



# Strategic Planning Document

## 2011 – 2013



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Where do I begin the dialog about equity as a means of improving the health and quality of life for Kansans from all walks of life, across the lifespan, speaking many languages, and living in urban and rural settings as well as on reservations? At our kitchen tables, the definition and concept of equity is not so abstract when we are trying to manage our lives, take care of loved ones, get the medical care we need, support friends and family, celebrate holidays and community events we have come to enjoy, and so much more.

Before we go to bed at night, we might find ourselves thinking about what has happened to the rivers we used to fish as children –are the fish still safe to eat? We might go to bed worried that we are unable to allow our children to play outside without close supervision because of unsafe neighborhoods or streets. We may go to bed hungry. We may go to bed avoiding the decision to follow through on a colonoscopy or other test because we don't know where the money will come from to pay for the test, and we are afraid to learn what the results may be.

Before we go to bed at night, we may be so grateful for many things that are going right knowing that we have, or are maintaining, good jobs, that we are finishing a college or vocational school degree, that we lost the weight we set as a goal for ourselves, that we were able to support a policy change in our communities that would assure safer playgrounds, more recreation areas, school lunches that are healthier, that we had the resources to help out a friend in need, that we knew that we were loved and appreciated.

In my profession, health results from choices that people are able to make in response to the options they have. These conditions are referred to as “social determinants” of health: the conditions in which we live, learn, work, play, pray, and age. In public health, we work with communities to identify root causes of diseases and illnesses (such as poverty or polluted environments which go far beyond medical care once a disease has progressed or individual behavior change). We look at opportunities to reduce escalating health care costs by taking steps to prevent illness. We view the process of achieving and sustaining better health and quality of life in terms of solutions which connect modifiable social conditions with individual choices for better health and development of policies which can have some of the greatest impacts on these conditions. To promote equity (fairness) as a way to talk about reducing health disparities (differences in health status between population groups in our state) is an important next step in building and maintaining a bright future for our children and elders and generations to come.

Good health enhances quality of life, improves workforce productivity, increases the capacity to learn, strengthens families and communities, supports sustainable habitats, and contributes to security, poverty reduction, and social inclusion (our sense of belonging and relationship to others and community). (Adelaide Statement on Health in All Policies 2011)

While the strategic plan for the Center for Health Equity will likely not be late night reading, the introduction to this plan is a relatively current story about what our state residents look like, the health disparities we experience in terms of data that's been collected at the state and national level, as well as action steps being taken over a three year period by the Center for Health Equity to fulfill the mission of the Kansas Department of Health and Environment.



Aiko Allen is the Director of the Center for Health Equity at KDHE.

## Advisory Committee 2011

Advisory Committee activities may include: study of critical issues related to social determinants of health, equity, and health disparities; independent research; networking and community mobilization, strategic planning, and evaluation. Activities support committee preparation to discuss, formulate, and forward well-developed, thoughtful recommendations that assist the Center to achieve its mission and vision.

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Over the past decade, Kansas has become a more diverse place to live. Kansans live in a wide range of contexts, from rural and frontier regions to large, urban areas. Kansas is a State in which 39 languages are spoken and Hispanic/Latino, Asian, and Multiracial groups continue to grow at rates greater than the general population. The Kansas population continues to get older on average, but certain groups (i.e. Hispanic/Latinos) have younger populations. Kansans are also diverse in income, disability, and other factors.

In the context of this diversity, health disparities (defined as differences in health that are related to “social or economic disadvantage”) are increasingly prevalent. On the 10 Key Health Indicators highlighted by the “Healthy Kansans 2010” report Kansans with less income and less education tend to have worse health outcomes. For example, Kansans earning less than \$15,000 a year in annual income are more likely to smoke cigarettes, be obese, and suffer from depression than those with a household income of \$50,000 or more.

Differences also exist according to race/ethnicity. Black Kansans are more likely to be overweight or obese, while Hispanic/Latinos are more likely to have no health insurance. These differences extend to the leading causes of death with Blacks having higher death rates from heart disease, cancer, and stroke than other racial/ethnic groups. These disparities are described in further detail throughout this report.

To address these disparities, the Office of Minority Health (eventually renamed the Center for Health Equity) was established in 2005. It’s mission is to “promote and improve the health status of all Kansans through shared leadership and collaboration across the public health system in order to reduce identified and emerging health disparities among racial, ethnic, tribal, and underserved populations.”

During the spring and summer of 2011, the CHE Advisory Committee convened for intensive planning session which created a three-year Strategic Plan. This process highlighted the goals of CHE and set specific targets for achievement. The final pages of the report present this Plan.

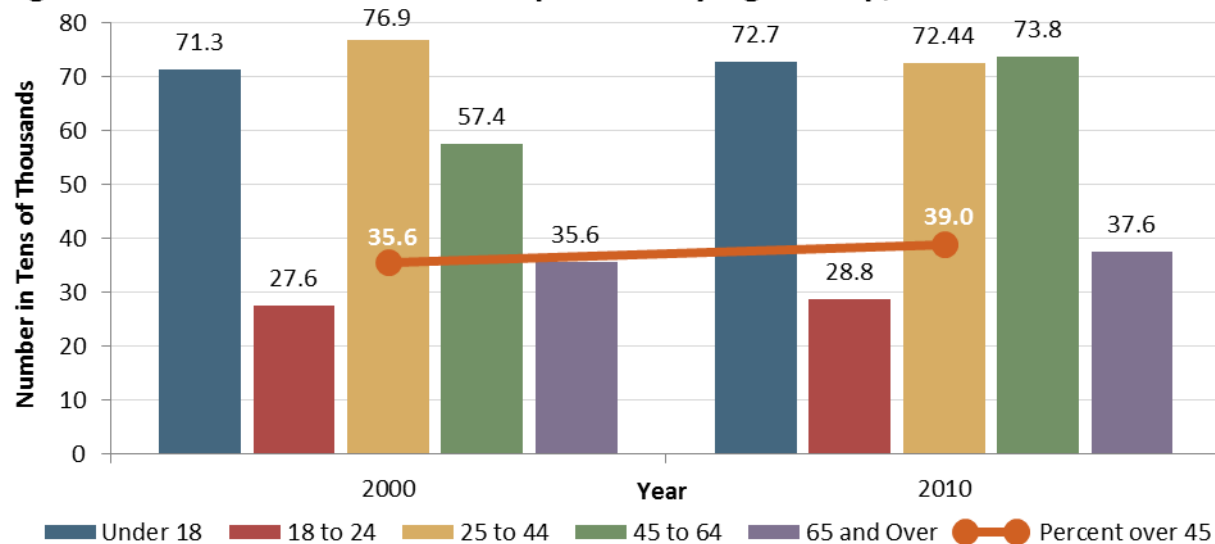
## Population Growth in Kansas

Between 2000 and 2010, Kansas increased its population size by seven percent to 2,853,118 residents (U.S. Census Bureau, 2000, U.S. Census Bureau 2010). Estimates suggest another nine percent increase will occur over the next 20 years with 3,123,830 residents projected in 2030 (Wichita State University Center for Economic Development and Business Research, 2008). As the Kansas population continues to grow, it is also becoming increasingly diverse.

## Diversity in Age

As found in the U.S. population, the Kansas population is growing older. Between 2000 and 2010, the 45 to 64 age group showed the largest percentage of growth, gaining 28% for males and 29% for females. In the coming years, this group will continue to age and move into the 65+ age category. Projections for 2020 predict that 1 in 6 Kansans (16.6%) will be 65 years of age or older. Figure 1 shows the age breakdown for 2000 and 2010 census data, with the percent of those over 45 in orange.

**Figure 1: Distribution of Kansas Population by Age Group, 2000 & 2010**



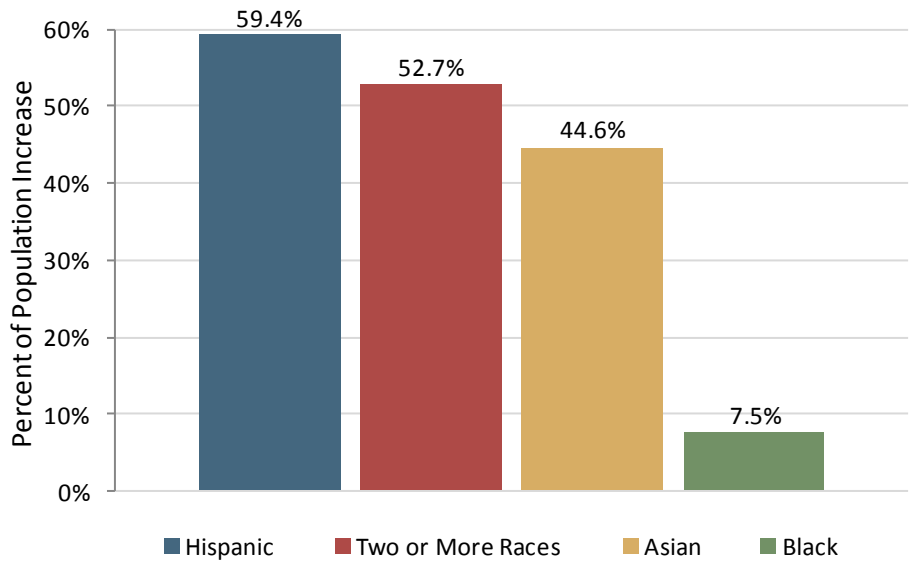
Source: U.S. Census Bureau, 2000 and 2010

## Diversity in Race/Ethnicity

Kansas continues to become more racially and ethnically diverse. Although the majority of residents are still non-Hispanic Whites (78.2%), large increases have occurred in many populations. Between 2000 and 2010, the Hispanic/Latino population in Kansas grew by 62.7% jumping to 10.5% of the population.

Over 300,000 Kansans are Hispanic/Latino, the majority of which originate from Mexico (247,297), Puerto Rico (9,247), or Cuba (2,273). Figure 2 shows the percentage of growth for key groups between 2000 and 2010. At the same time, the Asian population in Kansas grew by 44.8%. The most populous Asian groups in Kansas include Vietnamese (14,015), Asian Indians (13,848), Chinese (11,188), Filipinos (5,545), and Koreans (5,234). Table 1 displays the population numbers of each group.

**Figure 2: Percent of Change in Key Race/Ethnic Groups**



Source: U.S. Census Bureau, 2010

Note: Asian and Black groups are non-Hispanic. Black = Black or African American.

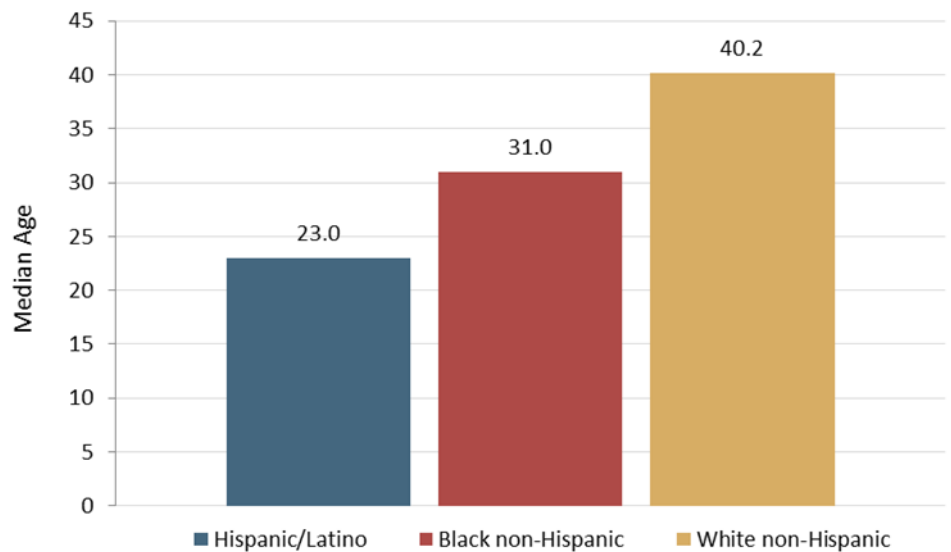
**Table 1. Race/Ethnicity in Kansas, 2000 and 2010**

Race/Ethnicity	2000		2010	
	Number	%	Number	%
White/Caucasian	2,233,997	83.1%	2,230,539	78.2%
Hispanic/Latino	188,252	7.0%	300,042	10.5%
Black/African American	151,407	5.6%	162,700	5.7%
Asian	46,301	1.7%	66,967	2.3%
Two or More Races	42,508	1.6%	64,891	2.3%
American Indian / Alaskan Native	22,322	0.8%	23,037	0.8%
Native Hawaiian / Pacific Islander	1,154	0.0%	1,978	0.1%
Other Race	2,477	0.1%	2,928	0.1%
<b>Total</b>	<b>2,688,418</b>	<b>100.0%</b>	<b>2,853,118</b>	<b>100.0%</b>

Source: U.S. Census Bureau

While the Hispanic/Latino population is growing in Kansas, they are also significantly younger than other groups. Thirteen percent of Kansas Hispanics are under age 5 and 40.52% are under age 18. These numbers are twice as high as the White non-Hispanic population, with approximately six percent of Whites under age 5 and 22.29% under age 18. Median ages for the key groups are found in Figure 3.

