









# Health Commission 2008 Annual Report

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EXECUTIVE SUMMARY AND  
HEALTH COMMISSION  
RECOMMENDATIONS

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## Executive Summary

During 2008, the Kansas City Health Commission continued its efforts to provide sound recommendations and collaborative plans for improving the health of Kansas City. These efforts included policy recommendations to the City Council and the Kansas City community in the areas of 1) addressing health inequities and cultural competence related to infant mortality and 2) appropriate allocation of health levy funds. Some Health Focus Area workgroups addressing the eight Health Focus Areas from the Community Health Improvement Plan (*CHIP*) completed several new and ongoing projects.

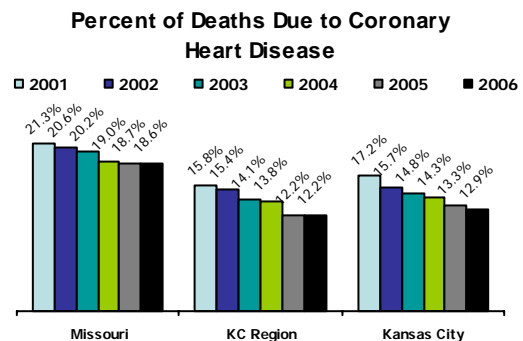
At the same time, the standing committees of the Health Commission have continued to:

- Create a community with smoke-free businesses and public places;
- Identify the social determinants of health that contribute to persistent health inequities in our community;
- Develop a community response in areas with high infant mortality rates;
- Gain a better understanding of the impact of public funds through site visits with the organizations funded by the health levy and ongoing review of safety net contract data.

The Health Commission published the first *CHIP* in 2006 to identify the areas of most importance for collective, community-wide planning and response. That *CHIP* document was the result of two years of community planning and data collection. As part of its ongoing charge, the Health Commission revisited its health priority identification during 2008 and identified five Health Focus Areas to target over the next three years. The process was greatly accelerated this time because the data collection is now ongoing and community input was gained during annual Health Summits. The 2009-2011 Health Focus Areas are concentrated in the following areas:

- Clean Indoor Air – Smoking Cessation
- Wellness for Women and Infants to Reduce Infant Mortality
- Mental Health Disease Management
- Improved Health Care Access and Quality Assurance
- Violence, Crime and Other Social Determinants of Health

Reducing exposure to tobacco smoke continues as a community priority from the 2006-2008 efforts. During 2001-2006, deaths in Kansas City due to coronary heart disease decreased by 26.3% compared to a decrease of 13% for the state of Missouri. Statistical projections based on a national software package from the CDC indicates that on average over 700 Kansas City residents die from direct or indirect exposure to tobacco smoke. Kansas City has experienced some improvement for exposure to second-hand/environmental tobacco smoke. In 2006, 70% of residents surveyed indicated that they do not allow smoking in their home. In addition, 74% do not allow smoking in their vehicles.



This was higher than the rate for Missouri and consistent with national trends. Between 2001 when the Health Commission initiated discussions about a local clean indoor air ordinance and 2007 when KC passed a comprehensive ordinance, annual smoking attributable productivity losses dropped by over \$84 million dollars.

Infant mortality continues to be a community priority for overall health indicators in Kansas City. The most recent data shows that for 2006 the local infant mortality rate (9.4 deaths per 1,000 live births) was significantly higher than the state rate (7.4 deaths per 1,000 live births) and the national Healthy People 2010 goal of 5 deaths per 1,000 live births. When compared to the 2003 rates for 53 large metropolitan areas, Kansas City had the nineteenth highest infant mortality rate. Recommendations for addressing infant mortality using culturally-appropriate strategies for minority populations were developed through a joint effort by the Women's, Infant's and Children's Health Committee and the Minority Health and Health Equity Committee. Those recommendations are presented in Appendix A of this report.

As reported in the KC Star, the availability of service at the Western Missouri Mental Health Center has been reduced to 75 acute care beds with half of those being occupied by patients who would be better served in long-term care facilities. Recently, Governor Nixon proposed an additional 3% cut in spending for mental health services that have seen total reductions of 20% since 2003. Up to 60% of inmates in the municipal corrections center have mental health concerns. At the same time, most inmates remain in the facility for 60 days or less. A report by the Mid America Regional Council pointed out gaps in the behavioral health system including a lack of coordination between medical services and behavioral health services. Successful management of those with long-term mental health needs has the potential to affect cost in many other areas including acute medical care, chronic health care, public education, City and county incarceration, housing, and other social services.

Passage of HB 1549 during the 2008 session of the Missouri General Assembly stand as one of the greatest threats to protecting open access to quality health services. This statute bars use of any state or local funds to provide health services or non-emergency medical care to undocumented persons. As a result, questions exist about the ability of some safety net providers (SNPs) to continue providing needed care to all residents. In addition, KCHD continues negotiations with the SNPs to increase contract performance measures which demonstrate to taxpayers that health levy funds are spent in a cost-effective manner. In 2009, the Health Commission will closely monitor the City's budget process in hopes of ensuring that health levy funds are allocated according to the five principles developed by the Health Commission to ensure efficient use of public funds designated for public health services and medical care for the uninsured/underinsured.

In the 2008 Citizen Satisfaction Survey, Kansas City residents gave low satisfaction ratings to many services that create environments where residents can be safe and healthy. Unfortunately, many social determinants of health (particularly those associated with public health services) are not tracked in this annual survey. A new, national campaign, Unnatural Causes: Are Inequities Making Us Sick, offers new insights on how health is impacted by more than just personal health choices. Efforts are underway to increase local awareness of this video series and to engage in a discussion on the role of social determinants on Kansas City's health outcomes.



## Health Commission

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**Public Health**  
Prevent. Promote. Protect.

### MEMORANDUM

Date: December 23, 2008

To: Mayor Mark Funkhouser  
Cc: City Council Members  
From: Kansas City Health Commission

Re: **Recommendations for FY 2009-10 Budget Allocations for Health Levy Funds**

By City Ordinance, the Kansas City Health Commission was established to help improve the health of all Kansas Citians, with a goal of reducing health disparities that can be the product of ethnicity, demographics and economics. The Health Commission has adopted the following as part of its charge: 1) advise the Mayor, City Council and City Manager regarding how best to utilize the public health and safety net dollars generated by the Health Levy Funds, 2) to maximize primary and secondary illness prevention, 3) to assure equal access, public accountability and transparency of the city funds, and 4) to assure a sound system of safety net providers that provide accessible quality care to the uninsured and underinsured.

Because of the responsibility of the Health Commission to guide the utilization of the Health Levy Funding, we respectfully offer the following two budget recommendations and five allocation principles.

- I. Despite the enormous budget pressures that the City of Kansas City is experiencing this year and is projected to face next year, the Kansas City Health Commission respectfully urges city officials to limit the use of health levy funding to the purpose voted upon by the voters. The purpose is financially supporting the Kansas City Health Department, the safety net providers and MAST so that each entity can make its respective contribution to improving the health of Kansas City residents who are most in need due to medical indigence.
- II. While limiting the use of the Health Levy Funds solely for the Health Department, the safety net providers, and MAST, the Kansas City Health Commission recommends that funding allocations between and among these three groupings be based upon documented community need and the capacity of each funded entity to provide quality preventative and treatment services to those Kansas City residents most in need.

**Principle #1) Protect the Integrity of Health Levy Funding** – As the City Council struggles with current and future budget shortfalls, the Council should not attempt to transfer existing City services or programs from other City Departments into the Health Levy. The Kansas City Health Levy has received support from voters on three occasions spanning a fifty-year period (1955, 1989 and 2005). This ballot success occurred because voters have been confident that the funds generated would be used for the stated purposes; to protect the health of Kansas Citians by funding public health services and to provide a health care safety net for those who would otherwise go without care. Failure to ensure integrity for the use of Health Levy Funds could jeopardize future support by the voters.

**Principle #2) Ensure Equitable Funding for Public Health Services** – A recent national study found that for every 10% increase in public health funding there were decreases of 1.1% to 6.9% in infant mortality and deaths due to chronic diseases. This same study documented that community-based, prevention programs aimed at decreasing smoking, increasing physical activity and improving nutrition provide a return on investment of \$5.60 for every \$1 spent. The most effective way to maximize the positive impact of health levy funding on the health of Kansas City is to ensure that health protection and primary prevention services are adequately supported. Specifically, health protection services eliminated in the FY 2008-09 Health Department budget should be restored. The Health Commission is highly supportive of the principles of public health and primary /secondary prevention. Health Levy Funds should be allocated to those entities in an equitable manner, based upon their capacity with appropriate attention to affordable cost of living adjustments and any attendant historical cost of living adjustments which may or may not have been equitable.

**Principle #3) Increased Emphasis on Primary and Secondary Prevention Across All Uses of Health Levy Funds** – Kansas City regularly finds itself at the bottom of national assessments to find the “fittest” cities (or at the top of “Fattest” City lists). Kansas City fails to meet most of the Healthy People 2010 objectives for chronic diseases including diabetes, cardiovascular health and cancer. There is a need to ensure health levy funds continue to support evidence-based prevention services like chronic disease management programs and early screening/diagnosis of chronic diseases. All prevention services should be based on proven models and have measurable outcomes.

**Principle #4) Ensure That Health Levy Funding Be Invested in A Strong System of Safety Net Providers That Provide Documented Quality and Cost Effectiveness.** - The safety net provider agencies should strive to meet the five financial indicators for agencies contracting with the City as established by the Kansas City’s auditor’s office. This would result in appropriate use of funds for maximum community value.

**Principle #5) Adjust Funding Based on the Changing Geographic Needs for Health Levy Services** – While the majority of need for services funded by the Health Levy remains in the urban core of Kansas City, there are growing needs in the northern and southern areas of our community. These needs should be considered in allocation decisions regarding Health Levy funds.

As the City faces budget shortfalls in the current fiscal year and as you plan for coming budget deliberations, we urge you to carefully consider how the health of our residents impacts other areas of the local economy including economic development, educational achievement, consumer purchasing, business productivity and personal financial stability. The Health Commission strongly recommends that you apply the preceding general principles to all coming deliberations and budget decisions regarding allocation and expenditure of Health Levy funds:

The Health Commission recognizes that allocation of Health Levy funds covers only a portion of the health protection, prevention and health care needs. For our part, the Health Commission adopted five principles related to “The Use Of Health Levy Funds For Public Health And Health Care Services” and requested that those principles be incorporated into system planning and contract negotiations between the Health Department and the safety net providers. These five principles are attached as a reference and will appear in the 2008 Health Commission Annual Report to the City Council. (See Appendix B of this report.)

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**2008 REPORTS FROM KANSAS CITY  
HEALTH COMMISSION'S  
STANDING COMMITTEES**

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## Budget And Contract Evaluation Committee

### HIGHLIGHTS FOR 2008:

- The Committee focused added attention to its 2006 goal to build better communication among the health department, the City's Budget Office, and Safety Net Providers (SNP). Multiple working groups consisting of the Kansas City Health Department (KCHD), safety net providers, and a member of the committee, have worked to better communicate cost issues related to the delivery of indigent care. A similar data collection work group identified diabetes as a significant health issue affecting the indigent population, agreed that data collection and analysis for intervention was appropriate, and designed three measures for data collection during FY 2009. These measures were incorporated in FY 2009 SNP contract agreements. The group will review a year's worth of data, when collected, and make recommendations for intervention.
- Surplus health levy tax revenue was made available for use during the latter part of FY 08. SNPs provided input for potential uses. Approximately 12 possible projects were identified. Funding was available to support the following four projects related to indigent care:
  1. Northland Health Care Access - \$100,000  
Funds supported planning and implementation of a school-based clinic at Crestview Elementary School;
  2. Cabot Westside Health Center - \$250,000  
Funds supported an operational shortfall related to increased provision of care for uninsured and underinsured at that facility;
  3. KC Free Clinic - \$150,000  
Funds supported additional clinic encounters during a period of heavy use, increasing the provision of health care for uninsured and underinsured;
  4. Clinic South of 75<sup>th</sup> Street - \$200,000  
Funds were placed into a restricted City funds account to be used for planning and implementation of a medical care clinic south of 75<sup>th</sup> Street, an area where the City has no formal safety net, health care presence.
- The Health Department's representative for management of the City's indigent care program successfully completed contract negotiations with SNPs earlier than in previous years and with improved relations over previous years. The City's Public Safety and Neighborhoods Committee Chair commended the collegial environment in which recent operations, reporting, and collaboration have been conducted.
- The Committee scheduled onsite SNP visits to increase understanding of their providers' challenges and accomplishments. The Committee visited four provider sites, with plans to visit the remaining sites in the coming year. Resource discussions aided committee members in their understanding of operations. A Health Department briefing on the

current budget status and impact of reductions in the FY 2009 budget also assisted committee members in their knowledge and understanding of the issues. These deliberations were referred back to the full Commission for further discussion. The 2008 calendar year was a significant, focused learning year for the Committee.

- The Committee recommended and the Health Commission approved a letter of support to be sent to the state legislature. The letter supports a state increase in core public health financial support to ease the current strain on local resources in provision of care to the uninsured/underinsured and restoring Medicaid funding support to pre-2005 levels to ease the strain on local caregivers.

### **PLANS FOR 2008:**

1. The FY 09 budget for the department will be analyzed in early 2008 and the Committee will provide comments to the Health Commission;
2. The Committee will continue to monitor the Health Levy Resolution through final approval by the Health Commission;
3. The Committee will continue to advise the Commission and Health Department how best to utilize health levy funds and to collaborate with SNPs in this process;
4. The Committee will advise the Commission and Health Department on recommended allocation of any surplus health levy funds through review of written proposals and other feedback from the SNPs.

