Living Storybook

Living Storybook

The living storybook is 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. 'Living' in that it is being written as the change occurs. And, a 'storybook' in that we emphasize the value of stories to, "entertain, teach, pass on wisdom, record history, represent beliefs, explore new ideas, share experiences, build community, express creativity, and heal"[1].

The living storybook is a record of the change towards a healthier community as it occurs. This includes steps taken, questions that have been asked, questions to be asked, sticky problems, and successes along the way. Vignettes that evoke the human spirit of those in the community are scattered throughout to ground the project in our common goal of supporting individuals with multiple chronic illnesses to thrive. In the photographs, we see our neighbor and partners in the project.

All involved are co-authors, and thus, the living storybook represents the collective voice of individuals, organizations, and the community. Each major step we take is captured in its own chapter and all subsequent chapters will build upon what has previously been written. In this way, the living storybook creates linkages that reveal co-creation, knowledge sharing, transparency, and accountability.

MY SOUL HONORS YOUR SOUL. I HONOR THE LIGHT, LOVE, TRUTH, BEAUTY AND PEACE WITHIN YOU, BECAUSE IT IS ALSO WITHIN ME. IN SHARING THESE THINGS WE ARE UNITED, **WE ARE THE SAME, WE ARE ONE.**

- Hindu greeting

Contents

THE SECRET OF CHANGE IS TO FOCUS ALL OF YOUR ENERGY, NOT ON FIGHTING THE OLD, BUT ON **BUILDING THE NEW**

- Socrates

Introduction

Kyle*

I TAKE 13 PRESCRIPTIONS EVERY DAY FOR PSYCHE AND BLOOD PRESSURE. I USED TO HAVE HEPATITIS C. IT WAS CURED BUT LAST YEAR I TOOK A PILL THAT COST $1000 SO IT COST $180,000 OVER SIX MONTHS. AND WITHOUT INSURANCE, I DON'T KNOW WHAT I WOULD HAVE DONE. IT CAME TO MY LIVER TO THE POINT THAT I HAD STAGE FOUR SCLEROSES AND THAT'S SOMETHING THAT I THINK ABOUT EVERY DAY.

I GET TO THE POINT WHERE I'M SICK OF BEING ON ALL THESE MEDS, ESPECIALLY THE PSYCH MEDS BECAUSE SOMETIMES THEY MAKE ME A ZOMBIE. IN THE PAST, I'VE HAD TIMES WHEN I SAY, "I'M FINE NOW AND I DON'T NEED THESE." AND I THROW THEM ALL AWAY. AND THEN I HAVE A PROBLEM. MY FAMILY JUST LOOKS AT THE CALENDAR AND SAYS, "WITHIN THREE MONTHS SOMETHING IS GOING TO HAPPEN BECAUSE I GET VERY MANIC TO WHERE I HALLUCINATE AND STAY IN BED FOR A WEEK.

MY KIDS, I HAVE TWO KIDS, 13 AND 14, THEY'RE MY WHOLE LIFE. THAT'S MY MAIN FOCUS IN MY LIFE. **MY FAMILY IS VERY IMPORTANT TO ME** NOW BECAUSE FOR A LONG TIME THEY DIDN'T WANT TO KNOW MY NAME BECAUSE OF THE WAY I USED TO LIVE. SO MY FAMILY'S VERY IMPORTANT AND I VALUE IT A LOT. IF I'M ACTING WEIRD OR SOMETHING, THEY'LL SAY, "WHAT'S THE MATTER?" "ARE YOU OKAY?" **IT FEELS GOOD TO HAVE TRUST BACK. THEY TRUST ME NOW.**

* Name and identifying information has been changed to maintain anonymity

How do we support individuals to thrive and flourish in community?

Big Question
By asking this question, we seek to understand how we may align our work with existing city efforts—such as the City Transformation Plan, Healthier Greater New Haven Partnership, and CARE—and state efforts—including Money Follows the Person, Community First Choice, and No Wrong Door—to support an individual's capacity to thrive and flourish within the City of New Haven. To thrive means to live within an optimal range of human functioning, one that simultaneously connotes goodness, generativity, growth, and resilience[2]. The core elements of well-being that support thriving include: psychological (agency, satisfaction, self-respect, and capabilities); physical (nourishment, shelter, health care, clothing, and mobility); and, social (participating in the community, being accepted in public, and helping others) [3].

Strength of Leeway
To contribute to this dream, Leeway and multiple stakeholders are working together to co-create a Community Living Model that will provide wrap around services and supports to individuals living with multiple chronic illnesses. Leeway is respected as a pioneer in the city. The nursing home is spoken of in high regards for its accomplished history of serving people with multiple chronic illnesses. The strengths and skills it takes to do so, while adapting to an ever-changing state of healthcare and reimbursement, is noteworthy. Because of these strengths, Leeway has been awarded a diversification grant funded by the Connecticut Department of Social Services (DSS). Leeway's mission has heretofore been dedicated to caring for those with HIV. As Leeway diversifies its services, the organization will move beyond caring for an individual with any one disease. Leeway's raison d'être establishes the soul of this project.

Goal
The project emphasizes personal empowerment, through health literacy and coaching, to prepare individuals to successfully return to the community by extending multidisciplinary care management services. The goal is to decrease hospital discharges to nursing facilities by 1.5% and to contribute to the statewide goal of transitioning 8,000 people from nursing facilities to the community by 2020. As the first step in achieving this goal, we ask the community to dream with a question, "What could the time between medical interventions look like so that it is filled with: a supportive, reliable, and loving social network; healthy options that support the mind, body, and spirit to thrive; and, a safe place to call home?" To achieve this dream, together we will increase choice, include a person-centered approach, and expand the existing continuum of long-term care services and supports.