**Figure 3: Median Age for Key Race/Ethnic**



Source: American Community Survey, 2010

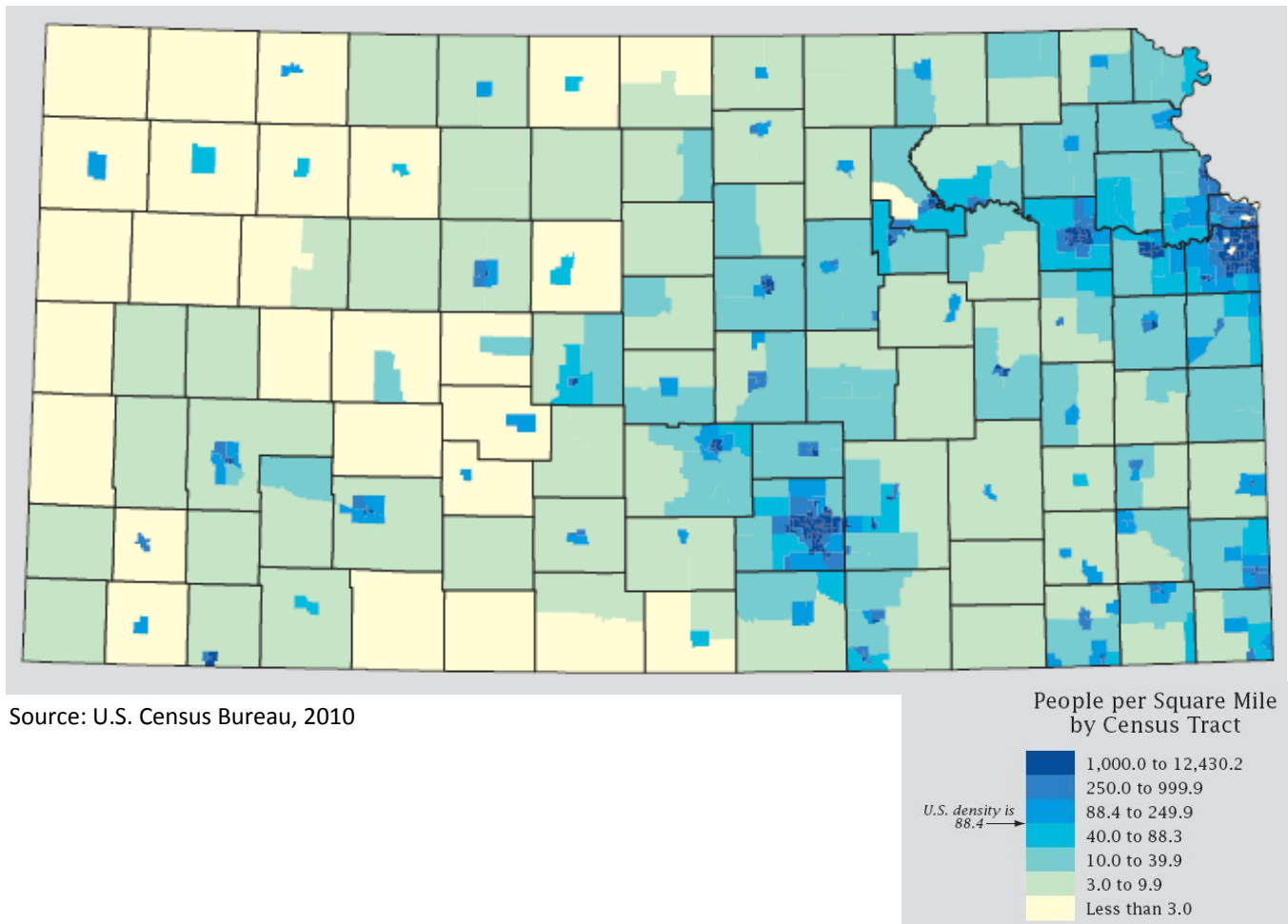
### Diversity in Languages

With a population diverse in race and ethnicity, many languages are spoken with Kansas. While 89% of Kansans speak only English, more than one in ten speak another language. The American Community Survey identified 39 languages spoken throughout the state. Top languages include Spanish (191,156), German (15,913), Chinese (12,406), Vietnamese (10,307), Laotian (5,545), French (5,089), and Arabic (3,354) (American Community Survey, 2010). More than 110,000 Kansans (4.3%) are not proficient in English (University of Wisconsin Population Health Institute, 2011).

### Diversity in Urbanicity

Kansans also live in a diverse range of locations including urban, suburban, and rural areas. Estimates show that an increasingly number of Kansans are moving to urban areas with 64% of the total population. Despite this increase, one in three Kansans live in rural and frontier areas (U.S. Census Bureau 2010). County population densities range from 1.6 persons per square mile (Greeley and Wallace Counties) to over 1,000 persons per square mile in Wyandotte and Johnson County. Map 1 shows the population densities across the state.

## Map 1. Population Density by Census Tract

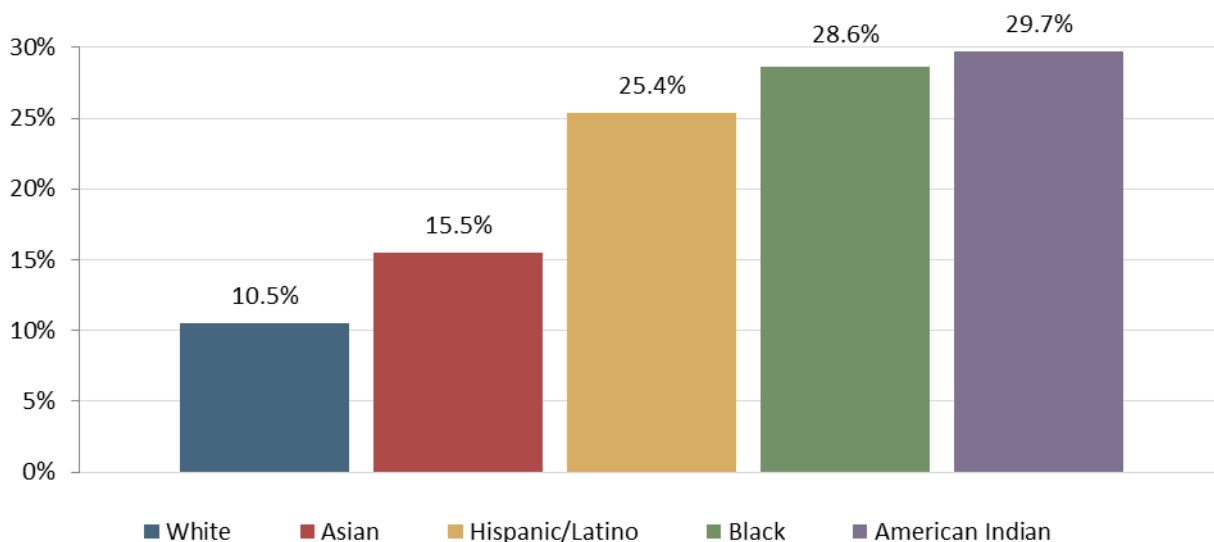


## Diversity in Income

Kansans are also diverse in income. Estimates show that 13.6% of Kansans live in poverty including almost one in five (18.4%) children. Poverty is defined by federal guidelines based on household income (i.e. , less than \$22,350 annual household income for a family of four) (Federal Register, 2011). Percentages of individuals in poverty differ greatly by race/ethnicity with the highest concentrations between Native Americans, Blacks, and Hispanic/Latinos. Figure 4 displays the percentage of poverty for each group. Almost one in four (24.2%) of high school dropouts live in poverty. Less than four percent of Kansas residents have a four-year college degree (American Community Survey, 2010).

Unemployment is another issue which affects Kansans. Based on 2010 estimates, 7.9% of the Kansas population 16 or over were unemployed. However, the likelihood of unemployment was greater among certain groups including Blacks (17.8%), American Indians (13.7%), Hispanic/Latinos (11.0%), and high school dropouts (14.0%) (American Community Survey, 2010).

**Figure 4: Percentage of Individuals in Poverty by Race/Ethnicity**

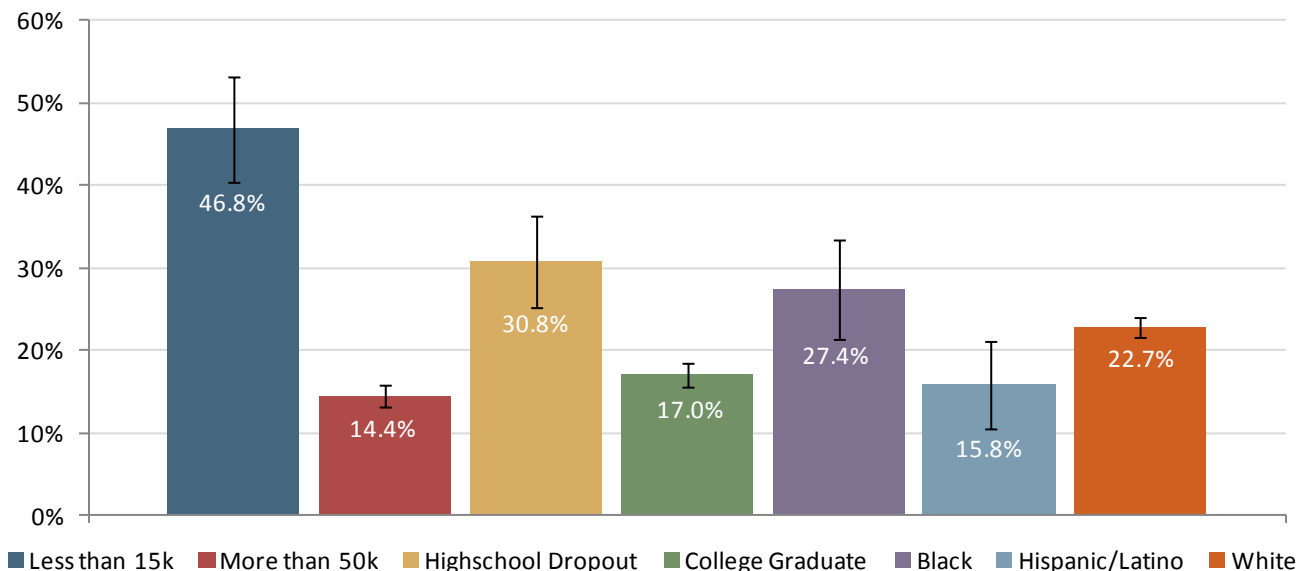


Source: Amercian Community Survey, 2010

### Diversity in Disability

About one in four (22.7%) of Kansas adults reported living with a disability. This includes information from two questions on the Behavioral Risk Factor Surveillance Survey (BRFSS), combining self-reported physical, mental, and emotional difficulties and the required use of special equipment including wheel chairs, canes, etc. Females are more likely (24.7%) to report a disability than males (20.5%).

**Figure 5: Percent of Key Kansas Population Groups Living with a Disability**



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2010

Notes: Low Income defined as < \$15,000 annual household income; High Income defined as > \$50,000 annual income. Black and White are non-Hispanic. Error bars represent 95% confidence intervals.

## **“Healthy Kansans”**

Based upon Healthy People 2010 standards for evaluating priorities and improvements in the health of the nation, the Kansas Department of Health and Environment (KDHE) launched “Healthy Kansans 2010” in 2005 to address improvements in health among state residents. Kansas was recently selected as one of 12 states to evaluate the new Healthy People 2020 goals. The new objectives build on those set for 2010 and have added social determinants of health as a key component with the goal of creating “social and physical environments that promote good health for all” (Healthy People, 2020).