### **ACCOMPLISHMENTS FOR 2008:**

1. A Health Department briefing on the FY 09 health levy budget and impact of reductions in the FY 09 budget was provided at the March 2008 committee meeting. The budget review and discussion resulted in a resolution requesting that “Health Levy funding remain restricted to indigent care and public health and not be considered for dilution from funding historically provided by General Revenue funds.” This resolution was forwarded to the full Commission for consideration.
2. The proposed Health Levy Resolution provides a vision from the Commission to the Council as to how they would like to move forward with the indigent care program. The Committee discussed how best to utilize health levy funds and collaborate with safety net partners to improve care and effectiveness of funds spent.
3. The Committee created recommendations which included five principles for “Use of Health Levy Funds for Health Care and Public Health Services” and two recommendations for “Allocation of Health Levy Funds.” The five principles were included in the 2008 Community Health Assessment and forwarded to the Mayor and City Council along with the two recommendations for allocation of Health Levy funds.

4. Additional discussions on criteria for allocation of any surplus health levy funding were placed on hold pending joint quality improvement discussions between the SNPs and KCHD. The Committee will monitor these discussions and provide input as needed.

#### **PLANS FOR 2009:**

- The Committee will monitor development of the FY 10 City budget and provide thoughts/recommendations to the Health Commission for consideration;
- The Committee will continue to monitor City Health Levy funds support, during these economically challenging times, to help assure funds are being utilized for the purposes intended and are used as efficiently as possible;
- The Committee will continue to participate in efforts to facilitate opening of a primary care clinic south of 75<sup>th</sup> Street to better serve the uninsured and underinsured of the south part of Kansas City;
- The Committee, having spent considerable time learning more about health disparities in our community and across our nation, will advocate strongly for increased funding support for health programs that feature prevention and mitigation strategies;
- The Committee will continue support of the data collection efforts of KCHD and SNPs, as they seek to identify prevention and mitigation strategies to improve health of the uninsured and underinsured.

#### **COMMITTEE CHAIR:**

Larry Blankinship, Commissioner Chair

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## Health Planning Committee

### HIGHLIGHTS FOR 2008:

- Coordinated the completion and approval of the 2007 Health Commission Annual Report. The Committee Co-Chairs also presented highlights from the Health Commission Annual Report to the Public Safety and Neighborhoods Committee of the City Council as required by City Ordinance No.051261;
- Completed a Gap Analysis of health needs identified by community members, service providers and health data versus health priorities addressed in 2006-2008 *CHIP* process;
- Coordinated two retreats for the Health Commission to initiate development of a new *CHIP* process. The retreat was shaped by the results of the Gap Analysis, the 2008 NACCHO National Leadership Conference, and committee reports approved at retreat. Barry Daneman, a member of the Committee and the Retreat Planning Task Force, was able to secure outside funding (Bank of America and the Health Care Foundation of Greater KC) to contract with a professional facilitator and cover other expenses related to both retreats.

### PLANS FOR 2008:

1. Determine how to improve upon the *CHIP* activities, for the furtherance of improving health outcomes of Kansas City;
2. Complete the Gap Analysis and priority initiatives derived from the Gap Analysis and the 2007 Health Summit. The next Health Summit will focus on the outcome of this Gap Analysis.

### 2008 ACCOMPLISHMENTS:

1. The Committee determined that a new *CHIP* priority setting and planning cycle was the best strategy for improving on the success of *CHIP* and to address the limited number of measurable indicators in the 2006-2008 *CHIP*. The Committee planned and secured facilitation of two retreats for the Health Commission to identify new health priorities, select new health focus areas (HFAs) and plan for implementation of new a new *CHIP* process.
2. The Committee completed the Gap Analysis and presented the results at the first Health Commission retreat.

### PLANS FOR 2009:

- Coordinate completion of a Health Focus Area Planning Framework template, including development of SMART Goals, for the five Health Focus Areas that will make up the 2009-2011 *CHIP*;
- Draft the new 2009-2011 *CHIP* and submit for Health Commission and City Council adoption. The final document will be published and distributed to community partners. The general public will have access on the Health Commission's web pages;
- Conduct planning activities for the Mental Health Disease Management Health Focus Area including development of SMART goals, completion of the HFA Planning Framework template and implementing action plans for each of the SMART goals;
- Review the operational structure of the Health Commission and draft a report for the Executive Committee based on the questions generated during the second retreat in 2008.

### COMMITTEE CO-CHAIRS:

Tom Cranshaw, Commissioner Co-Chair  
Stan Edlavich, Community Co-Chair

## **Minority Health and Health Equity Committee**

### **HIGHLIGHTS FOR 2008:**

- The committee spearheaded recommendations to make the Kansas City Community Health Assessment more user friendly by requesting a glossary of terms, community census data, and other health data sources be included in an appendix of the report;
- Specific recommendations were made for Infant Mortality and were included in the annual Kansas City Community Health Assessment, 2008.

### **PLANS FOR 2008:**

1. Review remaining chapters in the 2001 Minority Health Taskforce Report;
2. Continue to address health disparities as a result of evaluating and analyzing all available data;
3. Become more specific in recommendations that will increase health outcomes in the minority communities;
4. Complete recommendations from “Patients Bill of Rights.”

### **2008 ACCOMPLISHMENTS:**

1. The committee boasts representation from 26 different health, faith and community based organizations:

African Chamber of Commerce	Metropolitan Organization to Counter Sexual Abuse (MOCSA)
American Heart Association	Mid America Regional Council
American Indian Council	MO Dept. of Health and Senior Services
Beyond the Conviction	National Association for the Advancement of Colored People (NAACP)
Black Health Care Coalition	National Council on Alcohol and Drug Dependence (NCADD)
Blue Cross and Blue Shield	Our Health Matters - News Health Publication
Cabot Westside Clinic	Research School of Nursing
Church Health Ministry Coalition	Resurrection Services
Crystal Home Care	Samuel U. Rodgers Health Centers
HCA Midwest, Research	State of Missouri, Office of Minority Health
Healthcare USA	Thank You Christ Ministries
Healthy KC	Truman Medical Centers
Highland Park Nursing Home	UAW/Ford – Kansas City Quality Improvement Consortium (KC-QIC)
KC Free Health Center	US Department of Health and Human Services
Lincoln University- Extension	Vietnamese American Community of GKC
	Women on a Mission

2. The Committee reviewed remaining chapters in the 2001 Minority Health Taskforce Report (Injury Prevention, Immunization, Substance Abuse and Infant Mortality). Through this review, the Committee decided to provide specific recommendations to target the improvement of infant mortality outcomes in the local minority communities.
3. The Committee created a three-member workgroup to research and addresses the goal. They reviewed a mixture of materials that included local health data as well as looking into more unconventional issues such as the social and environmental inequities that influence health outcomes. The workgroup also collaborated with members of the Women’s, Infants and Children’s Health Committee to complete the process which resulted in a set of specific recommendations that addressed areas of improvement on the individual, community/health provider and policy/legislative levels. These recommendations were included in the annual Kansas City Community Health Assessment, 2009.
4. The Committee had presentations from the different community organizations to gain and understand the resources available to address different disparate health conditions and social determinants of health. These presentations included: Legal Aid of Kansas City, Kansas City Area Transportation Authority -KCATA, US Census Bureau, UAW Ford-Kansas City Quality Improvement Consortium (KCQIC), Women’s Infants and Children’s Health Committee, Metropolitan Organization to Counter Sexual Abuse (MOCSA).
5. The Committee developed recommendations from “Patients Bill of Rights.” A workgroup was assigned to address this goal. It initially discovered there were a wide variety of materials dealing with Patient’s Rights. Several medical disciplines had their own Bills of Rights for their patients. In addition, area hospitals and doctors offices have forms that are provided to each patient regarding their rights. The workgroup could not definitively decide on the path to achieve the goal of providing an outlet of informing the patients of their service rights. This endeavor was dismissed as a goal because it did not seem to have a direct impact on health outcomes in communities of color.

#### **PLANS FOR 2009:**

- The Committee will continue to make specific recommendations addressing the health issues that will increase positive health outcomes in communities of color;
- The Committee will focus on addressing the social determinants of health. It plans to bring awareness to the community regarding the impact that both environment and social deficits have on health outcomes by hosting dialogues in forum settings that could evoke action in improving inequitable social and environmental conditions.

#### **COMMITTEE CO-CHAIRS:**

Honorable Terry Riley, Commissioner Co-Chair  
Ruth Ramsey, Community Co-Chair

## **Tobacco Use Reduction Committee**

### **HIGHLIGHTS FOR 2008:**

- The Tobacco Use Reduction (TUR) Committee continued its leadership in the community by providing educational opportunities for area programs, such as the American Legacy Foundation's KCQIC Tobacco Cessation Recommendations, American Indian Community Health and Lesbian, Gay, Bisexual, and Transgendered smoking trends and resources;
- The TUR committee received reports from representatives of Clean Air KC and Metropolitan Healthy Communities Coalition on technical information needs and a basic status report on the various metropolitan communities and their progress towards clean air ordinances;
- Councilwoman Cathy Jolly presented to the committee on the best way to educate elected officials;
- The TUR committee received educational presentations from members of Clean Air Kansas City and the April 8 ballot initiative for Clean Indoor Air in Kansas City;
- The TUR committee received updates on the possible injunction of the newly adopted ordinance and received education updates surveillance and enforcement efforts when the clean indoor air ordinance was finally enforced;
- Over the five year period 2001-2006 Kansas City experienced 335 fewer deaths due to smoking attributable mortality;
- During 2001-2007, the adult smoking rate for the 7 county Kansas City region dropped 25% going from 31% to 23%.

### **PLANS FOR 2008:**

1. The TUR Committee plans to continue to provide education and technical support to the community regarding secondhand smoke and tobacco prevention and help support education efforts for ordinances and petitions.

### **2008 ACCOMPLISHMENTS:**

1. The TUR committee and its members worked to provide education for the Clean Indoor Air Ordinance (both by initiative petition and by Council action) in 2008. In April, the Clean Indoor Air Ordinance was voted on and adopted by the voters of Kansas City. Its adoption was the realization of a long-term goal of the committee.

### **PLANS FOR 2009:**

- The TUR committee plans to focus their efforts in smoking cessation. It will explore cessation opportunities in the Kansas City Metropolitan area and advocate for more cessation services and resources for residents;

- The TUR Committee will also advocate for improvements in the Missouri state tobacco tax policy. This effort will focus on educating decision-makers and the general public about the negative economic and health impacts of the state's current tobacco excise tax rate which is one of the lowest in the nation.
- The TUR Committee will continue to advocate and educate the general public, business leaders and elected officials on the benefits of passing and/or retaining strong clean indoor air ordinances.

**COMMITTEE CO-CHAIRS:**

Donald Potts, M.D., Commissioner Co-Chair

Michael Seward, Community Co-Chair

## **Women's, Infant's and Children's Committee**

### **HIGHLIGHTS FOR 2008:**

- Collaborated with the Minority Health and Health Equity Committee to produce Infant Mortality recommendations addressing minority health and health equity challenges;
- Identified opportunity for expanded use of KC-CareLink to add client information and to possibly track case management referrals for high-risk mothers (especially first-time mothers);
- Advocated for inclusion of preconception care as part of overall women's wellness efforts throughout the community (Women's wellness is included as central concept for the new Health Focus Area dealing with infant mortality);
- Identified Early Periodic Screening, Diagnosis and Treatment (EPSDT) as a past initiative that significantly impacted children's health and began to research status of that initiative in Missouri;
- Continued to serve as the Community Action Team for the Kansas City Fetal and Infant Mortality Review (FIMR) program by developing infant mortality recommendations based on FIRM findings and including those recommendations in relevant reports.

### **PLANS FOR 2008:**

1. Develop strategies and action steps that address the priorities and recommendations of the "Dying So Young" infant mortality report;
2. Disseminate and communicate the report to key policy makers, city officials, and community stakeholders;
3. Support and promote policies which address the reduction of infant mortality;
4. Research and identify broader crucial health issues, affecting women's, infant's, and children's health.

### **2008 ACCOMPLISHMENTS:**

1. Worked with the Minority Health and Health Equity Committee to develop infant mortality recommendations and strategies that are culturally relevant and specific to minority and underserved populations. (Those recommendations are included in Appendix A of this report.);
2. The "Dying So Young" Report was shared with community partners, Health Commission partners and community resources such as Blue Cross/Blue Shield Foundation and Rotary Club #13;
3. Conducted annual joint meeting with the FIMR Case Review Team to examine the key infant mortality risk factors identified through case findings and identify possible action in two areas – early detection of unintended pregnancies and early intervention to provide information and access to services. These included:

- **Early Detection**
    - a. Obtain resources to off set expenses of providers
    - b. Seek grant from Health Care Foundation of Greater Kansas City to support screening tests for young women
    - c. Address the growing problem of asthma
    - d. Promote United Way 211
  - **Early Intervention**
    - a. Provide nutrition counseling to every woman of child-bearing age during every visit to healthcare provider
    - b. FIMR's Community Action Team initiate efforts to obtain a grant for screening and nutrition counseling
    - c. Encourage schools to get involved with the Community Action Team and screening initiatives
4. Considered other possible interventions including 1) free pregnancy testing (especially for younger women), 2) early identification and referral of high-risk pregnant women, and 3) immediate determination of Medicaid eligibility after clinical confirmation of pregnancy.

**PLANS FOR 2009:**

- Create SMART Goals, strategies, progress indicators and action plans for Women's and Infant's Wellness Health Focus Area;
- Continue development of free pregnancy testing intervention to target young women for wellness outreach;
- Track effectiveness of initiative to provide Medicaid waivers to pregnant women who need immediate access to services.

