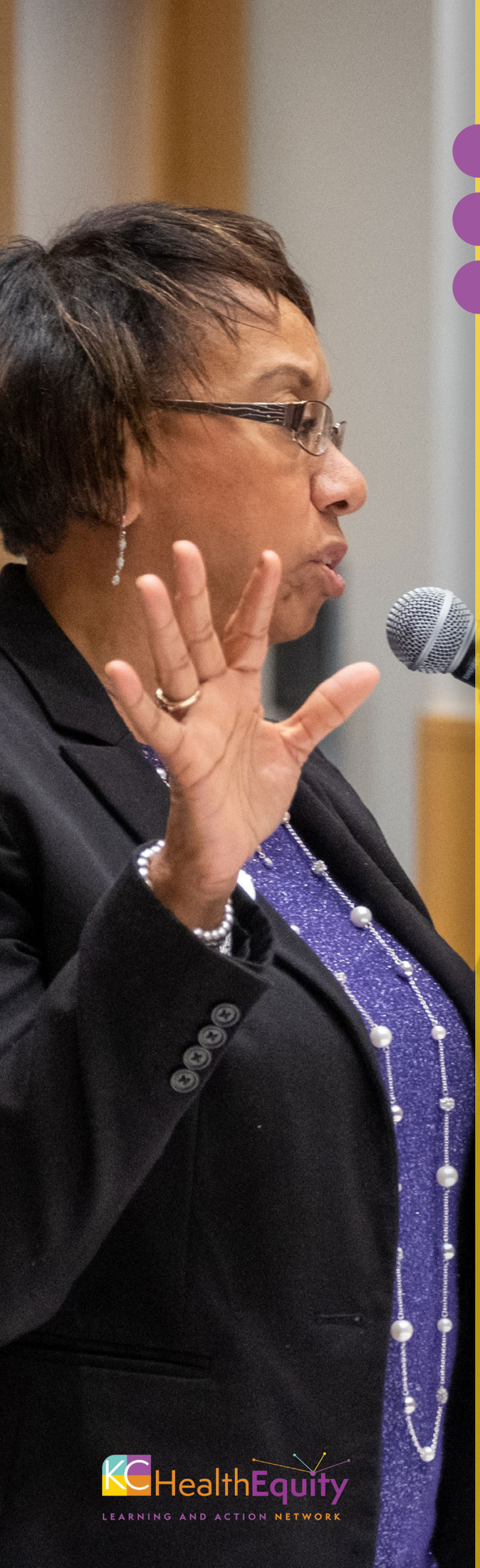
KC HealthEquity
LEARNING AND ACTION NETWORK

LAN Whitepaper

2022 - 2024



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LAN:
The Making of a Movement.

Watch Now

A long history of medical racism, accentuated by the COVID-19 pandemic, gave way to a community of people in the Kansas City region ardent for change. In 2020 plans began to unfurl for the LAN, fortified by the passage of Missouri Medicaid expansion – a ballot measure that was a signature win for Health Forward. At the same time communities of color died at alarming rates from COVID.

At the height of the pandemic, Black, Hispanic/Latino, and Indigenous people had nearly three times the mortality rate of white people. At the same time, social injustice moved to the forefront with the racially motivated murders of Breonna Taylor, Ahmaud Arbery, and George Floyd. Conditions were ripe for the Kansas City Health and Action Network (the LAN) formed under the leadership of Health Forward Foundation.

CEO Qiana Thomason said philanthropy is often best suited to tavkle root cause illness.

She made calls to CEOs throughout the region and talked with grassroots leaders about their interest in the LAN. They were intrigued.

She also approached KCHC on the strength of their mission as a convening table and a health equity bent. And there was also a call to IHI as their health equity model brought people together from around the globe. From Thomason's vantage point, IHI's model would prove more efficacious for the LAN if it assumed a place-based approach in the Kansas City region, combining the expertise and lived experiences of the community. IHI was also intrigued. As COVID devastated the nation more than five years ago, moves were being made to address anti-Black racism in Missouri and Kansas' health systems.

SIDE BAR

COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time

Over the course of the COVID-19 pandemic, analyses of federal, state, and local data have shown that people of color have experienced a disproportionate burden of cases and deaths. This brief examines racial disparities in COVID-19 cases and deaths and how they have changed over time based on KFF analysis of data on COVID-19 infections and deaths from CDC. It updates a February 2022 analysis to reflect data through mid-2022, amid the ongoing surge associated with the Omicron variant. It finds:

- Total cumulative data show Black, Hispanic, American Indian or Alaska Native (AIAN), and Native Hawaiian or Other Pacific Islander (NHOPI) people have experienced higher rates of COVID-19 cases and deaths compared to White people when data are adjusted to account for differences in age by race and ethnicity.

- Disparities in infections and deaths have both widened and narrowed at various times over the course of the pandemic, with disparities generally widening during periods in which the virus has surged and narrowing when overall infection rates fall. In data that has not been adjusted for age, there were some periods when death rates for White people were higher than or similar to some groups of color. However, in the age-adjusted data, White people have lower death rates than AIAN, Black, and Hispanic people over most of the course of the pandemic and disparities are larger for AIAN, Black, and Hispanic people, reflecting an older White population and higher rates of death across all age groups among people of color compared to White people.

Continuing to assess COVID-19 health impacts by race/ethnicity is important for both identifying and addressing disparities and preventing against further widening of disparities in health going forward. While disparities in cases and deaths have narrowed and widened over time, the underlying structural inequities in health and health care and social and economic factors that placed people of color at increased risk at the outset of the pandemic remain. As such, they may remain at increased risk as the pandemic continues to evolve and for future health threats, such as the Monkeypox virus, for which early data show similar disparities emerging.

The inclusion of IHI was also important to have health systems, namely hospitals, come to the table and pay attention. IHI, coupled with Health Forward's reputation and respect in the community, created a collaboration that strengthened with the inclusion of KCHC.

The LAN's mission is to help community stakeholders and health systems understand the work of health equity through an anti-racism lens by addressing deep, long-standing, systemic health inequities experienced by people of color.

