Kansas Maternal and Child Health Council (KMCHC) Meeting

Wednesday, October 10, 2018

Member Attendees	Absent		Visitors
Carrie Akin	Rebecca Adamson	Sharla Smith, PhD, MPH	Brandi Markert
Kayzy Bigler	Stefanie Baines, CES	Na'shell Williams	Jennifer Mellick, MD
Brenda Bandy, IBCLC	Linda Blasi	Stephanie Wolf	Chrisina Jordan
Kourtney Bettinger, MD, MPH	Ellie Brent, MPH	Taryn Zweygardt	
Lisa Chaney	Joseph Caldwell		
Stephanie Coleman	Julia Connellis		
Dennis Cooley, MD, FAAP	Greg Crawford		
Denise Cyzman	Beth Fisher, MSN, RN		
Diane Daldrup	Lisa Gabel, RN, BSN		
Mary Delgado, ARPN	Cory Gibson		
Stephen Fawcett, PhD	Beth Greene		
Sarah Fischer, MPH	Kari Harris, MD		
Terrie Garrison, RN, BSN	Lori Haskett		
Deanna Gaumer	Sara Hortenstine		
Charles Hunt	Elaine Johannes, PhD		
Tamara Jones, MPH	Kimberly Kasitz		
Jamie Kim, MPH	Patricia Kinnaird		
Elisa Nehrbass, Med	Peggy Kelly		
Lawrence Panas	Steve Lauer, MD, PhD		
Susan Pence, MD	Annie McKay		
Cherie Sage	Patricia McNamar, DNP, ARNP, NP-C		
Christy Schunn, LSCSW	Brian Pate, MD, FAAP		
Sookyung Shin	Melody McCray-Miller		
Lori Steelman	Mohamed Radhi, MD		
David Thomason, MPH	Cari Schmidt, PhD		
Lisa Williams	Katie Schoenhoff		
Donna Yadrich	Pam Shaw		
	Heather Smith		

Staff
Mel Hudelson
Connie Satzler

Agenda Items	Discussion	Action Items
Welcome & Recognize New Members/Guest	Members were welcomed, new KMCHC members were introduced	
Review & Approval of July 25, 2018 Minutes	It was moved to approve the minutes from July 25, 2018, all approved.	
Health Equity Planning: Strengthening State and Local Efforts for MCH Steve Fawcett, Ph.D., Unviersity of Kansas	Dr. Fawcett showed a video that illustrated how infant mortality has gone down in various countries to demonstrate how changeable health factors can be. **What determines public health?** Social economic factors make up 40% of public health and contribute to health inequities. **How MCH Health inequities are created group reporting:** Infant Mortality • Prenatal care access – reduce preterm birth and low birth rate. • Systemic racismis a global issue and black women don't have the same choices that other women have. • Support systems to address toxic stress and capabilities when have support. • Violence • Health literacy • Generational beliefs • Access and availabililty of services like transportation. • Education • Inflexibility of low income jobs Maternal • Access to care • Less trust in healthcare since many providers don't look like African americans • Substance use	

	• Criminal justice system • Mental health stigma. Commonalities with groups • Importance of support • Education • Cultural differences **Whose work is this?** Everyone - healthcare, education system, individual, government. A multi level issue. **What would things look like if KDHE MCH were optimally supporting efforts to promote health equity at KDHE and Kansas?** • KDHE advocates for a ubiquitous system of access to care with a single payer. Electorate better educated by KDHE (and electorate clients co-present to the legislative body with KDHE staff) about how their voting is a responsibility as a way to set policy for the optimal health and well-being of all Kansans (visitors, undocumented and residents) is their civic responsibility if less altruistically of self-preservation. • Every person with equal access regardless of income, race, or gender to healthcare, parenting/family supports, and education which would result in improved health, wellness, and state economy. • KDHE MCH would serve as the foundation for educating, promoting, and connecting services and resources to identify and correct health inequalities statewide. • Everyone has an opportunity to experience a healthy life span for themselves and their families. • Equity embedded in each Bureau and grantees with outcomes that are measurable and innovative (i.e. Required equity component, trauma-informed care, Dismantling Racism Evaluation, Annual Equity Assessment, equity goals included in employee Annual Review) • Every segment of KDHE, and KDHE-MCH especially, would have Health Equity Accountability as part of Plans and Goals and Actions. • KDHE would stand as a flag bearer (one of the flag bearers) for Health Equity. • Use a health equity mirror.	

	• All Kansas women and their families have equal access to care, education about care, and support to live healthy lives.
	• All KDHE employees integrate health equity into programs and evaluate progress frequently.
	• More black women and men (e.g. professionals, community members, and community leaders) would be present at KMCHC meetings, and other meetings (e.g. Maternal Mortality Review, Infant Mortality Review, on staff at KDHE, on committees).
	• This would be a standing agenda item for KMCHC meetings.
	• KDHE, MCH would lead and engage funders, government, partners, and consumers to explore the wide range of national, state, and community assets and determine a collective response to improve heath equity.
	• Equal opportunities for "the same" medical care and equal access to treatment.
	• Education for everyone that wants it; income-based fees versus University-set fees and cost.
	• Mobilizing resources to local communities, where they are both physically and culturally.
	  ○ Education programs that are catered toward countering social norms (i.e., educating mothers about SIDS or nutrition, in a way that is not seen as preachy)
	  ○ Working with companies and organizations on: affordable housing, new low-income clients, grassroots farming (i.e., urban farming in KC and other growing cities with food deserts in low-income neighborhoods)
	• The leadership and team at KDHE MCH would include more people of color as a representation of the population served. In this way we ensure all Kansans have their culture and voice represented.
	