Building on the work of “Healthy Kansans 2010” and looking toward the 2020 report, the ten key health indicators and priorities identified in “Healthy Kansans 2010” are discussed, highlighting the health disparities experienced among different populations in the State. These indicators continue to provide a rich context for dialogue as the Center for Health Equity advances its mission to “promote and improve the health status of all Kansans through shared leadership and collaboration across the public health system in order to reduce identified and emerging health disparities among racial, ethnic, tribal, and underserved populations.”

## **Physical Activity**

Physical activity is a key indicator of population health for both youth and adults. Recent data shows that 70.0% of Kansas youth are engaging in vigorous physical activity of twenty minutes or more, three or more times per week. The Healthy People 2010 goal was 85% (Youth Risk Behavior Surveillance System (YRBSS), 2005). Physical inactivity remains a big problem for many youth, particularly those of color. Data from 2009 revealed that Black (57.4%) and Hispanic/Latino (60.2%) youth were more likely to be physically inactive (less than five days a week with at least 60 minutes of physical activity) than were White students (48.0%) (YRBSS, 2009).

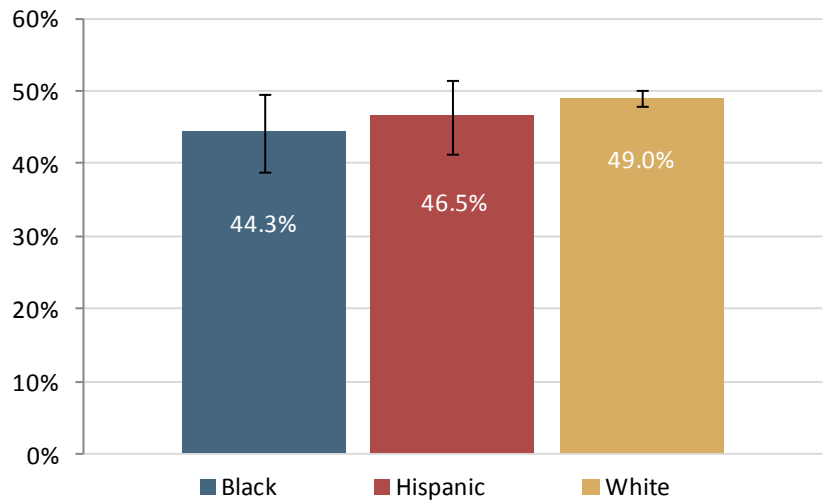
A similar picture exists for adults. Less than half (48.5%) of Kansas adults reported sufficient physical activity (Behavioral Risk Factor Surveillance System (BRFSS), 2009). As shown in Figure 6, 49% of Whites, 44.3% of Blacks, and 46.5% of Hispanic/Latinos reported participating in the recommended level of physical activity. Income and education also are factors in physical activity. Kansans earning less than \$15,000 income per year were less likely (36.9%) to meet physical activity requirements than were those who make more than \$50,000 per year (53.5%). Similarly, college degree holders were much more likely (52.3%) to exercise than those who dropped out of high school (37.5%) (BRFSS, 2009).

## Overweight and Obesity

Weight status is another key health indicator which affects both children and adults. In 2009, 12.4% of Kansas youth were classified as obese and 13.1% were overweight (YRBSS, 2009). For adults, more than half of Kansas residents are either overweight (34.4%) or obese (30.1%) (BRFSS, 2010). Seven out of ten Kansas males are overweight or obese (71.9%), compared to 57.0% of females (BRFSS, 2010).

Disparities can also be found in weight status. For example, Hispanic/Latino youth are much more likely (16.7%) to be obese than White (11.9%) or Black (8.9%) adolescents. While only 29.7% of Whites are obese in Kansas, 38.5% of Black adults are obese. About seven out of ten Hispanic adults (73.3%) in Kansas have an unhealthy weight status (overweight or obese) as compared to six out of ten White adults (64.1%) with an unhealthy weight status. As seen in Figure 7, disparities are also found according to income status and education level.

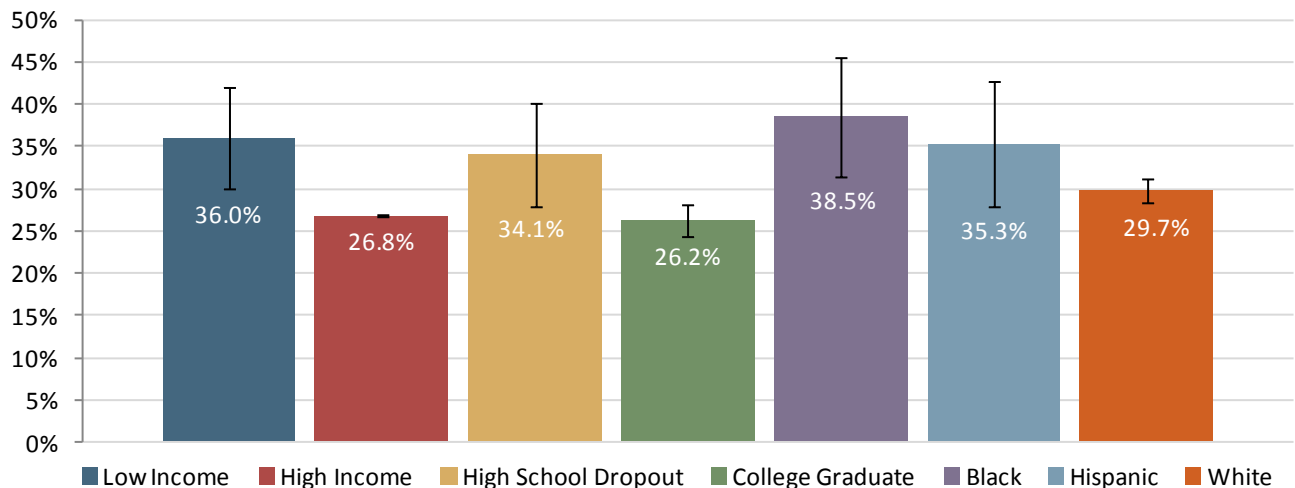
**Figure 6: Percentage of Kansans Meeting Physical Activity Recommendations by Race/Ethnicity**



Source: BRFSS, 2009

Note: Recommended level of physical activity defined as 30+ minutes of moderate physical activity five or more days per week, or 20+ minutes of vigorous activity three or more days per week. Error bars represent 95% confidence intervals.

**Figure 7: Percentage of Key Kansas Population Groups that are Obese**



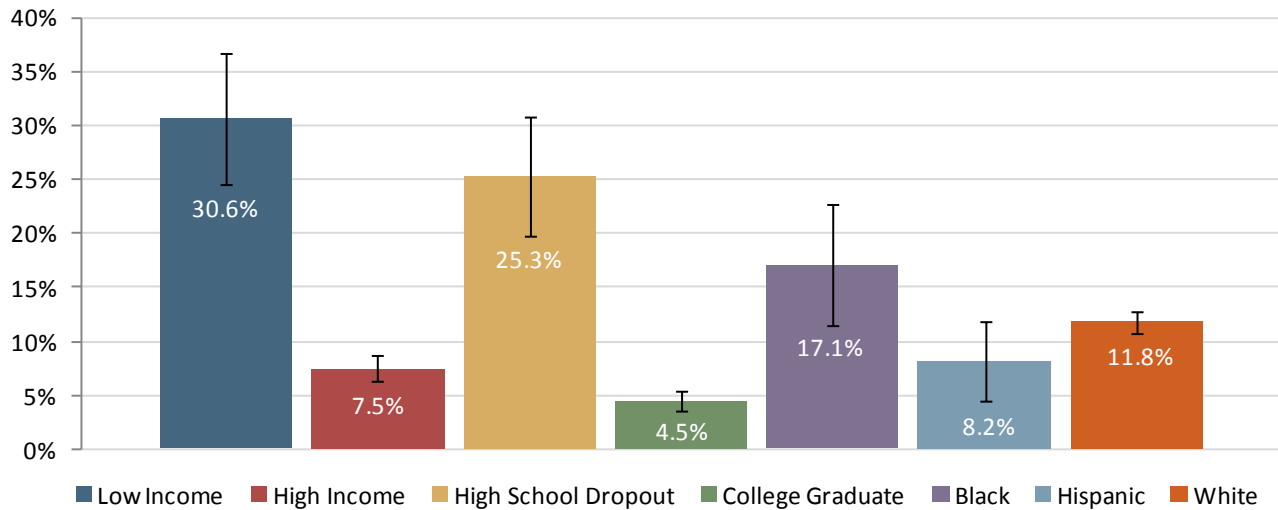
Source: BRFSS, 2010

Note: Low Income is defined as < \$15,000 annual household income; High Income defined as > \$50,000 annual household income. Black and White groups are non-Hispanic. Error bars represent 95% confidence intervals.

## Tobacco Use

Reduction in the use of tobacco products is another key goal for the health of Kansans. Recent numbers reveal that 16.9% of Kansas High School Students and 17% of Kansas adults were current smokers (YRBSS, 2009; BRFSS, 2010). Four out of ten youth report having tried a cigarette in their lifetime (YRBSS, 2009). Almost six out ten (58.8%) Kansas adults reported that they never smoked (BRFSS, 2010).

**Figure 8: Percentage of Key Kansas Population Groups that are Daily Smokers**



Source: BRFSS, 2010

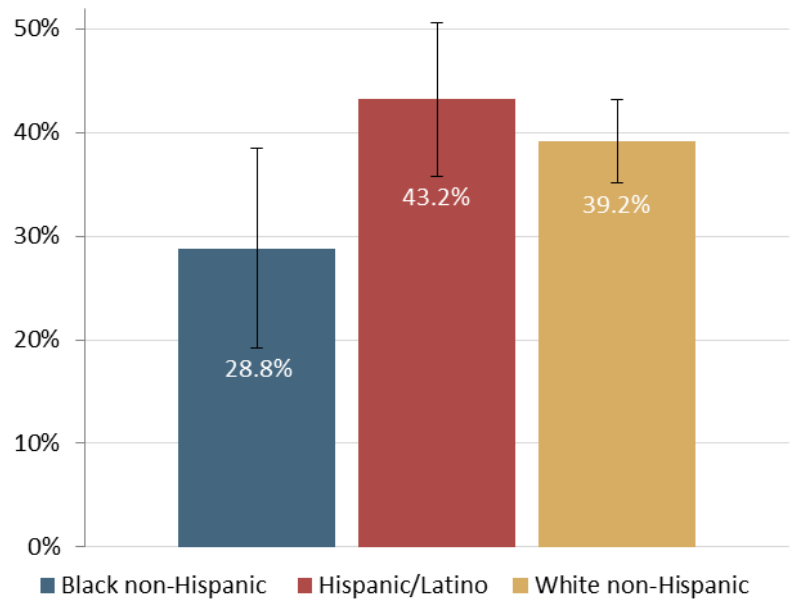
Note: Low Income defined as < \$15,000 annual household income; High Income defined as \$50,000 annual household income or more. Black and White groups are non-Hispanic. Error bars represent 95% confidence intervals.

Figure 8 displays the percentages of Kansans from different groups who smoke daily. Certain groups are at greater risk, including Kansans earning less than \$15,000 per year and those who dropped out of high school. Seventeen percent of Black adults reported smoking daily compared to 11.8% of White and 8.2% of Hispanic/Latino adults (BRFSS, 2010). However, this trend is reversed in youth. White youth are significantly more likely to have smoked in the previous month than are Black youth in Kansas (18.1% to 11.5%). Hispanic/Latino youth were less likely to smoke on a daily basis (2.7%) than White (7.5%) or Black (6.3%) youth (YRBSS, 2009).

## Substance Use

Use of alcohol and other drugs are another key health indicator for Kansans. Healthy Kansas goals have included reducing adolescent alcohol and drug use and limiting binge drinking in adults. Recent surveys have been mixed, indicating that as few as 27.0% or as much as 38.7% of Kansas youth have had at least one drink of alcohol in the previous month (Communities that Care Survey, 2009; YRBSS, 2009). Hispanic/Latino youth were more likely to report having drunk alcohol in the past month (43.2%) than were White (39.2%) or Black (28.8%) students (YRBSS, 2009). Figure 9 displays differences in youth drinking behaviors by race/ethnicity.