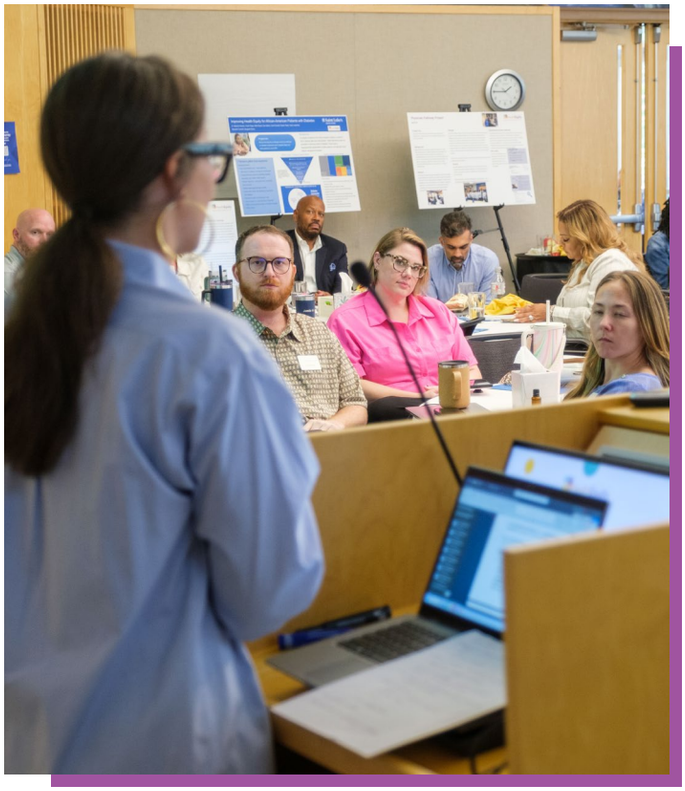
With this understanding, the design team, which consisted of patients, caregivers, and professionals from mental health, area hospitals, public health entities, and payers, spent two years planning, organizing, and developing the framework of the LAN.

Aspects of IHI's global health equity model were incorporated, specifically those frameworks that catered to public health and clinical settings. The LAN also intentionally coalesced the lived experiences and stories shared by people of color. These stories often illuminated inequities, including traumas from adverse clinical experiences. Among many things, it centered, humanized, and honored the voices and experiences of Black, Hispanic/Latino, and Indigenous people.

This allowed professional people of color to tell their stories and lived experiences. It helped lay the groundwork for understanding during the learning phase of the LAN. It also provided context for what performance improvement and adaptive thinking looks like with a health equity lens.

> "The LAN is a microcosm of the entire health care ecosystem where we can design bold, anti-racist practices, implement these practices, and then measure what happens in real time."

Hayat Abdullahi,
Director of Community Impact,
Health Forward Foundation



As the LAN's organizing body, they worked collaboratively to create high-quality health ecosystems rooted in equity, humanity, community, and anti-racist practices.

More than 50 organizations participate in the LAN, including federally qualified health centers (FQHCs), community-based health clinics, health systems, physicians, payers, employers, community mental health centers, community-based organizations, and public health departments.

The LAN includes a CEO roundtable, a learning cohort, and an action cohort that provides a forum for engagement. All three cohorts are guided by a shared agenda, with education, training, tools, and expertise to change systems, policies, and structures that perpetuate health inequity based on race and ethnicity. The ultimate goal is to eliminate disparities in health care delivery while developing the necessary competencies and practices to realize measurable improvements steeped in equity-centered, culturally responsive health outcomes for all health care consumers.

"The Health Forward Foundation, with its bevy of resources, had a duty to make health equity a critical part of its purpose and mission – and instigate the necessity of change in Kansas City."

Qiana Thomason,
President/CEO,
Health Forward Foundation

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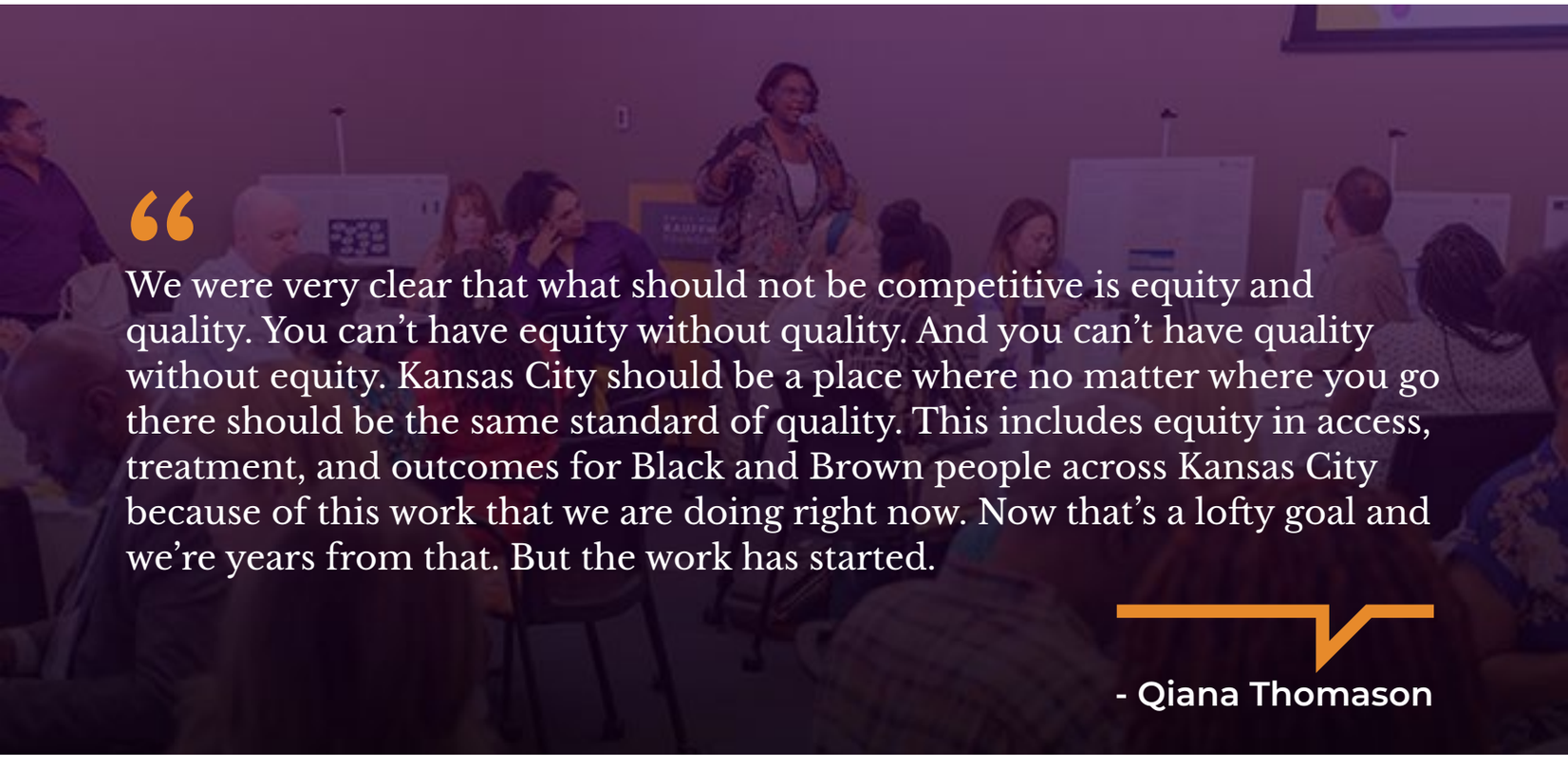
CEO Roundtable

