Creating a Health Economy through Health Hubs: Strategies and lessons learned while coordinating, integrating and increasing access to comprehensive community health services in Rural/Frontier Nevada

Sponsored by
Healthy Communities Coalition of Lyon and Storey Counties

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Health Economy through Health Hubs: Strategies and Lessons Learned while integrating, coordinating and increasing access to comprehensive community health services in Rural/Frontier Nevada

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Community Chest, Inc.
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Lions Club
Lyon County Human Services
Lyon County Juvenile Probation
Lyon County School District
Nevada Partners
Nevada Rural Community Health Services
Nevada Rural Counseling
Northern Nevada Dentist Society
Renown Rural Health Center
Sage Health Services
Silver Springs-Stagecoach Hospital District
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TABLE OF CONTENTS

Background 3

SECTION 1:
Description of the Health Hub 4

SECTION 2:
A Sense of Urgency--The Collapse of 2008 6

SECTION 3:
Our Approach: Transforming chaos to opportunity 8

SECTION 4:
Our Collective Impact Story 12
Radical Open-Mindedness 13
Cross-Community Team 14
Evolving Dynamic Partnerships 19
Prevention First as an Empowerment Strategy 22
Meet People Where They Are 25
Bridge Employees 27
Data-Driven Decision Making 29
Collective Enoughness 31

SECTION 5
Next Steps 34
Healthy Communities Coalition of Lyon and Storey Counties (HCC) is composed of hundreds of community volunteers of all ages, plus local, county, state, tribal, and federal agencies, a small staff and a formal board of directors all working on a collaborative leadership agenda to increase wellness and community vibrancy in the Lyon and Storey regions (see http://healthycomm.org/who-is-hcc/). (HCC) has been collaborating since 1996 and our mission is to create opportunities and remove barriers so that all people can live healthy and productive lives. We have been actively working towards eradicating poverty in our communities since 2006.

In June 2013, a group that evolved from the Healthy Communities Coalition's leadership team involved in planning the “school-based health center” convened and decided to shift from a place-based health services delivery system to a hub-based concept (see http://healthycomm.org/health-services-hub/). Inspired by the various ways that we had each encountered the idea of “hubs” we defined a “Health Services Hub” as:

A community hub that coordinates the delivery of health care and social services for the most vulnerable members of the community.

As of 2010 census the population for the region served by HCC was 56,000 including Storey and Lyon Counties, which together cover a total of 2040 square miles. Storey County is home to Virginia City, designated as a national historic monument.
Description of the Health Hub

**Our Hub**

The core leadership team — leaders and administrators representing each health and wellness sector — along with new members we’ve recruited specifically as partners with a stake in traditional health care as well as comprehensive systems of care, includes:

- A Health Services Hub convener and staff from the backbone agency— the community coalition;
- School District central administration and elementary through high schools (principals from our pilot schools)
- School and Community Health Nursing
- Public and private mental and behavioral health provider organizations
- County level health and human services agencies
- Non-profit community development organizations
- a Rural Health Center
- Early Intervention Services
- Children’s Rural Mental Health Consortia
- Food Bank/Food System staff and volunteers

**Our Purpose**

Sustain and evolve:

- Forward motion of our Hub priorities, funding, and implementation goals;
- Commitment of partner organizations to the Hub;
- Data-driven decision-making with integration of our systems as a key priority;
- The big picture” of our Hub efforts, as noted in our vision, charter, MOUs; A systems-focus where we are all connected and each part affects others in the Hub;
- The foundation on which implementation efforts are built—Ground Zero

**Our Beliefs**

We believe all members of rural, Western Nevada communities in Lyon, Storey and Mineral counties should have access to education, resources and services that will enable them to lead productive, meaningful and healthy lifestyles.

We believe that it is essential to cultivate a “prevention first” culture among our residents, and similarly, among the educators, community support systems, and mental health and medical providers that provide the resources and options from which residents will choose the most appropriate supports and opportunities to match their health and wellness needs.

**Our Principles**

Ideally, the Hub has the infrastructure to connect at-risk individuals to health and support services, while avoiding duplication of services. In concept, a Health Hub focuses on all community members and particularly the most vulnerable, providing quality care while working to eliminate duplication and disparities. Four principles guide our Health Hub:

1) Find-identify those at greatest risk
2) Treat- Ensure treatment through evidence-based interventions and evaluate their impact
3) Measure- Document and evaluate benchmarks and final outcomes.
   and
4) Inclusive- use a population-based, public health model for health delivery that focuses on wellness and prevention first for *all community members*. 

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hub

1. The effective center of an activity, region, or network.
   "the city has always been the financial hub of the country": center, core, heart, middle, focus, focal point, central point, nucleus, kernel, nerve center, nexus, polestar "the hub of family life"
Our Journey
The narrative that follows is a brief chronicle of our evolving journey and the critical elements involved in creating and sustaining a hub-based approach to the integration and coordination of comprehensive health services. We are still evolving. We are continually adapting what we do and how we relate or communicate as we take action and reflect on what we have learned together. As such, our story is also evolving, so this document represents a snapshot in time.

But two to three years into this effort, we have learned some lessons and seen how our intentional approach has made a difference. For those looking for an alternative to place-based or traditional delivery systems and who are working in rural/frontier communities, the Health Hub may serve as a model to replicate and adapt. We share this with you, offering prompts for your coalition or group to consider (i.e. questions in bold after each theme) as you hear what shaped our conversations, our considerations and our actions.
A Sense of Urgency- The Collapse of 2008: The context that drove us toward action

In 2008, Lyon County was the second fastest growing county in the nation with a population of 54,963, having boomed from a 2000 population of just 34,501. This growth was due to the inexpensive housing that was available so close to Tahoe, Reno, and Minden, which were very expensive housing markets. As a result, many first time homebuyers moved into our communities and had jobs in the construction fields. When the housing market crashed in the Reno -Tahoe area, the Lyon County market crashed as well, but more radically. Lyon County’s unemployment rate, according to the Nevada Department of Education, Training, and Rehabilitation remained the highest in the state at 15% for several years.

The county’s youth unemployment rate, according to HCC’s Community Norm Survey, was even higher, and youth reported that it was very difficult to find work. Lyon County’s foreclosure rate was also the highest in the state with 1 out of 28 homes in the Dayton and Fernley area in foreclosure, according to the National Realty Association.

HCC has a tradition of coming together in times of need. Before the economic crash of 2008, Lyon area unemployment rates hovered around 3.5%. After the crash, coalition members needed to work together more closely than ever before. By 2009, Lyon County’s unemployment rate peaked at a record high of 20% to 25%. In addition to record high unemployment and foreclosure rates, the food banks in each of our communities were reporting 100% increase in use. And because of their rural/frontier nature, many communities in Lyon County were also medically underserved. Unfortunately, all of this took a toll on community members and the Lyon County Sheriff reported an unofficial number of 28 suicides in 2009. All were adult males over the age of 40, with the exception of one female.

