the presence or absence of disease" . This definition supports the concept that healing is a process and not an end state and occurs primarily through dignified treatment. Promoting dignity—an individual's essential worth by virtue of being human —occurs through certain forms of treatment founded on recognition, a social form of granting positive status to another, and on acts of love, affirmation, respect, benevolence, care, and esteem . Dignity both exemplifies and is supported by our deeply social being, as humans are physically, psychologically, economically, and culturally dependent on others throughout their lives . This type of treatment and these acts have been shown to occur through relational processes , as well as through the environments we occupy.

The central and consistent notion is that: 'I am human, you are human, and together we share are humanness'. Informants specifically recognized that an other's circumstances could have been their own, and therefore the way to treat others is as you would want to be treated. Many times the path towards healing is not found in a physician's desk reference, but by listening to the individual, hearing their needs, and seeing everything else that is in their lives. Interestingly, in our findings from an R analysis of the transcripts, the word most highly associated with 'virus' was 'voice', representing how paramount it is to be heard. Yale New Haven Hospital has been utilizing a technology that breaks down language and cultural barriers, which previously left patients feeling like their treatment was less personal, less connective, and less dignified. iPoles is a tablet on a wheelbase that enables patients to connect in real time to a translator with cultural sensitivity training.

- How can sensitivity training become the lifeblood of our approach to change and care?
- How can Places of Dynamic Services (PODS) meet individuals where they are, and collectively support issues such as transportation and child care?
- How can the answer always be, "Yes! And…"

"I always say when I look at you I see me. When I look at someone in a bed I see me. A wheelchair. We forget how fragile we are. We all are not perfect. We all are made from the same type of mold."

- Leeway Staff Member

Case Study:
Atlantic City - Meeting Patients Where They Are At

AtlantiCare Medical Center hospital caters exclusively to workers with exceptionally high medical expenses. Patients are given unlimited access to the clinic without charges—no co-payments, no insurance bills. Doctors are incentivized to provide exceptional service. Coaches are key members of the medical team and have a knack for connecting with sick people. Coaches come from patients' communities and speak their languages. With this program, they achieved a total of a 25% drop in costs, revealing that promoting dignity is not just a good thing to do but there is also a business case to do so. The access patients are provided supports seeing, recognizing, and honoring where each individual is at on any given day.

(http://www.newyorker.com/magazine/2011/01/24/the-hot-spotters)

Positivity

Positive psychology focuses on strengths as on weaknesses, on building the best in life as much as on repairing the worst, and on fulfilling the lives of healthy people as much as on healing the wounds of the distressed.

- Optimism
- Hope
- Spirituality
- Self-Esteem
- Purpose

In 1998, Martin Seligman, the then president of the American Psychological Association, argued that since World War II, there has been a focus in psychology on human problems and how to solve them . After World War II, a sequence of accrediting clinical psychology programs, enacting licensing laws, and granting research dollars from the National Institute of Health for mental illness research contributed to this focus. This, coupled with the high rate of depression and mental disorders in the wake of the war, caused the primary objective of psychology to turn solely to curing mental illness. While this deficit bias has made significant advancement and progress in moving individuals with psychological illness towards health, it is grounded on the assumption that human beings are inherently fragile or flawed. In contrast, positive psychology assumes that "goodness and excellence are not illusions but are authentic states and modes of being that can be analyzed and achieved" .The discipline focuses on strengths as on weaknesses, on building the best in life as much as on repairing the worst, and on fulfilling the lives of healthy people as much as on healing the wounds of the distressed . Positive psychology does not limit itself to helping people to feel better about their lives but is actually concerned with helping people to have better lives. Psychologists do this by finding out what social conditions make people more optimistic, happy and satisfied, and then help these conditions to come about.

- How can purpose become a guiding light to healing?
- How can the power of positive thinking build self-esteem?
- How can we build a workforce within each neighborhood that supports possibilities for change and creates purpose for all those that live in their neighborhood?

"My faith and my belief came. And I thought, God has something for me and I just need to be patient."

- Community Member

Case Study: Milwaukee - Providing Purpose and Hope for Community Health Workers and Those They Serve

The Milwaukee Community HUB model is a care coordination system to support family and social needs. With this model, the city positively creates jobs within community that build community. The model includes health care providers, insurance companies, public health, community organizations, social services, the school system, and police and fire, as well as a key group of individuals: Community Health Workers (CHWs). CHWs are trained professionals from the communities of the patients they are serving. They know what is good for their neighbors and what their strengths are as they have been there themself. In addition to being boots on the ground health care providers that provide care door to door and by phone, CHWs provide support and guidance from the change maker board through upstream policy work. Integrating CHWs into clinical settings impacts the effects of chronic diseases while working towards the sustainability of the profession. CHWs have the knack to connect with individuals and give them hope. They help individuals to be more optimistic and to believe in their own ability to affect the course of their health and well-being.

Milwaukee developed a partnership with the Rockville Institute and their Pathways Community Hub Model to advance its vision and build a stronger infrastructure for communities to use resources more efficiently and effectively, address risk, track and improve outcomes, and align payment. The model has 20 pathways that measure risk and align the right care coordination services at the right time and place. The hub is like air traffic control linking care coordination agencies together and tracking pathways or outcomes across the community and region. Over time they have gathered data which now supports sustainable reimbursement and payments through the state of OHIO and other ACO partnerships. This model gives us hope for our PODS and shows us how the power of positivity can support one person at a time.

(https://pchcp.rockvilleinstitute.org/)

Self

To heal, an individual has to want to heal and to have a stake in the process. The individual must be somewhat accountable for their healing path and it is the healthcare provider's role to "do with" the individual and not "for" the individual.

- Accountability
- Empowerment
- Choice
- Goal Setting
- Doing with, not for

Positive change, finding meaning, and realization of wholeness occur in the home, community, in nature, and through the power of the self. New Haven citizens recognize there is only so much you can do for another and that another can do for you. To heal, an individual has to want to heal and to have a stake in the process. The individual must be somewhat accountable for their healing path and it is the healthcare provider's role to "do with" the individual and not "for" the individual. In exercising this philosophy, individuals are empowered to direct their path through choice and with achievable goals. And, that caring for the whole human being is much broader than health and wellness alone. It includes understanding who that person is… their social network, what they enjoy, what their dreams are, what their past is, etc. Supporting that individual to thrive requires listening, understanding, recognition, acceptance, and ultimately providing a sense of belonging and purpose. In this way, the immediate needs of the individual are heard and addressed in lieu of a 'one size fits all' approach or solution.

The Community Living Model project supports the implementation of the State of Connecticut 's Community First Choice program and its alignment with person-directed care. The development of the plan for services is person centered in that it is: directed by the individual, non-medical, goal driven (not task driven), and guided by the goal of increasing overall health outcomes and the individual's quality of life in their home. The social services worker who conducts the assessment provides support, coaching, and planning assistance. CFC is a fundamental shift from 'serving for' to 'serving with'.

- How can we coach and educate in small steps that count to the individual?
- How can health literacy and knowledge of services impact accountability?
- How can we care through choices and options rather than through prescriptions and judgment?

"I put 50 percent, you put 50— …percent. We did our hundred. We both saved your life."

- Community Case Manager

Case Study: Omada - Empowerment with Support

Omada helps organizations identify those within a population who are most at risk for developing costly, but largely preventable, chronic conditions such as type 2 diabetes and heart disease. They do so by designing and launching a custom communication and enrollment campaign that guides goal setting and empowers indivudals to achieve healthier outcomes. For this campaign, they utilize behavioral medicine that is clinically supported and evidence-based, guiding participants through an inspiring and interactive journey that integrates seamlessly into everyday life. Once enrolled, indiviudals participate in Prevent, a program where every participant is supported by a dedicated, full-time health coach and robust social network for real-time support and accountability. A support network 'walks along with', but does not 'do for' the individual. They send every enrolled participant a wireless digital scale, pedometer, exercise bands (and more!) directly to their doorstep.

In a study evaluating the efficacy of Prevent and its alignment with the Centers for Disease Control (CDC) Diabetes Prevention Program (DPP), two hundred participants underwent a core 16-week intensive lifestyle change intervention and were then offered to continue with a post-core lifestyle change maintenance intervention, with the entire intervention totaling 12 months. Results indicate that Prevent meets CDC outcome standards for diabetes prevention programs and performs favorably to other DPP translations. One hundred eighty-seven participants met inclusion criteria for the core program and achieved an average of 5.0% and 4.8% weight loss at 16 weeks and 12 months, respectively. They also had a 0.37% reduction in their A1C level at final measurement. One hundred forty-four of these same participants also met inclusion criteria for the post-core program and achieved an average of 5.4% and 5.2% weight loss at 16 weeks and 12 months, respectively, and a 0.40% reduction in A1C at final measurement.

(https://www.omadahealth.com/)

Give & Receive

In aiming to enhance quality of life, each individual's wants can be advanced through the gifts of others. Often, the generosity individuals are willing to give tends to be greatly underestimated.

- Peer support
- Volunteering
- Student Involvement
- Family and Social Support

Success comes through a dynamic exchange of giving and receiving, and does not have to come at another's expense. In aiming to enhance quality of life, each individual's wants can be advanced through the gifts of others. Often, the generosity individuals are willing to give tends to be greatly underestimated . Building on the power of positivity, it has been shown that the presence of altruism, learning, and hope lead to a positive exchange of give and receive. In addition to this ring of reciprocity, we heard many people speak of the reward they receive from giving, showing that those who are traditionally givers (of care, services, and supports) are as much receivers (of perspective, meaning, and values) while receivers (individuals accepting care) are often givers (of life lessons and volunteer hours for example). In this vein, volunteering and the reward of giving back is a theme that emerged.

Peers are crucial to a strong community and to the social aspects of well-being. When positive relationships are nurtured, flowers grow from cement. These relationships are founded on trust, sharing, mutual respect, compassion, and are experienced as mutually beneficial . The strength of an interpersonal tie is a combination of amount of time, emotional intensity, mutual confiding, and the reciprocal services that characterize the tie. This theoretical basis reveals how a peer network can work to turn weak ties into strong ties and to support an individual to thrive in community. As one wisdom council member said at their recent visioning session, "I've seen it, been there, and lived it. I can't help everybody, but I can always help one. And then it trickles down like a domino effect." In the city of New Haven, there is also the unique opportunity to maximize a network of support from the six higher education institutions and the involvement of students, research, and areas of expertise.

- How can peer relationships be the difference maker?
- How are family and strong relationships at the center of give and receive solutions?
- What is each PODS willing to give and what do they need to receive to change the experience of care?

"I need to remember maybe my story will help other people."

- Community Member

Case Study:
Share the Care - Receiving Help Supports Giving More

The healthcare system is overwhelming. The amount of time it takes to get through everything is overwhelming. We need people to help us through. Share the Care is a peer support program that recognizes caregivers own well being is often neglected. Share the Care organizes friends, family members, and community members to rotate the responsibilities associated with care giving through a common bond. Individual strengths are offered, thereby playing to strengths and mitigating burden of undesired responsibilities. Additionally, the peer support network offers emotional and psychological support to each other through socialization and communication. Not only does the individual needing care benefit, but the peer support network does as well. Allowing people to help us is hard, as we have created superman and superwoman socialization. A common bond and common goal ultimately makes a group successful. Helping gives caregivers great purpose. Additionally, compassion, trust, and love abound throughout the network. A strong positive outcome of the program includes the ability of ill individuals to stay home and out of a nursing home due to a network that shares the care giving. It is through giving and receiving that this is successful.

(http://sharethecare.org/)

Care

Patients are more likely to follow medical regimens and follow-up medical services when patients are satisfied with interactions with their medical providers, "thus, treatment is likely to be more efficient and recovery more [rapid]".

- Availability
- Trust
- Compassion
- Person-directed

The importance of social interactions between medical providers and patients for effective health care is widely acknowledged. For example, patients are more likely to follow medical regimens and follow-up medical services when patients are satisfied with interactions with their medical providers, "thus, treatment is likely to be more efficient and recovery more [rapid]" .When wrap around care does not happen, people are lost in the system and trust is lost. Compassion is a generative force that opens up new vistas, expands resources, and creates new insights. It is a force in the sense that it propels and motivates action, in this case, actions towards wellness by adhering to recommendations of medical practitioners. In support of this type of treatment, the City of New Haven has unleashed a "kindness initiative", where speaking to another should be just "as if it's your mother". On the initiative, Police Chief Anthony Campbell said, "Make sure that when you leave, that that person's humanity is acknowledged." Another key word association our R analysis revealed is that the word 'grandmother' and 'grandma' are most frequently associated with 'support'. This reveals the importance of family and of the love and care a grandmother provides. Ideal wrap around care supports the individual as well as their own support system, including family and friends. It provides resources and tools to help family define their family and individual goals. This model of care reiterates that we are deeply social beings and rely on each other for our betterment.

- How can we build trust and compassion through each point of entry?
- How can we solve for and remove the wall of fear and build possibility?
- How can we make ourselves available when and where individuals need us most…in their homes, off-hours, and on the weekends?

