The Community Living Model[1]

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Introduction

> *I am isolated and alone. I am 63 years old and a doctor recently told me that I have high blood pressure and is watching my heart. This is hard for me to deal with as I have suffered from major depression for most of my life and am a Type 2 diabetic. In the past two months, I have had nine different doctors appointments and have had to scramble to find the transportation necessary to get me there. The system feels overwhelming to navigate. A perfect storm of events has left me with limited resources. I have some family, but they are all far away and I worry how receptive they will be to hearing I have another diagnosis. My friends have all left the area or find themselves in similar situations—strapped for resources, unable to figure out the healthcare system, and isolated from certain portions of the community. With each passing day, I feel anxiety and fear. Who can I turn to? How can I not only recover but also thrive? How can my community provide support that enables me to flourish?*

For those that comprise vulnerable populations within our communities, whether they be individuals with multiple chronic illnesses, the elderly, low-income populations, or other groups, situations like the one described above are all too real. Often, vulnerable populations do not know how to access resources available to them, have trouble navigating the health system, and feel like outsiders residing on the fringe of society. As a result, crafting an interconnected and easily accessible web of support services for these individuals can have an immense impact on their lives.

Community-driven models of care have had a tangible impact within municipal jurisdictions. These models draw on the old adage that it "takes a village."[2] For example, Illumination Foundation, a non-profit organization in Orange County, CA, is geared specifically to providing medical and wraparound services for low-income and homeless populations.[3] By working with a group of highly motivated and dedicated community partners, they established a public-private partnership that addresses the needs of this population by creating a mobile medical unit team that provides medical care and wrap-around services[4]. A guiding principle of this effort is that it is possible to connect individuals to primary care homes and other services by providing a "hand up" rather than a handout. By doing so, people learn the skills necessary to succeed and climb out of the cycle of poverty. Seeing a community come together to combine resources has led to impactful and sustainable results.[5]

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[1] Can you trademark this to HPG?
[2] Direct origin unknown, although attributed to African cultures; "It Takes A Village To Determine The Origins Of An African Proverb", *Goats and Soda*, NPR, July 30, 2016
[3] Orange County Mobile Unit Thttp://archived.naccho.org/topics/modelpractices/database/practice.cfm?PracticeID=508
[4] The model developed by this partnership received the 2009 NACCHO (National Association of County and City Health Officials) Model Practice Award for its efforts. http://bos.ocgov.com/legacy5/newsletters/volume3issue35.htm
[5] Mainero, Christina, "An Analysis of Whether or Not Various Socioeconomic Factors Match Indicators of Poor Health in Four Mobile Unit Clinics in Orange County, California," Claremont McKenna College, Thesis, (2010).

Another example is Puentes Clinic. This clinic is integrated with the larger health system in Santa Clara Valley. The clinic has fostered trust and convenience amongst its patients by providing social determinants of health services—such as soup kitchens, syringe exchange sites, and shelters—in addition to medical services and supports.[6] Within its primary care home, key downstream targets include medical, mental health, and addiction issues. The promotion of key upstream goals is also in place. They cater to the human spirit by delivering services with a welcoming and inviting facility. Waiting rooms fashion refreshments and individuals are greeted by a facilitator who discusses both issues and perceptions of health and the healthcare system, empowering patients to understand their health as well as the way in which they should navigate the healthcare system.[7]

A third example is that of 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 themselves. 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 wellbeing.

Through these and other examples, studies have illuminated the importance of considering the ecosystem of factors that impact an individual's health in order to best solve for how we might improve care delivery for each person. As Kwan et al note: 'the medical care of the medically vulnerable patient requires creative approaches that accommodate the burdens of mental health and substance abuse as well as the competing priorities of shelter and a warm meal. If we [as a society] do not address the competing priorities of food, housing, substance-abuse, and mental illness, healthcare becomes a distant priority [for patients]".[8]

Community Living Model

With this paper, we present the Community Living Model (CLM), which builds upon and enhances a rich history of community-based models and public-private partnerships that have been developed to better meet the complex challenges of delivering care to vulnerable populations. Based on the Triple Aim of healthcare[9]—patient experience, population health, and per capita cost—the CLM addresses the need for improved systems of both downstream care coordination and proactive upstream prevention.