A drawback to such a quick community growth spurt was that infrastructure development did not keep up with housing development, and thus services were playing catch-up in a very grim economic environment. Many families were stuck in a rural environment that was expensive to live in due to a lack of services, no public transportation, tripled gas prices, and very little choice in food outlets. For example, in Silver Springs, the only grocery outlet was a gas station mini-mart. We priced apples at $1.25 each. This lack of availability impacted youth, with 56% of middle and high school youth reporting not eating green leafy vegetables (2009 Youth Risk Behavior Survey). This lack of available nutritious foods combined with unhealthy eating behaviors resulted in our area reporting some of the highest rates of chronic disease along with other health risks.
By 2010, HCC began working to expand capacity to meet the food needs of low-income persons in a healthy way while supporting the local food system using interagency approaches and collaboration with multiple stakeholders. With grant funding from USDA and a number of other sources, in 2010 HCC began strategically building a food system in the Lyon region that focused on 1) increased access to healthy local food, 2) increased awareness of the role of healthy food in curtailing chronic disease, 3) increased demand for healthy local food, 4) increased supply by supporting small sustainable farms and new farmers, and 5) providing entrepreneurial opportunities and training for youth and adults around food systems (see http://healthycomm.org/food-hub/).

Clearly, in high poverty areas, access to food—healthy food and health care are interrelated—and also correlate with poor health outcomes. As such, Lyon County was also faced with a health crisis. No help was coming from “above” – the federal government was slow to act, and the state government’s coffers were empty. Most providers of health care services were frozen in panic – rising needs and few resources meant there was high burnout and limited capacity to consider doing anything more than hold on and hope to get through. But in Lyon County, something was different this time – there was desperation, an overwhelming sense of concern that these economic problems would never be solved – and that was unacceptable. Frankly, the spark was desperation.
Our Approach: Transforming chaos to opportunity

The group chose to believe in the words of Hildy Gottlieb, President of the Community-Driven Institute, Creating the Future and author of The Pollyanna Principles:

"If it's not physically impossible, it's possible."

Although it appears more a leap of faith than a strategic plan, collective effort has been documented in leadership and philanthropic research as an essential element of long-term success. Our process has shown that collective effort can be a success, and relies less on the perpetual optimism of group members than one might imagine. Our group members are directors of agencies and organizations – they are rational, realistic, and grounded.

"Strength builds upon our strengths, not our weaknesses." (Pollyanna Principle #5)

We were faced with community needs that appeared insurmountable, and refused to accept failure as an option for the children and families of Lyon and Storey Counties.

The status quo silo-based operations were clearly insufficient, and the community leaders were tired of feeling hopeless in the face of such great need. The "scarcity mindset" of fear, retrenchment, and turning inward was simply not working. As one group member stated:

"At some point even the dollars aren't enough to make a decision - until we're ready to help ourselves think bigger and achieve more, we can't help others."

As one participant noted, the community will drive the process of developing better communities:

“We can solve the puzzle in places that are rural, isolated, using these resources, because there’s 20 people who want to.”
As leaders of health and human services, education and law enforcement agencies we all deeply understand that our individual missions are inextricably bound to the health of our community and people. Whether it’s strong families, positive learning and development of children, public safety or economic viability, these can only be achieved when we raise the bar on health indicators—when more people of all ages are healthy and thriving than are sick and surviving.

When the scales tipped toward the negative and data despair rather than delight we knew we must act. We didn’t know how, but we could no longer postpone action.

Group members recognized that one of the critical problems for Lyon County is the lack of medical providers. The communities had not attracted recent medical school graduates even with loan repayment options. Likewise mental health providers are few and far between. Most of the local population is covered by Medicaid, with notoriously low and slow reimbursement that makes private practice of any kind inefficient and ultimately unsustainable. One of the community coalition staff had seen information on the Remote Area Medical (RAM)\(^1\) program and called to learn whether we were eligible to have them come to our communities. Because Nevada at that time did not permit out-of-state medical and health professionals to practice without a Nevada license—even for humanitarian purposes—we were not able to participate. As a stopgap, we planned and implemented a Medical Outreach Rural Event (MORE) in 2012 and were overwhelmed by the dire health status of our community members. One stakeholder characterized this as “low hanging fruit,” that is, providing emergency care to this community.

It was hard to know where to start...so we started with what we COULD do and with what presented itself as an opportunity using the resources we did have in place. Even if it was a “bandaid” given the extent of the medical needs present, we knew waiting for the perfect solution was not an option. We needed to catalyze our partners to take action and learn as they went. Over time (2013 Legislative session), we were successful in getting Nevada to change its laws and allow out-of-state medical providers to provide services for humanitarian purposes.

\(^1\) https://ramusa.org/
In 2013, as we were planning our second annual MORE, HCC was offered the opportunity and funding to conduct a targeted needs assessment on the health status of the community and its school-age population, and plan for a school-based health center. We recruited and trained university students to assist us in collecting local data on the health status of MORE attendees—combining service delivery with data collection activities.

We also took advantage of this opportunity to galvanize our core group of leaders within the coalition for whom health was one of their top priorities. We knew that people who came together from health and human services were charged with meeting the needs of their clients. They had a wisdom and experience that could be the catalyst for initial planning and action, even as data was gathered and used to support or refute their assumptions and knowledge. They could (AND DID) participate in the data collection effort as they had networks and allies that trusted them enough to share important perspectives about how they viewed their community and what that community could do to more effectively use its resources to meet their needs.

At the time we convened this group of leaders, we had yet to identify ourselves as a Health Hub. The leaders joined in the needs assessment by facilitating conversations with their networks and conducting key stakeholder interviews. This consolidated the timeframe for data collection and shifted the coalition and convener’s role to one of development and training in the methods to use to consistently collect information across groups.

Early on in this process we departed from the norm—we redefined how we wanted to conduct the needs assessment, calling it what our Coalition Director fondly referred to as "heel and toe:"

This heel and toe approach, or what is also called the action learning cycle, provided opportunities for teams of new partners and old partners to make small changes in their organizations and services by introducing new interventions in smaller doses. In this way they gained practice and reflected on lessons learned as they tested their ideas—which motivated them to pay more attention to what the results were and how these could direct them to new ways of thinking and acting as a collective and as independent providers and organizations.
By carrying the needs assessment out as an action learning cycle (ALC), we were prepared to think differently about how we went about doing our everyday work. The ALC also supported us coming together as a unified team AND supported our reflection during our ongoing conversations: this led to a group resolution that our health initiative needed to be more broad-based.

The idea for a Health Services Hub also grew out of the success of our coalitions’ Food Hub initiative, and rapidly replaced the more traditional idea of a school-based health center. “Health” became defined in the broadest sense.

Our definition of health is holistic and moves everyone toward wellness through education and prevention, early intervention, and treatment that spans the continuum of health care and supports the health and wellness needs and choices of the residents of Lyon, Storey and Mineral Counties. Health and wellness involves primary care, oral and vision health, mental and behavioral health, and social-emotional education and support services.