Vision
With stakeholders at all levels and through all stages of the project we aim to develop Places of Dynamic Services that encourage healthy living through promoting personal growth and fostering security. The grand vision is then to design and build a Place of Well-Being that serves as a one-stop shop for individuals with multiple chronic illnesses. As we know, navigating the medical system can be trying, difficult, and confusing. This is true for any one of us and is particularly magnified for individuals who also live with mental illness, substance abuse issues, or a lack of knowledge on how to advocate for themselves.

Imagine a Place of Well-Being where individuals are welcomed with peace, calm, and belonging and are provided access to all required long term care services and supports offered in the community under one roof.

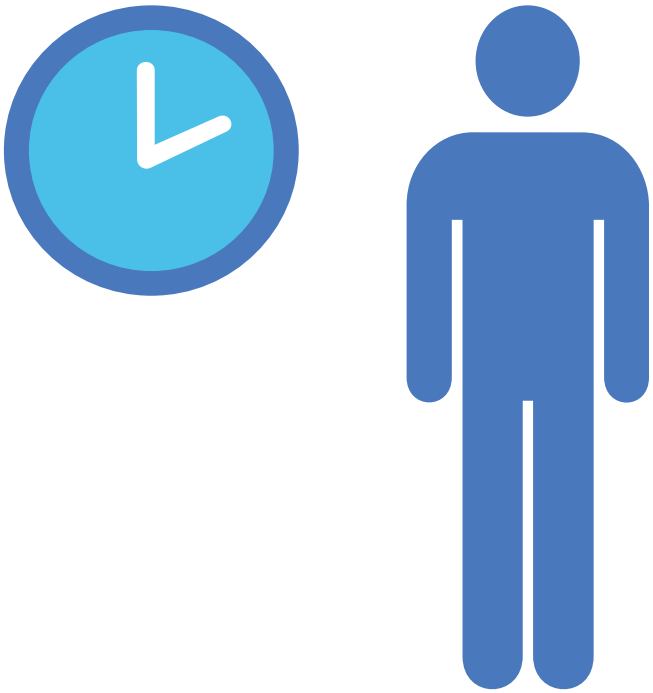
Strengths Based Approach

This project assumes a positive view and lens through which to look at existing strengths in the community. The premise is that together we can travel much further by building on our collective strengths than we can by trying to shrink our gaps. To support this view, we are using an Appreciative Inquiry methodology. 'To appreciate' is to recognize the full worth of something or someone and 'to inquire' is to explore and discover through questions, knowing that we find answers to the questions we ask. Appreciative Inquiry is strengths-based, artful in its search, collaborative in every aspect, inclusive, and generative. The methodology moves through four phases from discovery to dream to design and then destiny. We will carry Appreciative Inquiry throughout the entire change process.

During initial interviews participants shared high point stories of what works when things are working really well. Our main questions revolve around strengths of each partner organization, well-being, community and connections, and the dream of a Place of Well-Being. As the leader of this change, we began by asking about the strengths of Leeway and heard the voices of staff, residents, and alumni. From there, we branched out to case managers operating in the city and individuals who live with multiple chronic illness in the community. We continue to gather information and schedule more interviews so that the voices of all stakeholders are heard.

Co-creation

We also believe that co-creation through multiple stakeholder groups at all stages of the project is essential to long-term success. While we are reviewing exemplar cases to learn from past successes and refrain from reinventing the wheel, we know that scholarly literature [4], best practices [5], and failed initiatives [6] reveal that no amount of data-driven and evidence-based practices will insure a successful social change without the direct and early engagement of community members, as partners. 'Doing for' is a recipe for failure whereas 'doing with' supports accountability and ownership [7]. 'Doing with' also considers the local context that simply applying a best practice may not assume. Over time we will all advance the change together as trust is built, community ownership forms, and partners' capacities are pushed forward.



What could the time between medical interventions look like so that it is filled with: a supportive, reliable, and loving social network; healthy options that support the mind, body, and spirit to thrive; and, a safe place to call home?

Places of Dynamic Services (PODS)

PLACE OF WELL-BEING

CREATIVE ARTS PODS

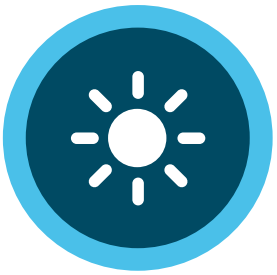
EDUCATION PODS

MEDICAL PODS

HOUSING PODS

SUBSTANCE ABUSE PODS

INSURANCE PODS



MENTAL HEALTH PODS

FOOD & NUTRITION PODS

INTEGRATIVE THERAPIES PODS

RECREATION PODS

PURPOSE PODS

SOCIAL SUPPORT PODS

SPIRITUALITY PODS

VOCATIONAL TRAINING PODS

THE BEGINNING
IS THE MOST
IMPORTANT PART
OF THE WORK

- Plato

Why Here?
Why Now?

Jada

EVERYONE THAT COMES IN THE DOOR IS A SPECIAL PERSON. I JUST HAVE COMPASSION. I HAVE FAMILY MEMBERS WHO LIVE WITH HIV. I HAVE A FAMILY MEMBER STRUGGLING WITH DRUG ADDICTION NOW. AND, MENTAL HEALTH ISSUES. YOU NAME IT I'VE SEEN IT. I'VE LOST A LOVED ONE DUE TO HIV. EVERY DIAGNOSIS I'VE DEALT WITH IT IN MY OWN FAMILY. SO I CAN'T HELP BUT BE COMPASSIONATE.