The traditional model of healthcare has focused on addressing medical problems once they occur. In part, due to the Affordable Care Act and the transition to value based care, we are observing a paradigm shift to a focus on the time in between medical interventions and notably on the social determinants of change that prevent medical problems from occurring in the first place. Because this

[6] Kwan et al, 2008
[7] Mainero thesis
[8] Kwan quote, cited in thesis
[9] Health Aff (Millwood). 2008 May-Jun;27(3):759-69. doi: 10.1377/hlthaff.27.3.759

shift is happening now, there is a need to respond with systems that align community partners to a common vision and that can offer ways to strategically integrate medical and social care.

The goal of the CLM is to weave a more tightly supportive web of services, available to individuals within their communities, through the development of Places of Dynamic Services (PODS) and a Place of Wellbeing (POW). These places provide access points so that the right services are coordinated to help manage care and, ideally, prevent these individuals from presenting with additional co-morbidities in the future. Simply put, PODS and a POW allow individuals to connect with their communities.

From the change literature, we know that scholarly research[10], best practices[11], and failed initiatives[12] 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[13].'Doing with' also considers the local context that simply applying a best practice may not assume. Adopting this evidence based philosophy, and, in lieu of taking a purely top-down approach, the CLM prioritizes grassroots solutions, multi-stakeholder involvement, and co-creation. The philosophy works to positively affect the fundamental aim of expanding choice and enhancing one's quality of life while simultaneously lowering costs because of the networked nature of this initiative. The CLM is versatile in that it may be tailored to different locations based on each locale's needs (i.e. adapted to place-based culture) and applied to multiple populations.

In a nutshell, the CLM is a hub and spoke model achieved through two phases: program collaboration and service integration. The model is based upon guiding principles that create a common vision and emerge through the voices of all stakeholders.

How does the Community Living Model work?

How the change is chronicled

The first 'how' of the CLM answers how the model is chronicled and recorded as the change happens. A Living Storybook (LSB) is a record of change towards a healthier community as it occurs. This book includes steps taken, questions that have been asked, questions to be asked, sticky problems, and successes along the way. Vignettes and stories that evoke the human spirit of those in the community are scattered throughout to ground the project in the common goal of supporting individuals to thrive. In photographs, we see neighbors and partners in the project.

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[10] Barnes, M., & Schmitz, P. 2016. Community Engagement Matters (Now More Than Ever). *Stanford Social Innovation Review*.

[11] Mark Zuckerberg and Dr. Priscilla Chan for the Bay Area News Group. n.d. Mark Zuckerberg and Dr. Priscilla Chan:Why we're committing $120 million to Bay Area schools. *San Jose Mercury News*.; http://www.mercurynews.com/opinion/ci_25859659/mark-zuckerberg-120- million-bay-area-schools. Neas, R. 2003.; *Community Voice or Captive of the Right? A Closer Look at the Black Alliance for Educational Options*. Special Report,Washington DC: People for the American Way. http://www.pfaw.org/sites/default/ les/ le_237.pdf. The Center for Collaborative Change. n.d. Strong *Healthy Communities*. http://newarkchange.org/projects/healthyhubs/.

[12] Russakoff, D. 2014, May 19. Schooled: Cory Booker, Chris Christie, and Mark Zuckerberg had a plan to reform Newark's schools. They got an education. *The New Yorker*. http://www. newyorker.com/magazine/2014/05/19/schooled.

[13] Yunus, M. 2008. Banker To The Poor: Micro-Lending and the Battle Against World Poverty. New York: PublicAffairs.

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

How the sweet spot is identified and aligned to ongoing initiatives

The second 'how' of the CLM answers how needs, strengths, and opportunities are discovered and aligned to others in the community. Evidence suggests that central to community engagement and systematic transformation is the discovery and alignment to guiding principles. As with any change of this magnitude, an initial step is conducting a thorough needs assessment. As a philosophy, the CLM chooses to assess both needs and strengths, knowing that it is possible to achieve much more by building upon what works than by trying to shrink gaps. To support this view, the CLM uses Appreciative Inquiry to collect powerful quotes and stories. '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. During initial interviews, participants share high point stories of what works when things are working really well. Main questions revolve around strengths of each partner organization, wellbeing, community and connections, and the dream of a Place of Wellbeing.