"With the patients, there is something that is important to each of them, so you make sure they have what is important to them."

- Leeway staff member

Case Study: Geriatric Resources for Assessment and Care of Elders (GRACE) Model - Care Unique to Each Person's Life, from the Medicine Cabinet to the Kitchen Cabinet

The GRACE model is a practice-based coordination model with care transition elements that support older persons with multiple chronic illnesses and geriatric conditions to receive recommended standards of care. Key goals are to improve quality of care and reduce acute care utilization among a high-risk group without increasing costs. A support team made up of a nurse practitioner and a social worker complete a home visit to conduct an initial comprehensive assessment from the medicine cabinet to the kitchen cabinet. Based on the findings, a larger interdisciplinary team develops an individualized care plan. Collaborating with the primary care physician, and consistent with the patient's goals, the support team then implements the plan that is integrated into EMR. The support team is available seven-days per week for home visits and phone calls as needed by the individual. Typical intervention duration is 1-3 months post-discharge. Show outcomes include: Better performance on ACOVE Quality Indicators and Enhanced quality of life by SF-36 Scales; Lowered resources used and costs in high risk group; 30% Hospital admits; 35% SNF admits; and, 25% ED visits. The support team is available to individuals when they need them. Much of their success is based on the trust individuals have in them. Their delivery of care is intensely person-directed as it begins in their home and is unique to each individual.

(http://graceteamcare.indiana.edu/home.html)

Collaboration

As New Haven continues to put itself on the map as a city of well-being, collaboration amongst service and support providers is key to a common agenda that serves the city.

- Seamless service
- Consistency and Continuity
- Breaking down silos
- Greater than the sum of our parts

In a project as complex as this one, that works to affect systematic change by broadening and building the strengths of a community, there are a few best practices in respect to organizational collaboration that can help guide the initiative. Public and social sector leaders may increase impact while reducing inefficiency through data-driven change and evidence-based practices. Melody Barnes and Paul Schmitz suggest leaders: aim to insure that the process is transparent; signal what is to come so that stakeholders can prepare for impending change; show empathy for concerns over excitement about new practices; and acknowledge trade-offs. Additionally, relating to stakeholders includes the ability to cooperate among stakeholders, the support of leadership, and a structure of alliances. Although finding a common vision can prove difficult, it is also key to developing a common agenda. Once a common agenda is identified, it becomes important to acknowledge each organization's role in promoting community health and well being. As New Haven continues to put itself on the map as a city of well-being, collaboration amongst service and support providers is key to a common agenda that serves the city. And thus, together we aim for collective impact, a framework for collaborative social change that requires five conditions for success: common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support organizations.

- What are the breakdowns and bottlenecks to continuity and how can we deliver consistency?
- How can PODS make sure community members are always at the table when making decisions affecting the community?
- How can grassroots efforts and collaboration support sustainable change?

"A culture of health to me is a place where people work outside of their unique silos to complement each other to have greater collective impact on the issue of health and wellness."

- Thought Leader

Case Study: Camden Coalition "Hot Spotters" – Breaking Down Siloes to Build Up Beyond Dream Results

In 2001 in Camden, NJ, Jeffrey Brenner used the billing records from the three main hospitals to create maps that tabulated ER visits and patient flows. His motivation was improving better care to those most in need, which correlated to those with the highest medical costs. His calculation revealed that 1% of the 100,000 person total population accounted for 33 1/3% of the city's medical costs. In working with patients, Brenner uncovered a number of things. For starters, he double-checked that prescriptions and medical plans fit together, and when they did not he got on the phone and sorted them out. He teamed up with a nurse practitioner that made home visits for routine monitoring. A third key component was that he brought a social worker in to help case manage services and supports and encourage sense of meaning in life with the patients. Care professionals built relationships with those in crisis (relationships encourage changed behaviors), inquired about emerging health issues, check for insurance or housing problems, asked about unfilled prescriptions, and at times conducted unplanned home visits to perform an examination, order some tests, and provide a prescription. Patients received the team's urgent-call number, which is covered by someone who can help them through a health crisis and knew and trusted the health care providers (otherwise they'd never make a call). Outcomes for the first 36 super utilizers revealed a decrease in ER visits per month from 62 to 37 (40% reduction) and a decrease from an average of $1.2 million hospital bills per month to and average of just over 500,000k (56% reduction). The success of hot spotting relies upon the collaboration of multiple organizations that must come together around a common goal that is broader than the confines of any one organization alone. This collaboration requires real time seamless delivery that is consistent and continuous.

(http://www.newyorker.com/magazine/2011/01/24/the-hot-spotters)

Community

"Neighbor, families, friends, coming together for the good of each other." (Community Member) We are using a change approach of co-created solutions where everyone is invited to the table.

- Access and Awareness
- Transparency
- Data driven change
- Grassroots solutions

We asked, "What does community mean to you?" R Analysis—a method to analyze qualitative data—revealed that in a cluster diagram for words used at least 25 times, the cluster that includes the word "community" also included the terms "care" and " need". This reveals that caring for and needing each other is central to the community of New Haven.

To me, community means...

Support, love, coordination, freedom, teamwork, unity, revive, dignity. *-Community Member*

A whole bunch of people working together. It doesn't make no sense to be out there fighting this alone. They get people that help us everyday. *-Community Member*

Here, the community is all of the residents. So we have a lot of commonality. We all need to take medications. And get it on time. *-Community Member*

Coming together—everybody—all the different colors, shapes, sizes, nationalities, backgrounds, everything. *-Leeway Staff*

Well, I think of my church when I think of community. We're all together, we worship together, we celebrate different events together and we do for each other when a person is in need, when somebody is sick. - Leeway Staff

My community would be my support system and me. It's kind of loosely the people I live around but not so much. More my support system and the people I can go talk to and feel comfortable with. Someone I am contributing something to and they are contributing something to me. *-Provider – Hispanic*

Connections, warmth, help. *-Leeway Staff*

Neighbor, families, friends, coming together for the good of each other. *-Leeway Staff*

A community is the mental and spiritual condition of knowing that the place is shared. And that the people who share the place define and limit possibilities of each other's lives. It is the knowledge that people have of each other, their concern for each other, their trust in each other, and the freedom with which they come and go among themselves. *-Thought Leader*

The idea that any group or any community can get together and find its strengths and elaborate on that, whatever capacity that is, so that any removal of stigma for anything is better. *-Leeway Staff*

Friends, work, church, family. *-Community Member*

Well, community means a common unity. A common shared floor. Common shared direction. And when you say community in New Haven, to me that means togetherness. That means proactive movement towards common goals. *-Case Manager*

The community to me means everything. If you don't support the smaller people you don't have the big picture. *-Leeway Staff*

- How can spirituality play a role in making positive disruptive change in community?
- How can a clean and safe community and home contribute to positivity?
- Through No Wrong Door, how can New Haven be the model of how access and awareness changes how our community thrives?

Case Study: Santa Monica Well-Being Project - Power of Community to Achieve Well-Being

The Santa Monica Wellbeing Project is an initiative started and funded by Bloomberg Initiatives in 2014. This city has a history of innovative government policies, such as affordable housing and sustainability, and is now of the first to measure wellbeing and use the data to improve the lives of its residents. This initiative identified and measured the factors necessary for communities to be their best. Factors include life satisfaction, personal time, work-life balance, volunteering, mobility options, and lifelong learning1. With the findings, Santa Monica is actively implementing changes that will improve overall quality of life within the community. Underlying well-being is the idea that a true state includes "being socially connected to each other, feel[ing] that they are committed to their community, and hav[ing] a future in their community". The Wellbeing Project has identified issues that need to be addressed including social isolation, stress, the cost of living, and access to education. Jonathan Mooney, the Community Advisor for the Wellbeing Project, points out that in order to improve on these measures, there needs to be a collaborative effort of residents, organizations and local government. The cohesiveness of communal entities working together to improve wellbeing for the residents of Santa Monica is the most crucial step in creating a truly prosperous community. Key to bettering well-being at the city level includes access and awareness to services and supports.

(http://wellbeing.smgov.net/)

Place

Healthy community environments reduce the burden of chronic illnesses. Thus, there is an opportunity during the design of physical space to express all sides of human life, not just material, but spiritual, social, and moral as well.

- Continuous learning and growth
- Social connectivity
- Healing surroundings
- Compassionate Support

Healthy community environments are a priority of the National Prevention Strategy as they have been shown to reduce the burden of chronic illnesses. In recent years, building design has progressed from sustainability focused on physical and environmental (i.e. material) resources and mere subsistence to building design that promotes psychosocial thriving and a sense of meaning. Human flourishing is defined as the optimal range of human functioning, including goodness, generativity, growth, and resilience . Ehrenfeld and Hoffman present flourishing as a "workable metaphor for the bundle of things that make life worth living and produce well- being." Stakeholders were asked, "If you could design a place of well-being (POW) where all services and supports were provided under one roof, what would this look like? What would it feel like?" The following are initial ideas.

- How can PODS and a POW bring people together in their shared humanness rather than separate and stigmatize by disease?
- How can the POW be the disruptive change to meet the demands of intensive care needs?
- How can a POW, as a one-stop shop, address issues of transportation?
- How can we design a place where just being there is healing?

Professionals on site:

- Dedicated and high quality employees
- Caring, giving, generous, kind, and compassionate

Services and Supports:

- Books, reading, and literacy
- Meals, food, and nutrition education
- Spirituality
- Employment placement
- Pharmacy
- Recreation (music, biking, bowling, playing cards, movies, singing, hiking, meditation, yoga, art)
- Legal counsel
- Housing
- Major medical
- Support groups
- Recovery support
- Psychologist/Psychiatrist/Social worker
- Pet therapy
- Life skills classes and counseling
- Cultural and language inclusive

Environment:

- Sense of community
- Clean
- Safe
- Spacious
- Promotes healing
- Promotes recovery
- Home
- Open door
- Relaxing
- Fun
- Promotes activeness & engagement
- All-inclusive
- Inviting
- Positive
- Instilled sense of purpose
- Joyful
- Happy

Case Study: Psychosocial Value of Space – Designing from survival to well-being

In response to concern over animals' psychological and social well-being, zoos have undergone a radical transformation over the past few decades with key lessons applicable to all building design. Natural habitats, geographic clustering of animals, mixed species spaces, free-ranging spaces, and returning control over an animal's own behavior are a few of the key changes. Key lessons include: look beyond survival to well-being, build on "primitive preferences" and connections to nature, and design for the senses as well as the body. In discussing an optimal healing environment, biologist Stephen Boyden argues, "environments need to fully satisfy both "survival needs" and "well-being needs". Survival needs deal with aspects of the environment that directly affect human health, such as clean air and water, lack of pathogens or toxins, and opportunity for rest and sleep. Well-being needs, on the other hand, are associated with fulfillment, quality of life, and psychological health. Whereas failure to satisfy survival needs may lead to serious illness or death, failure to meet the well-being needs can lead to psychosocial maladjustment and stress-related illnesses. Environmental psychologists have also considered other needs such as comfort maintenance and sense of equity, which are important in today's building environments." Key components of an optimal healing environment include a sense of refuge, a hearth, a connection to nature, daylight and sunlight, and ephemeral qualities. Key design for the senses includes freedom of movement, organized complexity, fractal patterning, organic shapes, emotions and shapes, and multisensory. The key takeaway is that buildings affect our psyche as well as our bodies. They can be inspiring and supportive of daily activities, or they can deplete the spirits and undermine the best intentions of the designer. It is not by chance that such results occur.

