Master of Public Health

Integrative Learning Experience Report

ADDRESSING HEALTH EQUITY IN RILEY COUNTY

by

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MASTER OF PUBLIC HEALTH

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// Summary

This report details an applied learning experience completed with the Flint Hills Wellness Coalition under the supervision of the Julie Hettinger, Health Educator at the Riley County Health Department and Past-Chair of the Flint Hills Wellness Coalition. The scope of work includes time spent as the Flint Hills Wellness Coalition intern. As an intern (formally known as the Coalition Liaison), the focus was on capacity building, communication, and health equity.

Subject Keywords: Flint Hills Wellness Coalition, Health Equity, Riley County

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Chapter 1 - Literature Review

"Health equity" and "health disparities" are terms that are seen relatively often in regard to public health. It is important that these two terms be defined to avoid any confusion or inconsistencies. Health disparities are defined as "health differences that adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion" (Braveman, 2014). Health equity is defined as "the principle underlying a commitment to reduce – and ultimately, eliminate – disparities in health and in its determinants, including social determinants" (Braveman, 2014). According to Braveman (2014), healthy living and working conditions should not be treated as commodities but should be distributed according to need. Braveman also makes it clear that not all health differences are health disparities, because health disparities must concern social justice with regard to the treatment of more advantaged vs. less advantaged groups when it comes to health and health care.

Carter-Pokras and Baquet (2002) determined that in the context of public health, a health disparity should be viewed as a chain of events signified by a difference in environment, access to utilization of, and quality of care, health status, or a particular health outcome that deserves scrutiny. Most definitions of health disparities discuss health differences in health status and access to care as they relate to racial and ethnic minority, medically underserved, and poor rural populations. Nationally, racial and ethnic health disparities have been well documented, with data showing that individuals from minority populations suffer disproportionately from cardiovascular disease, diabetes, asthma, and cancer (Payne-Sturges, 2006). These causes are of course multifactorial and according to Betancourt et al. (2003) the largest contributors are those that are related to the social determinants of health. Members of minority communities tend to have lower levels of education, work in jobs with higher risk of occupational hazard, and tend to be more economically challenged. According to Betancourt et al.

(2003), Hispanic Americans represent 13% of U.S. population but represent 25% of Americans without health insurance. Lack of health insurance can cause adverse health effects like high rates of emergency department use and less access to preventative care. The same article stated that African Americans have been linked to poor health outcomes due to racism. Betancourt (2003) also notes that concern for those with access to care is just as great, as these populations also experience similar health outcomes.

Kawachi et al. (2005) examined three separate causal interpretations of health disparities including (1) viewing race as a biological category which views these health disparities as inherited susceptibility of diseases, (2) viewing socioeconomic stratification as the culprit behind health disparities, and (3) treating race as a distinct construct of health disparities. The aim of this specific article was to dissect public and academic dialogue on health disparities and to highlight the idea that rather than treating race and class separately when we look at disparities, we should examine the interaction between them to begin to understand health disparities more clearly. An understanding of all causal interpretations of health disparities is necessary to understand disadvantages and inequities experienced by certain populations. There are still many unknowns in this area of study and more information is needed to understand the health implications related to these disparities.

One area where health disparities are prominent concerns maternal outcomes. Love et al. (2010) points out that African-American women were twice as likely as non-Hispanic white women to have a low birth weight infant, and the risk of infant death was 2.4 times more likely for African American women. As a possible explanation for the differences in maternal outcomes, the concept of "weathering" was proposed by Geronimus et al. (2011). The term weathering refers to the early deterioration of health in African American women as a consequence of socioeconomic disadvantage (Geronimus, 1992). This hypothesis states that "the health of African-American women may begin to deteriorate in early adulthood as a physical consequence of cumulative socioeconomic disadvantage." What we know is that black women experience adverse health outcomes as compared to their white counterparts. An article by Love et al. (2010) explored the idea that black women experience accelerated aging due to

stresses from disadvantage, bearing the responsibility for their family, and other racial stratifications. Love et al. (2010) also found that black women living in poorer communities showed significant weathering with regard to low birthweight (LBW), small for gestational age (SGA), and preterm birth (PTB). There is still a gap in the knowledge for understanding the racial differences in LBW births. For African American women, infant mortality is actually at its lowest during their teenage years, and birth outcomes worsen as these women age (Geronimus et al. 1992). This is theorized as the phenomenon of weathering and can be explained by socioeconomic disadvantage and the health of African American women.