In addition to qualitative data, the collection of quantitative data and exemplar case studies ensures an evidence-based foundation. The data gathered and utilized aims to confirm that a project underscores what matters most to community members and leaders and aligns the project to initiatives already in play. From these resources and ongoing conversations with key service and support stakeholders, downstream outcomes and upstream targets emerge as key areas of focus where the CLM can boost the city-wide support system to a new level.

How the hub and spoke is created

The most compelling reasons for the CLM are program collaboration and system integration. The model is designed such that these two reasons roll out in two phases. Key to program collaboration, Places of Dynamic Services (PODS) are a focus in Phase I. Key to system integration, a Place of Wellbeing (POW) is the focus in Phase II. Together, the PODS and POW create a hub-and-spoke, care coordination infrastructure that provides services and supports that expand choice for individuals to remain successfully in their home environment.

Places of Dynamic Services. Despite many passionate, hardworking, well intentioned care coordinators working within a city, there is an opportunity to improve how the care coordination system functions and how it keeps individuals from falling through the cracks. The goal in not to implement a single program or service in isolation but to co-create a systematic, integrated approach for wrap-around care management that will not only enhance, but will transform, community-based services and supports. Through program collaboration, the intent is to leverage the great work already happening by broadening and building seamless access to care and service through PODS. PODS solve for the importance of evaluating the time in between medical interventions and the opportunities to improve life in community through a focus on the social determinants of change.

PODS consider questions such as: "How can PODS change the system of care coordination in a city and collectively change the experience of care from surviving to thriving?" And, "For those living with multiple chronic diseases and striving to remain at home how does spirituality, purpose, social connectivity, nutritional supports, and access to transportation become as integral as the next doctors appointment and the next prescription?"

Place of Wellbeing. Through the second phase of development, service integration, a POW—a place where medical and social care is provided with seamless access to services under one roof—is designed. A POW supports needs beyond any one diagnosis and is an environment where just being there promotes healing. Individuals needing intensive medical and social care coordination have the opportunity to come to a one stop shop, mitigating the need to navigate throughout a city and coordinate the accompanying transportation required. In this phase, the aim is to consider how community agencies and key staff from PODS may be located in the same location as they strive to enhance communication, collaboration, and integration of services.

> At a human interaction level,[14] healthcare delivery happens at the interface of the patient and the practitioner during the care experience. At a tactical level, it is the interaction of the patient's presented symptoms and the practitioner's treatment regimen. At the perceived meaning level, it is the patient's subjective account of their entire experience. The convergence of the changing operational focus, as well as the need for supportive environments to provide meaningful engagement, has provided a perfect platform for a complete and holistic transformation of the patient experience, including the physical environment in which this experience occurs. Being able to meet all aspects of a human being—body, mind and spirit—is now considered a successful outcome.[15]

A Place of Wellbeing, or POW, recognizes that we, as humans, seek places of respite and rejuvenation. Throughout history, individuals have articulated that access to spaces that evoke nature can have immense healing effects. Even in ancient Greece, chronically and terminally ill patients would retreat to the temples of Asclepius, who was the Greek god of healing, in order to access a healthy diet, pure water, music, social interaction, prayers, and dream-laden sleep. In the 1850s, nurse Florence Nightingale was a strong proponent of natural light as well as open, airy spaces as places of healing. In 1984, Roger Ulrich wrote a seminal paper, which shared that merely having a view of nature from the hospital bed could markedly improve your healing.[16] Just imagine, you are a patient walking into a doctors appointment, wouldn't you prefer to smell food cooking in a demonstration kitchen where nutrition is the focus, to hear the sound of a musician playing in the lobby, to see neighbors and friends socially interacting, and to feel a healing meditative space where you could take a deep breath and go inward? And imagine all of this surrounded by views of nature. Imagine a place where just being there is healing.