**COMMITTEE CO-CHAIRS:**

Deborah Jantsch, M.D., Commissioner Co-Chair  
 Betty Cook, Community Co-Chair

**DEVELOPMENT OF  
HEALTH FOCUS AREAS  
FOR 2009-2011**

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## 2008 Report To *CHIP* Community Partners

### **I) Health Commission Overview**

The Kansas City Health Commission is authorized under City Council ordinance and appointed by the Mayor. The role of the Kansas City Health Commission is to serve as an independent health policy voice, to advocate on behalf of all KCMO for improvement of community health with a reminder that health is more than the absence of disease. A major focus is advocacy on behalf of the underserved who suffer from health inequities due to economics, race, lack of health care access, limited behavioral health services, or lack of access to other needed services which adversely affect health and wellness. Our vision is for Kansas City to become the healthiest City in the nation with equitable access to health-related prevention and treatment services for all residents.

Therefore, this Commission is charged with: 1) advising the mayor and city council on public health matters; 2) implementing the recommendations from the Minority Health Improvement Task Force; 3) providing structure and oversight for the development of a Community Health Improvement Plan for Kansas City; and 4) beginning discussions for launching a collaborative process for developing a metro-wide Community Health Improvement Plan. [The 2006 Community Health Improvement Plan (*CHIP*) is available on the Health Commission's webpage at [www.kcmo.org/health/HealthCommission/CHIP3-21-06.pdf](http://www.kcmo.org/health/HealthCommission/CHIP3-21-06.pdf).]

The Health Commission works by emphasizing collaboration amongst all city, regional, state, and federal health resources. The collaboration includes public health agencies, health care providers, behavioral health providers and human service agencies (both public and private). This approach requires communicating and seeking joint advocacy with other public health, health care, behavioral health and human service interests in the region.

The commission's backbone is its five standing committees, established to carry out the work of improving the health of Kansas Citians. Each committee has a commissioner co-chair and a community co-chair. The committees consist of community members as well as members of the Health Commission, who are charged with carrying out the Community Health Improvement Plan. Community members attend regularly scheduled committee meetings held independent of Commission meetings. These committees report on their progress at regular intervals and assist in the development of the Commission's annual report to Kansas City's Mayor and City Council. These committees include:

- Budget and Contract Evaluation Committee
- Health Planning Committee
- Minority Health and Health Equity Committee
- Tobacco Use Reduction Committee
- Women's, Infant's and Children's Health Committee

### **II) 2008 Health Commission Recommendations**

In September 2008, the Health Commission, identified health priorities and a structure for moving forward with a new Community Health Improvement Plan (*CHIP*). The new *CHIP* will implement action plans for the updated, priority health issues in Kansas City as determined by

health data and committee input. These issues were chosen because of their relevance to the health and well-being of the Kansas City community, particularly populations disproportionately affected by health disparities. They include both the substance of the work to be accomplished by the Health Commission and guidance on how the Health Commission will approach this work. Overarching standards that will direct the work on addressing these priority issues are:

- Increase awareness of the connection between the health of the community and overriding issues such as crime, violence, housing, and other social determinants of health;
- Foster primary and secondary preventive services, management of health conditions, and accessible quality care to all residents of Kansas City with a focus on reducing minority and economic disparities;
- Assure transparency and accountability of health levy funding to benefit the recipients of health care services and public health services funded by the health levy;
- Convene and invite grass roots input and participation in all Health Commission deliberations, including SNPs, community advocates, other health care providers and City Departments.

### **III) 2009-2011 Health Focus Areas**

*The Health Commission selected six Health Focus Areas, from its list of 2008 health priorities for Kansas City. These Health Focus Areas are established for three years as the basis for the next Community Health Improvement Plan. The 2009-2011 Health Focus Areas are listed below:*

**Health Focus Area #1: Advocate for the availability of tobacco cessation services,** based on nationally accepted best practices.

*Committee: Tobacco Use Reduction Committee*

*Mentor: Dr. Donald Potts, Professor Emeritus UMKC School of Medicine*

*Monitor: Bill Snook, Kansas City Health Department*

**Health Focus Area #2: Improve wellness of women and infants** in order to reduce infant mortality.

*Committee: Women's, Infant's and Children's Health Committee*

*Mentor: Dev Maulik, Senior Associate Dean of Women's Health and Chair of OB/GYN Department at UMKC*

*Monitor: Cynthia Eldridge-Davis, Kansas City Health Department*

**Health Focus Area #3: Improve mental health disease management** so those with long-term mental health challenges will not die 25 years younger than the general population.

*Committee: Health Planning Committee*

*Mentor: Tom Cranshaw, Executive Director of Tri-County Mental Health Services*

*Monitor: Frank Thompson*

**Health Focus Area #4: Improve health access, quality and outcomes** among Kansas City residents, while focusing on health equity, primary and secondary prevention and for City spending on health related issues.

*Committee: Budget and Contract Evaluation Committee*

*Mentor: Pending*

*Monitor: Clyde Bolton, Deputy Director – Kansas City Health Department*

**Health Focus Area #5: Help reduce impact of crime, violence, perceived safety issues and other social determinants of health on the overall health** of the community. Creating healthy neighborhoods across the city will reduce hopelessness, which in turn will reduce crime and violence.

*Committee: Minority Health and Health Equity Committee*

*Mentor: Pending*

*Monitor: Ursula Copeland*

The work on each Health Focus Areas will be assessed by the Health Planning Committee.

The Health Planning Committee is also responsible for developing responses to the following outstanding issues:

1. Ensure completion of statement of inclusion with emphasis upon ensuring that racial and economic disparities as well as primary and secondary prevention will be incorporated in the deliberations of each Health Action Area;
2. Create a task force on the structure, operations and role of the Commission , established by the Co-Chairs of the Health Planning Committee, to provide a final report with recommendations to the Executive Committee;
3. Bring closure to former Health Focus Area Workgroup members through personal communication and an invitation to participate in the work of the new *CHIP*;
4. Review action steps for each strategy and health action areas, including all plans for specificity, measurability, attainability, relatedness and time required for achievement;
5. Assure mentors and monitors for each health action area;
6. Review progress and update action strategies in relation to changes in community health environment. (Reporting mechanisms to City Council and to Community to share approaches for new issues.)

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## Health Commission Context and Operations

The chart on page 23 represents the structure and context under which the Health Commission operated during the period (2006-2008) covered by the first Community Health Improvement Plan (*CHIP*). As shown in the graphic, the previous structure consisted of five standing committees and eight *CHIP* workgroups. The standing committees each focused on issues and projects related to the charge adopted when the committee was created. (The charge for each committee is available on this webpage - <http://www.kcmo.org/health.nsf/web/docommittees>.)

Each *CHIP* workgroup was responsible for developing objectives and action plans for the Health Focus Areas outlined in the *CHIP* document approved by the KCMO City Council in January 2006 (available at - <http://www.kcmo.org/health/HealthCommission/CHIP3-21-06.pdf> .) Most of these *CHIP* workgroups worked independent of the Health Commission committees and reported their progress to the Health Planning Committee at least twice each year. Each year, one of those update reports coincided with the annual Health Summit where community members were invited to engage in the action planning process for each Health Focus Area.

During 2007, three of the eight *CHIP* workgroups were aligned with one of the standing committees. In the “Health Commission Context” graphic, these relationships are represented by a two-way arrow connecting the committee icons and the *CHIP* workgroup icons. Over the next two years, the areas aligned with a committee tended to show the most consistent progress when reports were submitted to the Health Planning committee. It should be noted that two *CHIP* workgroups (Chronic Disease Secondary Prevention and Environmental Health and Safety) that were not aligned with a standing committee made considerable ongoing progress. For the Chronic Disease Secondary Prevention workgroup, this progress was facilitated by association with a cardiovascular disease grant (developed as a response to the efforts of the workgroup). The Environmental Health and Safety workgroup aligned itself with a pre-existing community coalition that supported the action plans developed by the workgroup.

As planning began for the 2009-2011 *CHIP* process, the Health Planning Committee reached a consensus that all priority areas for the next plan should be aligned with a standing committee of the Health Commission. This recommendation was shared with the Health Commission during its two planning retreats. The Health Commissioners agreed that prior experience clearly demonstrated better progress when the Health Focus Area priorities were associated with a committee or other alliance that included staff support, a defined membership, access to resources, and a commitment to the issues/activities that went beyond the *CHIP* workgroup.

Going forward, each standing committee will devote part of its ongoing efforts to implementing goals, strategies and action plans for a specific Health Focus Area. A new Health Commission Context graphic showing the new alignment between the standing committees and the *CHIP* Health Focus Areas will be developed and included in the final 2009-2011 *CHIP* document.

Following the “Health Commission Context” graphic is the “Health System Improvement Progress Tracking Scale.” This scale was adapted from a federal health improvement initiative

and shows current progress toward an ultimate goal of Kansas City becoming a national benchmark for healthiest communities.

# KCMO HEALTH COMMISSION CONTEXT



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Health Commission Context Graphic

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## Kansas City Health System Improvement Progress Tracking Scale<sup>†</sup> 2009-2011

STEP:		KCMO Equivalent:
☑	1 <b>Catalyst Steps Forward and Community Ready (Ready)</b>	<b>Health Department releases Minority Health Indicators Report, following Ford/UAW KC Community Assessment Factbook. Both documents highlight minority health disparities as a key health challenge and eventually lead to creation of Minority Health Task Force.</b>
☑	2 <b>Community Dialogue Occurs (Talk)</b>	<b>Newly created Health Commission initiated community assessment and dialogue using a national model called Mobilizing for Action through Planning and Partnership (MAPP) – Community Speaks About Health and KCMO Citizen Health Survey reports issued</b>
☑	3 <b>Community Champions Commit (Commit)</b>	<b>Health Commission publicly commits to a vision of improved health, equal access and reduced health disparities for KCMO health “system” – COMMUNITY HEALTH IMPROVEMENT PLAN (<i>CHIP</i>) created!</b>
☑	4 <b>Vision Declared (Declare)</b>	<b>Health Commission engages stakeholders and broader community in discussion of how vision will be realized (action steps, measures of success and timelines) – Health Focus Area (HFA) Action Plans are developed</b>
☞	5 <b>Stakeholders Align Assets (Align)</b>	<b>Health Commission encourages community partners to align existing resources consistent with <i>CHIP</i> to increase access, improve health and/or reduce disparities – Implementation of HFA Action Plans</b>
☞	6 <b>Comprehensive Health System Changes (Build)</b>	<b>Community stakeholders and users adjust the local public health system in accordance with community vision (<i>CHIP</i>) and Action Plans.</b>
☞	7 <b>Results are Seen (Results)</b>	<b>Community produces results which are evaluated against measures of success and timeline developed by Health Commission and community stakeholders</b>
	8 <b>Public Celebration (Celebrate)</b>	<b>Community accomplishments are publicly celebrated</b>
	9 <b>Continuous Improvement (Improve)</b>	<b>Community and Health Commission assesses progress and continue to improve community health</b>
	10 <b><i>CHIP</i> Goals Achieved</b>	<b>KC Community becomes a national benchmark.</b>

☑ - Completed Step      ☞ - Step in progress

<sup>†</sup> Adapted from “100% Access / 0% Disparity” Initiative, Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services, 2000

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**COMMUNITY HEALTH  
IMPROVEMENT PLAN (*CHIP*)  
IMPLEMENTATION PROCESS:  
2006–2008 HEALTH FOCUS AREA  
FINAL REPORTS**

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## Health Focus Area: Primary Prevention

The Primary Prevention Work Group continued the Health Commission's top priority goal: "To promote Primary Prevention as the top priority for the Kansas City metropolitan area with a special focus on minorities and the underserved." For purposes of the *CHIP* process, the emphasis is placed on improving health status of minority residents, enhancing the entire community's awareness on wellness/primary prevention and to mobilizing all stakeholders to work together. In 2008, The Primary Prevention Work Group was combined in the efforts of the Health Commission's Minority Health and Health Equity Sub-committee. Through this mechanism

Primary prevention means taking action to build resilience and to prevent health problems before they occur. The purpose of primary prevention is to limit the number of people who develop a disease or condition by controlling causes and risk factors for one or more diseases/conditions prior to the development of a health issue. The goal of the Health Commission's work is to build momentum for effective primary prevention programming in Kansas City and its surrounding communities.

Primary prevention measures include activities that promote adoption of healthy lifestyles, improve nutritional status, increase physical fitness, expand immunization against infectious diseases, promote the use of automobile passenger restraints and bicycle helmets and create safer living environments. Examples include active immunization against disease as well as health-protecting education and counseling. Since successful primary prevention helps avoid the suffering, cost and burden associated with disease, it is typically considered the most cost-effective form of health care. Primary prevention can be accomplished by the promotion of health and the reduction of risk factors through personal and community-wide efforts.

A key primary prevention approach for eliminating health disparities focuses on advancing a deeper understanding of how fundamental causes of disparity, (e.g., economics and oppression) shape community environments and these environments, in turn, shape underlying determinants of health and illness.

### **Goal:**

Create and list strategies that influence positive health outcomes among communities of color, to be included in the annual Community Health Assessment

### **Strategies:**

- Using data from the most recent Kansas City Community Health Assessment, select at least one health issues to create strategies;
- Enlist the input of service providers and community members to create strategies;
- List the strategies.

### **Action Steps:**

1. Obtain a copy of the most recent Community Health Assessment;
2. Identify local health care providers or social services agencies to participate;
3. Arrange times and dates for the discussing the recommendations;
4. Finalize all recommendations;
5. Submit recommendations to Health Commissioners for acceptance and request to have placed in 2009 Community Health Assessment report.