**Figure 9: Percentage of Alcohol Use by Kansas**

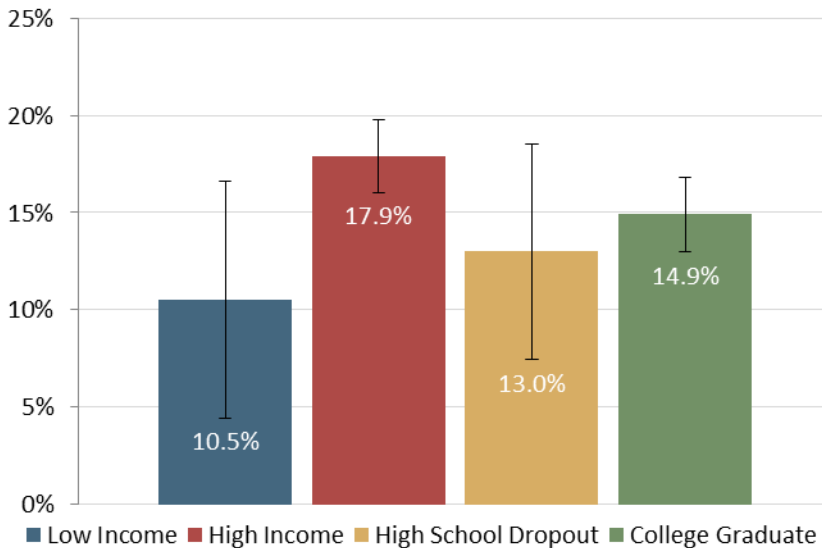


Source: Youth Risk Behavior Surveillance System (YRBSS), 2009

Notes: Alcohol Use defined as at least one drink in 30 days prior to completing survey. Error bars represent 95% confidence intervals.

Binge drinking is also a serious issue with one in four Kansas high school students reporting that they have drunk five or more drinks in a row within the past month.

**Figure 10: Percentage of Kansas Adults Engaged in Binge Drinking in the Previous Month**



Source: BRFSS, 2010

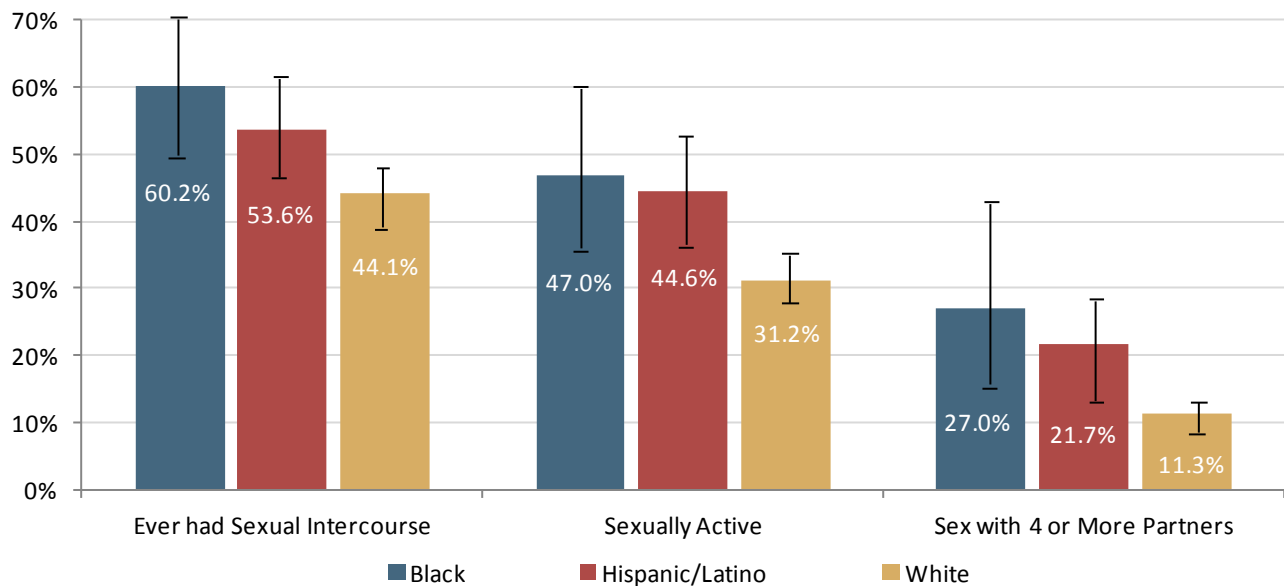
Notes: Low Income defined as < \$15,000 annual household income; High Income defined as \$50,000 annual household income. Error bars represent 95% confidence intervals.

Binge drinking also affects adults. In Kansas, 15.1% of adults report having engaged in binge drinking (i.e. 5 drinks a row for males or 4 for females) within the last month. Males were more than twice as likely (21.4%) to binge drink than were females (9.0%). Kansans with more education and income report high rates of binge drinking as shown in Figure 10. The highest rates of binge drinking are found among Kansans 18 to 34 years of age (BRFSS, 2010).

## Responsible Sexual Behavior

“Healthy Kansans 2010” set a goal of increasing the number of Kansas adolescents who remain abstinent from sexual activity. The latest data revealed that almost half of Kansas high school students reported having sexual intercourse in their lifetime (46.6%) with 34.2% having done so in the past three months. Among those who are sexually active, only 39.9% reported using condoms during their last sexual intercourse. As displayed in Figure 11, Black and Hispanic/Latino youth are more likely to have had sexual intercourse, to currently be sexually active, and to have had four or more sexual partners over their lifetime than were White students.

**Figure 11: Reported Sexual Behavior of Kansas High School Students by Race/Ethnicity**



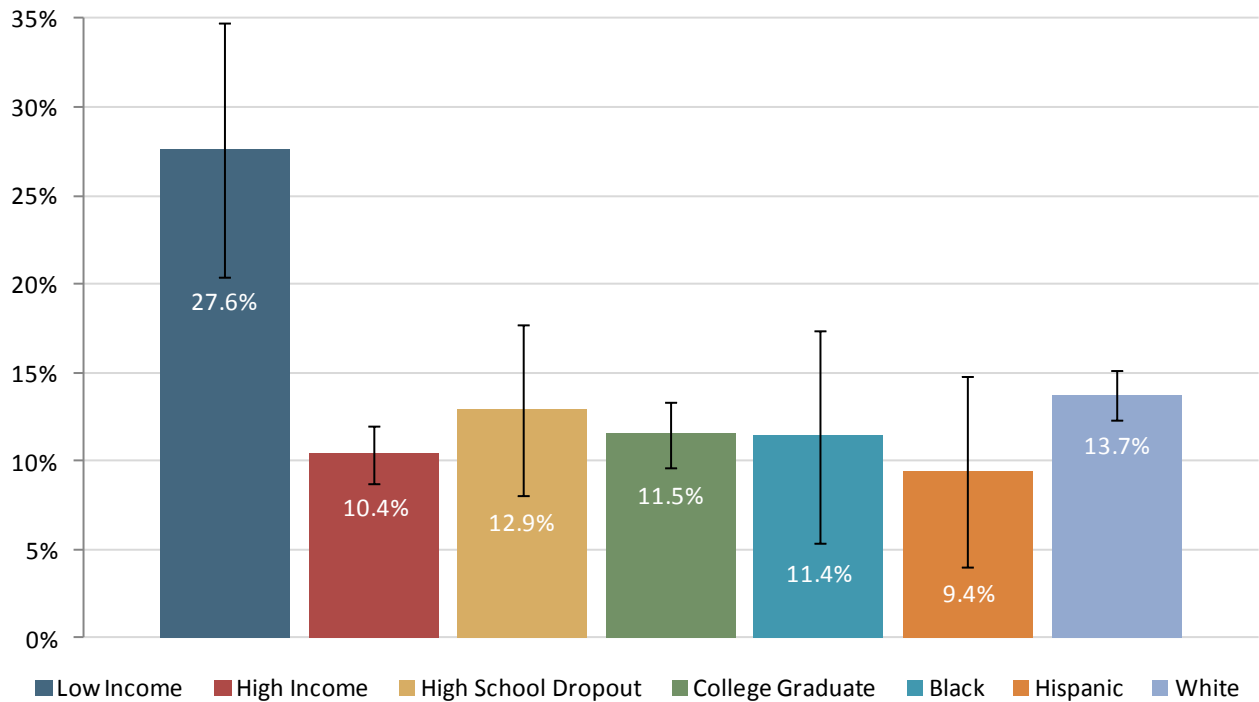
Source: YRBSS, 2009

Notes: Sexually active defined as intercourse at least once in past 3 months; Sex with 4+ partners is over lifetime. Black and White groups are non-Hispanic. Error bars represent 95% confidence intervals.

## Mental Health

Depression and anxiety disorders are important health concerns for Kansans as well. Data revealed that almost seven percent of Kansas adults reported currently experiencing depressive symptoms while 13.5% having been diagnosed with a depression at some time in their lives. Females were twice as likely to have been diagnosed than males. One in ten Kansas adults reported having been diagnosed with an anxiety disorder (including obsessive-compulsive disorder, post-traumatic stress disorder, and panic disorders). The key goal set by “Healthy Kansans 2010” was getting adults diagnosed with depression into treatment. The most recent BRFSS data revealed that 42% of Kansas adults self-reporting a diagnosis of depression had sought treatment (BRFSS, 2008). Disparities are also prevalent in mental health. As shown in Figure 12, Kansans with lower household income suffer from depression at disproportionate rates compared to other groups.

**Figure 12: Percentages of Key Kansas Population Groups Diagnosed with Depression**



Source: BRFSS, 2008

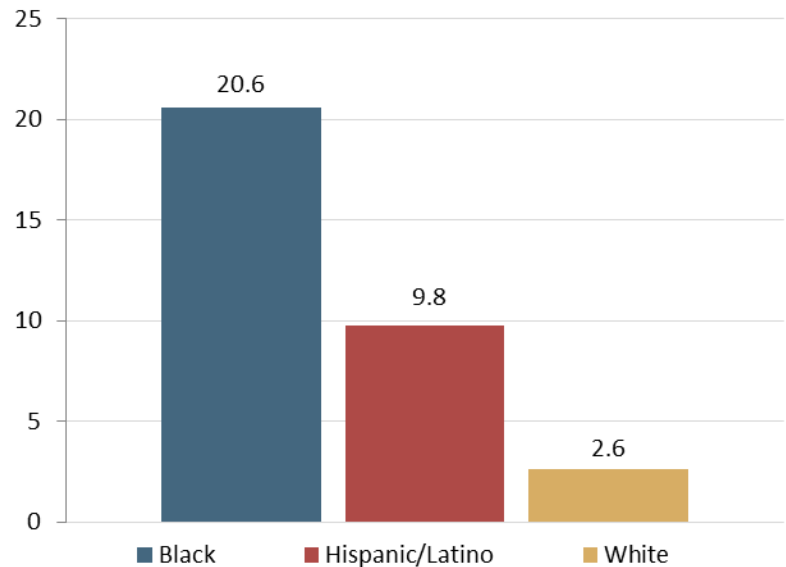
Notes: Low Income defined as < \$15,000 annual household income; High Income defined as \$50,000 annual household income. Error bars represent 95% confidence intervals.

## Injury and Violence

Reductions in deaths due to motor vehicle crashes and homicide were two indicators included in the “Healthy Kansans 2010” report. In 2010, there were 470 deaths in Kansas due to motor vehicle accidents, up 18.1% from 2009 numbers. Younger Kansans (ages 15 to 24) and Kansans 65 years of age and older were most likely to die from motor vehicle crashes (KDHE Vital Statistics, 2009, 2010).

In 2010, 108 Kansans were murdered. Homicide is the third leading cause of death among 15 to 24 year olds. As shown in Figure 13, disparities in homicide are clear. Looking at rates per 100,000, Black Kansans are almost eight times more likely to die from homicide (20.6) than are Whites (2.6) and two times more likely than Hispanic/Latinos (9.8) (KDHE Vital Statistics, 2009,2010).

**Figure 13: Homicide Rates by Race/Ethnicity in Kansas**



Source: KDHE Vital Statistics, 2009

Notes: Age-adjusted rates per 100,000

## Environmental Quality

Air quality was another key health indicator cited by “Healthy Kansans”. The stated goal was to reduce persons exposed to air which violate ozone standards. According to the U.S. Environmental Protection agency, no Kansans were exposed to unhealthy air in 2010.

## Immunizations

Immunizations are a key health indicator in reducing the spread of disease and preventable illness. “Healthy Kansans 2010” set goals for the immunization of children and older adults. Data shows that 78.2% of Kansas children have been fully immunized, although disparities exist based upon income and race (National Immunization Survey, 2008).