My applied practice experience was spent with the Flint Hills Wellness Coalition. The Flint Hills Wellness Coalition (FHWC) was established in 2011 to address specific health needs in the City of Manhattan and Riley County. These health needs focus on nutrition, transportation, physical activity levels, and more. The coalition works with citizens and groups in Riley County to develop community norms that support healthy behaviors and environments. Their mission is to create a healthy, equitable community for residents through policy, system, environmental, and personal change. The coalition has come a long way since they were first established, and they have been successful in improving access to healthy foods (establishment of Food and Farm Council), reducing exposure to tobacco in public parks (Clean Air Ordinance), and advocating for bicycle/pedestrian friendly environments. In 2015 the FHWC began developing the Community Health Improved Plan (CHIP) which involved over 200 stakeholders in reviewing data, discussing needs, and identifying priorities. In 2017 the coalition formed workgroups to put their results into action. Workgroups include Nutrition, Mental Health, Access and Coordination of Services, Active Transportation, and Advancing Health Equity.

The project that I worked on focused on health equity, but more specifically, health equity in regard to Hispanic and African American women in Riley County. My project was to create a presentation to be used to educate members of the coalition about health equity and its importance, and to further research topics regarding health equity and women's health equity in Riley County. The hope with this presentation is

that information gathered will be used to further investigate these topics and for it to be incorporated into the work being done within each of the workgroups.

I chose to focus on this specific area of interest because of data collected by the Kansas Health Institute regarding possible health disparities in Riley County. Data from this document titled *Chartbook: Racial and Ethnic Health Disparities in a Changing Kansas (2017)* authored by Lawrence John Panas, Ph.D. was reviewed and utilized for creating the foundation for this project. After analyzing the data, a few points of interest stuck out to me including disparities in low birth weight births, premature births, births to mothers with less than HS education, pregnancy rates for ages 15-19, and mothers receiving adequate or better prenatal care. My project focus relates these data points back to health equity in Riley County.

Chapter 2 - Learning Objectives and Project Description

I began my work with the FHWC in January of 2018 and will conclude in December 2018 when I transition a new intern into my position. I was the first intern for the coalition so this was a new experience for everyone involved. Our first meeting was dedicated to creating learning objectives and action items to be accomplished during my time with them. My time with the coalition culminated in my work on a presentation regarding health equity in Riley County that I will present to the coalition and will be utilized by the coalition after my time with them has ended. The presentation encompassed the knowledge that I had gained throughout my time with them and included information pertinent to the mission of the coalition. The learning objectives for my experience included:

- Understand the difference between “health inequity” and “health disparities” and why this distinction is important
- Be able to understand and describe health data and how it relates to the work being done within the coalition
- Create a presentation to be used to educate members of the coalition on health equity issues in Riley County
- Interview health professionals in Manhattan, KS about their role and how that work relates back to the concept of health equity
- Gather personal stories and insights on health inequities in Manhattan and the populations that are most affected by these

The first part of my learning experience with the Flint Hills Wellness Coalition was to understand the basic structure of the coalition, to understand the role that the administrative team played, and to understand each of the individual workgroups. Throughout my time with the coalition, I attended many group meetings and held my own individual meetings to better understand each individual and group role within the coalition. Large group meetings included monthly meetings with the coalition where I took minutes, administrative team meetings where I participated as the “coalition liaison”, and workgroup meetings that included Active Transportation, Nutrition, Access and Coordination of Services, and Health Equity. While I did not function as an active

member of any specific workgroup, attending their meetings was crucial to my success as the coalition liaison. Outside of group meetings, I also held individual meetings with different members of the coalition to gather updates, answer questions, and learn more about each workgroup's progress. This information was gathered and reported back to the administrative support team to make sure everyone was updated and informed. Interconnectedness and transparency between administrative leaders and individual members was held in high priority and this was where a large sum of my efforts were focused from the beginning.