### **Progress Status:**

Action Steps 1-5. The Minority Health and Health Equity sub-committee completed these action steps between May 2008 and August 2008.

### **Measures:**

Action Steps 5. Completed report accepted and included in the 2009 Community Health Assessment.

### **Actual/Expected Behavioral Changes Or Impact Occurrences And Measures:**

- Inclusion of specific recommendations in the 2009 Community Health Assessment;
- Use of recommendations by individuals and health service organization to increase health outcomes in the identified health area.

### **Expected Long Term Health Outcomes And Measures:**

- An increase in the number of health service providing organizations in Kansas City that incorporate the recommendations into their service delivery;
- By the end of 2009, 20 different community health providing or social services agencies will have viewed the recommendations;
- After reviewing, participants will select at least one recommendation to implement in their service delivery options.

### **Health Focus Area Co-leaders:**

Ruth Ramsey, MHHE Community Co-Chair, Our Health Matters Publication  
Terry Riley Co-Chair, Councilmember City of KCMO  
Ursula Copeland, MSW, Health Department Staff

### **Health Focus Area Workgroup Members:**

Minority Health And Health Equity Committee

Teresa Gerard\*-Blue Cross Blue Shield  
John Cyprus\*-KC Quality Improvement Consortia  
Ron Ellison\*-KC Wellness Network  
Byran Love-Healthcare USA  
Charles Swinton-Church Health Ministry Coalition  
Min Gregg Wilson-Thank You Christ Ministries  
Kelli Hare-Thank You Christ Ministries  
Marva Miller-Thank You Christ Ministries

Barbara Davis-NAACP  
Mona Perry-American Indian Council  
Hazel Wesson-KC Free Health Care Clinic  
Lt. Tracy Branch-U.S. DHHS Region VII Office of Minority Health  
Janette Lockridge-Truman Medical Centers  
Marion Halim-Lincoln University Extension  
Barbara Courtney-Reconciliation Services  
Bobbi McCanse-Research School of Nursing  
Cynthia Hughes-Truman Medical Centers  
Tasha Dixon-Truman Medical Centers  
Preston Washington-Nat'l Council on Alcohol and Drug Dependence  
Robin Barger-NAACP  
Doris Grant-Black Health Care Coalition  
Nina Howard-Samuel Rodgers Health Care Center  
Dorothy Fauntleroy-Health Commissioner

**Other *CHIP* Participating Organizations:**

See Health Focus Area Workgroup Members listed above.

**Potential Future *CHIP* Participating Organizations:**

Cabot Health Center  
Children's Mercy Hospital  
KC Free Health Clinic  
Research Medical Center  
St. Joseph Medical Center  
Samuel Rogers Health Center  
Swope Parkway Health Center  
Private providers

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## Health Focus Area: Tobacco Use

The Tobacco Use Health Focus Area chose to focus on supporting revising the Kansas City Clean Air ordinance. The ordinance ties directly to two other goals and would significantly reduce the number of individuals in our city, both youth and adults, who start using tobacco products, as well as helping to decrease the exposure to secondhand tobacco smoke. In 2008 a major goal was achieved (the adoption of a strong clean air ordinance), and the TUR committee worked to explore a new goal and strategies.

### Goal:

We will work to eliminate secondhand smoke.

### Strategies:

- Promote and encourage changes in the business environment related to all aspects of tobacco use;
- Strengthen and develop policies to reduce secondhand smoke;
- Educate individuals and businesses that no ventilation system can eliminate the toxic products in tobacco smoke;
- Increase enforcement of current policy.

### Action Steps:

1. Provide testimony and education to elected officials on the importance of clean indoor air ordinances;
2. Monitor surrounding Kansas City Metro clean indoor air ordinances;
3. Outreach and partnership with other coalitions and organizations (including organizations in Kansas) who have a similar mission or support clean indoor air environments;
4. Provide technical support to jurisdictions wanting a clean indoor air ordinance.

### Measures:

- Action Step 1. Provided testimony to city council and health commission in winter and spring of 2008 on clean air ordinances brought forth to the council;
- Action Step 2. Devoted TUR Committee meeting time to jurisdictional reports;
- Action Step 3. Continued outreach to different organizations and provided time for informational/educational sessions during meetings.

### Progress Status:

- Action Step 1. From the beginning the TUR Committee's primary focus and goal was to work towards a strong clean indoor air ordinance for the City of Kansas City, Mo. On April 8<sup>th</sup>, the voters of Kansas City passed a very strong clean indoor air ordinance, which included restaurants and bars. However, casino gaming floors were exempted through trigger language aimed at creating a level playing field across jurisdictions that have casinos. The TUR Committee is encouraged by the significant strides made to protect people from the harms of second hand smoke;
- Action Step 2. The committee will continue to monitor and work towards the implementation of the clean indoor air ordinance on casino gaming floors.

**Actual/Expected Behavioral Change Or Impact Occurrence And Measure:**

1. While the TUR committee remains committed to advocating for clean indoor air ordinances and policy change, the committee will put forth more energy to explore and offer ways to help tobacco users quit (cessation);
2. After a discovery and recruitment phase, the committee will construct and decide upon new action steps and measures to direct the work of the committee.

**Expected Long-Term Health Outcomes And Measures:**

- Decrease in chronic diseases contributable to tobacco use;
- Decrease in premature deaths contributable to tobacco use;
- Increase in productivity in affected businesses and organizations;
- Decrease in emergency room and/or physician visits for cardiac and pulmonary diseases.

**Health Focus Area Co-leaders:**

Donald Potts, M.D., Commissioner Co-Chair  
Michael Seward, Community Co-Chair

**Health Focus Area Work Group Members:**

Tobacco Use Reduction committee of the City of Kansas City, Mo., Health Commission

**Other *CHIP* Participating Organizations:**

None

**Potential Future *CHIP* Participating Organizations:**

To be determined

## **Health Focus Area: Mental Health and Addictive Disorders**

These challenging economic times have catapulted mental health disorders into a growing public health concern. Joblessness and financial crisis causes anxiety, stress and depression.

Community-wide stakeholders of consumers and providers have called for improved access to a continuum of mental and physical health resources at a time when budget pressures are raising concerns about cutbacks. The stakeholders are encouraging person-centered programs with cultural competence throughout an expanded system of mental health services with improved care coordination in health care and human services.

The result of economic challenges has been a major shift toward reliance on expensive, crisis-driven services. Clogged emergency rooms, homelessness and incarceration of persons with mental illness are now the norm. Nationwide trends are reflected in Missouri: at least half of jail and prison inmates suffer from a mental illness. The Kansas City Municipal Correction Institute reports that 60% of inmates have mental health and/or chronic health conditions requiring ongoing treatment. Because of challenges with effectively serving mental health consumers and the lack of availability of specialized resources, mental health consumers experience significant disparities in morbidity and mortality outcomes. Tri-County Mental Health, which serves the northern portion of Kansas City, reports that its consumers are 6.6 times more likely to die from pneumonia or influenza and 5 times more likely to die from respiratory diseases.

### **Overarching Goal (From Metropolitan Mental Health Stakeholder's Continuum of Care Committee)**

We will work to make sure there is consumer input and cultural competency at all levels of mental health and addictive disorders planning and programs.

#### **Subgoal Number 1**

We will seek collaborative solutions to address the behavioral health needs of consumers and their families.

#### **Strategy**

- Assure that funding and/or monitoring of behavioral healthcare services include a cultural competency plan, which adheres to minimum standard.

#### **Action Step**

1. Metropolitan stakeholders have encouraged expanded mental health services;
2. Recommendations made to funders to encourage cultural competence;
3. Community mental centers have embraced principles of cultural competence.

#### **Progress Status**

Action Step 1. Completed;  
Action Step 2. Progressing;  
Action Step 3. Progressing.

#### **Measures**

Action Step 1. Completion of behavioral health needs assessment;  
Action Step 2. Monitor impact of above needs assessment recommendations on funding patterns;

Action Step 3. Creation of future assessment reports to monitor cultural competence of available services.

**Actual/Expected Behavioral Change Or Impact Occurrence And Measure**

- Continued awareness of community interest and Health Commission involvement in cultural competency standards for funding of behavioral healthcare

Measure: Documented evidence of increase community awareness and Health Commission involvement

**Expected Long Term Health Outcome And Measure**

- Provide empirical basis for future awareness, information dissemination, and technical assistance

Measure: Report used as an empirical basis for future awareness, information dissemination and technical assistance

**Health Focus Area Co-Leaders**

Bruce Eddy - Jackson County Mental Health Board

Luis Cordova - Mattie Rhodes

**Other *CHIP* Participating Organizations**

Metropolitan Mental Health Stakeholders Group

**Potential Future *CHIP* Participating Organization**

To be determined

## Health Focus Area: Environmental Health and Safety

On October 7, 2008, the work group implemented a point-in-time study to capture domestic violence resource utilization data. Twenty community partners from various disciplines including law enforcement, healthcare, victim services and courts participated in the survey (see “Other *CHIP* Participating Organizations”). Over 800 service hours were documented in the Kansas City metro area during the 24 hour period. Data analysis is underway and a report of the findings will be available in early 2009.

The most challenging data to collect continues to be that of healthcare services. This is due to the often lengthy process required to assure patient confidentiality and compliance with privacy laws. However, the point in time study presented the opportunity to begin working through this barrier. Efforts in this regard need to continue as data is necessary to track occurrences, resource utilization and outcomes.

### Goal:

We will work to reduce the number of times people are victims of crime and violence.

### Strategy:

- Reduce the number of intimate partner violence (IPV) cases.

### Action Steps:

Create a centralized Intimate Partner Violence (IPV) database that will combine data from various organizations and agencies addressing IPV

1. Review current data being collected from IPV responding agencies;
2. Standardize data elements among agencies using CDC surveillance guidelines;
4. Conduct a point-in-time survey to expand partnerships and gain understanding of resource utilization;
5. Use resulting data to obtain support for development and maintenance of centralized client database with a long-term goal of in-depth research resulting in interventions that are more effective.

### Progress Status:

Action Step 1. Finished;  
Action Step 2. Finished;  
Action Step 3. Finished;  
Action Step 4. Progressing.

### Measures:

Action Step 1. Knowledge of data elements currently being collected;  
Action Step 2. Organizations and agencies collecting standardized data elements;  
Action Step 3. Point-in-time study conducted and reports distributed;  
Action Step 4. Creation of centralized client database.

**Actual/Expected Behavioral Changes or Impact Occurrences and Measures:**

- Extent of community resources required for IPV response determined  
Measure: Reports of resource utilization available;
- Improved understanding of scope of problem  
Measure: Target population identified.

**Expected Long Term Outcome And Measure:**

- More effective use of resources  
Measure: Decreased incidence of domestic violence;
- Ability to measure outcomes  
Measure: Identification of IPV trends.

**Health Focus Area Co-Leaders:**

Vicki Beezley – KCMO Health Department  
Dennis Meier – Synergy Services

**Health Focus Area Workgroup Members:**

Amy Bainbridge – Synergy Services	Mary Anne Metheny – Hope House
Sara Brammer – Synergy Services	Susan Miller – Rose Brooks Center
Connie Brogan – St. Luke’s Hospitals	Martha Rigby – KCMO Prosecutors Office
Leslie Caplan - Newhouse	Rick Radakivich, MD – NKC Hospital
Lisa Fleming - Rose Brooks Center	Rosa Underwood – Truman Medical Centers
Captain Mark Folsom – KCMO Police Department	Robin Winner – Synergy Services

**Other *CHIP* Participating Organizations:**

Blue Springs Police Department	Lee’s Summit Police Department
Grandview Police Department	Legal Aid of Western MO
Independence Police Department	Mattie Rhodes Center
Jackson County Family Court	MO Department of Corrections
KC Anti-Violence Project	MO Probation and Parole, District 4
KCMO Municipal Court	
Metropolitan Organization to Counter Sexual Assault (MOCSA)	

**Potential Future *CHIP* Participating Organizations:**

Cabot Health Center  
Children’s Mercy Hospital  
KC Free Health Clinic  
Research Medical Center  
St. Joseph Medical Center  
Samuel Rogers Health Center  
Swope Parkway Health Center

## **Health Focus Area: Women's, Infant's, And Children's Health**

As a community, the health and welfare of women and children is our greatest gift and our largest responsibility. Our abilities and shortfalls in providing timely healthcare for our children will leave a legacy for most of their lives.

In addition to the ongoing goals and strategies listed below, this year the Kansas City Health Commission met in retreat to focus on an aspect of change with high significance to our community. This area of focus is Infant Mortality. The impact we hope to achieve crosses lines and goals of all health-related committees and further characterized the commitment we have as a community to better the lives of our youngest citizens.

### **Goal:**

We want to increase prevention in the number of diseases and deaths among women, infants and children and to promote wellness in their lives.

### **Strategy:**

- Find out what barriers to healthcare and opportunities for wellness exist for women, infants, and children in our community and work to improve the outcomes.

### **Action Steps:**

1. Continue to analyze Fetal and Infant Mortality Data through the Kansas City Health Department database, the Fetal and Infant Mortality Report project of the Mother and Child Health Coalition and other sources.
2. Broadly distribute the needs statements determined by the analysis of this data.
3. Convene a call to action from the analysis of women, infants, and child health outcomes data.
4. Link and Strengthen maternal and child health collaboratives in the Kansas City Area.
  - a. Identify collaborative opportunities.
  - b. Convene directed meetings.
    - i. Early Access To Prenatal Care
    - ii. Access To Care Clinic In Underserved Area Of Kansas City
  - c. Follow The Mission Statement.
  - d. Work To Fulfill The Mission.

