



**Health Care
Foundation**
OF GREATER KANSAS CITY



A DECADE
of DIFFERENCE





TO OUR COMMUNITY PARTNERS,

This summer marks the 10th anniversary of the first grants awarded by the Health Care Foundation of Greater Kansas City (HCF). Since then, we are proud to report that we've given more than \$200 million to area agencies in support of quality health for the uninsured and underserved.

In anticipation of this key milestone, we asked our partners to tell us about the successes and challenges they've experienced along the way, as well as their thoughts about what may lie ahead. The opinions and expertise of those we spoke with are reflected in this publication and on a digital timeline available at HCFDecadeofDifference.org.

We've learned, of course, that many difficulties remain. Yet much has been accomplished. And amazing opportunities abound. So while it is important to understand the lessons of the past 10 years, it is equally essential to celebrate how far we've come together. This is our time to reflect on the many partnerships formed, the countless conversations and discussions, the meetings, the late nights and fundraisers, the helping hands, the determination and sheer grit that have contributed to better health in our community.

For HCF, it has been a privilege to work alongside so many committed individuals and organizations and to invest in truly imaginative ideas. Together, we've seen how these efforts have blossomed and transformed the lives of those who struggle at the margins of our society.

All of us seek a safer, more equitable and healthier world. But we understand we will never accomplish this goal alone. Now more than ever, we need assistance from those who haven't traditionally engaged in health. We need partners across the community—not just agencies and government, but educators, employers, associations, clubs, families and individuals.

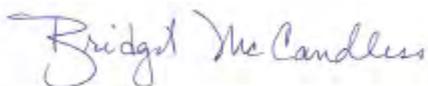
By pulling together, we can create a culture of health in our community where everyone has access to healthy foods, clean water and clean air; where peace of mind exists and people can walk safely throughout the city; where they're able to raise children who grow up with energy and joy and who feel comfortable in their own skin, free of the complications of psychological trauma and preventable disease.

Yes, it's a dream. But we invite you to dream with us. Because each step builds on the one that came before. And each step brings us closer to making that dream real. The path may be crooked, steep and long. But together, we will get there.

It is our hope that this opportunity to look back provides you, as it has us, with a sense of pride in what we've been able to accomplish together. We also hope that it renews your energy and determination to tackle the work ahead.

We want to thank those of you who have participated in this project for sharing your successes, for teaching us about the real and often-dire needs in this community and for imagining and working toward a better culture of health. We look forward to discovering what the next 10 years can bring.

Sincerely,



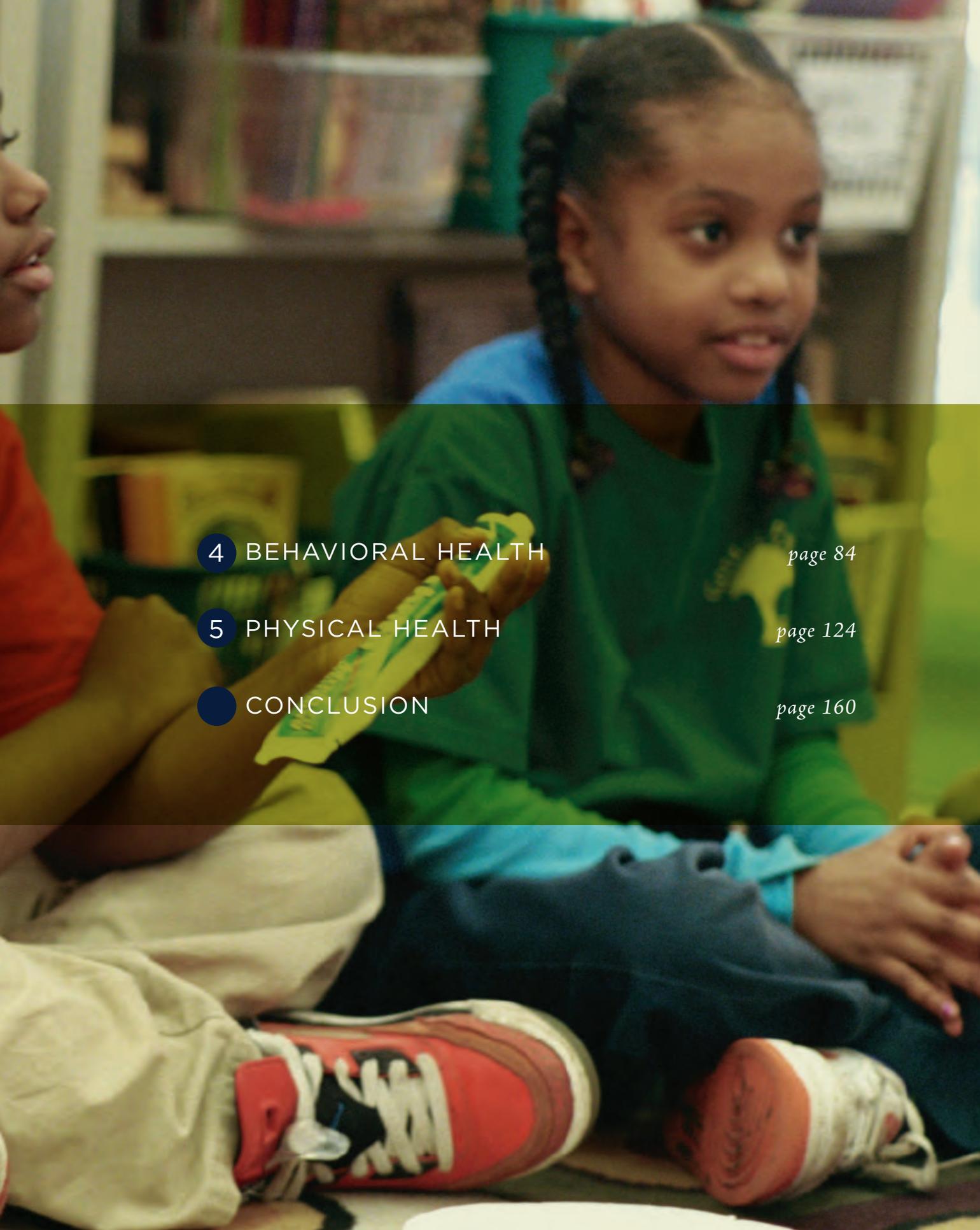
Bridget McCandless, M.D.
HCF President/CEO



A photograph of two young boys sitting and talking. The boy on the left is wearing glasses and has his hands clasped. The boy on the right is looking towards him. They are both wearing red t-shirts. The background is slightly blurred, showing what appears to be a classroom setting with a blue bulletin board.

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INTRODUCTION

In 2005, the Health Care Foundation of Greater Kansas City (HCF) began making grants to Kansas City area organizations committed to eliminating barriers to quality health for the uninsured and underserved.

HCF was created two years earlier through the sale of Health Midwest hospitals to Hospital Corporation of America. Since 2005, HCF has awarded more than \$200 million to over 400 organizations.

The past decade has been a difficult period for many individuals and organizations served by the foundation. Yet it has also been a time of unmatched opportunity. Most notably, the passage of the Patient Protection and Affordable Care Act (ACA) in 2010 represented a landmark event in the evolution of health care reform.

As HCF completes its first decade of grantmaking, we have looked back across the health care landscape to better understand the accomplishments and obstacles surrounding care to the uninsured and underserved in the Kansas City region. Our objective is to learn from, and reflect upon, past experience, in order to better inform the community's collective efforts going forward.



THE PROCESS

HCF contracted with researchers to conduct a series of interviews and focus groups with health care stakeholders. The results of those conversations represent the heart of this report. Nearly 200 individuals participated in the process. Their reflections and insights about the past, present and future of health in the region were enormously beneficial.

But even though stakeholder feedback forms the bulk of this document, the final product inevitably has been filtered through HCF's lens. The contents therefore ultimately are the responsibility of HCF.

This document is not meant to be an evaluation of HCF or the grants we've funded over the past 10 years. Nor is this an assessment of population-level health needs or secondary data trends, which are already available in the community. Rather, the goal was to take advantage of our unique perspective in the health community to examine system-level challenges, changes and opportunities.

This assessment has allowed us to more clearly see the enormous strides that have been made in our region since 2005. Too often, those knee-deep in the day-to-day work of bringing about change are unable to pause to appreciate the role they have played in advancing the field. A spirit of cooperation, collaboration and commitment is reflected in these pages and in these efforts, and HCF is proud to be a part of the progress our community has experienced.



COMMUNITY CONVERSATION on health,
Kansas City, Missouri.

LOOKING BACK

Difficult economic times over the past decade left many providers and community agencies grappling with growing demand for services even as funding and resources fell. The Great Recession, which officially began in December 2007, marked the most extensive economic decline in the U.S. since the Great Depression. Unemployment, loss of income and loss of health insurance reduced access to health services for tens of thousands in the Kansas City area.

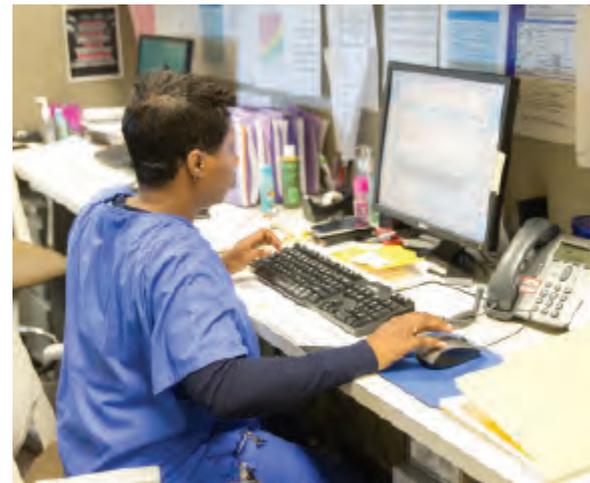
The economic uncertainty also affected individual health care decisions. Reports suggest that during periods of recession, some individuals choose to forego not only elective surgeries and preventive screenings, but also basic care for acute and chronic conditions.

One significant change over the past decade has been a major shift in the demographics of the greater Kansas City area. The region has experienced an increase in poverty, particularly in suburban areas, such as Johnson County. There has also been a dramatic change in racial and ethnic demographics, including rapid growth in the Latino population.

The political landscape likewise has been altered. Changes at the local, state and federal level influenced a variety of developments across our region. Clearly the largest of these was the passage of the ACA, which was signed into law in 2010. The ACA created a range of opportunities for those served by the safety net system.

While the ACA's health insurance marketplace has made health insurance coverage available to 96,000 people in Kansas and 253,000 in Missouri, the law's full impact on the uninsured remains unknown due to the lack of Medicaid expansion in both Missouri and Kansas.

The law also promises significant investments in provider capacity and help in delivering care in a more coordinated manner. Specifically, the ACA has encouraged the creation of innovative delivery systems, such as patient-centered medical homes, community-based collaborative care networks and accountable care organizations (ACOs).



Despite the ACA's potential, stakeholders continue to express uncertainty about the legislation's ultimate impact, given the systemic change it seeks to initiate and the inevitable setbacks or complications that may accompany these changes.

Importantly, the last decade saw a positive shift toward greater collaboration at multiple levels across the area health community: New relationships were established between similarly situated agencies, providers and other public and private organizations.

These partnerships have helped agencies work smarter and accomplish more with less. This spirit of collaboration has perhaps been felt most keenly in the area of healthy eating and active living, as organizations have worked together to foster a powerful movement that is changing daily behaviors across the community.

The health care workforce has shifted over the past decade in response to a rapidly changing environment. Increasingly, the safety net system has changed from volunteer-driven organizations to a paid provider model.

There have also been changes in the types of roles needed to provide quality care. Care coordinators, patient navigators and community health workers all have emerged or re-emerged as the integration of care has accelerated. Building a diverse workforce dedicated to the mission of working with low-income populations has been, and will remain, a challenge. For example, competition with better funded, for-profit organizations makes it difficult to recruit and retain skilled professionals.

One important philosophical change that has occurred over the past decade involves the way in which we view a healthy community. In the past, the system has concentrated on identifying and treating sickness. Today we're more focused on promoting wellness.

The recognition that good health comes not just from receiving quality medical care but from stopping disease before it starts is taking hold in all aspects of our lives, including where and how we live, eat, learn, work and play. As part of this awareness, we've come to understand that everyone — individuals, families, businesses, educators, health care providers and government — all has a role in creating a healthier community.



**WE'VE COME TO
UNDERSTAND THAT
EVERYONE HAS A ROLE
IN CREATING A
HEALTHIER COMMUNITY.**

LOOKING AHEAD

Stakeholders were asked to share their thoughts about what can be done to build on the gains of the past decade and address current challenges. Several themes emerged.

ACA: Although some of the potential of the Affordable Care Act has yet to be realized, it is clear that the law will continue to shape and drive transformation in our health care system for years to come. Debates will continue around Medicaid expansion, shifts in employer-based commercial insurance and emerging models such as the patient-centered medical home and accountable care organization.

INTEGRATION: We know that many individuals receiving care for behavioral health conditions also have physical and oral health conditions that require medical attention, and vice versa. In the past, providers have tended to operate independently with resulting gaps in care, inappropriate care and increased costs. But new and promising approaches are being pursued to integrate physical, behavioral and oral health care, as well as preventive, chronic and acute care.

NEW AND PROMISING APPROACHES ARE BEING PURSUED **TO INTEGRATE THE SPECTRUM** OF HEALTH CARE.



TECHNOLOGY: The science and technology of health care are evolving at a rapid pace. Widespread and meaningful use of electronic health record systems, combined with a robust infrastructure for health information exchange, can improve the quality, safety and efficiency of health care for everyone. Yet it will take money and commitment to keep up with the rapid developments in the field and reap the promise such systems offer.



HEALTH EQUITY: To achieve quality health in our region, societal factors impacting health must be addressed. These include, but are not limited to, poverty, environmental threats, educational inequalities, neighborhood disinvestment and inadequate access to health care due to income level, race and ethnicity.

We know now that ZIP codes matter to health as much as genetic codes. In truth, they often represent major barriers to health for many. We also know that events that occur early in life, particularly traumatic ones, can influence physical and behavioral health for years afterward. Health providers consequently are realizing that they need to look beyond their own exam room to better treat patients. We need to continue developing strategies that improve the health of the disadvantaged and address the many disparities that plague our community.

COLLABORATION: We understand that it will take the combined efforts of multiple sectors, including those for which health is not a primary focus, to make the Kansas City area a healthier region. The problems we face will never be solved by one group alone.

Throughout these pages, we've reported on five broad areas: behavioral health, healthy eating and active living, oral health, physical health and tobacco prevention. Our goal is to paint a picture of the distance we've collectively traveled over the past 10 years. In so doing, we hope that all who have contributed to this journey will realize that despite many challenges and significant setbacks, enormous progress has been made.



CHAPTER ONE

**HEALTHY
EATING
&
ACTIVE
LIVING**



HEALTHY LIVING PARTNERSHIPS FLOURISH IN KANSAS CITY

Recognition that wellness and prevention are the ultimate antidotes for chronic disease and rising health care costs is driving broad-based efforts nationwide and across the region to improve community health through better nutrition, active living and healthier lifestyle choices.

The Health Care Foundation of Greater Kansas City (HCF) has played a central role in supporting area healthy living initiatives since the organization began grantmaking in 2005. Grant funding has allowed vital programs to take root and flourish; foundation leadership has bolstered essential stakeholder collaboration.

THE RESULTING EFFORTS HAVE TRANSFORMED
THE STATUS QUO AND **HIGHLIGHTED** THE POWER OF
COOPERATION AND **INNOVATION** IN THE **FACE**
OF SEEMINGLY INTRACTABLE **PUBLIC HEALTH** PROBLEMS.

Although the health problems set in motion by poor diet, obesity and a lack of physical activity are complex and entrenched, the past decade has seen dramatic progress in the Kansas City region.

Over that time, an evolution has occurred in the way good health is perceived and pursued, with the focus shifting from simply educating individuals on healthy habits to embracing a holistic, community-wide approach.

Urban food opportunities have bloomed through partnerships that are bringing healthy food into underserved areas. An abundance of community gardens, urban farms and regional family farms — coupled with innovative distribution systems and purchasing incentives — have increased access to fresh fruits and vegetables. And support for active lifestyle opportunities has produced new attitudes, programs, exercise facilities, and pedestrian and bicycle pathways across the area.

“Kansas City is reaching a point of critical mass in terms of programs that extend healthy living opportunities to all levels of our society,” said Brenda Calvin, a program officer with HCF. “It’s exciting to see so many innovative and effective ideas coalesce in a community-wide push to improve both individual and community health.”



COOPERATION AND LEADERSHIP

A decade ago, few groups were working in the area of healthy eating and active living. But organizations such as Kansas City Healthy Kids, which has helped push many of the policy changes that have occurred in the past 10 years, soon emerged to become the architects of a local movement that relies on a systemic approach to eating well and staying active.

The growth of backbone organizations such as Cultivate KC, Weighing In and Kansas City Community Gardens further expanded the scope of the Kansas City area's healthy living efforts. That momentum has continued, and today, many organizations that didn't exist 10 years ago are working side by side to bring healthier habits and options to the area.

"This really used to be a grassroots movement, but today it has become more institutionalized and involves a far greater range of different arenas, sectors, and economic, racial and ethnic classes," said Katherine Kelly of Cultivate KC, which was created in 2005.

In 2007, the Greater Kansas City Food Policy Coalition was created to advocate for a food system capable of providing healthy, sustainable and accessible foods for all area residents, regardless of economic status.

Thanks in part to \$475,000 in funding from HCF, the coalition now includes dozens of organizations and individuals working together to support relevant legislative initiatives and grassroots programs in Missouri and Kansas. Key objectives include increasing purchasing of locally grown, fresh and nutritious food and reducing food insecurity for the approximately one in seven metropolitan area residents who don't have enough to eat.

Many of these groups have collaborated to achieve some significant accomplishments. Recent joint successes include:

- Helping establish the H2O to Grow Pilot Grant Fund to install water taps at community gardens and urban farms in Wyandotte County.
- Supporting legislation in Missouri to establish a land bank agency in Kansas City that allows vacant, tax-delinquent properties to be conveyed for gardens and urban farming.
- Working closely with the Kansas City, Missouri, City Council to update and codify ordinances governing urban agricultural activity.

"There are so many more non-traditional partners now," said Adriana Pecina, a program officer at HCF. "We see domestic violence agencies taking on healthy eating and active living, and we've developed unlikely allies, such as the Port Authority, which is partnering on ways to increase the distribution of farm-fresh, healthy food."



KANSAS CITY HEALTHY KIDS

KC Healthy Kids has been dedicated to reducing childhood obesity through healthy eating and active living since its inception in 2005.

KC Healthy Kids is a leader in helping turn Greater Kansas City into a region that promotes healthy lifestyles by influencing policies that shape our food environment and the built environment. They have been involved with farm to school programs, grocery stores, community gardens and farmers markets; quality physical education and recess; safe walking or biking to school; and safe parks, playgrounds and other places to play.

HCF has awarded KC Healthy Kids eight grants totaling more than \$1 million for core operational support, food and policy assessments and policy initiatives.

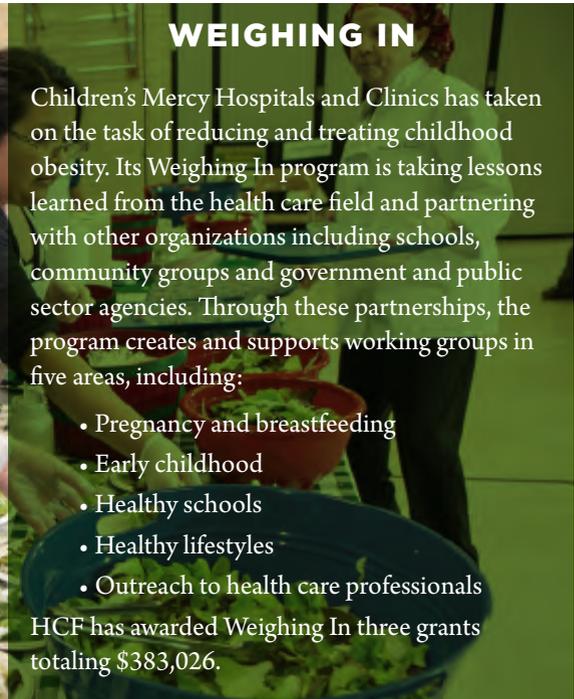


WEIGHING IN

Children's Mercy Hospitals and Clinics has taken on the task of reducing and treating childhood obesity. Its Weighing In program is taking lessons learned from the health care field and partnering with other organizations including schools, community groups and government and public sector agencies. Through these partnerships, the program creates and supports working groups in five areas, including:

- Pregnancy and breastfeeding
- Early childhood
- Healthy schools
- Healthy lifestyles
- Outreach to health care professionals

HCF has awarded Weighing In three grants totaling \$383,026.



COMMITTED COMMUNITIES

The Kansas City region's commitment to healthy living also can be measured through local governments' efforts to pursue key policy initiatives.

In Wyandotte County, change was spurred in 2009 by the Robert Wood Johnson Foundation's inaugural county health rankings report, which put the county last in the state in overall health indicators. Concerned about the prevalence of chronic disease and a citizenry dying too young, civic leaders brought together residents and representatives from more than 50 neighborhoods and organizations to brainstorm solutions.

Leading the effort was former Kansas City, Kansas, Mayor Joe Reardon. Reardon worked to establish partnerships aimed at altering the conversation about health and its determining factors. He also committed the Unified Government of Wyandotte County to rethinking the connections between health, prosperity and government policy.

Momentum established under Reardon's leadership has been sustained by Mayor Mark Holland, and real results have been achieved. Wyandotte County is using casino tax revenue to provide grants in support of a range of healthy eating and active living initiatives.

Plans also are under way to construct a \$12 million, state-of-the-art community center near downtown equipped with a track, pool, weight room and basketball courts. The downtown area's master plan further calls for a new grocery store, multi-family housing and urban agriculture facilities that include space for a farmers market, orchards and gardens.

Citizens are part of the solution in Wyandotte County and work alongside county government in pursuit of healthy living objectives. Community gardeners, for example, are responsible for assessing garden water access applications, and bicyclist organizations provide input on how best to retrofit streets for safer bike and pedestrian travel.





ALLEN COUNTY, Kansas

“The most important thing to come out of our community engagement is that we’ve learned to trust community members, and community members are learning to trust policymakers,” said Joe Connor, interim assistant county administrator. “It doesn’t happen overnight, but it is a very important step in developing effective solutions.”

In Allen County, Kansas, local government, schools and community advocates all are working together to improve residents’ health. David Toland, executive director of Thrive Allen County, a community organization focused on improving health in Allen County, described the combined efforts as a “marble cake” of leaders and organizations, with Thrive playing an oversight and coordinating role.

“I think it’s a sign of a powerful and sustainable movement when the efforts are not just directed or centered around a handful of people, but instead are benefiting from the energy and creativity of a lot of different stakeholders,” Toland said.

HEALTHY COMMUNITIES WYANDOTTE

The Healthy Communities Wyandotte coalition was established in 2009 by Kansas City, Kansas, Mayor Joe Reardon and Joe Connor, interim assistant county administrator. It is a county-wide initiative to involve local leaders and residents in improving the health of the people in the community.

As community members came together to address different elements of public health, they secured government buy-in for initiatives such as a comprehensive bike route map, a new sidewalk master plan, a grant program for community garden water access, improvements to make parks more usable and a sold-out May 2014 Food Summit, under the leadership of Mayor Mark Holland.

HCF has awarded the coalition \$440,000.

NUTRITIONAL INNOVATION

At the most basic level, good health begins with improved nutrition. As a result, efforts aimed at educating community members on how to eat better have continued to expand across the metro area. But it's just as important to ensure reliable access to healthy, locally produced food, and this can be particularly difficult in underserved, low-income areas.

Fortunately, organizations have stepped up to help fill the void. Over the past decade, the number of urban farmers, residential gardeners and school and community gardens in the metropolitan area has exploded.

Cultivate KC is working to grow both food and farms, primarily in Kansas City's urban core. The organization works to develop growers and help start sustainable farm businesses in vacant lands. They also serve as a connector between farmers and the community.

Cultivate KC, the Kansas City Community Gardens and the Lincoln University Cooperative Extension have joined forces to more efficiently provide technical assistance in support of new farm and garden implementations.

CULTIVATE KANSAS CITY

Cultivate Kansas City was established in 2005 to be a catalyst for the production and consumption of locally grown food by farmers using sustainable production techniques in Kansas City neighborhoods.

Their efforts are focused in three areas: Educating and organizing farmers, growing food and helping farmers connect with their communities. Cultivate KC uses strategies like the Urban Farm Tour, school-based farming and internship programs to support future generations of farmers.

HCF has awarded a total of \$680,710 and six grants to Cultivate KC for organizational capacity, urban farmer development, the Juniper Gardens Training Farm and Get Growing KC project.

KANSAS CITY COMMUNITY GARDENS

Kansas City Community Gardens (KCCG) supports community, school, church and home gardens by supplying plots and plot maintenance (such as tilling and planting assistance), water, gardening tools, resources and education.

It has expanded its efforts to work with community groups throughout the metropolitan area and now works with more than 1,000 low-income households, 210 community partner gardens and 136 school gardens. The staff also manages five large community garden sites that provide rental plots for gardening to surrounding communities.

HCF's first award to KCCG was \$5,000. It since has awarded KCCG an additional \$640,470.



KATHERINE KELLY, Cultivate KC

Ben Sharda, executive director of Kansas City Community Gardens (KCCG), said there was a time in the not-too-distant past when he was intimately familiar with virtually every community garden project in the city. No more.

The KCCG staff today works with more than 1,000 low-income households, 210 community gardens and 136 school gardens on both sides of the state line. Gardens range from small, family-sustained plots to fruit orchards and large, multi-crop production areas. According to Sharda, the benefits of urban agriculture extend beyond the production of fresh, healthy food.

“Gardening is one of the most important pieces in the whole health puzzle,” Sharda said. “Sometimes, just starting a garden will make people begin to think about the entire spectrum of healthy living. They’re growing healthy vegetables and they are getting more exercise. And from that, they start looking for other ways to get healthier.”

The rise of community agriculture isn’t limited to urban areas. In rural Allen County, 120 plots have been made available for community gardens. A fast-growing farmers market in Iola is helping meet the needs of residents who’ve embraced the benefits of a healthier lifestyle.

“We’re not just planting seeds, we are building skills and building the community,” said Carolyn McLean, a pioneer in the county’s community garden movement. “The gardens are a place where people can come together.”

KCCG has seen a

25
PERCENT
GROWTH

in garden plots
from 2011-2013.

The number of
low-income
gardeners has
grown by

30
PERCENT

since 2008.

KCCG now has
more than

10,000
STUDENTS

participating in
school or
community
gardens.



“SOMETIMES *just* STARTING A GARDEN MAKES PEOPLE START”



THINKING ABOUT THE WHOLE SPECTRUM *of* HEALTHY LIVING.”

BEN SHARDA
KANSAS CITY COMMUNITY GARDENS





MATCHING SUPPLY WITH DEMAND

As more fresh food is produced locally and demand increases, better distribution systems become a must. Distribution involves not just the sale of fresh products, but also the steps required to bring produce to market, including processing, packaging, storage and transportation. These often-overlooked links in the food chain are critical to ensuring that healthy foods are available for those who need them most.

“Farmers aren’t going to grow something unless they know they have a market for it,” said Lorin Fahrmeier, a project coordinator with the University of Missouri Extension Office. “So right now we’re working on building this small network of producers. For example, if a school wants tomatoes, we have to have enough tomatoes to fill their weekly supply.”

The importance of distribution was apparent to Diana Endicott and her husband, Gary. The couple quit their jobs in landscaping to return to their family farm. When they grew more than they needed, the Endicotts began selling the excess to Hen House markets.

As the operation grew, the Endicotts realized that a new approach was needed to distribute and market the production of small, regional farms like theirs. With help from Bridging the Gap and Hen House Markets, they founded Good Natured Family Farms. Today, the pioneering alliance includes more than 100 local family farms working together to bring sustainably produced, farm-fresh food to Kansas City through the Hen House and Ball’s Price Chopper supermarket chains.

The alliance has helped fill a vacuum for many small growers, who frequently find that the only outlets for their products are local farmers markets. Despite demand for large quantities of fresh produce among institutions like schools, hospitals and restaurants, many buyers are reluctant to work with smaller growers due to concerns about quantity and availability.



In 2013, HCF took steps to address this problem by providing \$130,000 to help fund a year-long, regional food hub feasibility study. Food hubs are distribution centers that aggregate large quantities of small farm production to better meet the demand of institutional buyers like schools and hospitals.

“We kept hearing about the lack of infrastructure in light processing, aggregation and distribution for small and medium producers,” said Beth Low, the Greater Kansas City Food Policy Coalition. “So we wanted to learn more.”

Ironically, the problem of distribution for smaller producers is a relatively new one. Over the past half-century, the infrastructure needed to bring smaller local production to market has all but disappeared as agriculture and food production has scaled up and consolidated.

Whether, and to what extent, that infrastructure can be reestablished and a food hub developed in Kansas City remains to be seen. But the feasibility study marked an important start in identifying the market and policy barriers that must be overcome to make the concept work.

In lieu of broad-based solutions like food hubs, local policies are being modified to encourage alternative food production and distribution. In 2010, for example, the city of Kansas City, Missouri, created urban agriculture zones, which allow gardeners, farmers and community gardens to sell their produce in residential neighborhoods.

The following year, the city council passed an ordinance that allowed vendors at farmers markets to provide samples of their products for customers. A “chicken ordinance” also was passed to reduce restrictions on keeping chickens in residential neighborhoods.



IN KANSAS CITY, MISSOURI, URBAN AGRICULTURE ZONES WERE CREATED TO ALLOW GARDENERS, FARMERS AND COMMUNITY GARDENS TO SELL THEIR PRODUCE IN RESIDENTIAL NEIGHBORHOODS.

ENSURING THE ESSENTIALS

As necessary as distribution is, urban agriculture clearly would not exist without requisite land and water. Once again, however, a collaborative approach is helping increase land and water access on both sides of the state line.

In 2012, a two-year legislative effort in Kansas City, Missouri, involving multiple organizations resulted in the creation of the Land Bank, a milestone in the evolution of area urban farming. Through the Land Bank, more than 3,500 abandoned, foreclosed or vacant lots and properties in Kansas City are being identified and cataloged. Once documentation is complete, the land can be sold, leased or rented at reasonable prices to buyers with specific improvement plans, which can include urban farms and gardens.

The program is not only strengthening urban agriculture, but also boosting community pride, home ownership and economic growth in some of the city's most economically depressed neighborhoods.

The Unified Government of Wyandotte County has implemented H2O to Grow, a program to install free water taps for urban gardens and farms that meet specific program criteria, including improvements in the lot's appearance.

Kansas City, Missouri, is working with several organizations, including KCCG, to increase water access through the KC Grow program. KC Grow helps farmers and gardeners estimate water needs and then find the resources to meet their requirements. Those who qualify can receive funding for a variety of water projects, including rainwater and storm water catchment systems, municipal water line tap and hydrant installations.

COLLABORATION IS
STRENGTHENING URBAN
AGRICULTURE, AND
BOOSTING COMMUNITY
PRIDE AND **ECONOMIC**
GROWTH IN DEPRESSED
NEIGHBORHOODS.





EVOLVING HUNGER RELIEF

For thousands of Kansas Citians, accessing hunger-relief agencies became a necessity through the years of the Great Recession and in the lingering, uncertain aftermath that followed. Many families, in fact, no longer use food aid as a periodic supplement but instead rely on it as a primary source of regular meals.