(https://www.wbdg.org/)

Power of the Powers Together

The powers represent the values and guiding principles of the Community Living Model project. They progress from:

A human to human practice
(Dignity)

To a strengths based approach
(Positivity)

To the individual and their role in their own change
(Self)

To the dyadic level where giving and receiving between two individuals benefits them both
(Give & Receive)

To this place, New Haven, and its positive progression to put itself on the map as a place of well-being

(Place)

To all people with a shared common goal, within a shared location, working together at all levels

(Community)

To a team of teams working together to broaden and build their ties to one another

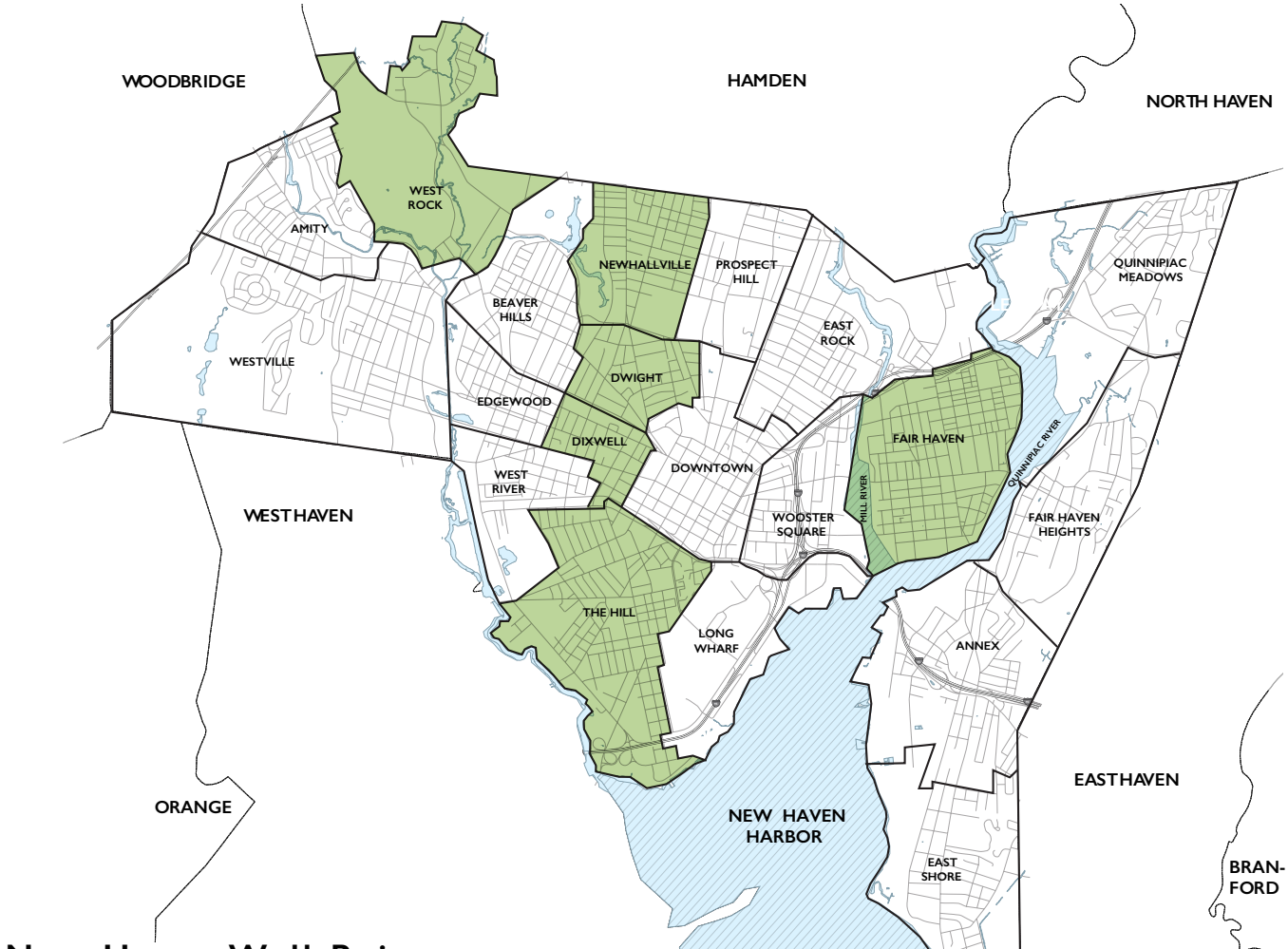
(Collaboration)

To a team providing care and social support that wraps around each individual

(Care)

Data and Alignment with City Initiatives

The Opportunity is Here:
New Haven on the Map



New Haven Well-Being

- Greater New Haven ranked 19 of 130 metropolitan areas around the country in their composite of wellbeing score
- More than 4 out 5 residents are satisfied with where they live and similar proportions are satisfied with daily life and work
- Job access, cost of living, responsiveness of local government, assistance for low-income residents, public safety, and youth opportunities are the biggest concerns of residents

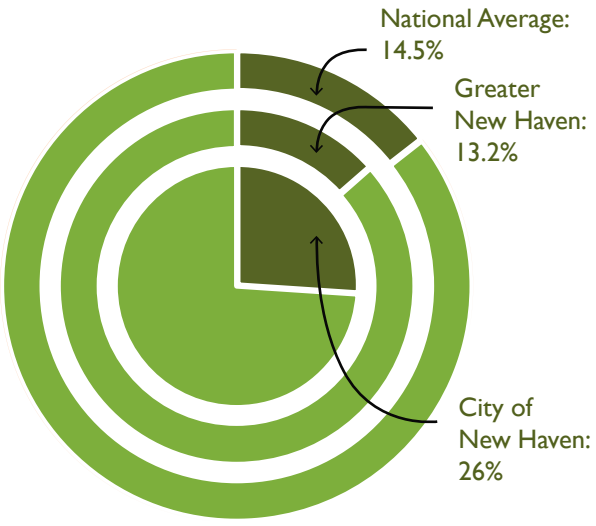
New Haven Demographics

- 130,553 people in the city of New Haven (2014)
- Greater New Haven 2014
  - 13 towns and 465,227 people
  - 363 non-profit organizations (50 in health alone)
  - 59 documented collaborative initiatives
  - 6 institutions of higher learning

Poverty Stats

- 54% of Greater New Haven's poor live in 6 neighborhoods: Dixwell, Dwight, Fair Haven, Hill, Newhallville, and West Rock (visualized in orange on map)
- 26% of the Greater New Haven population has an income below poverty level
- Poverty rates are disproportionately high among blacks (29.5%), Latinos (38.3%), and children (37.4%)

New Haven & National Poverty Levels Compared



- **Persons Below Poverty Line (Last 12 Months)**
- **Persons Above Poverty Line (Last 12 Months)**

The people who make up Greater New Haven, more than any other region, closely represent the demographics of the U.S.

A recent study revealed Greater New Haven's demographics are the most like America's today in comparison to all other U.S. regions. As such, Greater New Haven provides the unique opportunity to test and pilot programs and services in a manageable way with the potential to make a real impact on a broader scale. Yet, while the metropolitan area represents the country as a whole, the demographics of the city, particularly as they relate to poverty levels, reveal a significant gap in services between an urban area and a metro area. It is our aim that the Community Living Model will begin to address this gap.

During the appreciative interviews and focus groups, stakeholders were asked about the strengths of our local community. In response, a food and nutrition provider said, "New Haven is an amazing Petri dish that is such a contained market that it really does lend itself well to piloting programs and trying to test different methodologies for success because we have a pretty relatively small population and a lot of surfaces that are touching people."

On its manageability, a case manager from a leading health care providing clinic said, "New Haven is a really small town. Seems big. And it's got big politics and all that. But it's really, really small. Once you get around you just know everybody. And then you find out that everybody is really interconnected with everybody else." This interconnection is a huge asset for the area. As we work to focus the Community Living Model project, we aim to align with multiple citywide initiatives including: CARE, Community Action Agency, DataHaven, Healthier Greater New Haven Partnership, and the City of New Haven Transformation Plan. To provide the greatest opportunity for impact, we are collaborating to 'add on' to these efforts and are refraining from duplicating.

Zip code is a better predictor to health than genetics.

Yale New Haven Hospital:
Narrowing Our Target Population

Here we present data supplied by Yale New Haven Hospital. With this data—in conjunction with stakeholder conversations, the upstream and downstream data, additional information from other citywide initiatives, and the needs spoken of through interviews and focus groups—we begin to narrow our target population.

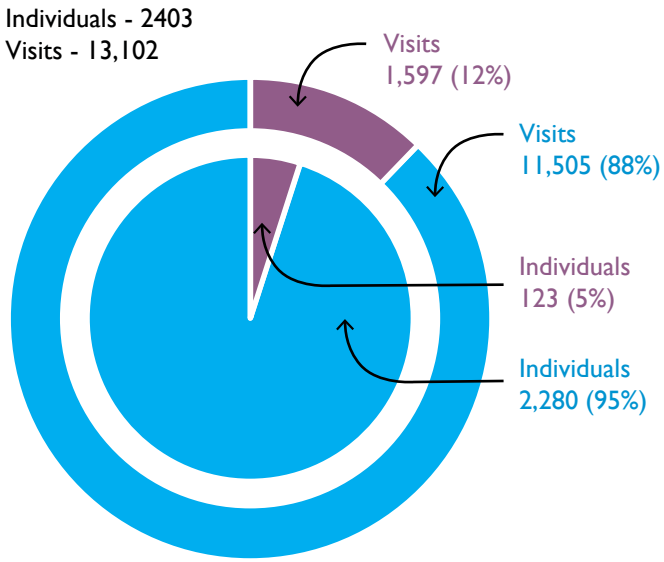
Top 5 Primary Symptoms for YNHH Admitted Patients - 09/15/2015 - 09/19/2016
Sepsis, unspecified organism
Acute kidney failure, unspecified
Pneumonia, unspecified organism
Chronic obstructive pulmonary disease with (acute) exacerbation
Non-ST elevation (NSTEMI) myocardial infarction

Top 5 Readmission Primary Symptoms for YNHH 30-day Patients - 09/15/2015 - 09/19/2016
Sepsis, unspecified organism
Acute kidney failure, unspecified
Infection following a procedure, initial encounter
Chronic obstructive pulmonary disease with (acute) exacerbation
Acute on chronic diastolic (congestive) heart failure

Top 5 Primary Symptoms for YNHH Observation Patients - 09/15/2015 - 09/19/2016
Chest pain, unspecified
Syncope and collapse
Encounter for supervision of other normal pregnancy, third trimester
Unspecified abdominal pain
Suicidal ideations

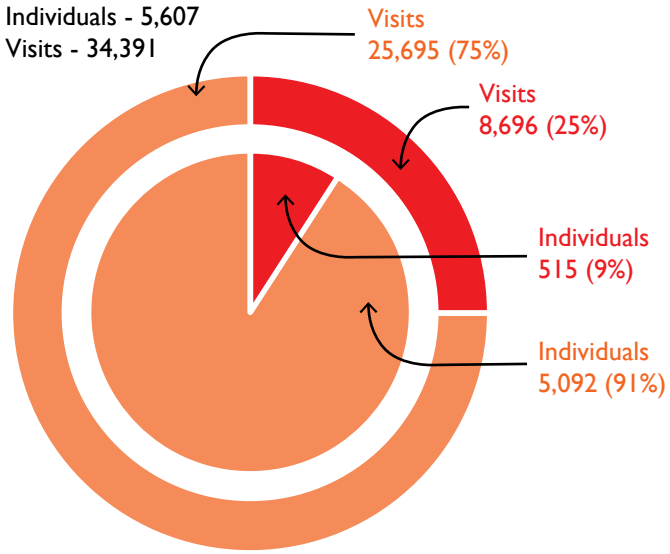
Post acute care disposition data for patients discharged between 9/15/16 – 9/16/16
60.16% to Home Health Services and Home Care
25.7% to Skilled Nursing Facility (SNF)

Individuals with Multiple Chronic Illnesses 3+ INPATIENT VISITS between 9/15/15 and 9/15/16



- 4-9 visits
- 10 visits or more

Individuals with Multiple Chronic Illnesses 3+ EMERGENCY DEPARTMENT VISITS between 9/15/15 and 9/15/16



- 4-9 visits
- 10 visits or more

Upstream Downstream: Aligning with City Wide Upstream Goals to Affect Downstream Outcomes

We reviewed reports and data supplied by DataHaven, City Transformation Plan, Yale New Haven Hospital, CARE, and the Healthier Greater New Haven Partnership. From these resources, and our ongoing conversations with key service and support stakeholders, the following downstream outcomes emerged as key areas of focus where the Community Living Model can boost the city-wide support system to a new level. The downstream outcomes identified support our goal to keep people out of nursing homes and hospitals, as these are the biggest risks. We will solve for this by using the voices of New Haven to build a 'new' haven of well-being.

KEY:

(D) DATAHAVEN
Report 1: Greater New Haven Community Index 2016
Report 2: Greater New Haven Community Index 2013
http://www.ctdatahaven.org/

(Y) YALE NEW HAVEN HOSPITAL
Report 1: Internal Reports

(H) HEALTHIER GREATER NEW HAVEN PARTNERSHIP
Report 1: 2016 Community Health Improvement Plan
https://www.ynhh.org/about/community/health-needs-assessment.aspx

(C) CITY OF NEW HAVEN
Report 1: City Transformation Plan
http://www.transformnewhaven.org/download-the-plan

DOWNSTREAM OUTCOMES

How do we keep people out of the hospital and skilled nursing facilities?

DIABETES / OBESITY

- Obesity rates in greater New Haven have increased 11% in the past 5 years (from 21% to 32%) (D)
- 32% of residents in the city of New Haven self-report being obese; this number increases by 30% for low income residents; 11% self report having Diabetes (D)
- The city of New Haven has 57% more hospital encounters from diabetes per 10,000 residents (948) than the average of greater New Haven (476), The Inner Ring (484), and the Outer Ring (262) (D)

DENTAL RELATED DISEASE & EMERGENCY

- 31% of city of New Haven residents reported not having seen a dentist in the past year; this % is the highest of all towns in greater new haven and 8% higher than self-reports of state residents (D)
- The city of New Haven has 60% more inpatient encounters from preventable dental conditions per 10,000 residents (102) than the average of greater New Haven (54), The Inner Ring (44), and the Outer Ring (25) (D)

NUTRITION AND ACTIVITY

- Promote healthy eating and physical activity (H)
- Reduce % of adults who report food insecurity from 22% to 15% (C)

DENTAL CARE

- Increase adults access to dental services (H)

How do we support an individual to thrive and flourish within the City of New Haven?