Prior to the launch of the learning phase, the LAN engaged about 10 CEOs, many of whom represented competing health systems. Because Health Forward served as the primary funder, there was no financial commitment. However, CEOs were asked to make health equity a strategic priority within their organizations and approve the allocation of resources in existing and future budgets for this work.

Some codified their commitment by signing an attestation. From there, the CEO roundtable was formed. They were asked to leverage their positional power and authority, with help from the LAN, to be accountable for health equity. Although not taken through the same rigors that the LAN's learning and action teams experienced, the CEOs had their own shared learning experiences.

Many were stratified along a continuum of understanding of health equity and the historical and contemporary problems around racism. This stratification included knowing what racism and antiracism means. The CEOs also displayed varying degrees of connectedness to their individual power and authority to do something within their respective organizations and systems about health inequity and racist policies.



> "We were very clear that what should not be competitive is equity and quality. You can't have equity without quality. And you can't have quality without equity. Kansas City should be a place where no matter where you go there should be the same standard of quality. This includes equity in access, treatment, and outcomes for Black and Brown people across Kansas City because of this work that we are doing right now. Now that's a lofty goal and we're years from that. But the work has started.
>
> **- Qiana Thomason**

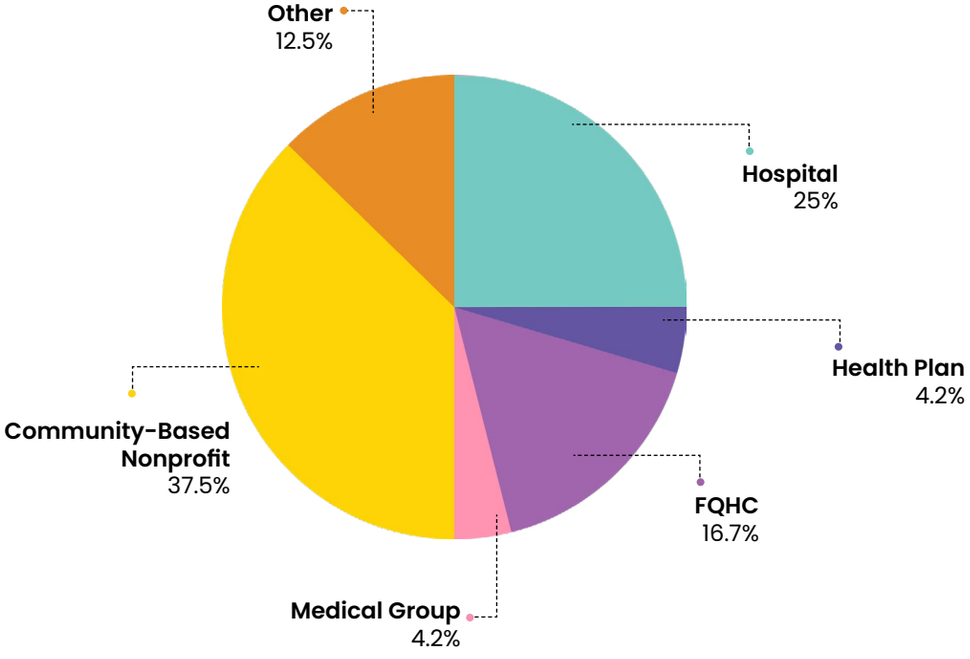
As a result, the LAN's principal charge was and is to connect people to their positional power and authority to address health equity.

This meant not allowing the buck to be passed to payers, clinicians, providers, or the state or federal government—with the understanding and acknowledgement that there are multiple systems at play.

It was made clear that this is a structural issue that took centuries to build, and it will take a long time to deconstruct. The LAN has remained committed to offering a safe space to do the work of health equity.

They rolled up their sleeves and met for two consecutive years concurrent with the learning phase that included many of the same individuals who work with these CEOs at their organizations and in their health systems.