Nearly 15 percent of all Americans today are food insecure, or lack enough food to remain healthy and active, according to the United States Department of Agriculture. That's up from 10 percent before the economic collapse of 2008.

Food assistance agencies consequently are scrambling to meet soaring demand. Most have traditionally depended on non-perishable foods to help feed the hungry, primarily because of the ease with which these products can be stored and distributed. Unfortunately, many traditional food relief items also are high in sodium, fats and sugars. Agencies are therefore searching for new ways to incorporate locally produced, fresh food into their meals and charitable distributions.

Harvesters, Kansas City's regional food bank, dispersed 15 million pounds of fresh produce throughout its 26-county service area in northwestern Missouri and northeastern Kansas in 2014. That represented about 35 percent of the organization's total distribution for the year.

Harvesters was able to boost fresh food distribution by increasing staff and shifting its delivery model. Significantly, the organization also nearly doubled its cooler and freezer space to a total of 34,000 square feet.

The USDA suggests that

15
PERCENT
of all Americans
are **FOOD**
INSECURE.

John Hornbeck, former president and chief executive officer of Episcopal Community Services of Kansas City, said he believes hunger relief organizations can play a major role in the fight against obesity and chronic disease. The organization provides thousands of meals annually in the Kansas City region to the homeless and working poor.

“Ultimately, hunger represents an extreme form of poor nutrition, and we’ve seen clearly how it impacts the ability of adults to work productively and children to perform well in school,” Hornbeck said. “But until fairly recently, nutrition was not a high priority in hunger relief.”

To change that, Episcopal Community Services is working with a number of organizations, including grocery stores and restaurants, to identify ways to improve the nutritional content of relief meals. The group also has established several gardens to supply food for its Meals on Wheels and food pantry programs.

At the same time, new organizations that collect, transport and distribute food that would otherwise go to waste are helping agencies like Harvesters and the Episcopal Community Services ensure that they have enough fresh produce.

The Society of St. Andrew (SoSA) is a nationwide effort that leveraged volunteers to pick surplus produce in fields, orchards and gardens. The group also picks up unused food from produce companies and distributes it to food banks and other hunger-relief organizations. This work, generally known as gleaning, is now being overseen locally by After the Harvest.



SOCIETY OF ST. ANDREW (SOSA) WEST 2008-2013

DISTRIBUTED
15
 MILLION
 pounds of produce
 to feed hungry people

SUPPORTED
1,284
 GLEANINGS
 (from farmers, farmers markets,
 produce companies and growers)

with
7,617
 VOLUNTEERS

and
664
 PRODUCERS
 in the Kansas City area

MAXIMIZING FOOD ASSISTANCE

Although a growing number of families depend on hunger relief organizations for some or all of their nutritional needs, many others continue to use traditional government food assistance programs to put food on the table.

Limited resources, however, often mean that families and individuals must make hard choices between lower quantities of more expensive fresh foods and cheaper, less-healthy processed and non-perishable products.

In Kansas City, a unique solution has emerged to help resolve this dilemma and make fruits and vegetables more affordable for families on assistance. Beans&Greens encourages local residents receiving government aid to shop at local farmers markets.

When SNAP (Supplemental Nutrition Assistance Program) or Kansas' SFMNP (Senior Farmers Market Nutrition Program) benefits are spent at participating markets, Beans&Greens provides a dollar-for-dollar match on the purchases.



The match makes locally grown produce more accessible and affordable to those receiving assistance, while providing area farmers with new customers and revenues. When Beans&Greens was started in 2010, supporters were optimistic that the program could have an impact. Yet few foresaw how successful it would be.

In 2009, just \$7,900 in SNAP benefit fresh produce sales took place at Kansas City-area farmers markets. But a year later — thanks to Beans&Greens and the organizations that backed it, including the Menorah Legacy Foundation — that number had exploded to \$97,000. Even more remarkably, SNAP farmers market sales reached \$214,000 in 2011.

“The Health Care Foundation was an early supporter and provided a special initiative grant when this was just an idea,” said Gayla Brockman, executive director of the Menorah Legacy Foundation. “Since then, they’ve maintained that support and are on this journey with us. Even when every question wasn’t answered, they believed in us first.”

Thanks to programs like Beans&Greens, sustainable family farmers are seeing their customer base grow. And most importantly, families in need are sitting down to healthier meals.

MAKING DESERTS BLOOM

Nutrition advocates more than a decade ago coined the evocative term “food desert” to describe urban or rural neighborhoods that don’t have ready access to stores stocking healthy, affordable food.

These areas typically are marked not only by the absence of healthy options, but also by an overabundance of fast food restaurants and convenience stores selling inexpensive, unhealthy food products. A lack of available transportation and often-unsafe areas for pedestrian travel compound the problem for many residents.

The United States Department of Agriculture calculates that approximately 23.5 million people live in food deserts nationwide, with more than half residing in low-income areas. Locally, officials have estimated that at least 66,000 people in Wyandotte County, Kansas, and Jackson County, Missouri, live in food deserts.

To address the problem, groups across the metro have partnered with store owners to stock healthy, affordable food. New grocery stores are being built and old ones retrofitted. And mobile solutions are being deployed in underserved areas. Residents are also given food demonstrations.

“Grocery stores are now our leading economic development focus as we try to bring fresh fruits and vegetables into areas that are extremely underserved,” said Wyandotte County’s Joe Connor.

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AMONG THE AREA'S RECENT SUCCESSES:

THE MID-AMERICA REGIONAL COUNCIL (MARC)

has provided healthier food options for urban core residents through small, neighborhood retail convenience stores. By 2013, MARC had established four healthy corner stores in food deserts across Jackson County.

TRUMAN MEDICAL CENTERS

has developed the Healthy Harvest Mobile Market, a bus retrofitted as a mobile food market. The vehicle makes regular weekly market visits to a number of underserved neighborhoods. Within three months of going into service in 2012, the mobile market had served 2,400 customers who purchased approximately 16,000 fresh produce items.

THE ARGENTINE NEIGHBORHOOD DEVELOPMENT ASSOCIATION (ANDA)

raised more than \$1 million to build a grocery store in a neighborhood previously considered a food desert. Through an additional grant, a walkway was constructed from a nearby bus stop to the store's entrance. The store opened in December 2013.

INCLUSION OF VULNERABLE POPULATIONS

Much of the work aimed at expanding healthy eating in Kansas City has focused on ensuring ready supplies of nutritious foods. But the harsh reality is that better nutrition is often a low priority when families and individuals are struggling just to get by.

“It’s always hard for me to talk to families about making healthy purchases when there’s not a grocery store available, or they don’t have the money because they have to pay the most and have the least,” said Nozella Brown, with the Kansas State Extension.

Learning how to effectively engage with populations in need is consequently a key objective for HCF and its partners. Part of that process involves bringing more diverse organizations and perspectives into the healthy living movement. And for HCF, an important goal has been overcoming preconceptions that surrounded the field in its early days, when many in underserved communities saw it as elitist, out-of-touch and controlled by “fit people who go to farmers markets.”



Since then, the foundation and its partner organizations have worked to alter perceptions by acknowledging and addressing cultural differences. One example: The Mattie Rhodes Center, a community organization active in Kansas City’s Hispanic neighborhoods, worked closely with the Cultivate KC and the Beans&Greens programs to establish a Latino farmers market, La Chalupa.

Efforts were made to provide the market with foods and healthy recipes that were consistent with traditional cooking styles. The meat vendor, for instance, was asked to provide cuts that were favorites with Latinos. Over time, this cultural awareness has helped break down barriers that were keeping individuals away from farmers markets and the healthier foods they provided.

Closing the often-wide chasms that exist between cultures and socioeconomic groups is clearly a challenge that extends well beyond healthy living initiatives and efforts.

“...WE’VE **TRIED** TO MAKE IT **COOL**
TO **JOIN THIS MOVEMENT...**”

DAVID TOLAND, THRIVE ALLEN COUNTY

Yet these programs can still play a role in stimulating greater mutual understanding, respect and shared vision. As such, their benefits ultimately may include more than just the health improvements they’re designed to create.

Creating active lifestyles and changing people’s eating behavior does not happen overnight. But the small steps many organizations are making in this region are beginning to transform attitudes about the importance of healthy eating and active living.

Toland said the goal of Thrive Allen County is to change the culture in the county. As a result, they’ve targeted many different groups to make exercise and healthy eating accessible to all.

“What we’re trying to do is make active lifestyles and healthier eating the norm, not the exception,” he said. “To do that, we’ve tried to make it cool to join this movement and to eliminate prejudices or preconceptions that some still carry about eating well and being active.”



GETTING ACTIVE



Like healthy eating, exercise has traditionally been viewed as a personal lifestyle choice. And ultimately, it still is: We can choose to move or sit. What's different now is the recognition that it's a lot easier to get exercise when the appropriate facilities, infrastructure and support are readily available.

Children, for instance, are more inclined to sit inside and play video games if there isn't a park or basketball court nearby. And they'll probably take the bus instead of walking to school if streets aren't safe. Nor are adults as likely to get out and walk or bike if sidewalks or paths aren't available. Planners increasingly understand that investments in community centers, swimming pools, walking and biking trails, and free public sports fields are key to engaging residents in active living.

Since 2006, Greater Kansas City LISC (Local Initiatives Support Corporation) has strategically concentrated its resources and responded to the needs of six metropolitan area communities. Through its NeighborhoodsNOW program, LISC attracts resources and brings together influential partners to address complex problems faced by blighted urban-core neighborhoods to foster livable, safe and healthy environments.

"Over the past decade, we have seen a transformation in how local communities view active living infrastructure," said Marlene Nagel, director of MARC's Community Development department. "It is something that increasingly is seen not as a luxury but as a necessity."

**“...WE HAVE SEEN A TRANSFORMATION
IN HOW LOCAL COMMUNITIES VIEW ACTIVE
LIVING INFRASTRUCTURE...AS A NECESSITY.”**

MARLENE NAGEL, MARC COMMUNITY DEVELOPMENT

EFFORTS BY MUNICIPALITIES

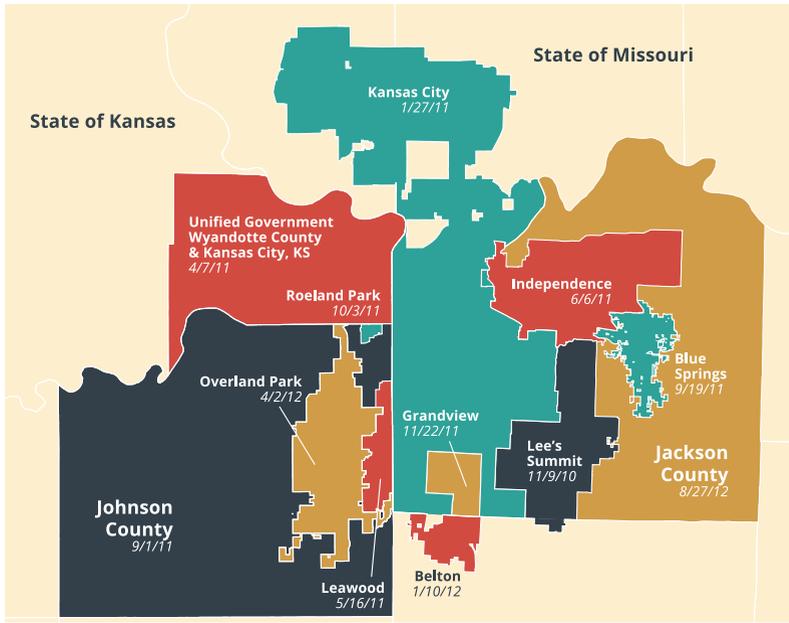
Since 2010, a dozen municipalities in the region have implemented complete streets resolutions. A “complete street” is a street that allows for multiple modes of transportation, such as walkers, bikers, bus riders and wheelchairs, in addition to cars.

Many municipalities in the region are also working to create areas more conducive to physical activity. Johnson and Platte counties have trail systems financed by dedicated sales tax. Lee's Summit and Blue Springs have developed several bike lanes. A bike/pedestrian crossing of the Missouri River has been established.

This kind of visible leadership and financial investment have played a crucial role in setting the stage for other organizations to extend and invest in the efforts.



AREAS WHERE COMPLETE STREETS ORDINANCES ADOPTED



Kansas City, Missouri, has taken that lesson to heart and emerged as a leader in expanding active living access. In 2008, the city created Bike KC, a long-term plan to install 600 miles of bike lanes and 50 miles of trails throughout the city. So far, nearly 200 bike lanes have been added, along with signage and bike parking facilities. The city also has worked in concert with the local cycling community to improve safety by removing hazardous drainage grates and other obstacles from bike lanes and trails.

Another city program, Active Living KC, has partnered with the Hickman Mills School District to promote safe routes to school, walking school buses and more biking opportunities for the children. By 2012, the group, which is sponsored by the Kansas City Public Works Department, had established walking school bus routes at three schools and participation has continued to grow as the group has matured.

A partnership between Blue Cross and Blue Shield of Kansas City and the non-profit BikeWalkKC, meanwhile, gave rise to Kansas City B-Cycle. B-Cycle is a bike-sharing program that, for a small fee, allows individuals to check out a bike at various sites in downtown Kansas City. The bikes can be used for short bike trips and then returned to any of the bike share sites.

These efforts and others resulted in Kansas City being awarded bronze status as a bike-friendly community in 2013 by the League of American Bicyclists.

Thrive Allen County spearheaded the development of the Southwind Rail Train in 2013. Built from a converted railroad corridor between Iola and Humboldt, Kansas, the 6.5-mile stretch is now used for recreational biking and is maintained and managed by the county.

ENGAGED NEIGHBORHOODS

In addition to municipalities, neighborhoods also are stepping up with grassroots solutions to stimulate active living and combat the health risks associated with sedentary lifestyles. In 2008, Wyandotte County's Rosedale area, an ethnically diverse, low-income community of 14,500 people, was confronted with an alarming statistic — 51 percent of Rosedale's school-aged children were considered obese.

In response, residents — under the leadership of the Rosedale Neighborhood Association — took action. A community walking club and walking school bus were created, and Fisher Park was made more pedestrian-friendly with trail markers and benches. Community leaders also provided bicycle safety and repair classes through schools and supported Freewheels for Kids and bicycle rodeos. Additionally, five new sporting opportunities for local youth were sponsored in Rosedale, including soccer and disc golf.

“If you have a sidewalk in front of your house, you are probably more active than if you live on a busy street,” said Heidi Holliday, executive director of Rosedale Development Association. “We have the first mile of bike lanes outside our office and we just opened the first mile of trails at Rosedale Arch Park — we finally have the resources to carry out the community's vision.”

ROSEDALE DEVELOPMENT ASSOCIATION

The Rosedale Healthy Kids Initiative supports access to healthy foods and active lifestyles. Rosedale's efforts to increase access to healthy foods included community gardens, farmers markets and policy initiatives. Rosedale established approximately seven community and schoolyard gardens and was able to expand several in 2011 and 2012, despite drought conditions. The Development Association distributed home garden kits and planned to install five gardens at the Belrose Manor Public Housing complex. They have also worked with the Unified Government to create a Rosedale Master Plan and a Green Corridor Plan focused on a half-mile wide, 3.9-mile corridor along Southwest Boulevard/Merriam Lane.

HCF has awarded Rosedale six grants totaling \$385,578.

IVANHOE NEIGHBORHOOD COUNCIL

The Ivanhoe Neighborhood Council was organized in 1967 and reorganized in 1997 as a 501(c)(3) organization with a mission to build a “clean, beautiful, safe and thriving neighborhood.” Since then, this neighborhood organization, which represents approximately 8,000 residents, has become one of the city’s most dynamic examples of revitalization.

HCF has awarded Ivanhoe four grants totaling \$279,514.

Ivanhoe, an ethnically diverse, low-income neighborhood in central Kansas City, through the years has wrestled with a range of problems, including high crime, struggling schools, a low owner-occupancy housing rate and a lack of local businesses.

To address the issues, the community decided to concentrate on the assets of the neighborhood. “What we saw was a group of people who were willing and committed and who wanted to stay in their homes,” said Dina Newman of the Ivanhoe Neighborhood Council. “We also saw lots of vacant land and the possibilities and partnerships that could help address some of the major challenges of the neighborhood.”

Ivanhoe began working to make area streets and parks safer. Walking groups were created and vacant lots and abandoned houses were beautified. A community garden was started in 2012 on a lot provided by a local church. A new grocery store eventually came into the area, providing local jobs and improving access to healthy, low-cost foods.

**“MORE AND MORE AREAS
ARE SEEING THE POSSIBILITIES OF
MAKING REAL DIFFERENCES...”**

GRETCHEN KUNKEL, KC HEALTHY KIDS



“There is real excitement within neighborhoods when they know they’re in control and able to make positive changes,” said Gretchen Kunkel, president of KC Healthy Kids, a non-profit dedicated to reducing obesity and improving health among children. “More and more areas are seeing the possibilities of making real differences, and that’s why I think this kind of movement is only going to grow.”

LEVERAGING SCHOOLS

Because children spend up to 2,000 hours each year at school, the educational environment can have enormous influence on behaviors relating to exercise and nutrition. For that reason, many school districts are changing policies and improving access to healthy eating and active living for children and families.

Much of this effort has been spurred by national legislation, including a 2004 funding law that required all schools taking part in the National School Lunch Program to create wellness policies and to develop guidelines for food and beverages sold on school grounds.

Since the legislation took effect, many schools have eliminated vending machines, changed lunch menus, created school gardens and supported programs like walking school buses.



BECAUSE COMMUNITIES OFTEN REVOLVE AROUND THEIR **SCHOOLS**, THEY CAN **PLAY A MAJOR ROLE** IN BUILDING **HEALTHIER ENVIRONMENTS**.

In 2010, the Healthy, Hunger-Free Kids Act mandated that school wellness policies include evaluation and public reporting on the schools' progress. The act also reauthorized child nutrition programs and included new guidelines for school lunches, which are served to approximately 32 million students annually nationwide. Implementation of the law has been rocky. Many students have rejected the foods, and lunch staffs have complained that the guidelines are cost-prohibitive.

HCF funded a study in 2012 by researchers at the University of Kansas Medical Center and Children's Mercy Hospital to examine the efficacy of area school wellness policies and programs.

Among the study's revelations was that program implementation varied significantly from school to school. The mandate to establish wellness programs has produced mixed results, with programs frequently failing to meet national recommendations for nutrition or physical activity. For example, many schools were not engaging families in wellness and parents often were pushing back on the issue. More than half of schools used junk foods and high-fat foods in fundraising. Equally troubling, food was often used to reward students, while restrictions on physical activity were used to punish.

According to Deborah Markenson, director of Weighing In, Children's Mercy Hospitals and Clinics, communities must move away from assigning blame when it comes to battling childhood obesity in the school environment.

New nutrition guidelines affect

32
MILLION
STUDENTS

who are served school lunches annually.

“We really need to focus on changing policies, like getting more recess time back in the school setting,” she said. “We’re squeezing out the very elements that are not only foundational to health, but also important to academic success and to an overall productive life.”

A United States Department of Agriculture initiative, the Farm-to-School Program, works to provide schools with locally grown products in support of healthier lunches. The Missouri Farm-to-School Act is supporting the program with a taskforce that includes representatives of state agriculture and educational agencies, as well as individuals involved in agribusiness and school service programs.

The task force will provide recommendations to help schools incorporate locally grown products into their food service programs. Findings and recommendations will be reported to the governor and General Assembly by the end of 2015.

Some local districts are taking part in programs such as the Alliance for a Healthier Generation. The program is a joint effort with the American Heart Association and the Clinton Foundation aimed at boosting health in schools and improving policies that affect healthy eating and inactivity.

11 Ways TO CREATE HEALTHY SCHOOLS

- 1.** Staff role model healthy behaviors.
- 2.** Families support school wellness goals.
- 3.** Restrict marketing of unhealthy choices.
- 4.** Assure healthy options in vending machines, school stores & à la carte.
- 5.** Reduce or avoid use of food as a reward.
- 6.** Regulate food served at class parties and other school celebrations.
- 7.** Ensure adequate time to eat.
- 8.** Regulate food sold for fundraising at all times (not only during the school day).
- 9.** Provide regular physical activity breaks for students during classroom time (in addition to recess and PE).
- 10.** Stop taking away students' physical activity times as punishment.
- 11.** Provide adequate daily recess time for elementary grades.

For more information on this report and the Weighing In and Healthy Schools Committee, visit <http://hcfjkc.org/resources/nutrition-and-obesity>

Health Care Foundation
www.hcfjkc.org

Children's Mercy Hospital
KU Center for Health Equity

PE4LIFE

PE4Life was an innovative not-for-profit that helped schools and communities develop quality, daily physical education programs that emphasize lifetime sports and physical activity. They provided customized training, technical assistance and equipment to schools and were the first to introduce fitness testing and movement-generated video games into the gym class setting. Schools that adopted the PE4Life program saw significant reductions in school suspensions, improvements in academic performance and a profound reduction in the number of kids asking to be excused from gym class.

Early funders were Menorah Legacy Foundation and Blue Cross and Blue Shield. HCF provided more than \$1,400,000 for assistance in six school districts, with many of the schools in the Kansas City, Missouri, and Kansas City, Kansas, school districts.

BUILDING INCREMENTAL CHANGE

When DeLaSalle Education Center began its healthy eating and active living efforts, the school followed a fairly traditional path. This included policy changes such as providing healthier vending options for students and faculty.

Later, DeLaSalle started a community garden and developed Healthy Lifestyles Day, a program that required all educators to incorporate nutrition and physical activity content into their courses. Over time, parents and other student family members became engaged in the pursuit of healthier habits, and the school eventually hired a chef to prepare fresh food daily for students and faculty.

By moving incrementally and providing room for experimentation and discussion, the school developed momentum that ultimately has proven unstoppable.

“DeLaSalle Education Center has a philosophy that is focused on looking at a child holistically and not just academically,” said Vanessa Van Goethem-Piela, former development director at the school. “Healthy lifestyles represented a natural fit for DeLaSalle, and over the years those efforts have continued to grow.”





The Independence School District similarly realized some time ago that academic objectives could not be achieved without considering the whole student. Poor nutrition, inadequate physical activity and an alarming rise in obesity were putting learning at risk. The district began looking for ways to address these external factors.

With the financial support of HCF, the Independence district implemented preventive programs that helped reshape health in the classroom. They also built staff capacity surrounding health issues and reset the district's culture to focus on the entire student's well-being.

Later, a wellness committee was created to institutionalize these investments and a preventive health approach was extended to district faculty and staff. The district's efforts helped drive a cultural shift that, over time, has made health a key part of a school's business.

Today, district officials are working to take the next step as they move from an exclusively prevention-focused approach toward helping children and their families connect with weight-loss intervention programs.

**THE INDEPENDENCE
SCHOOL DISTRICT IS DRIVING
A CULTURAL SHIFT THAT HAS MADE
HEALTH A KEY PART OF A
SCHOOL'S BUSINESS.**

NEW PARTNERS AND CHAMPIONS

Institutions such as hospitals and universities are traditionally and understandably advocates for healthy communities. But in the past decade, the fight has attracted other organizations. Today, the business sector, social service agencies and restaurants all are working to integrate better nutrition and more physical activity into their programming, workforce options and services.

One increasingly popular approach among businesses has been the advent of wellness programs. Many of these involve smoking cessation, incentives for healthy behaviors and efforts to improve the condition of workers with chronic illnesses.

Some employers, however, are using even more inventive solutions to improve employee health. Children's Mercy Hospital, for example, has removed all sugary beverages from their vending machines, cafeterias and gift shops. In 2013, they became a member of the Karat Gold Partnership by committing publicly to increasing the amount of locally grown, sustainable food they provide to patients.

Other employers have partnered with Good Natured Family Farms (GNFF) to implement employer-based, community-supported agriculture options for employees. The Mid-America Coalition on Health Care recruited several large employers to collaborate with GNFF in providing access to fresh produce on-site to employees.

Response to the program has been overwhelming, with companies like Sprint and Hallmark getting involved. In fact, interest in the program was so high that some would-be participant companies were turned away. Local construction giant JE Dunn began modifying meals and also started offering healthy cooking demonstrations and recipes for employees. Workers noticed as the company tried to engage employees and cultivate healthier eating: JE Dunn human resources staff received unsolicited thank-you notes from employees who were grateful for the efforts.

In 2014, the Greater Kansas City Chamber of Commerce — in partnership with Blue Cross and Blue Shield of Kansas City and a number of regional health and wellness leaders including HCF — created Healthy KC.

The organization's purpose is to create high-level task forces that can focus on key health issues and bring a regional approach to health and wellness. A 16-member commission representing a broad swath of business and health care communities has been working on these topics and an action plan is scheduled to be launched this year.





“It’s EXCITING TO SEE *so many*
INNOVATIVE *and* EFFECTIVE IDEAS COALESCE
in a COMMUNITY-WIDE PUSH *to* IMPROVE BOTH
INDIVIDUAL *and* COMMUNITY HEALTH.”

BRENDA CALVIN
HEALTH CARE FOUNDATION OF GREATER KANSAS CITY

LESSONS LEARNED

The focus on healthy communities has expanded tremendously in the past decade. What began in the early 2000s as slow and steady efforts to educate and engage individuals, policy makers and service providers has helped fuel a boon in programming and services in the late 2000s and beyond.

Among the key lessons learned on the journey thus far:

- Multi-sector formal and informal partnerships have become common as the field has grown. Traditional hunger relief organizations and social service organizations are partnering by integrating nutrition and physical activity programming into their work.
- Support from local and elected champions has been critically important, and policy and infrastructure improvements are helping sustain momentum for healthier communities.
- School-based programming is important but cannot sustain all community and neighborhood activities. Community-based programming therefore must complement and support school-based efforts, as schools ultimately have an educational mission and limited resources to devote to health.
- The growing demand for healthier foods is putting pressure on the local food system to ramp up its supply and distribution channels, but it is also ensuring a market for producers.

AS IT SHOULD BE, GOOD HEALTH IS INCREASINGLY BEING THOUGHT OF AS A RIGHT FOR EVERYONE, REGARDLESS OF THEIR CIRCUMSTANCES.





On a more direct and individual level, possibly the most important lesson has been the awareness that health is not solely the result of individual choices, but also relies on our environment. Our ZIP code has as large an impact on our health as our genetic code.

This understanding has helped foster a more holistic approach in the way people look at the issue. In the past, healthy living and active lifestyles were viewed as a luxury of the upper and middle classes. But the movement is spreading and becoming imbued into our culture. As it must and should be, good health is increasingly seen as a right for everyone, regardless of circumstances.

Kansas City's energetic and generous spirit, combined with its boundless creativity and practical, problem-solving skills, have produced a cornucopia of healthy living solutions over the past decade. Successes have been large and small, public and private. Progress has been made in the schools and at the local and federal government level. Promising partnerships are emerging in the business sector. And grassroots efforts continue to spring up to help build healthful and connected communities.

Changing people's behavior does not happen overnight and must be pursued incrementally. It will require that current stakeholders and new partners come to the table.

LOOKING AHEAD

The Kansas City metro area has made enormous strides over the past 10 years in improving nutrition and increasing physical activity. But much remains to be done.

Among the priorities facing the community:

INCLUSION OF NON-TRADITIONAL VOICES

Over the past decade we have seen great improvements in the fight against obesity in almost every group. Yet the gains have not been as great in communities of color. As we move forward, we need to ensure that all voices are heard. What is often overlooked in efforts to improve opportunities for healthy eating and active living are the voices and experiences of underresourced communities. Those most impacted need to be included in these efforts.



CONTINUED ENGAGEMENT OF MULTI-SECTOR PARTNERSHIPS

In order to progress in this work, we need to continue to work not only with different sectors but also on different levels and dimensions from the grassroots to the grassroops. Even those who currently work in the field, such as food retailers and health care providers, are perceived as less than fully engaged in the movement to improve nutrition and increase physical activity. On top of that, there is still a need to engage the business sector and civic leaders to a greater extent.

ENSURING THE SUPPLY OF HEALTHY FOODS MEETS LOCAL DEMAND

One of the challenges of increasing the visibility and importance of local, healthy foods is attempting to manage the increase in demand that may result. Lorin Fahrmeier, a project coordinator for the University of Missouri Extension Office, described this in terms of achieving balance in the marketplace, so that the food system — particularly the supply chains for healthier food — is not shocked by demand that cannot be met. This could erode consumer confidence and stall transformation. It will therefore be imperative to work toward building producers' capacity to respond to increased need.



LONG-TERM AND SYSTEMIC CHANGE IS DIFFICULT TO SUSTAIN

Sustainability concerns are particularly relevant given the very long trajectory of the changes required to create healthier lifestyles. It can take months or years for behavioral changes to take root in a population and yield significant progress on health outcomes.

IMPROVING SCHOOL-BASED HEALTHY EATING AND ACTIVE LIVING PROGRAMS

There is still much to learn about how to most effectively change school policies in order to improve nutrition and physical activity in schools. Researchers have found that it is valuable to write policies in an explicit, comprehensive manner. Equally important, efforts must be made to monitor and enforce those provisions to promote a healthy school environment.

One area that is frequently overlooked but that will be important to address in the coming years is food offered to children outside of the school nutrition program.

Despite recommendations to the contrary, many schools continue to sell foods like candy bars and other unhealthy snacks. Frequently, these sales provide income schools need for bands and other special activities.





CHAPTER TWO

**TOBACCO
PREVENTION**



MAJOR VICTORIES IN BATTLE TO REDUCE SMOKING, BUT REGION STILL LAGS BEHIND

In the half-century since the U.S. Surgeon General's landmark report on the risks of smoking, the number of Americans who indulge in the once-pervasive habit has continued to drop, from 42 percent in 1965 to just 17.8 percent today.

Nevertheless, tobacco products remain the most preventable cause of disease, disability and death in the U.S., according to the Centers for Disease Control and Prevention (CDC). More than 16 million Americans suffer from illnesses caused by smoking, and almost 500,000 die prematurely each year due to tobacco use.

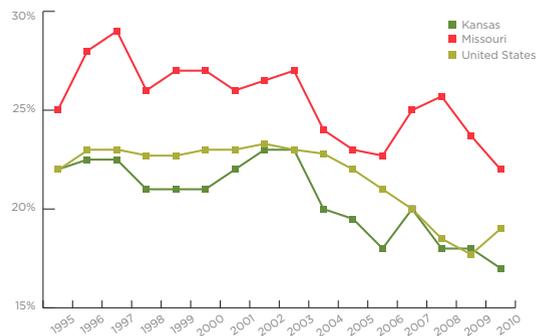
In Missouri and Kansas, tobacco use continues to be an enormous health problem, with the percentage of smokers in both states — 22 percent and 20 percent, respectively — well above the national average. The higher incidence translates into about \$3 billion spent annually on tobacco-related health care in Missouri and more than \$1 billion spent in Kansas.



Smoking rates in Kansas and Missouri are higher than the national average.

Despite the insidious nature of tobacco addiction, major progress has been made on both sides of the state line in reducing this public health risk. Over the past decade, the total number of area smokers has continued to decline, indoor smoking has been greatly reduced and in many cases, eliminated, and educational programs have helped prevent a new generation from picking up the habit.

Adult Cigarette Smoking Rates, 1995-2010





TERMINAL A, Kansas City International Airport,
Kansas City, Missouri.

CLEARING THE AIR

Arguably the most encouraging development in the Kansas City area in recent years has been the dramatic upsurge in municipal, clean indoor air ordinances. In the early 2000s, prohibiting smoking indoors was not even on the radar in most communities across the metro. But as a growing body of evidence confirmed the dangers of secondhand smoke for patrons and workers alike, advocates launched a push to limit or eliminate smoking in public places.