Outside of attending meetings and connecting members of the coalition, I was also able to begin work on an outreach and communication plan for the coalition. The objective of this responsibility was to update the community about what the coalition is, as well as to build capacity and to encourage other members of the community to attend the monthly meetings. The first step was to create and update an Instagram page to be used as another outreach tool, the next step was to coordinate workgroups to update the coalition's website and the information portrayed on it, and the last step was to create a communication plan that would guide and streamline internal and external communication. The improvement of communication was an ongoing theme during my time with the coalition and was something that was prioritized with not only the administrative team, but within work groups as well.

My final project during my time with the coalition was a presentation focused on health equity in Riley County. When I first began working on this project, I was not sure what direction it would go. My main objective with it was to create a learning tool to help educate members of the coalition on an important population health matter. The project started with information from the Kansas Health Institute that was gathered between 1999 and 2013. After pulling data specific to Riley County from *Chartbook: Racial and Ethnic Health Disparities in a Changing Kansas,* I translated it into tables and from there, into readable graphs. Below is an example of translating data from chartbook to table to graph.

Figure 2.1 Example of Data Obtained from *Chartbook: Racial and Ethnic Health Disparities in a Changing Kansas*

Figure F5a. All Mothers Receiving Adequate or Better Prenatal Care in Kansas, 1999-2013