UPSTREAM GOALS AND TARGETS

SOCIAL DETERMINANTS OF CHANGE

MENTAL ILLNESS & SUBSTANCE ABUSE

15 % of adults in the city of New Haven self report having anxiety whereas 12% self report depression. These are the highest self reporting percentages of any town in Greater New Haven (D)

Alcohol dependence with withdrawal is one of the top 10 primary diagnoses for YNHH 30 day readmissions (Y)

Suicidal ideations and altered mental status are 2 of the top 10 primary diagnoses for YNHH observation patients (Y)

Substance abuse related issues were the 4th highest reason for ER utilization (Y)

Substance withdrawal is the 6th highest reason for readmission within 30 days of discharge (Y)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) / CONGESTIVE HEART FAILURE (CHF)

The city of New Haven has a disproportionately higher % of inpatient encounters for heart disease, lung cancer, and COPD than the average of Greater New Haven (D)

COPD is the 4th leading cause of 30 day readmissions and of all admitted patients (Y)

CHF is the 5th leading cause of 30 day readmissions (Y)

BARRIERS TO CARE / HIGH COSTS

YNHH Uncompensated and Undercompensated Care Costs (in thousands)

Total liabilities and net assets: $2,981,095

Total uncompensated and under-compensated care costs $354,012 (12% of total) (Y)

MENTAL HEALTH & RECOVERY

Enhance training to providers in trauma-informed practices (H)

Enable greater coordination among local mental and health outcomes for patients with complex medical and/or behavior health illnesses (H)

Increase awareness of current substance abuse and mental health issues to local providers (H)

Reduce the number of ED visits and hospitalizations for mental health-related concerns by 28% (C)

SMOKING CESSATION

Educate the community about the dangers of all forms of tobacco (H)

Decrease percentage of adults who smoke from 18% to 14% (C)

ACCESS TO CARE / INSURANCE

Decrease the number of people who are negatively impacted by insurance redetermination (H)

Decrease the number of patients expressing difficulty in accessing health care services due to lack of transportation (H)

Community Living Model Alignment

Many organizations have dedicated significant time and energy to align forces aimed towards a shared common goal. Led by Mayor Toni Harp and Community Services Administrator Dr. Martha Okafor, the City Transformation Plan (CTP) seeks to transform the city to one of promise, opportunity, and innovation. The purpose of the CTP builds upon what makes New Haven great, while acknowledging the unevenness of the city's socioeconomic landscape. The New Haven story is described as the "tale of two cities" in which wealth, well-being, and opportunity coincide with race, place, gender, and age.

Healthier Greater New Haven Partnership (HGNHP) measures and monitors health status and quality of life, with the goal of improving the health and well-being of Greater New Haven residents. With several community partners, HGNHP has developed a collaborative regional health improvement plan which is now guiding specific strategic initiatives and outreach efforts. This plan encompasses three areas of focus including: Healthy Life Styles, Access, and Mental Health and Substance Abuse.

The Community Alliance for Research & Engagement (CARE) continues its grassroots efforts to promote the prevention of chronic disease by focusing on social, environmental, and behavioral risk factors. CARE has recently co-located so that it has a home at both Yale School of Public Health and Southern Connecticut State University. Moving forward much of their accomplishments will come from increased student involvement, whose charge will advance into evaluation.

The CTP, CARE, and the HGNHP are greatly informed and enriched by the wellbeing surveys, data analysis, and comprehensive reports prepared by DataHaven. With funding support from the Community Foundation of Greater New Haven, Data Haven recently launched the Greater New Haven Community Index 2016. This report updated the 2013 Greater New Haven Community Index with an extensive analysis of information gathered directly

from local residents in 2015 and 2016 and from extensive state and national agencies. The report provides detail on how Greater New Haven rates highly on many national and state measures of quality of life and economic opportunity.

While there is a countless number of organizations in New Haven to recognize for advancing well-being, two organizations that closely align and inform needs and strengths include Community Action Agency (CAA) and Clifford Bears. CAA has researched whether individuals remain enrolled in healthcare; assessed individuals' access to medical home and a primary care physician; identified obstacles that may prevent individuals from using their healthcare coverage; and, ensured that newly enrolled individuals are able to use their healthcare coverage. Clifford Beers has been pioneering wraparound care management in New Haven (WANH)--a Centers for Medicare & Medicaid Services (CMS) Health Care Innovations Award-funded program providing in-home, multigenerational care coordination for children and their families experiencing medical, behavioral health, and biopsychosocial challenges. Our hopes are to learn from their experiences and align efforts to ensure wrap around care becomes a sustainable, reimbursable program.

Additionally, the Community Living Model has been accepted to receive coaching from the County Health Rankings and Roadmaps, a Robert Wood Johnson Foundation program. The six team members are leaders who convene stakeholders around evolving well-being efforts in New Haven. By aligning with these leaders, the Community Living Model planning and execution works in concert with ongoing efforts. Organizations represented include: the city of New Haven, Community Alliance for Research & Engagement (CARE), Healthier Greater New Haven Partnership, Community Action Agency, Leeway Inc, and HoodenPyleGil. The program offers guidance in: effectively improving community health; strategies to do so; and utilization of Robert Wood Johnson guides, tools, and protocols. The commitment of team members reflects a citywide commitment to join efforts in the name of a common goal: promoting and bettering the health and well-being of the citizens of New Haven.

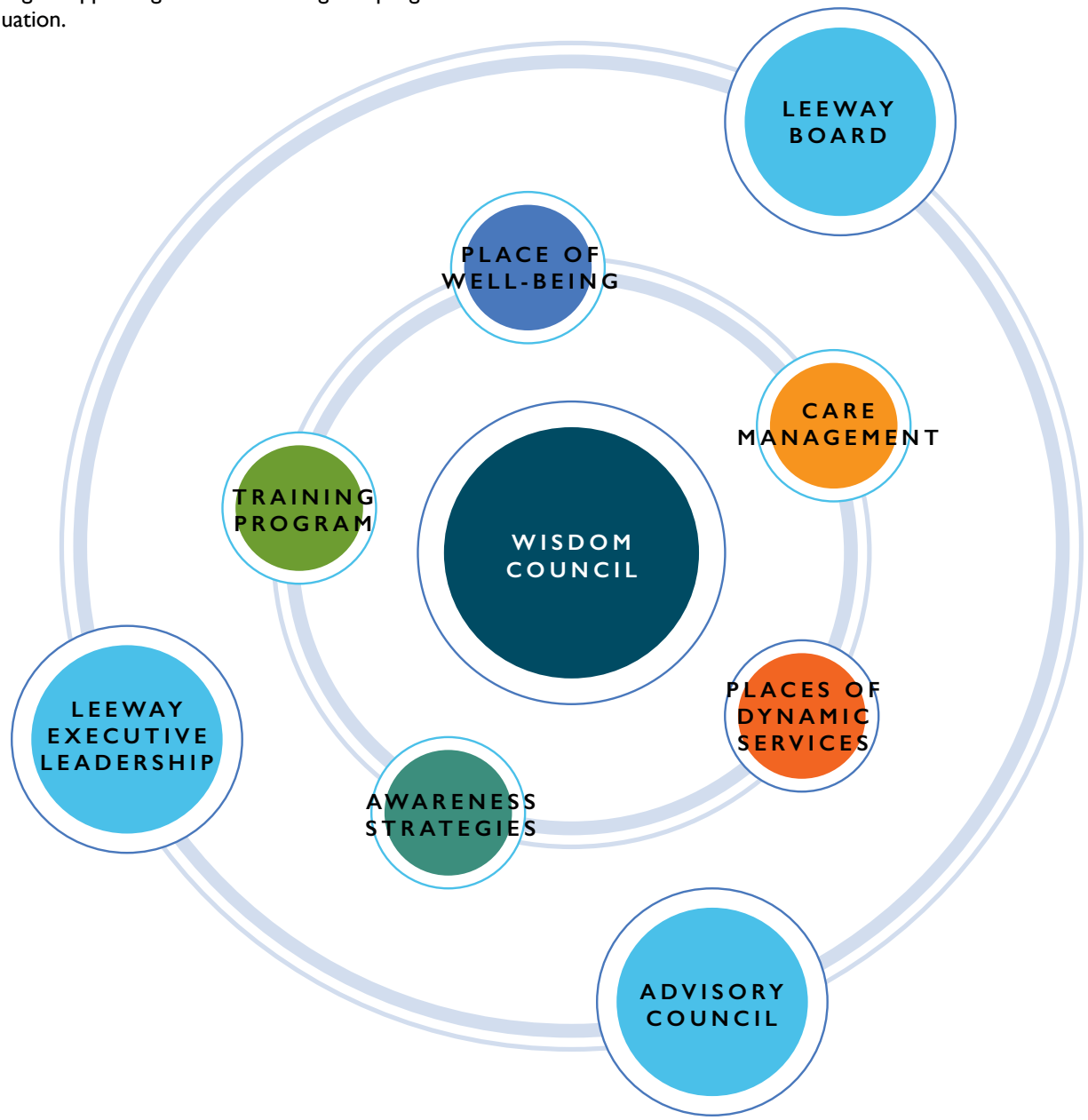
Movement towards Action

Deployment

To execute in a successful and sustainable way, 5 action groups will take a deep dive into respective group goals while working across groups to insure cohesion. Each group will discuss opportunities for program evaluation and data analytics. They will also explore ways to leverage the great programs already in place and ensure increased visibility to what is already working.

The Wisdom Council will continue to ground the project with grassroots efforts by meeting monthly.

The Advisory Council, Leeway Board, and Executive Leadership Team will continue to provide quarterly oversight supporting decisions making and program evaluation.



Timeline

What we have accomplished

The project has achieved a number of exciting gatherings thus far, each of which has advanced the direction and dream. Highlights of what's been and placeholders for what's to be are listed below.

2016

JUN | JUL | AUG | SEP | OCT | NOV

June 28th
Think Tank

- 50 people in attendance.
- 29 organizations represented.
- 76% of attendees believe the project is aligned with the work their organization is already doing.
- Built awareness, buy-in, and momentum.

August 17th
Wisdom Council

- Used images to describe the ideal healthcare experience.
- Shared personal experiences and built trust as they underscored importance of loving relationships.
- Much discussion around self-esteem and raising the confidence of others.

September 14th
Care Management

Produced a few future state goals and outcomes, including:

- Client education about the client's own role in care, motivation, and encouragement will empower individuals to self-advocate.
- Providing information enables questions based on personal needs.
- Integrating family, friends, and faith providers in the ideal model of care will promote and improve awareness and support.
- Helping others to overcome fear and eradicate stigma will support individuals to grow and thrive.

September 15th
Wisdom Council

- Gave voice to those with multiple chronic illness who regularly navigate the healthcare system.
- Key topics spoken about: prescriptions and their effect on an individual's life; how a care provider who assists with reminders and dosages is an asset to a healthier and happier life; and, empowerment to help others just as the wisdom council members themselves have been helped.

November 7th
Advisory Council

- 23 organizations represented.
- Alignment with existing organizational initiatives was reinforced.
- Representative from the state shared why this project is important here and now. Individuals who need long term care services and supports should have a choice on how and where they receive the care they need. This project creates a model that supports these services and supports to be provided in the home.
- An energetic portion of the meeting revolved around brainstorming both "what is already being done in New Haven" and "what is possible in New Haven" as it relates to each power.

November 16th
Leeway Board Retreat

- Board members conducted a SWOT analysis.
- Brainstormed the priorities and opportunities that exist with grant execution.
- Reflected on how the Community Living Model will expand Leeway's mission and evolve Leeway's Brand.

"We will aim high and we will shoot for the stars, but if we fall through the clouds, we will still be on higher ground."

-Bill Dyson, Leeway, Board Chairman

What is next

2017

DEC | JAN | FEB | MAR | APR | MAY

December 15th

Wisdom Council

- Being a member of the council provides great purpose and motivation to make healthier options.
- Desire to grow by current members recruiting others.

January 25th

Care Management Visioning Session

- This group will work to create a systematic approach to implementing the evidence-based program, known as GRACE (See page 21).

February

Hiring Staff

- We will recruit and hire individuals for the wrap care management team including APRN, Pharmacy, Mental Health, and Psychiatry.
- This search will be heavily based in New Haven as we strive to align the Community Health Worker concept.
- This group is instrumental in laying a solid foundation by which the entire program will be designed.

PODS Visioning Session

- This group will look at methodologies and the relevant elements essential to deepening collaboration and alignment of organizations. An example is the Community Hub Model as described on page 15.

Awareness and Access Visioning Session

- This group will work to identify two neighborhoods in New Haven that will begin a grass roots effort to implement the DSS program No Wrong Door.

