NACCHO
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2017 Model Practices

Applicant Information

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Model Practice Title

Please provide the name or title of your practice: *

Cultivating a Culture of Health Equity by Strengthening a Partnership between Public Health and Community Organizers

Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select all the practice areas that apply.: *

- [ ] Access to Care
- [x] Advocacy and Policy Making
- [ ] Animal Control
- [x] Coalitions and Partnerships
- [ ] Communications/Public Relations
- [x] Community Involvement
- [ ] Cultural Competence
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Food Safety
- [ ] Global Climate Change
- [x] Health Equity
- [ ] HIV/STI
- [ ] Immunization
- [ ] Infectious Disease
- [ ] Informatics
- [ ] Information Technology
- [ ] Injury and Violence Prevention
- [ ] Marketing and Promotion
- [ ] Maternal-Child and Adolescent Health
- [x] Organizational Practices
- [ ] Other Infrastructure and Systems
- [x] Organizational Practices
- [ ] Primary Care
- [ ] Quality Improvement
- [ ] Research and Evaluation
- [ ] Tobacco
- [ ] Vector Control
- [ ] Water Quality
- [ ] Workforce
- [ ] Conference Theme: Bridging Clinical Medicine and Population Health

Other::

Is this practice evidence based, if so please explain. :

Yes. In Principles of Community Engagement, Second Edition, the U.S. Surgeon General makes a call for those of us working in public health to create strategic partnerships that will lead to improved health for our nation. “Creating these healthy environments for people of all ages will require their active involvement in grassroots efforts. Private citizens, community leaders, health professionals, and researchers will need to work together to make the changes that will allow such environments to flourish. Across the United States, coalitions are working together to create change, and we are already seeing results. The most effective collaborations include representation from various sectors—businesses, clinicians, schools, academia, government, and the faith-based community. This work is not easy, but it is essential.” Research conducted by Paul Speer, Associate Professor at Vanderbilt University, supports this idea. His work in the area of community organizing, social power, and community change focuses on studying organizational strategies for sustained civic engagement and improved health outcomes. Speer has published over 40 articles and chapters in a variety of journals including the American Journal of Community Psychology, Health Education & Behavior, and the American Journal of Public Health. His work continues to support the union of public health and community organizing and demonstrates positive outcomes. In a recent scholarly work titled “Community Organizing: Practice, Research and Policy Implications”, published in Social Issues and Policy Review (2015), Speer encourages the development of community organizing/public health partnerships in the following ways: “Public-sector entities can sometimes find shared purposes with grassroots organizing groups. More generally, they can design policy-making processes that allow for increased engagement with grassroots groups. In addition, they can often support the local community institutions on which organizing depends. For non-governmental organizations, community organizing groups should be considered as promising partners for community-driven health promotion and community development efforts. Community organizing also serves as a model for deeply democratic work oriented toward change in policies and systems.” The KCMOHD-CCO collaboration is a living, breathing, and working model of what Speers’ research supports regarding community organizing and public health.

Winnable Battles

To keep pace with emerging public health challenges and to address the leading causes of death and disability, CDC initiated an effort called Winnable Battles to achieve measurable impact quickly.Winnable Battles are public health priorities with large-scale impact on health and known effective strategies to address them. Does this practice address any CDC's seven Winnable Battles? If so, please choose from the following:: *

- ☐ Food Safety
- ☐ HIV in the U.S.
- ☐ Nutrition, Physical Activity, and Obesity
- ☑ Tobacco
- ☐ Healthcare-associated Infections
- ☐ Motor Vehicle Injuries
- ☐ Teen Pregnancy
- ☐ None

Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community
- Describe public health issue
- Goals and objectives of the proposed practice
- How was the practice implemented/activities
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
  - Were all of the objectives met?
  - What specific factors led to the success of this practice?
- Public Health impact of practice

- Website for your program, or LHD.