"Despite the resources Connecticut devotes to healthcare, consumers often face an uncoordinated and fragmented system."

"This system does not consistently perform well, as is witnessed by our high emergency department utilization rates, especially for non-urgent conditions; a relatively high rate of hospital readmissions and; significant racial, ethnic and economic health disparities. In addition, growth in healthcare spending has outpaced the growth of our economy. In 2012, healthcare spending in Connecticut was $29 billion, the third highest per capita among all states. These figures raise concerns about access to care and the long-term affordability of healthcare coverage. High healthcare costs also strain the resources available for other governmental programs such as education and housing, and threaten the ability of government to sustain social services and Medicaid benefits. Increasingly employers pass on the costs of insurance to employees and customers; and the competitiveness of Connecticut's business community is endangered" [8].

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.

To succeed, the goals of the state are:

- Transition 8000 people by 2020 (originally 700)
- Increase $$ to Home and Community-Based Services (vs. institutions)
- Increase hospital discharges to the community vs. institutions
- Increase probability of returning to community within 1st 6 months of institutionalization
- Increase % of LTSS users served in the community vs. institutions

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%

The average cost to support these individuals in the community

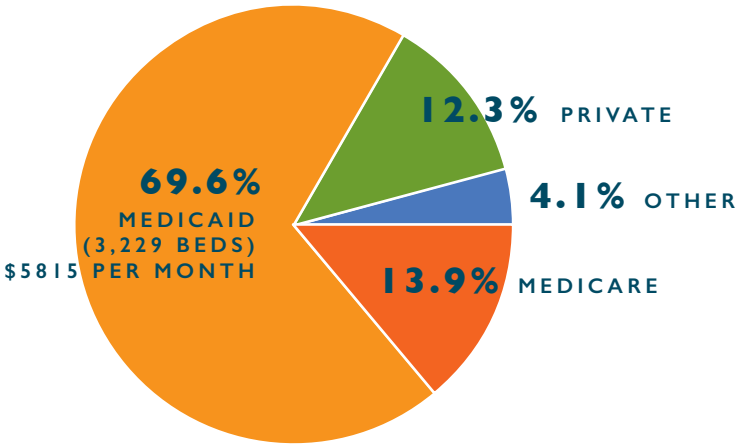
$ 4,000 PER MONTH

is less than in an institution

$$ 6,250 PER MONTH

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 2007 discharges 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).

FUNDING FOR NURSING HOMES [9]



NURSING HOMES IN GREATER NEW HAVEN [9]