The entire community was in need of resources and support, not just children and parents. Early in our review of school-based health centers and information on the health status of Americans, we encountered this statement:

“Every American should have the opportunity to be as healthy as he or she can be. But right now, millions of Americans suffer from diseases that could have been prevented...For decades, the healthcare system has been set up to treat people after they are sick rather than keeping them well in the first place. Our country has a sick care system rather than a healthcare system.”

Trust for America’s Health, June 2013

So the group, now the Health Services Hub, agreed to broaden its scope to health services for the entire community.

Conversation Prompts for your Consideration:

- What keeps coming up in your conversations as urgent and is not easily reconciled?
- How does your coalition respond to crises or urgency? Do they see themselves as resource-poor or do they come together and use this as an opportunity to plan and act?
- If not, how might you frame the message differently to actually deliver a “call to action?”
As happens frequently in the chasm between research and practice in rural/frontier communities, we found a way of claiming our process as a credible, evidence-based approach when we were sent an article by one of our regional partners who was serving as a member of the planning committee on “Healthy Communities” in our neighboring urban county. We were delighted to read the 2011 article in the Stanford Social Innovation Review, “Collective Impact” that examined successful community-level social change efforts from around the United States. The authors found five conditions that were necessary for collective success in terms of measurable community change: 1) a common agenda; 2) a shared measurement system; 3) mutually reinforcing activities; 4) continuous communication; and 5) backbone support organizations (Kania & Kramer, 2011).

These described our process fairly closely and participants agreed that the Health Services Hub’s successes can be attributed to these factors — although some are still a work in progress. We also saw other attributes that were critical to our success and we share our “collective impact story” so that other community coalitions and community-based groups might be inspired to design and adapt their own version of a Health Hub. In addition to these five conditions—or perhaps within the framework for collective impact we identified seven other favorable conditions that were essential to creating and supporting Kania and Kramer’s five conditions for success:

1. Radical open-mindedness
2. Cross-community team of leaders and providers
3. Evolving and Dynamic Partnerships
4. "Prevention first" as an Empowerment Strategy
5. Meeting people where they are
6. Bridge employees
7. Data-driven decision-making
8. Collective enoughness

As can be seen from our early start as a Health Services Hub--from the needs assessment forward--we benefitted from our capacity to go beyond either/or thinking to both/and thinking: a needs assessment as an action learning cycle; a school-based health center as a community health hub. Our needs assessment was initiated as a vision-based process--we established a vision, a common agenda, before collecting a single digit or byte. Beyond a common agenda--our success was rooted in our ability and willingness to suspend judgment and delay decisions—long enough to have deep conversations, explore possibilities together, and consider what otherwise might be seen as rigid, regulated, or impossible — as actually holding a new promise or solution. Our thinking was characterized by flexibility and we tried to keep our options open and fully transparent at each step. This opened the door to take risks, ask questions, and investigate with an attitude of “why not?” or “we can.” We believed that we had the resources we needed to make a difference if we were willing to think creatively and flexibly and keep our eye on the horizon—affordable, accessible, consistent, integrated high quality comprehensive health care.

An excerpt from a recent coalition staff meeting emphasized how the coalition takes on the role of creating a space for thinking differently about what’s possible—supporting radical open-mindedness. These qualities are critical to being able to create a meaningful hub model that will potentially change some if not most of the way in which individual agencies have been doing business.

**Conversation Prompts for your Consideration:**

- What characterizes the conversations you currently have in your coalitions or task forces?
- Would you characterize your coalition as having a “can do” attitude, or “we’ll do whatever it takes?”
- What happens during and after the conversation when that “can do” attitude prevails?

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**Convener:** What is sticking? What’s important about the work of all the programs together? You’ve referenced this shift in thinking.

_F:_ Healthy Communities is becoming the go-to for everything: health, toys, mental health. It’s a safe place to go to. It’s available after hours. If you call, we answer.

_P:_ The food pantry is a door people feel comfortable walking through. It’s a welcoming place.

_F:_ because they’re taking charge and taking steps.

**Convener:** how are you conveying that?

_W:_ It’s the greet, it’s the job boards, it’s the information… not just food. What else can we do to help you get your footing?

_P:_ People know that about the pantry, so they come in for food and open up about their other needs. There’s a comfort level with volunteers and our Volunteer Coordinator.

**Convener:** Can you remember how you became informed about how to have the conversation about what’s available?

_W:_ I went to Silver Springs Coop to have a meeting with L. I was there for an hour and a half, got irritated as I saw people coming in and out. Really? These people come in every week? What are we doing?

**Convener:** Are we just feeding people/ making them dependent?

_W:_ And then I saw the conversations and that it’s so much more than food. You could tell me that all day, but until I saw it I didn’t really get it.

_F:_ That’s why it’s so important to grow the volunteer base so everyone can see and experience it – kids, adults...

_W:_ It’s gonna change from the kids, which is why I love that we’re in the schools.
A Cross-Community Team of Leaders and Providers

The “Hub” concept we chose as our model contradicted the prevailing notion of a central place or physical space that joined together the independent and often isolated service providers who operated in siloes–into the one-stop shop approach.

The “Hub” was a virtual hub, characterized by strong, integrated relationships—people to people—forming a central way of thinking and being, a new unified team that was capable of creating an integrated service delivery system. The team saw the patient, the student, her family, or the person living alone, often a senior, as the “hub” around which they would gather to engage in continuous communication and mutually reinforcing activities. The hub of health providers gathered strength from one another and formed a tight-knit presence when they gathered together to remove institutional barriers, reach out and join in community events, and bring what they had to offer where it was needed.

Together, by sharing the same space and time—whether to plan, problem-solve, or serve—they became a cohesive, unified team and created a busy hub of commerce—a health economy that would not otherwise exist if they stayed within the walls of their own agency.

Central to our success as a team was including the schools and their leadership as key partners and leaders of the “Hub.” Children are one of the main audiences on which we focused our health screening and prevention services. Conversations about the favorable conditions needed to learn and succeed in school were central to the development of our model and standards of practice. We had a school district willing to address the needs of the “whole child.” They acknowledged that children who are hungry, worried, or in pain are less able to learn and thrive. There are piles of research on the impact of poverty and poor health on a student success, and we were fortunate to have a school leader who started many of the Hub meetings with summaries of these findings and reminded us how important this work was for his students, in spite of or in addition to the many other demands on the school to make sure students succeed.
One of many partner organizations that volunteered services during a MORE (Medical Outreach Response Event) in 2013

“We have kids coming in who are homeless, who need food, whose parents are into drugs. [In the past there has been] this sort of chaotic response, [and now] there’s a meaningful response that’s going to leave that family, that system, better. However they finish, it’s better than what they encountered [previously]. This is, I think, the outcome we’re all hoping for.”