Resistance to the idea was predictably fierce from tobacco companies and from many businesses. Bars and restaurants, most notably, argued that no-smoking rules would drive customers away. Yet the opposition gradually began to soften as clinicians and advocates knowledgeable about the health dangers of secondhand smoke joined the fight.

In 2004, Lawrence became the first community in Kansas to pass a comprehensive smoke-free workplace ordinance. Two years later, Lee's Summit and Independence were the first on the Missouri side to pass similar laws. Today, a remarkable 95 percent of the Kansas City metropolitan area is covered by smoke-free ordinances. Only seven of the region's 34 municipalities do not have a smoke-free ordinance of any kind.

"Twenty years ago, smoking was everywhere," said Traci Kennedy, former executive director of the statewide coalition Tobacco Free Missouri. "It was not uncommon for people to smoke in a hospital or on an airplane. But today, more than a quarter of Missourians are covered by a smoke-free ordinance. That means more Missourians than ever have the freedom to earn a paycheck or enjoy a meal without having to worry about damaging their heart and lungs from secondhand smoke."

95
PERCENT

of the Kansas City
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1.5
MILLION

people, is
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ORDINANCES**

36 STATES

and Washington,
D.C. now have
some type of
**PUBLIC
SMOKING
— BAN —**

STATEWIDE EFFORTS

Statewide smoke-free efforts on the Kansas side have been largely successful. In 2010, the passage of the Indoor Clean Air Act prohibited smoking in public places and workplaces across the state. Exceptions to the law included 20 percent of hotel rooms, casino gaming floors, tobacco shops and private clubs licensed before Jan. 1, 2009.

Advocates say the act fundamentally changed attitudes toward smoking in the state. In 2011, an attempt to repeal the act was blocked, and a 2013 poll conducted by Clean Air Kansas found that three of every four Kansas voters favored the act. Ten communities statewide now have local regulations more stringent than the state law.

While many had hoped that the momentum established by local communities in developing their own smoking bans ultimately would lead to statewide, smoke-free legislation, no such initiative in Missouri has yet emerged. But that day may be coming. Data from the Missouri Department of Health and Senior Services in 2013 showed that 75 percent of Missourians support local smoke-free laws, versus only 50 percent 15 years ago. The steady increase in public support for smoke-free ordinances reflects a continued evolution in social norms regarding smoking.





OVERBLOWN FEARS OF ECONOMIC IMPACT

One of the most common arguments against indoor smoking bans in both Kansas and Missouri has been that prohibitions would negatively impact the revenue of restaurant, bar and hospitality businesses. But evidence suggests those fears are misplaced. In 2011, the Health Care Foundation of Greater Kansas City (HCF) funded a study through the University of Kansas that showed no negative effect on sales or employment following the adoption of the 2008 Kansas City, Missouri, smoking ordinance. Some restaurants even reported sales increases after the ban was enacted.

“Overall, we have a great deal to be proud of,” said Joyce Morrison, Clean Air KC. “The majority of our metro area has changed its culture and gone smoke-free, and this has become the norm. Kansas’ statewide law also is a great success. Those wins have had major trickle-down effect.”

The benefits of clean air were documented in a study that showed air quality levels in Kansas City, Missouri, restaurants had improved dramatically following passage of the Clean Air Act. Conversely, air quality levels at establishments in two Missouri suburbs with weak or nonexistent policies continued to register at dangerous levels.

The dramatic progress made in eliminating smoking in offices, restaurants and public places has led advocates to seek other opportunities for reducing secondhand smoke exposure. In 2013, Kansas City, Missouri's Parks and Recreation Board passed an ordinance making parks smoke-free. The following year, the Housing Authority in Kansas City, Missouri, made all publicly owned housing smoke-free. The latter move, which affected more than 1,700 residential units and 5,000 adults and children, was not without controversy. Critics have expressed concerns about the timing of the policy and fear that it may lead to increased homelessness. As a result, those involved continue to monitor and develop implementation strategies to address these issues.

“**THE MAJORITY OF OUR METRO HAS CHANGED ITS CULTURE AND GONE SMOKE-FREE, AND THIS HAS BECOME THE NORM.**”

JOYCE MORRISON,
CLEAN AIR KANSAS CITY

Essential to the success of the smoke-free movement over the past decade has been the efforts of advocacy groups, including Clean Air Kansas City, Tobacco Free Kansas, and Tobacco Free Missouri.

Locally, Clean Air Kansas City — with more than 300 grassroots members and 55 partner organizations — has played a central role in the passage of almost every clean indoor air ordinance in the metropolitan area. National groups like the American Cancer Society, American Heart Association and the American Lung Association also have been highly supportive.



CLEAN AIR KANSAS CITY

Clean Air Kansas City began in 2005 and was started by the Metropolitan Healthy Communities Coalition to support communities in their efforts until the region is smoke-free.

Clean Air KC partners with organizations and serves as a resource to other groups working to reduce smoking rates and exposure to secondhand smoke. They have created a model for efforts and offered up tool kits and processes to empower communities for working on the issue.

HCF has given the group eight grants totaling \$278,815.



TOBACCO SETTLEMENT — A MISSED OPPORTUNITY

In the national fight to reduce smoking, a historic victory occurred in 1998 when a settlement was reached in civil litigation between major tobacco manufacturers and attorneys general from 46 states. The Master Settlement Agreement established limits surrounding the manner in which tobacco could be advertised, marketed and promoted. The agreement also mandated that the tobacco industry pay the plaintiff states approximately \$10 billion a year for the “indefinite future.” Through 2014, Kansas had received \$900 million and Missouri \$1.8 billion via the agreement.

Although the CDC recommended that states allocate about 15 percent of the settlement funds toward tobacco control and cessation, most states have directed far less toward those efforts since payments began. A 2006 report by then-Missouri State Auditor Claire McCaskill found that during the first five years of the program, only about \$1.8 million of the \$965 million in tobacco payments to Missouri was spent on tobacco-

related programs. Most of the dollars were moved to the state’s general fund to build a savings account that would provide funds to cover budget shortfalls and program funding and to replenish cuts to Medicaid.

In Kansas, the legislature

voted to spend the majority of settlement funds on early childhood programs like education, health and services for children with disabilities. However, recent “sweeps” have pulled those funds into general revenue to cover budget shortfalls.

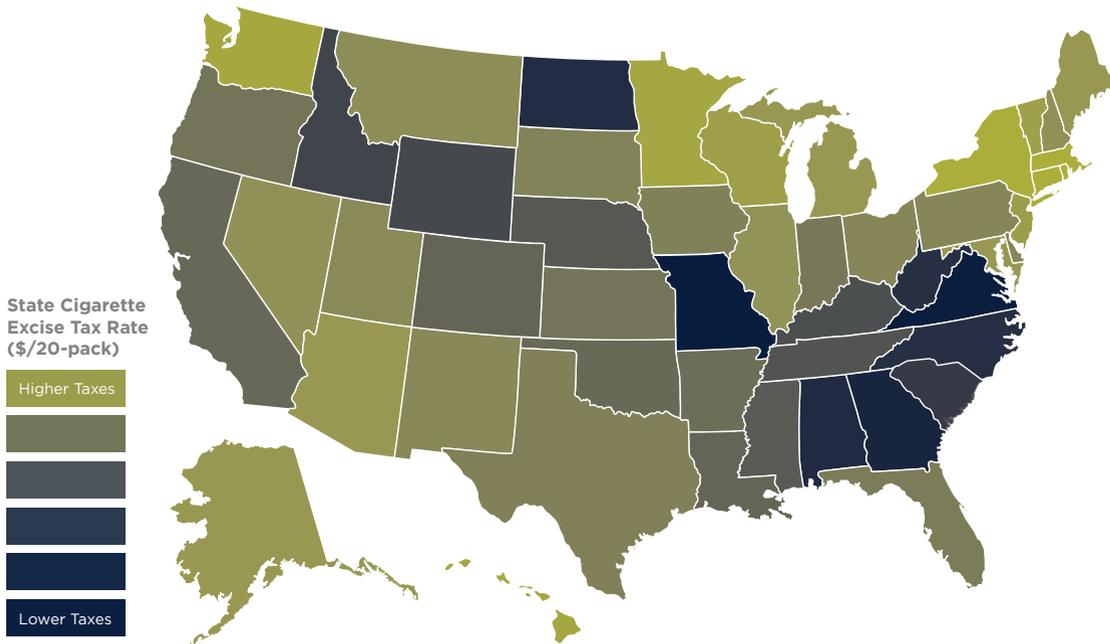
This challenge continues. In 2014, the CDC recommended that Missouri spend \$72.9 million on smoking prevention efforts. In reality, the state spent only about \$76,000, or 0.1 percent of the recommended funds. Kansas also fell short, spending just over 3 percent of the recommended level of \$27.9 million, or \$946,671.

While it’s true that settlement dollars have gone to areas of need, many of which are health-related, the Master Settlement Agreement payments overall represent a major missed opportunity for tobacco prevention efforts.

THOUGH FUNDS HAVE GONE **TOWARD**
AREAS OF NEED, THE SETTLEMENT FUNDING
 REPRESENTS **A MISSED OPPORTUNITY**
 FOR TOBACCO PREVENTION EFFORTS.



State Cigarette Excise Tax Rate, 2015



INCREASING TOBACCO TAXES

Historically, one of the most effective strategies for reducing smoking has been to increase the cost of tobacco through higher taxes. According to the American Lung Association, a 10 percent increase in tobacco cost reduces consumption by about 4 percent among adults and 7 percent among youth. Each year, 6,500 Missouri youth start smoking, while 2,900 start smoking in Kansas.

Despite the positive health impact of higher taxes, however, increasing tobacco taxes has proven difficult in Missouri, where three unsuccessful attempts were made in 2002, 2006 and 2012. Unlike many other states, substantial tax increases in Missouri must be voted on by the public per the Hancock Amendment. This requirement limits the power of state and local government to increase revenue or to pursue public health objectives through tax increases.

As a result, Missouri now holds the dubious distinction of having the lowest tobacco tax rate in the country, at 17 cents per pack. In contrast, the national average is \$1.60 per pack. The rate in Missouri has not been increased since 1993, when it was raised 4 cents.



Missouri rates 50th out of 50 states for having the lowest tobacco tax rate in the nation:

17
CENTS
PER PACK

The national average is

\$1.60
PER PACK



PROP B rally, Lee's Summit, Missouri.

The 2006 attempt was spearheaded by the Missouri Hospital Association but lacked the coordinated efforts of a robust coalition. The 2012 campaign, called Show-Me a Brighter Future, was led by the American Cancer Society and HCF. The ballot initiative narrowly failed due to public resistance to tax increases and mistrust of government spending. In the wake of the defeat, collaboration between statewide advocates has waned.

Some advocates nonetheless remain convinced that increasing the tobacco tax should continue to be a priority. And although recent efforts have come up short, tobacco prevention advocacy has undeniably led to increased public awareness about the risks of tobacco use.



Kansas has fared better than its eastern neighbor when it comes to higher tobacco taxes. In 2003, Kansas policy makers raised the state's tobacco tax from 70 cents to 79 cents. More recently, budget woes forced legislators to raise the tax again by 50 cents. The new 2015 combined tax of \$1.29 makes the cigarette tax in the state the 31st highest in the nation.

PROTECTING YOUTH

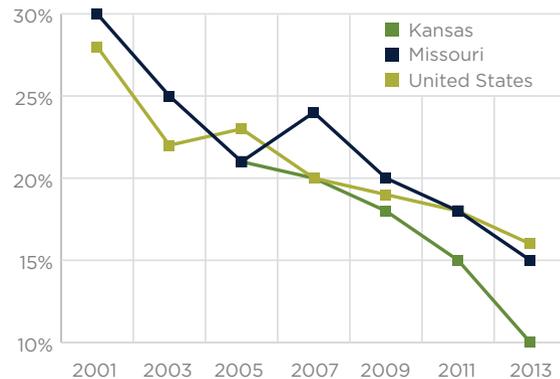
In the early 2000s, enforcement of prohibitions regarding the sale of tobacco to minors was lax. Tobacco companies consequently were marketing heavily in venues and vehicles that reached young people, including magazines, sporting events and NASCAR racing.

Fortunately, as Master Settlement money began flowing to states, advertising designed to counter the tobacco makers' messaging started to appear. Among the most memorable early anti-smoking spots was one showing young people dumping body bags in front of Philip Morris' headquarters in New York.

Efforts to prevent vendors from selling to minors also were ramped up. Advocates in Kansas and Missouri report that retailers have reduced tobacco sales to minors from a 70-percent sale rate in 2002 to 11-percent rate today.

The shift in advertising and better enforcement of underage purchasing has helped drive down the number of youth smokers dramatically. This is significant, since approximately 90 percent of adult smokers begin before the age of 18. A reduction in youth smoking, therefore, represents a major step toward preventing future smokers.

High School Youth Cigarette Smoking Rates, 2001-2013



HCF HAS FUNDED **13 GRANTS** TOTALING **\$1.1 MILLION** TO SUPPORT **YOUTH TOBACCO PREVENTION** EFFORTS.

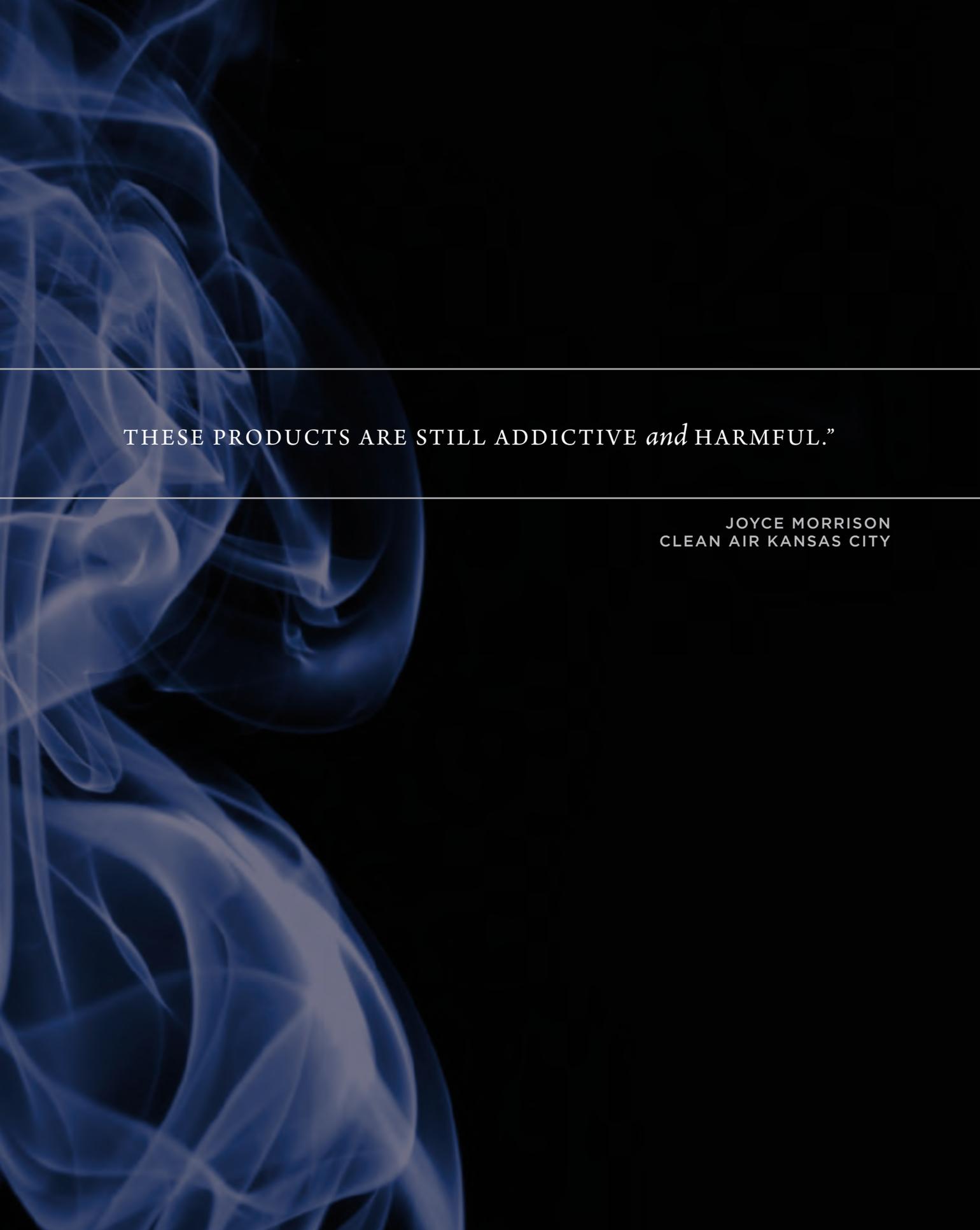
Yet challenges have emerged in the battle to reduce tobacco usage by minors. These include an increase in the use of smokeless tobacco products and, perhaps most significantly, new nicotine delivery systems such as e-cigarettes. According to the Youth Tobacco Survey, the percentage of high school males who had used smokeless tobacco in the past 30 days doubled from 2003 to 2013 to 18 percent.

E-cigarette use, meanwhile, has exploded among minors. The number of high school students who have used e-cigarettes rose from 4.7 percent in 2011 to 10 percent in 2012, according to the CDC's National Tobacco Survey. Nationwide, nearly 2 million middle and high school students have tried e-cigarettes. The concern is that vaping users will turn to cigarettes, which are cheaper to use.

"I think that the biggest challenge going forward will be vapors and e-cigarettes, because kids believe they are healthier," said Morrison of Clean Air Kansas City. "We need to get youth to understand that these products are still addictive and harmful."



“WE *need* TO GET YOUTH TO UNDERSTAND THAT



THESE PRODUCTS ARE STILL ADDICTIVE *and* HARMFUL.”

JOYCE MORRISON
CLEAN AIR KANSAS CITY



LESSONS LEARNED

Over the last 10 years, the tireless efforts of tobacco prevention advocates in the Greater Kansas City metro area have resulted in more smoke-free ordinances, reductions in tobacco use and shifts in the social norms around smoking. Clean Air Kansas City, in particular, has worked to create smoke-free workplaces and public places to reduce heart attacks, lower insurance premiums, cut health care costs, and produce healthier families and communities.

With the continued support of foundations like HCF and better state and local funding, area tobacco prevention advocates can apply the lessons learned over the past decade to the ongoing tasks of the present. Future efforts should include reducing youth smoking, increasing the tobacco tax in Missouri, implementing clean indoor air ordinances in the remaining communities in greater Kansas City and the state of Missouri and addressing the new vaping culture.

The result should be a continued reduction in smoking rates, greater protection from secondhand smoke, and broad improvements in public health in the years to come.

EFFORTS DURING THE LAST
10 YEARS **HAVE CREATED**
MORE SMOKE-FREE
ORDINANCES, **REDUCTIONS**
IN TOBACCO USE
AND SHIFTS IN SOCIAL NORMS
AROUND SMOKING.

LOOKING AHEAD

The Kansas City metro area has made great strides over the past 10 years in reducing exposure to secondhand smoke and in restricting sales to youth. However, Kansas and Missouri continue to have smoking rates above the national average, and escalation of exposure to new nicotine delivery devices among teens and young adults is cause for great concern.

As a result, priorities have shifted. Efforts are currently focused on tobacco use related to those with behavioral health problems, making schools tobacco-free, eliminating smoking in casinos, e-cigarettes and public housing.

CASINOS

Although the Kansas Indoor Clean Air Act prohibits smoking in casino restaurants, gaming floors in the state remain exempt. The casino lobby in both Kansas and Missouri is strong and opposes any additional smoking regulations affecting their facilities. Politicians, for the most part, are reluctant to push the issue, given the significant amount of tax revenue that casinos generate for municipal and state governments.

And while the compromise that was approved in the Indoor Clean Air Act makes a distinction between casino restaurants and gaming floors, these kinds of exceptions can be difficult to overturn once they're in place. Little headway has been made on this issue of late, despite research that shows the harmful impacts of secondhand smoke on casino workers.

In 2011, the University of Missouri's School of Medicine found that full-time employees in Kansas City casinos could be exposed to 106 percent of the Environmental Protection Agency's average annual limit for particulate matter air pollution. Advocates consequently continue to advocate for entirely smoke-free casinos in order to protect the health of both workers and patrons.



NEW FORMS OF NICOTINE

E-cigarettes represent a rapidly emerging and dangerous new avenue for nicotine addiction. Experts worry that individuals, particularly young people, see e-cigarettes as less harmful than regular cigarettes. Ultimately, the Food and Drug Administration's decisions regarding the regulation of e-cigarettes will help guide communities grappling with how best to address the issue.

In the meantime, many cities are discussing whether to include e-cigarettes in smoke-free ordinances. Concerns remain about the reemergence of youth-directed advertising and flavored products that appeal specifically to teens. There are also serious worries in the scientific community about the health effects of the flavor additives, as well as long-standing warnings about the addictive nature of nicotine, especially in the teenage brain.



At the state level, Kansas in 2012 enacted House Bill 2324, an electronic cigarette law that requires vendor licensing to sell the products and prohibits the purchase and possession of e-cigarettes by minors. Whether Kansas chooses to extend the Indoor Clean Air Act to include e-cigarettes remains to be seen. Questions surrounding e-cigarettes are evolving and will likely require input from tobacco control advocates, as well as local, state and federal governments.

YOUTH MARKETING AND SALES

One strategy for reducing smoking that is being discussed in the Kansas City area is to increase the legal age for buying tobacco to 21. Similar legislation has been passed in Columbia, Missouri, and in the state of New Jersey, and cities like New York. The Campaign for Tobacco Free Kids endorses this move, noting that 95 percent of smokers begin before the age of 21. Moreover, the ages of 18 to 21 represent a crucial period when individuals move from occasional smoking to daily, regular usage. In addition to restricting access, increasing the age limit also may boost compliance with under-age sale prohibitions among retailers.

As with most health advocacy efforts, tobacco prevention has experienced a significant decrease in state and grant funding in the past several years. As resources become scarcer, organizations have found it increasingly difficult to mobilize, communicate, poll and lobby. Collaboration between organizations consequently has declined. To reverse these trends and develop common goals and coordinated efforts, leaders in the tobacco prevention field say more resources are essential.

THE AGES OF 18 TO 21
 REPRESENT A **CRUCIAL PERIOD**
 WHEN INDIVIDUALS MOVE FROM
OCCASIONAL SMOKING TO
 REGULAR, **DAILY USE.**



CHAPTER THREE

**ORAL
HEALTH**



ORAL HEALTH EMERGES AS PUBLIC HEALTH PRIORITY

Increased oral care capacity, improved collaboration among safety net providers and a growing awareness of the relationship between oral and general health all have helped push oral health care nearer to the forefront of public health over the past decade.

Although the supply of oral health safety net services in the Kansas City area still falls short of demand, the availability of services for the uninsured and underserved is far greater than in the early 2000s. In those days, the oral health safety net was small and fragmented; rural areas faced chronic provider shortages and community-based screening and prevention programs were few and far between.

**“IT’S A PRETTY
FRAGMENTED ORAL
HEALTH INFRASTRUCTURE
AND THAT MAKES
IT HARD TO PROVIDE
POPULATION ACCESS TO
ORAL HEALTH CARE,”**
SAID ONE PROVIDER.

Fortunately, the Patient Protection and Affordable Care Act (ACA) — coupled with a better understanding of the links between poor oral health and disease — have helped spur the integration of primary care and oral health locally and across the nation. At the same time, well-organized oral health advocacy efforts have scored important policy successes in Missouri and Kansas.

“We’ve seen remarkable progress over the past decade,” said Jessica Hembree, program officer at the Health Care Foundation of Greater Kansas City (HCF). “Oral health has been transformed from almost an afterthought to an increasingly salient public health issue. As a result, we’ve been able to increase service to thousands who previously would have done without. We still have a long way to go, but momentum is in our favor.”

EXPANDING INFRASTRUCTURE

Access to dental services for low-income populations in the Kansas City region has grown dramatically since the early 2000s. Between 2006 and 2015, the number of safety net providers in Kansas offering oral health services increased from nine to 22, according to the Kansas Association for the Medically Underserved. In Missouri, the number of oral health access points operated by Federally Qualified Health Centers (FQHCs) jumped from 39 in 2008 to 79 in 2015.



In Missouri, the number of oral health access points operated by FQHCs jumped from

39

IN 2008

to

79

IN 2015.

Swope Health Services, Samuel U. Rodgers Health Center, Health Partnership Clinic of Johnson County, and the Live Well Community Health Center of Lafayette County — all FQHCs — currently provide a full range of oral health services. In addition, other non-FQHC public health entities have been established or have expanded oral health capabilities and services.

“Things looked very different 10 years ago,” one stakeholder said. “Back then, there were basically two safety net clinics that provided dental care. But we’ve seen FQHCs really flourish and area hospitals have taken a larger role as well. There also has been an increase in dental care provided in specific community settings, such as homeless shelters.”

The Kansas City CARE Clinic has expanded its services to include dental care and is today a training site for the University of Missouri-Kansas City School of Dentistry. Through the CARE Clinic, comprehensive dental care is provided to more than 500 patients annually. Seton Center also offers dental services to Medicaid, insured and self-pay patients. In 2013, the organization provided nearly 6,000 dental services to low-income patients in the metropolitan area.

Access to care in rural areas also has improved. In 2009, a multi-sector task force in Cass County began planning a safety net dental clinic for the county. The facility, known as the Cass County Dental Clinic (CCDC), opened in 2011 in Belton and today provides care for low-income, uninsured children ages 0-20. In addition to offering dental services, the clinic works to reduce the risk of dental disease by providing oral health and behavioral education to families and by serving as a community resource on oral health issues.

The success of the clinic prompted the opening of a second facility in July 2015 at the Cass Regional Medical Center in Harrisonville. The new location helps provide much-needed dental access to central and southern Cass County. Both clinics are funded and operated by the Cass Community Health Foundation.

CASS COUNTY DENTAL CLINIC

BEGAN OPERATIONS IN

2011

ONLY
SAFETY NET DENTAL CLINIC IN CASS COUNTY

FIRST
MEDICAID OPTIONS FOR PEDIATRIC DENTISTRY IN CASS COUNTY

PROVIDE **URGENT** AND NONURGENT SERVICES (preventive education, early intervention and comprehensive dental care)

TREATED **2,158** PATIENTS THROUGH **4,826** ENCOUNTERS DURING 2014

**opened additional location in Harrisonville in 2015*

Five oral health
clinics in Johnson
County, Kansas,
now serve

12
LONG-TERM
CARE
communities.

REACHING OUT TO AT-RISK POPULATIONS

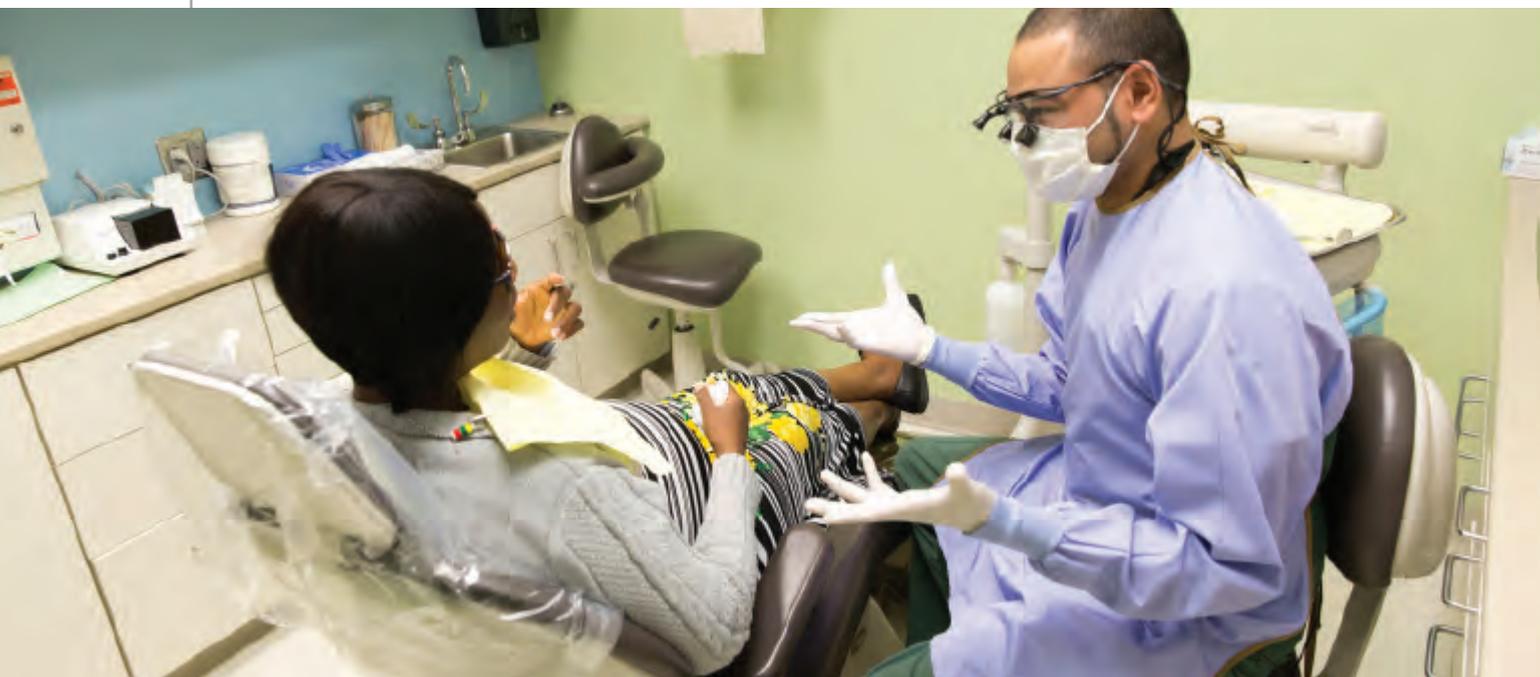
In addition to new general service clinics, the area also has benefited from an expansion in dental care access for special needs and elderly populations. Oral Health on Wheels, a 40-foot mobile dental clinic operated by Johnson County Community College, provides professional dental cleaning and other maintenance services to special needs populations.

A dental services van operated by Truman Medical Center-Lakewood travels throughout Missouri to provide free oral health services to children and adults with disabilities. Oral health services for seniors also have been strengthened: Five oral health clinics in Johnson County now serve 12 long-term care communities.

Oral health education and prevention services targeting school-age children likewise have expanded on both sides of the state line. In Missouri, Miles of Smiles, Inc. has offered portable dental health in Clay and Platte counties since 2002. Through the program, dentists and dental assistants provide free care to low-income children at schools and social service organizations throughout the two counties.

The Missouri Preventive Services Program (PSP) provides oral health education, supplies, screening and fluoride varnish to schools, day care centers, Head Start programs and other groups. Participation in the voluntary program has grown from 4,377 children served in 2005-2006 to over 72,000 students in 2012-2013. Significantly, the proportion of third-grade students in the state with untreated decay declined from 27.0 percent in 2004-2005 to 25.6 percent in 2012-2013.

In Kansas, the number of students between 3rd and 12th grade screened through a similar program — Smiles Across Kansas — increased from 34,511 in 2008-2009 to 92,177 in 2011-2012. The proportion of Kansas third graders with untreated decay, meanwhile, fell dramatically from 25.1 percent in 2004 to 9.4 percent in 2012.



WORKFORCE IMPROVEMENTS

Important developments throughout the dental workforce have played an essential role in supporting the expansion of the area's oral health safety capacity. Increasingly, dental schools are reaching out to engage students from underserved areas in the hope that the students will return to their communities upon graduation.