### **Progress Status:**

Action step 1: Yearly completion and ongoing.

Action step 2: Yearly completion and ongoing.

Action step 3: Started and ongoing.

Action step 4: Ongoing with grants explored and RFP proposals funded.

### **Measures:**

Action step 1: Support the staff and committee members that review and analyze project data.

Action step 2: Complete and publish annual reports and supplemental progress reports.

Action step 2: Strengthened call to action through commitment of Health Commission Retreat adoption of focus areas.

Action step 4: Foster links to collaboration developed this year and continue this activity. Secure resources and funding through these collaboration efforts.

### **Actual/Expected Behavioral Changes Or Impact Occurrence And Measure:**

*The Impact Occurrence and Measure is the same for all of the above action steps:*

- Women's, Infant's, and Children's Health Committee enabled to identify and recommend interventions.

Measure: Women's, Infant's, and Children's Health Committee identify a minimum of five (5) community interventions from the supplemental report to the Kansas City Annual Community Health Assessment Report.

Measure: Implement the area of focus on Infant Mortality adopted during the Kansas City Health Commission recent retreat.

### **Expected Long Term Health Outcome(s) And Measure:**

*The expected long-term health outcomes are the same for all of the action steps:*

- Reduce Infant Mortality and decrease racial/ethnic health disparity gap within the Kansas City community.

Measure: Review the Kansas City Health Department's Annual Community Health Assessment Report, and other health outcomes data, to determine whether a decrease in infant mortality occurred and a decrease in the disparity gap occurred.

### **Strategy 2:**

- Encourage and increase father and male involvement in women's, infant's, and children's health issues.

### **Action Steps:**

1. Identify, link, and strengthen fathering initiatives or programs into a collaborative.

### **Progress Status:**

Action step 1: Progressing with partners such as Healthy Start, Mother and Child Health Coalition

### **Measures:**

Action step 1: Programs identified;

Action step 1: Written description of collaborative developed.

**Actual/Expected Behavioral Changes Or Impact Occurrences And Measures:**

- Health Outcomes and Measures will be determined.

**Strategy 3:**

- Support and increase the awareness of benefits of breast-feeding for wellness in infancy.

**Action Step:**

1. Identify, link, and strengthen breast feeding initiatives or programs into a collaborative.

**Progress Status:**

Action step 1: Progressing with partners.

**Measures:**

Action step 1: Programs identified;

Action step 1: Written description of collaborative developed.

**Actual/Expected Behavioral Changes Or Impact Occurrences And Measures**

- Health Outcomes and Measures will be determined.

**Strategy 4:**

- Identify measure of wellness among preschool and school age children.

**Action Steps:**

1. Identify, link, and strengthen wellness measures initiatives or programs for young women into a collaborative.

**Progress Status:**

Action step 1: Identify at least two programs to link with pregnancy testing initiative.

**Measures:**

Action step 1: Programs identified.

**Actual/Expected Behavioral Changes Or Impact Occurrences And Measures:**

- Health Outcomes and Measures will be determined.

**Health Focus Area Co-Leaders:**

Betty Cook – Community Citizen Activist  
Judy Moore-Nichols – KCMO Health Department

**Health Focus Area Workgroup Members:**

Janice Anderson - Swope Health Services	Deborah Jantsch, MD – Committee Chair
Mary Jean Brown - Maternal and Child Health Coalition	Susan McLoughlin – Mother and Child Health Coalition
Mariah Chrans – Resident, Youth Advocate	Judy Moore-Nichols - KCMO Health Department
Kay Connelly - TMC-Start Right Teem Moms	Betty Novak - Independent Contractor
Rosemary Graves - N. KC School District	Barb Wiman – St. Luke’s Health System

**Other Chip Participating Organizations:**

None

**Potential Future Chip Participating Organizations:**

To be determined

## Health Focus Area: Chronic Disease Secondary Prevention

The Chronic Disease Secondary Prevention Committee has continued to focus its efforts on utilizing Stanford's Chronic Disease Self-Management Training Program as an avenue to teach individuals how to manage their chronic conditions. In March 2007, approximately 20-22 individuals were trained as Chronic Disease Self-Management Program (CDSMP) Community Leaders. Each leader will be expected to conduct a series of two workshops in their respective organizations (i.e., neighborhood association, faith-based organization, community center, etc.). The purpose of the workshops is to train individuals how to control their chronic diseases through proven self-management methods. Due to the current level of program success, community interest, and discretionary funding provided by the Missouri Department of Health and Senior Services (MDHSS), the group will continue to provide the educational workshops throughout the year. At the June 2, 2007 Health Summit, the committee decided, by majority vote, to continue working on Goal 2 and to choose an additional strategy (i.e., give people useful information and education to help reduce any complications they could get from their chronic diseases).

### Goal:

We will work to make sure people who have chronic diseases do not get sicker.

### Strategies:

- Give people useful information and education to help reduce any complications they could get from their chronic diseases;
- Train patients to take control of their chronic diseases through proven self-management methods.

### Action Steps:

1. Review available chronic disease self-management curricula;
2. Select from among the chronic disease self-management curricula reviewed;
3. Implement the chronic disease self-management program;
  - a. Select agencies to implement program,
  - b. Identify and train the program leaders of each agency,
  - c. Conduct chronic disease self-management classes;
4. Identify Measures of success from program implementation;
5. Address integration of cultural competence/sensitivity;
6. Develop a program structure and plan for sustainability;
  - a. Classes offered by each agency (ask for a 3-year commitment),
  - b. Individual client impact/outcome measures;
7. Identify available/local resources for persons living with chronic health conditions;
8. Explore avenues for promoting the awareness of available/local chronic disease resources.

### Measures:

- Action step 1: Reviewed available chronic disease self-management curricula in 2006;  
Action step 2: Selected Stanford's Chronic Disease Self-Management Curriculum;  
Action step 3: Implemented the chronic disease self-management program (a, b, and c);  
Action step 4: Identified measures of success from program implementation;  
Action step 5: Addressed integration of cultural competence/sensitivity;

Action step 6: Developed a program structure and plan for sustainability (a and b);  
Action step 7: Identified local resources available for persons living with chronic diseases;  
Action step 8: Explored avenues for promoting existing chronic disease resources.

### **Progress Status:**

Action Step 1. Finished: On May 2, 2006, several committee members presented and reviewed cardiovascular health and chronic disease related curricula from the American Heart/Stroke Association (AHA), American Diabetes Association, Centers for Disease Control and Prevention (CDC), National Heart-Lung-Blood Institute (NHLBI), and Stanford University's School of Medicine. Curriculum manuals presented for review included materials such as Search Your Heart (AHA), Health and Aging, The Heart Truth Campaign for Women (NHLBI/AHA), Act in Time to Heart Attack Signs (American Heart/NHLBI), Honoring the Gift of Heart Health (NHLBI), Your Heart-Your Life (NHLBI), and Chronic Disease Self-Management (Stanford);

Action Step 2. Finished: Following the presentations, review, and discussions regarding the various curricula, the committee decided unanimously to utilize Stanford's Chronic Disease Self Management curriculum as the tool for teaching individuals how to manage their chronic health conditions. The Chronic Disease Self-Management Program is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries, and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are usually non-health professionals with a chronic disease (s) themselves. Some of the topics discussed consist of the following: techniques to deal with problems such as frustration, fatigue, pain and isolation; appropriate exercise for maintaining and improving strength, flexibility, and endurance; appropriate use of medications; communicating effectively with family, friends, and health professionals; nutrition; and how to evaluate new treatments. All workshops are free. Each participant in the workshop receives a copy of the resource book, *Living a Healthy Life with Chronic Conditions*. Additional chronic disease related resources are provided throughout the workshop at no charge to the participants. Classes are highly participative, where mutual support and success build the participants' confidence in their ability to manage their health and maintain active and fulfilling lives;

Action Step 3. Ongoing:

- a. In 2008, the following agencies have implemented the CDSMP in a variety of settings (i.e., health centers, health departments, senior centers, faith-based organizations, other community-based organizations, etc.): Kansas City Health Department, Kansas City Chronic Disease Coalition, Swope Ridge, Rodgers Health Center, Guadalupe Center, City of Kansas City, Missouri (Neighborhood and Community Services-Mohart Center), Kansas

City U Church, Phi Delta Kappa, Clay County Public Health Center, and St. Luke's Hospital (Regional Arthritis Center);

- b. In 2007, the Kansas City Health Department and the Kansas City Chronic Disease Coalition recruited/identified twelve local community-based organizations to participate in the CDSMP Leader Workshop. Each organization was required to send two representatives that would attend the CDSMP Leader Workshop. Those organizations included Phi Delta Kappa, Victorious Life, Vineyard Neighborhood Association, Mattie Rhodes, Ivanhoe Neighborhood Association, Oak Park Neighborhood Association, Jackson Memorial Free Will Baptist Church, Thank You Christ Ministries, Macedonia Baptist Church, St. James United Methodist Church, Willis Chapel African Methodist Episcopal Church, and St. Stephen's Baptist Church. Approximately 24 persons were trained as CDSMP Leaders in March 2007. In September 2008, four staff/volunteers from Clay County Public Health Center were also trained as CDSMP Leaders;
- c. Approximately 93 CDSMP classes have been facilitated by leaders. Approximately 302 persons have attended the class sessions facilitated by these leaders. Additional CDSMP Leader workshops and classes will be provided as requested;

Action Step 4. Ongoing: The program has been provided in a number of settings, generally where there is an audience readily available (i.e., patient education classes, senior centers, church group/ministry, etc.). It has also been successful at reaching and serving both persons living with chronic health problems as well as those who do not. The majority of the participants have been persons over the age of 40. At the end of the six-week period, participants have stated that they feel more empowered to communicate with their health care providers and family members regarding their health concerns. They are more inclined to make a list of questions and medication concerns to share with their health care team. Other comments have included benefits from group sharing, brainstorming sessions, action planning/setting weekly goals, and using the problem solving steps in everyday situations (those that are health and non-health related). A few of the participants have also indicated an interest in becoming a CDSMP Leader. Funding to support the CDSMP efforts in the KCMO area continues to be provided by MDHSS. Through this funding, additional classes can be provided and more individuals will be trained as leaders. Funding will be used for supplies, materials, and other local meeting expenses relevant to program implementation. Current funding/grant award period is from June 30, 2008 to June 29, 2009. Due to continued interest in leader training, the next four day CDSMP Leader Workshop has been scheduled for January 29-30 and February 5-6 (2009);

Action Step 5. In Progress: According to research, studies and evaluation done by Stanford, the CDSMP is a one of the best practices/approach to teaching individuals self-management skills. Trained leaders are required to follow Stanford's CDSMP guidelines and procedures. This action step (i.e., addressing integration of

cultural competence/sensitivity) will be further discussed and explored at future task force/committee meetings;

Action Step 6. In Progress:

- a. Funding to support the CDSMP efforts in the KCMO area continues to be provided by MDHSS. Through this funding, additional classes can be provided and more individuals will be trained as leaders. Participating organizations and trained leaders are provided with supplies, materials, and other necessary items (i.e., light refreshments, room rental costs, etc.) needed to conduct CDSMP workshops/classes. Current funding/grant award period is from June 30, 2008 to June 29, 2009. Due to continued interest in leader training, the next four day CDSMP Leader Workshop has been scheduled for January 29-30 and February 5-6 (2009). As new CDSMP Leader Workshops are provided, trained leaders will be expected to facilitate at least one 6-week class. Through limited funding, leaders will be provided with the resources needed for program implementation;
- b. This part of the action step will need to be discussed and explored at future task force/committee meetings. Currently, leaders are administering workshop evaluations during the final week (Week 6 - Session 6) of the workshop. Committee members and/or leaders are collecting, tracking, and maintaining individual client data/outcome measures;

Action Step 7. In Progress: During committee/task force meetings, committee members bring and share chronic disease related resources. Educational materials have been provided by representatives from the American Diabetes Association, American Heart Association, American Cancer Society, American Lung Association, St. Luke's Hospital (Regional Arthritis Center), American Stroke Association, Kansas City Chronic Disease Coalition, Kansas City Health Department, and Missouri Department of Health and Senior Services (Live Like Your Life Depends On It Campaign), St. Joseph Health Center, and HealthyKC.org;

Action Step 8. Ongoing: The committee and CDSMP Leaders have utilized the several avenues for promoting the availability of chronic disease resources. First, a CDSMP brochure was designed a by local contractor. The brochure highlights the components of the CDSMP and will be used as a means for program/participant recruitment. The brochure will be distributed at events like health fairs, health observances activities/interventions, coalition meetings, and other community events. Second, chronic disease information is presented in employee newsletters (i.e., Fountain Pen.), community health newsletters/print media (i.e., Our Health Matters) and water/utility bill inserts (i.e., City Streams). Third, a variety of materials are placed on organizational websites from sources like Healthy KC, American Heart/American Stroke, and MDHSS-Live Like Your Life Depends on It campaign. Fourth, chronic disease resources are continuously made available during the CDSMP Leader workshops and classes.

### **Immediate/Short-Term Behavioral Changes or Impact Outcomes and Measures:**

- Commitment to group leadership training with the Stanford curriculum of personnel from agencies that provides services to a cultural mix of people with chronic illnesses.

Measure:

A three-year commitment from each of the twelve agencies occurred, to provide the Stanford curriculum, to at least 2 groups, each of ten to twenty participants, with chronic illnesses each year;

- Agencies will be assisted with advertising Stanford curriculum's availability.