	Every segment of KDHE would be accountable to movement on improving health equities
	
	Look internally for diversity within KDHE staff, committees, and coalitions
	
	Collaboration – not one group or individual. Everyone on the same page, across bureaus
	
	KDHE would advocate for a single payer for all Kansans	

	KDHE would better educate the electorat about optimal health for all Kansans. Everyone has to have the same vision starting at the Governor all the way down. Lead and engage funders, government entities and population There is not a barrier to addressing Community and systems change: The work is being done, and there is no barrier to doing more of this work. **Essential Services 3, 4 and 8** **Educate and Empower People** *Reworded ES#3 slightly to* Inform, educate, and **equip** people about health (and equity) issues with a **trauma-informed approach**. • Use data, advocacy, and other expertise to support community-led social justice efforts that would improve health equity. • Partner with communities experiencing inequities in ways that intentionally share power and decision-making. Co-develop, adopt, and promote a shared agenda, narrative, and resources to advance health equity. • Create a culture of respectful co-learning, evaluation, reflection, and transparency about department and community needs/priorities to build trust between department and community partners **Mobilize Partnerships** • Develop working relationships and multi-sectoral collaborations with city/county/state agencies of labor, transportation, education, corrections, economic development, housing, and public safety to influence their decision making in ways that promote health equity. Seek inclusion in related agencies' policy discussions and decision making . • Include voices of the people experiencing health inequities in all stages of program and policy development and create meaningful opportunities for community engagement and evaluation. • Ask communities to identify health indicators they want to target and the measures of progress that will be meaningful to them in achieving health equity. • Require educational system to be at the table.	

	Workforce Preparation • Have an ongoing process of education, structured dialogue, and organizational development that engages all department staff to: a) Explain the evidence around health inequities and its sources; b) Explore the root causes of health inequities and how to address them; c) Discuss the values and needs of the community; d) Build core competencies and capacities of staff to successfully achieve health equity Include voices of the people experiencing health inequities in all stages of program and policy development and create meaningful opportunities for community engagement and evaluation. • Create recruitment, retention, promotion, and training policies to ensure that the professional workforce — including sub-contractors — reflects the demographics of the populations served, reflects equity. • Build awareness of the connection between the social determinants and health with government agencies, elected officials, and community stakeholders. Advance a narrative that says: a) health is more than health care, and b) to improve health, we must focus on community conditions that lead to health. **Priority Strategies:** **Discussion:** These strategies are achievable and are necessary. Should be built into workflow so that they are not just "flavor of the month". Infrastructure needs to be changed at all levels. Every state department has a role, as well as other organizations partnering throughout the state. Big picture topic and has to be a mindset change, and a long journey that takes persistence. Family engagement in all areas is important and not always asked. Funding is often the motivator for change, but it has to be a long term change done for the right reasons. Information and consequences matter.	
11:30 Break & Lunch		
MCH Population Domain Small Group Discussion	The small groups met and worked to identify strategies for strengthening the health equity infrastructure and prioritize strategies to advance health equity related to and in line with MCH State Action Plan. Overview:	

	Educating, informing and increasing skill set of individuals is one level, then community level need to draw on networks. Need to create an infrastructure beyond our own organizations so that this is more a long term systems level change. Who is the workforce for this? Those at risk for adverse outcomes need to be just as involved in this work as KMCHC members. Reaching them and engaging them is a key step in equity promotion. There are groups reaching them (tobacco), we should make sure that we learn from them what to do.	
1:15 Break		
Topeka Doula Project *Juliet Swedlund*	Juliet educated the group about her work providing support to at risk mothers before, during, and shortly after childbirth. The Topeka Doula Project Make refers out to local resources as they work with mothers after birth to connect them to ways to meet her needs. Modeled after the "By My Side" project in New York City that had a 50% reduction in preterm births. Discussion: There is a waiting list for mothers and the Topeka Doula Project is planning to train more doulas. Juliet is currently working as a volunteer to show the benefit of having doulas support high risk mothers. Maybe there could be legislation to have doula services provided by Medicaid groups.	
Kansas PRAMS Update *Lisa Williams & Brandi Markert* *KdHE Bureau of Epidemiology & Public Health Informatics*	Brandi Markert was introduced. Lisa and Brandi distributed information on the original analysis plan to get feeback on any changes. Data request process – distributed the application for data request. Don't know yet if county data will be available. Will know once they know how much data collected from each county. Should have regional information to distribute.	

	Can this be a regular agenda item so that the coalition can be regularly updated on data? It was suggested that the group collect questions beforehand so that they can have specific information ready to provide. We should be able to compare data with other states once we have enough data to report. Going forward we should look into providing information to those who took the survey so they know how to access the report.	
Announcements & January Meeting Agenda *KDHE Staff & KMCHC Members*	KDHE Staff provided the following announcements to the coalition: • One key question trainings coming up • New maternal mental health grant – will focus in SW Kansas and will be hiring a mental health coordinator. • Maternal mortality review and committee • Palliative Care Program & Committee/Council • Newborn screening & expansion – working toward adding four new conditions per recommendations from the Newborn Screening Advisory Council. • Care coordination updates – we have satellite offices across the state, showing a 71% improvement rate in care. • Birth defects updates – coordinator job is open, right now this is focused around Zika. • Supporting You was launched – a peer to peer mentoring project that will work with several programs. Currently identifying and training supporting peers. Right now working with special health care needs and school for the deaf. Hoping to expand to other groups soon.	
Closing Remarks *Dennis Cooley, MD, Chair*	Dr. Cooley thanked the speakers and KMCHC members for their work at th meeting. The meeting was adjourned at 3:00.	
Future Meetings	The following dates are for meetings coming up: • January 23, 2019 –**Shawnee County Library** • April 10, 2019	