At the same time, a growing number of dental graduates are seeking work in clinics rather than setting up solo or partner practices. This change has been attributed to a desire among dentists to spend more time providing services and less managing the business side of dentistry. Another contributing factor has been the increased exposure to public clinic settings that students have received during their rotations.

“It used to be that we would have an advertisement for a children’s dentist in a clinic for a year without filling it,” said one provider. “Now we get 20 to 30 qualified applicants.”

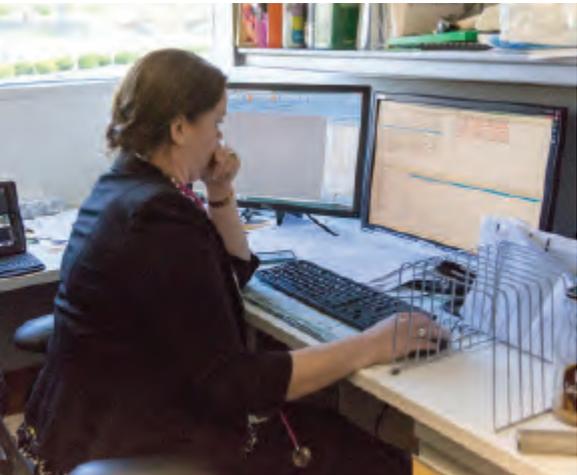
In 2013, a new school of dentistry and oral health was established at A.T. Still University, a Kirksville, Missouri-based private graduate school focusing on health sciences. The program was created to help address disparities in oral health care in Missouri and across the nation. Under the school’s doctoral program, fourth-year students split their time between a St. Louis clinic and a community health center or other safety net clinic.

DENTAL **HYGIENISTS AND ASSISTANTS** ARE TAKING **A BROADER ROLE TO PROVIDE** ADDITIONAL **SERVICES** THROUGH **EXTENDED CARE PERMITS.**

In Kansas, an extension of the scope of services that dental hygienists are allowed to provide also has contributed to enhanced access. Extended Care Permits (ECP) enable hygienists to place temporary fillings, use local anesthetics, extract baby teeth and provide other expanded duties. In 2009, 89 of 1,593 Kansas registered dental hygienists had ECPs. As of December 2012, a total of 143 ECPs were active at Kansas practice locations.

“DENTISTS IN OUR COMMUNITY ARE VERY GOOD ABOUT OFFERING SERVICES TO THE UNDERSERVED, BUT THERE IS A LIMITED NUMBER OF DENTISTS,” SAID ONE PROVIDER.

A sufficient number of dentists, at least in urban areas, has helped support safety net care. The ratio of dentists to population in the metropolitan counties on both sides of the state line continues to exceed levels used by the federal government to identify dental health provider shortage areas. That said, the proportion of private dentists in both Kansas and Missouri who accept Medicaid adult and children patients – approximately one in five — has remained virtually unchanged over the past decade.



Concerns exist about future capacity, given an aging dental workforce. In 28 Missouri counties, more than half of practicing dentists plan to retire within 10 years, according to the Missouri Department of Health and Senior Services.

One area that has seen positive policy developments has been the promotion of broader clinical roles for dental hygienists and dental assistants. In 2003, Kansas amended its state Dental Practice Act to allow Extended Care Permits (ECPs) for dental hygienists. This change enabled dental hygienists to work in the community with the signature (rather than sponsorship) of a dentist.

In 2012, the law was expanded to permit hygienists to provide additional services, including temporary fillings and extraction of loose primary teeth. Since 2001, dental hygienists in Missouri who've been in practice for at least three years and who are working in a public health setting can provide fluoride treatments, teeth cleaning and sealants to Medicaid children without supervision of a dentist.



“IF YOU ARE A PATIENT WITH PRIVATE DENTAL INSURANCE, YOU ARE OK – THERE IS ENOUGH SUPPLY,” SAID ONE PROVIDER.



THROUGHOUT THE ORAL **SAFETY NET** COMMUNITY,
A **GROWING SPIRIT** OF COLLABORATION IS **CREATING**
NEW SYNERGIES AND **OPPORTUNITIES.**

GREATER COLLABORATION

Throughout the oral safety net community, a growing spirit of collaboration is fueling new synergies and opportunities. Clinics increasingly are working together to coordinate efforts and match resources. Oral health programs are being integrated with primary care through patient-centered medical homes. New relationships between local dental schools and safety net providers are enabling dental students to have rotations in practices that serve low-income patients.

Yet even with these strides, the availability of acute and specialty care remains limited for lower-income individuals, stakeholders say. Care for special needs patients also can be difficult to access on a consistent basis. And fragmentation is still a major issue throughout the system.

Part of the problem stems from divisions created by the state line. Missouri and Kansas differ in the structure and coverage of their Medicaid programs, the scope of practice for mid-level providers, oral health screening requirements for schools and practice ownership regulations. These factors inevitably influence how dental health providers operate and how care can be accessed.



LONG WAIT TIMES

Other challenges remain. Existing services are still insufficient to meet the demand for low-cost oral health services. Long wait times for appointments, incomplete care, transportation challenges, insurance paperwork confusion and lack of access to oral health specialists were identified as major concerns in a 2014 regional oral health needs assessment conducted by HCF.

Participants in a recent focus group of community residents offered sometimes-pointed descriptions of the difficulties they frequently encounter when accessing dental care. One noted: “I had better dental care when I was in prison.” Quality of care emerged as a prominent theme. “They try to take the cheapest way out and pull it, rather than deal with filling it,” another participant said.

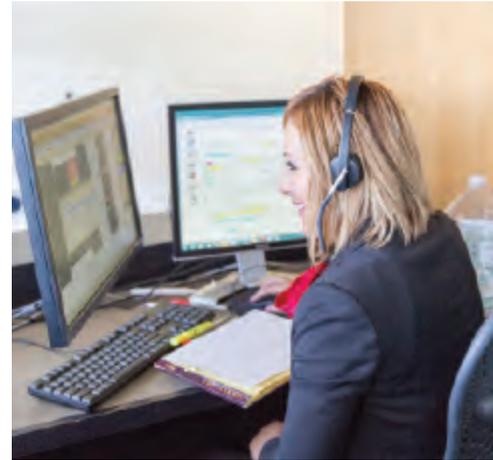
Others expressed concerns about receiving incomplete care and providers’ tendency to limit their focus to just one aspect of a problem. The difficulties are undeniably complicated by the fact that dental hygiene and preventive care remain low priorities for many who face major challenges in their daily lives.

THE AFFORDABLE CARE ACT

Changes affecting the health policy landscape over the past decade have been dramatic. At the federal level, passage of the Patient Protection and Affordable Care Act (ACA) in 2010 has led to a substantial expansion of the health care safety net, including oral health services, nationwide.

With support of ACA funding, Federally Qualified Health Centers (FQHCs) have been able to increase access by expanding facilities and establishing satellite sites in underserved and largely rural areas. Dental services provided by FQHCs increasingly are being integrated with primary health care and, more recently, behavioral health services. New funding also has helped FQHCs invest in technology, including electronic health records, to enhance efficiency and support quality care.

Yet even with the many positives associated with the ACA, most stakeholders believe the landmark legislation fell short by failing to establish dental coverage as a mandated insurance benefit. Pediatric dental services, by contrast, are defined as an essential health benefit and must be offered by all plans in the individual and small-group markets. But because dental insurance may be sold as a separate policy, adults buying a plan that does not include dental coverage do not face any repercussions if they do not obtain dental coverage for their children.



DESPITE **MANY POSITIVES** ASSOCIATED WITH THE ACA, **IT FELL SHORT** IN ITS FAILURE TO ESTABLISH **DENTAL COVERAGE** AS A MANDATED **INSURANCE BENEFIT.**

MEDICAID CHANGES

In both Missouri and Kansas, policy progress in the oral health arena has been hampered by reductions in state revenues and ongoing budget cutbacks. In 2005, Missouri's Medicaid program eliminated comprehensive dental benefits for adults. Although pregnant women, the blind, developmentally disabled adults and nursing home residents continued to be covered, other adults were covered only by emergency services. An estimated 300,000 Missouri adults lost coverage.

Some of the damage done by the 2005 cutbacks was reversed in 2015, after advocacy efforts helped secure the reinstatement of adult dental benefits. This development marked a significant win for oral health access in Missouri.

In Kansas, oral health coverage for Medicaid enrollees expanded in 2013 with the creation of KanCare, the Medicaid managed care program in the state. Previously, only emergency dental services for adults were covered. KanCare, however, provides coverage for two cleanings, one exam and X-rays each year. However, KanCare does not cover restorative dental care, such as filling cavities, orthodontia or crowns.

And even with the expansion of Medicaid oral health coverage, low reimbursement rates in both states create little incentive for providers to accept Medicaid patients. In 2013, the pediatric dental Medicaid fee-for-service reimbursement rates in Kansas and Missouri were, respectively, 47.2 percent and 40.2 percent of the commercial dental insurance rates charged for equivalent services in each state. The national rate was 48.8 percent. Unfortunately, these percentages decreased substantially between 2003 and 2013, from 68.2 percent in Kansas and from 50.5 percent in Missouri.

Both Missouri and Kansas' Medicaid programs are required to provide comprehensive dental care to children through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. In 2008, Kansas passed legislation requiring that every child receive a dental exam before starting school.

Unfortunately, neither state has adopted a statewide sealant program. Both Missouri and Kansas policies relating to children's dental health were graded "C" in 2011 by the Pew Center on the States. Lack of schools with sealant programs and low Medicaid rates for dental care were among the reasons cited for low scores in both states.

PEDIATRIC DENTAL MEDICAID FEE-FOR-SERVICE REIMBURSEMENT RATES

as a percentage of the commercial dental insurance rates charged for equivalent services in each state



KANSAS

MISSOURI

NATIONAL

2013 47.2% 40.2% 48.8%

2003 68.2% 50.5%

EFFECTIVE ADVOCACY

A stronger advocacy infrastructure has helped contribute to the elevation of oral health as a significant public policy issue in both Missouri and Kansas over the past decade. Through the infusion of funding from foundations in 2010, the Missouri Coalition for Oral Health was reshaped from an organization focusing on oral health education to one that plays a more active role in policy advocacy.

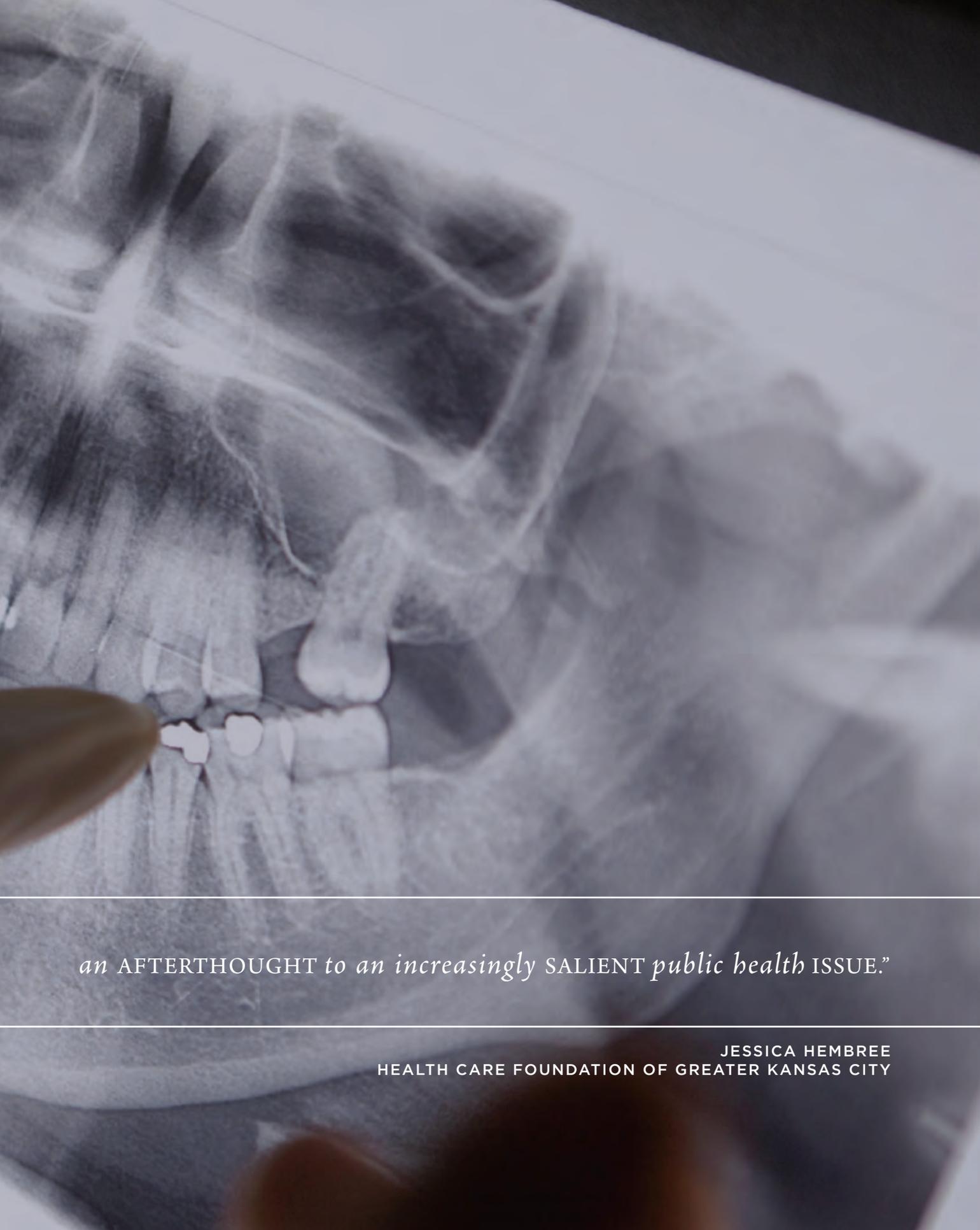
The reconstituted group helped secure several important policy wins over the past few years, including securing funding for the state Dental Director after a 10-year vacancy at the post. The group also helped ensure that adult oral health coverage was reinstated in the state Medicaid program.

In Kansas, advocacy initiatives have been led by Oral Health Kansas, a statewide coalition formed in 2003. The group has achieved several notable policy successes over the past decade. These include efforts to broaden the dental hygienist Extended Permit Law (2007), securing funding for Medicaid dental services for pregnant women (2008), incorporating a Medicaid preventive dental benefit for adults in the state's new Medicaid managed care program (2012), and defeating legislation that would have compromised water fluoridation (2014).





“ORAL HEALTH *has been* TRANSFORMED *from almost*



an AFTERTHOUGHT to an increasingly SALIENT public health ISSUE.”

JESSICA HEMBREE
HEALTH CARE FOUNDATION OF GREATER KANSAS CITY

LOOKING AHEAD

Stakeholders point to a number of major difficulties that continue to confront the oral health safety net in the Kansas City area. Most importantly, demand still exceeds supply for free or low-cost safety net services. As a result, increasing access to care, at both the policy and programmatic levels, remains a primary objective. Ensuring funding for adult Medicaid dental coverage in Missouri and boosting Medicaid reimbursement rates for dental services in both states were viewed as important steps in achieving this goal.

“Anything we can do to increase access to care is important,” one advocate said. “But 99 percent of the time, greater access is about better coverage and increased reimbursement.” Indeed, a 2013 survey of oral health providers indicated that increased reimbursement rates for low-income patients represented a critical need.

Expansion of dental outreach programs offered through community-based organizations also is vital, stakeholders say. Challenges surrounding transportation, time and convenience make it important to provide services at locations that people can easily access. These settings could include schools, health departments, WIC offices, childcare centers, pharmacies and churches.

“Anywhere there are large numbers of people would be the right place,” one stakeholder said, noting that schools are an especially valuable location for oral health services. “The school district is a vital point because we have kids for an entire day and can catch them young. We can also access parents and families.”

But even with the promise school-based services offer, concerns exist about limitations surrounding the types of oral health care that can be provided, as well as the potential difficulties that may arise when more complex cases need to be referred elsewhere.



STAKEHOLDERS SUGGEST **EXPANSION OF DENTAL OUTREACH** PROGRAMS OFFERED **THROUGH** COMMUNITY-BASED ORGANIZATIONS **IS VITAL** TO INCREASE **ACCESS TO CARE.**





Continued support for on-the-ground services, particularly in seriously underserved areas such as Wyandotte County, will be important. This includes expanding services provided by non-dental community providers, such as schools, nursing homes and organizations serving special needs populations.

Public education about oral health also remains a pressing need. As one advocate noted, “There haven’t been any comprehensive public education and awareness programs. We haven’t done a good job helping people who need dental care figure out how to get it.”

Education initiatives could take the form of both specific access guidance and broader messaging, such as an oral health awareness month. Information could be disseminated through WIC offices, schools and churches. The continued integration of primary and oral health care also creates opportunities for providers to share information and educate patients. Given the demographic changes that have occurred over the past decade across the metropolitan area, providing educational information in multiple languages undoubtedly would be beneficial.

The pervasive idea that dental care “is just something you think about when you have pain” can be overcome by pushing to make oral health a central element in the larger public health dialogue, advocates say.

“Oral health should be on the radar screen in public health circles with the same intensity, passion and frequency that now accompany obesity and chronic disease,” said HCF’s Jessica Hembree. “Elevating oral health and integrating it within public health will not only improve the lives of many low-income residents in the Kansas City area, it will also draw more partners together into synergistic, community-wide collaborative efforts.”



A photograph of a woman with blonde hair and a young boy sitting at a wooden table in a library. The woman is on the left, wearing a beige cardigan over a leopard print top and a white watch. The boy is on the right, wearing a red and black hoodie with 'SPIDERMAN' written on the sleeve. They are both looking down at books on the table. A green circular graphic with white text is overlaid in the center.

CHAPTER FOUR

BEHAVIORAL
HEALTH

IN TROUBLED TIMES, BEHAVIORAL HEALTH ORGANIZATIONS ATTEMPT TO DO MORE WITH LESS

The challenge of providing care and services to vulnerable populations has long been a struggle nationwide. In the best of times, the behavioral health system often lacks continuity, and resources inevitably fall short of need.

Today, in the uncertain aftermath of the Great Recession, that tension has never been greater. The unforgiving economic climate has dramatically altered the profile of those seeking mental health services and greatly increased demand. Unfortunately, this surge has come at a time when program funding at the state and local levels has continued to decline.

Compounding the predicament is an ongoing migration away from institutional care, as well as new mandates to privatize services. The end result is a fragile and fragmented mental health system that is increasingly dependent on already-hard-pressed institutions like shelters, hospitals and law enforcement agencies. The difficulties have been further aggravated by the departure of longtime caregivers from the field and growing burnout among those who remain.

As pervasive as these problems are, they have not stopped the progression of treatment methods and the growing adoption of evidence-based practices.

Nor have they undermined the determination of local organizations and individuals to strengthen behavioral health care in the Kansas City area. In fact, the opposite has occurred: Mental health advocates and providers understand that they must be more efficient and effective than ever to truly help those in need.

A new emphasis on collaboration has emerged, and this spirit of cooperation is producing a range of creative, pioneering solutions. The ultimate objective is the development of an integrated, community-based system of care that can respond quickly and appropriately to the full spectrum of mental health needs.

To that end, agencies and clinicians are implementing new programs to help first responders more effectively understand, address and defuse volatile situations. New courts have been created that substitute treatment for incarceration in non-violent cases where behavioral problems have contributed to criminal behavior. Technology is being harnessed to extend mental health care to underserved areas.

Since 2005, HCF has awarded

289 GRANTS totaling
\$49,302,498
TO SUPPORT behavioral health projects.



Agencies and care providers are working together to understand and address the underlying causes of behavioral health problems, including childhood and adult trauma.

Integrated approaches that link physical and behavioral care are becoming more widespread. And growing efforts are being made to improve the cultural competency of providers so they can provide high quality care to all populations.

At schools, a greater emphasis is being placed on programs designed to address adolescent mental health issues, and many of these have produced dramatic improvements.

Finally, education and outreach efforts are being developed to reduce misconceptions about mental illness and the discrimination that comes with them.

“These are, without a doubt, very challenging times in mental health, not just in the Kansas City area but nationwide,” said Mary Kettlewell, a program officer with the Health Care Foundation of Greater Kansas City (HCF). “But the good news is that entities that used to work independently are banding together to develop powerful solutions to long-standing problems. We have a long way to go, but I believe there is a growing sense that together, we will eventually get where we need to be.”

THE ULTIMATE OBJECTIVE IS
THE DEVELOPMENT OF AN INTEGRATED,
COMMUNITY-BASED **SYSTEM**
OF CARE THAT CAN **RESPOND**
QUICKLY AND APPROPRIATELY
TO THE FULL SPECTRUM OF
MENTAL HEALTH NEEDS.



A FRACTURED LANDSCAPE

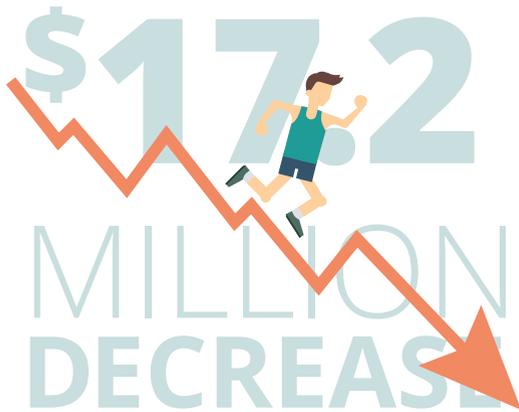
In the past decade, state and local governments facing budget shortfalls have significantly reduced funding available for traditional behavioral health services. Cuts have affected the full range of agencies and programs, from Medicaid to public health initiatives, emergency medical assistance and other funding mechanisms and grants.

Major cuts in the Missouri Medicaid program in 2005 produced substantial changes in eligibility for low-income families, disabled and elderly participants. Ultimately, 147,000 state residents lost coverage. This rollback brought rate cuts to hospitals, shortfalls at community health centers, decreases in public health initiatives, such as the State Children's Health Insurance Program, reductions in emergency medical assistance and cuts to mental health services.

"One of the groups that was hurt most by the Medicaid cuts was addicted mothers, since many of those women were no longer eligible if they earned more than \$290 a month," said Alan Flory, executive director of ReDiscover.

MISSOURI DEPARTMENT OF MENTAL HEALTH

FUNDING FOR COMMUNITY-BASED SERVICES
2009-2012



Substance abuse programs have been hard hit by the funding reductions. In the Kansas City area, the closure of long-time programs operated by MOSOS-Salvation Army, Renaissance West and Imani House over the past decade has diminished detoxification beds. Today, only the Heartland Center for Behavioral Change continues to operate detox beds on the Missouri side of the state line.

Predictably, gaining access to the few detoxification beds that remain has become increasingly difficult, due to constrained supply as well as restructured eligibility criteria and shifting admissions policies.

"The loss of beds has disrupted the whole treatment system," said Oneta Templeton of Children's Mercy Hospital. "Recovery is a journey and not a quick, linear process, but if the resources required to start that journey are not available, the individual frequently goes backward."

Funding cuts have affected not only accessibility but also the

way non-profits function.

"What it has meant for agencies is stagnant salaries, high turnover rates and high stress for the employees," said Marsha Morgan, chief operating officer at Truman Medical Center Behavioral Health. "In addition to the Medicaid cuts, there has been increased accountability for the service that we provide. So what you have is a safety net system that is very fragile and that struggles to serve those that need the services."

SHRINKING CAPACITY, GROWING NEED

The budget reductions have come at a time when the demand for mental health services has never been greater. Job losses and other economic problems associated with the financial collapse of 2008, as well as the precarious recovery that has followed, produced many new and acute behavioral health needs. Increasing numbers of working poor, middle-class families with no insurance, and new immigrants have presented for care. Yet agencies have found it more difficult than ever to provide necessary services.

The situation has been complicated by a long-term shift in the way care is provided. In the 1990s, states began to transition mental health patients from longer-stay, state-owned institutions toward shorter-duration community settings. Much like the loss of detox beds, this development has reduced capacity and undermined the continuity of care.

The 2006 closing of the Western Missouri Mental Health Center marked a pivotal event in the Kansas City behavioral health community. Although the loss of the center’s residential beds was mitigated somewhat when Truman Medical Center began providing inpatient mental health services through an agreement with the state, the impact nonetheless was significant. Truman’s shift in focus from an intermediate level of care to shorter acute care resulted in reduced lengths of stay and — combined with other closures — further constricted the availability of comprehensive residential treatment options across the region.

INCREASING NUMBERS OF WORKING POOR, MIDDLE-CLASS FAMILIES, AND NEW IMMIGRANTS HAVE PRESENTED FOR CARE, YET AGENCIES HAVE FOUND IT MORE DIFFICULT THAN EVER TO PROVIDE NECESSARY SERVICES.



WESTERN MISSOURI Mental Health Center, Kansas City, Missouri.



RAINBOW Mental Health Center, Kansas City, Kansas.

Another major blow occurred in 2011, when the state of Kansas closed all but six beds at the Rainbow Mental Health Center, then a 50-bed psychiatric hospital. In 2014, the state partially reconstituted the facility by converting Rainbow into a 10-bed, crisis-stabilization resource. The facility today is designed to connect those with serious and persistent mental illness to community-based services and provides a place for short-term detox as an alternative to emergency room treatment or arrest.

Children and adults previously treated at inpatient facilities are now presenting at community-based mental health agencies, often with multiple complex diagnoses, including mental disorders, developmental diagnoses and serious medical conditions. Too often, agencies simply are not equipped to provide appropriate stabilization, follow-up, support and monitoring.

On the positive side, the reduction in acute and residential mental health capacity is seen by many professionals as an appropriate and necessary, if difficult, step in the journey toward community-based treatment.

Clinicians and program leaders interviewed by HCF through a series of focus groups recognize that increasingly scarce government dollars must be put to use as efficiently and effectively as possible throughout the care system.

The problem, they say, is that this shift is occurring without the corresponding policies, programming and funding necessary to fully support community-based mental health services. That means the early identification, assessment and intervention services essential to a community-based approach too often are not in place.

“Everybody would probably agree that residential treatment should be reserved for kids who are properly assessed to need that high level of care,” one program leader said. “But, there’s no policy that says, in addition to trying to move those kids that we can out of residential treatment, we’re also paying attention to what got them there in the first place.”

The overarching dilemma, then, is to develop a comprehensive and robust care continuum that can appropriately balance and accommodate both institutional and community-based care, and do so within today’s acute budget constraints.

QUESTIONS ABOUT PRIVATIZATION

Adding complexity to this situation is the fact that a reliance on private, for-profit agencies and managed care organizations has increased as the government’s role in delivering mental health services has diminished. Many observers remain wary about the shift toward privatization and believe much remains to be done to create an equitable and effective public-private approach to mental health care.

In Kansas, managed care organizations began overseeing and administering Medicaid mental health services with the launch of KanCare in 2013. Among other concerns, some question the overall efficacy and fairness of managed mental health care.

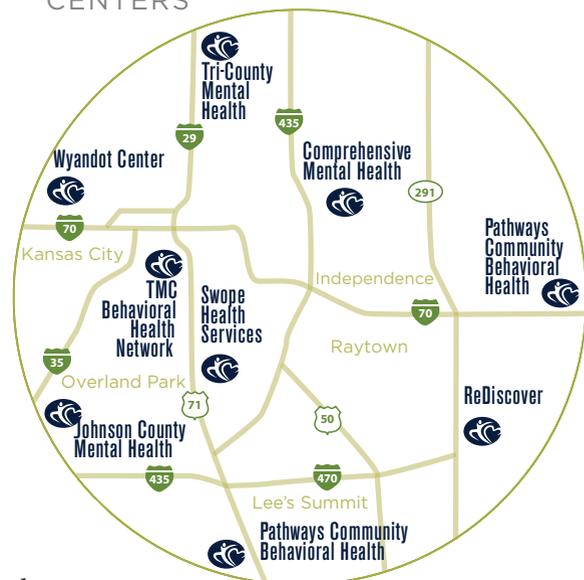
Other stakeholders argue that insurance companies are basing care not on the comprehensive clinical assessments necessary to help define a person’s behavioral health needs. Instead, they say, companies are pursuing systematic, one-size-fits-all approaches that are primarily concerned with cost reduction.

Despite these criticisms, most professionals agree that privatization does create significant potential for bringing innovation and energy to the mental health arena. The rise of privatization also has prompted increased collaboration among advocates, private agencies and government officials. The area’s mental health community recognizes the need for public-private partnerships to address the emerging gaps in services and to develop responsive and effective community-wide programs.

Ultimately, all public and private providers have a role to play in ensuring the safety, health and well-being of children, adults, families and communities. While the shift toward privatization has revealed significant shortcomings in the system, it also has opened up opportunities for community problem-solving, service innovation, and cross-system and interagency collaboration.

THE AREA’S MENTAL HEALTH COMMUNITY **RECOGNIZES THE NEED** FOR PUBLIC-PRIVATE PARTNERSHIPS TO ADDRESS **THE EMERGING GAPS** IN SERVICES AND TO DEVELOP RESPONSIVE AND EFFECTIVE **COMMUNITY-WIDE PROGRAMS.**

GREATER KANSAS CITY COMMUNITY MENTAL HEALTH CENTERS



LEANING ON LAW ENFORCEMENT

One of the most problematic consequences of today's shrinking spectrum of behavioral health options has been a growing reliance on public agencies and nonprofit institutions to help fill the void. These entities include hospital emergency rooms, homeless shelters, police departments and correctional institutions.

Ironically, the difficulties many have in accessing comprehensive services mean that, in some cases, the only way to receive some level of mental health care is to experience a crisis that requires intervention by law enforcement. This dependence puts an added burden on agencies that were never designed to be sources of proactive care.

State and county jails, in particular, have seen a dramatic increase in prisoners with mental health issues. A survey of local jails performed by the Hale Center for Journalism revealed that 45 percent of inmates indicated they had mental health problems and 60 percent had problems with alcohol or drugs.

Similarly, a 2009 Health Management Associates Behavioral Health Needs Assessment for Metropolitan Kansas City found that 60 percent of incarcerated women had a mental illness problem, 80 percent had substance abuse issue, and 86 percent were homeless or had unstable, inadequate housing.

Beyond producing less-than-adequate care for many, reliance on the justice system also has put public safety officers in an increasingly untenable position. "It is extremely unfortunate that, as a community, we're asking police officers to do a lot more than they should have to," said one focus group participant. "We expect them to be clinicians in the field and they simply don't have the training or support systems for that. The result is that they end up taking people to jail and you really can't blame them, because most are not aware of other options that may exist."





OVERBURDENED SHELTERS

Just as the law enforcement system has been strained by an influx of behavioral health patients, so too are domestic violence shelters becoming a default provider in today's mental health care system.

Most shelters are wrestling with the same fundamental challenges that other social service agencies face, including reduced funding and increased demand. But even though the number of shelter beds in the Kansas City region actually went up from 297 to 324 between 2009 and 2013, demand has far exceeded supply.

More than 7,000 individuals were turned away from shelters because of full beds in 2013, up from 4,749 in 2009.

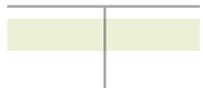
“When the economy goes down, domestic violence goes up,” said MaryAnne Metheny of Hope House. “So we saw the demand for services soar during the recession.”

A significant percentage of that increase, unfortunately, has been due to the fact that many had nowhere else to turn. The net result? Domestic violence agencies are faced with a growing number of clients experiencing severe mental illness in addition to their trauma-related issues. These cases present the agencies with complex problems and scenarios they've never dealt with before.

A focus group of domestic violence providers convened by HCF reported that over the past decade, virtually all caregivers have seen an enormous increase in the number of severely, persistently mentally ill individuals seeking assistance. Most agreed that there was direct correlation between the rising numbers of clients experiencing acute problems and the poor economy.