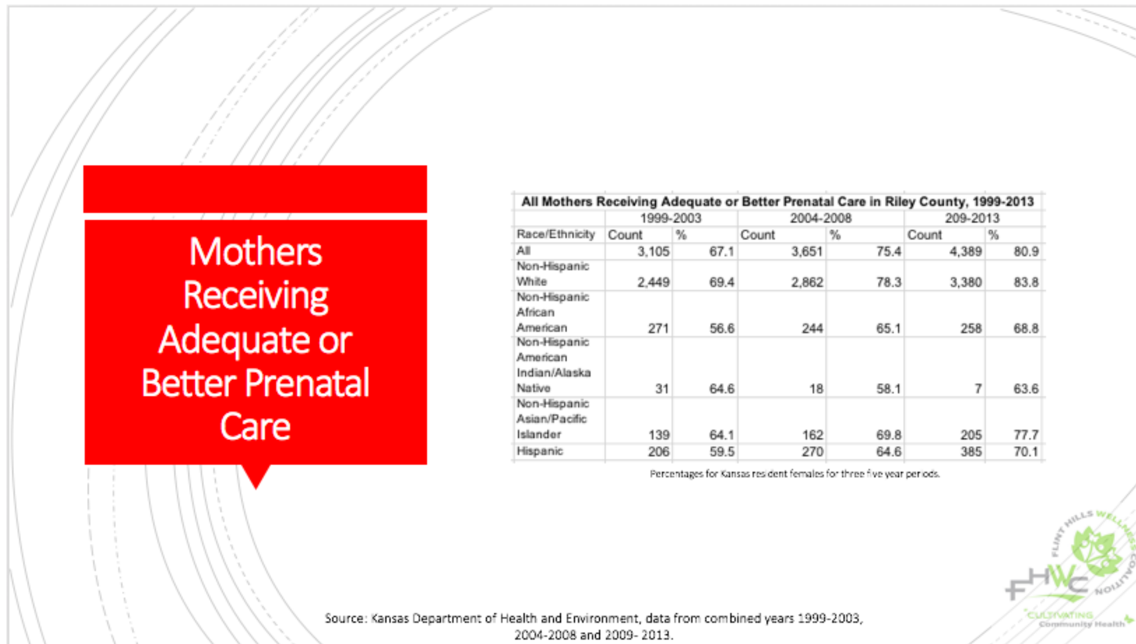
Geographic Area	1999-2003		2004-2008		2009-2013	
	Count	%	Count	%	Count	%
Osborne	149	79.7%	141	77.5%	172	84.7%
Ottawa	305	85.4%	279	84.8%	272	86.9%
Pawnee	261	77.7%	259	82.0%	261	72.9%
Phillips	252	77.8%	198	72.0%	190	64.8%
Pottawatomie	1,013	77.5%	1,273	81.8%	1,532	85.8%
Pratt	422	76.2%	470	78.7%	546	82.4%
Rawlins	73	70.2%	80	78.4%	94	80.3%
Reno	3,246	77.4%	3,315	80.4%	3,052	80.6%
Republic	186	81.9%	186	78.5%	197	87.2%
Rice	439	71.6%	432	71.3%	464	78.8%
Riley	3,105	67.1%	3,651	75.4%	4,389	80.9%
Rooks	240	80.0%	212	74.9%	249	77.6%
Rush	149	80.5%	131	78.4%	109	77.9%
Russell	256	74.9%	279	76.2%	342	78.4%
Saline	3,146	84.8%	3,187	80.4%	3,241	82.5%
Scott	227	68.8%	206	59.9%	231	71.3%
Sedgwick	30,723	82.4%	30,362	80.3%	32,129	83.4%
Seward	1,388	56.1%	1,368	60.2%	1,421	61.9%
Shawnee	10,527	86.4%	9,942	80.9%	9,484	81.9%
Sheridan	112	84.8%	120	82.8%	107	78.1%
Sherman	314	78.1%	266	73.9%	294	78.0%
Smith	133	89.3%	141	87.0%	128	80.0%
Stafford	189	76.5%	184	76.7%	185	83.0%
Stanton	146	74.5%	125	73.1%	103	69.6%
Stevens	255	59.9%	267	64.2%	280	66.5%
Sumner	1,358	84.7%	1,177	81.1%	1,152	84.0%
Thomas	405	82.0%	407	81.2%	416	78.3%
Trego	132	83.5%	122	78.2%	113	80.1%
Wabaunsee	324	83.1%	351	82.6%	365	82.8%
Wallace	77	77.0%	50	74.6%	58	69.0%
Washington	258	81.9%	242	81.8%	274	83.0%
Wichita	127	76.0%	115	65.3%	85	61.2%
Wilson	462	80.9%	488	80.7%	477	83.2%
Woodson	136	78.6%	129	79.6%	142	82.1%
Wyandotte	9,887	70.9%	7,897	64.4%	8,583	68.1%

Note: See *Technical Notes, Appendix H* for description of Adequate or Better Prenatal Care. "-" indicates that data are unavailable or suppressed. Percentages for Kansas resident females for three five-year periods. Counts and percentages for Other non-Hispanics are not included as a separate category due to the use of bridged-race estimates for denominators. These counts are included in the count for All Kansans. Using bridged-race estimates, persons identifying as Some Other Race and Two or More Races have been reapportioned to one of the following racial categories: White, African American, American Indian/Alaska Native, and Asian/Pacific Islander.

Source: Kansas Department of Health and Environment, data from combined years 1999-2003, 2004-2008 and 2009-2013.