Sectors Represented



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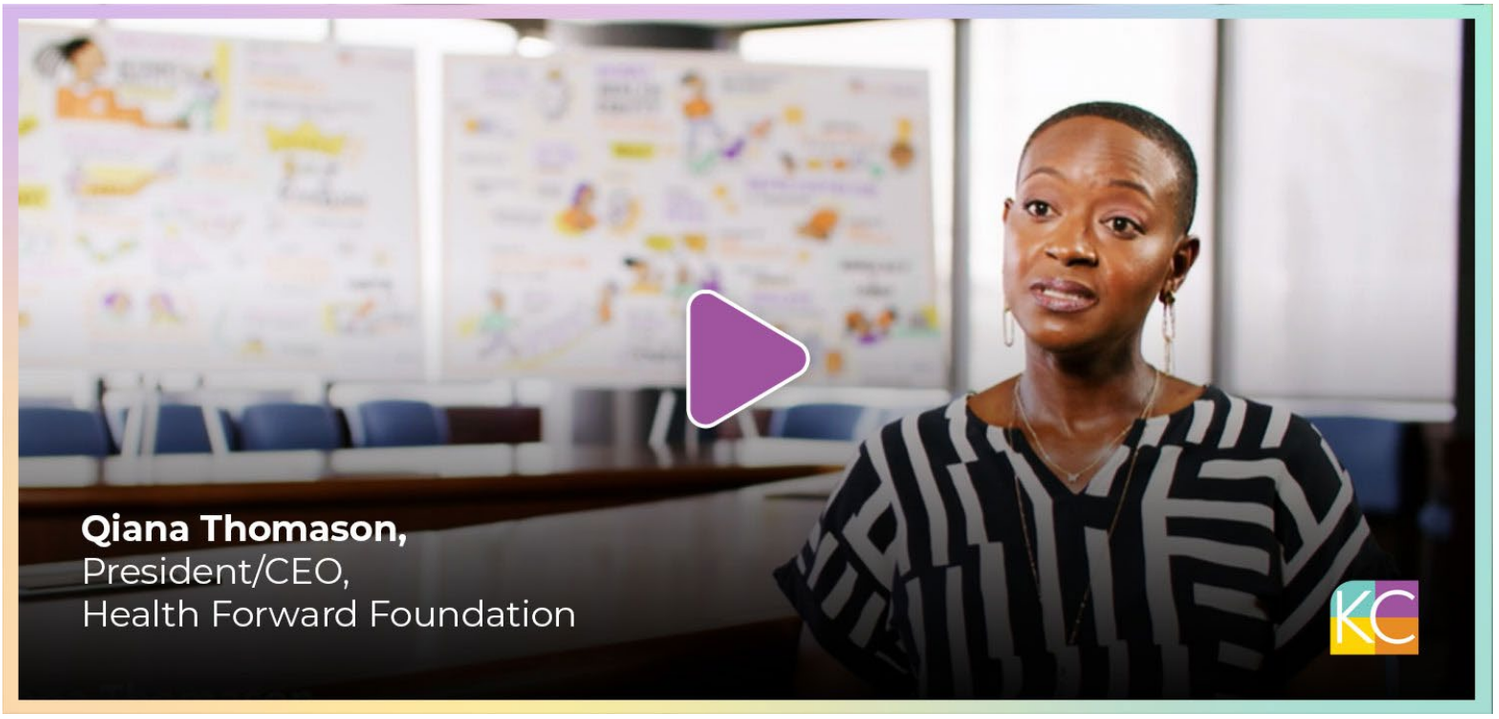
The **Learning** Community ...



Watch Now

Although more rigorous than the CEO roundtable, the learning community was focused on three areas: equity as a strategic priority, equity in community and clinical care treatment, and equity in access to social drivers of health.

IHI's global health equity initiative was also instrumental in helping the LAN create a community transformation map used to measure change, pre- and post-intervention of the work that manifested from both the learning and action phases of the LAN.

Health Forward, IHI, and a local group of players that made up the area's health ecosystem — including grassroots organizations and health care consumers — developed the learning curriculum.

In February of 2022, the learning community officially launched. Because of the pandemic, the first session was an online event held via Zoom. The LAN came with structure, community, helpful tools, resources and information. For instance, shared definitions was one tool the learning community used so that everyone had a common starting point, and a unified understanding of what words, like health equity, meant.

However, learning the language did come with challenges. Words like anti-Black racism, white supremacy culture, white dominant culture, systemic racism, and structural racism, among many others, came with a sting at times and caused tension at the earlier stages of the learning phase.

One LAN facilitator, Cecilia Saffold, CEO of HealthTeamWorks, described tension as the strain that's needed for growth because without discomfort change cannot be achieved. In some instances the shared language and definitions made some people start from a place where they felt deeply accused, pointed out, and shamed. Some felt discussions about privilege and power meant they were individually racist and prejudiced, and the cause of anti-Black racism in health care settings.

Some whose lived experience included abject poverty with minimal financial resources and social support felt particularly called out by discussions of white privilege and were resistant to align that definition with themselves. Breaking through meant deconstructing what is referred to as empowered or white fragility, which is discomfort or defensiveness when information is presented about racial inequality and injustice.

The shared definitions, along with a call to anti-racist practices, ways of thinking, and acting can be intellectually jarring and emotionally challenging. For this reason the learning community had access to licensed clinicians during every session to speak with confidentially while they processed, reflected, and expressed whatever emotion they felt in that moment.

> "Hearing stories, hearing experiences, hearing outcomes that resulted from systems that are designed to benefit one group to the detriment of another group provoked an immediate response that these same systems are detrimental to me, too. And it's not saying that nothing negative has happened to you. It's not saying that you've not had egregious experiences or poor experiences. But the LAN's focus is the inability for individuals to receive equitable access and delivery of care because of race, ethnicity, religious background, national origin, and other factors — elements that are completely out of one's control.
>
> **- Qiana Thomason**

SIDE BAR

Racial Equity Institute Groundwater Approach

If you have a lake in front of your house and one fish is floating belly-up dead, it makes sense to analyze the fish.

Picture five lakes around your house, and in each and every lake half the fish are floating belly-up dead! What is it time to do?

We say it's time to analyze the groundwater. How did the water in all these lakes end up with the same contamination? On the surface the lakes don't appear to be connected, but it's possible—even likely—that they are.

In fact, over 95% of the freshwater on the planet is not above ground where we can see it; it is below the surface in the groundwater.