Shelters have likewise seen more clients with physical health and/or chronic medical conditions, as well as a growing number of older women presenting for services. Compounding the challenges has been the fact that many new clients have diverse linguistic needs.

Shelters are equipped to care for the needs of victims of domestic violence and provide counseling and other behavioral health services. But they are not the best entry point into the mental health system for people with intensive problems.



Since 2005,
HCF has funded

81

GRANTS

totaling

\$8.4
MILLION

to support
domestic
violence shelters
across the HCF
service area.

In Jackson
County, Missouri,
the annual cost
burden of
UNTREATED
SERIOUS
MENTAL
ILLNESS
is estimated to be

**\$283
MILLION**



IN SEARCH OF SOLUTIONS

As difficult as the funding environment is, there have been a few bright spots for agencies dealing with mental health and substance abuse issues, particularly in Jackson and Lafayette counties in Missouri. The Jackson County Mental Health Fund, which receives its funds from a tax levy, produces about \$11.5 million annually to fund grants focused on domestic violence, children and families, non-clinical consumer support and other behavioral health solutions.

Another Jackson County funding source, the Community Backed Anti-Drug Tax (COMBAT) tax, generates about \$19 million a year via a one-quarter-of-one-percent sales tax. The money helps fund drug treatment and prevention, drug courts, corrections and other drug and violent crime-related programs. The COMBAT tax has enjoyed widespread public support and was renewed by voters in 2009 by almost a two-to-one margin.

In Lafayette County, a one-eighth cent sales tax was passed in 2005 to create the Children's Services Fund, which supports counseling, family support and residential services for youth. The fund enabled the creation of the Brighter Futures Consortium by superintendents of the six public school districts in Lafayette County. The consortium has worked to identify mental health needs among their student populations and sought to increase promotion, prevention, detection and access to care.

As welcome as these funding sources have been, they represent the exception rather than the rule. Finding effective ways to overcome financial challenges consequently has required determination, resilience, creativity and most importantly, collaboration. The mental health community recognizes that public-private partnerships involving health centers, law enforcement, the courts and others are essential for developing responsive, effective programs that can help overcome reduced funding and widening gaps in service.

“ IN THE PAST **TWO** OR **THREE YEARS** I HAVE SEEN
A SIGNIFICANT **INCREASE** IN **COLLABORATION**,
AND THAT HAS REALLY **HELPED US OUT.** ”

Theresa Presley, Community Services Director,
Pathways Community Health

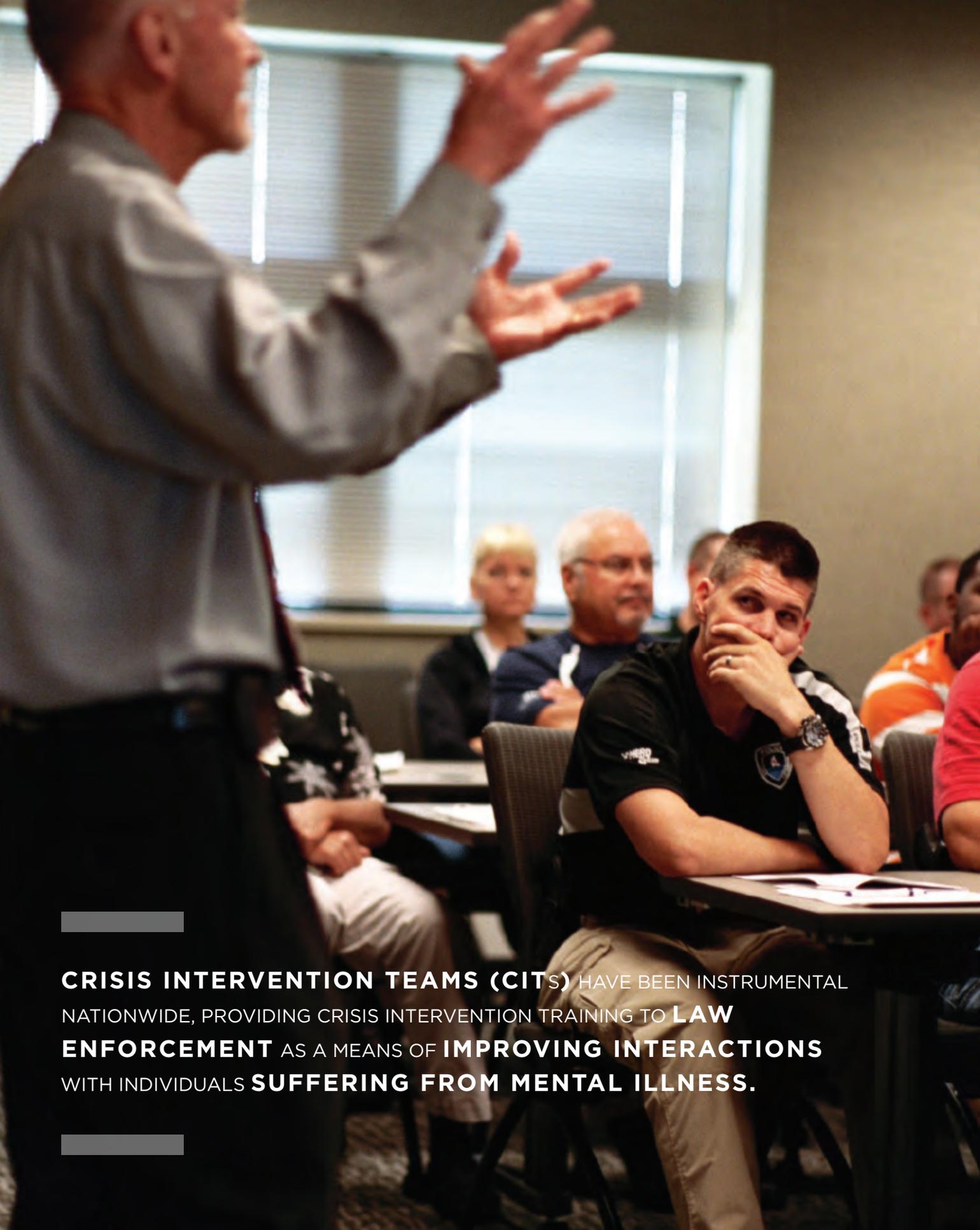
Nearly every focus group or interview identified some way in which enhanced collaborative capacities have improved the mental health service system in the region. The economic downturn significantly influenced the need for interagency collaboration, as noted by one focus group participant: “Maybe the silver lining in budget cuts is that it forced us to be more collaborative. It forced us to partner with each other. Social service agencies and state entities are now reaching out and saying, ‘We can’t afford to do this alone and it’s not the best kind of care.’”

“It used to be that organizations would operate in isolation, but now we are working together at a much deeper level and truly collaborating to make sure that we’re able to provide effective services for our clients in a holistic manner,” said Julie Donelon, president/chief executive officer of the Metropolitan Organization to Counter Sexual Assault (MOCSA).

Cooperation is occurring at many levels throughout the community: Between similarly situated agencies, safety net mental health providers and other public and private organizations. As a result, barriers that long existed between organizations have been removed and strong partnerships are emerging in their place.

Although these relationships resulted in large part from the Great Recession, the sentiment among stakeholders was that this new, integrated approach is here to stay. This is because the benefits of conducting business in this manner go beyond simply doing more with less.





CRISIS INTERVENTION TEAMS (CITS) HAVE BEEN INSTRUMENTAL NATIONWIDE, PROVIDING CRISIS INTERVENTION TRAINING TO **LAW ENFORCEMENT** AS A MEANS OF **IMPROVING INTERACTIONS** WITH INDIVIDUALS **SUFFERING FROM MENTAL ILLNESS.**

ENGAGING LAW ENFORCEMENT

The growing dependence on law enforcement to provide behavioral health interventions has spawned a range of solutions aimed at helping public safety personnel respond safely and effectively. New initiatives also have emerged to help keep those struggling with mental health problems out of jail.

In Johnson County, the Community Violence Action Council (CVAC) works to improve police responses to domestic disturbance situations. The Safe from the Start program provides officers with a card containing questions for children present at domestic violence scenes to help determine whether the child has also been victimized.

Both Jackson and Johnson counties have adopted Lethality Assessment Protocols (LAPs) to reduce the likelihood of intimate partner homicide. LAPs are partnerships between first responders and domestic violence organizations that are designed to immediately connect those in need with available resources and services.

Similarly effective is the Crisis Intervention Team (CIT) approach. CIT, first developed at the University of Memphis in 1987 after a mentally ill person was killed by a police officer, has expanded to more than 2,600 local and 300 regional programs nationally. CIT provides crisis intervention training to law enforcement as a means of improving interactions with individuals suffering from mental illness.

**CIT HAS EXPANDED TO MORE
THAN 2,600 LOCAL AND
300 REGIONAL PROGRAMS
NATIONALLY.**



The program relies on enhanced partnerships between law enforcement and mental health care providers to produce better outcomes for individuals, family members and communities. Central to the approach is pre-arrest jail diversion to mental health services for those experiencing a mental health crisis.

CIT was initially rolled out in the metropolitan area in 2000 by the Lee's Summit Police Department and has now expanded to most of the municipalities in the metro area.

"Crisis Intervention Teams have been the biggest factor in success in the community over the last 10 years," said Guyla Stidmon, executive director of the National Alliance on Mental Illness. "It has diverted people from jail to treatment and has been highly successful in making the community a safer place to be."

COMPASSIONATE COURTS

Community courts also have been effective in keeping those with behavioral health problems out of jail in non-violent cases. The courts, created through extensive collaboration between the judiciary, law enforcement and the mental health communities, offer treatments to help non-violent individuals deal with underlying issues that contribute to criminal behavior.

The programs focus on successful rehabilitation through early, continuous and intense supervised treatment, and in the case of drug abuse and addiction, periodic testing. Community courts were pioneered in Jackson County in 1993 and Lafayette County in 1996. Since then, they've become an increasingly accepted practice on both sides of the state line.



Since 2005, HCF has awarded

12 GRANTS totaling
\$1,700,000

TO SUPPORT specialty courts across
the HCF service area.

“Over the last decade, there has been a tremendous increase in specialty courts, including drug courts, mental health courts and veteran-to-treatment courts,” said Stephanie Boyer, deputy court administrator with the Kansas City, Missouri, Municipal Court.

“The impact has been huge. Individuals coming through the criminal justice system are able to access these services, frequently for the first time. It also can have a very positive impact on individuals’ families.”

Ideally, programs should be in place that can provide at-risk individuals with positive intervention before a crime is committed.

The courts depend on both public and private systems and require input and effort from a range of individuals, including judges, probation and parole officers and intervention providers. And while the partnerships have been shown to improve outcomes for offenders and victims of domestic violence by focusing on underlying causes of violence, the fact remains that they are not an ideal system entry point for someone requiring mental health services.

SPECIALTY COURTS GAIN TRACTION



MISSOURI  126 COURTS



KANSAS  15 COURTS



NUMBER OF SPECIALTY COURTS

JACKSON
COUNTY
MISSOURI  16 COURTS



CASS
COUNTY
MISSOURI  17 COURTS



*AS OF 2013

WYANDOTTE
COUNTY
KANSAS 



ADULT DRUG COURT
EST. 2008

JOHNSON
COUNTY
KANSAS 



JUVENILE DRUG COURT
EST. 2001

JACKSON
COUNTY
MISSOURI 



**OLDEST METRO AREA
DRUG COURT**
EST. 1993



CHANGING MODELS OF CARE

Just as the mechanisms for delivering behavioral care have evolved, so too have the nature and substance of the services provided. Like all health care providers, behavioral health agencies are migrating toward evidence-based care, or consensus best practices that offer clinically proven treatment protocols and pathways for a range of illnesses and conditions.

Evidence-based mental health care has become more embedded locally over the past 10 years in part due to encouragement from the funding community. The approach helps ensure optimal treatment by reducing care variance and by making best practices more accessible for small agencies.

For all the benefits, adopting evidence-based practices can be a complex process, and one that typically is done in stages. Identifying the appropriate practices or protocols and ensuring their adoption among all caregivers frequently requires a level of organizational efficiency that traditionally has not been required of community behavioral health agencies.

Most evidence-based practices involve proprietary instruments which require that agencies purchase the rights to deliver programming and work with an authorized trainer, coach or consultant during implementation. In many instances, it is expected that agencies will also implement the programs in the way they were designed. All of these stipulations require a financial commitment. Ongoing workforce challenges also have affected the sustainability of evidence-based care programs, given that high workforce turnover requires continual training of new workers.

“It’s probably taking us longer than we had expected, but I think we’ve tried to be thoughtful about it and make sure that it really takes hold,” said one caregiver. “There really is a commitment to this model and a desire to infuse it across our entire organization.”

TRAUMA’S TOLL

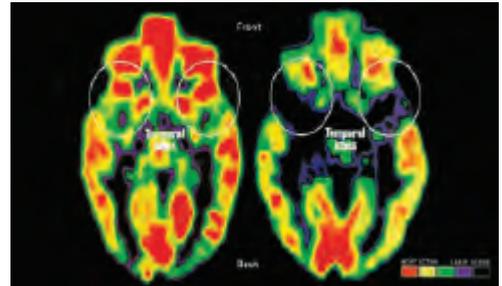
The shift toward evidence-based care is being complemented by new approaches in the understanding and treatment of mental illness. Among the most effective of these is trauma-informed or trauma-responsive care, an emerging field in which the Kansas City area has taken a leadership role nationwide.

Trauma-informed care is grounded in the knowledge that traumatic events or situations often produce lasting physical, emotional and behavioral effects. This understanding has led not only to new service priorities but also to cultural changes among community agencies.

“Probably the most significant change over the last decade for our organization and for the community at large is the increased understanding around trauma,” said one care provider. “This knowledge continues to change the way we interact with children and families and how we think about the way we do our work. As a result, it has brought new directions and greater effectiveness to our service delivery models.”

The current focus on trauma is due in part to several key studies, including a 1998 report known the Adverse Childhood Experiences (ACEs) study. Authored by Dr. Vincent Felitti, the study was one of the largest ever to assess associations between childhood maltreatment and traumatic events and later-life health and well-being. The results were sobering: Adults who experienced traumatic events as children were at greater risk for illness and premature death, with higher reported incidences of obesity, addiction, depression and suicide attempts, ischemic heart disease, cancer and liver disease.

Other studies have confirmed the correlation between trauma and poor mental and physical health and defined a range of trauma triggers and responses. Today, the term “toxic stress” is used to describe the long-lasting and extreme changes that take place in the developing brain due to searing childhood experiences.



BRAIN SCANS (L) show healthy function and (R) affected by trauma.

Impact of ACEs (Adverse Childhood Experiences)

AS THE NUMBER OF ACEs INCREASES, SO DOES THE RISK FOR NEGATIVE HEALTH OUTCOMES



POSSIBLE RISK OUTCOMES

BEHAVIOR

- LACK OF PHYSICAL ACTIVITY
- SMOKING
- ALCOHOLISM
- DRUG USE
- MISSED WORK

PHYSICAL & MENTAL HEALTH

- SEVERE OBESITY
- DIABETES
- DEPRESSION
- SUICIDE ATTEMPTS
- STDs
- HEART DISEASE
- CANCER
- STROKE
- COPD
- BROKEN BONES

ACE QUESTIONNAIRE

The ACE Study included only those 10 childhood traumas because those were mentioned as most common by a group of about 300 Kaiser members; those traumas were also well studied individually in the research literature.

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
No ___ If Yes, enter 1 ___
2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
No ___ If Yes, enter 1 ___
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
No ___ If Yes, enter 1 ___
4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
No ___ If Yes, enter 1 ___
5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
No ___ If Yes, enter 1 ___
6. Were your parents ever separated or divorced?
No ___ If Yes, enter 1 ___
7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
No ___ If Yes, enter 1 ___
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
No ___ If Yes, enter 1 ___
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
No ___ If Yes, enter 1 ___
10. Did a household member go to prison?
No ___ If Yes, enter 1 ___

Now add up your "Yes" answers: ___

This is your ACE Score

TRAUMA COLLABORATION

Because the economic downturn spawned a rise in all types of trauma — from unemployment and housing disruptions to family violence — many area clients have experienced “trauma on top of trauma.” Repeated events that produce stress, anxiety or fear can result in complex clinical cases that may present as attachment disorders, substance abuse, bipolar conditions or post traumatic stress disorder.

As a result, expanding community awareness about the toll trauma takes has become a priority in the Kansas City mental health community. Trauma Matters KC, created by the Metropolitan Mental Health Stakeholders group, is a coalition of more than 30 social service agencies, behavioral health centers, philanthropies, institutions and individual providers from across the metropolitan area working to increase awareness about trauma-focused care.

Trauma Matters KC provides information on best practices related to trauma care and the causes and results of trauma. The organization promotes education, assistance and advocacy for trauma-related services, and engenders long-term improvement around practices and issue awareness.

Similarly, the Trauma-Informed Care Task Force (TICTF) of Johnson County was launched in 2012 with a grant from the HCF to create and support a more trauma-informed community. The Task Force's efforts include training educators, clinicians and other professionals. Local agencies designate staff to learn about trauma care, then bring that knowledge back to their offices to develop and implement in-house strategies, policies and procedures. These strategies both help clients cope as well as minimize additional trauma from the institutions serving clients.

The program is touching a broad group of agencies, including traditional behavioral health providers as well as police departments, the Johnson County District Attorney's office and Head Start of Shawnee.

CHILDHOOD TRAUMA

Significant efforts also are being made to zero in on the problem of trauma at life's earliest stages. A pioneering local initiative known as Head Start Trauma Smart — created by Kansas City's Crittenton Children's Center and supported by HCF — focuses on childhood trauma intervention.

Trauma Smart serves as a practice model for preschool providers, parents and caregivers to help children calmly navigate serious emotional challenges. Through innovative coping strategies and hands-on tools, the program provides children with strategies for dealing with anger and stress so they can return to a more productive emotional state.

"The program provides knowledge about the sources and symptoms of trauma and gives adults the skills they need to therapeutically intervene with children when appropriate," said Janine Hron, executive director of Crittenton.

The program helps children who have experienced stressful events develop self-comforting skills and better executive function. These skills will be essential for relationships and later school success.

Since its inception, Hron said, Head Start Trauma Smart has shown that when families become more engaged in their child's school experience, there is a 50 percent decrease in the number of children who require therapy services. The initiative also is improving day-to-day relationships between adults and children in Head Start classrooms to better prepare students for learning once they move into kindergarten.

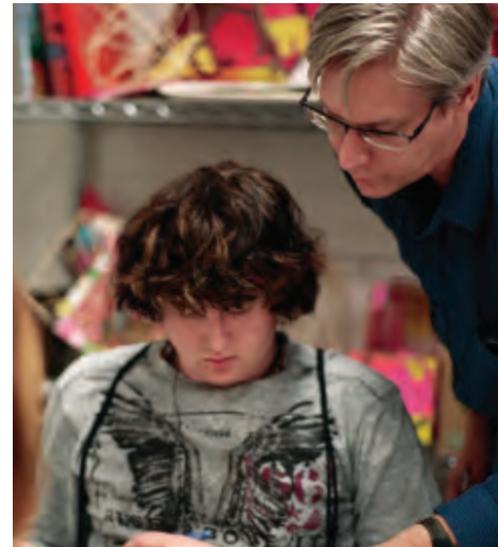
The innovative program has received considerable national recognition and acclaim and was awarded a \$1.4 million grant from the Robert Wood Johnson Foundation (RWJ) in 2013, with additional funding from HCF. Significantly, the money is helping expand interventions across Missouri and into Wyandotte County, Kansas. The program was taken as a national initiative by RWJ and started in additional communities.



CARING FOR THE CAREGIVERS

Along with increasing understanding of behavioral problems in at-risk populations, the new focus on trauma also has led to a greater awareness of the “secondhand trauma” routinely experienced by caregivers and other professionals in the mental health field.

The impact of encountering the damage that trauma inflicts multiple times a day can have lasting consequences for caregivers, including diminished physical and mental health, chronic burnout and high stress. This, in turn, impacts the system by leading to lower morale and higher turnover.



The Secondary Trauma Resources Center was created to help alleviate this serious but frequently overlooked problem. The local nonprofit was created by women from various Kansas City-area service organizations who saw an opportunity to reinforce and sustain the mental health workforce. The resource center teaches strategies for reducing secondary trauma’s impact through educational presentations, tools and training for staff, workshops and retreats.

In addition, many local mental health care agencies are adopting the Sanctuary organization model. This trauma-informed, evidence-supported operating approach is specifically designed for human services organizations and emphasizes a non-hierarchical, highly participatory system of employment and service delivery. The objective is to help staff function in a healthy, humane, democratic and socially responsible manner in order to improve job satisfaction, reduce burnout and provide optimal care to clients.

INTEGRATING CARE

Growing knowledge about the relationship between the body and mind is driving a wider movement to more effectively integrate behavioral and physical health sciences. Increasingly, researchers and clinicians are pursuing comprehensive treatment solutions that transcend traditional barriers between mental and physical health.

Mounting evidence supports the shift. A 2010 report by the Milbank Memorial Fund found that up to 70 percent of primary care visits are related to psychosocial issues, even though patients often seek help for only their physical health concerns. The report further notes that it is frequently mental health or substance use issues that trigger the primary care visits in the first place. Yet primary care doctors typically have little or no training in mental health care.

Clinicians say an integrated approach can be particularly effective in the areas of pediatrics, substance abuse and for patients whose developmental disabilities are accompanied by physical or mental illness. Ultimately, however, all patients can benefit from a more holistic approach to health.

In the Kansas City area, the idea of integrating multidisciplinary services and practice continues to gain traction. Providers are working on mechanisms to jointly address individual well-being in one location. The concept is not without challenges and requires new kinds of thinking. But providers say the need is real.

“At Wyandot, Inc., we recognized that many of our consumers had many medical needs that were going unattended,” said Randy Calstrom of Wyandot, Inc., a community mental health center serving patients in Wyandotte County, Kansas. “As a result, a few years ago we opened a primary health care clinic inside the mental health center, and it’s turned out to be an extremely effective approach. We serve a population that doesn’t get medical treatment in any other way and generally has never sought out medical care. So, for the first time they are finally getting the treatment that they need.”

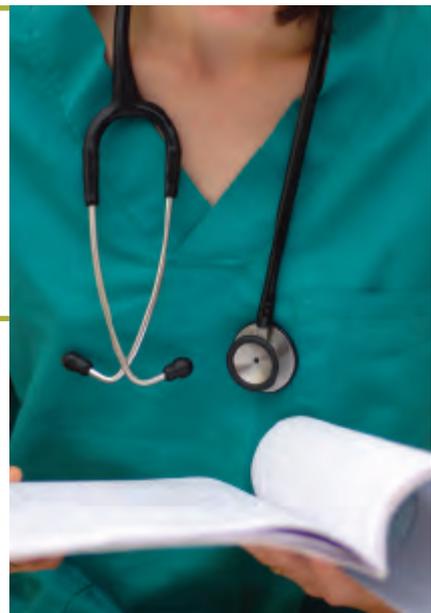
A 2010 report found that up to

**70
PERCENT**

of primary care visits are related to

**PSYCHO-
SOCIAL
ISSUES.**

**IN THE KANSAS CITY AREA, THE
IDEA OF INTEGRATING MULTIDISCIPLINARY
SERVICES AND PRACTICE **CONTINUES**
TO GAIN **TRACTION.****





WORKFORCE SHORTAGES

Essential to the success of a behavioral health system is a committed and competent base of professional caregivers. Yet beyond the inherent stress associated with the profession, numerous challenges are pressuring the Kansas City-area workforce. One chronic problem is a general shortage of psychiatrists, master's level clinicians and qualified substance abuse treatment professionals. Observers say the scarcity of professionals is due in part to aging demographics and increased retirements, which inevitably result in organizations losing their most experienced workers.

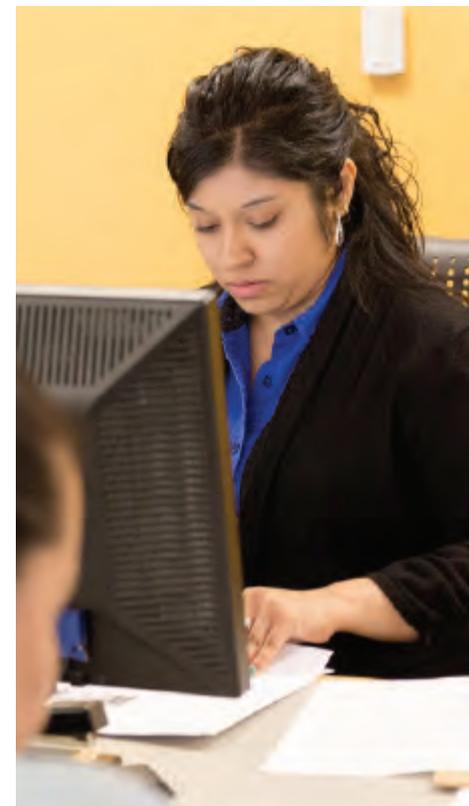
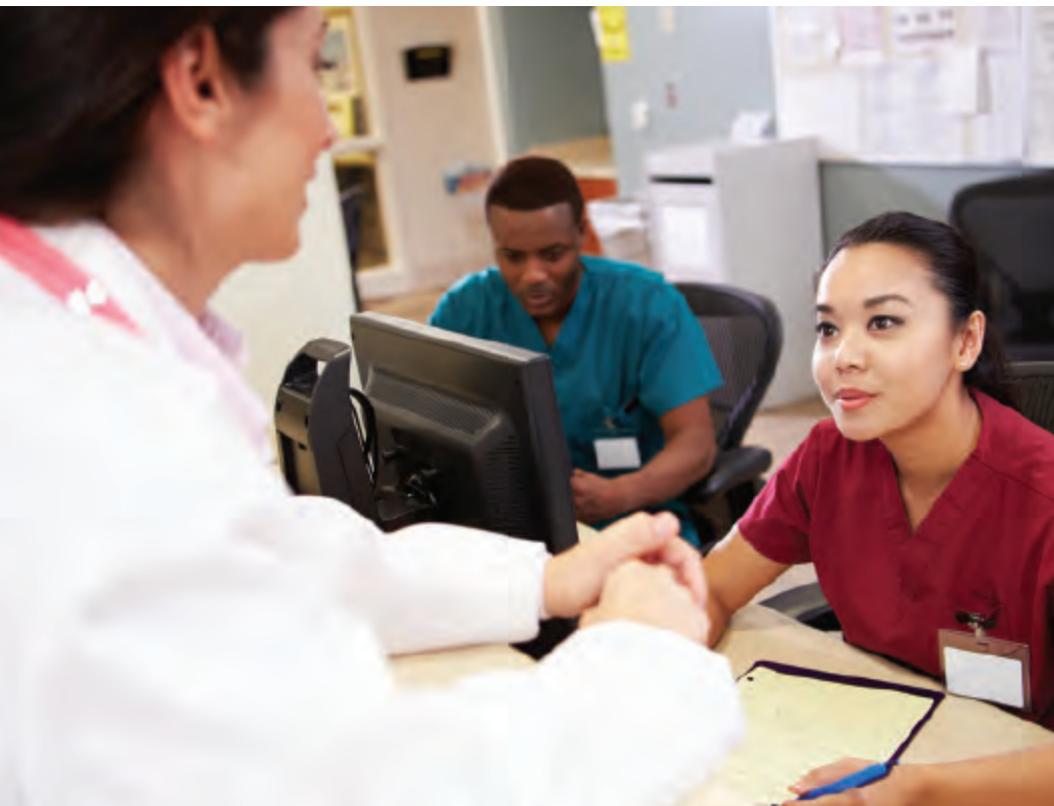
Also contributing to worker shortages is new competition from for-profit managed care organizations. These businesses typically are able to pay higher salaries than public mental health agencies, and this has been especially true in the wake of public budget cuts over the past decade. In Kansas, large numbers of staff at multiple agencies were lost when managed care organizations took over the state's Medicaid mental health services. Staff turnover puts a continual strain on the behavioral health system, as most positions have low salaries and high stress.

For all agencies, the issue of turnover is ongoing and requires continual attention and strategizing. One approach found to be effective is focusing on high-quality training and skilled supervision. And while evidence-based practices can be challenging to implement and sustain, these modalities can help strengthen the skills, confidence and ultimately, the job stability and satisfaction of frontline practitioners.

Agencies also are continuing to explore new ways to boost recruiting and attract more young people to the field. Part of this effort involves working to increase the diversity of the mental health workforce. As the general population has become more racially and ethnically diverse, mental health providers have struggled to bring in caregivers of color to care for these populations. More bilingual clinicians consequently are needed to serve clients who speak Spanish and other languages.

“We’ve seen an exponential increase in the number of Latina families in recent years, and finding licensed or properly credentialed staffers that are bilingual continues to be a significant challenge,” said one focus group participant.

Nor is it only Spanish that creates communication difficulties. The participant noted that 53 different primary languages are present among students attending one Kansas City, Kansas, school.





The Hispanic population in Missouri rose

79
PERCENT
from 2000-2010.



In Kansas, the Hispanic population rose

59
PERCENT
from 2000-2010.

CREATING CULTURAL AWARENESS

Cultural competence is similarly viewed as a critical workplace issue that must become institutionalized and standardized throughout the behavioral health system. Changes in internal practices and policy guidelines that result from cultural competency training not only make providers more aware of the consumers their agencies serve, but also pave the way for consumers to have a more active voice in agency planning and service delivery.

A lack of culturally competent services to meet the increased needs of the Latino community is of particular concern in the Kansas City region. According to the U.S. Census, the Hispanic population in Missouri jumped by 79 percent between 2000 and 2010 and now accounts for about 3 percent of the state's total population. In Kansas, the Hispanic population increased by 59 percent between 2000 and 2010 and currently represents approximately 10 percent of the state's total population.

Budget constraints and cultural gaps in the Kansas City area have made providing necessary care for Latinos increasingly difficult. The problems have been especially pronounced in the areas of child welfare and children's mental health, where long wait lists for children, a lack of Spanish-speaking clinicians and high staff turnover are too often the norm.

Among the organizations tackling this problem is Rose Brooks, a domestic violence shelter. Rose Brooks created a Diversity Connections Committee and subsequently hired a training coordinator. The coordinator is responsible for creating and implementing an internal staff development program focused on cultural competency. Importantly, the organization makes some of its training available to other community organizations serving diverse populations. Rose Brooks made a commitment to increase not only the diversity of staff, but also their board of directors. Ongoing strategies will be used to emphasize the importance and visibility of the issue of diversity at the board level.

Mattie Rhodes, a Kansas City social services organization, likewise has made a point to include their board and community members in their diversity initiatives. The organization's cultural competence committee trains board members, and one board member, in turn, is assigned a seat on the committee. The approach helps ensure that cultural competency and diversity remain a priority.