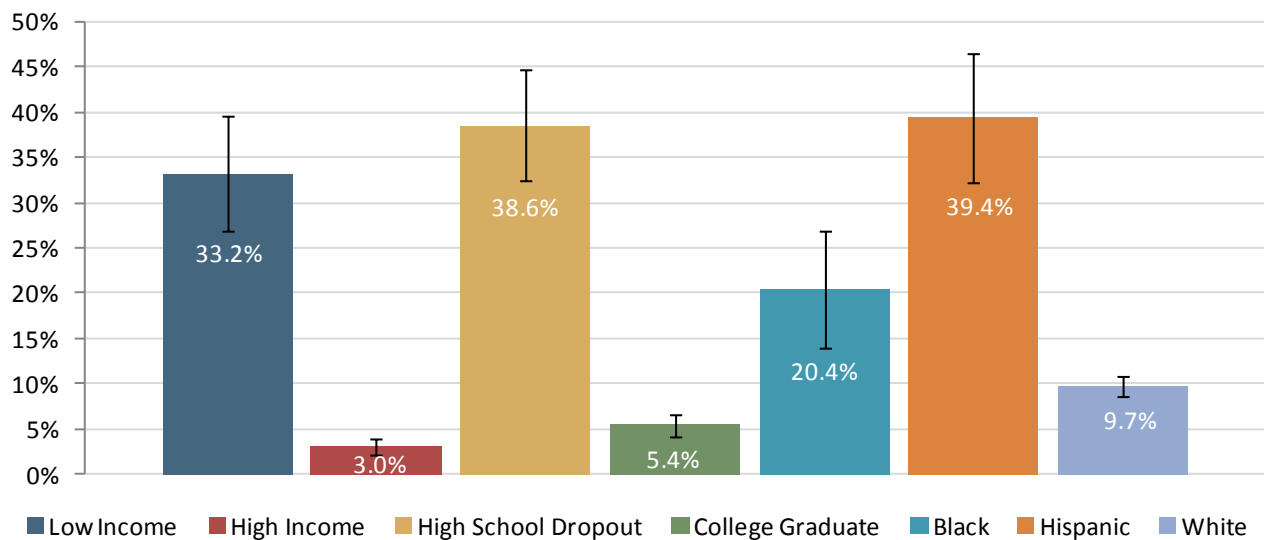
Other indicators are the percentage of adults over 65 who are vaccinated for flu and pneumonia. The most recent data showed the 68.6% of older Kansans received a flu shot in the past year and 68.5% had a pneumonia immunization.

### Access to Care

The final health indicator discussed by “Healthy Kansans 2010” is access to health care. In Kansas, 12.5% of residents are uninsured. This includes 8.1% of all children and 21.9% of young adults (BRFSS, 2010). Disparities are prevalent based upon race/ethnicity, income, and education level. Key disparities are highlighted in Figure 14.

Prenatal care is a vital indicator of birth outcomes with an emphasis on starting care within the first trimester of the pregnancy. Overall, three out of four Kansas women started prenatal care in the first trimester, but 41.6% of Hispanic/Latino, 37.8% of Black, and 33.5% of Native American women didn’t start care early enough. Black and Hispanic/Latino women were about four times as likely to have no prenatal care than were White women (KDHE Vital Statistics, 2010).

**Figure 14: Percentage of Key Kansas Population Groups without Health Insurance**



Source: BRFSS, 2010

Notes: Low Income defined as < than \$15,000 annual household income; High Income defined as > \$50,000 annual household income or more. Black and White groups are non-Hispanic. Error bars represent 95% confidence intervals.

The average life expectancy for a Kansas baby born in 2007 was 78.4 years, slightly lower than the U.S. Average. Females (80.8 years) are expected to live longer than males (75.9 years). As with key health indicators, disparities are found in how long people are estimated to live. Estimates show that Hispanic/Latino (85.4 years) and Asian Kansans (84.0 years) will live longer than White (78.6 years) or Black (73.9 years) residents of the State (Kaiser Health Foundation, 2011). The following report will describe disparities in the top five causes of death for Kansans in 2010. Rates for key demographic groups for each of these causes are listed in Table 2. Disparities in diabetes and infant mortality are also discussed. Diabetes is included because of its continued rise and interconnection to a variety of social determinants of health. Infant mortality is included as an indicator of interest because infant mortality is a bellwether of the health of a state and a nation.

**Table 2. Death Rates for Leading Causes of Death by Race/Ethnicity**

Cause of Death	Black	Hispanic/Latino	White	Other
Heart Disease	200.98 (200.44 – 201.53)	91.66 (91.46 – 91.85)	166.15 (166.02 – 166.27)	213.24 (212.54 – 213.95)
Cancer	233.89 (233.26 – 234.53)	103.21 (102.98 – 103.43)	171.63 (171.50 - 171.76)	201.75 (201.09 – 202.42)
Cerebrovascular Disease	64.51 (64.33 – 64.68)	29.03 (23.09 – 36.04)	42.31 (42.28 – 42.34)	72.41 (72.17 – 72.65)
Chronic Lower Respiratory Disease	33.13 (33.04 – 33.22)	14.28 (10.20 – 19.45)	52.39 (52.35 – 52.43)	63.18 (62.98 – 63.40)
Unintentional Injuries	32.93 (32.94 – 33.02)	34.05 (33.98 – 34.13)	41.21 (41.18 – 41.24)	40.62 (40.48 – 40.75)

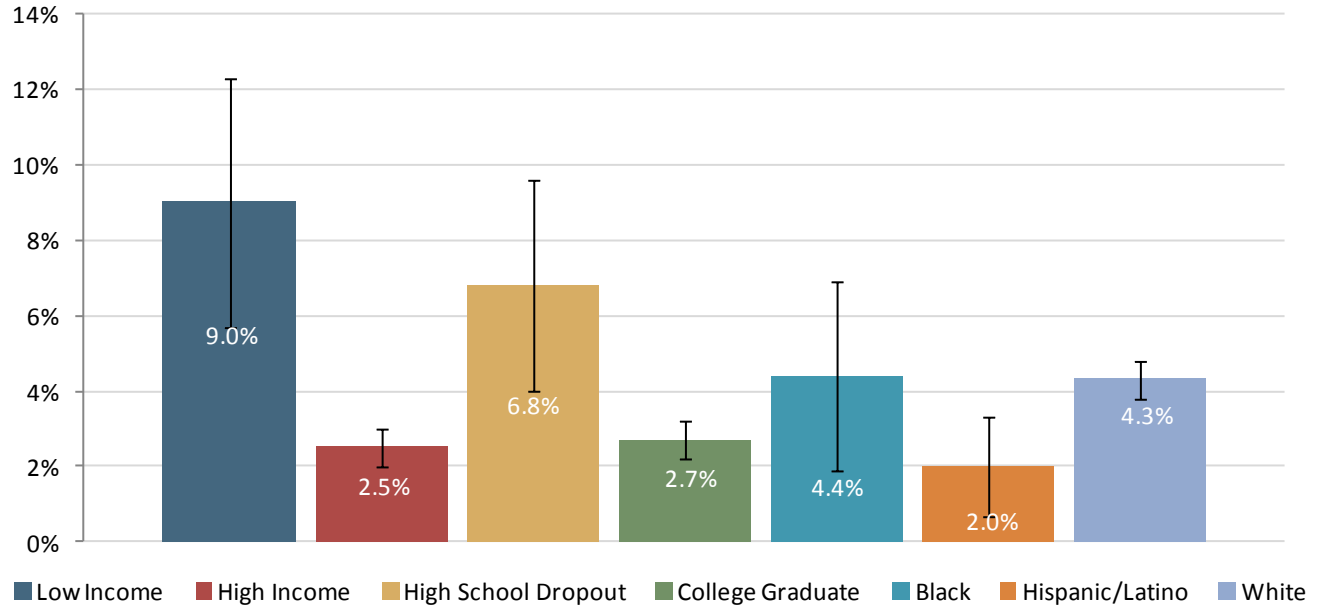
Source: KDHE Vital Statistics, 2010

Notes: Death rates defined as age-adjusted rates per 100,000 for 2010. Black and White groups are non-Hispanic. 95% confidence intervals displayed in parentheses.

## Heart Disease

Heart disease is the leading cause of death in Kansas, claiming more than 16,000 lives in 2010 alone. Hispanic/Latino Kansans are the least likely to die from heart disease (91.65 deaths per 100,000 population) compared to White (166.15), Black (200.98) and Other races (213.24) (KDHE Vital Statistics, 2010). Over four percent of Kansans report that they have been diagnosed with heart disease (BRFSS, 2010). As shown in Figure 15, these rates vary by race/ethnicity, income, and education level.

**Figure 15: Percentage of Key Kansas Population Groups Diagnosed with Heart Disease**



Source: BRFSS, 2010

Notes: Low Income defined as < \$15,000 annual household income; High Income defined as > \$50,000 annual household income or more. Black and White groups are non-Hispanic. Error bars represent 95% confidence intervals.

As shown in Table 3, similar disparities are seen in heart attack risk and blood pressure. Multiracial Kansans reported higher heart attack risk than other groups. Low income and Black Kansans were more likely to suffer from high blood pressure (BRFSS, 2009).

**Table 3. Percentage of Kansans Reporting Heart Attack and High Blood Pressure**

Group	Heart Attack	High Blood Pressure
Black non-Hispanic	2.9 (1.5 – 4.1)	38.6 (33.9 – 43.3)
Hispanic/Latino	2.2 (1.0 – 3.4)	20.3 (16.7 – 23.9)
White non-Hispanic	4.2 (3.7 – 4.6)	29.0 (28.1 – 29.3)
Other	5.5 (1.7 – 9.3)	22.2 (17.3 – 27.2)
Multiracial	12.3 (5.2 – 19.4)	30.0 (23.3 – 36.8)
Low Income	9.3 (6.2 – 12.4)	34.7 (30.9 – 38.5)
High Income	2.0 (1.5 – 2.4)	23.6 (22.5 – 24.7)
High School Dropout	7.8 (4.8 – 10.7)	32.8 (29.2 – 36.4)
College Graduate	2.6 (2.1 – 3.0)	24.4 (23.2 – 25.6)

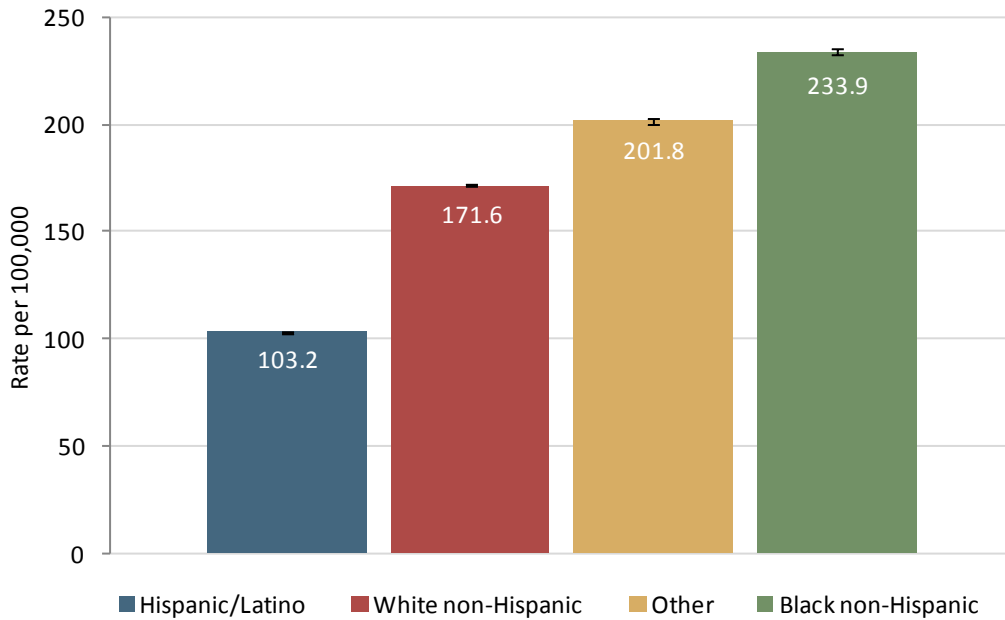
Source: BRFSS, 2009-2010

Notes: Other includes all other non-Hispanic races. Multiracial is defined as two or more races. Numbers in parentheses are 95% confidence intervals.