39
NURSING HOMES

4,639
BEDS

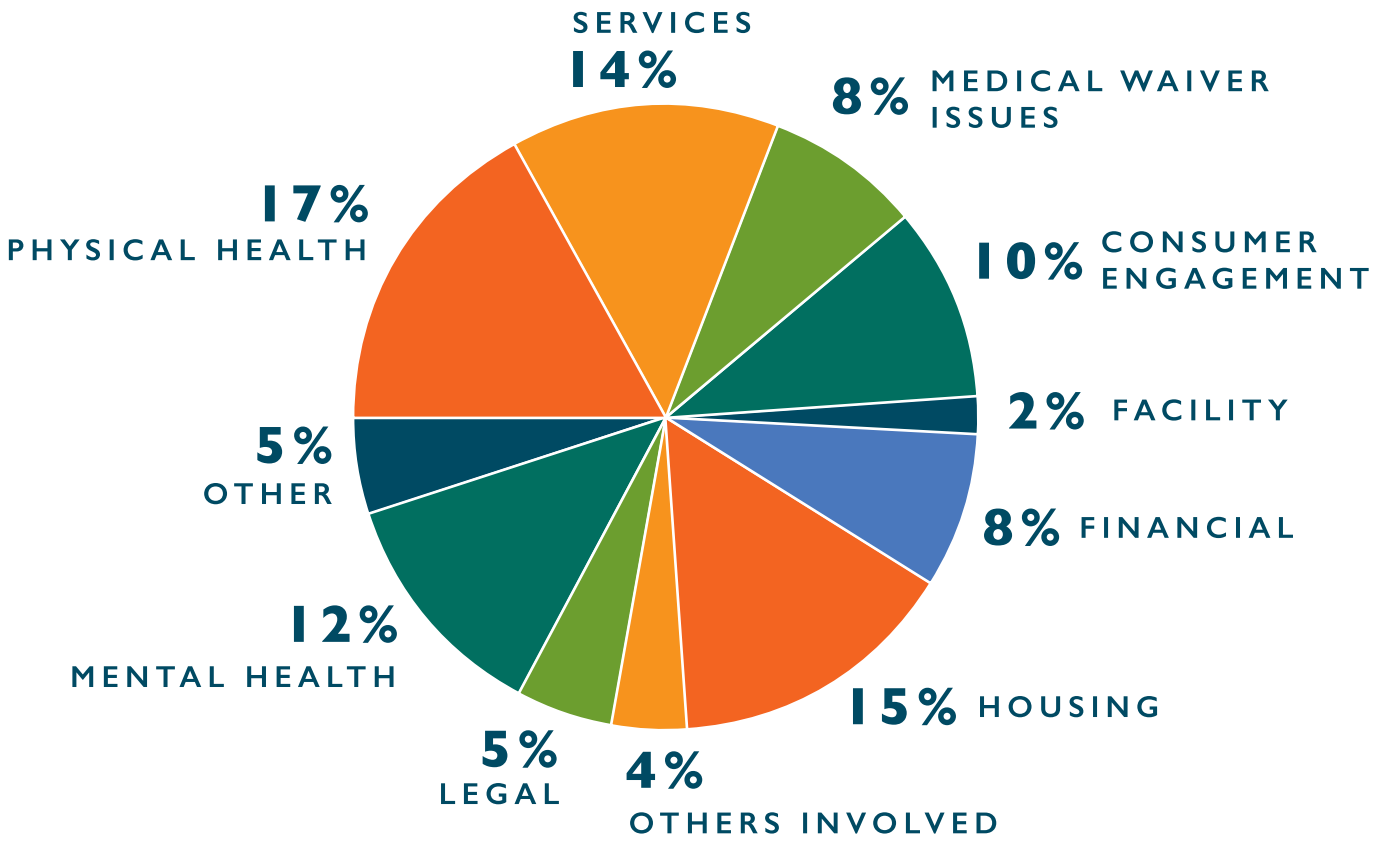
4,169
RESIDENTS

GOAL

Decrease hospital discharges to nursing facilities by 1.5% and to contribute to the statewide goal of transitioning 8,000 people from nursing facilities to the community by 2020

3436 TRANSITIONS AS OF 5/10/16

TRANSITION CHALLENGES BY TYPE



SOMETIMES YOU PUT WALLS UP NOT TO KEEP PEOPLE OUT, BUT TO SEE **WHO CARES ENOUGH TO BREAK THEM DOWN**

- Socrates

Project Phases

Maria

YOU KNOW WHAT I MEAN? **I LOVE MY PEOPLE**. I DON'T NEED PEOPLE TELLING ME HOW GOOD OF A JOB I'M DOING. I JUST NEED MY PATIENTS TO BE HEALTHY AND DOING WELL. AND WHEN THEY ALWAYS COME BACK TO ME, THAT IS MY REWARD. ONE PERSON HAD FALLEN OFF HIS HORSE. HE CAME BACK TO ME AND SAID, "I'M SORRY FOR FAILING." I SAID, "YOU DON'T GOT TO APOLOGIZE, MAN. YOU'RE DOING GREAT. KEEP DOING GREAT. A DOOR CLOSES TO OPEN MANY NEW DOORS." I SAID, "WE'LL START AGAIN." HE SAID, "OKAY." "I PUT 50 PERCENT, YOU PUT 50" I ALWAYS ASK MY CLIENTS, "YOU EVER HAD A BODYGUARD?" THEY GO, "A BODYGUARD? I'M NOT A MOVIE STAR! I DON'T NEED A BODYGUARD." I WAS LIKE, **"WELL, NOW YOU GOT A BODYGUARD. I'M YOUR BODYGUARD. SO WHERE YOU GO, I'M THERE."**

PROJECT PHASES

The project is laid out into 5 phases that span a 2 year engagement.

Phase 1:
Needs assessment, project visioning, and program design

Phase 2:
Project infrastructure of people, partners, and process

Phase 3:
Project launch including planning, positioning, and kick off

Phase 4:
Program training and deployment

Phase 5:
Pre-development and design of a Place of Well-Being

Ongoing:
Program evaluation including monitoring and reporting

Number of people met with to date

85

INDIVIDUAL VOICES FROM INTERVIEWS & FOCUS GROUPS

76

STAKEHOLDER MEETINGS

Represented stakeholder groups

- COMMUNITY AGENCY
- UNIVERSITIES
- HEALTHCARE
- COMMUNITY MEMBERS
- GOVERNMENT
- INSURANCE

Phase 1: Needs assessment, project visioning, and program design

The project is laid out into 5 phases that span a two year engagement. Phase 1 is currently unfolding as we simultaneously begin Phase 2. For the past three months, the grant team has been hitting the pavement to spread the word, align the project, understand the lay of the land, and to conduct Appreciative Inquiry interviews and focus groups upon which future action steps will be built.

Data for the needs assessment continues to be gathered. Within the needs assessment we will present research and evaluation of evidence-based care management, community-based well-being programs/ services, and optimal healing spaces. We will also more clearly align the Community Living Model with city- and state-wide initiatives to show how we can contribute and build upon existing efforts. A key component of this research includes developing a clear understanding of care coordination processes and technology currently within the local continuum of care.

Our target population is individuals living with multiple chronic illnesses that receive reimbursement from the state, and live within the city of New Haven. Information from DataHaven, CARE, CHIME, Robert Wood Johnson County Health Rankings, Centers for Medicaid and Medicare, the U.S. census, and other sources are presently being culled to answer a set of initial questions. As co-creation evolves, the many authors of this book will continue to ask more questions so that we find the answers we seek.

Phase 2: Project infrastructure of people, partners, and process

Building on the voices and stories collected from the Appreciative Inquiry interviews and focus groups, as well as continuing to compile a library of exemplar cases, alternative wrap around care management models, and successful shifts in reimbursement, the next steps include the deployment of action groups focused on implementing different aspects relative to the grand vision. Following deployment, we will transition to campaigning, implementing, and evaluating, with a focus on strong feedback loops where knowledge sharing and capacity building [10] is a driving force.