750 Word Maximum

Please use this portion to respond to the questions in the overview section. : *

Description of LHD/Demographics: As its name suggests, the Kansas City, Missouri Health Department (KCMOHD) serves the great city of Kansas City, Missouri, which stretches into four counties on the Missouri-Kansas boarder. It is home to a diverse population of approximately 475,361 individuals of various racial and ethnic background. Approximately 60% of Kansas Citians classify themselves as white, 30% as black, 3% as Asian, and less than 5% as any other race; 3% are multiracial. Approximately 10% consider themselves Hispanic or of Latino background. Similar to the U.S. average, our median age is 36, with almost half of the population between the ages of 25 and 54 years old. Issue: Unfortunately, Kansas City is not unique in having significant health inequities, influenced greatly by its history of geographic racial divides and systematic prejudice. In the early 2000s, KCMOHD came to this reality via local statistics that unveiled a 6.5-year difference in life expectancy at birth between white and black residents and a 13-year difference across our many zip codes. Of all deaths in KCMO at that time, approximately half were attributable to social, economic, and environmental factors. As a department, we would not stand for our citizens to die from these “unnatural causes”, but this was a very large task to undertake. To truly impact life expectancy and health outcomes, we needed to first address the “upstream” factors related to education, social support, employment opportunities, income, and others that were outside of the traditional role of most local health departments. Goals/Objectives: Our goal was to create the ability to address these important root causes while staying within our department’s means. We needed to expand our toolset without adding substantial costs, while recognizing that with this new project, we could be addressing some of the largest issues in public health. We needed to think critically and innovatively about how we could work in the community to address the inequities of health and society. At that time, the community engagement work in our department was more siloed and specific to our typical work. We needed experts who knew how to work more broadly and generally in community engagement. One such group of experts was CCO, Communities Creating Opportunity. Implementation: After discussing our concerns with our community partners, we realized that both groups could benefit from a direct and clearly-defined relationship. As a team, we created a clear and unique partnership through the formation of an MOU (Memorandum of Understanding), which defined each party’s roles and responsibilities and our joint objectives. The basic framework for the collaboration centers around five key areas: 1. A shared vision: creation of conditions for good health for all 2. A shared focus: elimination of health inequities based on race, class, gender and power 3. Alignment: local public health agencies with faith-based communities, neighborhood associations, labor groups, and more 4. A shared space: CCO is co-located within the health department 5. Shared outcomes and evaluation Results: As a result from this solidified partnership, both parties have seen incalculable reward. Social justice and health equity are now a part of the daily conversation for KCMOHD. CCO helps us mobilize the community and has helped to expand our sphere of influence. We have been able to provide CCO with important data assistance and networking that are key to our mutual successes. After just four years of working in an official partnership, all of our mutual objectives are either complete or making progress. Public Health Impact: The public health impact of our work has been very encouraging. In comparing data from before the start of our collaboration to the most recent available, the difference in life expectancy at birth between white and black residents has decreased from 6.5 years to 5 years. Life expectancy has also increased for all subpopulations of racial and gender categories. We have also seen geographic racial segregation decrease by approximately 7%. Additionally, Kansas City has seen an increase in employment and greater income equality, which we know are important “upstream” factors that enable residents to live healthier lives. While not all of these improvements can be attributed solely to this new collaboration, there is no doubt that this partnership has expedited numerous advocacy and policy changes. It is important to clarify that “this collaboration” does not just include the work of KCMOHD and CCO. Our efforts have involved the work and partnership of many other community groups, without whom this progress would not be possible. Websites: KCMOHD http://kcmo.gov/health/ CCO http://www.cco.org/ MOU http://kcmo.gov/health/wp-content/uploads/sites/6/2016/07/LHDoftheyearCCOMOU2016.pdf

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be (1) **new to the field of public health (and not just new to your health department)** OR **(2) a creative use of an existing tool or practice**, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

- Statement of the problem/public health issue
- What target population is affected by problem (please include relevant demographics)
    - What is the target population size?
    - What percentage did you reach?
- What has been done in the past to address the problem?
- Why is the current/proposed practice better?
- Is current practice innovative? How so/explain?
    - Is it new to the field of public health
      OR
    - Is it a creative use of existing tool or practice:
      What tool or practice did you use in an original way to create your practice? (e.g., APC development tool, The Guide to

Community Preventive Services, HP 2020, MAPP, PACE EH, a tool from NACCHO's Toolbox etc.)

- Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF Recommendations.)

2000 Word Maximum

Please state the Responsiveness and Innovation of your practice (2000 Word Maximum) : *

Problem Statement / Public Health Issue: The issue at hand is social injustice and structural inequities, leading to health inequities throughout Kansas City, Missouri. Approximately 20% of Kansas Citians live below the poverty level, but even though 60% of the total population classify themselves as white, only 11% of those below the poverty level are white. Comprising only 10% of the total population, those of Hispanic or Latino background make up 29% of those living in poverty. Comprising only 3% of the total population, 16% of those in poverty classify themselves as Asian. Also with only 3% of the total population, those are who multiracial make up 14% of those living below the poverty level. Living below the poverty line is an important “upstream” factor in determining one’s ability to make healthy decisions and avoid adverse events. Systematically, living in poverty predisposes residents to more risk. If we move up the stream, we also see stark differences for educational attainment. 94% of white children graduate high school, while only 86% of black children, 74% of Asian children, and 62% of Hispanic or Latino children graduate high school. We know that those with higher levels of education tend to have higher incomes and a better chance of not living in poverty. Moving one more step upstream, a March 2014 report by the U.S. Department of Education’s Office for Civil Rights found that Missouri is one of 11 states with higher gaps than the national average for school suspensions between black students and white students, for students of all genders. Keeping students in school is an important factor for graduation rates. These are systematic inequities that must be addressed by changing the narrative, developing endogenous leaders, and changing policy. “Building a Culture of Health means creating a society that gives all individuals an equal opportunity to live the healthiest lives possible, whatever their ethnic, geographic, racial, socioeconomic, or physical circumstances happen to be.” – Robert Wood Johnson Foundation’s From Vision to Action report Target Population: The KCMOHD aims to help empower and lift up these Kansas Citians who have been disadvantaged, and in so doing, lift up the entire population of Kansas City, Missouri. Efforts would be focused on groups that suffer disproportionately and can gain the most from intervention and prevention, such as children, minorities, convicted criminals, women, the uninsured, and those living in poverty. It is difficult to quantify all of our citizens who need additional support in this way. However, the target is to actually benefit the entire population of KCMO through these efforts (almost 500,000 individuals). Past Efforts: Prior to our current practice, the KCMOHD worked casually with CCO and other community partners in a traditional approach. We already had a lot of similar goals and advocated for many of the same changes, but we were not fully integrated. This left gaps in knowledge and power for both groups and led to duplicate work. “When it comes to improving health, well-being, and equity in America, we often say that we are all in it together. But we as a nation have largely addressed health issues in parallel tracks, with limited cross-sector collaboration.” – Robert Wood Johnson Foundation’s From Vision to Action report Current Practice and Innovation: Our current practice involves a formalized partnership with a well-known, established, historically faith-based community organizing group, CCO, through the formation of an MOU. CCO is driven to promote justice and equity throughout the community, and by making them a formal partner, justice and equity have become primary lenses for the work of the KCMOHD. Rather than working in the same areas but in silos, we now work more efficiently and in tandem due to our clearly defined mutual objectives. The notion of utilizing an MOU to improve partnerships is not new to the area of public health. For example, the Centers for Disease Control and Prevention has been using MOUs for several