## Cancer

The second leading cause of death for Kansans is cancer. As shown in Figure 16, Black Kansans were the most at risk to die of cancer in 2010 with a rate of 234 per 100,000 residents. This was significantly higher than Hispanic/Latino (103.21) and White (171.63) rates. In cancer, early detection is a key, but data shows that Kansans with less annual household income and education are less likely to get screened. Disparities in screening for men and women of different education levels are shown in Figure 17.

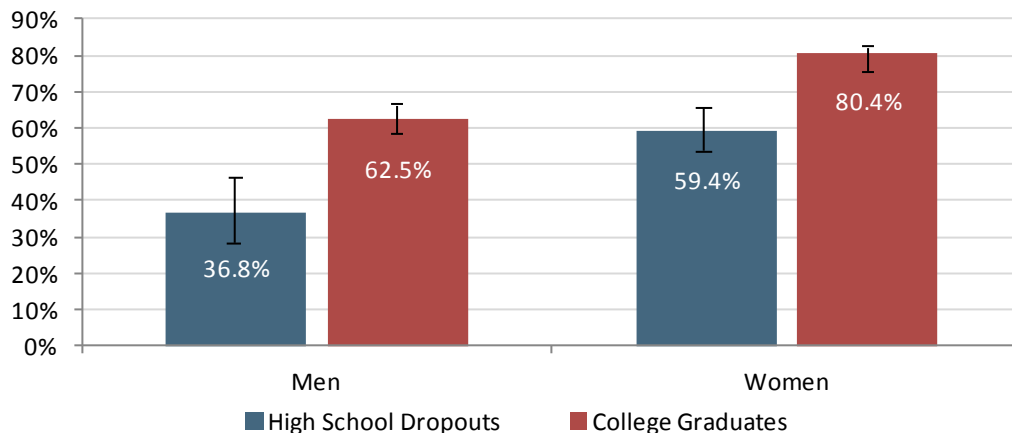
**Figure 16: Rate of Cancer Death by Race/Ethnicity**



Source: Vital Statistics, 2010

Note: Other includes all unrepresented non-Hispanic groups. Error bars represent 95% confidence intervals.

**Figure 17: Percentage of Kansas Woman and Men (40+) Receiving Screening for Breast/Prostate Cancer**



Source: BRFSS, 2010

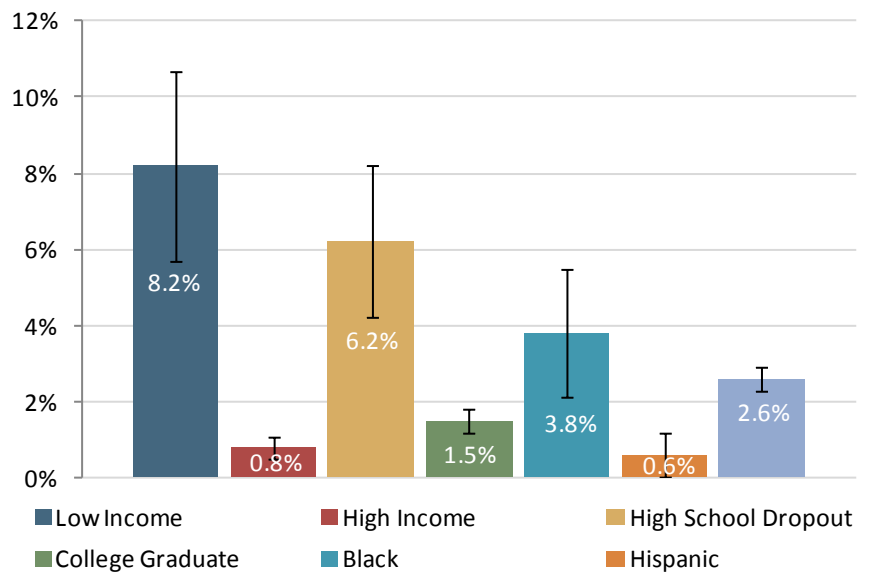
Note: Error bars represent 95% confidence intervals.

## Cerebrovascular Disease

Cerebrovascular disease, most commonly referred to as stroke, was the cause of death for 4,314 Kansans in 2010. Kansans of “other” races had the highest rate of death due to stroke (72.41) followed by Blacks (64.51). Hispanic/Latinos across the state had the lowest rate of death from cerebrovascular disease at 29.03 (BRFSS, 2010).

Survey data shows that 2.6% of Kansans report having had a stroke. As shown in Figure 18, these numbers vary greatly based upon race, income, and level of education (BRFSS, 2010).

**Figure 18: Percentage of Key Kansas Population Groups Diagnosed with Stroke**



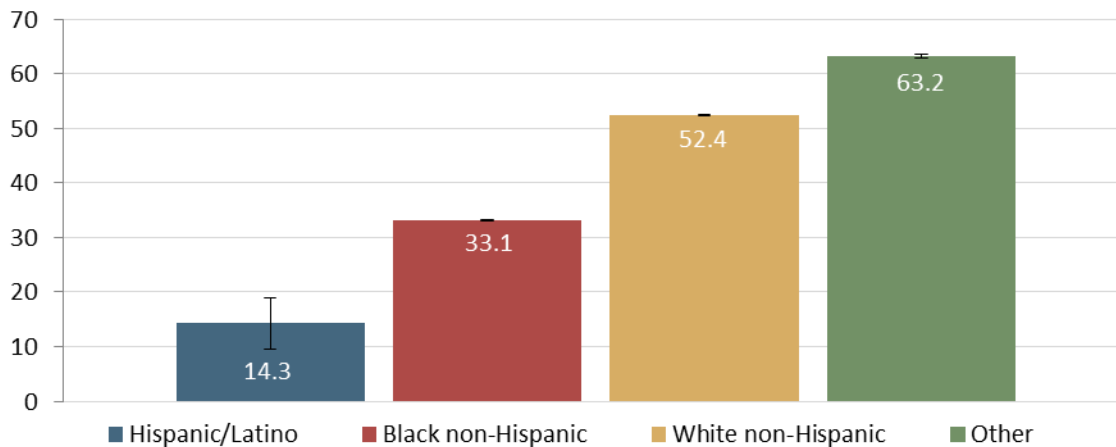
Source: BRFSS, 2010

Note: Black and White groups are non-Hispanic. Error bars represent 95% confidence intervals.

## Chronic Lower Respiratory Diseases

Chronic lower respiratory diseases were the primary cause of 4,773 deaths in Kansas during 2010. These diseases include bronchitis, emphysema, asthma, and other conditions. As shown in Figure 19, members of Other races (63.2 per 100,000 population) and Whites (52.4) were much more likely to die from chronic lower respiratory disease than were Hispanic/Latinos (14.3).

**Figure 19: Age-Adjusted Rates of Chronic Lower Respiratory Disease Death by Race/Ethnicity**



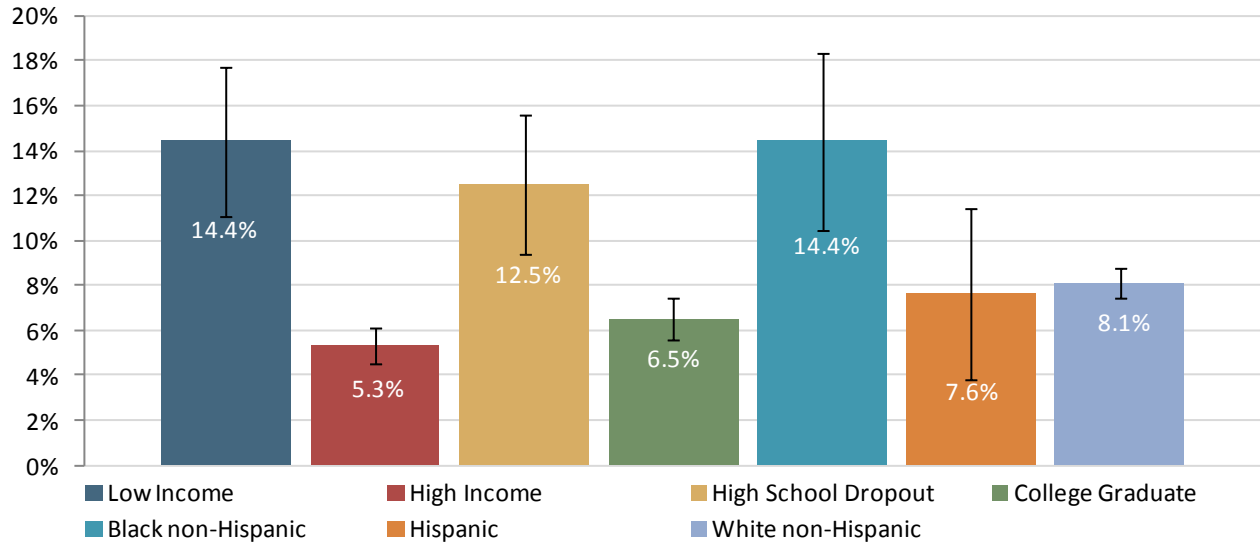
Source: KDHE Vital Statistics, 2010

Note: Other includes all unrepresented non-Hispanic groups. Error bars represent 95% confidence intervals.

## Diabetes

Diabetes is both a leading cause of death (7th in 2010) and a major risk factor for heart disease and stroke. Over 8% of Kansans report having been diagnosed with diabetes with a greater burden falling on certain groups. Figure 20 displays disparities in diabetes diagnosis in Kansas.

**Figure 20: Percentage of Key Kansas Population Groups Diagnosed with Diabetes**



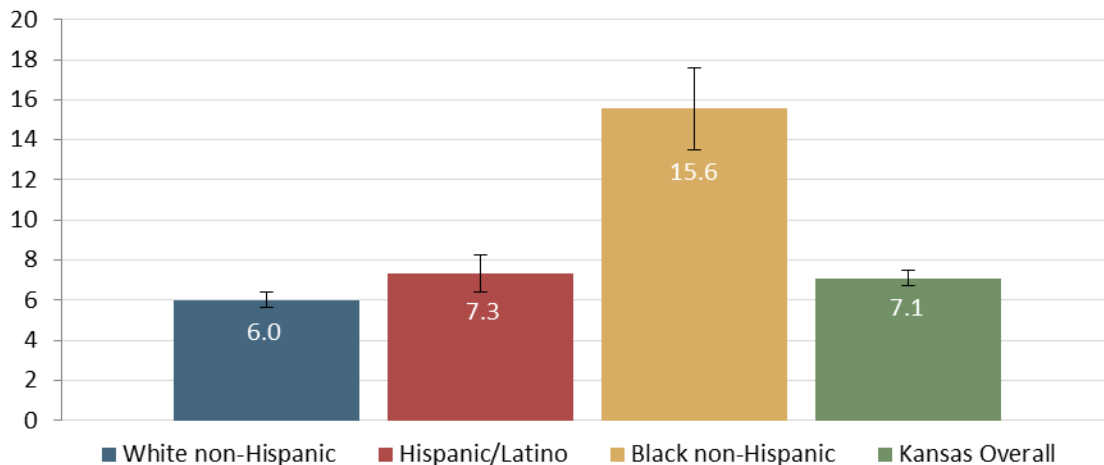
Source: BRFSS, 2010

Note: Low Income defined as < \$15,000 annual household income; High Income defined as > \$50,000 annual household income or more. Error bars represent 95% confidence intervals.

## Infant Mortality

Disparities are also prevalent in the rate of infant death. The infant mortality rate is defined as the number infant deaths (under 1 year of age) per 1,000 live births. In Kansas, babies born to Black mothers are more than twice as likely to die in their first year of life than are White or Hispanic/Latinos. The disparity in rates is illustrated in Figure 21.

**Figure 21: Infant Mortality Rate by Maternal Race/Ethnicity**



Source: KDHE Vital Statistics, 2006-2010

Notes: Error bars represent 95% confidence intervals.

## Background

In 2005, the Office of Minority Health (eventually the Center for Health Equity) was established by executive order of the Secretary of Kansas Department of Health and Environment (KDHE), Roderick L. Bremby. Sharon Goolsby was named the Center's director, and the Advisory Committee was established in September 2005. They were charged to help institute a framework for addressing and eliminating health and health care disparities for racial, ethnic and tribal populations in the state. During 2005 and 2006, the Advisory Committee participated in facilitated strategic planning activities, releasing the first statewide plan in 2007. The Advisory Committee has remained a permanent committee since then.

In 2009, the strategic plan was updated for FY 2011-2015. Through work with the Region VII Office of Minority Health, a technical revision of the plan released in 2010.