As the group broadened its scope, it retained a sense of unity by developing a charter and vision to guide its efforts—what the authors of “Collective Impact” referred to as the common agenda. The common agenda was first a common goal: to establish a School-Based Health Center. Although that goal remains on the agenda, the scope of work for the Health Services Hub was broadened, and the charter and vision were created intentionally as a framework for the group’s beliefs and efforts. The language of the charter is, by design, aspirational and broad, and as such does not serve as a strategic plan per se. Members of the Hub have struggled with this from time to time, as it can be difficult to pinpoint the purpose of the group—it is many things, and often different things to different participants.

As one participant said, “People were having a very difficult time conceptualizing what the Health Services Hub was. It was very nebulous as to how it would turn out.”

Leaders committed to meeting monthly, and continued to hone their own communication skills to present and reinforce the Hub concept—vision and values—to their staff and networks. Nearly three years into this effort, we continue to explore and refine our understanding through Hub meetings and conversations and create tools (see Hub Graphic and definition) to insure we are consistently communicating the same thing about the Hub model even as we personalize the message.

(School Administrators)
The Health Hub leaders meet monthly to engage in deep conversation and planning; they provide guidance as the processes evolve and programs are piloted and implemented; they review lessons learned and make the decisions necessary to stay focused on our vision. An important lesson learned, and one that compelled us to create a new structure within our Health Hub--the provider network--was that the relationships and evolving partnerships were taking place largely or even exclusively among the leaders of the different Health Hub partner agencies.

"The challenge is getting that information back from the decision makers to the direct service providers. And an example of that is I now have a better understanding of where the schools are in this conversation, just because I’m at the table with the decision-makers from the school. But being able to carry that back to my department and share that out is challenging. And I would just assume that some of the other decision-makers at the table have that same challenge. So we’re at the table saying, ‘hey, this is who we are and this is how we can connect some of these dots, and is J (principal) and K (superintendent) able to get that down to their school counselors? So that their school counselors know who to connect with? So I think that was one of our biggest challenges--getting the information from one level to another. And I think the service provider breakfasts will be valuable in that...connecting those levels to have information going back and forth."
Quarterly provider network breakfasts--hosted by the Food Pantry volunteers--and facilitated by a partner agency leader, with member agency staff taking responsibility for rotating presentations and mini-trainings--have served to galvanize a group that was key to the Health Hub's success. **These provider network meetings** are distinguished from the monthly coalition meetings where they might also come to connect and update their colleagues, but are not as actively involved in shaping what the agenda will be or engaging in deeper conversations and reflective activities. They are also distinguished from MDT (multi-disciplinary team) meetings where the focus is typically on one or more students or families when they come together across agencies; instead **the focus is on the assumptions, values and behaviors that underlie how they might serve all students or families better.** At these meetings they are building personal relationships and practicing the behaviors that marked the quality and impact of the Health Hub leadership team--they are unifying around the same common agenda, practicing radical open-mindedness, evolving new partnerships, and finding practical solutions to put the charter into action together.

The entire group is now able to see their work as a team working under an umbrella--where projects and programs are materializing--that otherwise would have become stand-alone programs or associated only with funding streams.

Taken together the success of the Health Hub lies in its leaders, providers and consumers. The leaders create a culture that supports experimentation and inquiry. The work groups, who initiate cross-disciplinary projects and ongoing action learning, provide the lessons that stimulate discussions and opportunities to shape organizational and regional policies and practices. **The providers** are central to putting what has been thoughtfully created and decided into action, and are the most critical element of the hub in maintaining and sustaining a coordinated system of health care delivery--in every word they say and action they take they directly affect how a consumer comes to see their own health and the options they can exercise to get healthy and stay healthy--for better or worse. The consumers within this coordinated and integrated system of health care delivery will begin to feel supported and ultimately become informed health consumers, capable of making healthier choices, managing their health and become a true partner in creating better health outcomes for themselves as well as for their community. As we said, you must take the long view and continue to dip your toe in and step back on your heels to see whether your assumptions are making sense, or ultimately, making positive change.

"Collective impact initiatives depend on a diverse group of stakeholders working together, not by requiring that all participants do the same thing, but by encouraging each participant to undertake the specific set of activities at which it excels in a way that supports and is coordinated with the actions of others"  
(Kania & Kramer, 2001, p. 40)

Now, with cross-sector coordination and teamwork, the discussion about “how” easily shifts to "who" as one organization will provide physical space and location, another secures professional volunteers, and yet another refers their vulnerable clients rather than seeking independent funding and trying to do it all--they pool their strengths and
Each and every one of us is creating the future, every day, whether we do so consciously or not."
(Pollyanna Principle #2)

So, we choose to step up and consciously and intentionally work toward outcomes we can only achieve as a team...leaders, providers and consumers.

**Conversation Prompts for your Consideration:**

- What might be different for your group if they defined a common agenda—a charted vision and values—that is truly organic, guides your discussions and hold you accountable to one another and to collective impacts?

- What barriers to access and coordinated services might you be able to address differently if you saw yourselves as a unified team instead of separated agencies collaborating with one another and regulated by different policies?

- What changes in your work when/if every member of your Hub steps into their role as a leader of this change effort—and as a member of a unified team dedicated to collective impact?
Evolving Dynamic Partnerships

The charter and vision include goals for positive communication, economic viability, thriving families, integrity, compassion, respect, and collaboration. So much of the vision seemed purely aspirational at the beginning, but two years later the community is seeing actual results: agency staff committed to strengths-based service provision, and inter-agency partnerships that have resulted in new funding and programs for vulnerable families.

Forming a unified team rests on the capacity of all three groups, leaders, providers and consumers (i.e., youth/students, parents/caregivers/families, and other community members), to engage in projects that they could not accomplish alone--to become partners in action.

These partnerships (and thus programs) would not have been possible even two years ago, as the relationships and trust simply did not exist. Perhaps what speaks most strongly to the impact of these partnerships is the difference they are making in the lives of children. Test scores are up, average daily attendance is up, and perhaps more powerfully: children want to come to school each day, looking forward to being part of a community where they can learn and grow.

Partnerships through Projects

An example of partnerships are those that have developed between the school district and other local organizations, including the Boys and Girls Club and the local community coalition, to provide three meals a day to students in Title I schools, dental hygiene services including tooth sealants and fluoride treatments to children in elementary schools, an on-site gardening program that is linked to curriculum and food services, an on-site food pantry managed by volunteers and the community coalition, and a few targeted social support and mental health services to at-risk teens. “One of the [first steps toward engagement in the Hub] was our school board really being open to bringing in the Boys & Girls Club into our schools... they could use our school facilities before and after school for programs. And I think that after that was shown to be a success, that kind of opened the door for the rest of these things to be supported from the get-go than what you might see somewhere else.”

(School Administrator)
An important aspect of evolving and dynamic partnerships is *continuous communication*. For us, it often resulted in our ability to rethink and reframe what was possible as new information came to light or as we reflected on the implications of our decisions. In one early situation, as we shifted from our leadership during the needs assessment process and created a more permanent structure for our Health Hub, we decided to form work groups around key health themes: Primary care (medical and dental); Mental/behavioral health etc. Advocacy was separated into yet another work group.