Measure:

A *CHIP* participating agency will provide media advertising assistance concerning the Stanford curriculum's availability to people with chronic illnesses;

- Participation in the Stanford curriculum by 150-200 people with chronic illnesses during the first year.

Measure:

Eight of the twelve committed agencies provided the Stanford curriculum, to at least 2 groups, each of ten to 20 participant people, with chronic illnesses, by February 28, 2008;

- People with chronic illnesses who have participated in the Stanford curriculum will identify their own measures of confident self-management.

Measure:

Each agency that is providing the Stanford curriculum to people with chronic illnesses will provide this committee with data that documents participants' own measures of confident self-management

### **Expected Long Term Health Outcome and Measure:**

- Over 3 years 12 committed agencies will provide the Stanford curriculum to 400 to 600 people with chronic illnesses.

Measure:

By 2010 400 to 600 people with chronic illnesses will have participated in the Stanford curriculum;

- Each committed agency will commit to an outreach effort or change in procedure or protocol intended to improve the health of their client population.

Measure:

Each committed agency will provide documentation of at least one outreach effort or change in procedure or protocol intended to improve the health of their client population.

### **Health Focus Area Co-Leaders:**

Bobbi McCanse – Research School Of Nursing

Sherbert Harvey – Kansas City, Missouri Health Department

### **Health Focus Area Workgroup Members:**

Maria Boudreaux – Boudreaux and Assoc.

Karlease Bradford – American Heart Association

Lisa Britt – MO Dept. of Health and Senior Services

John Carney – Center for Practical Bioethics

Toni Gatlin – CDSM Leader/ community participant

Judy James – American Heart Assoc.

- Karen Lee – Carondelet Health
- Sharon Maddox – Kansas City U Church
- Orvie Prewitt – St. Luke’s Hospital
- Christine Riederer – KC Health Department
- Marianne Ronan – Kansas City Chronic Disease Coalition (KCCDC)
- Mario Mendoza – KCCDC
- Ella Tolbert – KCCDC
- Tonya Williamson – KCCDC
- Charles Swinton – Church Health Ministry Coalition
- Martina Bowden – City of Kansas City, Missouri (Neighborhood and Community Services)

**Other *CHIP* Participating Organizations:**

None at this time.

**Potential Future *CHIP* Participating Organizations:**

- |                                |                            |
|--------------------------------|----------------------------|
| Kansas City Free Health Clinic | Truman Medical Center      |
| Rodgers Health Center          | VA Hospital                |
| Swope Health Services          | Black Healthcare Coalition |
| Guadalupe Centers, Inc.        |                            |

## Health Focus Area: Oral Health

Three years ago, during a difficult budget year, the State of Missouri decided to terminate Medicaid dental benefits for adult beneficiaries (ages 21 and older). Those affected included the frail elderly, developmentally disabled, mentally ill and medically compromised. Without Medicaid, many of these individuals have no source of payment and cannot afford needed dental care. Safety net dental providers are unable to adequately meet their needs, despite generous support from the Health Care Foundation of Greater Kansas City and Reach Healthcare Foundation. The only long-term solution for meeting the needs of these vulnerable groups is the restoration of Medicaid Dental Benefits within MO Health Net.

Two years ago, when the State of Missouri enacted MO HealthNet to replace the Medicaid Program, it reinstated dental benefits for adults, but failed to budget the monies to implement the reinstatement.

Last year, Governor Blunt put monies in the executive budget to fund adult dental benefits in Mo HealthNet, but the funds were removed by the Legislature. So, the benefit has not been restored. In the 2008 election, Governor Nixon campaigned on restoring the Medicaid cuts of 2006.

### Goal:

We will work to restore adult dental benefits for low-income individuals and families covered by MO HealthNet.

### Strategy:

- Educate the community, providers, insurers, and elected officials about the oral health needs of Missourians.

### Action Steps:

1. Work with other health advocates to establish a new statewide consumer health advocacy organization – the Missouri Health Advocacy Alliance – to provide a united consumer in Missouri health policy;
2. Advocate to reinstate funding for adult dental benefits for Mo HealthNet beneficiaries;
3. Work with other health advocates to establish a statewide grassroots health organization, Missouri HealthCare for All, aimed at securing quality affordable health care (including oral healthcare) for all Missourians.

### Progress Status:

Action step 1: Finished;

Action step 2: Progressing;

Action step 3: Progressing.

### Measures:

1. Action Step 1. MoHAA was established with a grant from the Missouri Foundation for Health in January. Four Kansas City area residents were selected to serve on the interim board, which developed an organizational structure, by-laws, mission, vision and values statements, strategic directions, and recruited an executive

director. The organization incorporated in November and led a statewide advocacy summit to coordinate efforts for the 2009 legislative session;

Action Step 2. Several advocacy groups pushed for the reinstatement of adult dental benefits during the 2008 legislative season: the Missouri Budget Project, Missouri Progressive Vote, Jobs with Justice, Missouri Dental Association. Governor Blunt placed the funds into his executive budget, but they were removed during the legislative session;

Action Step 3. Missouri HealthCare for All established the goal of recruiting one million grassroots members and has began a statewide campaign to raise the visibility of the plight of the state's uninsured and under-insured.

**Actual/Expected Behavioral Changes or Impact Occurrences and Measures:**

*The impact occurrences are the same for both action steps*

- Missouri's health consumers get an effective voice in health reform efforts;
- Policymakers in Missouri gain access to valid and reliable data on the oral health status of their citizens;

Measure:

Missouri policymakers restore funding for adult dental benefits in MO HealthNet.

**Expected Long Term Health Outcome and Measures:**

- Improvement in oral health of Greater Kansas City residents.

Measure:

Reduced dental morbidity, pain and suffering.

**Health Focus Area Co-Leaders:**

Barry Daneman – UMKC Dental School

Brenda Lasater – Seton Center

**Health Focus Area Workgroup Members:**

Karen Dent - Oral Health Network of Missouri

Steve Roling - Health Care Foundation of Greater Kansas City

Michael McCunniff, DDS, MS – Missouri Coalition for Oral Health

Marie Peoples – Missouri Department of Health and Senior Services

**Other Participating CHIP Organizations:**

None at this time

**Potential Future CHIP Participating Organizations:**

AARP

Missouri Dental Association

Missouri Health Advocacy Alliance

Missouri Healthcare for All

Missouri Primary Care Association

Greater Kansas City Chamber of Commerce

## **Health Focus Area: Communicable Disease Prevention and Bioterrorism Preparedness**

This group chose to work on Goal 1 because it was the first priority of those who were in the group at the Health Summit. Members chose to survey current healthcare providers in our area because they felt it was the most effective way to initiate agreements between healthcare agencies for reciprocal referral services as well as the most efficient way to identify healthcare service gaps within our community. Communicable Disease Response is one of the most significant ways that outbreaks and other public health emergencies are avoided in our community. Through the data analysis of disease surveillance information provided to the KCMO Health Department by community healthcare providers, members are able to provide follow-up for initial cases. This prompt follow-up may include prophylactic medications or vaccinations for contacts to prevent secondary transmission of the communicable disease. Further analysis may reveal changing trends by year or geographic area. These trends can be used to develop appropriate disease prevention and intervention activities as well as educational materials for those target populations.

### **Goal:**

We will work to prevent communicable diseases in our communities.

### **Strategy:**

- Link programs and initiatives that promote communicable disease prevention.

### **Action Steps:**

1. Create data collection tool by February 28, 2008;
2. Collect inventory of available resources/services from local health care providers;
  - a. Determine respondent list by March 30, 2008;
  - b. Distribute survey to local health care providers by June 30, 2008;
3. Analyze collected data and assess for service coverage gaps and potential linkages;
4. Report findings and recommendations;
5. Contact KC Care link to determine extent of this information they have already collected.

### **Progress Status:**

Action Step 1: Progressing;  
Action Step 2a: Progressing;  
Action Step 2b: Pending;  
Action Step 3: To start;  
Action Step 4: To start;  
Action Step 5: To start.

### **Measures:**

Action Step 1: Availability of completed form;  
Action Step 2a: Availability of respondent list;  
Action Step 2b: Evidence that survey has been mailed or hand-delivered to providers on respondent list;

Action Step 3: Written report, including maps and other graphics depicting current service coverage and current partnerships and linkages;

Action Step 4: Distribution of written report created in Action Step # 3 to *CHIP* and any other parties with a need to know or an interest in the information [number of copies distributed, type of organizations distributed to];

**Actual/Expected Behavioral Change or Impact Occurrences and Measures:**

- Enable all community providers to better link clients with necessary and appropriate preventive and rehabilitative services.

Measure:

Number of referrals made;

Outcome of referrals made;

Increase in clinic census due to referrals.

**Expected Long Term Health Outcomes and Measures:**

- Increase in number of communicable diseases reported;
- Reduction in secondary transmission of targeted communicable diseases.

Measures:

Percent difference between diseases reported in the current year versus the previous year;

Calculations of previous year's rate of secondary transmission versus current year's rate.

**Health Focus Area Co-Leaders:**

Karen Miscavish – KCMO Health Department

Johanna Koskinen – Hepatitis C Multi-Cultural Outreach Program

**Health Focus Area Workgroup Members:**

Ron Griffin – KCMO Health Department

Tiffany Wilkinson – KCMO Health Department

Lisa Hubbert – KCMO Health Department Bonnie Martin – KCMO Health Department

Tim Gridley – KCMO Health Department

**Other *CHIP* Participating Organizations:**

KC Care Link

**Potential Future *CHIP* Participating Organizations:**

To be determined

## Conclusion

This year has been one of focus, education, and advocacy. There has been advocacy on key health priorities and community initiatives that show movement toward positive outcomes. The Health Commission's central goal of promoting of primary prevention is threaded into each focus area. Overarching most Health Commission activity has been the special focus on minorities and the underserved.

Of special significance during the year is the clean air ordinance passed in April 2008. This represented a major victory for public health and the Health Commission. Other municipalities are following Kansas City's lead. The U.S. Centers for Disease Control acknowledged the City's initiative and the U.S. Surgeon General personally traveled to Kansas City to acknowledge two milestones on the journey to a smoke-free region (passing the comprehensive ordinance in Kansas City and protecting over two-thirds of the metropolitan population through corresponding ordinances).

The building of alliances and partnerships can be seen across the spectrum of *CHIP* initiatives. Behavioral health and oral health have been placed more into perspective as they affect the physical health of the community. Chronic Disease Secondary Prevention has completed a stellar year in providing education and tools for chronic disease self-management. Part of prevention is the mitigation of existing disease to lessen the effects or prevent worsening. This initiative has embraced community partners in senior centers, churches, libraries, hospitals, health departments, and other venues to touch residents in a positive way. Communicable Disease Prevention and Bioterrorism Preparedness provides clarity to the *CHIP* programs in its regional approach to education, awareness, and joint planning for prevention and response. Regional planning is occurring, with mutual support, and data gathering is a major focus. The entire community, including grassroots partners like faith communities, will be much better prepared to address public health outbreaks and other public health emergencies. The yearlong focus on prevention and health disparities has crystallized public awareness of the true factors in good community health, the barriers that must be removed, and the importance of community action planning for health improvement.

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# Appendices

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Health Commission  
Strategies and  
Recommendations

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2008 Annual Report

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**Appendix A: Infant Mortality**

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## Executive Summary

### STRATEGIES AND RECOMMENDATION OF THE KANSAS CITY HEALTH COMMISSON

*Infant Mortality remains a disheartening statistic in this country as well as our city. Some areas of Kansas City fall below the standards of nations in the developing world. Health disparities contribute on a large scale to these poor outcomes and comprise the highest challenge to the measure of health in our community.*

This year the Kansas City Health Commission would proudly like to spotlight the work of its own committees and enrich the Kansas City Community Health Assessment report.

All organizations, faith institutions, social service agencies, medical care providers, employers, governmental agencies, elected officials, foundations and community leaders are encouraged to develop action steps to implement the recommendations in this report. The Health Commission stands ready to collaborate with all groups willing to work on these issues.

These strategies and recommendations are presented as a supplement to this Kansas City Community Health Assessment Report. These recommendations represent many hours of dialogue and a common commitment from those inspired by a vision that improves the health of our community and the health our citizens, especially those most vulnerable. The Minority Health and Health Equity Committee, the Women's Infant's and Children's Health committee, and Tobacco Use Reduction Committee collaborated and convened a joint task force to review the evidence of priority needs in the areas of infant mortality and other maternal and child health issues. The Committees drew heavily on local assessments, case reviews and other resources dealing with infant mortality. A complete listing of these sources is provided at the end of this supplement.

The development of these recommendations addressed the following five areas:

- A. Nutritional Health Strategies and Interventions
- B. Prenatal Care Health strategies and Interventions
- C. Addiction and Lifestyle Health Strategies and Interventions
- D. Asthma and Maternal Medical Health Strategies and Interventions
- E. Psychosocial Risk Factors for Health and Interventions

(The list above is not a prioritized list. Items are listed in order of completion)

Each section of this supplement is presented with overarching goals followed with a chart that examines specific problem or barriers and strategies for addressing the

concern. The strategies are further delineated by focusing the target of interventions towards individuals, communities/organizations or policies. The strategies and recommendations for intervention in this section reflect the diversity of our community and come at action from different viewpoints. The level of stakeholder involvement nurtures the achievement of success in groups that are under-represented and favors balance in access to health care. The recommendations are shared with the Kansas City Community to provide direction for community efforts to improve the health status of the youngest and most vulnerable members of our community.