INITIAL NEEDS ASSESSMENT QUESTIONS

- What are the top 5 most prevalent chronic illnesses?
- What are the demographic breakdowns? (i.e. prominence within race? Sex? Nationality? Age?
- What is the density breakdown by zip code?
- What is the percentage of individuals living with multiple chronic illnesses who also suffer from mental illness? And what are the leading co-morbidities within this population?
- What is the percentage of individuals living with multiple chronic illnesses who also suffer from substance abuse? And what are the leading co-morbidities within this population?
- What is the percentage of individuals living with multiple chronic illnesses who also suffer from homelessness at one time in their life or more? And what are the leading co-morbidities within this population?
- What are the chief complaints for readmissions? And amongst those who are most frequently readmitted?
- What are the leading co-morbidities for those discharged to a SNF?

Care / Caring

Dignified treatment / Compassionate care / Ubuntu
Seeing an individual => recognizing where they are at => accepting them for who they are => and then achieving a sense of belonging

Gift of giving - The gift and meaning a giver receives from the act of giving

Healing - The action of an individual moving from a current state towards well-being, and the associated skills, positive attitudes, outside influences, and strategies that enable this action to happen

Ideal design of the time between - Practices in place, or suggestions for the future, that inform the way the time between medical interventions can be designed for well-being

Ideal wrap around care management - Practices in place, or suggestions for the future, that inform the design of ideal wrap around care management

Support - The many strategies that provide assistance, whether perceived directly in this way or not

Outcome of well-being

Proactivity and prevention - Steps/ actions/decisions that inhibit negative outcomes

Well-being - food and nutrition - Of or relating to food and nutrition traditions, practices, networks, and wishes that promote a sense of happiness

Well-being - physical space - Design elements, vibe / intangible feeling, and services included in physical space that leads to thriving

Well-being - social support - Members of a social community that provide support and the outcomes of being a part of a social support network

Well-being – spirituality - Reference to church or other spiritual concepts and the places they hold within individuals' lives

Well-being – wellness - Thriving as it pertains to physical health (not psychological or social) and all of the actions and support that lead to a healthy body

Community

Community - Meaning of the concept of community including definitions, aspects, and examples

Connected and relational city - Networks; development and maintenance of relationships, both individual and organizational, across stakeholder groups

Organizational thriving - Missions, skills, and capabilities that lead to a thriving organization

Thriving at Leeway - Missions, skills, and capabilities that lead to a thriving Leeway

Self

Perceptions of life and death - Living' in the here and now as there is this one life and it is finite

Self-direction - Accountability, empowerment, self-motivation, ownership that enable an individual to direct their own life