years to help establish clear community partner relationships with several of its divisions, particularly in the area of disaster preparedness. (http://www.cdc.gov/about/pdf/business/policy597.pdf) However, we believe that the KCMOHD-CCO partnership is an innovative use of an existing tool due to the depth and type of our collaboration. Our partnership is not one that operates simply out of convenience or just when the time calls for it. It is also not one that was entered into lightly. Our two groups sought each other out and recognized the tremendous impact we could have as a team. This courtship developed over 5 years before the MOU became official. After establishing shared objectives, CCO moved to co-locate in the health department, directly across the hall from the Director’s office. The Director then became a member of the CCO board, and the Chief Operating Officer of CCO become a chair of our Health Commission. (http://kcmo.gov/health/overview/) We are now an integrated team that works and resides together. Further, both KCMOHD and CCO have created new internal positions specifically designed to communicate with each other. CCO hired a new Community/Public Health Organizer and KCMOHD established the office of Community Engagement, Policy and Accountability in January 2016. The KCMOHD/CCO collaboration represents a strategic alliance that works to define a new narrative as “organized” public health to develop an “arena of power” that will help improve the quality of health and life for all Kansas Citians. In doing so, we have added to the Institute of Medicine’s 1988 statement of public health that “Public Health is what we do collectively, as a society, [through organized actions] to assure the conditions in which [all] people can be healthy.” Evidence: In Principles of Community Engagement, Second Edition, the U.S. Surgeon General makes a call for those of us working in public health to create strategic partnerships that will lead to improved health for our nation. “Creating these healthy environments for people of all ages will require their active involvement in grassroots efforts. Private citizens, community leaders, health professionals, and researchers will need to work together to make the changes that will allow such environments to flourish. Across the United States, coalitions are working together to create change, and we are already seeing results. The most effective collaborations include representation from various sectors—businesses, clinicians, schools, academia, government, and the faith-based community. This work is not easy, but it is essential.” Research conducted by Paul Speer, Associate Professor at Vanderbilt University, supports this idea. His work in the area of community organizing, social power, and community change focuses on studying organizational strategies for sustained civic engagement and improved health outcomes. Speer has published over 40 articles and chapters in a variety of journals including the American Journal of Community Psychology, Health Education & Behavior, and the American Journal of Public Health. His work continues to support the union of public health and community organizing and demonstrates positive outcomes. In a recent scholarly work titled “Community Organizing: Practice, Research and Policy Implications”, published in Social Issues and Policy Review (2015), Speer encourages the development of community organizing/public health partnerships in the following ways: “Public-sector entities can sometimes find shared purposes with grassroots organizing groups. More generally, they can design policy-making processes that allow for increased engagement with grassroots groups. In addition, they can often support the local community institutions on which organizing depends. For non-governmental organizations, community organizing groups should be considered as promising partners for community-driven health promotion and community development efforts. Community organizing also serves as a model for deeply democratic work oriented toward change in policies and systems.” The KCMOHD-CCO collaboration is a living, breathing, and working model of what Speers’ research supports regarding community organizing and public health.