#### Resources:

- ❖ The Kansas City Health Department Community Health Assessment - 2008
- ❖ Dying So Young: Infant Mortality in Kansas City Report -2007
- ❖ Kansas City Fetal and Infant Mortality Review (FIMR)
- ❖ The Maternal and Child Health Community Assessment Report - 2007
- ❖ Kansas City Community Health Improvement Plan (*CHIP*) - 2006
- ❖ Kansas City Area Snapshot: 2006 American Community Survey
- ❖ Social Determinants of Health: What, How, Why, and Now
- ❖ World Health Organization: Social Determinants of Health

#### Health Commission Committees:

- ❖ Women Infants and Children Committee
- ❖ Minority Health and Health Equity Committee

## A. Nutrition Recommendations and Strategies

**Nutrition** factors of obesity or poor pregnancy weight gain; poor pre-pregnancy, prenatal, or postnatal diet

**Goal: Insure that every (potentially-) expectant mother and new mother and infant have the proper nutrition.**

1. Provide nutritional counseling to every mother at the first prenatal visit and every visit thereafter and ensure early entry into and continued use of the Women, Infants, and Children Program (WIC).
2. Distribute nutrition informational materials.
3. Link expectant mothers to community resources such as Food Banks and additional counseling; and track linkages.
4. Address women's health prior to pregnancy by encouraging the daily intake of folic acid and other vital nutrients.
5. Encourage coverage for and intake of prenatal vitamins.
6. Encourage increasing fiber intake in the first trimester to reduce the risk of developing preeclampsia.
7. Encourage breastfeeding and church/workplace support for nursing mothers (e.g., private areas, refrigeration, policies, culture).

Strategies for Interventions		
Nutrition		
Target	Problem /Barrier	Intervention Recommendation
Individual		
# 1	Nutrition counseling not conducive to the cultural palate	<input type="checkbox"/> Have nutritional counseling and materials available that support diverse nutritional palates i.e. Spanish/Mexican cuisine, American Indian cuisine, African American soul food cuisine  <input type="checkbox"/> Emphasize the positive foods in cultural diet  <input type="checkbox"/> Enroll individuals into WIC
#1	Nutritional value of available food lacks	<input type="checkbox"/> Nutritional counseling should reflect the positive aspects of each cultures cuisine. <input type="checkbox"/> Nutrition counseling should focus on risk reduction food preparation techniques
#2	Nutrition counseling materials	<input type="checkbox"/> Uses brochures that emphasizes positive cultural food in diet selection of nutrition pamphlets
#2 RE	Information is not being connected with mothers and potential mothers	<input type="checkbox"/> Identify locations to interact with mothers

# 3	Women not fully aware of available resources	<input type="checkbox"/> Link to social worker to inform of community resources the meet families unmet needs <input type="checkbox"/> Create tracking mechanism to link mothers to community resources
# 4 and # 6	Women don't know benefits of fiber as it relates to birth outcomes	<input type="checkbox"/> Combine fiber intake with first prenatal visit
Community		
# 2	Materials limited to district	Identify places where large groups of people from the target population shops, socialize, worship, work, learn to distribute educational materials
# 3 FT	People lack access to and the knowledge of where to get affordable nutritious foods	<input type="checkbox"/> Link to community food banks, farmers markets, discount stores and transportation
# 4	Lack of focused message	<input type="checkbox"/> Create campaign to reach target audience
# 4 & # 6	Community doesn't know benefits of folic acid or fiber	<input type="checkbox"/> Integrate information into school system via health /home etc/ PE classes
# 5	Insurance companies feel this is a waste of funds	<input type="checkbox"/> Encourage women/employees to demand coverage
#5	Cost of services	<input type="checkbox"/> Make it a state mandated coverage under Medicaid carriers <input type="checkbox"/> Make it a mandate coverage under commercial insurance carriers
	Coverage for prenatal vitamins respective to existing barriers	<input type="checkbox"/> Establish policy to encourage coverage for and intake of vitamins as well as worked with community organizations
# 7	New moms and the community don't fully understand the value of breastfeeding	<input type="checkbox"/> Education the community, new moms on the value of breastfeeding
Policy		
# 4	The community lacks an understanding of pre-conceptual health concept	<input type="checkbox"/> Create a community awareness campaign of pre-conceptual health: stress folic acid intake and link it to healthy birth outcomes in communities of color
# 4	There are not enough access points for WIC	<input type="checkbox"/> Have satellite clinics <ul style="list-style-type: none"> <li>▪ Create school health clinics</li> </ul>
# 7	Community HR policies aren't breastfeeding friendly	<input type="checkbox"/> Encourage HR policy provisions for breastfeeding (allowance of breaks to express milk, sanitary private places to express milk, place to store milk)

## B. Prenatal Care Recommendations and Strategies

Late entry or no prenatal care; inadequate prenatal or postnatal care

**Goal: Insure that every (potentially) expectant mother and new mother and infant have access to quality health care.**

1. Reduce barriers to early entry into prenatal care.
2. Offer extended hours of service into the evening and weekends [in varied locations as well as quick prenatal visits] for women of childbearing age, especially prenatal services.
3. Have a single personal care provider throughout the pregnancy to increase prenatal care adherence.
4. Coordinate enrollment in Medicaid (including Presumptive Eligibility, Family Planning Waiver, Temporary Medicaid During Pregnancy Program, and Emergency Medical Care for Ineligible Aliens) and WIC (see above) and choose a provider at the same time.
5. Explore ways to remove the cost barrier for pregnancy testing and prenatal services.
6. Provide prenatal classes in Spanish, i.e. English as Second Language patients.
7. Explore ways to get and keep expectant mothers engaged with their care, i.e. classes at prenatal clinics.
8. Consider a comprehensive public awareness campaign with billboards and radio to increase awareness of referral mechanisms and available resources.
9. Identify community/neighborhood ambassadors to assist with identifying at-risk women of childbearing age and expectant mothers for appointment referrals.
10. Monitor the continuation and quality of prenatal care.
11. Educate women on family spacing, family planning, and emergency contraceptives.
12. Insure well-child exam visit schedules are followed.
13. Work with professional community on developing prenatal care guidelines.
14. Review the 25 mandatory newborn screenings offered and recommend additional mandatory screenings, as appropriate.

<b>Strategies for Interventions</b>		
<b>Prenatal Care</b>		
Target Issue	Problem / Barrier	Intervention Recommendation
Individual		
# 1	Women, particularly teens don't understand the importance of prenatal care	<input type="checkbox"/> Conduct a comprehensive community campaign especially in targeted at age, racial/cultural and geographic communities of need
#1	No transportation to appointments	<input type="checkbox"/> Provide vouchers for public transportation
#1	Mothers are not aware of necessity of prenatal care	<input type="checkbox"/> Create a public awareness campaign to increase awareness for first time moms
# 2	Hours, location, availability and waiting room times of prenatal care	<input type="checkbox"/> Encourage easy access and publicize prenatal care site information
# 5	Cost of pregnancy test	<input type="checkbox"/> Offer free or low cost pregnancy tests and triage positive results.
# 6	Lack of prenatal classes in Spanish	<input type="checkbox"/> Encourage Spanish prenatal program expansion and explore alternatives such as videos in Spanish and promotores.

# 7	Keeping expectant mothers engaged	<input type="checkbox"/> Provide ongoing recognition and reinforce the importance of prenatal care at clinic/office sites.
# 11	Education on child-bearing issues	<input type="checkbox"/> Provide education on family spacing, family planning, and contraceptives.
# 12	Clients don't keep appointments	<input type="checkbox"/> Use a telephone reminder system regarding upcoming appointments
Community		
# 1	Young African American women fail to enter into early prenatal care	<input type="checkbox"/> Stress the importance of early entry into and continuation of prenatal care services through community public awareness health media campaigns
# 1	Materials limited to district	<input type="checkbox"/> Identify places where large groups of people from the target population shops, socialize, worship, work, learn to distribute educational materials
# 1	First-time moms have problems with timeliness into timeliness of entry into prenatal care	<input type="checkbox"/> Reduce wait times for first appointments by prioritizing scheduling of first appointments
# 2	Clients are working or in school when services are offered	<input type="checkbox"/> Get agencies to create extended clinic hours. <input type="checkbox"/> Coordinate extended hours of service to create comprehensive coverage to provide service hours in the evening somewhere in the community throughout the urban core <input type="checkbox"/> create a marketing plan to the target the urban
# 4, # 5, # 7	Women don't always have the financial resources to access care	<input type="checkbox"/> Enroll women into Medicaid the first visit <input type="checkbox"/> Allow MC+ plans to come to facility to educate women on their plan benefits and to enroll women into their program.
# 5	Cost of pregnancy test at most providers may pose a barrier to young women	<input type="checkbox"/> Develop programs and resources to offer free pregnancy testing targeting young African American women
# 5	Young African American women are not accessing prenatal care due to a cost of pregnancy testing and thus fail to enter into early prenatal care	<input type="checkbox"/> Develop programs and resources to offer free pregnancy testing targeting young African American women
# 6	Clients don't know where to get services in their language	<input type="checkbox"/> Identify community organizations that provide ESL prenatal care services. <input type="checkbox"/> Provide services using an interpreter
# 8	Public awareness campaigns don't typically last long and they aren't always comprehensive	<input type="checkbox"/> Public awareness campaigns need to be ongoing at least in two year cycles. <input type="checkbox"/> Public awareness campaigns should be comprehensive incorporating both print and broadcast media as a part of the plan <input type="checkbox"/> Public awareness campaigns should

		<p>be created by agencies that are indigenous to the target community</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Public awareness campaigns should be placed in media outlets/ papers that primarily target communities of color</li> </ul>
# 8	Funding for public awareness campaigns are limited	<ul style="list-style-type: none"> <li><input type="checkbox"/> Program budgets should also include funds for public awareness campaigns</li> <li><input type="checkbox"/> Require a certain percentage of program funds be spent with media that reach the communities of color through media outlets that are indigenous to the communities of color</li> <li><input type="checkbox"/> Require public awareness campaigns to be targeted where greatest disparities are identified</li> </ul>
# 9	Case-management has been shown to improve birth outcomes for both first time and high risk moms but most programs can't provide this level of service to the client population	<ul style="list-style-type: none"> <li><input type="checkbox"/> Expand availability of prenatal evidence based case-management services for all high-risk (low income and first time) moms</li> </ul>
#11	Women don't know about the health ramifications of birth spacing	<ul style="list-style-type: none"> <li><input type="checkbox"/> Conduct a comprehensive community campaign especially in targeted at age, racial/cultural and geographic communities of need</li> </ul>
#1-14	High-risk women face multiple barriers for successful pregnancy outcomes prenatal care	<ul style="list-style-type: none"> <li><input type="checkbox"/> Link mothers to evidenced-base prenatal case-management for high-risk low income first-time moms</li> </ul>
#1-14	Personal transportation not always available to access services	<ul style="list-style-type: none"> <li><input type="checkbox"/> Fund public/mass transportation i.e. bus passes/cab/ to and from prenatal health services</li> </ul>
#1-14	Not enough access points to prenatal services	<ul style="list-style-type: none"> <li><input type="checkbox"/> Create small clinics throughout the community</li> </ul>
# 1	Many women are hindered by a variety of personal/ system and community issues that prevent early entry into the prenatal care service system	<ul style="list-style-type: none"> <li><input type="checkbox"/> General—Comprehensive prenatal / postnatal case management program—early identification, referral to community / prenatal resources, tracking care delivery, monitoring outcomes:</li> <li><input type="checkbox"/> Establish Prenatal Program Advocates to help facilitate the process and systems across programs, organizations, and geographies</li> </ul>
# 8, # 9,	Program are not well promoted in the communities of color	<ul style="list-style-type: none"> <li><input type="checkbox"/> Develop a grassroots communications / outreach campaign to get at-risk individuals into the health provision system sooner.</li> </ul>
# 10	Prenatal services are not monitored for continuation and quality	<ul style="list-style-type: none"> <li><input type="checkbox"/> Monitor prenatal services to ensure continuation and quality of prenatal care services</li> </ul>
# 12	Not every child receives comprehensive screenings	<ul style="list-style-type: none"> <li><input type="checkbox"/> All children should receive well child exams which should include screenings for Asthma, Allergies,</li> </ul>

		Medical/Dental Conditions and Behavioral Health
Policy		
#1	Young people don't understand about preserving their health and don't know what's important to a developing	<input type="checkbox"/> Incorporate this information into school Health, Home Economics, Life Science or PE classes
#4	Clients are forced to visit multiple agencies to access needed support services or assistance programs	<input type="checkbox"/> All provider sites (testing and care) should have staff trained to conduct enrollment into all assistance programs.
# 13	Prenatal care services are not provided according to best practices for 100% of visits.	<input type="checkbox"/> Adopt guidelines to ensure best practices of prenatal care services are applied for all visits based upon women health status <input type="checkbox"/> Work with health care payers to pay for the care related to each individual's personal health needs
#14	There should be a review of the mandatory screenings infants receive	<input type="checkbox"/> Review the mandatory 25 infant screenings and make suggestions for additional

## C. Addiction and Exposure to Cigarette Smoke, Alcohol and Street Drugs Recommendations and Strategies

**Goal: Provide assistance for every (potentially) expectant mother and new mother to eliminate her addictions and exposure to others with addictions.**

1. Encourage all women of childbearing age to seek smoking cessation preconception through the first year of infancy. In addition, encourage all expectant mothers to reduce/quit smoking any time throughout the pregnancy, even in the last month, for a healthier birth outcome.
2. Encourage parents/caregivers of infants to decrease/eliminate exposure to second hand smoke (i.e. at home, at child care sites, in vehicles, in public places) to reduce negative respiratory conditions such as asthma.
3. Screen all expectant mothers for tobacco, alcohol and drug use and support remediation through service referrals and follow-up.
4. Encourage dialogue about this subject at the first prenatal care visit. Assess for underlying (mental health issues), with potential for self medication.
5. Support timely referrals to health care professionals for focused counseling to end substance use prior to and during early pregnancy; and track referrals.