After struggling to divide the tasks we realized that this designation was not only arbitrary, it violated our overarching goal of integration and coordination—back to silos. We decided to have specific projects that people across disciplines and organizations would contribute to as "work groups" that would foster cross-pollination of ideas and action. As a whole, the leadership team would review data on what was learned or accomplished and decide whether the changes needed were around advocacy or procedural changes.

Our first pilot implementing a dental clinic in the schools resulted in both: We were overwhelmed by the number of pre-K through 3rd grade children who were identified as needing significant dental treatments so we later championed our state to support children without dental insurance getting Medicaid to pay for the follow-up treatments they needed by clarifying that children raised by guardians could be enrolled even if their caregivers personally weren't eligible; and we transported groups of children to a willing urban dental clinic when repeated attempts to secure a mobile dental van did not materialize in a timely or consistent manner.

*Continuous communication* is an essential element of trust and meaningful working relationships between agencies. And stronger, trusting relationships between providers are a powerful outcome of the process. Strong relationships are the basis of formal, successful partnerships—MOUs on steroids. One Health Hub partner remarked:

"The greatest success for me is the network we're strengthening. Because the network has always been there, it just hasn't been strong. Strengthening the network is preparing us for the future—for reaching our big vision at the end."

We got a phone call the other day from a mother who was in a flat-out panic. She couldn’t find her daughter, a first-grader, anywhere. She had looked all over the house, she had gone outside calling her daughter’s name until she lost her voice. She called the school for help—what should she do? We took a look, and the girl was in her classroom—right where she was supposed to be. Mom had been drinking the night before, had a hard time getting up, and so the little girl had gotten up on her own, gotten herself breakfast, gotten herself dressed, and gotten herself to the bus stop—on time. Because school was where she knew she belonged, where she felt safe and it was where she wanted to be. A first-grader. (paraphrased report by a school administrator during a Hub meeting)
Continuous communication and active participation are essential ingredients to strengthening the network—you have to show up, participate, communicate—and maintain "radical open-mindedness" as our young JPO member reminds us.

Other examples of evolving and dynamic partnerships that have supported our goal of integrated, coordinated and comprehensive health services were just as critical as those with the school:

- A new intensive home visiting program to support new mothers and families with children 0-5 years was made possible through a partnership between two agencies—a county agency and local non-profit—to jointly serve the region and residents from each other’s counties and service area, crossing boundaries with a shared purpose.

- Local mental health leaders of state agencies and emerging non-profits have had the opportunity to receive functional and emotional support from one another when they otherwise would typically work in isolation—the support has reduced burn-out and increased retention rates. In rural communities, losing a provider must be avoided if at all possible.

- Community-wide health events involved diverse professional volunteer service providers from within and outside the region and state—our MORE (Medical Outreach Rural Event) and RAM (Remote Access Medicine) events—and have given local residents access to health and dental services they would otherwise not receive.

The Health Hub was able to collaborate with two other counties and the state around a federal Safe Schools Healthy Students grant to expand mental and behavioral health services to students in the schools and provide early childhood social and emotional learning opportunities to young children and their families. This provided the funding to expand upon our first pilot to implement our Hub concept and its charter into other communities in our region.

"I know now if we have a family with a student I could call [school administrators] and say "what can I do?" or "who can you connect me to in your school?" I don't think we had that level of relationship four or five years ago...I now understand some of their limitations, and also their passion for our projects and goals. It's not just the schools; it's all of the service providers. When you meet on a regular basis those relationships are enhanced. I see a lot of hope."

Conversation Prompts for your Consideration:

- What relationships in your own coalition are strongest and are capable of expanding to include others?
- Who are the providers that can model how strong relationships and collaboration actually makes each agency more competitive and effective?
- How do you support people coming together and getting to know one another more personally as well as professionally so that they are bound together in a new way of doing business?
"Prevention First" as an Empowerment Strategy

Under the ACA, both coalitions and medical providers are likely to care about creating a hybrid of “health homes” and “medical homes”—that serve all community members—as appropriate to their needs and situations. Ideally, this will be accomplished through a combination of primary care practices and practitioners, community mental health, FQHCs/RHCs, and support services—where bridge employees link community members to resources—with the goal of moving toward overall individual and community wellness.

Various definitions of Health Home Hybrids offered us a perspective of what we were trying to insure through our Health Hub.

**Health Homes:**

- include a combination of people who serve as bridges to services and supports (Care Coordinators, Community Health Workers, Resource Coordinators; Community Paramedics) —who walk alongside as a mentor and coach until community members/clients gain their footing and take their health into their own hands.

- involve building relationships where people come first and providers share a vision for community health founded on shared core values.

- engage public and primary care health professionals who offer specialized care, treatment and services along with preventive strategies that are critical for our communities to prevent and manage chronic illnesses, stay healthy and thrive.

Together we can educate our communities and insure that every community member is health literate—everyone has the tools, the information, the access and support they need to take charge of their lives, make healthy decisions and manage their health—to get healthy and stay healthy.

This requires that we take the long view. We can address health crises, but we can’t actually make this the sole focus for using and expending resources, even as urgent as the crises before us appears. We must believe and invest in this belief, that people can and will learn to manage their own health given the opportunity and information to do so. Children will make healthier choices if they are exposed to early, regular and frequent health messages, screenings and education.

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3 see How is a Health Home different from a Medical Home in https://www.advisory.com/research/health-care-advisory-board/blogs/the-blueprint/2011/12/what-is-a-medicaid-health-home
For example, in our Health Hub this required a shift of focus and resources from the ever-present and urgent need of middle and high school students and their families with significant mental and behavioral health issues, often resulting in run-ins with the legal system, toward a significant allocation of resources and programming at the Pre-K and elementary level. **The commitment to move down the lifespan continuum to younger children and their families meant letting go of our focus on problems as our motivation to come together** to put a greater stake in prevention and strengthening families with the belief that in the long run, fewer resources and less costly strategies would be needed as children transitioned to adolescence.

In our Food Pantries, where consumers experiencing poverty and its aftermath—hunger and helplessness and poor health—come daily, we have put into practice a pathway to success—from consumer, to consumer-volunteer, to employee—believing that each one can teach one and peers are often better allies than professionals in helping neighbors learn how to make better choices. In this case, the Food Hub overlaps with the Health Hub as we create new ways to link our most vulnerable to health care.