March

Advisory Council Meeting

Leeway Board Meeting

April

Training and Development Visioning Session

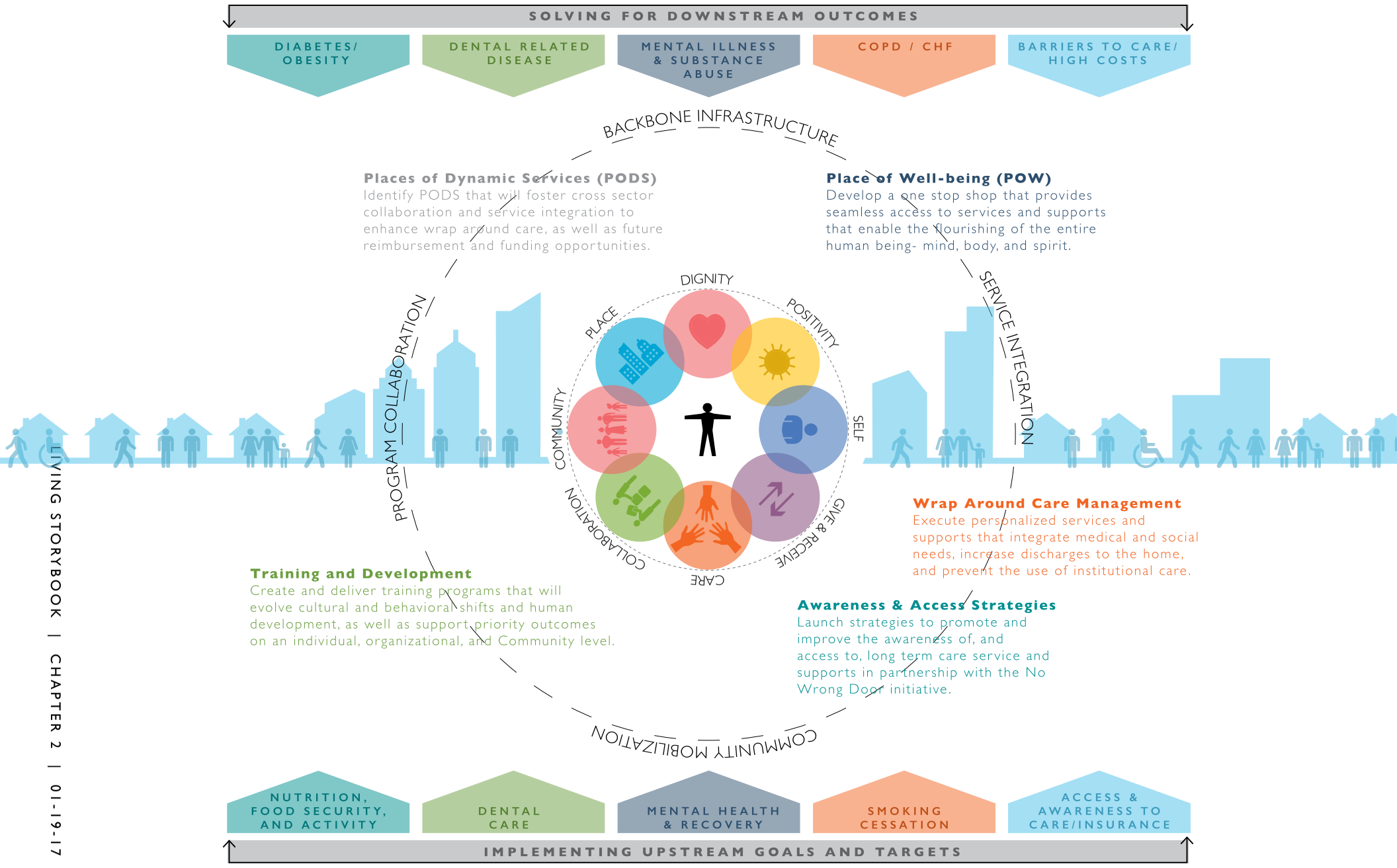
- This session will identify the opportunities for learning on an individual, organizational, and community level. A focus on the use of positive psychology methodologies will be introduced through local and national experts.

Place of Well-being Visioning Session

- CAMA Inc., a New Haven based company leader in evidenced based healing design, is presently scanning environments nationally as the basis from which we will dream.

Community Living Model Visioning and Implementation

On the next page, we present a consolidation of everything we have covered in this chapter. This infographic shows the data and alignment to city initiatives that we discovered in our assessment of needs and strengths, visible in the downstream outcomes and upstream targets that are prevalent in New Haven. We know that these are areas where the Community Living Model can make great impact. The way we will make impact is through movement to action by way of the 5 action groups described above. Each action group will independently tackle their specific goals while working across groups to insure cohesion. At the very center is the heartbeat of the project, the 8 powers, which serve as the guiding principles in all that we do. These powers emerged from the voices of stakeholders as being necessary and desired. With emphasis on systemic change through these powers, our goal is to support the creation of backbone infrastructure, service integration, community mobilization, and ultimately further program collaboration in the City. The culmination is our philosophy towards this change, that by inquiring about what matters most, and appreciating the best of what is through inclusion of all, we will achieve sustained and long lasting change.



SOCIAL DETERMINANTS OF CHANGE

Spoken needs... Reframed as **Possibilities for Inspiration**

As we conducted appreciative inquiry interviews and focus groups, needs and gaps naturally arose. These needs are spoken of below. Yet, 100 studies of costly turnover will tell us nothing about magnetic work environments. Therefore, we have reframed these needs as possibilities and dreams. This new way of looking from the other side builds upon the voices of stakeholders who spoke of their own dreams for a new New Haven and an enhanced model of wrap around care.

[EXPRESSED NEEDS AND GAPS]

Imagine the possibilities

[Mental health / Psychiatry]
Quality moments, can-do coaching, strength in abilities

[Consistency, follow-up, and continuum of care]
Revolutionary customer responsiveness

[When they need help you are there for them]
Remarkable availability

[Communication]
Compelling ways of relating

[Resources]
An abundance of capital

[Access to insurance, food, and information]
Open door to, and easily retrievable, necessities

[Extended hours]
Round the clock concierge system

[Confusing medications]
Outstanding and simple medication plan

[Housing]
A home for all

[Food access and insecurity]
Bounty of meals

[Citizens living alone]
Creating and sustaining positive relationships

[Transportation]
An exemplar network of mobility

[Focus beyond most impoverished neighborhoods]
Whole city as one big hope

[More home care]
Door to door service

[Working together in a way that makes sense]
Improbable collaboration through integrity in action

[Trying to meet the demand]
Masterful fulfillment of all cases, 'Let's do it!'

[Education…natural literacy, health literacy]
Continuous learning and teaching

[Environmental health]
A living, breathing, flourishing city

Appendices

'Needs' Quotes

I'd really like the mental health to be improved in the community. I would like everyone to be aware of the situation and the issues. So many people do not realize that they have mental health issues. That would solve a lot of problems. Violence. Drugs. Just a lot of problems. I think a lot of Blacks and Hispanics aren't aware of that and shrinking would be very helpful. You're able to let it out. You're able to talk. It's not something you should be ashamed of; it's something you should be proud of. (Leeway Staff)

To me the best thing we could give them is psych. And they need follow up. Consistency and follow-up. And to know that when they need the help you are going to be there for them. (Leeway Staff)

I mean the communication with a home therapist is, there's none. ... Even the reports are very limited. I mean just from personal experience in home care. I only get a report from certain facilities and half the times I'm calling up the previous therapist and saying, oh, what were you guys doing? But that takes a lot of time and it doesn't always happen. I like when they come with the paperwork but that doesn't happen very frequently actually. (Leeway Staff)

It's really minimal. If we had five more drivers we can probably service, you know, almost another hundred families. (Provider – Food and Nutrition)

One of the barriers in serving a lower income community is what we can cover by insurance. (Provider - Health and Wellness)

They need a lot of resources. We see this revolving door that is unbelievable. They get healthy, they go back, they take their drug of choice, and then they end up in the ER. Opiates and heroin are rampant. Patients absolutely burn all of their bridges, financially, with their family, utility companies, whatever is going to make them feel good is their priority, because of credit checks of background or this or that they don't do very well, their history kind of haunts them. (Leeway Staff)

We see people mostly are coming in at 3:00, 4:00, or 5 o'clock, right as the office is closing so… why not extend the hours to make things more accessible? But we don't actually have concrete data points besides appointments and then the people coming in. (Provider - Health and Wellness)

Probably the biggest thing we deal with here is a lot of people confuse their medications. (Community Member)

…if we could do something to improve that, you know, of getting housing for folks, or making a process of getting into housing or in any of these places easier, I think that's something we should focus on as well. (Leeway Staff)

Mental health; that there was some way to deal with mental health issues. (Leeway Staff)

Food access and insecurity also go with nutrition. (Provider - Food and Nutrition)

There's 4,500 low-income, approximately, low income senior citizens living alone in New Haven that are under the poverty level. So imagine your grandmother living by herself. 3,400 are women, and Fish is the only pantry that delivers to people in their homes, and they're reaching 125 of those 4,500. So of those 900 to 1,000 phones calls a day, not just elderly, Fish couldn't even get to. And of those, to give you an idea of the phone calls that would come in, an elderly couple that were in their 70s hadn't eaten for three days. No food. A young man in his 20s was in the Iraq War, had a head injury. Can't really go out in the sunlight without going into seizures. Hadn't eaten for four days. All he had was a bottle of water. That's the reality of what's happening in New Haven. (Provider - Food and Nutrition)

I'd have to confirm this, but about three months ago, I was made aware that the Mass Transit Systems, the buses, no longer allow carts on the bus. So if you go to the grocery store, you now have to carry your groceries. Now imagine going through chronic illness … or elderly in the snow trying to get your groceries home, or with three little kids, you know, it's difficult. So the access is just as important as the insecurity, so— (Provider - Food and Nutrition)

Whether you're a drug addict or not, you have to eat. Whether you have chronic illness or not, you have to eat. But a lot of times the biggest issue is the transportation. Yes, there are free pantries and yes there are soup kitchens, but the majority of the people that I've worked in the city with are elderly that have chronic illnesses. … To get up out of bed and get to the grocery store or ride the bus or have the funds to pay the taxi and then bring your groceries upstairs, it's—I've had a few surgeries, so I haven't had chronic, but I mean, I would have given anything for somebody to show up at my door with two bags of groceries, you know. (Provider - Food and Nutrition)
What I find in my little bit of time here is that people tend to focus on a few neighborhoods, three in particular, and I feel like it needs to be broadened. You know, that's great to focus on those three that are the lower income, but there's low income all over our city, obviously, or our numbers wouldn't be the way they are. So I tend to like to look at the broad picture, so I wouldn't just pick the neighborhoods that are low income. (Provider - Food and Nutrition)

Because you can have support and spirituality, happiness, you can do—even do fitness inside. Meditation inside. Nutrition inside, but, like, if I hurt so bad, or I'm post-surgery, or whatever, what's available to me at my home? I would like to see the community do more of that old school, back, you know, Midwest, whatever, to where we're going to the homes rather than them having to get on transportation. (Provider - Food and Nutrition)

When you bring people around the table there is often no actionable results. No good effective mechanism where they can be working in a way that makes sense. Where someone is shepherded from health to wellbeing. Not talking to each other in a way that makes sense. (Provider – Spirituality)

And their sense of community is that facility. … It's not a real community. It's really commercialized which can be challenge. It's like where's the corner store? Where is, a park? Where is a church? Where are other people gathering? (Provider – Library)

I think one of the main issues is, you know, just trying to meet the demand, right, even there was just a very small non-profit. Just try and meet the demand. And so keeping up with any type of collaboration or partnership becomes overwhelming. (Provider – Hispanic)

Data would help a lot to address this inequality. Data that connects patrons with healthcare. In other words, the people I'm seeing are the people you're seeing. (Provider – Spirituality)

It's so good to be able to help people, and one of the biggest barriers to helping people, I have found, is education. (Provider - Health and Wellness)

I'm huge on education. Any type of education. Natural literacy, health literacy. Huge, huge, huge. Because that's definitely a way out of poverty. (Provider – Hispanic)

But when you asked about well-being, you know, the fundamental question about what someone needs to live well or to be happy or to be content, this is where I would say body, mind, spirit—you need to address all three. So what would someone need? Just really the basics. Housing, access to good food and to healthy food. So we look at that as definitely a place where in metropolitan medicine we can help people, to educate people on what that looks like. So food, water, also for wellbeing there is the environmental piece, too, because across the country there's a problem with clean drinking water. So here's where we get into, in terms of the physical health, environmental health plays a role on our physical health. (Provider - Health and Wellness)

I'd like to see continuum of care. That when individuals transition from one stage of care to another, that they could continue with the same rehab and nursing staff, whether in home care or otherwise. (Leeway Staff)

'Place of Well-Being (POW)' Quotes

And my drawings, I draw pictures, you know? And I draw nice pictures. And they hung those few that I did in the room. A bunch of pictures up there in each room. (Community Member)

Having residents and everybody together like as one. I think it kind of sets up for a better, I don't know if I'm going to call it lifestyle or just a different—not good at words as you can tell—different environment. You know, it's—you forget. A lot of times I could just walk down here and I wouldn't think for a second this is work. You laugh, you sit, the personalities alone are great. And a lot of the residents are fun, man. They're cool, cool people. (Leeway staff)