ITS BETTER TO **LIGHT A CANDLE**
THEN CURSE THE DARKNESS
- Eleanor Roosevelt

Visioning & Implementation

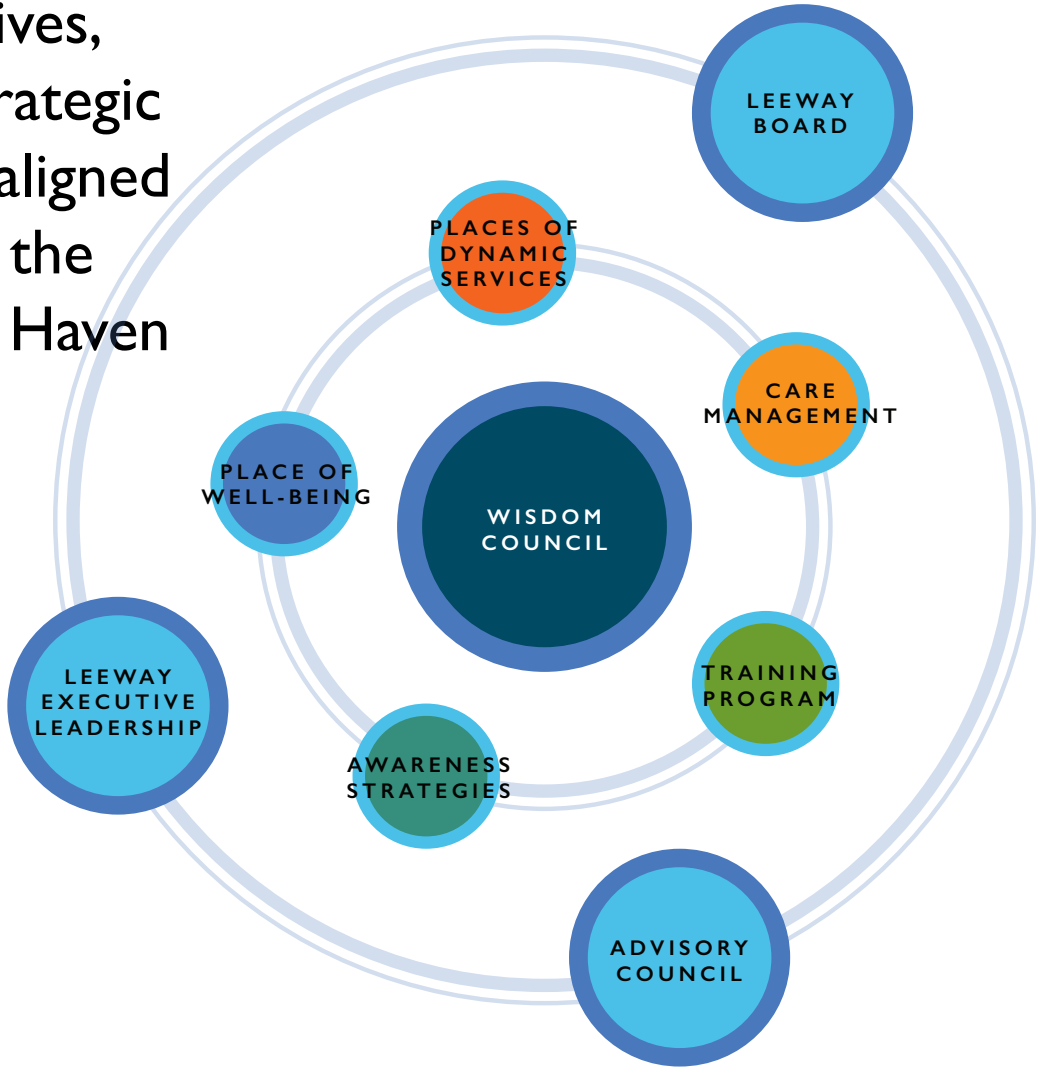
Carly

WELL-BEING, TO ME, IS A SENSE OF CONTENTMENT THAT I'VE REACHED GOALS THAT I'VE SET FOR MYSELF, AND ACHIEVED WHAT I WANTED TO, AND JUST A SENSE OF PEACE. WELL THAT'S WELL-BEING, IT'S JUST PEACE, CONTENTMENT, HAPPINESS. WHERE YOU STRIVE, AND WHERE YOU EXCEL, AND KEEP GOING FORWARD, AND NOT GOING BACKWARDS.

VISIONING & IMPLEMENTATION

This project is aimed at creating, evaluating, and implementing best practices while: assuring the highest quality of care and services, adhering to evidenced based findings, achieving fiscal soundness of all such initiatives, and driving strategic development aligned with needs of the Greater New Haven Community.

Leeway's leadership and staff will work with Community stakeholders to systematically leverage existing programs as well as create an overall program design that mitigates gaps in services and supports. Design and implementation will occur through two planning segments: 1) Program Collaboration and 2) Service Integration. During the Program Collaboration segment, we will work to coordinate multidisciplinary care interventions and programs across the continuum in coordination with community stakeholders offering complementary person-centered services. The providers will be referred to as Places of Dynamic Services. The second planning segment will involve designing a place where multidisciplinary care is provided with seamless access to services under one roof. Through Service Integration a Place of Well-Being will be designed as a one stop shop for personalized health and wellness services. A hub and spoke method, the Place of Well-Being and Places of Dynamic Services, will be a first of its kind, scalable Community Living Model co-created by multiple stakeholders.



I SEE THINGS DIFFERENTLY NOW. THAT EVERYONE HAS A VOICE AND THEIR TRUTH IS THEIR TRUTH. YOU AND I MAY BE MEETING IN THIS ROOM RIGHT NOW AND I TAKE AWAY SOMETHING DIFFERENT. THAT DOESN'T MAKE THIS MEETING LESS SUCCESSFUL. IT IS WHAT I TOOK FROM THE MEETING AND YOU VALIDATE THAT. AND I VALIDATE YOU. *(Partner)*

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.** *(Partner)*

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. *(Partner)*

Family: Advisory Council

DESCRIPTION

The role of the Advisory Council is to oversee and monitor the progress of all grant deliverables.

Members work to:

- Guide the overall vision
- Establish priorities
- Formalize partnerships
- Provide first-hand knowledge and experiences
- Serve as vehicles for dissemination for key information and grant deliverables.

The Council will align its work with New Haven's Community Transformation Plan, Healthier Greater New Haven Partnership Improvement Plan, and other key initiatives as identified by the members and Leeway's Board.

MEETING FREQUENCY

- Quarterly or as directed by Council

QUESTIONS TO PONDER

1. How can mutually agreed upon values and guiding principles propel our work?
2. How do we better integrate health and well-being services?
3. How can our work impact state reimbursement and be sustained?
4. How will we evaluate and measure our progress?

IT'S NOT JUST SURVIVING, WHICH IS DIFFERENT FROM LIVING. *(Leeway staff)*

WHEN YOU FEEL MOST VALUED, YOU PUT OUT YOUR BEST. *(Leeway staff)*

THE MIND IS A POWERFUL THING. IF THE MIND TELLS YOU THAT YOU ARE SICK, THEN YOU ARE. **YOU HAVE TO FIND A WAY TO ENJOY LIFE** AND ENJOY THE DAY BEYOND THAT. *(Leeway staff)*

Family: Wisdom Council

DESCRIPTION

The role of the Wisdom Council is to ensure the consumer, patient/family voice and input is heard and is central to all of our work. Members represent Leeway Alumni and individuals from New Haven's Community Districts.

The Council will assist with:

- Identifying needs and priorities
- Identifying ways to broaden awareness
- Actively participating in decision-making and implementation.

Deliverables such as Places of Dynamic Services identification, care coordination services, and training opportunities will be reviewed and vetted through this Council.

MEETING FREQUENCY

- Quarterly or as directed by Council

QUESTIONS TO PONDER

1. How can the individual's voice best be heard and drive the project?
2. How can we best recruit ambassadors to ensure a grassroots effort?
3. What does the time between presently look like for an individual living with multiple chronic illnesses?
4. How will we evaluate and measure our progress?