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"Prevention First" as an Empowerment Strategy

Many of our residents have chronic diseases, including diabetes, chronic pain, and heart disease. Our local Rural Health Clinic agreed to open its clinic early for a week to run a pilot with our food pantry volunteers. The typical protocol was for people to come to the clinic, meet with a primary care physician, then determine through assessment and diagnosis, what ailed them and what treatments were needed. Once seen, they could get an order for a blood panel and begin learning about how to make better health choices and manage their chronic conditions. We were able to get the clinic staff to agree to suspend the requirement for a physician's order, and do blood work on anyone willing to sign up. They were also enrolled in the clinic's on-line personal charting program that every patient can access from their smartphone or computer, getting their lab results in days. At the same time as they had their blood drawn, they were given an appointment to see a primary care physician and review their results if they indicated further care was needed. This approach of "getting information first" and services second proved helpful in linking a segment of our community to a primary care provider whereas they would otherwise have resisted going to a doctor until they were in an emergency situation or great pain. Lest you think this all worked smoothly, we are still working on the details of payment and assuring that all staff at each level of our organizations is aware of the agreements and feels empowered to make the necessary changes within the system—in this case billing and invoicing—to insure our community members perceive their access to the health care system as welcoming and respectful.
An emphasis of the vision and charter is to partner with people and support them managing their own health—holding the expectation that with support and education they will make healthier choices—thus our tag line: Take Charge of Your Life—Get healthy...stay healthy. There have been surprises along the way as we see how empowering people can have significant implications—particularly when those people are children and students. Empowering kids to step up and ask for the support they need. “I am going to take charge of my life.”

These two stories demonstrate how the educational intervention allowed students to step in and step up, and get connected with other pieces. In the Hub we talk about removing stigma—normalizing the discussion for students. One of the Community Health Workers commented at a staff meeting:

“We’re starting to reduce stigma in the schools so as they graduate they can change.”

**Conversation Prompts for your Consideration:**

- What drives your coalition or group's attention? Is it "what's wrong?" and is critical or urgent, or is it a vision for what's possible and can be achieved through early intervention and prevention?

- What would it take to shift resources toward paying for prevention and wellness?

- How can you make the case to local providers, policy makers, funders and consumers that prevention will result in a greater return on investment (ROI)?

- What role can your young people play in shifting the focus toward what matters to them and toward a view that their problem doesn't define who they are; that they are a person first with the capacity to move toward their own wellness with your support?

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“When we were doing the Signs of Suicide (SOS) last year at a middle school, they watched a video and completed a response card indicating their need to talk to someone. A girl in class handed in the folded card with “please help me” written in red. I took her aside to talk. At the THRIVE conference, the girl ran up for a hug saying “do you remember me?” She had been referred to the school counselor, and started working with someone in the community. It was an early intervention, she had just moved and changed family situations. She was struggling, depressed, scared, but then she became a part of Rachel's group in the community gardens.” (Mental Health Counselor/Educator)

“SOS also picked up a late middle school kid who was on the verge of suicide - he got his separated parents to sign the form and made sure he was the first person in the room to be screened.” (Mental Health Counselor/Educator)
We have children in schools; hungry people at food pantries; families and workers at places of business; and homebound seniors. Others are accessing support services. These are strategic places where education and health prevention strategies can easily be delivered.

More recently we worked collaboratively with our school district, our local community health nurses and ECE staff and our state’s early intervention services staff to reach out to parents and caregivers of young children 0-5 years through the district’s existing child find events. Our goal is to reach 300 families by each September 30th and conduct developmental screens with their children. We want to make sure that every child and their family members that need additional supports can receive these prior to entering school. The earlier the better.

Dental Days: Meet People Where they Are

Our first collaborative experiments involved bringing our community health nurses, our dentists, hygienists, our food pantry volunteers, and our teachers and school staff together to deliver on-site dental screens. We were able to screen (get data from dental event and plug in) and we also used this service event to learn what worked and what we needed to improve. A big lesson was how we communicated with school personnel. We had done what we thought was appropriate by working with the administration and counselors, distributing consent and information forms, bringing in our community-based partners and implementing an adapted version of the dental screens from our southern partners who were fortunate to have the university’s Dental School provide hygienists to the schools. We had secured the space, the equipment and supplies. We quickly learned that we would not be able to screen most of the pre-K through 8th grade children and tapered our focus to the Pre-K through 3rd graders and took referrals for older youth who had the greatest need. We had provided a brief overview to teachers and asked them to send the children on their list whose parents had consented to the room at a designated time—when a volunteer came to get them. We experienced some resistance from teachers initially, but as the event went on, they learned more about the importance of the screens and how so many children had extreme oral health issues that were preventing them from being able to stay engaged and learn. We prioritized our list of children for follow-up care—those who had X greater than X number of cavities—X in all—remaining dismayed at the lack of dental care and capacity to follow-up on all the needs of the children we saw during Dental Days. Teachers shared that if they had understood what we were doing they would have reached out to more parents to get them to consent for their children to participate. Subsequent dental days are more coordinated and we have been able to establish a system for consistent follow-up with a few providers and partners. We have also been able to have a designated room where we have purchased basic dental equipment and chairs so that we can more effectively screen and do some basic dental care at the school.
After attending five series of school communities’ Child Find events we had a total of 15 children with developmental screens registered in our system. More groups of children are being screened by the exceptional childcare center and our partners on the Classroom On Wheels (COW) Bus; some are being screened through the district’s state-funded Pre-K program. None of these have been entered into our system as of yet. Still, we had trained 26 screeners and only managed to screen 15 over the course of two weeks—if there were others, they had not been inputted into the system we have created to capture screenings whenever and wherever they happen. These data are now bringing our early childhood cross-agency team together to strategize about how to better reach our families with young children. Where are they gathering and how might we meet them where they are? Clearly, the perception of “Child Find” events as a welcoming and inclusive event for all children under five years has not resonated for our families, so we need to think differently.

Conversation Prompts for your Consideration:

- Where do people in your community gather?
- How often have services been coordinated in conjunction with school or community events?
- What might be possible as a starting place for bringing your diverse partners together to address the whole needs of the children, their families or others in your communities?
There are so many gifted people in our communities who are trusted allies in their neighborhoods; whose richness stems from the relationships and networks they’ve built versus the jobs they hold. They often come to us as volunteers and are able to bring others into the conversation, the meeting, or through the door of a health provider, where none of us had succeeded before. They work for the community. When we recognize their value—and our potential to foster these volunteers’ good will AND find opportunities to employ them in these roles as paraprofessionals—we actively begin to see that they, too, along with the patient or community member were at the center of our hub.

We have the responsibility to find, nurture, and create career paths for community members who volunteer their time so they can gain critical skills that enhance their “natural helper” qualities and help them become gainfully employed. It is critical to help them learn and earn a livable wage while staying in our communities as valuable assets and resources. They are key members of our diverse health team that can “bridge” the client, the customer—the patient—to the professionals that can help them manage their health.

What does a Community Health Worker or a Resource Coordinator do as a bridge employee?