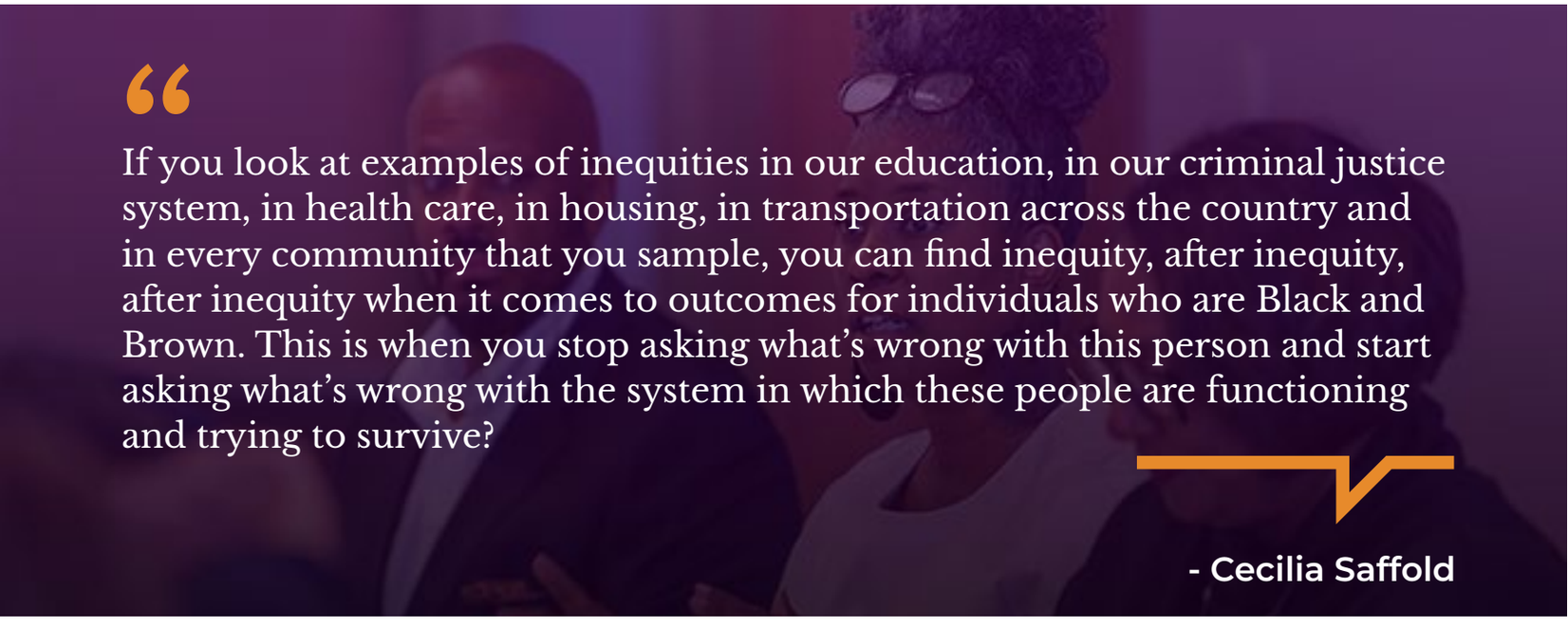
To "fix fish" or clean up one lake at a time simply won't work—all we'd do is put "fixed" fish back into toxic water or filter a lake that is quickly recontaminated by the toxic groundwater.

The groundwater metaphor is designed to help practitioners at all levels internalize the reality that we live in a racially structured society, and that that is what causes racial inequity.

The metaphor is based on three observations: racial inequity looks the same across systems, socioeconomic difference does not explain the racial inequity; and inequities are caused by systems, regardless of people's culture or behavior.

Embracing these truths forces leaders to confront the reality that all our systems, institutions, and outcomes emanate from the racial hierarchy on which the United States was built.

In other words, we have a "groundwater" problem, and we need "groundwater" solutions.



"If you look at examples of inequities in our education, in our criminal justice system, in health care, in housing, in transportation across the country and in every community that you sample, you can find inequity, after inequity, after inequity when it comes to outcomes for individuals who are Black and Brown. This is when you stop asking what's wrong with this person and start asking what's wrong with the system in which these people are functioning and trying to survive?

- Cecilia Saffold

KC LAN's Equity Scores Reveal Continual Gains in Strength

Community Transformation Map

To measure change resulting from the learning and action communities, the IHI helped the LAN create a community transformation map (CTM) designed to:

- Assess capacity to engage effectively in health equity work.
- Determine potential next steps by providing a road map to what better and more equitable looks like.
- Prioritize areas of improvement.
- Facilitate community conversations about health equity.
- Track progress over time.

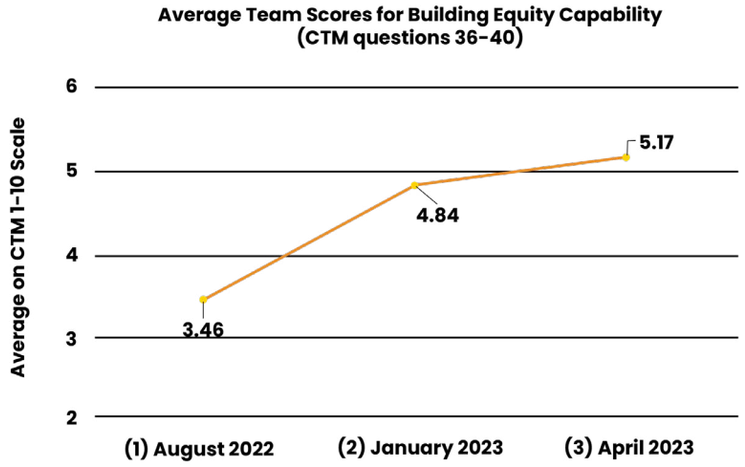
The CTM focuses on three areas: building equity capability (BEC); building quality improvement capability (BQI); and building capability to tackle adaptive challenges (BAC).

CTM questions are scored from one through 10 placing the community on a continuum. Scores are broken down as follows:

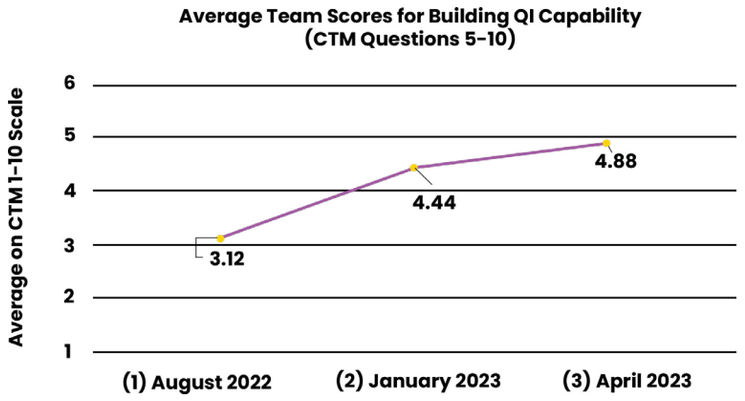
1 = Not Yet Started
2 - 4 = Starting
5 - 7 = Developing Strength
8 - 10 = Sustaining

LAN members completed the CTM on three different occasions — answering the questions individually, as well as collectively within their team to discuss their answers and agree upon a score as a team. It's important to note that teams were asked to think of "community" as the broader Learning and Action Network (the LAN). As seen in the charts to the right, scores continued to show an uptick toward strength development as it relates to these three dimensions.