FOR THE FIRST TIME IN 10 YEARS HE HAS TEETH, HE HAS GLASSES SO HE CAN SEE, WHICH HE HASN'T HAD IN SEVERAL YEARS. HE IS GOING TO GET A HAIRCUT. SO WE DEFINITELY SEE IT WHEN WE SEE THE CHANGE IN BEHAVIOR. THEY START CHANGING THEIR PHYSICAL APPEARANCE. THEY START CHANGING THE WAY THEY ACT, SOMETIMES EVEN THE WAY THEY SPEAK. WHEN THEY FIRST COME IN IT'S LIKE, "OH, I DON'T CARE ABOUT ANYBODY AND NOBODY CARES ABOUT ME." AND, THREE MONTHS DOWN THE ROAD THEY'RE LIKE, "YOU KNOW, I THINK I AM GOING TO GO VOLUNTEER SOMEWHERE." **YOU SEE THE CHANGES IN THEM THAT SHOW THEY ARE FEELING BETTER ABOUT THEMSELVES.** *(Leeway staff)*

I THINK COUNSELING. **TO REALLY GET THEM IN TUNE WITH THEMSELVES AND WHY THEY DO SOME OF THE THINGS THEY DO.** TO TRY TO GET THEM TO FOCUS ON THAT. THAT IS A BIG PART OF RECOVERY. *(Leeway staff)*

WE HAVE TO SET PEOPLE UP FOR SUCCESS SO THAT THEY CAN GET BACK INTO THE COMMUNITY AND HAVE A MEANINGFUL LIFE. IT IS JUST NOT GOOD TO STAY IN A HEALTHCARE FACILITY THE REST OF YOUR LIFE. *(Leeway staff)*

Family: Care Management

DESCRIPTION

The role of this family is to identify strategies and practices to:

- Optimize risk stratification
- Minimize hand-offs
- Eliminate redundant work
- Align care coordination roles
- Standardize safe and high quality care coordination practices

Evidenced based models and best practices will be researched and applied that align with needs assessment and as vocalized by Advisory and Wisdom Councils.

MEETING FREQUENCY

- 2 half day visioning sessions and as directed by the family

QUESTIONS TO PONDER

1. What inhibits choice and independence? And, how can we combat these inhibitions?
2. How can we best minimize hand-offs, eliminate redundant work, and align care coordination roles?
3. How do we map the time between for individuals living with multiple chronic illnesses? What would the ideal future state look like?
4. How will we evaluate and measure our progress?

WE ALL KNOW RELATIONSHIPS ARE KEY. AND **BUILDING TRUST IS KEY.** *(Leeway staff)*

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.** *(Partner)*

JUST BREAKING DOWN THESE SILOS, AND I'VE ONLY BEEN WORKING HERE THREE MONTHS, BUT **I NOTICED HOW HARD IT IS JUST COMMUNICATING WITH EACH OTHER**, AND LIKE WE GET SO MUCH DONE WORKING TOGETHER, AND REACH SO MANY MORE PEOPLE IF WE WORK TOGETHER VERSUS TRYING TO SAY KEEP DOING WHAT WE'RE USED TO DOING. I THINK BECAUSE WE JUST REACH SO MANY MORE PEOPLE, AND **YOU DON'T HAVE TO KEEP REINVENTING THE WHEEL**, BECAUSE THERE'S SOMETHING OUT THERE PROBABLY THAT ALREADY WORKS, SOMEONE IS ALREADY DOING IT. *(Partner)*

Family: Places of Dynamic Services

DESCRIPTION

The role this family is to create the design and systems for a strategic alliance of diverse stakeholder providers/groups that intentionally work together to align values as well as approaches and practices such as communication, training, and technology.

The Places of Dynamic Services promote inclusivity, transparency, and champion a new narrative with and for individuals facing stigma, disempowerment, and marginalization.

Together the Places of Dynamic Services will implement and evaluate targeted programs and services that will intentionally impact gaps in care, as well as, future reimbursement and funding opportunities.

MEETING FREQUENCY

- 2 half day visioning sessions and as directed by the family

QUESTIONS TO PONDER

1. How do we all help each other?
2. How can we align philosophy, practices, and approaches to achieve systematic change?
3. What technology is needed to support Places of Dynamic Services?
4. How will we evaluate and measure our progress?

WITH EVERY PERSON YOU WORK WITH, YOU ASK THEM WHAT THEIR GOALS ARE. THERE IS SOMETHING THAT IS IMPORTANT TO EACH OF THEM, SO YOU MAKE SURE THEY HAVE WHAT IS IMPORTANT. *(Partner)*

HOW WOULD WE FEEL? HOW WOULD WE WANT IT TO COME TO US? AND DO THAT EVERY TIME. *(Leeway staff)*

YOU HAVE TO BE WILLING TO BE CARING, COMPASSIONATE, NON-JUDGMENTAL. YOU HAVE TO CHECK YOUR VICES AT THE DOOR. *(Partner)*

Family: Training and Development

DESCRIPTION

The role of this family is to identify training programs to be delivered for the benefit of individuals with multiple chronic diseases, organizations, and the community.

The goal is to leverage programs that already exist and are working, as well as create and develop programs that will evolve cultural/behavioral shifts, human development, and support outcomes expected through the project.

This family will also align its priorities to state/local workforce development needs.

MEETING FREQUENCY

- 2 half day visioning sessions and as directed by the family

QUESTIONS TO PONDER

1. What are the training programs needed to empower and engage Community members towards prevention and management of chronic disease?
2. How can we create learning experiences?
3. How do we address health literacy in all that we implement?
4. How will we evaluate and measure our progress?