In 2010, the Center transitioned from the Office of the Secretary to the Division of Health, and Aiko Allen was hired as the new Director. Also this year, the Center for Health Equity (CHE) was awarded its first federal grant from Health and Human Services (HHS), Office of Public Health Sciences; this grant supports its operation as a state Office of Minority Health. CHE is a member of Region VII (including Iowa, Nebraska, and Missouri). The grant award is for \$130,000 annually 2010 through 2013. The fiscal year goes from October 1 to September 30.

During the spring and summer of 2011, the Advisory Committee convened for intensive strategic planning sessions to thoroughly review and update the strategic plan, in consideration of current Kansas priorities and HHS grant requirements. This resulting plan focuses on the grant period FFY11 through FFY 13

In the summer of 2011, one of the first actions on the new strategic plan was implemented: KDHE Center for Health Disparities was renamed KDHE Center for Health Equity.

**Vision:** Promote health equity among all Kansans.

**Mission:** Address health disparities and differences in health status through shared leadership, collaboration, and advocacy.

**Goals:**

1. **Focal Point for Capacity Building:** Serve as a focal point empowering and supporting public health leadership to increase capacity to raise awareness and address health equity issues.

Three areas of capacity building:

- Strengthen infrastructure
- Resource hub
- Data

2. **Collaborative Partnerships:** Promote multi-sector collaboration with private, public, and tribal partners to improve the well-being of all Kansans by reducing health disparities.

3. **Funding:** Secure resources and funding to support Center for Health Equity efforts.

## Implementation

An actionable plan for the three goals is given on the following pages. The Center for Health Equity Director, Aiko Allen, the CHE Advisory Committee, and CHE Working Groups are playing an important role in implementing the plan. Four working groups have been formed around the goals:

- Infrastructure and Resource Hub Working Group
- Collaborative Partnerships Working Group
- Data Working Group
- Funding Working Group

<b>Goal #1 Focal Point for Capacity Building: Serve as a focal point empowering and supporting public health leadership to increase capacity to raise awareness and address health equity issues.</b>			
<b>Objective</b>	<b>Strategies and Activities</b>	<b>Outputs and Accountability Measures <i>Target Date</i></b>	<b>Responsible Party</b>
<b>Area: Strengthen Infrastructure</b>		<b>Overall Responsible Party: CHE Infrastructure/Resource Hub Working Group</b>	
<b>1.1 Build organizational identity, infrastructure and capacity within the Center for Health Equity (CHE)</b>	1) "Brand" and market CHE. a) Change name to "Center for Health Equity". b) Maintain, update, and advertise CHE website.	1) Utilize Division of Health bureaus to provide information about CHE as activities occur. a) Name changed by <i>June 2011</i> . Press release issued on <i>June 7, 2011</i> . b) CHE developed, maintained, up-to-date; website address included in all publications; <i>Ongoing</i>	CHE Infrastructure/Resource Hub Working Group, Advisory Committee a) Aiko Allen b) Aiko Allen, KDHE Communications Team
	2) Update and disseminate CHE Strategic Plan.	2) Plan completed and disseminated by <i>August 2011</i> .	Aiko Allen, Advisory Committee, Contractor
	3) Strengthen CHE Advisory Committee membership, roles, and responsibilities: a) Finalize 2011-2012 membership ("re-energized, engaged"). b) Develop and adopt bylaws. c) Utilize Advisory Committee and Strategic Plan to promote state, national, and tribal priorities and address reduction of health disparities.	3) CHE Advisory Committee strengthen through the following activities: a) 2011-2012 membership finalized by <i>July 2011</i> . b) Bylaws developed and adopted by <i>July 2011</i> . c) Advisory Committee workgroups by key Strategic Plan topic areas formed by <i>March 2012</i> . Advocacy network to support efforts statewide and with sovereign nations developed by <i>June 2013</i> .	Advisory Committee a) Aiko Allen, Advisory Committee b) Aiko Allen, Advisory Committee, approved by KDHE Secretary c) Aiko Allen, Advisory Committee, CHE Working Groups
<b>1.2 Support and strengthen the infrastructure within the Division of Health</b>	1) Integrate the CHE mission and goals into operation of the Division of Health. 2) Identify, coordinate, leverage, and communicate about existing resources within the Division of Health to address reduction of disparities.	1) Opportunities to include CHE in Division and agency planning efforts: number of participation opportunities documented by <i>December 2012</i> . 2) Participate in DOH bureau meetings and provide technical assistance to bureau directors as requested. <i>See also activities under Infrastructure Objective 1.1 in the CHE Year 2 Grant Program Plan.</i>	1) Aiko Allen, Bureau Directors 2) Aiko Allen, Bureau Directors, other KDHE staff and leadership
<b>Area: Resource Hub</b>		<b>Overall Responsible Party: Infrastructure/Resource Hub Working Group</b>	
<b>1.3 Provide educational resources on addressing, reducing, and eliminating health disparities</b>	1) Educate about the role of equity, social and economic determinants of health and cultural competence in community health assessment. 2) Post relevant information on website as it becomes available and maintain links to partner resources	1) "Unnatural Causes" video series provided to all 15 preparedness regions by <i>September 2012</i> . 2) Relevant information posted. Website reviewed and updated at least once a quarter. <i>Current and ongoing</i>	1) Aiko Allen, CHE Infrastructure/Resource Hub Working Group 2) Aiko Allen, KDHE Communications Team

**Goal #1 Focal Point for Capacity Building: Serve as a focal point empowering and supporting public health leadership to increase capacity to raise awareness and address health equity issues.**

Objective	Strategies and Activities	Outputs and Accountability Measures <i>Target Date</i>	Responsible Party
<p><b>1.4 Recommend experts on addressing, reducing, and eliminating health disparities.</b> Work through existing conferences and other established venues</p>	<p>1) Participate on Governor’s Public Health Conference planning committee to assure focus on reducing disparities.</p> <p>2) Engage Prevention Institute in follow-up training with public health stakeholders involved in public health accreditation, quality improvement, and community health assessment.</p> <p>3) Become a sponsor of Kansas Public Health Leadership Institute.</p> <p>4) Participate and promote addressing health disparities in KDHE strategic planning process.</p>	<p>1) Experts scheduled on conference agenda to address health disparities issues. <i>Annually April 2011, April 2012, April 2013.</i></p> <p>2) Public health stakeholders provided skills in integrating Prevention Institute concepts into accreditation, quality improvement, and community health assessment processes in Kansas. Provide information to, at a minimum, KDHE Bureau Directors, Kansas Health Institute, Multi-learning Collaborative <i>by September 2013.</i></p> <p>3) Sponsorship finalized by <i>May 2011</i>. One topic on equity, disparities, and social determinants included in training curriculum <i>by September 2012.</i></p> <p>4) Information provided for strategic planning process <i>July 26-27<sup>th</sup> 2011.</i></p>	<p>1) Aiko Allen, Governor’s Public Health Conference Planning Committee</p> <p>2) Aiko Allen, CHE Infrastructure/Resource Hub Working Group</p> <p>3) Aiko Allen, Suzanne Hawley, Shirley Orr</p> <p>4) Aiko Allen</p>
<p><b>1.5 Promote cultural competency in the public health workforce by training in health literacy and other cultural competency topics.</b></p>	<p>1) Complete regional training with local hospitals and Bureau of Community Health Systems on health literacy.</p> <p><i>Also see related activity under Infrastructure Objective 1.1 as well as activities with Infant Mortality Objective 1.5 activities.</i></p>	<p>1) Regional training provided in Bureau of Community Health Systems regions <i>by September 2012.</i></p>	<p>1) Aiko Allen, Sara Roberts, Toni Pickard</p>
<p><b>Area: Data</b></p>			<p><i>Overall Responsible Party: Data Working Group</i></p>
<p><b>1.6 Collect stories on the “why” behind health disparities and the potential root causes of and solutions for health disparities</b></p>	<p>1) Initiate contest of success stories related to health equity.</p> <p>2) Share success stories through electronic media.</p> <p>3) Record how stories or data is being utilized in the communities or among populations.</p>	<p>1) 12 winners selected (one per month) starting <i>March 2012.</i></p> <p>2) Winners posted in special section on webpage starting <i>May 2012.</i></p> <p>3) Partners surveyed (using SurveyMonkey) <i>by September 2012.</i></p>	<p>1) Aiko Allen, Jerry Schultz, Advisory Committee representatives review</p> <p>2) Aiko Allen, KDHE Communications Team</p> <p>3) Aiko Allen, CHE Data Working Group</p>

**Goal #1 Focal Point for Capacity Building: Serve as a focal point empowering and supporting public health leadership to increase capacity to raise awareness and address health equity issues.**

Objective	Strategies and Activities	Outputs and Accountability Measures <i>Target Date</i>	Responsible Party
<p><b>1.7 Identify, disseminate and promote utilization of relevant data to raise awareness of health disparities</b></p>	<ol style="list-style-type: none"> <li>1) Provide public health indicators for health chapter of the Kansas African American Affairs Commission report of the State of African American Affairs in Kansas.</li> <li>2) Review KDHE data products, such as Kansas Information for Communities legislative report cards, that can be improved or repackaged to highlight disparities data.</li> <li>3) Utilize “State of African Americans in Kansas” report as a sentinel product or model for future products.</li> <li>4) Determine readiness for State of Hispanic/Latino Americans health report.</li> <li>5) Meet with new director of Native American Affairs to learn priorities and exchange information about center for health equity.</li> <li>6) Work collaboratively with KDHE Data Dissemination workgroup to identify currently available race/ethnicity data and its uses. <i>See also Infrastructure Objective 2.1 activities in the CHE Year 2 Grant Program Plan.</i></li> <li>7) Collaborate with Workforce Development Public Health Accreditation Committee to identify products suitable or adaptable for “101” provider-level and community-level training sessions (including webinars) about collecting and using health disparities data.</li> </ol>	<ol style="list-style-type: none"> <li>1) “State of African Americans in Kansas” report disseminated by <i>August 2011</i>.</li> <li>2) Review and initiate at least one indicator addition or modification by <i>February 2012</i>. At least one data product modified/repackaged and disseminated by <i>December 2012</i>.</li> <li>3) Develop minimum of one product (issue brief or other document) based on “State of African Americans in Kansas” by <i>April 2012</i>.</li> <li>4) Report feasibility evaluated and documented <i>December 2012</i>.</li> <li>5) Documented exchange of information by <i>March 2012</i>.</li> <li>6) Tool developed and baseline public health race/ethnicity metadata collected by <i>July 2012</i>.</li> <li>7) At least one disparities data (cultural competency) training resource identified by <i>December 2012</i></li> </ol>	<ol style="list-style-type: none"> <li>1) Aiko Allen, Mildred Edwards</li> <li>2) Aiko Allen, Lou Saadi, Henri Menager, Rhonda Lewis, Chris Kirk, CHE Data Working Group, constituents</li> <li>3) Aiko Allen, Mildred Edwards</li> <li>4) Aiko Allen, Adrienne Foster of the Kansas Hispanic &amp; Latino American Affairs Commission</li> <li>5) Aiko Allen, new director of Native American Affairs Commission</li> <li>6) KDHE Data Dissemination Workgroup, CHE Data Working Group</li> <li>7) Suzanne Hawley, Toni Pickard, Patricia Thomas, CHE Data Working Group</li> </ol>

**Goal #1 Focal Point for Capacity Building: Serve as a focal point empowering and supporting public health leadership to increase capacity to raise awareness and address health equity issues.**

Objective	Strategies and Activities	Outputs and Accountability Measures <i>Target Date</i>	Responsible Party
<p><b>1.8 Regularly utilize media to disseminate information on CHE, health equity concepts, and health disparities data</b></p>	<p>1) Share this information in a redundant, consistent way with the media:</p> <ul style="list-style-type: none"> <li>- CHE exists</li> <li>- CHE is working for ALL Kansans</li> <li>- Examples of disparities we are working to help eliminate versus only periodic bursts of information on specific issues</li> <li>- Success stories; best practices of what has been accomplished related to disparities</li> <li>- Promotion of NPA and HHS plans</li> </ul> <p>2) Offer assistance and assure disparity information is being shared for monthly health promotional issues.</p>	<p>1) Basic communication plan developed to include social media, where applicable, <i>by April 2012</i>. Formal health communication and social marketing plan developed <i>by December 2012</i>.</p> <p>2) Information about disparities and equity included in national health promotion campaign months, distributed through KDHE and partner publications <i>starting March 2012, then ongoing</i>.</p>	<p>1) KDHE Communications Team, Jerry Schultz, Chris Kirk; <i>Note:</i> Assistance will be requested from KU Journalism class to see if there is interest in taking this on as a class project</p> <p>2) Chris Kirk, Bureau Directors, KDHE Communications Team, CHE Data Working Group</p>