When the state initiated a Community Health Worker program and began funding positions around the state, we asked if we could recruit volunteers from our communities and support them to participate in the training the state offered. They agreed. So began our first volunteer roles as Community Health Advocates (we changed the name to reflect our priorities). We recruited three individuals who participate in the state’s monthly webinars, trainings and other network activities. They have served people who use the Food Pantries by linking them to other services, designed and coordinated the school-based Dental Days, coordinated client access at our MORE and RAM events, and offered tobacco cessation and diabetes self-management workshops, among many other activities. They also lead youth teams at the local high schools to do peer-to-peer education and substance abuse prevention activities at their schools and in the community. When our coalition was awarded a Safe Schools Healthy Students grant, we worked with our school partners to create a Resource Coordinator position that would support two of our volunteer CHAs to step into this role and focus their work with families and children from K-8th grade, linking those referred for additional support and services with providers and community partners. Our third CHA was trained in the high schools Certified Nursing Assistant (CAN) program and is now pursuing a degree at the local community college. Eventually we envision a full cadre of volunteer, stipended, and paid Community Health Workers and Community Paramedics who receive their training while living in our communities and are based in schools, community agencies, and health facilities, and serve as bridges for people of all ages.
We have experimented with the Community Health Advocate (CHA) as a bridge employee and were able to evolve that role into a school-based Resource Coordinator through another grant—to focus their work more exclusively with students and their families. The training and competencies of both positions are comparable, and ideally we will train our bridge employees in a common set of core competencies so that we…and they...have flexibility as new positions open or we expand our reach.

Community Coalitions are keenly aware of the untapped potential of their community members as a workforce for current and future employment opportunities. They are also keenly aware that when our youth leave to receive training elsewhere the chances of them returning diminish—and we lose the very resources we need to build our capacity, become vibrant, economically viable communities. Our Health Hub has initiated bridge employees through volunteerism at our food pantries, Dental Days, and other health events. HSH works closely with our schools to place high school students enrolled in career technical programs, like CNAs, into internships or part-time work in their own communities so that we can continue to support their post-secondary training and goals while benefitting from the skills they have already gained. Bridge employees are a successful strategy but depend on how we as a Health Hub have also been able to develop and strengthen two other favorable conditions—to create a cross-agency team of leaders and providers and evolve dynamic partnerships to carry out projects together. Ideally, bridge employees are not owned or regulated by any one agency, but serve as the link—to create the spokes within the hub that can bring our consumers together with the providers they need to get healthy and stay healthy.

**Conversation Prompts for your Consideration:**

- Have you inventoried your community members to learn what gifts they might contribute to your health initiative?

- What opportunities are there for community members who volunteer their time to intern in agencies or health facilities and learn new skills?

- What potential is there for bringing training directly to your community—starting with your high schools—and leading into post-high school training opportunities for community members without leaving their communities to enhance their career potential?
Data-Driven Decision-Making

We defined success on our own terms and used the multitude of resources and expertise already available in our state that collect, analyze and publish health data. We agreed to shared outcomes and indicators and to measure our collective impact over time. For some of our measures of success we designed our own tools to drill down more locally to what mattered and where we concentrated our efforts. We were unabashed in asking for help from university students and volunteers to help us gather our local data. We set baselines and benchmarks and periodically checked our progress and considered what it meant. We were willing to bring our stories and collective wisdom to bear on and make sense of numbers and admit when the whole picture wasn’t clear, wasn’t working or wasn’t acceptable.

Some of the areas where we have benefitted from data-driven decision-making include:

- Rethinking how we treat the dental needs of our school-age children when screening data shifted from prevention to identification.
- Scheduling a brainstorming session to identify new ways to reach our families with our youngest children when Child Find events proved unsuccessful as a strategy to reach families with children 0-3 years.
- Identifying policies such as the Volunteer Medical Provider for Humanitarian Care act and the “Pickle” act and the “cottage industry” act that will improve the health and economic status of our most vulnerable.
- Training our CHWs in the Stanford Heart Disease Prevention model when we realized the extent to which many of our residents living in poverty were challenged by diabetes, obesity, and chronic diseases along with other health issues.
- Working with the schools to create a more universal consent form and health status inventory for distribution at the beginning of the school year when we recognized that parent consent was a barrier to getting our most vulnerable children treated.

The data from our early childhood developmental screens let us know we were falling very short of our goal. They also were an indicator of the fact that we needed to build capacity and provide support so that we could insure the data we have was accurate.

What was needed to insure our partners felt as compelled as we did to record the screening data for children they have seen during the course of their busy days?

Thinking ahead, another qualitative issue for us is how successful we have been at spreading the message about our Health Services Hub and its charter. Are we perceived as walking the talk? And if so, by whom? How has the Hub Leadership conveyed our message and core values to the direct service providers? Where can we provide greater support to insure our community members experience the Health Hub with dignity, respect and as partners in their own health management?

A follow-up meeting after reviewing results of the staff survey led to further discussion around workforce development and the suggestion to market the Health Hub and create incentives for students to consider working in our rural communities.
Ideas ranged from sharing what we were doing with community colleges and universities so we could successfully recruit people to our communities. We predicted that the economic opportunities coming through the Tahoe Research and Industrial Center in Storey County would increase health care needs in our community. If we were to be successful we needed to have a targeted focus on health care professions; we needed to assess and see who had an interest in the health professions and support them getting more training that was mutually beneficial. We decided progressive management and collaborative efforts are vital to recruiting and retaining qualified health providers. As a next step in supporting this effort we scheduled cross-agency Board-to-Board and Peer-to-Peer conversations to plan and act in coordination.

The press is on...the story continues to unfold. We are in the middle of this narrative and can imagine that as we bring information in to compare to our baselines we will be strategizing around many of our goals for children and families and other vulnerable members of our communities for years to come. And we will see how we are improving and where we still need to improve.

**Conversation Prompts for your Consideration:**
Coalitions collect lots of information, conduct numerous needs assessments and attempt to evaluate the outcomes of their efforts.

- What of that data is brought into conversations to focus the group’s decision-making?
- How has your coalition and those concerned with addressing the health needs of your communities defined success?
- What would it take to involve state and university experts in your conversations as partners and contributors to collecting, analyzing and using data to plan and act?
- What would inspire your young people to partner with you in looking at data and serving as health ambassadors to address new ways of getting the message of health out to their peers—that our communities’ health rests on their healthy choices, their career choices and their contributions?

**Data Driven Decision-Making to Expand the Unified Team Concept**

At a recent Health Hub Steering Committee Meeting we reviewed the results of a recent staff survey conducted with direct service providers of our Hub partner agencies. The results were both uplifting and confusing. The conversation that ensued acknowledged that our staff was more educated than we had imagined, yet this in itself didn’t address the fact that there was still turn-over and that most of our staff did not come from or live in the communities they were serving. They had not grown up here; they often left the community at the end of their workday to travel to another community of residence. Several ideas were generated based on a review of the data, as we also realized that the voices of others who serve our community were not included: On a positive note, we hoped that the Health Hub served as protective factor to reduce isolation and reinforce the value of each staff member. We observed that they were given opportunities through the Hub to problem-solve together and leverage resources. We envisioned that the power of attraction offered in our provider network breakfast meetings could be useful for staff to build upon their success and bring in more resources and collaboration as new health issues arose in their daily work. It still wasn’t clear whether our staff could speak in “concrete” ways about how they have used the Hub and what their role is and how what they DO has changed because of our coordination and integration efforts.
Together we have many resources that can be very useful in solving our community’s health priorities. We can be more efficient and effective in our use of these resources if we leverage them alongside our partners—which also creates a new synergy, a more integrated and cost-effective way of delivering health care.