Clean, safe and spacious (promotes healing), provides a home; a place to be; 3 meals; come and go; receive major medical; support system; Phenomenal employees who are dedicated, care, giving, generous, kind, and compassion. (Leeway Staff)

They had lots of books and it is a really relaxing place. You can go and just do nothing or join in. They have church and they have shop. It is a nice place to recover. (Community Member)

Jobs. A lot of the patients don't have that family support. So, some kind of support system where they know that you are not alone and can call and speak with someone regarding what they are experiencing. Or a place where they can go and share. And nutrition and the medication piece. (Leeway staff)

Things done for fun: play music, biking, bowling, spending time with friends and family, walk on the beach, play cards, shopping, watch movies, going to the park, read, singing, going to church. (Community Member)

I think I would make sure that they are active in the community and don't stop because they have their own place now. And to, maybe try to provide a service that keeps them active. That keeps them doing some of the things that they do. Like, when they're here they do things like, where they go out and they play games and they participate in walks and all these things. So, maybe try to continue to keep them active instead of moving out and just… It's easy for them to kind of go back to the lifestyle that they may have had before too. (Community Member)

One patient going out to the hospital and coming back and saying, 'I'm home'. That's heartfelt. … It just makes you feel so good that they recognize this home. It's just different. (Leeway Staff)

To put it under one roof it makes it easier for compliance, it's easier for tracking. It seems to produce better results because the clients are happier, right. Because it's easier for them to get what they need. (Provider – Health Care)

I'm really proud of the fact that we don't turn people away. (Provider – Cultural)

Meditation and yoga and creating a more positive environment. (Community Case Manager)

We have a lot of recently release probationers who were in prison because of some sort of violation of the Connecticut general statutes. You know, criminal activity, sub-cultured activity. When they come out sometimes they on probation or parole. We helped them navigate the parole system and the probation system. We also help them, if they have not been incarcerated yet with the legal system. If they need a lawyer for certain things a lot of them are in debt. And sometimes debt collectors, you know, come after their clients. You know? Sometimes they need, you know, assistance for that. You know, legal assistance for that. So, we try to help them with all types of issues with regard to, you know, just civil stuff. (Community Case Manager)

Team of people, psychologists number one, rehabilitation from all types of things, drugs, trauma, whatever their root issue is that leads them here 'cause I know a lot of 'em used to be on drugs. … stable housing, just having a support system too like support groups and different support programs. (Leeway Staff)

We're really trying to find the people that don't have the ability to get to the grocery store easily. And if you have to take four buses and pull cart we don't consider that… (Leeway Staff)

a lot of people come in here in bad shape. They don't really understand diets or how they should be living, and this place puts in a program so that they know that. (Leeway Staff)

In the community there is no program to teach someone how to eat right. (Leeway Staff)

There's a lot of people who take their pet along with them. They're homeless and they have a pet. (Provider – Librarian)

I keep going back to employment, because I think employment is kind of a real key in this whole factor for all people involved in any kind of community support. Work gives people value. I mean, it really does. And work gives people income. (Leeway Staff)

Life skill classes and counseling. It's one thing to heal the body and not have the mind right. It's like, I'm healed, but I still have the same mind set, so what am I going to do? Chances are, I'm going back out there and do what I been doing. It may not be normal to you, but this is the way I live. That's why they need to be taught life skills and addiction recovery. (Leeway Staff)

Fabulous recreation, they take people out, unrelated to therapy, movies, Wal-Mart, bring choirs in, Spanish mass, a church group that comes in and sings, gone to plays, a parade, art work, attending HIV awareness activities, joy and happiness group. (Leeway Staff)

Yeah. So, he's the artist, Katro Storm. ARTE Inc. is an organization in New Haven and David—I can't think of David's last name, David's a member of our board. He's openly homosexual. He's an artist. He donated money for each branch to hire an artist ...to come in and paint with the community. That's what you see out there on the floor. Those are paintings from the community. They're down—you can go walk over there and you see. Those are people who came in and we did families. And they came in and they painted with him. See, we have a little boy there with special needs. That's his mom. And so, [unintelligible] was so excited about it. It's like, I did it, I did it, I did it. So, that's painting program. We could probably get more money to do that. (Provider – Librarian)

They hold support meetings, they have men's group, they have whatever it is. They do a lot of things up there. (Leeway Staff)

I would have a support system for men, somewhere they can bond. They have like a meeting, men's meeting, or something where they can hash things out or talk things out or what their difficulties are for men. (Leeway Staff)

That would change a lot of people's lives. It really would. Because when you're active, you're not depressed. Okay, when you're doing something, you know. Having – you know, groups and having activities, you know. (Community Case Manager)

Quotes

Access - Reimbursement

With each grant cycle, again, you know we actually will modify our programs based on what it is that the funding provides. (Case Manager Community)

There is research and statistics out there that could be presented to insurance companies. More research is needed, but it's definitely something that hasn't been done really well yet, especially in Connecticut. (Provider – Health and Wellness)

Accountability

Listening to them. Not so much being their friends but being friendly towards them. Letting them know that you're sincere in helping them receive the services that they need. And most importantly, I believe in self-efficacy. The fact that, yes, I will help you and I will hold your hand and bring you through this. However I'm also going to teach you how to do it too. (Community Case Manager)

Michael Jackson says if you want to make the world a better place, take a look in the mirror. If a person would look at themselves in a mirror and change the negative about themselves, then it truly will be a better environment today. (Community Member)

Availability

I would give them my number to always be able to contact me. If there is ever an issue that I can try to help you with and if not I'll point you in the right direction. Or church. (Leeway Staff)

They were always there if you wanted to talk to them; they would do anything to help you. (Community Member)

Awareness

The whole world. Everybody, because you can't really select a specific group that you think—you know, you have to reach out to everyone, because although they may not necessarily need the services, they may know people who do. (Leeway Staff)

So they have to have the confidence that this is easy, I can get it done. That it's kind of like I get that off the list. So that would be an important aspect for us is being able to make it easily accessible and having a nice methodology for how we would swap the information, right? And how they contact us, you know, what kind of protocol there would be so that they would also have the assurance that I only need to touch this once and it will happen. (Community Case Manager)

Being accepted

I love it that this is all they focuses on. It is specialized. And they are compassionate. And knowledgeable about what HIV and AIDS is. You don't have to hide what you are here for. It is something I have, not who I am. (Community Member)

Has helped me pick my head up. People hug you and do not look down on you. (Community Member)

Being acknowledged (heard and seen)

I like it, like, if you - when they reward you. Not with presents. With gracefulness. Like, if they see you doing good, they compliment you. Make you feel important, you know? It's not every day people make you feel good, you know? And they just don't say it because it's their job or say it just because. They say it because they really care about us. (Community Member)

One of the residents was having a bad day and they had this picture in front of them. I just happened to be walking by and I asked 'em about the picture and we just began to talk. I found out that they're an artist. They draw and do tattoos and whatever like that. I didn't know they did that. And the person sitting next to him, she went to her room and she came back and brought a poster to me, and she was a minister and I had no clue. That was something great because they shared their stories with me. They made me feel better and they seemed to be better. (Leeway Staff)

Being respected

I think my job is really to give emotional support to other people. To other residents here. And I try to do that just through the way I treat people. With respect. (Community Member)

…if you're, if you come here and you're HIV positive and you're an active drug user then we want to do harm reduction with you. We don't want to take you down a road where you're not ready to go. We want to respect where you are as an individual. (Provider – Health Care)

Belonging as an equal

I think it's made me feel lucky because some of these people have come from very difficult backgrounds. Born into a family where drug abuse was rampant and you look at their lives and think if they were born into a different family or someplace else their lives could have been so different. So it gives me an appreciation of where I've come from and what I've had and the advantages that I've had that a lot of these people haven't just on a personal level. (Provider - Healthcare)

How would we feel? How would we want it to come to us? And do that every time. (Leeway Staff)

Breaking down siloes

Collaborating with people. Well, you want to come over here and do this with me? I'll come and do that with you. That's what it's all about. (Provider – Library)

We're very open and we're very honest with each other and there's no ego. We have to set the ego aside. If someone is wrong we'll say well, that's wrong. And at the same time if someone's right you get rewarded by saying, yes, you're right that's a great idea let's move forward. (Community Case Manager)

Choice

What if for one week of their life they got to tell the kitchen what they wanted every day for lunch? No questions asked, this is what I want every single day. Like how happy would that make them? And how hard is it? For a week straight I just want to have bubble gum ice cream every single day. It's little decisions like that that they need to be able to make that I think would give them a little sense of control and independence over something. They need something. My favorite movie is 'Gone with the Wind' and we're going to watch it on St. Patrick's Day every year. They need to pick out something. Just something that's theirs. They need to have control over something but stay inside the rules. (Leeway Staff)

There needs to be more people listening to their needs and what they need. That is how it needs to be met. We can have that bridge, but you need people to listen and take heed of what people are saying to them to make it work. Conversations. Some people don't always have time to sit down and listen to what that person needs and that's what they need the most. Sort of like an assessment should be done, maybe before they leave to find out, exactly, what they need-what areas are lacking, and how it can be resolved. (Leeway Staff)

Compassion

The most important thing is wanting to feel appreciated and loved and that somebody cares for you. (Leeway Staff)

It is amazing the satisfaction you get when you take them out, see them bowl, exercise, laugh, treat them like themselves, introduce them to your friends. They feel that this person really cares for me. They [then] want to be part of society. (Leeway Staff)

Consistency and continuity

I never let go of my patients…. They could get stable. But they always touch base with me. They—one point or another down the line, they're gonna touch base with me. (Community Case Manager)

I take the help with the caseworkers getting an apartment. I've had four caseworkers since I started and they've all been great. If you have a problem, they're sincere and they really try to help you. They follow through. They just don't say, 'Here you go', and then that doesn't work out. I've never had a problem where I had to come back again and again. It was just the first time. (Community Member)

Doing with, not for

I want you to be able to know how to get the things that you need. ... You have to help yourself. And I have to message that to these clients. I'm hoping that they're walking away with the knowledge. (Community Case Manager)

It's never, I know you can't read. I'll read this book to you. It's, we can look at this together. (Provider – Library)

Empowerment

It's kind of like they want the information but they don't want you to be representing them because they don't want to feel as if they're less than capable. (Community Case Manager)

I mean, you can give them the groundwork for it, but for them to actually take initiative and say, hey, look, you know what? I'm going to take care of myself and do what I got to do and it's cool to see because somehow, some way, I had something to do with that. Even if it's a tiny bit, you know what I mean? (Leeway Staff)

Give and Receive

It gave me a sense of community and it's broadened my scope in being patient, with understanding people. And not to make a quick judgment at first glance. (Community Case Manager)

And I also love that we really give people an opportunity to get involved in the community in a really important way. Our volunteers will tell you that it's one of the more rewarding things that they do. Because you're bringing people food they're so happy to see you, they're so grateful. It's really a mutually lovely thing. (Provider – Health and Nutrition)

As they are learning from me, I am definitely learning from them. (Leeway Staff)

Once I saw the facility, I wanted to be a part of it. It is the idea of giving back... you always receive more when you give. (Leeway Staff)

Goal Setting

To see a few people that achieve what they want, especially when you get to know them a little bit, you know, from where they were at, where they came from and now they're, you know, they got their own place and they're paying for it, they're making their own dinners, they're making their own lunches, they're taking care of themselves, they're going shopping, they're doing this, doing that, and like that's the whole thing. (Leeway Staff)

Along that bridge would be small goals, what do you want to do? What do you-where do you want to be? Do you want to be here forever? Do you want to be a little bit more on your own? They want to be on their own. They want to be healthy and in some cases I see some of our resident care patients have been able to do that, so it's having little goals and how to get there. So, if it's, I don't know, let's say, you know, well, I want to exercise more. Okay so your diet is there for you and everything so how do you want to do that? What do you want to do? Do you want to start walking up and down the block and then around the block? So, that kind of thing, you know, just small goals that are achievable and there to help them or answer them, where do I go from here kind of thing? And let them take responsibility. (Leeway Staff)

Greater than the Sum of Our Parts

I literally find programs that help 6,000 individuals. Can't do that without partnerships and without support to us. It's just… We can't. So, we have other partnerships. (Provider – Cultural)

You know, we've got to keep in contact more with the community, because this is—you know, it's holding hands.... You know, it's a chain reaction. You know, we help each other. We're all in the same family. I don't mind helping anybody, you know what I mean? But you know, we've got to help each other. So to make it easy for the patient, especially the difficult ones, because if we don't keep our eye on them, they'll go back to drugs, they'll go back to alcohol. (Community Case Manager)

Hope

Each day we wake up, we're given another chance. (Leeway Staff)

I tend to be a little bit more on the positive side. I try to do the motivational interviewing aspect of it so that I'm only focusing on the positive. the more you focus on the negative that's going to just keep your attitude down and keep your -- everything is going to be on the negative. You're not going to see that little glimmer of hope, that little light, that one little thing that you can turn around might be that change. (Community Case Manager)