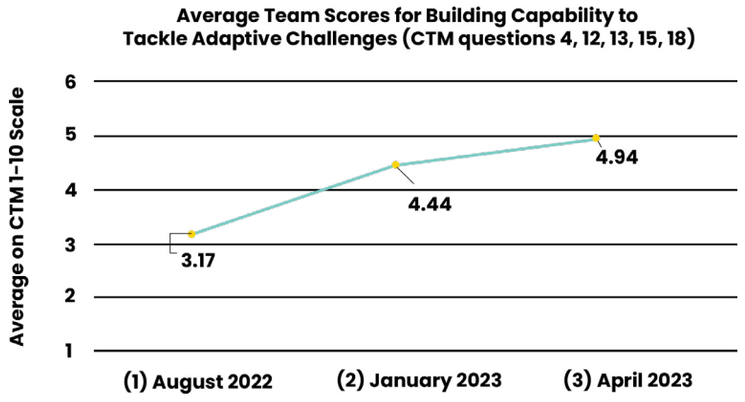
Equity Capability



Quality Improvement (QI) Capability



Building Capability to Tackle Adaptive Challenges



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Action Teams

1. Centrus Health of KC
2. Children's Mercy
3. El Centro, Inc.
4. First Call
5. KC CARE Health Center
6. KU Health System
7. Mission Vision Project
8. Newhouse KC
9. ReDiscover
10. Saint Luke's
11. Swope Health
12. The REL Team
13. Unified Government
14. University Health
15. Uzazi Village

From Learning to Action

Outcomes resulting from the learning phase gave way to an action phase launched in the summer of 2022.

It included a competitive application process that required applicants to submit concepts that focused on methodologies that identified, addressed, and developed strategies to tackle health injustices using an equity-centered, anti-racist approach. Fifteen teams, that include 17 organizations, make up the action community.

Varied Focus. Far-reaching Benefits.

Projects included everything from University Health's work to address health injustices around renal functioning assessments (referred to as eGFR) using race-based clinical algorithms that are known to delay diagnosis and treatment for Black kidney patients — a national issue — to the University of Kansas Health System's community health worker program, that among many things, focuses on social drivers of health. Action teams were paired with coaches who had experience with traditional models of performance and community improvement. The coaches' roles included providing guidance and support, while also challenging them to ask the tough questions. Like, what does systems change

Inspired Collaboration

To tackle questions like that one, action team members attended Community Health Improvement Leadership Academies (CHILAs) where they collaborated, shared ideas, and witnessed how each project worked collectively to address biases throughout the Kansas City health ecosystem.

> "We were thoughtful about how we curated the action teams. And of course, we looked at organizational readiness. We wanted to ensure that we had both clinical and non-clinical projects because health equity championship, especially in centering anti-racism, requires work at multiple levels – including at the policy level and at the community level."
>
> **- Qiana Thomason**

The CHILAs served as a monumental evolution from the learning phase to the action phase, starting from a mindset of very technical change and then evolving into an action community focused on collaboration, deep sharing, peer-to-peer learning, and adaptive change. This was achieved through a commitment to listen to people with different lived experiences and center their voices while working to drive change.

The Work Continues

Action team members continue to be vocal about the LAN's impact on the organization's ability to address health equity from an anti-racist lens.

For instance, an action team member said because of their experience with the LAN, they remain even more committed to advancing equitable research practices and ensuring that every patient and family served is seen, valued, and supported.

In other instances, race, ethnicity, and language (REL) data is the use of demographic data to understand unique health risks and health care needs — from a social experience vantage point and not as a biological factor — to improve quality care.

One action team member said the LAN played a huge role in how they used REL data to treat their diabetes patients while also addressing social drivers of health.

Additionally, equity-centered workforce recruitment efforts aimed at ensuring those hired reflect those served by an organization is also making an impact.

> "The LAN represents everyone working together proving that policies can change, and systems can shift. You don't even have to agree, all you need to see is the business case. That's when it hit me that the LAN is not a program or initiative. It is a true movement.
>
> **- Hayat Abdullahi**

Watch Now

There was statistical significance when it came to making changes to advance health equity. Across all changes, these were the primary themes.

Policies

- **REL**
  Data Collection
  Dashboards
  Data Disaggregation
- **Changes in Algorithms**
  (Race)
- **Personnel/Board**
  (Inclusive Hiring & Representation)