Collective impact stories are most powerful when they can demonstrate how resources can be saved or more efficiently used to achieve something more than what each individual agency is required, mandated, or desires to achieve for a target group. Collective impacts change the formulas we often find in logic models—when we stick with linear thinking and consider how one outcome is derived from a staged series of inputs and outputs—we limit our thinking and our impact to a unidirectional, linear logic. Collective impacts are often the result of messy, dynamic and system level thinking and collaboration where leaders of organizations, like our Health Hub, identify what they all have in common and what they want to achieve together to move the needle on the problem dial toward possibility.

Well-Child Screens are the Responsibility of Multiple Partners

Our story about how we are attempting to reach children 0-5 years of age so that we can provide developmental screens and get them the support they need to help them be ready for school is a prime example of how together we can achieve collective impacts with this subgroup in our region. Our Community Health Nurses (CHN) offer developmental screenings for children 0-5 years as EPSDTs (Early Prevention, Screening, Detection and Treatment). Our schools schedule “Child Find” events for 3-5 year olds every spring and at the end of summer. Our home visitors must administer the Ages and Stages Questionnaire to the children they are seeing in the homes. Our COW Bus staff also administer this tool as a requirement of their funding sources. We have never systematically pooled our data to consider how we might collectively affect this age group. Now we are. Despite learning that our child find events are not the outreach mechanism we had previously thought, we are committed to finding a way to bring together our diverse outreach capacities and our standardized screening approaches to identify and refer children at the earliest moment to give them and their families the support needed to make sure they are ready for kindergarten. Ultimately we are going to be able to provide many more families with these screens and link them to needed supports and services—if we use the four resources in combination and not require families with multiple ages of children to access these services in different locations. We can also bring an important service that CHNs offer—the well-child check-up or EPSTD—that can identify other health and dental needs and get them covered under Medicaid. This represents a viable means of insuring that the children and their families who are unable to pay for the support services we refer them to, can now access them.
Collective Impact Comes from our Collective Strengths

In fact, at our most recent Core Leadership Team meeting, we considered all the favorable conditions we had identified two years ago in our theory of change and asked ourselves:
“What do you see that you would like to bring back to our attention?”
“What do we need to make sure we take the time to...?”

Our conversation never made it beyond one or two, focusing on the condition that we began to see underlies all that we are working toward and are identifying as our collective impact. It weaves together early screening, prevention and intervention—resulting in more children who are ready for school, students who succeed in school and upon graduation are able to successfully transition to adult roles with the capacity to manage their health, thrive and lead meaningful and productive lives. That one condition that we need to take more time to focus on was staying strength-based—both in terms of seeing what’s right about our youth and what assets they can build upon, but also what’s right in our communities and what assets we can build upon to continue to provide the supports, opportunities and services we know are necessary for healthy development and learning.

We all agreed that this perspective—this condition—affects our collective work in that we realized we cannot endorse screening and assessment that only looks at what is missing, lacking or potentially troublesome, adding to the stigmatization we are all committed to eradicating. Further, we believe that it communicates a message we agreed in our charter was not one we wish to send to our children, our elders, our families, our investors—that they are somehow lacking and are the sum of their problems. This disempowers and does not inspire or motivate people to see that they are capable and have the potential to achieve a better status—educational, health, employment, and relational.

The discussion began to wrap around and circle back to the question we had come together to explore as a group:
- What does success mean to us (now) and of the many indicators we’ve identified previously, which are of highest priority?
- What results that we’re tracking/propose to track will be of greatest interest to the various target audiences with whom we will have ongoing communication?

The discussion had been prompted by a question, a condition, and a dilemma. The state was moving toward universal mental health screening for students, based on the recent events at a couple urban schools in the north and south, where students had taken their own and others’ lives. Were we to respond from a place of fear or from a place of sensibility and sensitivity? Could we honor both the despair these situations caused, but also the resilience of so many of our children and youth who are able to thrive through early intervention, caring relationships and meaningful participation at home, school and community, despite the many hardships they face? We chose to focus on what the research on developmental assets tells us—the more assets a young person has, the more likely they are to succeed in school and life and avoid unhealthy behaviors. So we agreed to co-develop a position statement to that effect, basing our argument to our state level colleagues on research and an approach we know works, and that does not exclude the capacity to identify youth who need higher levels of intervention. As a group, we wrote and submitted a letter for our Director and other mental health professionals from partner organizations to share at the next Statewide Mental Health Coalition meeting.

4 Search Institute’s 40 Developmental Assets Research: http://www.search-institute.org/research/assets/assetpower
Our collective impact is more than the reduction of what’s wrong or what we perceive as problems that prevent our communities from thriving. Our collective impact must be measured by what we change for the positive.

**Conversation Prompts for your Consideration:**

- What happens when you begin to define what success looks like as a group?

- What does your group feel are the most important outcomes you can measure to define what success looks like when you collaborate, partner, and become a unified team?

- How does your group stay strength-focused and shift thinking toward what you want to put in place rather than what you want to prevent or decrease?
Next Steps

We continue to evolve and sharpen our focus as we complete each year together. This past year we considered what it would look like if we reached out along Nevada’s major through-ways and joined our efforts with other rural/frontier communities in Nevada. We have taken our Health Services Hub model on the road and are convening conversations with sister coalitions as well as creating a regional Health Services Hub through a newly formed health network—the Rural Nevada Health Network.

Our sister coalitions and their partners are also challenged to meet the health needs of their residents and face many similar issues that have become priorities. To that end we have joined forces to address four critical areas we all are committed to improve:

1. **increasing workforce development opportunities** in the allied and professional health careers that supports community members getting training and employment in their own communities while providing a career ladder for their ongoing professional development;

2. **increasing our use of telemedicine/telehealth systems** in our state and providing our residents with access to specialty care, therapists, and other mental and primary health services;

3. collaborating with existing statewide and national systems (2-1-1) to make them more user-friendly for our consumers and providers by supporting access to information on health resources through Google/GIS on-line apps and SmartPhones, tablets and computers; and,

4. **advocating for legislative changes to support “bridge employees” like the Community Health Workers** we referenced and piloted in our Health Services Hub as well as Community Paramedics, who can coordinate health homes for patients by walking alongside our residents to link them to community resources, support their compliance to discharge plans and increase their skills to manage their own health and chronic diseases.

Together we strengthen our voices, can more wisely use resources that might otherwise be cost prohibitive if only available in one locale, and support each other in maintaining the will and spirit it takes to see what’s possible rather than what isn't working.
We are also considering a name change for our model to more accurately capture what our focus is: Prevention first—Health Promotion, Wellness—and treating illness and disease in a continuous, integrated, high quality manner. So we’re considering what some of our sister organizations are already naming their efforts: a Health and Wellness Hub.

What do you think?

For additional information or resources on creating a Health Hub in your region or community contact:

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