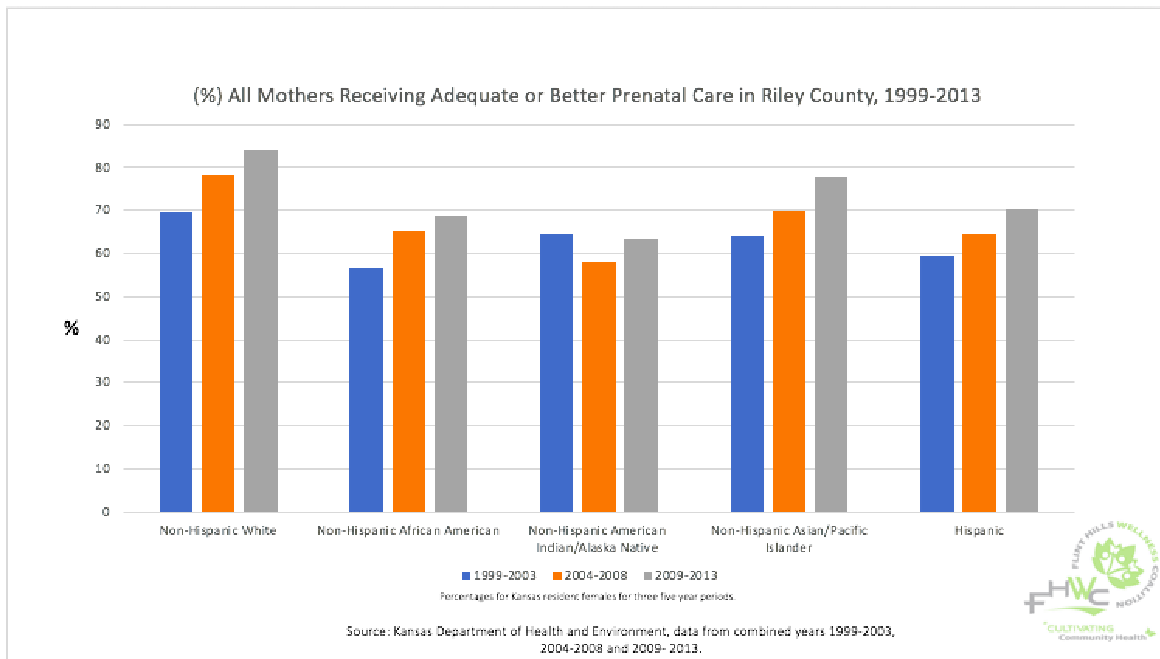
F-76 | Chartbook: Racial and Ethnic Health Disparities in a Changing Kansas   Kansas Health Institute

Figure 2.2 Example of Data Translated from *Chartbook: Racial and Ethnic Health Disparities in a Changing Kansas Into Table*



All Mothers Receiving Adequate or Better Prenatal Care in Riley County, 1999-2013						
	1999-2003		2004-2008		209-2013	
Race/Ethnicity	Count	%	Count	%	Count	%
All	3,105	67.1	3,651	75.4	4,389	80.9
Non-Hispanic White	2,449	69.4	2,862	78.3	3,380	83.8
Non-Hispanic African American	271	56.6	244	65.1	258	68.8
Non-Hispanic American Indian/Alaska Native	31	64.6	18	58.1	7	63.6
Non-Hispanic Asian/Pacific Islander	139	64.1	162	69.8	205	77.7
Hispanic	206	59.5	270	64.6	385	70.1

Figure 2.3 Example of Data Translated from Table to Bar Graph



After reading through the chartbook, all data relevant to Riley County was translated into tables (Appendix) by me and then presented by Lawrence Panas, Ph.D.,

author of *Chartbook: Racial and Ethnic Health Disparities in a Changing Kansas.* After that, all data was then translated into more digestible graphs (Appendix). I sorted through those graphs and chose a few specific data points to focus on for my presentation on health equity. I chose to focus on these data points because of an inherent interest in women's health. What was concerning to me was that the data pointed to possible disparities within these specific racial/ethnic groups (Hispanic and African American), and that women in these populations were suffering from adverse health outcomes. After further research on the issue of maternal health outcomes, it became clear to me that this was what my focus should be with this project.

Before the start of this project, I knew little about this specific area of study and wanted to use this project to not only educate others, but to educate myself as well. My presentation was created with the intention of providing education and a new outlook on health equity for members of the coalition. During the process of creating my presentation, I conducted interviews with key experts in this area including Jennifer Green, Director of the Riley County Health Department; Earlisha Killen, Breastfeeding Consultant; Jan Scheiderman, Raising Riley; Breva Spencer, Maternal and Child Health; and Maria Baquero, Spanish Interpreter. The purpose of these interviews was to gain knowledge that could not be collected from reading necessarily, but could only be gathered directly from experts themselves. A sample interview guide which includes example questions is provided in the appendix (figure 4).