Practices

- **Hiring Staff**
  (CHWs)
- **Health Equity Training**
- **Language**

Programs

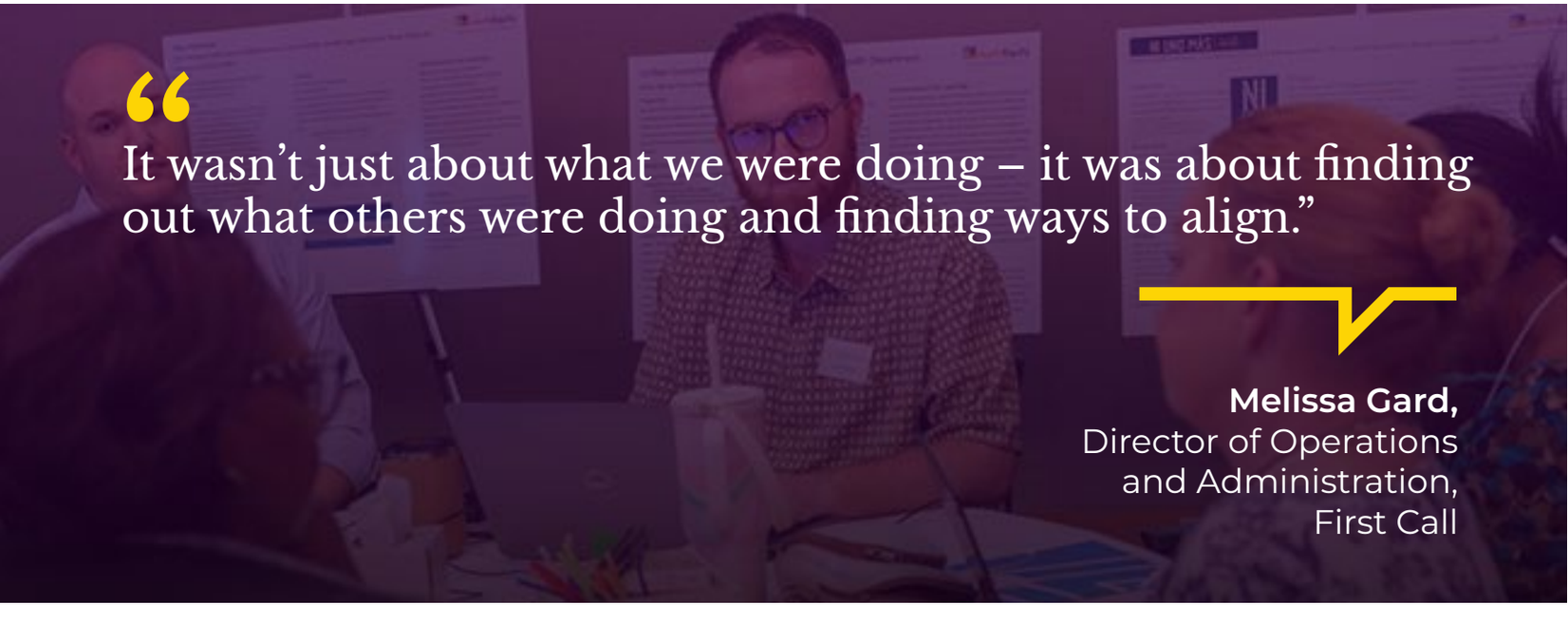
- **Chronic Disease Prevention**
  (Diabetes)
- **SDOH Screening**

Total Number of Policy, Practice, and Program Changes Completed by LAN Members: 153

Measure	Number Completed	50% of Planned Changes Completed
Policy Changes Completed	67	47%
Practice Changes Completed	43	42%
Program Changes Completed	43	45%

Changes in Systems/Policies, Practices, Programs

The LAN will continue to convene the action community, follow each project, and provide support as their equity work deepens. The expectation is to see consistent and sustained movement around accountability for those who hold positional power and authority.



“It wasn’t just about what we were doing – it was about finding out what others were doing and finding ways to align.”

Melissa Gard,
Director of Operations and Administration, First Call

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What's Next for the LAN?

Birth Equity.

The LAN is preparing for yet another iteration of health equity work, with its core partners KCHC and IHI. The focus now shifts to the region's maternal health crisis, with improved outcomes for Black women, birthing people, and their infants at the center. This birth equity work assumes a quadruple approach.

One goal is to align the work of community-based organizations already steeped in birth equity, while adding a clinical component that fosters community collaboration. Listening to the voices of Black women, respecting the knowledge of their own bodies — and lived experience — is one component. The ultimate goal is to build trust and communication between patients and providers.

Blood Pressure

Blood pressure will be used as a key metric, and an area of intervention, due to the prevalence of hypertension among Black women and birthing people. The LAN will advocate for regular hypertension screenings, as well as provide specific training around this measure for both patients and providers. Additionally, community collaboration includes partnerships with pharmacies and health clinics to increase access to blood pressure monitoring devices and resources to empower self-management and self-advocacy.

> "We will center [belief] in that process – believing the voices of Black people and Black women, and believing they are most knowledgeable about their own bodies and experiences. We'll explore how to bridge the use of community with clinical systems and we'll look specifically at blood pressure, knowing that it disproportionately affects Black women and Black birthing people. We'll ensure that blood pressure, as a specific metric, is an area of intervention in this birth equity work.
>
> **- Qiana Thomason**

Doulas

According to the March of Dimes, when pregnant women and birthing people are paired with a doula, they are two times less likely to experience birth complications; four times less likely to deliver a baby with low birthweight; have fewer C-sections; and experience anxiety and depression at lower rates, among many other benefits. Doulas provide informational, emotional, and physiological support, and patient advocacy during the perinatal and postpartum periods — helping to mitigate health and racial inequities at doctor visits and during labor, delivery, and after birth.

Doulas connect culturally with the birthing people they support, respecting and protecting their values, beliefs, and preferences. The LAN will partner with doulas and organizations that train and facilitate trust-based, team-based integration with clinical providers. The goal is to address race-based disparities and improve maternal and infant health outcomes.

Data

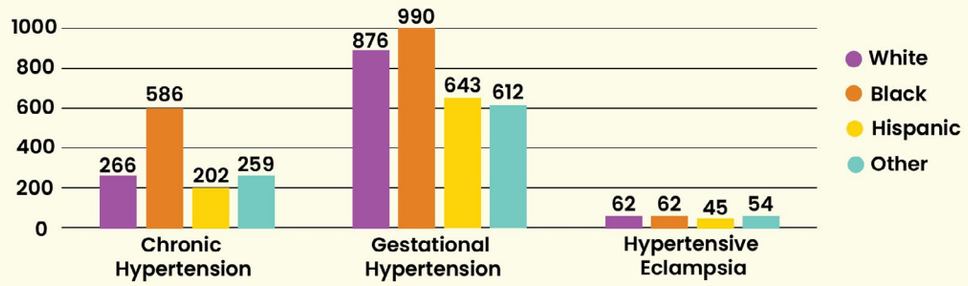
Using race, ethnicity, and language (REL) data, the LAN will build a robust data collection and analysis system of factors that contribute to maternal health disparities to effectively allocate resources to address the root causes of these disparities. REL data is demographic information used to understand unique health care risks and health care needs. It is used to improve quality in health care settings. Race and ethnicity are reflections of identity and social experiences, not biological facts.

The LAN will work with health systems to glean transparent reporting of maternal health outcomes as a measure of transparency and accountability for improving maternal and infant health outcomes for Black women and pregnant people. The LAN will also engage Black women and community stakeholders in the design, implementation, and interpretation of maternal health data to ensure interventions are culturally relevant, responsive to community needs, and aligned with the priorities of those most affected by maternal health disparities.