Meet me where I am at

I purposely have magazines right there, because magazines have pictures and some of our patrons cannot read. (Provider – Library)

We're dealing with a population that is not easy to deal with. So, we just gotta meet them where they are and try to work with them. Try to break that ice, you know? My first goal is for them to trust me. Once I bring that trust, I got them. They're mine. I could work with them. They'll listen. ... I'll tell them a joke, you know what I mean? And make them feel confident ... Make them feel like when they come and see me I listen to them— …what you got to say? What you need? What's the best thing? You tell me? Cause sometimes a client will tell you how to do things a lot easier than the way we are taught to do so by paper. A lot of times you've got to listen to what they gotta say. A lot of times they talk too much, but a lot of times they want to just let it out. (Community Case Manager)

Optimism

The one day came from a long process. One of my residents came down and was talking to me and said, 'I'm just really proud of myself." And I said, "Oh, that's wonderful! What in particular is making you feel so proud?" And she said, "When I first met you, I couldn't ride the bus, I didn't go outside, I didn't walk really anywhere, I was involved in all of these dysfunctional relationships. And now, I'm putting myself first. And I'm making these strides." And now she can ride a bus. It didn't happen overnight. And now she walks. She had a physical disability due to her HIV and barely walked at all. And she is just up and about and all around and actually has the greatest struggles yet is the most determined. (Staff)

Life is short. You've got to live it. No matter what you're going through or what's going on in the world. You've got to live it. You know, everybody don't get that second chance so you just got to go day by day and live your life. (Leeway Staff)

Peer Support

It doesn't make no sense for you to be out there fighting this alone. (Community Member)

And that's where you really, kind of, toe the line up. Like, ooh. Like, how do I... How do I make your life awesome but then still follow the rules?... Because your life affects your neighbor's life. And, you know, the one down the hall. And it's—it's hard. (Leeway Staff)

Well, I think of the—one of the biggest reasons why people come through the door is through word of mouth. Okay. We do get some referrals from other agencies. Like, AIDS Project New Haven and from, you know, hospital. (Community Case Manager)

It started off with a group of individuals that were mostly all Puerto Rican who had traveled here from the island and wanted to create a sense of home for their family and friends and communities who were making the trip here. Because resources were limited, jobs were limited, they wanted to be able to have more options. And so they needed to make way, you know, this was four and a half decades ago. And they wanted to make sure that the individual didn't get lost when they arrived here. (Provider – Cultural)

Person-directed

So it's not a matter of finding always just cookie-cutter people into different roles. You have to really kind of fine-tune things to what their strengths and abilities are. (Leeway Staff)

I felt like if I hadn't been involved with him he never would have gained any more skills. I think he was isolated and by seeing him just flourish and be able to slow down, form his words, and I started to see other people begin to take the time to talk to him. Even though he was always out and about, I think in his own world he was isolated because of his communication skills. So that's what motivated him to want to work. Finally somebody was paying attention to him and giving him these strategies that he hadn't had before. And he liked the attention too. (Leeway Staff)

Seamless Service

If I refer them to a particular agency I ask them to please let me know how it went. I will first call. I do not do blind referrals, I will call and see if they still exist. See if they have changed their rules. I will take a moment to do that. So, I will call that food bank, 'is such and such still available?' Oh no, who is this? Do they still need IDs or no IDs. What time can they go what time can't they go? With some folks I am able to write it down. Some folks are really verbal. Some folks I have to draw a little map of how to get there. You just have to be creative. (Community Case Manager)

My success is based on how well I work with those out there by nurturing those contacts. (Community Case Manager)

Trust

I've had times where I've been able to really engage, and have people open up about themselves, and trust me with telling their story to me. … Helps them feel like they are not alone and it helps them stay well. Everybody needs connections and people in their lives they can trust and open up to. ... Just laughing and having fun gives them a purpose. (Leeway Staff)

I always have someone to talk to, whenever I am feeling anxious or need someone. (Community Member)

Alignment with State of Connecticut Initiatives

Leeway, Inc. was awarded a diversification grant, funded by the Connecticut Department of Social Services (DSS), to develop a model of community care that includes a robust community case management program. The program emphasizes personal empowerment, through health literacy and coaching, to prepare individuals to return successfully to the community by extending person-directed chronic care management services. As such, alignment with multiple state initiatives is paramount. Please see the appendix at the end of this document to see how the project directly aligns to the following key initiatives.

STATE INNOVATION MODEL (SIM)

The vision of the SIM is to: "Establish a whole-person-centered healthcare system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and health care; and improves affordability by reducing healthcare costs." The design is the product of two years of intensive input from multi-disciplinary experts and consumers. The phases of SIM move healthcare offered by the state from: 1) a fee for service model; to, 2) accountable care; and ultimately to, 3) health enhancement communities.

RIGHT SIZING AND REBALANCING

Governor Malloy is leading a comprehensive and legislature-supported rebalancing plan. In support of this plan, nursing facilities are required to diversify their services so that they participate in less costly home- and community-based trends. The goal is to transition individuals out of institutional settings and into community settings with appropriate supports. A relatively small number of individuals use long term care services and supports (LTSS) (~5%), but associated costs are a significant portion of the Medicaid budget (~45%). These individuals have high needs and high costs and benefit from coordination of service and supports. The average cost to support these individuals in the community (~$4,000 per month) is less than in an institution (~$6,250 per month).

BALANCING INCENTIVE PROGRAM (BIP)

Funded through the centers for Medicare and Medicaid, the state of Connecticut was awarded $77.07m in grant funds to initiate: No Wrong Door, conflict-free case management services, a core standardized assessment instrument, expansion of community LTSS, and the development of infrastructure for a more streamlined process for clients seeking community LTSS. BIP allows the state to take a systems approach to support peoples' need to access and use information. The key components of this plan include a pre-screen, universal application, Medicaid application, universal assessment, eligibility determination, and a care plan.

NO WRONG DOOR (NWD)

NWD supports the state's rebalancing plan by helping people access services, healthcare, and a higher quality of life through coordination of existing resources and strengthening the network. NWD recognizes the uniqueness of place in each of the 169 Connecticut towns and thus it is regionally based with the goal to understand how wrap around care is currently conducted in each community. There are four classifications of organizations and individuals: influencers, connectors, navigators, and providers. Influencers help lead initiatives and may have budgetary control. Connectors are common places where individuals tend to frequent and/or cluster. Examples of connectors include Dunkin' Donuts and libraries. The state will provide common materials at all connector locations that connect individuals to navigators. Navigators are identified by the state, help lead the initiative, and build capacity. Leeway, Inc., Mary Wade, United Way, and AAA have been invited to be navigators in New Haven. Navigators work with individuals to identify needed supports with the goal of building autonomy and empowerment. Providers offer services and supports.

NWD is fundamentally about coordination of a network and use of common language. NWD is presently in a pilot phase. Invited navigators have been asked to sign a memo of understanding which insures participation, provides person-centered training offered by the state, and includes agreement to be a part of a living lab with other state-wide navigators and to offer common information at no cost. The ultimate goal is to keep individuals out of institutions. My Place CT is the central hub of information. One goal is a 30-day cycle from the time an individual walks through a door to inquire about services and supports to the time they first receive and pay for supports.

MONEY FOLLOWS THE PERSON

Money Follows the Person (MFP) is a program encouraged by the federal government that supports right sizing and rebalancing[1] with a 'housing plus supports' model. At the core of MFP is consumers' informed choice and control supported by a transitional team of a specialized case manager, transition coordinator, and if needed, a housing coordinator. Under MFP, the state funds the following services: transitional funds; addiction services and supports; peer supports; and, a transitional recovery assistant. As the sustainability of the plan is tested, promising strategies include: community collaboratives, social determinant interventions, and collaboration with the NWD Initiative. A number of challenges inhibit transitions from institutions.

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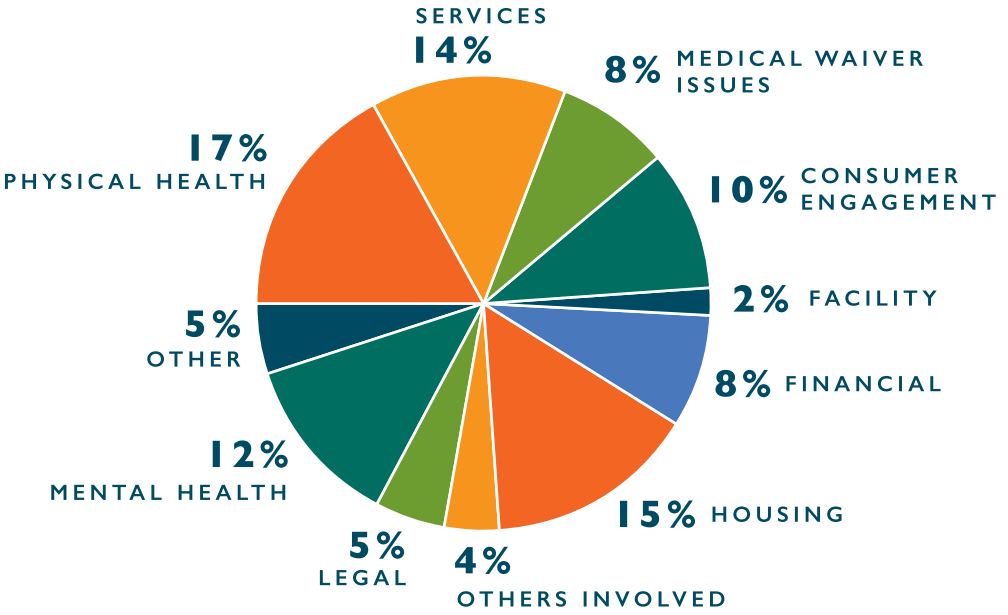
[1] Governor Malloy's budget includes four initiatives that will strengthen the state's rebalancing efforts by reducing the high cost of medication administration and aligning the state's medication administration policy with the principles of person-centered planning and consumer choice: (1) reducing the reimbursement rate for medication administration, (2) allowing agency-based personal care assistants (PCAs) to administer medications in the home, similar to the PCAs under the PCA waiver where the care is self-directed, (3) permitting nurses at home health agencies to delegate administration of medication to home health aides, and (4) allowing clients to gain a higher level of independence at less cost by utilizing assistive technology such as medication reminders and automatic pill dispensers when it is cost-effective.

TRANSITION CHALLENGES BY TYPE



Benchmarking reveals the trend is moving in the desired direction. Second quarter reporting for 2015 revealed that since 2007 the population of individual's receiving home and community care funded through Medicaid increased from 33% to 45%. Additionally, the same quarter of reporting showed that since 2007discharges to the home increased from 47% to 53%. A third benchmark reveals that in 2007 28% of SNF admissions returned to the community within 6 months, while at the second quarter of 2015, 36% had. A fourth benchmark shows that 60% of individuals receive LTSS in the home and community (a 8% increase from 2007).

PRESUMPTIVE ELIGIBILITY (PE)

Presumptive Eligibility (PE) is a pilot program of MFP that allows individuals to access LTSS while their Medicaid application is being processed. By doing so, individuals can be discharged from hospitals to the community and their home, rather than to an institution, and maintain a continuity of care through access to services and supports. This service significantly cuts costs from those accrued at a facility. As the pilot is underway, data being analyzed by the state includes the identification of: individuals stuck in the system; barriers to community discharge; identification of individuals eligible for PE.

COMMUNITY FIRST CHOICE (CFC)

Started within MFP and under an allowance from the Affordable Care Act[2], states are enabled to implement a new Medicaid entitlement that is person-centered and self-directed. All individuals that meet Medicaid level of care[3] are eligible. The maximum allowance, without further need, is $5,818 per month, which

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[2] CFC is not a part of right sizing and re-balancing in that it is not necessarily a cost savings, although it is intended to change health outcomes and to de-institutionalize individuals

[3] If an individual meets the minimum requirements for level of care, then they are eligible for nursing placement or home based services funded by Medicaid. Level of care is based upon competency of five activities of daily life (ADL): bathing, dressing, toileting, transferring, and eating. The minimum requirements for level of care include: 1) cueing and supervision only, plus a need factor, for 3 or more ADLs; 2) hands on assistance, plus a need factor, for 2 or more ADLs; and, 3) a cognitive impairment that requires supervision plus a need factor.

matches the cost to cover an individual in a nursing home for the same period of time. PCA, ABI II, and CHCPE waivers have been amended to reflect this new entitlement, as CFC is not waiver based. Presently, access agencies, elder care attorneys, and diversification grant recipients are the only providers informed of the program to insure a slow roll-out.

Applications can be made online and through 211[4]. The application process includes a screen for care, confirmation of Medicaid eligibility, and a visit by a social services level staff member[5] who conducts a universal assessment (UA). The UA, which is also being used by MFP, continues to be revised and tested at the state level to insure workability. Present average wait time from time of application to delivery of first service is presently 4 months[6].