Specific areas of interest for my presentation on health equity were Years of Potential Life Lost (YPLL) rates, low birth weight births, premature births, births to mothers with less than a high school education, pregnancy rates for mothers age 15-19, and mothers receiving adequate or better prenatal care. All data was collected by the Kansas Health Institute from 1999-2013 and is broken down by race/ethnicity.

Chapter 3 - Results

Key findings were interpreted from interviews conducted with various professionals within the health department. We wanted to identify what populations were facing health inequities as well as possible reasons for these inequities to exist. After reviewing the interviews and information presented by each professional, two common themes came to fruition: health inequity as a function of misunderstanding and health inequity as a function of miscommunication.

Inequity as a function of misunderstanding

What this means is that there is a lack of understanding between those providing a public health service and those receiving it. Every individual is unique and has a different set of needs. Misunderstanding can stem from a lack of knowledge of culture, race/ethnicity, religion, and other health needs. Having a basic understanding of an individual's needs is a good start, but being able to take it one step further to truly understand how to best serve them is ideal. With a limited number of resources in Riley County, this is not always possible. But when health care and service providers are able to understand the needs of each individual who walks through their door, we could be one step closer to achieving health equity within these populations.

The interview conducted with Jennifer Green helped to bring this theme into perspective. Jennifer is the director of the Riley County Health Department and works with a variety of populations every single day. She was the first one to introduce the idea of "weathering" and "accelerated aging" to me when looking at the adverse health outcomes that these populations were experiencing. The term weathering refers to the early deterioration of health in African American women as a consequence of socioeconomic disadvantage (Geronimus, 1992). The term accelerated aging refers to accelerated biological aging in response to stressors (Geronimus et al. 2011). Jennifer explained to me that many times African American women's concerns are misunderstood when it comes to what they are experiencing during pregnancy and after child birth. They are often seen to be exaggerating and their complaints are brushed aside. It might be that health professionals are not taking into consideration the health differences between this population and others, it might be an issue of generalization, or

it could be a general misunderstanding when it comes to their specific health needs. These possibilities might help explain why African American and Hispanic women in Riley County had higher rates of premature births and low birthweight births from 1999-2013 according to the data collected by the Kansas Health Institute.

Inequity as a function of miscommunication

A major issue with many individuals is communication barriers. Ideally, there would be a language interpreter to assist non-English speaking individuals with communication needs, but this is not always possible. Lack of communication causes everything to progress at a slower rate, and this can mean slower access to necessary health services. This issue of poor communication can also cause individuals to feel frustrated, nervous, and hesitant to seek out the services that they need. Individuals not understanding where they need to go next, what services they need, and what their next step is can quickly fall behind and get left behind.

Maria Baquero is employed as the Spanish interpreter for the Riley County Health Department and primarily works with Spanish-speaking women who are pregnant or who have recently given birth. As someone who works with a population who speaks little-to-no English, Maria emphasized that a prevalent concern for these women is communication. She said many of these women are fearful and confused when it comes to health services. She mentioned an initial fear also stems from their status (undocumented, expired visas, etc.) and the added communication barrier slows everything down. Because of this and other reasons, many of the families she sees do not have access to services that they need. This lack of access and communication barrier could help explain lower rates of adequate prenatal care for Hispanic women compared to other races in Riley County. The information from the interview with Maria also ties back to data regarding pregnancy rates for mothers aged 15–19 and births to Riley County mothers with less than a high school education. Both of these rates were exponentially higher for Hispanic women compared to other races from 1999-2013.