By focusing on Black pregnant women and birthing people, who experience the worst maternal health outcomes in the U.S., pervasive, systemic barriers to quality care will be highlighted and underscored. Identifying and addressing these barriers, through an anti-racist lens — and with the aim to infuse quality-driven approaches that improve maternal health outcomes for those who fare the worst will inherently lead to quality improvements in maternal health outcomes for all pregnant women and birthing people.

Maternal mortality and demographic characteristics of pregnant women and birthing people in Missouri from 2017-2021.

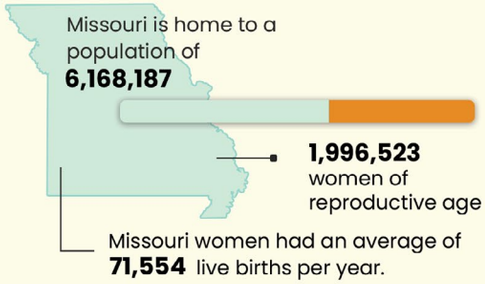
Hypertension During Pregnancy by Race 2018-2020, Ratio per 10,000



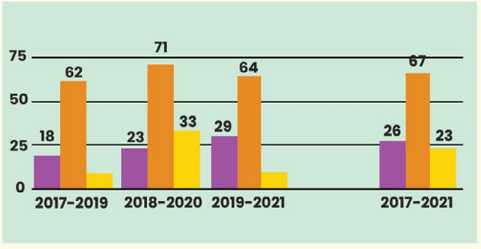
Pregnancy-Associated Mortality

Pregnant people who die in Missouri **every year** **70** **85** Highest number recorded in **2020**

Birthing Demographics in Missouri

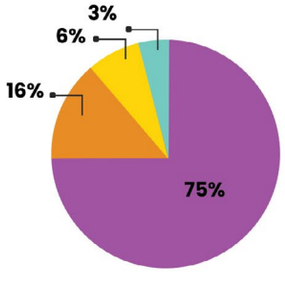


Pregnancy-Related Mortality Ratio per 100,000 Live Births by Race/Ethnicity



Pregnancy-related mortality is **highest among Black women,** with a ratio of **66.7 deaths per 100,000 live births.**

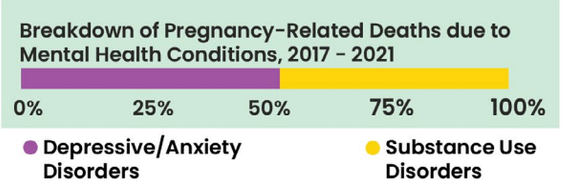
Percent of MO Live Births by Race/Ethnicity, 2017-2021



White Black Hispanic Other

**Other includes Asian, American Indian, Native Hawaiian, Alaska Native, Pacific Islander and other groups*

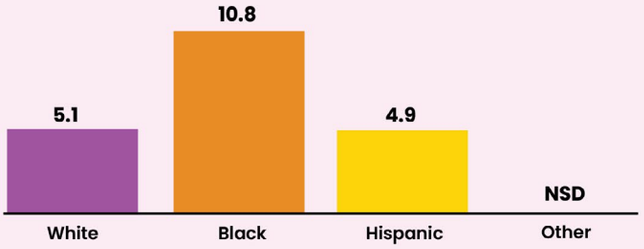
Pregnancy-Related Causes of Death



**Information provided by the MO DHSS 2017-2021 Pregnancy Associated Mortality Review (Published 2024)*

Maternal mortality and demographic characteristics of pregnant women and birthing people in Kansas from 2016-2022.

Infant Mortality Rate per 1,000 Live Births by Race Ethnicity, 2021, Kansas



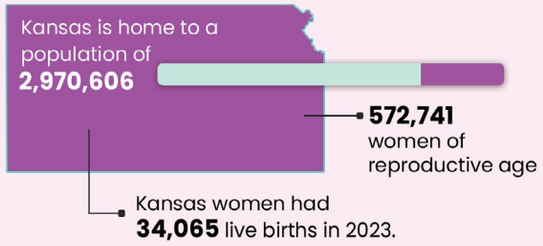
Source: *Kff.org*

Pregnancy-Associated Mortality 2016 -2022

Number of deaths **153** **59** Maternal mortality rate **per 100,000 live births**

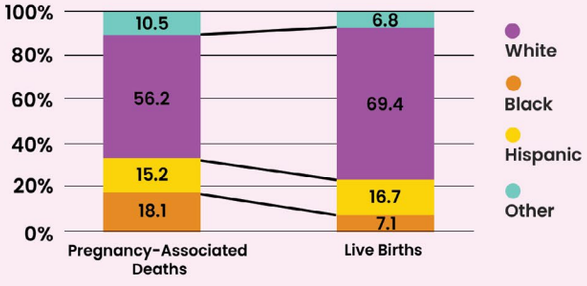
Source: *kmmrc.org*

Birthing Demographics in Kansas



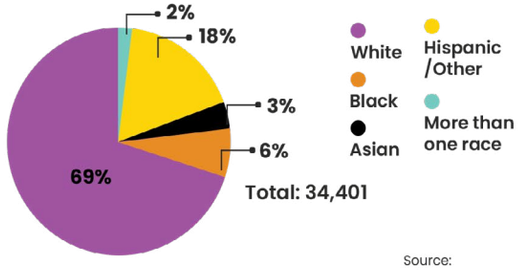
Source: *marchofdimes.org*

Percent of Pregnancy-Associated Deaths and Live Births by Race and Ethnicity, 2016-2020



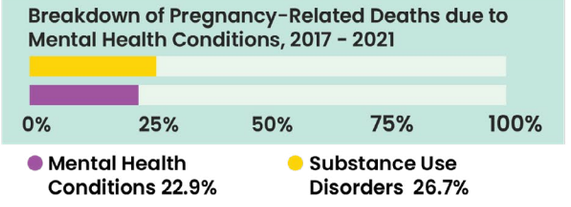
Source: *kmmrc.org*

Total Births, by Race, 2022



Source: *Kff.org*

Pregnancy-Related Causes of Death



Source: *kmmrc.org*

KC HealthEquity

LEARNING AND ACTION NETWORK

KCHealthEquity.org

Health Forward FOUNDATION

KC HEALTH COLLABORATIVE

Institute *for* Healthcare Improvement