CULTURAL COMPETENCY INITIATIVE

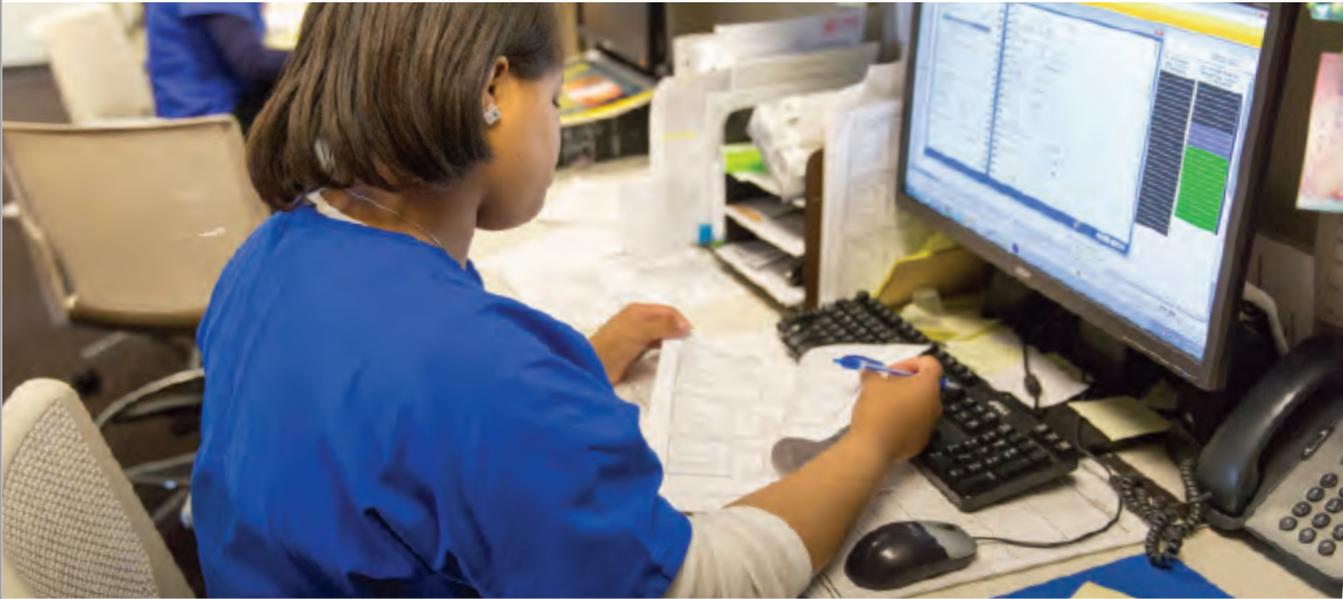
The Cultural Competency Initiative (CCI), created by the REACH Healthcare Foundation, has allowed more than 30 area health and social service providers to embrace a practice of cultural competency. The objective is to create systems, services and a workforce that are capable of delivering the highest-quality care to individuals, regardless of socioeconomic status, race, ethnicity, culture and language proficiency. Ultimately, the goal of the CCI is system-level change to reduce disparities in service.

SINCE 2009, HCF has provided
\$350,000
TO SUPPORT the
Cultural Competency Initiative.



A LACK OF **CULTURALLY COMPETENT** SERVICES TO MEET THE INCREASED NEEDS OF THE LATINO COMMUNITY IS OF CONCERN IN THE KANSAS CITY AREA.





GREATER EMPHASIS ON TECHNOLOGY

Finding more effective ways to extend behavioral health services to underserved areas has long been a challenge. Fortunately, telehealth, or telemedicine, is emerging to help meet the needs of those who might otherwise do without care. Telemedicine uses Internet capabilities to connect clients and patients with health care providers. The capability has been essential for many who receive some care in the greater metropolitan area but live in rural parts of Kansas or Missouri.

The University of Kansas' Center for Telemedicine and Telehealth, developed in the early 1990s, today reaches more than 100 sites throughout the state of Kansas. The center was one of the first in the region to use telemedicine to provide mental health services. Increasingly, other providers and agencies are following KU's lead and creating telehealth options to bring new behavioral resources to outlying communities.

Electronic health records also have become more prevalent in behavioral health over the past decade, with many organizations adopting them in recent years. Given the regulatory incentives to expand the use of electronic health records, it is anticipated that an increasing number of mental health providers will follow suit over the course of the next decade.

Despite the automation benefits that electronic health records provide, not all mental health providers are embracing the technology. The transition to electronic documentation is costly, and training and implementation can be time-consuming. Issues of confidentiality and privacy, always a challenge in health care, are exacerbated in the behavioral health arena.

Funding likewise remains a significant challenge. The desire to capitalize on technological advancements is not always matched by available funding streams. Ultimately, the extent to which technology is adopted in the mental health community will depend to a great extent on funders and state legislators.

EMERGING FROM THE SHADOWS

One positive and significant development in the local mental health community over the past decade has been a greater willingness by individuals, organizations and communities to discuss mental health issues. As long-standing taboos surrounding mental illness begin to fade, Kansas City has emerged as a leader in the collective search for answers through programs like Creating Community Solutions and a regional effort to promote mental health first aid.

In September 2013, the mayors of Kansas City, Missouri, Kansas City, Kansas, and approximately 360 others participated in a gathering designed to gain insight into mental health problems and solutions. The summit was set in motion by a federal initiative known as Creating Community Solutions, an effort developed by the Obama administration in response to much-publicized national incidents of violence involving persons with mental health issues. The program's objective was to stimulate community conversations about mental health issues in order to reduce misperceptions and promote community-based solutions to mental health needs.

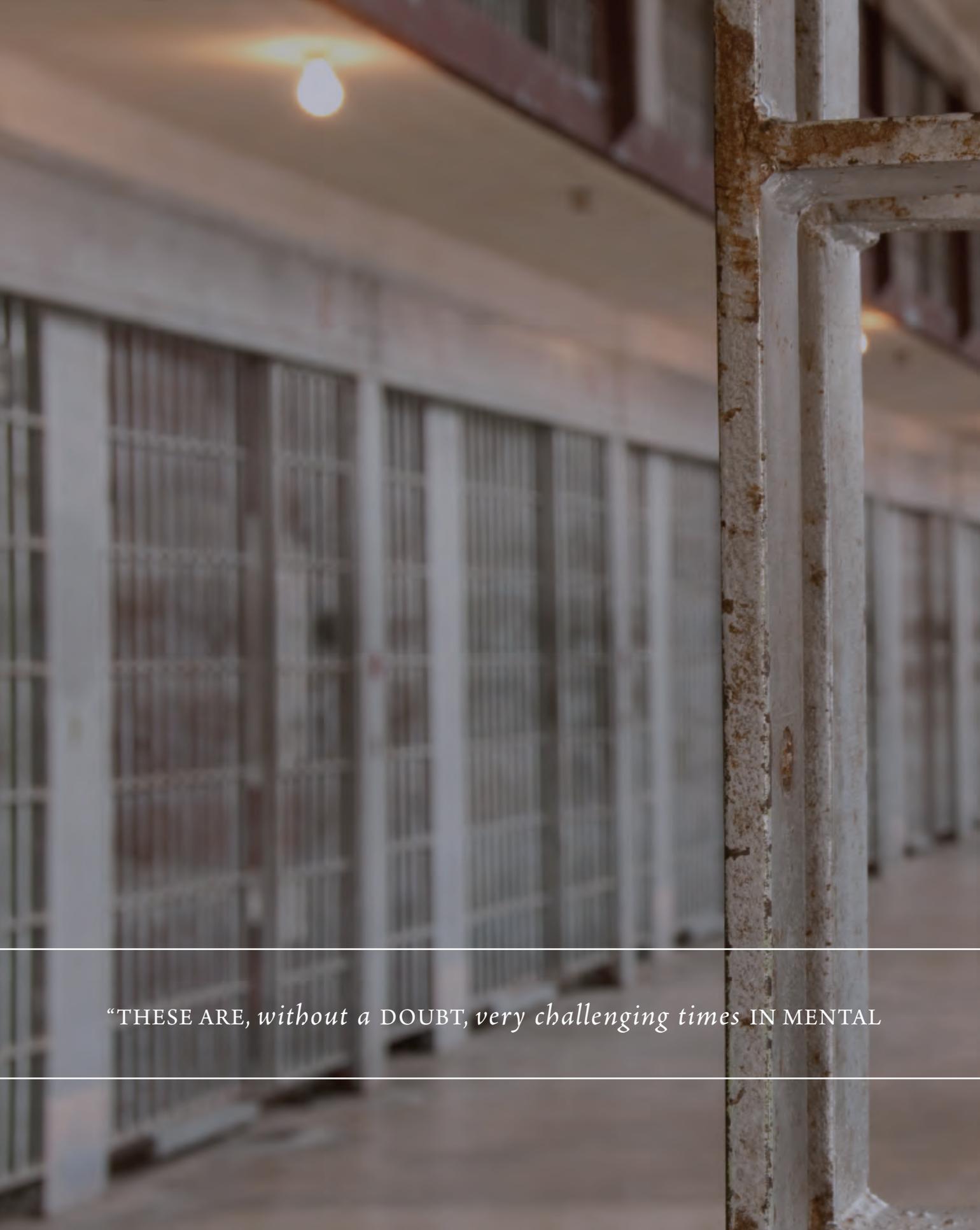
Participants in the Kansas City Community Consensus included the general public, mental health providers, general practitioners, as well as people with mental illness and their families.

“Tragic events across the country have provided an opportunity to open up community dialogues regarding mental health,” said Theresa Reyes Cummings from the Jackson County Mental Health Levy. “More community-based service organizations, schools, the faith-based communities, government sectors and law enforcement are requesting information about the signs and symptoms of mental illness and emotional stress, and how to help those who may be experiencing a crisis. People want to be proactive, rather than being caught in a crisis situation without the appropriate knowledge or resources.”

“**TRAGIC EVENTS ACROSS THE COUNTRY HAVE PROVIDED AN OPPORTUNITY TO OPEN UP COMMUNITY DIALOGUES REGARDING MENTAL HEALTH.**”

THERESA REYES-CUMMINGS,
JACKSON COUNTY MENTAL HEALTH LEVY





“THESE ARE, without a DOUBT, very challenging times IN MENTAL



HEALTH, *not* JUST IN THE *Kansas City* area but NATIONWIDE.”

DONNA BUSHUR
HEALTH CARE FOUNDATION
OF GREATER KANSAS CITY

Individuals attending the Kansas City event were polled to assess their understanding of mental illness, why they thought community involvement was important and what stake they had in the issue. Significantly, more than 80 percent of participants felt mental health services were not always available for those who needed treatment. Additionally, more than three-quarters felt society discriminates against people with mental illness.



MORE THAN 75% OF PARTICIPANTS FELT SOCIETY DISCRIMINATES AGAINST PEOPLE WITH MENTAL ILLNESS.

The meeting provided an opportunity to discuss and debate a wide range of problems and issues that surround mental health. These included the pain of stigma and isolation that comes with mental illness, the often-prohibitive cost of treatment, a fragmented system of care, a lack of awareness of trauma, the link between substance abuse and mental illness, a lack of mental health awareness within the criminal justice system, as well as the role that homelessness, poverty and social connectedness can play in one's mental health.

Solutions and strategies for improvement were identified. These ranged from increased focus and programming in schools to more extracurricular activities and more positive outlets for young people. Positive peer role models, life readiness and vocational training, family support, and law enforcement awareness likewise were suggested as ways to help young people avoid or overcome behavioral health issues.

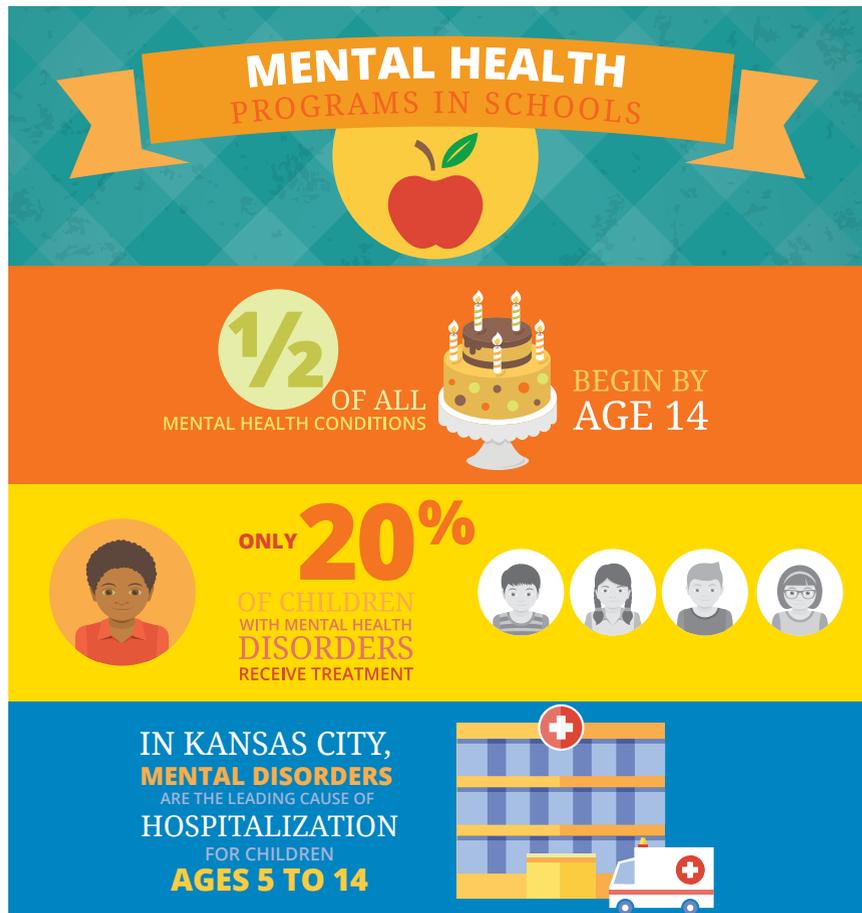
The meeting was important, not only because of the range of individuals and institutions it brought together, but also because it helped to encourage open discussions about mental health problems and community solutions.

SCHOOL-BASED BEHAVIORAL CARE

Many mental health problems initially appear in late adolescence or early adulthood. According to the National Alliance on Mental Health, half of all mental health conditions begin by the age of 14. Yet only about 20 percent of children with mental health disorders receive some kind of treatment. The numbers are even worse among low-income children. Primary barriers to appropriate treatment include the absence of a diagnosis, limited resources, complicated payer regulations and a fragmented system of services.

School-based programs, consequently, represent a critical element in the care continuum. School programs frequently work well because they're offered in a place where children feel safe and comfortable. And because they are provided during the school day, a wider range of students can be reached, including those who may not have transportation to access external treatment options.

School programs additionally can involve teachers in the treatments and empower them to play a more effective role in student mental health. For these reasons, professionals and educators have placed a greater emphasis on school-based programs over the past decade, and many of these have shown dramatic results.



Since 2005,
HCF has funded

40

GRANTS

totaling

\$3.9

MILLION

to support
school-based
mental health
services across the
HCF service area.

DeLaSalle Education Center is an alternative high school for students who have dropped out of traditional school or have had encounters with the legal system. Following implementation of a mental health program, 86 percent of students enrolled in the program either remained in school or graduated. That compares to a non-graduation/dropout graduation rate of 75 percent for students who did not take part in the initiative.

Genesis School, similarly, saw attendance improve by 20 percent among students who took part in an art therapy program. And at Gordon Parks Elementary School, visits to the CARE room (a location students are sent to following inappropriate behavior) dropped by 27 percent following implementation of a new therapy program.

For its part, the Belton School District saw a 50-percent decline in inpatient psychiatric placements of students versus previous years following the implementation of a broad-based mental health program.

Betsy MacLaughlin of Brighter Futures in Lafayette County said the organization has focused on specific areas of need in the schools. For example, when counselors saw self-mutilation among students on a regular basis, they developed a training program. Brighter Futures also targets substance use and abuse education in the middle and high school populations, and periodically brings psychologists and psychiatrists into the schools.

Community-wide fairs provide an opportunity to educate families, as well as offer wraparound services for parents of children with autism.

UPON IMPLEMENTING A **MENTAL HEALTH PROGRAM** AT DELASALLE, **86%**
OF STUDENTS ENROLLED REMAINED IN SCHOOL OR GRADUATED.

While the results of school-based programs have been predominantly — and often, dramatically — positive, implementing mental health programs at institutions designed for education is not a simple process. Recipients of HCF grants have identified some common challenges, including difficulty in garnering parent involvement, significant needs of students and an already-crowded school day schedule.

Finally, funding is consistently a challenge: Some schools have struggled to continue programs after initial grants expired. Others have tried to extend the small amounts of money they receive as far as possible, but generally must focus on high-risk students. Because the funds schools receive are competitive and finite, sustaining even highly successful programs can be problematic.





LESSONS LEARNED

The Kansas City area's behavioral health community has faced enormous hurdles in recent years, from budget shortfalls and a brutal economic downturn to rising caseloads and increased patient acuity. Despite these difficulties, organizations and individuals have pulled together and significant progress has been made.

While it's clear that much work remains, the community's success in developing collaborative solutions has generated new insight about the challenges ahead.

Perhaps the most important objective will be to develop an integrated, community-based continuum of care that can meet the full spectrum of mental health needs from childhood to old age. Given shrinking budgets, growing need and the increased privatization of care, envisioning and assembling this framework will not be simple.

The good news is that many of the pieces required, from evidence-based and trauma-informed care to technological platforms, already exist, albeit in isolation or in nascent form. The task, then, will be to support and expand the most effective of these programs and capabilities while integrating them into a coherent and responsive whole. As formidable as the job is, it will be made easier due to the many new relationships formed over the past decade.

Consensus about the larger objectives means that areas of unmet need — however critical they may be — increasingly are viewed not as insolvable problems but rather as opportunities for growth, and changes already under way are seen as springboards to further refinement and success. Working together against long odds, the Kansas City mental health community has not only prevailed but prospered. In so doing, progress toward an integrated, collaborative and ever-more efficient and effective system of care has continued, and with appropriate leadership, policy and funding, will hopefully only increase in the decade to come.

LOOKING AHEAD

For all the successes achieved, the breadth of unmet mental health needs in the Kansas City area is undeniably immense, and establishing priorities for future efforts is therefore difficult. Nonetheless, a consensus has emerged among clinicians and professionals about areas that clearly are under-addressed.

Current knowledge in neuroscience and attachment theory suggests that early developmental years are critical and may set the stage for a person's entire life. The regional community needs to increase its expertise in this area and strengthen approaches for reaching young children.

Transition-aged youth are another population that will require growing attention in the coming decade. Research shows that the human brain is not fully developed until the mid-20s. This is far later than the late-teenage range at which society has traditionally deemed young adults to be self-reliant and mature.

The real-world implications of a longer developmental cycle are often seen by safety net providers, who've watched older teenagers become homeless young adults with untreated mental illness during the tenuous late-stage developmental period. At present, the community lacks sufficient services for homeless youth, adolescents aging-out of foster care and transition-aged youth (18-21) with mental illness. The future therefore provides an opportunity to build awareness about this critical phase and create necessary structures capable of providing assistance when needed.





ADAPTING TO POPULATION SHIFTS

The region's demographics have changed dramatically in recent decades and are projected to continue to shift. The current need for bilingual, bicultural mental health providers therefore will remain a critical priority and will likely require continued workforce-related investments over the next decade.

The elderly population will increase substantially in the coming years. In 2011, approximately 12 percent of the metro region population was over the age of 65. The Metropolitan Research Center estimates this figure will double by 2040.

Many of these older people live in rural communities. In 2011, the metropolitan county with the highest percentage of people over age 65 was Allen County, Kansas. This creates a dual challenge of providing for the increased medical, psychological and social needs of older adults while overcoming the difficulties associated with providing care in rural areas.

Solutions will likely include the increased use of telemedicine, as well as possible incentives to bring more providers to rural areas and investments in non-professional resources, such as peer support programs.

EVIDENCE-BASED EVOLUTIONS

The last decade saw the emergence of more evidence-based care in the Kansas City area mental health community. Groups are experiencing positive outcomes by embracing this approach. Yet agencies also have faced significant growing pains relating to evidence-based care and will continue to do so. Fully and effectively implementing evidence-based mental health care requires significant time, personnel and financial resources, all of which are in short supply for hard-pressed agencies.

Moreover, the commercial payer reimbursement environment remains, at least for now, almost exclusively fee-for-service. As a result, few payers recognize or reward the quality and potential cost-saving benefits associated with building and sustaining an evidence-based medicine infrastructure.

Some agencies that have pursued evidence-based practice approaches without sufficient funding streams in place, in fact, have been forced to suspend their efforts. Lessons can likely be learned from traditional medical care, where evidence-based medicine is finally approaching critical mass after years of implementation efforts. It is anticipated that social services will follow a similar path and, with adequate investment, see significant increase in evidence-based care over the next decade.

TECHNOLOGY'S ROLE

Technological advancements of the last 30 years have affected virtually every aspect of our world, and in so doing, produced enormous benefits. The advent of telemedicine and electronic medical records, for example, offer enormous promise for health care providers. Yet technology's pervasiveness also presents new challenges for mental health agencies.

In the broadest sense, these include the strain on the economy resulting from deindustrialization and growing economic disparity triggered by the educational requirements associated with high-paying technology jobs. The resulting financial pressures inevitably will cause greater individual and family destabilization and concurrent behavioral health problems.

At a more personal level, a dependence on Internet communication can undermine those clients who require greater social activity and support. Yet the benefits of technology inevitably will outdistance the drawbacks. The Kansas City mental health service system will undoubtedly have multiple opportunities to continue making technological strides in the decade to come, providing they have the ability to take advantage through financial capabilities and access to expertise.



BOOSTING TRAUMA CARE

Rapid gains in understanding trauma and how it can be treated represent a major advance in behavioral health. In the Kansas City area, ongoing efforts to create a trauma-informed mental health community have enormous potential for improving care.

Its influence should continue to expand across a variety of areas and programs.

Opportunities exist in adult and child mental health, the courts, substance abuse initiatives, domestic violence programs and hospitals. What's more, the nature of trauma-informed care easily lends itself to collaboration among agencies.

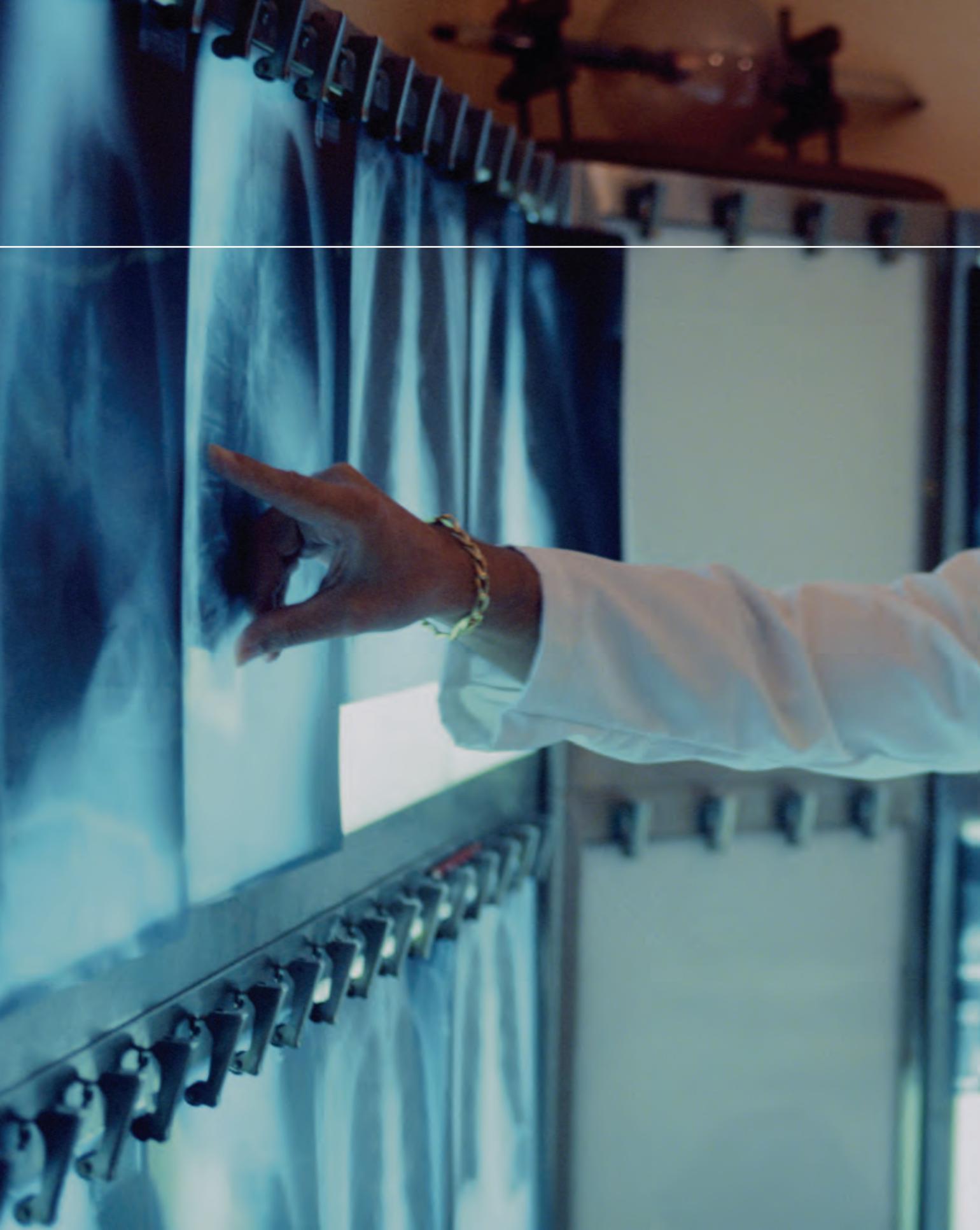
Gaining greater insight into trauma, including the realization that it can stem from a wide variety of events or situations, ranging from extreme poverty, an incarcerated family member or witnessing domestic violence or abuse, should enable organizations to better intervene in the future before the trauma occurs.

THE ROLE OF REFORM

Broad, sweeping changes have been made in health insurance in recent years. Because of those changes, the full implications of the Affordable Care Act on behavioral health remains to be seen. This is predominantly because the feature of the ACA aimed at providing health care coverage to low-income individuals — Medicaid expansion — has not been enacted in either Missouri or Kansas. This reality puts a continued strain on social service agencies that treat lower-income clients.

Moving into the future, stakeholders are cautiously optimistic that the passage of the ACA represents an important step in the journey toward adequate and sustained improvements in mental health funding and care. Yet the cloudy, ever-shifting care landscape in Missouri and Kansas makes it difficult to clearly read the road ahead.





CHAPTER FIVE

**PHYSICAL
HEALTH**

PROVIDERS STRENGTHEN SAFETY NET AMID DIFFICULT, CHANGING TIMES



The transformation under way across the U.S. health system has produced dramatic change throughout the Kansas City area over the past decade. Local free clinics, community health centers, safety net hospitals and community organizations all have scrambled to adapt in a fast-changing environment marked by new methods of care delivery, coordination and reimbursement.

The journey has not been easy. The challenges of providing quality care to the uninsured and underserved remain numerous and formidable. Beyond the profound structural changes brought on by reform, safety net providers have contended with the effects of the Great Recession, an increasingly complex and diverse client population and deep budget cuts at the state level. Yet through it all, they've managed not only to sustain safety net care, but strengthen it.

Improved business practices, increased provider capacity, more effective care coordination, expanding use of technology and stronger advocacy efforts all are emerging hallmarks of the area's safety net system. Importantly, many of these improvements have stemmed from better cooperation and collaboration between organizations.

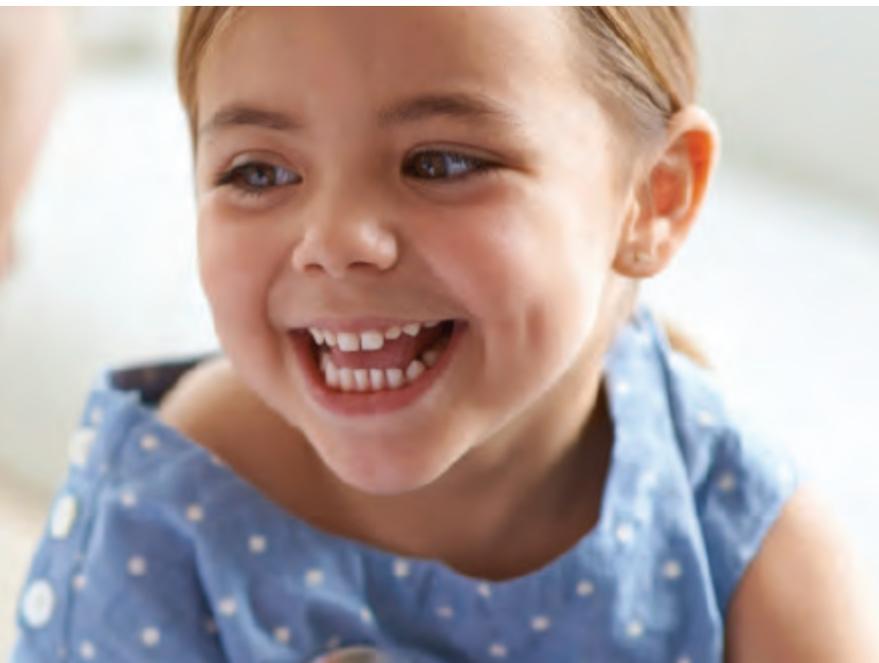
"The difficulties of recent years have brought people together and helped us develop creative and sustainable solutions," said Graciela Couchonnal, program officer at the Health Care Foundation of Greater Kansas City (HCF). "We're increasingly tackling our collective challenges in smarter, more cooperative ways."

SINCE 2005,
HCF has awarded

\$54 MILLION

in grants **TO SUPPORT**

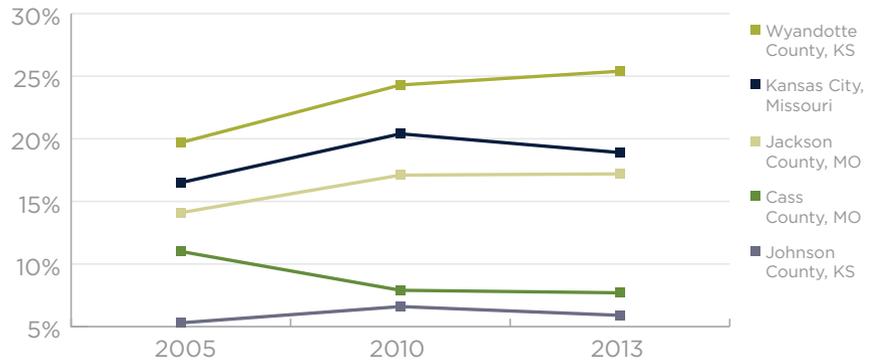
improving access to quality health care services.



IMPACT OF THE GREAT RECESSION

The Kansas City region’s safety net landscape is a far different place today than in 2005. In those days, most providers had simple organizational structures and were limited to offering basic primary and chronic care services to a smaller number of uninsured and underserved clients. Agencies worked in relative isolation and many were chronically understaffed and underfunded.

The economic free fall that began in 2008 turned up the financial pressure on providers and unleashed forces that continue to shape safety net care today. The number of working poor and uninsured jumped. Many middle-class breadwinners that traditionally had received health insurance through their employers suddenly found themselves out of work. As these individuals and families lost coverage, a growing number began presenting for care at safety net facilities.



PERCENT OF POPULATION BELOW POVERTY LEVEL by City and County, 2005-2013

SOURCE: U.S. Census Bureau, 2005, 2010 and 2013 American Community Survey 1-year estimates

CHANGING DEMOGRAPHICS

Dramatic growth in the ethnic diversity of residents living in the Kansas City area further accelerated demand for safety net services. According to the 2010 U.S. Census, nearly 10 percent of residents in Kansas City, Missouri, and 15.6 percent of residents in Wyandotte County speak a language other than English, with Spanish being most prevalent.

While many providers have expressed a willingness to support immigrant care, delivering services has been difficult due to state and federal policies that don’t include mechanisms for reimbursing non-citizen care. The language and cultural barriers immigrants face in attempting to access health care — coupled with a shortage of bilingual safety net staff — likewise have widened the gulf between those in need and those able to provide care.