SO, **NEW HAVEN IS A REALLY SMALL TOWN.** SEEMS BIG, BUT IT'S REALLY, REALLY SMALL. AND YOU JUST KNOW EVERYBODY. AND THEN YOU FIND OUT THAT EVERYBODY IS REALLY INTERCONNECTED WITH EVERYBODY ELSE IN SOME WAY. **YOU'RE EITHER A COUSIN OR YOU'RE A CLOSE FRIEND OR A RELATIVE SOMEHOW.** *(Partner)*

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.** *(Partner)*

Family: Awareness Strategies

DESCRIPTION

The role of this family is to build awareness of long-term services and support in partnership with DSS No Wrong Door initiative. The group will create a campaign aimed toward increasing access to services and to the programs/ services designed through the grant and the network of Places of Dynamic Services.

MEETING FREQUENCY

- 2 half day visioning sessions and as directed by the family

QUESTIONS TO PONDER

1. What would be the best platforms to share project progress?
2. How do we drive awareness of systematic and programmatic changes and opportunities?
3. How do we align and integrate with No Wrong Door so that access to services and supports is clear for the individuals who need to access them?
4. How will we evaluate and measure our progress?

WELL-BEING, TO ME, IS A SENSE OF CONTENTMENT THAT I'VE REACHED GOALS THAT I'VE SET FOR MYSELF, AND ACHIEVED WHAT I WANTED TO, AND JUST A SENSE OF PEACE. WELL THAT'S **WELL-BEING, IT'S JUST PEACE, CONTENTMENT, AND HAPPINESS**. WHERE YOU STRIVE, AND WHERE YOU EXCEL, AND KEEP GOING FORWARD, AND NOT GOING BACKWARDS. *(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. *(Partner)*

WELLNESS SERVICES IS LIKE, NUTRITION, DIET. FOR EXAMPLE A DIABETES PROGRAM WHERE THEY HAVE NUTRITIONAL PROGRAMS FOR PEOPLE WHO ARE DIABETIC. AND ACTUALLY SHOWING THEM HOW TO COOK FRESH VEGETABLES AND FOOD THAT ARE GOOD FOR YOUR DIABETES. I'M DIABETIC MYSELF. I'M ON AN INSULIN PUMP. I WISH THAT WAS OUT WHEN I WAS, YOU KNOW, GETTING EDUCATION BECAUSE, I MEAN, **THE HARDEST THING FOR ME WAS TO CHANGE MY LIFESTYLE** AND TO CHANGE THE THINGS THAT I ATE FOR MY WHOLE LIFE. I MEAN, WHO DOES THAT? I MEAN, **YOU GET AN ILLNESS, YOU KNOW, YOU'VE GOT TO CHANGE EVERYTHING.** *(Partner)*

Family: Place of Well-being

DESCRIPTION

This family will imagine a place that serves as a one stop shop for individuals with multiple chronic diseases. This place will provide seamless access to services that enable flourishing of the entire human being—mind, body, and spirit. The Place of Well-Being Family will explore and align evidenced based findings of how the built environment impacts behavior, health, and well-being outcomes.

Examples of integrated services and environments that may be offered include:

- Healthy Living Coaching
- Mental Health & Behavioral Resources
- Targeted Ambulatory Medical Services
- Pharmacist/Pharmacy
- Integrative and Rehabilitative Therapies
- Fitness and Nutritional Services
- "The Commons" A place of learning for all stakeholders
- Vocational Training
- Café fostering relationships
- Recreational spaces
- Art and Music Therapies
- Garden Space/Labyrinth/Meditation
- Ancillary Physician Services supporting the 5 senses including such as dental, vision, hearing

MEETING FREQUENCY

- 2 half day visioning sessions and as directed by the family

QUESTIONS TO PONDER

1. Where should a Place of Well-Being be located to best support the community member?
2. How would having health and well-being services under one roof change the experience and outcomes for individuals to thrive in Community?
3. What services and supports will be provided?

EVERY HEART SINGS A SONG
INCOMPLETE UNTIL ANOTHER
HEART WHISPERS BACK

- Plato

END NOTES

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Leeway

Hope Happens
Founded in 1995 as Connecticut's first and only free-standing skilled nursing center dedicated to caring for individuals with HIV/AIDS, Leeway continues its tradition of excellence today.

World Class Care, Local Impact
Leeway's continuum of care includes 30 skilled nursing beds, 30 Residential Care Beds, 41 units of independent housing and community case management. Leeway provides intensive medical, nursing and behavioral health services in a nurturing and positive environment. Residents also receive treatment for addiction, mental health diagnosis, and a variety of chronic illnesses that accompany HIV/AIDS.

History
In 1987 there was only one form of in-patient care available to individuals with HIV/AIDS, acute care in a hospital setting. After an acute episode, AIDS patients had to remain at the hospital, as there wasn't a place for them to go for the appropriate level of care. Catherine Kennedy, founder of Leeway and partner to AIDS Project New Haven, recognized a need for a hospice dedicated to individuals with HIV/AIDS. Through a myriad of meetings, conversations, introductions, and networking, Catherine assembled a board of directors from colleagues she had worked with, individuals that surfaced through networking, and strong business and minority leaders throughout the community. In the fall of 1995, Leeway accepted its first resident.

Adaptation
Leeway continues to be a nimble organization, responding to the specific and ever-changing needs of individuals living with HIV/AIDS. As advancements in technology and medicine continue, so do we continue to adapt and respond to the needs of our residents and supportive housing tenants.

Community Living Model
It is upon the strengths of community connections, networking, and the shared goal of supporting individuals with multiple chronic illnesses to thrive that Leeway received funds from DSS and leads the community in developing a model of wrap around care.

Leeway

40 ALBERT ST, NEW HAVEN, CT 06511
Learn more at www.leeway.net