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broad-based involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
    - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice
- Were other stakeholders involved? What was their role in the planning and implementation process?
    - What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)
- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

5000 words maximum

Enter the LHD and Community Collaboration related to your practice (5000 words maximum): *

Goals/Objectives: The goal of this collaboration was to create the ability to address important “upstream” factors and root causes in the Bay Area Regional Health Inequities Initiative (BARHII) Framework for Reducing Health Inequities while staying within our department’s means. (http://barhii.org/framework/) We needed to grow our ability to engage the community and mobilize for change without substantial additional cost. In doing so, our aim was to improve the overall health of the Kansas City, Missouri community with particular attention to closing the health gaps between many of our subpopulations. These groups included children, minorities, convicted criminals, women, the uninsured, those living in poverty, and any groups that suffer disproportionately or could gain the most from intervention and prevention. We divided our primary target measures into short- and long-term objectives. “Short-term” is relative, but in our language, it indicates a precursor measure to a long-term need. Many of these short- and long-term objectives are now included as top priorities in the Kansas City Health Commission’s 2016 – 2021 Community Health Improvement Plan (CHIP) https://data.kcmo.org/Health/KCMO-CHIP-2011-2016/gunq-ki6v. Short-term: • Improve the ability for convicted felons to find employment • Discontinue the ban for those convicted of drug-related crimes to get food stamp assistance • Raise the minimum wage to a living wage • Increase the availability of paid parental leave • Raise the legal age to purchase nicotine and vapor products to 21 years old and strengthen our clean indoor air ordinance • Increase awareness of the importance of early childhood learning • Decrease the amount of high-interest predatory lending Long-term: • Lower unemployment rates for all, but particularly for minority groups • Improved life expectancy for all zip codes • Smaller differences in life expectancy across zip codes • Less income inequality between racial/ethnic groups • Reduce the number of residents using or exposed to tobacco/nicotine products • Improved rates of 3rd graders being able to read at grade level • Higher rates of high school graduation for all, but particularly for minority groups Prior to the formation of the MOU, the community engagement work in our department was more siloed. We needed experts who knew how to work more broadly and generally in community engagement. One such group of experts was CCO, Communities Creating Opportunity, a primarily ecumenical faith-based community organizing group with a 39-year history of working toward a more socially-just society. Selection Criteria: CCO was specifically selected by KCMOHD, distinct from other well-known community organizing groups in the area, to engage in this unique arrangement because of their ability to quickly mobilize people around important issues and command influence in spheres where health departments are traditionally limited. They were also chosen because of their approaches in difficult, dividing situations. They are skilled at working with individuals and organizations from across the political spectrum in ways that lead to more fruitful, less divisive exchanges than might otherwise occur. Steps and Timeframe: The KCMOHD and CCO first recognized and began a casual partnership in 2007 when we began appearing at the same meetings and community events to promote the same issues and change. After working together in a traditional approach for a few years, CCO invited the Director of KCMOHD to join them at the first National Community Organizing and Public Health Exploratory Meeting in 2010. Shortly after this meeting, our two groups wanted to formalize the partnership and began writing the MOU in 2011. It was officially signed in the spring of 2012. After a few years of working within the guidelines of the MOU and evaluating the processes, the MOU was updated in January 2016 to strengthen the partnership and to make the objectives and practices more specific. Stakeholders and Role: The two major stakeholders in this partnership are the KCMO health department and CCO. However, as with any successful community organizing, this collaboration has involved working with other community groups and stakeholders as appropriate. CCO acts as the community engagement specialist and has worked with over 100 faith-based leaders and their congregations to gauge the pulse of the community, develop endogenous leaders, and mobilize them around key issues. KCMOHD continues to grow a team of statisticians and provides the data and statistical evidence needed to support and drive initiatives. We also partner with local safety net providers and hospitals to gather key health data and identify gaps. As a result of this partnership, the Mayor’s Health Commission has also been chartered. In 2001, this group was a Mayor’s task force via resolution. In 2006, it became an advisory board via city ordinance. With CCO’s help, in 2014, Kansas City residents voted to include this group in the City’s Charter. CCO has also helped KCMOHD remain as only one of five charted departments in the City. The Health Commission is now a citywide Mayoral-appointed health equity Charter Commission made up of city council members, issue experts, business representatives, and other members of the community. Both the Director of the health department and the Chief Operating Officer of CCO serve as chairs on the Health Commission. This commission is responsible for overseeing the 5-year Community Health Improvement Plan (CHIP) and for meeting its objectives, and they help us advocate for Health in All Policies (HiAP). A health-related issue can be identified in many ways. It could be from the health department through evaluating new data; it could be from CCO through talking to community groups; it could be from the Health Commission through discussions with city council or other organizations. Once an issue is identified, the KCMOHD and CCO meet to discuss how it is impacting the health of the community. Key players and influential community leaders are identified (such as the Health Commission), a plan for influence around the issue is created using grassroots community organizing tactics, and data needs and information gaps are determined. Then a strategy is formed. Each agency works together and within their sphere of influence to create a movement that is stronger than either entity could achieve alone. The MOU acts as both a tool and a roadmap as the two agencies invest sufficient time and resources to achieve the intended health equity and social justice outcome within the targeted area/population. Associated Costs: The MOU process was easy to execute, requiring only the approval of KCMOHD’s Director and CCO’s CEO, and affordable with minimal costs associated with the execution of contracts and a pledged membership to CCO by KCMOHD. Although both organizations did eventually hire additional full-time staff as a result of this partnership, it is difficult to say how much extra cost that entailed. Much of that cost is offset by the additional impact we are having in the community through advocacy, grants, etc. The MOU between KCMOHD and CCO enables the health department to function as if it had its own community organizing division while experiencing tremendous cost savings from not having hired, trained and maintained its own community organizing division. It is estimated that this process has saved KCMOHD upwards of $1.5 million annually to create the same level of influence and change as could be achieved with its own internal community organizing division.