“There’s a growing recognition of the necessity not only to find better ways to provide services for this population, but also for improved language and cultural access,” said Cathy Anderson, manager of language and cultural services at Jewish Vocational Services. “That’s very different than was the case 10 years ago.”

HCF has dedicated over

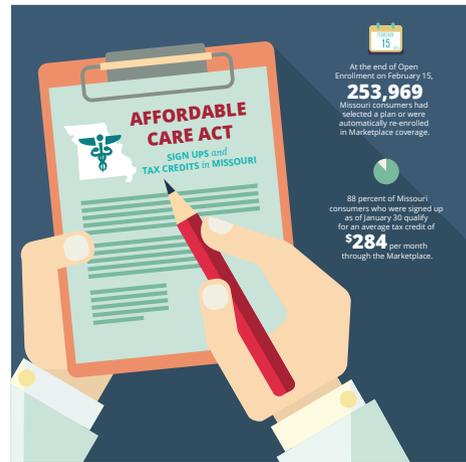
\$1 MILLION

to support the spectrum needed to get from awareness to access in the health insurance marketplace.

A REGULATORY REVOLUTION

The economic upheaval and shifting demographics seen in recent years have unfolded against a backdrop of major policy changes at the federal and state levels. Many of these new rules, programs and approaches have strengthened area safety net care. But others, most notably decisions in Missouri and Kansas to forego Medicaid expansion, have seriously undermined it.

There's no question that the Patient Protection and Affordable Care Act (ACA) has emerged as a primary driver of change across entire health care system since its passage in 2010. The sweeping legislation included provisions that make coverage more stable and affordable for those who already have it while extending insurance protection to those who don't. The law also aims to strengthen the health system through better care coordination, payment reform, promotion of health information technology, preventive health measures and other efforts.



AFFORDABLE CARE ACT

2010

MARCH 2010
President Obama signed the law

2010
Placed new rules on premium increases and rights to appeal insurance company decisions

2011

2011

- Required insurance companies to spend 80–85 percent of premiums on medical care
- Provided free preventive care and reduced prescription drugs for seniors
- Provided grants for wellness programs

2012

JANUARY
Incentivized physicians to create Accountable Care Organizations

Get

COVERED

Health Care  Foundation
OF GREATER KANSAS CITY

LEARN MORE > COVERKC.ORG



Improving access to care through federal and state insurance exchanges remains the centerpiece of the ACA. So far, the exchanges have played an important role in reducing the ranks of the uninsured, which have fallen from 14.4 percent nationwide in 2009 to 11.9 percent in 2015. In Kansas, 96,000 have gained coverage since the exchanges began in 2013; another 253,000 have been covered in Missouri.

During the first marketplace enrollment in 2013, HCF undertook outreach efforts to inform underserved, uninsured households about the new options available through the health insurance marketplace. The CoverKC Marketplace Coverage Initiative efforts included in-person enrollment assistance through certified application counselors, door-to-door canvassing, mail and Internet advertising. The effort was continued in subsequent enrollments periods through grants to organizations such as United Way's 211 and the Mid-America Regional Council.

2013

OCTOBER

Electronic recordkeeping is standardized and secured for exchanging health information

JANUARY

- Expansion for funding preventive services
- Increased Medicaid payments to providers
- Flat fee bundling

2014

OCTOBER

- States received two more years to fund children not eligible for Medicaid providers

JANUARY

- Health Insurance Exchanges coverage begins
- Individual mandate for coverage applies
- Medicaid expansion for low-income groups
- Insurance companies prohibited from exclusion due to pre-existing condition

2015

JANUARY

Physician payments tied to the quality of care they provide



UNINTENDED EFFECTS

The exchanges and the subsidies they provide have helped ease the burden on safety net providers by finally putting health coverage within reach for millions. Yet some of the newly insured continue to fall through the cracks, and the reforms triggered by the ACA have not been without negative consequences.

Many individuals and families who've enrolled in the exchanges' lowest-cost "bronze" plans, for example, have faced significant challenges. Bronze plans offer low monthly premium payments but include high deductibles and high out-of-pocket costs. Because the plans typically are chosen solely on the basis of their lower up-front cost, the large deductibles have left some enrollees functionally uninsured. Others are afraid to seek medical care because of the uncertainty about the costs.

Another complication emerging from the ACA has been the loss of benefit programs for some newly insured, low-income patients. When individuals obtain coverage through the federal marketplace, they are no longer eligible for pharmaceutical assistance programs that provide access to medications and supplies. Nor can they access a range of other programs at free clinics that serve only the uninsured.

SOME OF THE NEWLY INSURED CONTINUE TO FALL THROUGH THE CRACKS, AND REFORMS TRIGGERED ARE HAVING OTHER NEGATIVE CONSEQUENCES.

Finally, those who do not qualify for marketplace subsidies continue to face barriers to insurance coverage and health care. Many, in fact, have discovered that their incomes are too high to qualify for Medicaid but too low to be eligible for private plan subsidies. Their only remaining option is to pay full price for insurance, something that is cost-prohibitive for most low-income individuals and families.

“I think the ACA has been great for a large group of patients, but the insurance exchanges do not benefit many of the patients our safety net clinics and charitable care programs serve,” said Sheila McGreevy, M.D., of the University of Kansas Medical Center. “That group of patients is still there, needing help.”

THOSE WHO DO NOT QUALIFY FOR MARKETPLACE SUBSIDIES CONTINUE TO FACE BARRIERS TO INSURANCE COVERAGE AND HEALTH CARE.



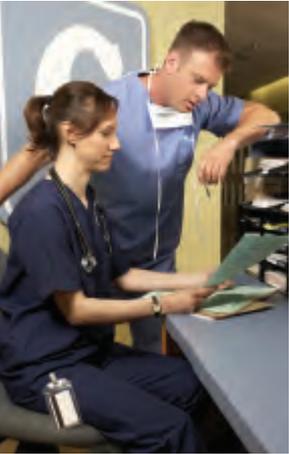
NEW MUSCLE FOR FEDERALLY QUALIFIED HEALTH CENTERS

Much of the ACA's focus to date has been on expanding insurance coverage, but new resources have been directed toward extending care to the underserved. One of the most important tools for accomplishing this has been the law's favorable treatment and increased funding for Federally Qualified Health Centers (FQHCs).

FQHCs are designated community-based health centers that provide comprehensive primary health care and behavioral and mental health services to all patients, regardless of their ability to pay or their health insurance status. Located in medically underserved areas, FQHCs are a critical piece of the health care safety net and play an essential role in expanding care through the ACA. FQHCs serve patient populations that are predominantly low-income, minority and uninsured or that rely heavily on public insurance.

FQHCs are entitled to a range of benefits in exchange for meeting rigorous federal requirements, including favorable cost-based reimbursement from Medicare and Medicaid, federal grants to offset the costs of caring for the uninsured, federal malpractice protection for providers and other benefits.

As is the case with other ACA initiatives, an emphasis has been placed on expanding preventive services and developing quality outcomes within the FQHC model. Particular attention has been paid to the needs of the low-income elderly and low-income special needs patients, since both populations tend to have higher medical costs and more complex care needs.



FQHCs ARE A CRITICAL PIECE OF THE HEALTH CARE SAFETY NET AND PLAY AN ESSENTIAL ROLE IN EXPANDING CARE THROUGH THE ACA.





“The new money for FQHCs was geared toward both supporting the existing facilities and getting new sites out there,” said Sheldon Weisgrau, director of the Health Reform Resource Project. “So we have a lot more safety net clinics than we otherwise would have had without this level of federal support.”

The Health Partnership Clinic of Johnson County functioned as a free clinic for many years before converting to an FQHC. The process of applying for and receiving FQHC designation is complex and resource-intensive, but the Health Partnership Clinic prevailed. The clinic now accepts a variety of insurance products and provides approximately five times more care visits annually for adults and children than it did in 2011.

In addition to the support for FQHCs, other federal-level policies have had an important positive impact on the safety net population. The Children’s Health Insurance Program (CHIP), while not part of the ACA per se, remains a primary source of public health insurance for children. The program allows families to purchase coverage for children at reduced rates and has proven highly effective in cutting the number of children who are uninsured while increasing appropriate screening and preventive services.

Currently, 93,000 children in Missouri and 76,000 in Kansas participate in CHIP. Congress recently passed legislation to extend the program through 2017, although uncertainty exists about long-term funding as the health insurance exchanges and the ACA mature.



MEDICAID WOES

Perhaps the most challenging aspect of ACA-related reform locally has been the decisions by both Kansas and Missouri not to participate in expanded Medicaid coverage. The ACA provided funding to increase Medicaid coverage. But the Supreme Court ruled in 2012 that it was up to the states to decide whether to implement expanded Medicaid eligibility and coverage.

Unfortunately, the rejection of expansion by Kansas and Missouri legislators has left thousands who would otherwise have health coverage without access to Medicaid. Not only does this undermine care for vulnerable populations, including the working poor, but it also has increased the already heavy burden facing safety net providers.

“Our patient population is largely not eligible for the ACA because they fall within that income eligibility gap, so our only saving grace could conceivably be Medicaid expansion,” said Hilda Fuentes, chief executive officer of Samuel U. Rodgers Health Center.

KANCARE WORRIES

In Kansas, the decision not to expand Medicaid left an estimated 60,000 residents uninsured who would have otherwise qualified for Medicaid and accelerated a trend of continually reduced funding for safety net providers. Many stakeholders believe the problems surrounding Medicaid have been compounded by the 2013 conversion of the state's entire Medicaid population to managed care plans.

Critics say the decision to shift Medicaid to commercial managed care under the KanCare initiative has significantly undermined the Medicaid system. Problems include difficulty in credentialing providers, low provider payment rates, slow payments to providers, limited options for enrollees seeking redress or adjudication, and major concerns surrounding a reduction of services to special-needs populations.

**IN KANSAS, THE DECISION
NOT TO EXPAND
MEDICAID LEFT AN ESTIMATED
60,000 RESIDENTS UNINSURED
WHO WOULD HAVE
OTHERWISE QUALIFIED.**



MISSOURI CUTS

As in Kansas, Missouri's rejection of Medicaid expansion has reduced access to care for many in need. An estimated additional 300,000 individuals would have been covered under the expanded program. Advocates say the decision compounds the extensive damage done to the Medicaid program by a series of deep cuts initiated in 2005. The funding reductions and changes in eligibility for some low-income families, disabled and elderly that year resulted in 147,000 individuals losing coverage.

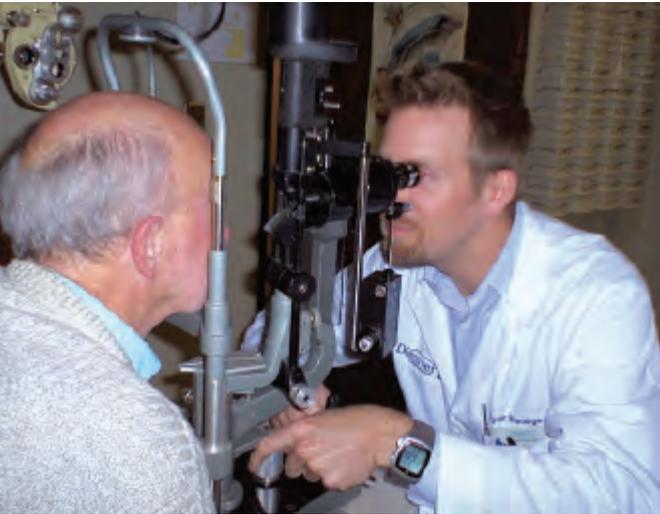
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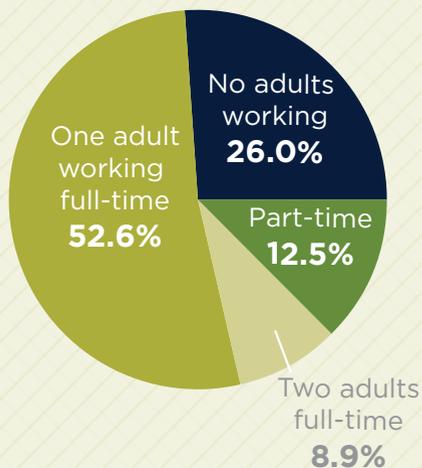
Other changes have contributed to weakened safety net care in the state. In 2013, the Missouri's Family Support Division underwent a significant reorganization. The consolidation of processing from local offices to regional centers led to difficulty in tracking applications, longer processing wait times and a lack of one-on-one access to informed case workers.

In 2014, Missouri initiated significant, phased-in tax cuts that will ultimately reduce the state budget by hundreds of millions of dollars per year. The full impact of these cuts will be felt in the upcoming budgets and will affect all levels of state safety net investment, including direct health services, support to economically vulnerable populations, public health and health care workforce training.

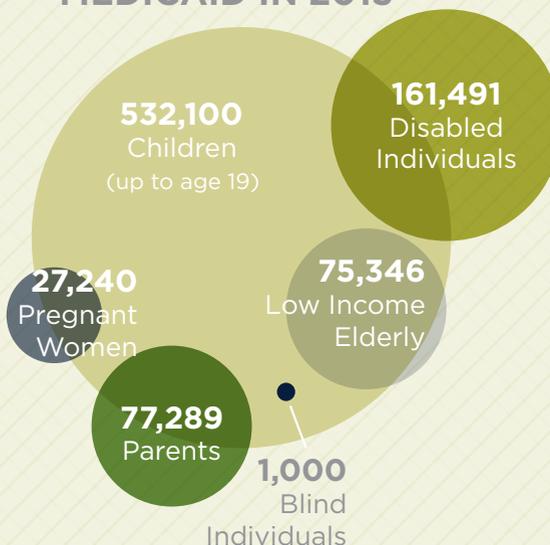
Budget pressures on both sides of the state line have already taken a toll on public health agencies. Although experiences varied across municipalities, most health department stakeholders reported that the reduction in prevention and public health funding has impeded their ability to meet the needs of the safety net population. Several area health departments have had problems maintaining services like lead screening, prenatal care and other important activities.



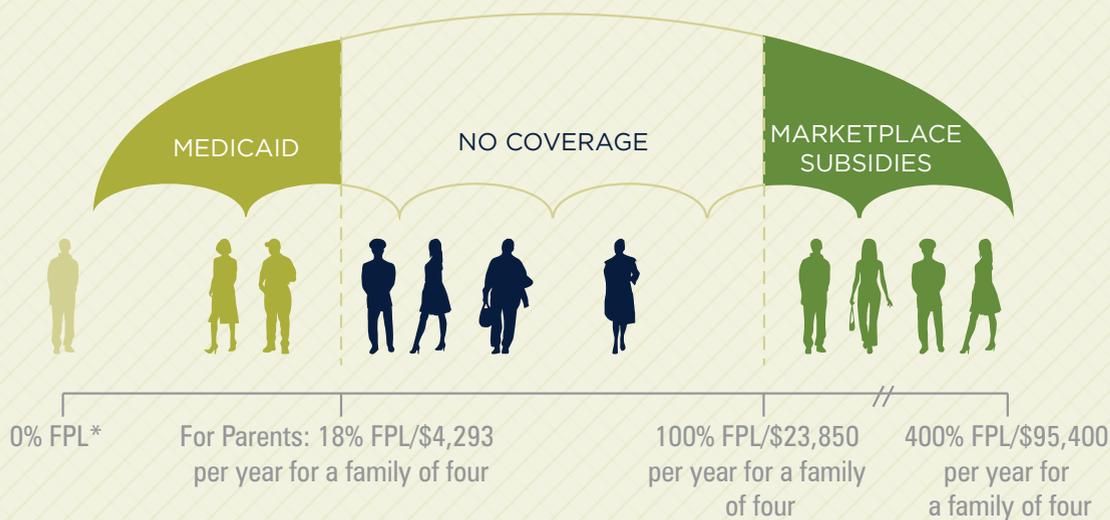
EMPLOYMENT STATUS OF THE UNINSURED



ENROLLED IN MEDICAID IN 2013



MISSOURI ADULT HEALTH INSURANCE COVERAGE GAP



*Federal Poverty Level

STRENGTH THROUGH ADVERSITY

Despite the increasingly grim political climate in Kansas and Missouri, stakeholders say collective advocacy helped produce several notable safety net successes over the past decade. In 2009, Missouri introduced “express-lane” eligibility for children’s health insurance enrollment. This simplified approach expedited children’s insurance eligibility determination and renewal and has helped prevent lapses in coverage.

Another bright spot was the recent reinstatement of Medicaid budget appropriations for the coverage of adult dental services in the state. The full impact of this funding will not be seen for more than a year, but it will help meet a major need for Medicaid recipients.

Locally, ongoing support for the Kansas City, Missouri, Health Levy continues to provide a vital lifeline for safety net providers. In 2005, Kansas City voters passed a 22-cent increase to the city’s health levy during a time when state Medicaid funds were being cut. Thanks in large part to the collective advocacy efforts of providers, advocates and local foundations, the levy was again approved in 2013. This extended funding for the local safety net system for an additional nine years.

The levy produces approximately \$50 million annually from property taxes and service charges and helps support Truman Medical Center, five safety net clinics, the Kansas City Health Department and ambulance services.

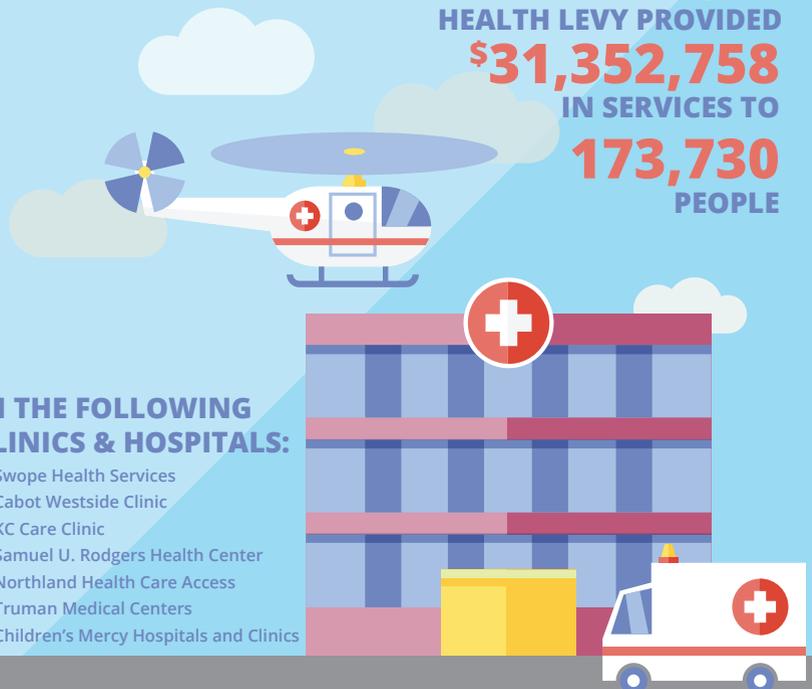
**KANSAS CITY,
MISSOURI, VOTERS
APPROVED A 22-CENT
INCREASE TO THE
CITY’S HEALTH LEVY
FOR THE SECOND TIME,
CONTINUING A VITAL
LIFELINE FOR LOCAL
SAFETY NET PROVIDERS.**

KANSAS CITY, MO HEALTH LEVY

IN 2012, THE
HEALTH LEVY PROVIDED
\$31,352,758
IN SERVICES TO
173,730
PEOPLE

IN THE FOLLOWING CLINICS & HOSPITALS:

- Swope Health Services
- Cabot Westside Clinic
- KC Care Clinic
- Samuel U. Rodgers Health Center
- Northland Health Care Access
- Truman Medical Centers
- Children’s Mercy Hospitals and Clinics



SAFETY NET CAPACITY EXPANSION

Since 2009, several clinics have worked together to provide more non-urgent care hours on both evenings and weekends. By partnering they have efficiently used resources, and added additional hours in a well-distributed way. The program has greatly increased access and also led to improvements in quality of care.

From 2009 – 2014, HCF has provided this program a total of \$2,584,525 in funding.

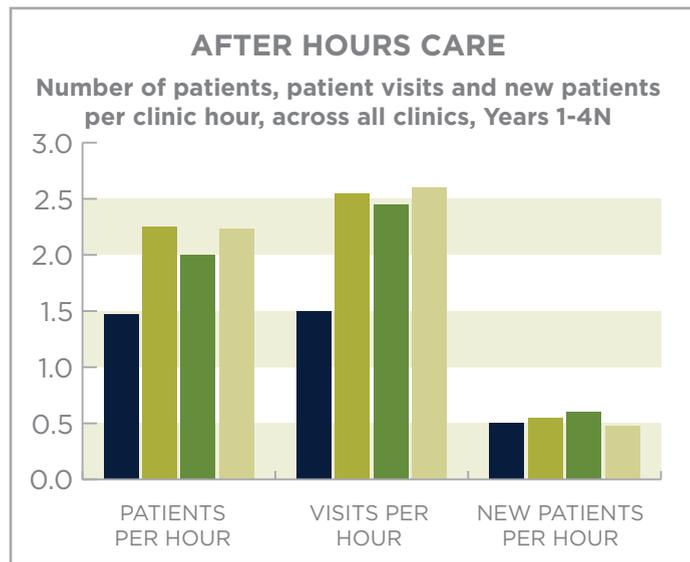
EXPANDING CAPACITY

Many organizations have increased capacity in the face of growing demand as part of their efforts to capture more revenue. Swope Health Service applied for and was awarded a grant from the Health Resources and Services Administration (HRSA) to open a new access point in Kansas City, Kansas, and Children’s Mercy Hospital has created a new pediatric care satellite location in Kansas City, Kansas.

Several safety net clinics, including Kansas City CARE Clinic, Swope Health Center, Southwest Family Health Center and Health Partnership of Johnson County, all have collaborated to increase their clinic hours during evenings and weekends. The goal is to provide an alternative to the expensive emergency department care for those with routine primary care problems.

Provider consolidation — a major factor in the larger, ongoing transformation taking place across health care — is not always an option for stand-alone safety net organizations. As a result, the economies of scale and new efficiencies that mergers and acquisitions can produce in the for-profit/non-profit care arena frequently are out of reach to safety net providers.

Nonetheless, consolidation has occurred and will likely continue in those situations where cultures and missions closely align. Cabot Westside Clinic, for example, was subsumed by the Samuel U. Rodgers network of health centers in 2013. The move was viewed as a positive for patients of Cabot Westside, since they gained access to the more comprehensive range of services available through Samuel U. Rodgers, a FQHC.



“THE EXPANDED ACCESS PROJECT

has enabled safety net providers to expand the hours of clinical services to meet the needs of our patients that are employed but cannot take time off during the work day to see a medical provider,” said Sheridan Wood, chief executive officer at the Kansas City CARE Clinic.



“It’s NOT about SICK CARE anymore. It’s ABOUT HEALTH CARE.”



Although we MAY NOT be there yet, that's WHERE we're HEADED."

CATHY HARDING
WYANDOTTE HEALTH FOUNDATION

EVOLVING SYSTEMS OF CARE

The hurdles facing safety net organizations on both sides of the state line, as significant as they've been, have compelled most agencies to adapt and evolve. The convergence of forces affecting the system, in fact, has triggered a number of positive developments, including new operational philosophies and more advanced approaches to care.



Increasingly, safety net organizations are adopting sophisticated business techniques to better align with changing reimbursement patterns and funding opportunities. For many, this process has meant transitioning to new models of care that allow for improved patient outcomes, greater efficiency and more sustainable operations.

“Safety net clinics are working to transition into this new world, and usually on a shoestring budget,” said Cathy Harding, president and chief executive officer of Wyandotte Health Foundation and previously executive director of the Kansas Association for Medically Underserved.

“It’s not about sick care anymore. It’s about health care. Although we may not be there yet, that’s definitely where we’re headed. So providers of safety net clinics and private practices alike who learned to practice medicine a certain way now must re-learn how to approach it.”

Altering long-standing funding strategies has been a key part of this shift. Even though local foundations, including HCF, continue to provide critical support to fill gaps created by reduced public contributions, organizations increasingly understand the need for financial self-sufficiency.

For many, the traditional dependence on philanthropic funding and fees from low-income patients has proven problematic in today’s environment. Donor funding can be an unpredictable, patchwork solution that too often is overly reliant on relationships with donors. If and when a funder’s priorities change, a clinic can lose access to those dollars.

William Pankey, M.D., medical director for Turner House Children’s Clinic, noted that restrictions on grant funding also create problems for safety net agencies.

“We spend a lot of time chasing grants to cover the core services that we provide, but so many of those grants are project-specific,” he said. “As a result, our biggest struggle is securing operating funds and capital improvement dollars. Fewer people are interested in funding those areas.”

Added one focus group participant of the changing operational environment: “If you have an organization that’s going to provide services, you’ve got to figure out pretty quickly how to keep the doors open and the lights on. In response to changes in the market, we’ve had to rearrange the financing and develop new ways to generate revenue, primarily through public and private insurance reimbursement.”

Fortunately, the ACA and the ongoing marketplace transformation have created opportunities for organizations seeking to transition from charity care to public and private reimbursement. Although Medicaid expansion currently remains on hold in both Missouri and Kansas, some entities that traditionally had offered services free of charge completed requirements for billing Medicaid in anticipation of an expanded client population. As a result, these providers are now generating Medicaid reimbursements and are looking for additional payer opportunities.

The Kansas City CARE Clinic (previously the Kansas City Free Clinic) shifted from providing free care to accepting patients with both public and private insurance coverage. Other safety net agencies have taken advantage of new federal grants available through ACA, including FQHC funds, to both enhance the capacity of existing centers and provide support for new access points. The result has been increased revenue streams and improved long-term stability.

Physical Health Care Provided in 2014

	Outpatient visits	Unduplicated patients
Samuel U. Rodgers Health Clinic	81,143	25,512
Health Partnership	36,138	14,333
JayDoc	1,197	1,197
Turner House	12,240	4,696
Southwest Boulevard	12,694	3,554
Duchesne	4,259	1,354
HCC	8,231	2,747
Truman Medical Center	322,387	112,814
KC Care Clinic	11,287	8,841
Swope Health Services	213,981	39,653



Making the transition from a charity-self-pay model to third-party payments and/or becoming an FQHC are not simple tasks. But the process ultimately has helped create more financially sound organizations. Turner House Children’s Clinic, though not an FQHC, has adopted a more rigorous business approach and in so doing, increased its financial viability as well as the number of patients the organizations can serve.

NEW CARE MODELS

Underpinning the financial and structural changes taking place in the safety net community are new delivery models designed to improve care quality, continuity and efficiency. Among the most prominent of these are the patient-centered medical home (PCMH) and the accountable care organization (ACO). Both approaches are designed to better coordinate and integrate care and are supported by a range of provisions within the ACA.

As these models have gained traction across the larger health care system, area providers and organizations have worked to adapt them to the safety net arena. Stakeholders overwhelmingly agree that this shift has been beneficial in meeting the needs of the underserved.

The PCMH model — developed and promoted by the Agency for Healthcare Research and Quality — is focused on transforming the way primary care is organized and delivered. PCMHs typically incorporate several key characteristics:

- Care is delivered in a patient-centered and coordinated fashion between different providers.
- The full spectrum of services is provided, including preventive services, acute care, chronic care and end-of-life care.
- Services are made as accessible as possible, with a heightened focus on patient communication, quality and safety.



Area safety net clinics were already moving toward the PCMH model before the ACA provided a framework and incentives for accelerating the transition. In the past few years, a number of regional safety net providers — including Turner House Children’s Clinic, Health Partnership Clinic, Silver City Health Center and Children’s Mercy Hospital — have become recognized by the National Committee on Quality Assurance as patient-centered medical homes.



“OVER THE YEARS the complexity of the patients we treat has grown with many being seen for chronic illnesses that require frequent appointments for multiple issues,” said Sheridan Wood, chief executive officer at the Kansas City CARE Clinic. “Being accredited by NCQA as a Patient-Centered Medical Home reflects our commitment to comprehensive care for these patients with a team that focuses on the individual’s unique needs.”

“To achieve this level of recognition, you have to truly transform how you provide care,” one advocate said. Another stakeholder emphasized that Kansas City safety net providers are fully committed to changing the way care is provided. “Whereas in other states it’s about checking the box, the clinics in this area said, ‘If we’re doing it, we’re doing it fully. We’re going all in.’”

A major component in the push toward more coordinated and integrated care has been recognition of the complexities that surround many safety net patients’ lives. “People want to be treated more where they live and regularly gather,” one provider said. “That’s part of the medical home concept. It’s why coordinated care matters so much.”

To date, much of the effort to improve integration locally has focused on linking primary health care with both behavioral and oral health.

“Our health centers have tried to build capacity to offer more services under one roof so that patients can get all medical services in one place,” said Joe Pierle, chief executive officer of the Missouri Primary Care Association. “You can no longer simply provide care in isolation. You need to take a coordinated approach. Yet you still have the same limited resources and portion of the population that is not reimbursed. So it’s definitely a challenge.”

Financial support for integration efforts has been crucial. Early funding was provided by the REACH Foundation, which in turn recruited Qualus, a national organization that has helped several local clinics achieve PCMH recognition. HCF, for its part, partnered with the Missouri Foundation for Health and a consortium of funders to support the Missouri Health Home Learning Collaborative. The collaborative is a statewide group of physical and mental health providers working collaboratively toward PCMH recognition.

“Today, parents can bring a child into Health Partnership Clinic for a medical visit, a dental visit and a behavioral health visit all on the same day and all delivered in an integrated manner,” said Jason Wesco, president and CEO of the Health Partnership Clinic.

“That’s going to save the entire system a lot of money. I’m not sure I can quantify those savings, but think about the improved nature of care that child will receive and how much easier accessing care has become for the family.”



“YOU CAN NO LONGER SIMPLY PROVIDE CARE IN ISOLATION. YOU NEED TO TAKE A COORDINATED APPROACH... SO IT’S DEFINITELY A CHALLENGE.”

JOE PIERLE, MISSOURI PRIMARY CARE ASSOCIATION

QUALITY CONTROL

Improved care quality is a primary goal of today's health care transformation and thus has been an integral element, directly or indirectly, in nearly all of the reform work done across the safety net community. A growing number of organizations are adopting evidence-based care, or systematic protocols that ensure clinical best practices. Improved patient safety — including medication safety — likewise has become prominent in area care programs. Not only do these programs support clinical improvements, but they can also boost reimbursements.



IN 2007, Children's Mercy Hospital received a PIN Grant from the Robert Wood Johnson Foundation, with matching funds from HCF, to develop the Clinical Scene Investigator program. This program provided nurses with the knowledge and support necessary to implement nurse-led quality improvement projects, which have been shown to improve patient and staff outcomes as well as boost economic efficiencies.

“What we're seeing with all the insurance companies is that we can get much better rates if we deliver on quality rather than just pure numbers,” said one stakeholder. Providers conceded that measuring quality outcomes for commercial payers can be challenging, in part because the federal government remains primarily focused on the volume of patients served.

And even with the benefits the PCMH model can create, not all organizations have the resources or capabilities to make the transition. Challenges that include safety net continuity, workforce shortages and information technology requirements have made it difficult for some providers to accommodate the PCMH model.

An accountable care organization (ACO) provides similar integration benefits for both providers and patients. A central goal of the ACO is to ensure that patients — particularly those with chronic health conditions — get the right care at the right time, while avoiding unnecessary duplication of services and medical errors. However, because ACO incentives at this point are primarily oriented toward the Medicare population, and because most safety net providers serve Medicaid patients, the approach has so far seen little uptake in the Kansas City area safety net community.



CONNECTING CARE

Information technology is essential to virtually all advanced models of health care. Better information exchange holds the promise of increasing care quality, efficiency and integration, while reducing costs for payers, providers and patients.