**Goal #2 Collaborative Partnerships: Promote multi-sector collaboration with private, public, and tribal partners to improve the well-being of all Kansans by reducing health disparities.**  
*Overall Responsible Party: Collaborative Partnerships Working Group*

Objective	Strategies and Activities	Outputs and Accountability Measures <i>Target Date</i>	Responsible Party
<b>2.1 Re-engage and collaborate with established partners to address disparities</b>	1) Establish an email list of partners with existing lists (disseminators) that could be used for the distribution of health disparities/health equity information. Distribute to bureau directors.	1) Send updates to Bureau Directors for dissemination to their coalitions at least twice yearly and as special events warrant.	1) Aiko Allen, Bureau Directors
	2) Develop initiatives with health departments in the State to model efforts to systemically address health disparities.  <i>See also Infrastructure Objective 1.3 activities in the CHE Year 2 Grant Program Plan.</i>	2) Technical assistance provided to local health departments to address health equity issues. Initiative in place by <i>December 2012</i> .	2) Aiko Allen, CHE Collaborative Partnerships Working Group
	3) Identify and strengthen partnerships with statewide commissions, organizations, and other constituency groups, by collaborating on at least one initiative of mutual interest  <i>See also Infrastructure Objective 1.4 activities in the CHE Year 2 Grant Program Plan.</i>	3) a) Host event of mutual interest (e.g., town hall meeting) with Kansas African American Affairs Commission and Kansas Hispanic and Latino Affairs Commission identified and implemented by <i>December 2012</i> . Collaboration on infant mortality continued. <i>Ongoing</i> . b) Identify at least one activity of mutual interest with Native American Affairs Liaison, Kansas Disability Concerns Commission, and Army Onesource by <i>June 2013</i>	3) Aiko Allen, Mildred Edwards, Adrienne Foster, CHE Collaborative Partnerships Working Group
	4) Represent the State of Kansas and participate in initiatives and activities of the federal Office of Minority Health, Region VII Office of Minority Health, National Association of State Offices of Minority Health, and other groups/task forces.	4) Meetings attended as required/requested by OMH.	4) Aiko Allen, CHE Collaborative Partnerships Working Group

**Goal #2 Collaborative Partnerships: Promote multi-sector collaboration with private, public, and tribal partners to improve the well-being of all Kansans by reducing health disparities.**  
*Overall Responsible Party: Collaborative Partnerships Working Group*

Objective	Strategies and Activities	Outputs and Accountability Measures <i>Target Date</i>	Responsible Party
<p><b>2.2 Develop new partnerships and collaborate on at least one cross-cutting issue.</b></p> <p><i>Current issue of focus: Reduce the high infant mortality rate in Kansas</i></p>	<p>1) Continue statewide infant mortality awareness campaign</p> <p>a) Launch fall campaign in September (infant mortality awareness), October (SIDS), and November (prematurity)</p> <p>b) Enlist partners from other fields (e.g., education, mental health) to provide information on infant mortality</p> <p>c) Expand campaign to additional rural and urban areas of interest (e.g., Salina, Ft Riley/Geary County, Butler County)</p> <p>d) Implement evaluation plan for campaign</p> <p>e) Report program results</p> <p><i>See also Infant Mortality Objective 1.1 activities in the CHE Year 2 Grant Program Plan.</i></p>	<p>1) Infant mortality campaign continued through activities below:</p> <p>a) Campaign launched and continued <i>September - November 2011.</i></p> <p>b) Documented commitment from at least one new partner <i>by October 2011.</i></p> <p>c) Contact made and documented with at least one new partner in a smaller community and infant mortality awareness materials distributed through new community partner <i>by October 2011.</i></p> <p>d) SurveyMonkey survey distributed via email; results collected and compiled <i>by January 2012.</i></p> <p>e) Results reported to Blue Ribbon Panel <i>by February 2012.</i></p>	<p>1) Aiko Allen, Christy Schunn</p>
	<p>2) Develop and implement safe sleep disparities pilot project in Wichita focused on reducing the risks of Sudden Infant Death Syndrome (SIDS)</p> <p>a) Work with Black Nurses Association, churches, Healthy Start to assess strategies to reach expectant mothers and their social systems.</p> <p>b) Identify “grandmothers”, who will be trained to provide program content.</p> <p>c) Conduct program</p> <p>d) Develop and implement evaluation plan.</p> <p>e) Conduct listening sessions, focus groups, pre/post surveys with target audience</p> <p>f) Report program results</p> <p><i>See also Infant Mortality Objective 1.2 activities in the CHE Year 2 Grant Program Plan.</i></p>	<p>2) Safe Sleep Pilot implemented through the below activities:</p> <p>a) Meet with at least two partners and document results <i>by December 2011.</i></p> <p>b) Trainers identified <i>by March 2012.</i></p> <p>c) Program completed at least once <i>by September 2012.</i></p> <p>d) Evaluation plan developed and measurement tools completed <i>by September 2012.</i></p> <p>e) Completed <i>by November 2012.</i></p> <p>f) Report update at <i>April 2012</i> Blue Ribbon Panel meeting. Report results at <i>November 2012</i> Blue Ribbon Panel meeting.</p>	<p>2) Aiko Allen, Christy Schunn, CHE Collaborative Partnerships Working Group</p>

**Goal #2 Collaborative Partnerships: Promote multi-sector collaboration with private, public, and tribal partners to improve the well-being of all Kansans by reducing health disparities.**  
*Overall Responsible Party: Collaborative Partnerships Working Group*

Objective	Strategies and Activities	Outputs and Accountability Measures <i>Target Date</i>	Responsible Party
	3) Assess potential opportunities to adapt/adopt the Safe Sleep Campaign with American Indian/Alaska Native communities a) Conduct listening sessions with leadership in HIS and tribal health clinics, tribal social services, and coalitions. b) Develop training for community members and/or tribal health center staff. c) Implement program. d) Evaluate success. <i>See also Infant Mortality Objective 1.3 activities in the CHE Year 2 Grant Program Plan.</i>	3) Potential opportunities assessed through the following activities: a) At least one listening session conducted <i>by August 2012.</i> b) Training module identified or adopted <i>by October 2012.</i> c) At least one training session conducted <i>by December 2012.</i> d) Initial survey sent <i>by April 2012.</i>	3) Aiko Allen, Christy Schunn, CHE Collaborative Partnerships Working Group
	4) Expand the network of partners who support the Safe Sleep Campaign <i>See Infant Mortality Objective 1.4 activities in the CHE Year 2 Grant Program Plan.</i>	4) At least two new providers identified and disseminating resources <i>by August 2013.</i>	4) Aiko Allen, Christy Schunn, CHE Collaborative Partnerships Working Group
<b>2.3 Provide leadership and resources to strengthen <u>government-to-government relationships with sovereign nations.</u></b>	1) Introduce tribes to CHE.	1) Ambassadors' tour scheduled by a delegation from KDHE with all sovereign nations <i>by August 2012.</i>	1) Aiko Allen, Dee Ann DeRoin, CHE Collaborative Partnerships Working Group
	2) Facilitate listening sessions to understand perspectives of tribal government and tribal agencies regarding opportunities and challenges to improve health in these communities.	2) At least one session held for KDHE employees focused on government to government relationships <i>by July 2012. Work is ongoing.</i>	2) Aiko Allen, Dee Ann DeRoin, CHE Collaborative Partnerships Working Group
	3) Connect and build sustained relationships with tribes.	3) Develop a cultivation plan for sustained relationships between CHE/KDHE and the tribes, including the principles of working and building relationships. <i>Ongoing</i>	3) Aiko Allen, Dee Ann DeRoin, Jerry Briscoe, CHE Collaborative Partnerships Working Group

**Goal #2 Collaborative Partnerships: Promote multi-sector collaboration with private, public, and tribal partners to improve the well-being of all Kansans by reducing health disparities.**

Objective	Strategies and Activities	Outputs and Accountability Measures <i>Target Date</i>	Responsible Party
<p><b>2.3 Provide leadership and resources to strengthen <u>government-to-government relationships with sovereign nations.</u></b></p>	<p>4) Build on steps taken so far to exchange data between IHS health system and KDHE.</p> <p>a) Identify other states that are doing well as potential models/best practices for this data exchange.</p> <p>b) Build on work that has begun in Kansas, such as through Cancer registry.</p>	<p>4) Progress made through the following activities:</p> <p>a) Information gathered from at least one other state <i>by July 2012.</i></p> <p>b) At least additional one meeting held with Cancer registry staff to determine the status of their data exchange, lessons learned, and how this might be utilized to start other data exchange initiatives <i>by July 2012.</i></p>	<p>4) CHE Collaborative Partnerships Working Group, CHE Data Working Group</p>
<p><b>2.4 Foster awareness, discussions and dialogues around health equity in Kansas communities</b></p>	<p>1) Create a forum where interested parties and stakeholders can gather to discuss issues related to Health equity in Kansas. This may be a quarterly or monthly conference call with partners. Consider hosting forum groups by sectors (e.g., business, housing, education).</p>	<p>a) By January 2012, identify key sectors that have statewide organizations.</p> <p>b) By June 2012, identify leaders within organizations and/or others working with those organizations.</p> <p>c) By December 2012, develop deliverable message for a minimum of one sector.</p>	<p>1) CHE Advisory Committee and partners, Kansas African American Affairs Commission, CHE Collaborative Partnerships Working Group</p>

<b>Goal #3 Funding: Secure resources and funding to support CHE efforts.</b>			<i>Overall Responsible Party: Funding Working Group</i>
<b>Objective</b>	<b>Strategies and Activities</b>	<b>Outputs and Accountability Measures <i>Target Date</i></b>	<b>Responsible Party</b>
<b>3.1 Maintain <u>current funding</u></b>	1) Reapply for OMH grant when opportunity becomes available	1) Apply <i>approximately July 2013</i>	1) Aiko Allen
	2) Fulfill current OMH grant requirements	2) Grant requirements fulfilled; <i>ongoing through 2013</i>	2) Aiko Allen
<b>3.2 Seek <u>targeted, collaborative funding opportunities</u> to support the Center's focus</b>	1) Evaluate funding needs to support CHE's focus. Strategically seek targeted new funding to support Center's mission and objectives	1) Funding plan developed by <i>September 2012</i> . Incorporate strategic, targeted funding goals within funding plan.	1) Aiko Allen, CHE Funding Working Group
	2) Partner with others on funding opportunities to achieve mutually beneficial objectives a) Collaborate with partners on targeted funding opportunities b) Insert CHE activities within partners' grants	2) At least one collaborative funding effort within the DOH by <i>September 2011</i> . At least one collaborative funding effort external to the DOH by <i>December 2012</i> .	2) Advisory Committee, CHE Funding Working Group, DOH colleagues, other partners
<b>3.3 Engage in grant/funding opportunities and access to resources at the national level</b>	Promote National Partnership for Action and Health and Human Services plans to reduce disparities; receive OMH supplemental funding	Plans promoted, funding received <i>in June 2011</i>	Aiko Allen
<b>3.4 Increase funding opportunities for funding across KDHE Divisions</b>	Increase CHE's knowledge about the divisions' activities that may impact health equity	1) Identify a champion in the Division of Healthcare Finance and discuss common interests <i>by December 2012</i> . 2) Identify a champion in the Division of Environment and discuss common interests <i>by December 2012</i> .	Aiko Allen, Division representatives, Henri Menager, CHE Funding Working Group

**Disparities:** A particular type of health difference that is closely linked with social or economic disadvantage.

Health disparities adversely affect groups of people who have systemically experienced greater social and/or economic obstacles and/or a clean environment based on their racial or ethnic group, religion, socioeconomic status, gender, age, mental health, cognitive, sensory, or

physical disability, sexual orientation, geographic location, or other characteristic linked to discrimination or exclusion (National Partnership for Action).

**Health Equity:** When everyone can attain their full health potential and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances” (Centers for Disease Control and Prevention)

**Social Determinants:** Life-enhancing resources whose distribution across populations effectively determines length and quality of life.

This includes social conditions that have an impact on health:

- Social institutions (including cultural and religious institutions)
- Economic systems
- Political structures
- Surroundings (neighborhoods, workplaces, towns, built environments)
- Social relationships (position in social hierarchy, differential treatment of social groups, social networks)

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