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice. Two types of evaluation are **process** and **outcome**. Process evaluation assesses the effectiveness of the steps taken to achieve the

desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
    - List any primary data sources, who collected the data, and how (if applicable)
    - List any secondary data sources used (if applicable)
    - List performance measures used. Include process and outcome measures as appropriate.
    - Describe how results were analyzed
    - Were any modifications made to the practice as a result of the data findings?

2000 Words Maximum

Please enter the evaluation results of your practice (2000 Words Maximum): *

Objectives and Achievement: The goal of this collaboration was to create the ability to address important “upstream” factors and root causes in the BARHII Framework for Reducing Health Inequities while staying within our department’s means. We needed to grow our ability to engage the community and mobilize for change without substantial additional cost. In doing so, our aim was to improve the overall health of the Kansas City, Missouri community with particular attention to closing the health gaps between many of our subpopulations. These groups include children, minorities, convicted criminals, women, the uninsured, those living in poverty, and any groups that suffer disproportionately or could gain the most from intervention and prevention. Our primary target measures for improvement include (results listed): Short-term: • Improve the ability for convicted felons to find employment o Via the “Ban the Box” campaign, removed the mandatory disclosure of criminal history on city job applications (2013) o Jackson County (2016) and the State of Missouri (2015) have also now adopted similar hiring policies • Discontinue the ban for those convicted of drug-related crimes to get food stamp assistance o Via the “Ban the Ban” campaign, removed the prohibition of providing SNAP benefits to those convicted of drug-related crimes (2014) • Raise the minimum wage to a living wage o City Council voted twice to approve an increase to the living wage (2015); however, that measure was preempted by the state, so now considering a state-wide ballot to make it official (2018) • Increase the availability of paid parental leave o The City of Kansas City, Missouri now offers 6-8 weeks of paid maternity and paternity leave following birth or adoption (2016), via vote of the city council • Raise the legal age to purchase nicotine and vapor products to 21 years old and strengthen our clean indoor air ordinance o Engaged stakeholders and the community to pass Tobacco 21, a city ordinance which raised the legal age to purchase tobacco from 18 to 21 and prohibiting the use of vapor products in enclosed public areas (2015) • Increase awareness of the importance of early childhood learning o Engaged more than 1,500 individuals in the Raising of America Kansas City campaign to view the Raising of America documentary and commit to support improving health outcomes for the city’s youth (2014) o Currently gathering support for a new property tax to fund universal, quality public education for 3- and 4-year-olds • Decrease the amount of high-interest predatory lending o Increased the number of banking institutions willing to provide small loans at reasonable rates (2012) o Currently working to promote legislation to cap the rate on payday loans Long-term: • Lower unemployment rates for all, but particularly for minority groups o Unemployment rates have decreased for all minority groups, and the gaps between groups have been reduced. In 2011, 6.6% of our white population was unemployed, while 20.2% of our black population and 12.2% of our Hispanic population were unemployed. In 2015, 4% of our white population, 7.9% of our black population, and 2.9% of our Hispanic population were unemployed resulting in a gap reduction of 9.7%. (2011 – 2015 American Community Survey) • Improved life expectancy for all zip codes o The difference in life expectancy at birth between white and black residents has decreased from 6.5 years to 5 years, and life expectancy has increased for all groups. (data from MO Department of Health and Senior Services, calculations performed by KCMOHD) • Smaller differences in life expectancy across zip codes o Geographic racial segregation has decreased by approximately 7% (using U.S. Census Data and the Index of Dissimilarity as published by William H. Frey, The University of Michigan Population Studies Center) o Initiatives to support these efforts were added to the Kansas City 5-Year Business Plan (https://data.kcmo.org/dataset/Submitted-FY-2016-2021-Citywide-Business-Plan/96gt-rafg) o Held the first ever KC Life Expectancy Summit to help integrate higher level goals into all city departments that will foster building a city-wide collaborative culture. The Life X Summit included presentations and interdepartmental collaborative discussions that addressed the life expectancy gap in six zip codes of our city. Small group discussions gave representatives from various city departments a space to innovate and brainstorm about opportunities and the chance to build off each other’s projects, in hopes of working together to achieve a common goal: improving the quality of life for all Kansas Citians. • Less income inequality between racial/ethnic groups o The percent of people living below the poverty level has decreased for all racial/ethnic groups (except those who classify themselves as “some other race”, not including white, black, American Indian, Alaska Native, or Pacific Islander), and the gap between ethnic groups has shortened from 20.3% to 18.9%. (2011 – 2015 American Community Survey) • Improved rates of 3rd graders being able to read at grade level o Added this goal as an initiative to the City’s 2016 – 2021 Community Health Improvement Plan • Higher rates of high school graduation for all, but particularly for minority groups o Added this goal as an initiative to the City’s 2016 – 2021 Community Health Improvement Plan Additionally: • Achieved a 70% voter approval rating to continue a citywide property tax for nine years and $15 million annually for illness and preventative health care for the indigent population (2014) Evaluation: KCMOHD and CCO are continually evaluating the partnership and MOU from each perspective and making adjustments to fit the needs of their shared goals. As the relationship has progressed, changes and adjustments have been made to create a stronger working environment. As an example, in 2012, CCO and KCMOHD co-located within the same building to increase and improve communication and working relationships across the two groups. This made joint-trainings, cross-trainings, agency education and day-to-day communication easier and more fluid. In addition, co-location provided cost savings for both, an advantage lauded by the leadership of both organizations, critical in a city with stiff competition for philanthropic dollars. As the practice has progressed, the two agencies have turned to the Community Engagement Continuum (Principles of Community Engagement, 2nd Edition) as a barometer in formally measuring the strength and effectiveness of community engagement outcomes as