How the CLM is deployed to action

[14] Harris, P., McBride, G., Ross, C. & Curtis, L. 2002. A Place to Heal: Environmental Sources of Satisfaction Among Hospital Patients. *Journal of Applied Social Psychology,* 32, 1276-1299.
[15] Mannen, D., MacAllister, L. Dignity by Design: A Shift from Formalistic to Humanistic Design in Organizations. *Humanism in Business Series*, 221-244. November 3, 2016
[16] Roger Ulrich (1984). View through a window may influence recovery from surgery. Science, 224, 42–421.

With guiding principles at the core, and framed by upstream goals and downstream targets, the CLM is implemented through action groups. Each group consists of community members and a cross sector list of organizations and stakeholders. Each group participates in at least one visioning session to: reflect on pertinent information gathered in the assessment of needs and strengths; asks and answers important questions; ensures decisions maximize the best use of resources; and co-creates a sustainable model in line with the other action groups.

A key action group, central to the CLM, is the Wisdom Council. The role of the Wisdom Council is to ensure the consumer, patient/ family voice and input is heard and central. The Wisdom Council assists with identifying needs, priorities, and ways to broaden awareness, as well as actively participates in decision- making and implementation. A second overseeing action group is the Advisory Council. the advisory council is made up of leaders that guide, govern, and monitor the progress of the project.

Three other action groups have already been discussed. They are focused on fleshing out: Places of Dynamic Services (PODS); a Place of Wellbeing (POW); and wrap around care management. Two other actions groups include: access and awareness; and, training. The role of the Access and Awareness group is to build awareness of long-term services and support. This group creates a campaign aimed toward increasing access to services and to the network of PODS. The role of the Training group 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. Evaluation of success will be identified by each action group who will designate targeted benchmarks and ensure strong data analytics. Progress will be monitored daily and transparent to the PODS and Community.

Just as behavioral economics suggests that we can nudge people into making decisions that are more socially responsible by simply changing our default options, evidence-based design can fundamentally improve the health and wellbeing of the population. Evidence-based design transforms how we deliver care even within a changing and complex healthcare environment. To that end, the CLM with its focus on PODS and the POW, becomes more important and integral to delivering care, especially as healthcare moves beyond the walls of the hospital and into the community. If each community can construct an integrated systems with the PODS and a POW, it is possible to enable individuals, who may have been alone or confused or isolated from their communities and healthcare systems to better connect in order to receive the care they need.

HPG & CAMA

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 their 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 health design lab, studio, and collection based in New Haven, CT. CAMA strives to design a LIFE INDOORS where all can thrive and flourish. CAMA seeks to design interior spaces and products that improve 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. CAMA utilizes credible research to make decisions about the built environment to achieve the best possible outcomes. CAMA designers anticipate emerging trends and deftly adapt to 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.

SOLVING FOR DOWNSTREAM OUTCOMES
DIABETES/ OBESITY
DENTAL RELATED DISEASE
MENTAL ILLNESS & SUBSTANCE ABUSE
COPD / CHF
BARRIERS TO CARE/ HIGH COSTS
BACKBONE INFRASTRUCTURE
Places of Dynamic Services (PODS)
Identify PODS that will foster cross sector collaboration and service integration to enhance wrap around care, as well as future reimbursement and funding opportunities.
Place of Well-being (POW)
Develop a one stop shop that provides seamless access to services and supports that enable the flourishing of the entire human being- mind, body, and spirit.
SERVICE INTEGRATION
Wrap Around Care Management
Execute personalized services and supports that integrate medical and social needs, increase discharges to the home, and prevent the use of institutional care.
Awareness & Access Strategies
Launch strategies to promote and improve the awareness of, and access to, long term care service and supports in partnership with the No Wrong Door initiative.
COMMUNITY MOBILIZATION
PROGRAM COLLABORATION
Training and Development
Create and deliver training programs that will evolve cultural and behavioral shifts and human development as well as support priority outcomes on an individual, organizational, and Community level.
SELF
GIVE & RECEIVE
CARE
COLLABORATION
COMMUNITY
PLACE
DIGNITY
POSITIVITY
NUTRITION, FOOD SECURITY, AND ACTIVITY
DENTAL CARE
MENTAL HEALTH & RECOVERY
SMOKING CESSATION
ACCESS & AWARENESS TO CARE/INSURANCE
IMPLEMENTING UPSTREAM GOALS AND TARGETS
SOCIAL DETERMINANTS OF CHANGE