Not all organizations have had access to the resources required to adopt new applications and maintain pace with the systemic changes driven by information technologies. However, those that have managed to secure funds to acquire and implement electronic health records (EHRs) and health information exchanges (HIEs) have seen significant benefits.

“The quality of care in the safety net system has improved dramatically with the advent of electronic medical records and health information exchanges,” said Dave Barber, president and chief executive officer of Swope Health Services. “Being able to review information such as lab reports, test results and medication history from other clinics provides a solid foundation for the care needed at that moment. It can also lessen the chances of someone receiving duplicate tests or excess medications.”

The push to help fund EHRs capable of facilitating quality reporting has grown as public funders and large foundations increasingly ask safety net organizations to report health outcomes data.

In Kansas, major support for EHRs has come from the Kansas Association for the Medically Underserved (KAMU). The organization was instrumental in helping Kansas City, Kansas, safety net providers move forward with selecting and implementing EHRs. KAMU is the federally designated Primary Care Association (PCA) in Kansas, and among other tasks, is required to provide training and technical assistance for FQHCs.

In 2009, another organization, the Kansas Foundation for Medical Care, received a regional extension center grant to help clinical practices implement electronic health records and achieve functional use of the systems.

Federal incentive programs — most notably 2009’s HITECH Act — have been developed to support the adoption of EHRs by physicians and hospitals and to provide decision support at the point of care. Unfortunately, few safety net providers beyond FQHCs have been eligible for the meaningful use funding to help offset the cost of EHR implementation. Nonetheless, Turner House Children’s Clinic and the Health Partnership Clinic have successfully received HITECH Act meaningful use funding. One of the most important aspects of this funding is decision support for providers at the time of visit.

**“ BEING ABLE TO
REVIEW INFORMATION...
FROM OTHER CLINICS PROVIDES A
SOLID FOUNDATION FOR
THE CARE NEEDED
AT THE MOMENT.”**

DAVE BARBER, SWOPE HEALTH SERVICES



IMPLEMENTATION CHALLENGES

Covering the costs of building and sustaining a robust health information technology (HIT) infrastructure continues to represent a critical gap in the transformation of the safety net system. But even when funding is available, the road to successful EHR implementation can be a bumpy one.

Several safety net providers noted that most EHR systems have not been developed with safety net care in mind, nor do they adequately address the needs of new integrated care models. As a result, implementations frequently require extensive redesigns or workarounds, as well as the adoption of new work flows.

Modifying internal processes to accommodate the EHRs, in turn, can require a steep learning curve and increase the time providers spend on technology-related activities. This diminishes opportunities for patient care and can lead to decreased provider productivity.

“I think many administrators were under the impression that the EHR would allow the entity to see more patients, but that hasn’t panned out,” one stakeholder said. “The documentation elements of EHR require that you spend the same amount of time as before.”

Overall, safety net providers agree that EHRs have enabled better coordination of care and improved patient outcomes. But implementation can be daunting, and many organizations are concerned that accommodating new technology will continue to divert energy and resources from their primary mission of caring for patients.

**OVERALL, SAFETY
NET PROVIDERS AGREE
THAT EHRs HAVE
ENABLED BETTER
COORDINATION OF
CARE AND IMPROVED
PATIENT OUTCOMES.**

REGIONAL INFRASTRUCTURE

Electronic health information exchanges (HIEs) provide a community-wide electronic infrastructure that allows EHRs and providers to communicate with each other. With access to an HIE, doctors, nurses, pharmacists, other health care providers and patients can securely share and access vital medical information. This capability contributes to improvements in the continuity, quality, safety and speed of care, while helping reduce costs.

Though still in the early phases of implementation, HIEs are emerging in the Kansas City region and are altering the way safety net providers operate. Safety net organizations in the greater Kansas City area are served by three HIEs: The Missouri Health Connection (MHC), the Lewis and Clark Information Exchange (LACIE) and the Kansas Health Information Network (KHIN).

Over the past decade, funding provided by HCF has played an important role in helping bring the HIE concept to life. One early effort that received HCF funding was the Kansas City Bi-State Health Information Exchange (KCBHIE). The initiative — which was incorporated in 2010 and later became known as eHealthAlign — was one of several initial collaborative efforts that brought together stakeholders interested in the sharing of health information.

Eventually eHealthAlign dissolved due to increased competition throughout the region, but it was nonetheless successful in helping develop a collective vision for a regional HIE system.

Most recently, HCF funding provided a group of Community Mental Health Centers and safety net primary care clinics with funds to build HIT capacity for improving care coordination and reducing both emergency department use and hospital readmissions.

OVER THE PAST DECADE, FUNDS
PROVIDED BY HCF HAVE PLAYED
 AN IMPORTANT ROLE IN HELPING **BRING**
THE HIE CONCEPT TO LIFE.



AN EXPANDING WORKFORCE

As important as technology is, it will ultimately be the clinicians, administrators and support staff on-site who will determine how effective today's health care transformation can be across the Kansas City area. Fortunately, the area's safety net workforce has continued to evolve to keep pace with changes in the design, delivery and reimbursement of care.

More formalized training and the creation of new roles have helped organizations adapt to new tasks and responsibilities. In fact, the Kansas City area has emerged as a leader in the development and training of a new professional designation focused on helping meet the needs of the underserved.

Stakeholders say one of the most far-reaching workforce changes that has occurred throughout the safety net community in recent years has been an evolution away from volunteer staffs to paid providers and administrators. This transition has helped create greater stability across organizations and ensured that the necessary skills are available to function effectively in an increasingly complex environment.

IN FACT, THE KANSAS CITY AREA **HAS EMERGED** AS A LEADER IN THE **DEVELOPMENT** AND **TRAINING** OF A NEW **PROFESSIONAL DESIGNATION** SPECIFICALLY FOCUSED ON **HELPING MEET** THE **NEEDS** OF THE **UNDERSERVED**.

A paid staff is especially important for those organizations that have applied to become FQHCs or have already achieved that designation, as well as entities that have shifted to the patient-centered medical home model. The importance of quality reporting and EHR use in the new delivery models necessitates greater HIT skills at both the clinical and administrative levels. Coordination of care and patient navigation also are vital in new delivery systems, as is the integration of care with non-clinical social service agencies.

The employed staffing model has played a major part in accomplishing these goals. And, a new professional role is emerging to help accomplish these objectives while boosting both the scope and quality of care in the region, stakeholders say.

Known as community health workers (CHWs), this public health professional credential is focused on preparing non-clinicians to take into account the experiences, language and culture of the populations they serve in order to improve outreach and education. CHWs also work to connect community members with health services and advocate for individual as well as community health needs.

The ACA included provisions that are helping enhance the role of CHWs in the U.S. health care system. These include an increase in federal and state funds to support efforts aimed at formalizing the CHW designation through standardization of definitions, scope of work practice, training and certification.

Area institutions are leading the way in codifying CHW educational requirements and role definitions. The Missouri Department of Health and Senior Services, for example, helped the Metropolitan Community College in Kansas City develop a CHW curriculum that included a six-week program for those interested in obtaining a CHW certificate. Scholarships made available with funds from the U.S. Department of Health & Human Services, Health Resources & Services Administration, Bureau of Health Professions and others have helped boost the program.

In addition, the Regional Health Care Initiative (RHCI) several years ago established a program to develop uniform CHW curriculum and training and to educate employers on how CHWs can strengthen the workforce and reduce costs. Other local resources include Care Connection, a collaborative CHW program between St. Luke's Hospital and Kansas City CARE Clinic that employs six CHWs.

Several programs supported by HCF are using CHWs to promote linkages between health systems and community resources with the objective of discouraging high utilization of emergency departments. Finally, the Kansas City CARE Clinic is working with Swope Health Services, Health Partnership of Johnson County and Family Health Center to provide CHWs to better connect patients with available community resources.

Because needs differ between organizations and no fixed blueprint for care coordination and patient navigation yet exists, the CHW position will continue to evolve to meet patient and provider needs, stakeholders say.

Funding to support professional staffing continues to be a major issue for all safety net organizations, despite the availability of federal grants and assistance from area foundations, including HCF. To help control salary requirements, some organizations are using physician extenders, such as nurse practitioners, in lieu of physicians. Efforts also are under way to expand the roles of other care professionals, including emergency medical technicians, pharmacists and physical therapists.



PULLING TOGETHER

One of the most encouraging developments that has occurred in the safety net community over the past decade has been a dramatic increase in collaborative efforts between and among organizations. Greater cooperation and communication continues to be instrumental in developing a range of solutions to systemic problems.

“In 2004, we had very few advocacy organizations or advocates in the capitol,” said Amy Blouin, executive director of the Missouri Budget Project. “With the infusion of resources in the policy-based organizations, we really developed a network of health advocates that could fight for the safety net. People have been working together much more strongly. In particular, there is currently a very broad, diverse group working on Medicaid expansion.”

The organizational isolation that had long characterized much of the area’s safety net community began to fade in 2007, when the Mid-America Regional Council’s Regional Health Care Initiative established a safety net collaborative. This effort brought providers together to improve trust and to develop a vision for collective action.

Funded by area foundations, including HCF, REACH Healthcare Foundation, the H&R Block Foundation, the Hall Family Foundation and others, the collaborative has continued to engage in strategic planning and also has developed topical sub-groups.

Numerous forums, meetings and facilitated conversations among grantees working on similar issues have deepened relationships among individual institutions and fostered new solutions.

“I think that philanthropy, including HCF, has played a critical role in building the infrastructure and in sustaining the limited advocacy that we have around those investments at the state level,” said Shannon Cotsonadis, president and chief executive officer of Kansas Action for Children.

“Without the strength of our philanthropic community, not only would we have not seen gains in the infrastructure and the ability to provide services, but we wouldn’t have had the advocacy that we have at the state level to benefit those vulnerable children and families.”

Along with collective advocacy efforts, the safety net system has engaged in numerous collaborative projects and programs over the past 10 years. In many cases, stakeholders said, the efforts were set in motion by joint funding opportunities. The result has been new partnerships and innovative initiatives across the system. One example: Truman Medical Center received an innovation grant from the Centers for Medicare and Medicaid Services (CMS) in 2012 and partnered with Communities Creating Opportunity to incorporate a community organizing component in their care coordination program.



HCF has
awarded the
Regional Health
Care Initiative

\$1.4

MILLION
DOLLARS

over the past

8 YEARS.

Another prominent collaborative success has been system-wide efforts to improve networking and referrals across organizations. Because not all institutions can provide a full range of services or have expertise in multiple fields, it becomes advantageous for providers to partner to help fill the gaps in care.

MetroCare and Wy/Jo Care are community partnerships with private physicians designed to improve access to specialty health care for low-income, uninsured residents throughout the metro. Accessing specialty care can be very difficult for the uninsured or underinsured. Without the ability to pay the high cost of care, patients often go without. These referral programs combine care provided in primary care clinics with donated specialty care offered in private practice offices. All told, the partnerships have leveraged approximately \$56 million in donated specialty services.

“Our thinking today is that we can’t do everything,” said Dave Barber, president and chief executive officer of Swope Health Services. “And, rather than attempt to, we’ve formed a robust referral network that allows each of us to play to our strengths and deliver the care people need.”

Stakeholders concede that the collaborative process is not without challenges. They note that working with other organizations can be time-consuming and can crowd out other priorities. In addition, aligning can be difficult when groups are at different points on the spectrum in terms of their own transformation efforts.

Some observers also described difficulties in getting partners to share similar data to more accurately evaluate initiatives, an issue that is particularly prevalent in programs involving both safety net and non-safety net institutions. Frequently, these problems stem from different approaches to measuring as well as reporting clinical information.

HCF HAS AWARDED
 the MetroCare/WyJo Care Specialty Care Project

13 GRANTS, totaling
\$3,284,700
 to engage medical professionals
 to provide voluntary health care services.

This funding **HAS LEVERAGED**
 more than **\$56 MILLION** in care.





LESSONS LEARNED

Even in a climate characterized by profound political and financial uncertainty, most observers believe the area safety net system today is stronger today than ever before.

An emphasis on rapid adaptation, coupled with greater collaboration and more diversified funding, has allowed the system to prevail in a period marked by frequent and dramatic change.

Greater system capacity, improved models of care and increased financial self-reliance all have emerged during the trial by fire that most providers have endured. At the same time, the broader commitment to reforming the health care system — as evidenced in the many changes brought about by the ACA — has created an increasingly solid framework for sustaining the hard-won gains of the past 10 years.

“We have traveled a great distance,” one provider said. “But the journey does not end.”

LOOKING AHEAD

The past decade has been a tumultuous time for the safety net community — one marked by major shifts in policy, technology, care delivery and reimbursement. Although the grinding uncertainty of recent years will likely continue, stakeholders are largely in agreement about priorities for improving safety net care in the years ahead.

Key objectives include:

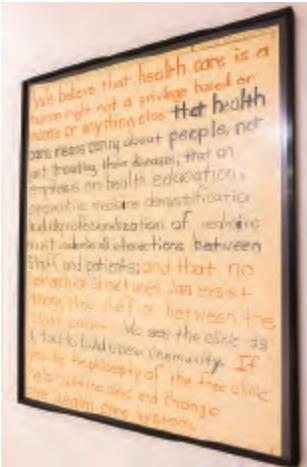
- Continuing to enhance the quality of integrated care through patient-centered medical homes and community health worker programs.
- Developing a greater focus on upstream social determinants of health.
- Increasing collaboration through collective advocacy and other avenues.
- Expanding funding for both core operations and innovative initiatives.
- Providing leadership to create a common vision and agenda for the future.

SOLIDIFYING NEW APPROACHES

The emergence of the PCMH, coupled with the role of community health workers (CHWs), has created opportunities to increase knowledge surrounding current trends and best practices. Because the process of becoming a certified PCMH can be time-consuming and complicated, efforts to share the lessons of those who've already progressed to certification should be formalized and expanded. As for provider integration efforts generally, stakeholders expressed a desire to learn more about the health and economic outcomes resulting from existing initiatives, both to inform future efforts and to help secure additional funding.

Community health worker programs, meanwhile, have the potential to significantly strengthen the safety net system and bring care directly to where patients live.

Observers agree that the Kansas City area should capitalize on its leadership role in the emerging CHW field to better define training and workplace roles, and to explore opportunities for public and commercial reimbursement.



MOVING UPSTREAM

As part of the PCMH's overall emphasis on treating the whole person, stakeholders emphasized that providers, funders and government need to focus more preventive social determinants of health. These include issues like poverty, educational opportunities, employment, housing and income. Working to address problems at an earlier stage can help mitigate health concerns later on.

Community-based organizations have emphasized the need to build healthy physical and social environments to support the lives of their clients.

“Safety net providers, in my opinion, can take a much wider role than just providing direct care,” said Joe Pierle, chief executive officer of the Missouri Primary Care Association. “I think they have to be rooted in the community and working to solve societal issues in a broader context.”

Examples of this kind of proactive approach could include working to rid a home of asthma-causing mold instead of merely treating the condition. Community-based organizations have emphasized the need to build healthy physical and social environments to support the lives of their clients outside of the clinical or social service setting.

One option for providing care where patients live is to enlist care coordinators to support patients in meeting basic needs for themselves and their families. “It could be as simple as having coordinators on-site with the medical providers to make sure that the individual is working with other social support entities in the community, whether it’s job training, housing or whatever else,” one stakeholder said.





EXPANDED COLLABORATION

Stakeholders believe more should be done to bring clinicians, community-based organizations, consumers and advocates together, despite the progress that's been made in recent years.

“There is a continued role for the safety net collaborative, but it needs to be inclusive,” said one stakeholder. “If we are going to change the culture of the safety net system, it can't be just the providers sitting at the table. There has to be meaningful and equal participation of other voices and entities to be able to shift how health care delivery happens here.”

Said another participant: “I wish there was a place where the safety net folks could meet and have real problem-solving sessions, and real discussions about what's going on or what's going to happen when x, y, and z occur.”

Clinics and other providers could also benefit from closer cooperation with hospitals outside of the traditional safety net system. Because all non-profit hospitals are required to conduct a regular collaborative community health needs assessment, this process could present an ideal vehicle for fostering greater system-wide collaboration.

Collective advocacy, which has played a role in bringing about important policy changes over the past decade, should continue to be a priority for area organizations.

Expanding these efforts to include more than a handful of organizations would improve the probability of sustaining a strong safety net system. One means of helping engage more providers is targeted education surrounding government policies. Many providers are not experienced with advocacy and are unaware of the opportunities that exist to influence policy.

Collective advocacy will continue to be essential around issues that affect the entire system, as evidenced by the work done around Medicaid expansion, CHIP reauthorization and the Kansas City Health Levy.

“When you look at what's going on in both states, all of us are affected by some of these policies, so we need to speak with one voice,” one stakeholder said.

RELIABLE FUNDING

Even with changing models of care that emphasize financial self-sufficiency, most safety net providers remain dependent on multiple sources of grant funding for core operations. It is therefore critical that a variety of funding sources continue to support both day-to-day operations as well as new programs for responding to the changing health care environment.

“I think anybody in health care now has a real sense of insecurity,” said Jason Wesco, president and chief executive officer of the Health Partnership Clinic. “We just don’t really know what the future is going to look like. We just know it’s coming really fast.”

Chronically underfunded operating budgets reflect, in part, the ongoing erosion of government contributions. In addition, philanthropic funders may lack a full appreciation of the resources required to operate a safety net institution.

“Many of the safety nets are small hand-to-mouth kinds of organizations,” said one stakeholder. “They scrap for every dollar, and they have been heroic in many cases just to be keep the doors open. It’s really hard to wake up each day and think about how you’re going to make payroll.”



“ THERE IS **TREMENDOUS PRESSURE** ON THE **CLINICS NOW** THAT WAS **NOT PRESENT** FIVE OR TEN **YEARS AGO.**”

JASON WESCO, HEALTH PARTNERSHIP CLINIC

One stakeholder pointed out that core funding can have a multiplier effect: “Increased access to core operating support leads to greater sustainability, expansion of services, increased encounters and greater professionalization of staff.”

Beyond core funding, organizations will require technical assistance and consultation, as well as a real-time feedback from funders to support implementations in new areas. Specific areas targeted for innovative solutions include behavioral health integration, telemedicine, modified medical home models and social entrepreneurship.



WORKFORCE CHALLENGES

Workforce issues present significant problems for many safety net providers. This has become particularly true as organizations shift from a volunteer approach to salaried staff. Competition for bilingual practitioners and primary care providers, as well as salary pressures from competing non-safety net organizations and the high debt loads carried by many new clinicians, all have made it difficult for safety net organizations to recruit and retain personnel.

“We do tend to bleed talent. We can’t pay what the others pay,” said one working group participant. “They can offer all kinds of incentives like 12-hour shifts, weekend differential, night-shift pay, and a lot of other incentives. We can’t really do that.”

In Wyandotte County, Kansas,

15.6
PERCENT

of residents speak a language other than English, with Spanish being most prevalent.

Because safety net providers learn to function in resource-limited settings and are trained to focus on population health, they are increasingly in demand by for-profit institutions outside the safety net system. And while the safety net workforce is largely mission-driven, the realities of higher salaries and better benefits continue to draw clinicians away.

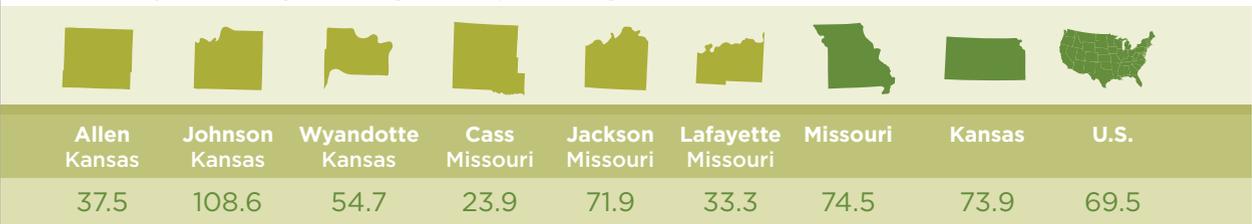
Most believe that the medical education system, with its increasing tuition and subsequent debt burden, hampers efforts to enlist new physicians. Additionally, many younger physicians are less available to volunteer to provide care free of charge.

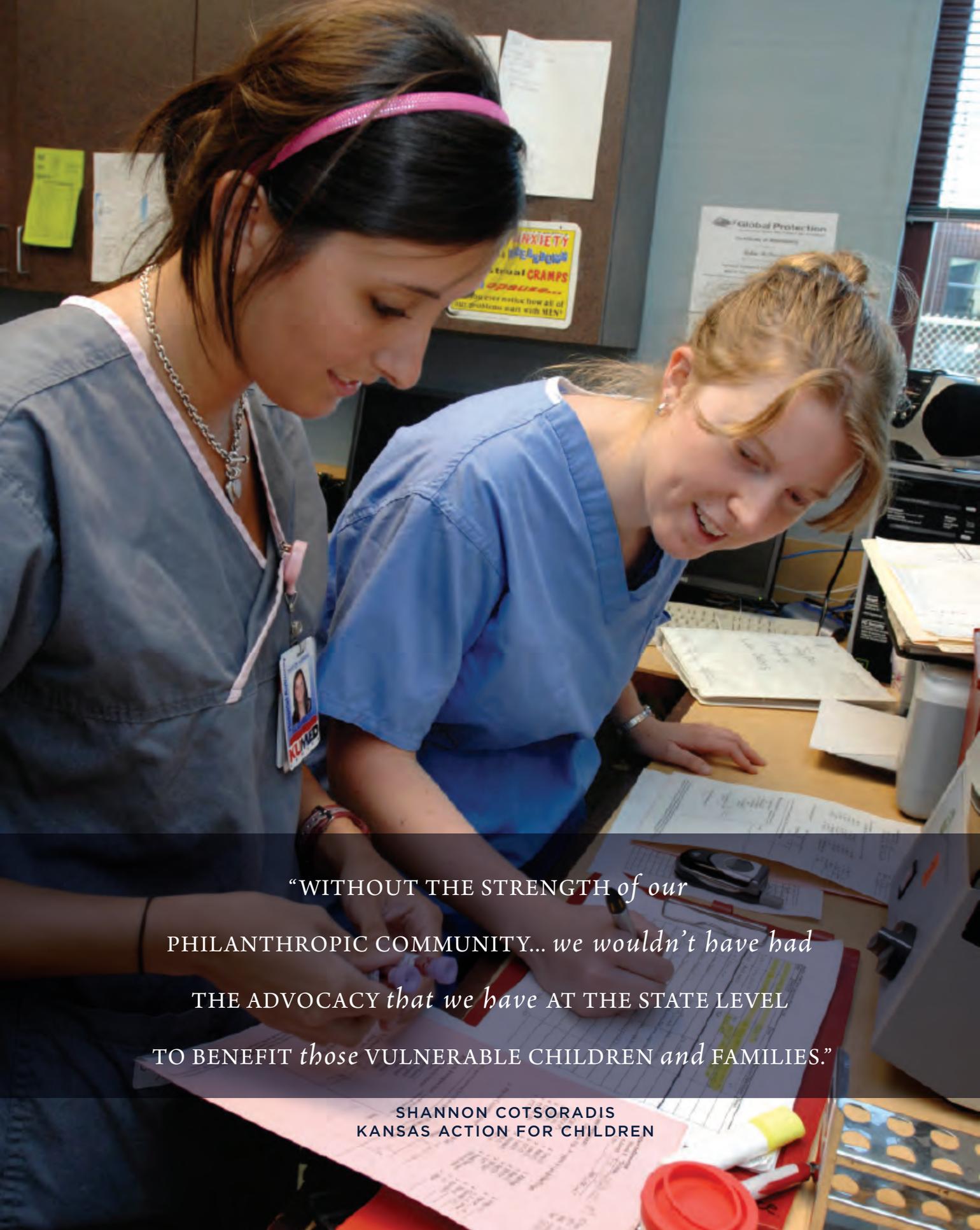
Finally, provider diversity remains a serious and chronic difficulty in the safety net system. Recruitment of bilingual staff has been a particular challenge. “When you start getting into the mid- and high-level professions, it becomes very difficult to find someone who speaks Spanish,” one focus group participant said. “We looked for nine months before we finally gave up.”

Eva Creydt Schulte, president and chief executive officer of Communities Creating Opportunity, said a greater emphasis should be placed on training diverse and bilingual providers across all skill levels.

“We need to be smart about Kansas City’s changing demographic and how we are preparing the labor force,” she said.

Primary Care Physicians per 100,000 Population





“WITHOUT THE STRENGTH of our
PHILANTHROPIC COMMUNITY... we wouldn't have had
THE ADVOCACY that we have AT THE STATE LEVEL
TO BENEFIT those VULNERABLE CHILDREN and FAMILIES.”

SHANNON COTSORADIS
KANSAS ACTION FOR CHILDREN

FINAL THOUGHTS ON KANSAS CITY'S HEALTH CHALLENGES AND OPPORTUNITIES

The Health Care Foundation of Greater Kansas City's first decade coincided with an era of sweeping change in the health care system and some of the harshest economic conditions since the Great Depression.

The combined impact of these forces continues to play a major role in shaping strategies and programs in each of the foundation's primary focus areas. Long-standing problems surrounding care for the underserved have been made worse by the difficult economic climate. Government funding has continued to fall. Yet new opportunities to strengthen care for vulnerable populations have emerged from the health system transformation now under way.

In the midst of these many challenges, area organizations have worked to capitalize on openings to improve care for the underserved while reducing financial risk. A community-wide commitment to flexibility and collaboration has led to new alliances between sectors, creative problem-solving and a willingness to think beyond traditional roles and responsibilities.

These efforts have produced lasting improvements across a wide range of areas. For HCF, the success of many of the programs we've supported has been gratifying and instructive. We are proud of the role we have played in helping bolster the health of the uninsured and underserved.

**WE ARE PROUD OF
THE ROLE WE HAVE
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THE UNINSURED AND
UNDERSERVED.**

At the same time, we realize that our duties extend beyond simply providing financial support. We welcome the opportunity to play an active role in policy and program discussions. We've worked to facilitate and solidify connections between organizations and agencies. We've served as a sounding board for novel and unorthodox ideas. In short, we've tried to be a reliable partner to the organizations and individuals doing the difficult but essential work on the ground.

Together, our region has come far. But we still have a great distance to go. The following snapshots offer highlights of program successes, as well as the key challenges stakeholders have identified as HCF's second decade begins.

BEHAVIORAL HEALTH

The behavioral health community has struggled with financial cuts over the past 10 years, yet opportunities for growth and collaboration have emerged. Positive changes have helped the community move toward a more responsive and inclusive system of care.

Significantly, the last decade saw the expansion of evidence-based practices throughout the region's mental health system. This approach is helping providers deliver more consistent and effective care. Given the cost and complexity, however, fully and effectively implementing evidence-based systems will continue to be a challenge for some organizations.

Another positive has been the growing body of knowledge surrounding early-life trauma and its lasting impact on behavior and health. In essence, trauma-based care creates a new imperative to seek opportunities for providing upstream assistance that can help minimize or eliminate social and economic trauma triggers.

As we look to the future of mental health services in the region, maintaining the current momentum surrounding greater integration of behavioral health and other safety net services will be a priority. It is important to remember that individuals enter the health system from a variety of points along the continuum of care. It therefore becomes necessary to ensure that mechanisms are in place to help patients quickly access the right level of care, regardless of where or how they enter the system.

It will also be important — given the region's changing demographics — for providers to continue to expand their efforts aimed at providing culturally competent services that can be accessed across the lifespan.

HEALTHY EATING AND ACTIVE LIVING

The Kansas City metro area has made great strides over the past 10 years in improving healthy eating and active living opportunities for underserved communities. Indeed, the area has emerged as a national leader in this critically important field, thanks in large part to the high level of collaboration between area municipalities, agencies, community groups and individuals. Yet more must be done in the region, especially for ethnic groups and communities that have not benefited fully from this broader trend. That's why we must ensure that all voices are heard and included in plans to strengthen communities through better access to healthy food and more opportunities for active living.

Ongoing engagement of multi-sector partnerships, including business and civic leaders, municipalities, city agencies and community organizations, will be essential to continued progress. Also important will be a greater focus on place-based solutions, from early childhood education in schools to neighborhoods.





PHYSICAL HEALTH

In spite of enormous political and financial uncertainty, the region's safety net system has been transformed over the past decade into a stronger, more collaborative and adaptive system of care.

Capacity has been increased and more sophisticated business models are being adopted to ensure that clinics are positioned to offer sustainable, high-quality care to the underserved. Providing care to a broader population base, including those who may have lost coverage due to the Great Recession, continues to be a key objective. At the same time, new models of care, such as the patient-centered medical homes are creating new opportunities to improve care continuity and strengthen patient engagement through a greater emphasis on prevention and chronic disease management.

There is also a greater emphasis on treating patients in a more holistic fashion and addressing upstream social determinants of health, given the social and economic challenges facing many of the uninsured and underserved. Going forward, the continued integration of behavioral, physical and oral health must be a priority.

Many unknowns remain. Chief among these are the ultimate impact of the Accountable Care Act and the disposition of Medicaid expansion. But stakeholders remain united in their desire to work together to maximize the ACA's benefits by helping people understand the best way to select and use insurance and by pursuing policy changes that can further improve access to quality care.

ORAL HEALTH

Over the past decade, the oral health system in our region has expanded dramatically, with multiple new access points and better integration of oral and primary care. Improved collaboration has supported shared best practices in ways that would not have been possible a decade ago. Public policy has also shifted to improve access to dental care for children and low-income adults.

Yet even with these gains, demand for free or low-cost services continues to far exceed the supply. Capacity must be increased, along with advocacy that supports policy changes and increases awareness about the key relationship between oral health and overall health. This need is particularly great in rural counties on both sides of the state line.

And while schools are seen as a potentially valuable location for providing oral health services and increasing oral health awareness, there is concern over the capacity of school-based services to provide services for more complex needs.

THE **PAST TEN YEARS** HAVE
TAUGHT US **WE CAN WORK TOGETHER**
TO **INFLUENCE AND IMPROVE** THE
HEALTH OF **THOSE AROUND US.**

TOBACCO

Over the past 10 years, determined efforts by many tobacco prevention advocates have produced a number of dramatic successes, including rapid expansion of municipal smoke-free ordinances, shifts in social norms around smoking and overall reductions in tobacco use.

New forms for tobacco, including e-cigarettes, are emerging and raising major concerns. Debates continue about youth marketing and whether municipalities should increase the legal age to purchase tobacco.

As we look out across the health and wellness landscape in Kansas City in 2015, many difficult challenges remain. Still, the past 10 years have taught us that despite barriers and the risks, we can work together to influence and improve the health of those around us. So while we take this opportunity to reflect on, and celebrate, 10 years of grant-making, it is important to remember that it takes much more than money to achieve genuine progress. Only the combined efforts and commitment of many different stakeholders can move us forward.

Therefore, we renew our commitment to working side by side in an ever-growing number of areas. Together, we can build on our region's leadership role in assisting populations in need. Most importantly, we can continue to make real and lasting improvements in the lives of our most vulnerable fellow citizens.

ACKNOWLEDGMENTS

For each of the topic areas featured in this report, we enlisted the assistance of researchers to collect and analyze primary data, review secondary data and other reports and produce a final report summarizing this information.

HCF would like to thank the following individuals for leading these efforts in their respective fields:

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- Oral Health: Health Resources in Action (HRiA)
- Tobacco Prevention: Meghann Beer

As noted previously, this publication is based on those findings, but also reflects HCF's filter. Any opinions therefore are solely those of the HCF. For additional information on the topics covered in this report, please visit the resources section of our website at hcfgkc.org.

HCF would also like to recognize the organizations and individuals who helped take the research and turn it into the document you see today:

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HCFDecadeofDifference.org