a result of the MOU. The continuum illustrates five increasing levels of community involvement, impact, trust, and communication. The MOU has helped guide and focus our efforts to move through this continuum, and after almost a decade of working together, KCMOHD and CCO believe to have achieved the 5th level: shared leadership. The importance of reaching this level is that we see broader health outcomes affecting a broader community than we did when we were working in a more siloed and narrow approach. KCMOHD and CCO co-led the City's Robert Wood Johnson Foundation Culture of Health Prize application. To date, we are the only health department in the country to receive PHAB accreditation, NACCHO's Local Health Department of the Year award for our work in health equity, and to lead their community to a Robert Wood Johnson Foundation Culture of Health Prize. http://www.rwjf.org/en/library/articles-and-news/2015/10/coh-prize-kansas-city-mo.html "The collaborative efforts of the Kansas City Missouri Health Department and Communities Creating Opportunity are working to influence change in health equity across Kansas City. Their efforts are purposeful and address the root causes of disparity through a broad, peaceful and positive approach. They excelled in all six of our prize criteria." - Carrie Carroll, Researcher – University of Wisconsin – Population Health Institute We have also been selected by the Aetna Foundation, the American Public Health Association and the National Association of Counties as one of only six early adopters of the "Healthiest Cities and Counties Challenge" to create economically competitive, inclusive and equitable communities. The National League of Cities has also recognized our work in health equity. They have selected us, through a competitive process, to participate as one of only five cities in the Mayor's Institute on Housing, Hazards, and Health. We will contribute to a rich exchange with other partners around the country to focus on the health aspects of rental properties, particularly focusing on areas in which health disparities are most severe and pervasive.

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (*NACCHO acknowledges that fiscal challenges may limit the feasibility of a practice's continuation*.)

- Lessons learned in relation to practice
- Lessons learned in relation to partner collaboration (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
    - Describe sustainability plans