<b>Strategies for Interventions</b>		
<b>Addiction and Exposure to Tobacco /Second Hand Smoke</b>		
Target	Problem/Barrier	Intervention Recommendation
<b>Individual</b>		
# 1	Women smoking during pregnancy can have a negative impact on the fetus' health	<input type="checkbox"/> Encourage all women of childbearing age to seek smoking cessation preconception through the first year of infancy. <input type="checkbox"/> Encourage all expectant mothers to reduce/quit smoking any time throughout the pregnancy, even in the last month, for a healthier birth outcome.
# 2	Women smoking around the infant can have a negative impact on the child's health	<input type="checkbox"/> Encourage parents/caregivers of infants to decrease/eliminate the child's exposure to second hand smoke (i.e. at home, at child care sites, in vehicles, in public places)
<b>Community</b>		
# 3	Women aren't always screened for use of tobacco or illicit drug use	<input type="checkbox"/> Encourage dialogue about substance use at the first prenatal care visit. <input type="checkbox"/> Screen all expectant mothers for tobacco, alcohol and drug use <input type="checkbox"/> Assess for underlying (mental health issues), with potential for self-medication.
# 4, # 5	Women who are identified as having a problem don't fully understand the meaning of addiction	<input type="checkbox"/> Educate women on the "disease" of addiction
<b>Policy</b>		
# 4, # 5	Women who are identified as having a problem with illicit drug use are not supported in	<input type="checkbox"/> Assign women to a social worker for adequate tracking and follow through <input type="checkbox"/> Construct and monitor a prenatal /

	treatment or recovery	postnatal care plan <input type="checkbox"/> Refer all expectant mothers for alcohol and drug use recovery services at current visit <input type="checkbox"/> Follow-up on patients progress at each visit throughout prenatal care
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## D. Other Maternal Medical/Dental Recommendations and Strategies

**Goal: Insure that expectant mothers and infants are served for other medical and dental conditions, especially asthma, diabetes, and hypertension.**

1. Encourage all women of childbearing age to engage in proper brushing and flossing and seek dental care for healthier birth outcomes.
2. Discourage consumption of soda pop for expectant mothers and infants.
3. Encourage proper, early oral hygiene and a child's first dental visit by age 1.
4. Encourage recommended immunizations for all women of childbearing age and caregivers of infants.
5. Promote awareness to providers about asthma as a discrete risk factor for diminished perinatal outcome.
6. Teach mothers of infants with asthma ways to reduce allergens in the home.
7. Teach mothers the importance of keeping regular visits for follow-up care for infants who have chronic health conditions.
8. Ensure that existing medical conditions that complicate pregnancies and new medical conditions resulting from pregnancies are managed.
9. Reduce maternal stress levels to decrease the risk of asthma and allergies in infants.
10. Refer infants to the Children with Special Health Care Needs (CSHCN) program, e.g. cerebral palsy.
11. Encourage testing for AIDS and STD's, e.g. herpes, Chlamydia, etc.
12. Continue to explore ways of increasing available community venues for disseminating SIDS Risk Reduction Recommendations.

<b>Strategies for Interventions</b>		
<b>Other Maternal Medical /Dental Health Issues</b>		
<b>Target</b>	<b>Problem /Barrier</b>	<b>Intervention Recommendation</b>
<b>Individual</b>		
# 1	Women don't know the importance of good dental hygiene and it impact on a pregnancy	<input type="checkbox"/> Educate all women of childbearing age to [engage in proper brushing and flossing and] seek dental care for healthier birth outcomes. (Priority Level-4)
# 3	Women don't know that children should see a dentist by the age of one.	<input type="checkbox"/> Educated women on early proper oral hygiene <input type="checkbox"/> Encourage mother to have child's first dental visit by age 1.
# 2	Women don't know the connection of between the consumption of some food items and its relationship to chronic diseases such as diabetes	<input type="checkbox"/> Discourage consumption of soda pop for expectant mothers and infants
# 4	Women don't understand all the immunizations they may need to maintain their health	<input type="checkbox"/> Encourage recommended immunizations for all women of childbearing age and caregivers of infants.
# 5	Expectant women don't know that asthma is a discrete risk factor for diminished perinatal outcome.	<input type="checkbox"/> Educate expectant mothers about asthma and its relationship to perinatal outcomes.
# 6	Because of psychosocial	<input type="checkbox"/> Educate mothers the importance of

	stressors mothers might choose not to attend all regular visits	keeping regular visits for follow-up care for infants who have chronic health conditions.
# 8	Women don't always relate other medical conditions as impacting a healthy birth outcome	<input type="checkbox"/> Ensure that existing medical conditions that complicate pregnancies and new medical conditions resulting from pregnancies are managed.
# 9	Women don't fully understand that stress can influence the outcomes	<input type="checkbox"/> Educate women to reduce maternal stress levels to decrease the risk of asthma and allergies in infants.
<b>Community</b>		
# 1	Doctor's don't screen for dental problems at prenatal visits	<input type="checkbox"/> Screen all women of childbearing age for dental health for healthier birth outcomes.
# 4		<input type="checkbox"/> Encourage recommended immunizations for all women of childbearing age and caregivers of infants.
# 5	Women don't know the connection between asthma and healthy birth outcomes	<input type="checkbox"/> Promote awareness to providers about asthma as a discrete risk factor for diminished perinatal outcome.
# 6	Mothers/caregivers might not be aware about how to reduce exposure to allergens	<input type="checkbox"/> Create a community public awareness campaign to educate mothers of infants with asthma ways to reduce allergens in the home.
# 7	Because of psychosocial stressors mothers might choose not to attend all regular visits	<input type="checkbox"/> Educate women of childbearing age the importance of keeping regular visits for follow-up care for infants who have chronic health conditions.
<b>Policy</b>		
# 1	Health Insurance doesn't cover dental problems	<input type="checkbox"/> Encourage private/public insurance to cover dental care for women while pregnant
# 11	Women might not know if they have sexually transmitted infections (STI's) while pregnant	<input type="checkbox"/> Encourage testing for AIDS and STI's, e.g. herpes, chlamydia, etc
# 12	Women don't know support is available for them and their child with special needs	<input type="checkbox"/> Refer expectant mothers to social worker for support in accessing special needs services or directly to the State Dept of Social Service <input type="checkbox"/> Refer infants to the Children with Special Health Care Needs (CSHCN) programs, e.g. cerebral palsy.

## E. Psychosocial Risk Factors Recommendations and Strategies

**Goal: Insure that expectant and new mothers are screened for psychosocial conditions, including depression, domestic violence, and homelessness.**

1. Screen women (both partum and post-partum) for depression and other mental health issues; and track referrals.
2. Assist expectant mothers, new mothers and infants facing domestic violence, i.e. battered women and child abuse.
3. Assist expectant mothers, new mothers and infants facing housing issues, i.e. homeless women and infants.

<b>Strategies for Interventions</b>		
<b>Psychosocial Risk Factors</b>		
<b>Target</b>	<b>Problem/Barrier</b>	<b>Intervention Recommendation</b>
<b>Community</b>		
# 1	Women might be experiencing depression or other mental health issues	<input type="checkbox"/> Screen women (both partum and post-partum) for depression and other mental health issues; and track referrals. (Priority Level-4) <input type="checkbox"/> Refer women for assistance if mental health issues are found.
# 2	Women might not know that they have alternatives other than staying in an abusive relationship	<input type="checkbox"/> Screen women for domestic violence issues upon first visit or if notable signs are present <input type="checkbox"/> Assist expectant mothers, new mothers and infants facing domestic violence, i.e. battered women and child abuse.
# 3	Women might not know of community resources regarding housing support	<input type="checkbox"/> Refer expectant mothers to social worker for support in accessing housing services or directly to a housing social service agency <input type="checkbox"/> Assist expectant mothers, new mothers and infants facing housing issues, i.e. homeless women and infants.

## List of Participants

The Health Commission would like to thank all the committees that participated in creating this section of the 2008 Health Commission Strategies and Recommendations. Additional thanks goes to the community organizations and agencies for their commitment to participating in all monthly Health Commission activities. Special thanks go to the following committee and community members listed below for their dedication in completing this endeavor. These members are denoted with an asterisk.

### MINORITY HEALTH AND HEALTH EQUITY COMMITTEE

Terry Riley Co-Chair	Councilmember City of KCMO
Ruth Ramsey Co-Chair*	Our Health Matters Publication
Teresa Gerard*	Blue Cross Blue Shield
John Cyprus*	KC Quality Improvement Consortia
Ron Ellison*	KC Wellness Network
Byran Love	Healthcare USA
Charles Swinton	Church Health Ministry Coalition
Min Gregg Wilson	Thank You Christ Ministries
Kelli Hare	Thank You Christ Ministries
Marva Miller	Thank You Christ Ministries
Barbara Davis	NAACP
Mona Perry	American Indian Council
Hazel Wesson	KC Free Health Care Clinic
Lt. Tracy Branch	U.S. DHHS Region VII Office of Minority Health
Janette Lockridge	Truman Medical Centers
Marion Halim	Lincoln University Extension
Barbara Courtney	Reconciliation Services
Bobbi McCanse	Research School of Nursing
Cynthia Hughes	Truman Medical Centers
Tasha Dixon	Truman Medical Centers
Preston Washington	Nat'l Council on Alcohol and Drug Dependence
Robin Barger	NAACP
Doris Grant	Black Health Care Coalition
Nina Howard	Samuel Rodgers Health Care Center
Dorothy Fauntleroy	Health Commissioner

### WOMEN'S, INFANT'S AND CHILDREN'S HEALTH COMMITTEE

Deborah Jantsch Co-Chair*	Midwest Women's Healthcare, PC
Betty Cook Co-Chair*	Community Participant
Mary Jean Brown*	Mother and Child Health Coalition
S. Jean Craig	Mother and Child Health Coalition
Kay Connelly	Truman Medical Centers
Mariah Chrans	Community Participant
Rev. Michael Brooks	Zion Grove Baptist Church
Dana Leonard	Healthcare USA
James Guillory	KCUMB
Betty Novak	Mother and Child Health Coalition
Barbara Winan	St. Luke's Hospital
Melissa Robinson *	Black Health Care Coalition

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Frank Thompson  
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# Health Commission Strategies and Recommendations

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## 2008 Annual Report

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### **Appendix B: Use of Health Levy Funds for Health Care and Public Health Services**

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## **Recommendations For Use Of Health Levy Funds For Health Care And Public Health Services**

The Kansas City Health Commission is working to achieve five principles with regard to use of public funds for public health and health care expenses. Those five principles are:

***Principle A: All Levy funds are to be invested with a focus upon quality improvement, public accountability, collaboration and transparency. These factors are to apply to all Safety Net Providers (SNPs) and the City Health Department as funds are allocated, utilized and reported.***

***Principle B: Contracts between the City and the safety net providers will include quality improvement measures jointly agreed upon by the City and the safety net providers with regular updates to the Health Commission.***

***Principle C: References to the development of electronic medical and health records, electronic bridging and electronic verification are intended to be directional and implemented to the extent affordable, feasible and not to the detriment of providing quality care to the residents in need of care.***

***Principle D: Collaboration between the Health Department and the safety net providers is encouraged with appropriate allowance for input into new policies and procedures.***

***Principle E: The ultimate goal is to ensure public accountability of all levy funds that are expended with a goal of maximizing access to needed care for the under-insured residents of Kansas City. Implicit in the accountability criterion is the need for the public to understand performance measures for services provided under the levy funds with reporting mechanisms that are informative to the public and non-duplicative to the providers.***

## List of Participants

The Health Commission would like to thank the Budget and Contract Evaluation Committee that participated in creating this section of the 2008 Health Commission Strategies and Recommendations. Additional thanks goes to the safety net providers, community organizations and agencies for their commitment to participating in all monthly Health Commission activities. Special thanks go to the following committee members and safety net representatives listed below for their dedication in completing this endeavor.

### BUDGET AND CONTRACT EVALUATION COMMITTEE

<u>NAME</u>	<u>ORGANIZATION</u>
Larry Blankinship, Chair	Blankinship Distributors (Business Representative)
Tom Cranshaw	Tri-County Mental Health, Inc. (Mental Health Representative)
Dr. Cathy Davis	UAW-Ford Community Health Care Initiative (Union Representative)
Dr. Deborah Jantsch	Midwest Women's Healthcare (Health Care Provider)
Linda Vogel	Community Volunteer

### EX-OFFICIO MEMBERS

Councilwoman Cathy Jolly, Health Commission Co-Chair	City of Kansas City – Sixth District At-Large
Landon Rowland, Health Commission Co-Chair	Everglades Financial (Business Representative)
Rex Archer, MD MPH, Health Commission Co-Chair	Director of Health - Kansas City (Public Health)

### SAFETY NET PROVIDER REPRESENTATIVES

<u>NAME</u>	<u>ORGANIZATION</u>
Jimmy Brown	Swope Health Services
Karen Dolt	Northland Health Care Access
Louise Edwards	Children's Mercy Hospital
Deanna Farley	Cabot Westside Clinic
Hilda Fuentes	Sam Rodgers Community Health Center
Gerard Grimaldi	Truman Medical Center
Kathryn Knotts	Truman Medical Center
Nicole Schmidt	Cabot Westside Clinic
Jason White	Metropolitan Ambulance ST
Sheri Wood	KC Free Health Clinic

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Frank Thompson, Health Commission Liaison

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