Contracted agencies, friends, or family members of the individual offer services and supports. The service providers are chosen by the individual[7] and are no longer judged by the state. Services and supports include for example: personal attendants (PCAs), personal emergency response systems (PERS), and home delivered meals[8]. A worker's compensation policy is built into CFC. If a service provider works more than 25.75 hours per week, then they must be covered by worker's compensation. While this is an added expenditure of the individual's budget, it also provides a continuity of care that was previously not an option.

The development of the plan for services is person centered in that it is: directed by the individual, non-medical, goal driven (not task driven), and guided by the goal of increasing overall health outcomes and the individual's quality of life in their home. The social services worker who conducts the assessment provides support, coaching, and planning assistance. CFC is a fundamental shift from 'serving for' to 'serving with'.

TESTING EXPERIENCE AND FUNCTIONAL TOOLS (TEFT)

TEFT is an initiative of DSS and DHS, in partnership with University of Connecticut Center on Aging and the University of Connecticut School of Nursing, to field-test a beneficiary experience survey for validity and reliability and identify, evaluate, and harmonize an electronic LTSS standard that aligns with the Office of National Coordinator's Standards and Interoperability Framework.

MY PLACE

My Place is a website[9] that gives people access to information that supports their informed choice with a comprehensive list of LTSS. The website will ultimately include information on eligibility, results of functional assessments, and implementation of personal health records.

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[4] 211 is the only Spanish speaking option

[5] Social services level staff members from South Central are presently conducting all visits and assessments in the city of New Haven.

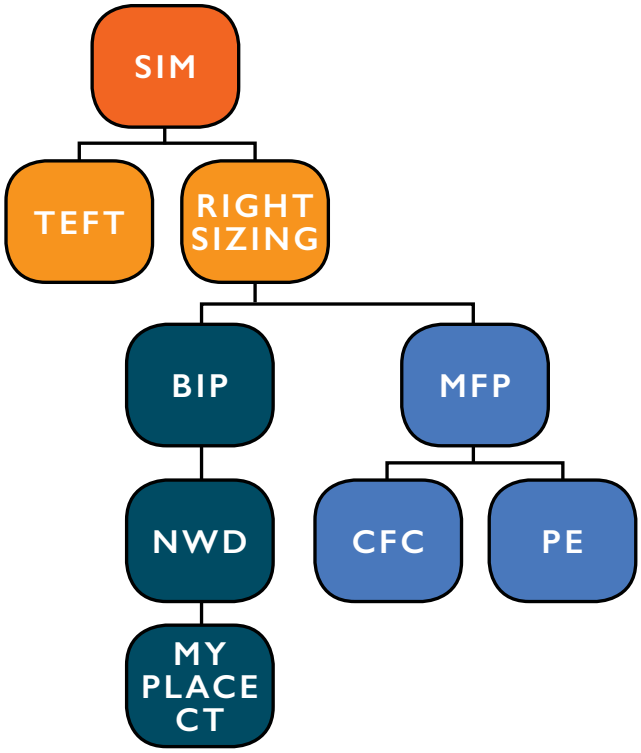
[6] The current wait time from application to delivery of services for X is a minimum of 2 years.

[7] The only two individuals who cannot offer the supports and services is a spouse or a conservator. Ex-convicts may be chosen after signing a waiver.

[8] A full list of services can be found at X

[9] http://www.myplacect.org

CONNECTIVITY OF STATE INITIATIVES



KEY GOALS OF STATE INITIATIVES

- Improve effectiveness and efficiency of Connecticut's Home and Community-Based Services (HCBS) system
- Increase hospital discharges to the community vs institutions
- Transition 8000 people from nursing homes to the community by 2020
- Increase probability of returning to community within the first 6 months of institutionalization
- Build capacity in the community workforce sufficient to sustain rebalancing goals
- Increase availability of accessible housing and transportation
- Adjust supply of institutional beds and community services and supports based on demand projections

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[10] There have 3436 Transitions as of 5/10/16

[11] Information in this section has been pulled from the following sources:

Connecticut State Innovation Model. 2002, 2016. http://www.healthreform.ct.gov/ohri/site/default.asp.

Legislative Office Long-Term Care Planning Committee Meeting. 2015. *Medicaid Long Term Services and Supports Rebalancing Initiatives*.

Marsh and McLennan Companies. 2012. *State of Connecticut Medicaid Long Term Care Demand Projections Mercer Report*.

State of CT Department of Social Services. 2013. *Strategic rebalancing plan:A plan to rebalance long term services and supports 2013-2015*.

State of CT Department of Social Services. 2016. *Community First Choice: My Service Planning Tool Kit*.

State of CT Department of Social Services. 2016. *Connecticut HUSKY Health: Improving Outcomes, Enabling Independence and Integration, Controlling Costs*. State of CT Department of Social Services. n.d. Rebalancing under Money Follows the Person. White Paper.

STATE INITIATIVE	STATE STRATEGY / GOAL	PROJECT ALIGNMENT	PROJECT PHASE
SIM, CFC, NWD	Develop a person-centered healthcare system that is directed by the individual, non-medical, goal driven (not task driven), and guided by the goal of increasing overall health outcomes and the individual's quality of life in their home	Co-Create a community living model with the voices of all stakeholders; Thoroughly understand the target population and the current healthcare system in New Haven; Create and deploy a wraparound care management family aligned with evidence based person-centered care models	Throughout
SIM	Ensure superior access, quality, and care experience	Expand the continuum of care; Build on community strengths identified through an appreciative inquiry methodology; Create PODS (places of dynamic services) by broadening and building existing bridges of the local care continuum; Increase awareness; Implement and evaluate the new model through feedback loops	Throughout
SIM, CFC, NW	Empower individuals to actively participate in their health and health care; fundamental shift from 'serving for' to 'serving with'	Listen to the target audience to hear their needs and wants; Walk side-by-side, and ultimately behind, individuals; build upon existing trauma informed care and motivational interviewing techniques presently used by local care management teams	Phase 1 – Needs Assessment, Project Visioning, and Program Design; Phase 4 - Program training and deployment
SIM, MFP, CFC, BIP	Develop and test a universal assessment of an individual's well-being and personal goals	Work with agencies utilizing existing state assessment tool and provide improvement feedback to the state	Phase 4 - Program training and deployment; Develop programs that will empower individuals to dream and identify their goals
SIM, Right Sizing and Rebalancing, MFP, PE	Improve affordability by reducing healthcare costs	Evaluate and incorporate other care models that have a proven business case of reducing healthcare costs	Phase 1 – Needs Assessment, Project Visioning, and Program Design; Phase 4 – Program Training and Deployment
Right Sizing and Rebalancing	Transition individuals out of institutional settings and into community settings with appropriate supports	Partner with YNHH discharge planners and social workers, as well as community wide care managers, to evaluate the point of discharge with a goal of transitioning more individuals to the home; Focus on enhancing the time between medical intervention so that it is centered on individual well-being	Throughout
BIP	Conflict-free case management services	Evaluate and incorporate other care models that are focused on conflict-free case management; Adopt elements of exemplar cases. Develop guiding principles for the Community Living Model and PODs that will address conflict free case management services	Phase 1 – Needs Assessment, Project Visioning, and Program Design; Phase 2 - Project infrastructure: people, partners, and process; and Phase 4 – Program Training and Deployment
BIP, NWD	Expansion of community LTSS, and the development of infrastructure for a more streamlined process for clients seeking community LTSS	The PODs will work to advance a streamlined process. Based on need and gaps, we will pilot and expand innovative services and workforce development in areas such as coaching, peer support, and wrap around care management	Phase 4 – Program Training and Deployment; PODs development; Marketing/Awareness Campaign
BIP, MFP, NWD	Systems approach (community collaboration) to support peoples' need to access and use information	Multiple stakeholder representation; Broadening and building formal and informal bridges; Refraining from duplication of services; Shared values and vision and communal effort towards change; Development of PODs	Throughout

STATE INITIATIVE	STATE STRATEGY / GOAL	PROJECT ALIGNMENT	PROJECT PHASE
NWD	Identification of influencers, connectors, navigators, and providers in the city of New Haven	Extensive effort to map the city according the NWD buckets as well as well-being buckets	Phase 1 – Needs Assessment, Project Visioning, and Program Design; Phase 2 - Project infrastructure: people, partners, and process
MFP	Social determinant intervention	Preventive modeling, Qualitative Analysis, Quantitative Analysis, GIS Mapping; Focus on developing and aligning supports needed during the time between medical interventions	Phase 1 – Needs Assessment, Project Visioning, and Program Design; Execution of Project infrastructure
MFP, CFC	Consumers' informed choice and control supported by a transitional team of a specialized case manager, transition coordinator, and if needed, a housing coordinator	Train staff who will implement the assessment in positive psychology and coaching	Phase 3: Project Launch: Planning, Positioning, and Kick Off; Phase 4 – Program Training and Deployment
PE	Individuals discharged from hospitals to the community and home while their Medicaid application is being processed	Partner with YNHH discharge planners and social workers, as well as community wide care managers, to better the point of discharge with a goal of transitioning more individuals to the home	Phase 4 – Program Training and Deployment
PE, CFC	Maintain a continuity of care through access to services and supports	Assess the continuity as it is today and dream into the ideal future, create objective steps towards the ideal, then implement these steps	Throughout
PE	Gather and share data with the state on individuals stuck in the system, barriers to community discharge, and identification of individuals eligible for PE	Regular reporting according to grant deliverables as well as ongoing communication with contacts at DSS	Throughout
TEFT	Field-test a beneficiary experience survey for validity and reliability	Project will be aligned with TEFT and support field testing as needed	Phase 2-Project infrastructure
TEFT	Identify, evaluate, and harmonize an electronic LTSS standard that aligns with the Office of National Coordinator's Standards and Interoperability Framework	Project will align with technology interventions developed through TEFT and utilized in the continuum of care in New Haven	Phase 1- Needs Assessment; Phase 2 - Project Infrastructure
My Place	Access to information that supports informed choice with a comprehensive list of LTSS	Through the needs assessment we will identify influencers, connectors, navigators, and providers in New Haven that will support access to information and informed choice	Phase 1- Needs Assessment; Phase 2 -Project Infrastructure

HPG & CAMA

HoodenPyleGil (HPG) and CAMA are fortunate to have the opportunity to work with the pioneering leadership of Leeway and are excited to continue to unfold the Living Storybook with all stakeholders and the city of New Haven.

HoodenPyleGil is a systems research and innovation lab. The company's mission is to seed extraordinary breakthroughs by inspiring individuals, organizations, and communities to thrive. At HPG's core is our approach: to promote human dignity and shared humanness as the tie that binds multiple stakeholders in collective co-creation of desired solutions. HPG was founded with the global expertise and passion for driving culture change through the use of qualitative and quantitative data and experiential group learning. HPG's core competencies are aligned with sustaining positive change on an individual and systematic level. It's core services include: qualitative field research; data and performance improvement design; program visioning and design; grant development; community mobilizing; stakeholder analysis; partnership development; designing and facilitating dynamic and engaging work groups; and overall project management.

CAMA is a design lab, studio, and collection based in New Haven, CT. We strive to design a LIFE INDOORS where all can thrive and flourish. We seek to design interior spaces and products that improve our health and wellbeing. For over 30 years, CAMA designers have investigated the different ways in which the built environment influences how people live, learn, work, play and heal. We utilize credible research to make decisions about the built environment to achieve the best possible outcomes. CAMA designers anticipate emerging trends and deftly adapt to our clients' changing needs. As the body of knowledge that supports the impact of design on human behavior grows, CAMA is well-poised to use this intelligence to further improve health and wellbeing indoors.

Leeway

Leeway, Inc. was the first non-hospital facility in the state of Connecticut to accept patients with HIV/AIDS. The original, and still to this day ongoing, mission is "to bring dignity, respect, and even hope to a population that had few positive experiences in their lifetime" . A current staff member reflects on this when saying, "I think it's the opportunity to help a population that really was shunned and was hopeless and I really think that we give them something to live for." The founder and pioneer, Catherine Kennedy, worked ruthlessly to make this happen as she firmly believed in working for people not profit and serving those who otherwise are not served.

Throughout its history, Leeway, Inc. has consistently managed patients with multiple chronic illnesses, substance abuse, and mental illness—those who are also burdened with the stigma of being feared and less than desirable. On this, a resident said, "It's always a great day here. Because you don't know what the community out there feels about you but in here, they accept you with open arms and I like that." Evolving from opening a facility, Leeway, Inc. has also: successfully restructured reimbursement, effectively lobbied to change policy and laws, been awarded grant dollars from the state, and acquired philanthropic dollars to support operations and future plans. They have evolved from a skilled nursing facility to add on 10 beds, to build a residential care wing, and then to manage X# of supportive housing facilities. They have also transitioned from providing strictly medical care and medication administration to social work, therapy, drug addiction expertise, and case management.

This history speaks to the reason Leeway, Inc. is a recipient of a State of Connecticut Department of Social Services Nursing Home Diversification grant and why Leeway, Inc. has been chosen as the convener of the Community Living Model Project.

Leeway

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Learn more at www.leeway.net

HPG HoodenPyleGil

Connecticut Department of Social Services
Making a Difference

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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CT TEFT

MFP MONEY FOLLOWS THE PERSON