1500 Words Maximum

Please enter the sustainability of your practice (2000 Words Maximum): *

Lessons Learned (Practice): While many of these elements of the collaboration might have been achieved without the formal MOU process, the MOU created a clear level of accountability for each agency in the partnership. Each entity accepted the responsibilities that came with the formalized and strategic work. The MOU, as a tool, clearly delineated roles and responsibilities leaving little question as to the expectations of each organization. During the process, we learned that location counts. Bring any partnering agencies as close in physical proximity as possible. Frequent face-to-face interaction between the two organizations has become a new standard and has helped improve communication, expand collaboration, and foster creative problem solving. KCMOHD has greatly benefited from having CCO operate within the same building. Beyond the importance of creating a formalized MOU, the KCMOHD learned that the document is only as good as the spirit under which it is executed. Willingness to work together, trust each other, and operate outside of ego-driven political agendas has been imperative to success. Lessons Learned (Collaboration): While being innovative is beneficial, we do not need to reinvent the wheel. It is important to identify key individuals and entities that can help with community organizing and accessing people of power who can influence social change. Operate within your own expertise and strength; allow your organization to utilize others to diversify your skills, tools, resources and reach. It is also important to give the practice the time it needs to grow. This process takes time and commitment to long-term change. In Kansas City, it took several years to build this model and realize its potential to impact health outcomes. KCMOHD dedicated approximately four years to shifting the perspective of its internal operations and helping employees understand why having these formal external partnerships is critical. For the CCO staff, they now participate in the health department's new employee orientation, and KCMOHD meets one-on-one with every CCO staff member. This helps both groups feel more integrated and to have a deeper working knowledge of each team's goals and processes. Finally, allow community organizing to remain external. Rather than starting from scratch to work on any issue, partnering with organizations that already know how to mobilize the community and expand the health department's sphere of influence is a key component. Keeping community organizing outside of your health department's formal internal structure allows for greater leveraging of power and resources. Cost/Benefit Analysis: No formal cost/benefit analysis was conducted on this arrangement. However, as mentioned previously, it is estimated that utilizing an established local community organizing agency saved KCMOHD upwards of $1.5 million annually in costs associated with creating and operating its own community organizing division. The successful work done through this collaboration to improve resources for health initiatives does provide additional revenues and cost savings for the community. For example, the efforts of KCMOHD and CCO assisted in achieving a 70% voter approval for a property tax in Kansas City, providing an additional $15 million in annual support for illness and preventative health services. With the additional successes through employment, education, and income equality, the actual fiscal benefit is near-impossible to quantify. Commitment to Sustainability: Sustaining the KCMOHD-CCO collaboration is relatively seamless, a highly desired attribute in any partnership. For the KCMOHD, it is hard to consider operating without the help of CCO. As a team, we are very pleased with our successes, but we recognize that this is only the beginning; we have many more initiatives in the works and are committed to seeing them through to create a healthier and more equitable Kansas City: • Establish a system of early voting in KCMO and our counties • Continue our work to expand Medicaid • Help establish a regional and, eventually, statewide prescription drug monitoring program • Work to pass a property tax in support of early learning programs for 3 and 4-year-olds • Pursue a voter-approved rental housing inspection ordinance By establishing a chartered Health Commission and getting key health equity improvement objectives into the City's 5-year business plan, we have ensured that health equity will continue to be a major part of the conversation in Kansas City, Missouri for the foreseeable future. The KCMOHD also recently hosted the City's first ever LifeX Summit. This summit included directors and deputy directors from all departments of the City to help bring to the forefront the importance of life expectancy and quality of life to the work that we all do. The discussions that were held and the potential projects that were identified will spur continuous work in health equity throughout the City for years to come. Furthermore, as this work is being recognized around the county, this partnership has been asked to hold multiple sessions and workshops in which other organizations can learn from our work and take advantage of what is already being done. So far, we have held a workshop at the annual NACCHO meeting, a webinar and workshop for the National League of Cities, and several other workshops and webinars, including a regional Public Health 3.0 developmental meeting. Through these efforts, our work will continue to evolve and to grow, not only in this partnership, but with the greater public health community at-large. As public health and society-at-large continue to grow and change, Kansas City's public health system, which includes community organizing agencies, is ready to evolve with them and continue to respond to the greatest needs of our population.

Additional Information

How did you hear about the Model Practices Program:: *

- [x] I am a previous Model Practices applicant
- [ ] At a Conference
- [ ] NACCHO Website
- [ ] Public Health Dispatch
- [ ] Colleague in my LHD
- [ ] Model Practices brochure
- [ ] NACCHO Exhibit Booth
- [ ] NACCHO Connect
- [ ] Colleague from another public health agency
- [ ] E-Mail from NACCHO
- [ ] NACCHO Exchange