Other Interviews

All five interviews conducted were very educational and informative as I sought out explanations for health inequity occurring in Riley County. While my interviews with Jennifer and Maria were more focused on specific health inequities, my interviews with Breva, Jan, and Earlisha were more focused on specific programs available to women and families through the Family and Child Resource Center through the Riley County Health Department. My very first interview was with Breva Spencer who works in Maternal and Child Health for the Riley County Health Department. Breva talked a lot about various programs offered through the health department in regard to maternal and child health including Becoming a Mom, Maternal and Infant Health Program, Newborn Home Visits, and the Home Visiting Program. These services provide direct assistance to new mothers as they transition into motherhood. Leslie James, MCH Clerk, reported the number of clients in the Becoming a Mother program and 2016 saw the highest enrollment at 186 clients. As of October of 2018, the program had 100 clients reported. Becoming a Mom classes are focused on educating new mothers on parenting and life skills and offer six prenatal education classes.

My interview with Jan Scheiderman was focused on the Raising Riley Program. Raising Riley provides child care subsidies to help parents pay for quality care, early literacy visits, mental health consultation, family education and support, and more. The program has been a part of the Riley County Health Department since 2000 and has been instrumental for years in bringing early childhood assistance to the community. Jan reported a fairly even distribution in the demographics of women that utilize this specific program, but did note that there are income eligibilities and families eligible to receive services must be at or below the gross yearly income as outlined in their application.

My interview with Earlisha Killen focused on her responsibility as a breastfeeding consultant in Riley County. Earlisha works with low income women who are seeking assistance through WIC (Women, Infants, and Children Nutritional Services). She consults women individually to educate them about breastfeeding, sets goals with them, and counsels them throughout their child’s infancy. Earlisha explained during our interview that each woman’s needs are different when it comes to breastfeeding because of different backgrounds, health concerns, cultures, and income levels. She

works with a diverse mix of women and noted that the individualistic aspect of her work is extremely important in providing personalized advice and tailored information specific to each woman's needs.

Chapter 4 - Discussion

The information that I gathered in my interviews and was able to use in my presentation is just the first step in solving a larger issue at hand. The data collected by the Kansas Health Institute and the interviews with various health department employees begin to reveal a larger problem occurring not only here in Riley County, but all over the country. The lack of understanding for individuals by healthcare providers, and the communication barriers that individuals at risk are facing is keeping them from achieving optimal health. The findings from my interviews and data presented by the Kansas Health Institute support similar studies looking at health inequities for women of color as mentioned in the literature review.

An article referenced in the above literature review helps support the ideas presented in the results chapter. Betancourt et al. (2003, p. 560) states that “variations in patient recognition of symptoms; thresholds for seeking care; the ability to communicate symptoms to a provider who understands their meaning; the ability to understand the prescribed management strategy; expectations of care (including preferences for or against diagnostic and therapeutic procedures); and adherence to preventive measures and medications” are all important factors to consider. These are the factors that influence decisions and interactions between patients and providers and thus contribute to health disparities. The findings from this study relate directly back to what I learned from my interviews and how important these interactions are.

Dressler et al. (2005) recognized clinical barriers that can occur between individuals and their healthcare providers. These barriers occur when sociocultural differences between patient and provider are not accepted, explored, or understood. Patients might have a different set of cultural beliefs, different attitudes toward medical care, and varying trust in health service providers. Providers are now dealing with a more diverse population and a greater proportion of patients who are inherently different than them. Dressler also stressed that provider-patient communication has a direct link to patient satisfaction and health outcomes. Communication barriers can adversely affect communication and trust which can in turn lead to dissatisfaction and negative health outcomes. When providers do not take social and cultural factors into

consideration, providers could resort to generalizing and stereotyping which could in turn lead to biased or discriminatory treatment of patients.

I hope to utilize this information to continue to spread awareness of this issue to those currently working in public health and to other individuals in our community. It is my hope that knowing this information will motivate and encourage public health professionals to take into consideration new methods and approaches in their practice. I think this can be done in a variety of ways and it is going to look different everywhere. Essentially what I hope is that new understanding is built when it comes to individuals of different backgrounds, cultures, and experiences. Each individual seeking service is unique and requires a unique set of services. Public health providers should recognize these unique qualities and base their services on those needs, and not just on a generalized understanding of people.

While much of this information is being studied around the country, and a lot of literature currently exists on the topic of health equity, little research has been done in Riley County specifically. Riley County is so unique in that it combines people from university, international, military, local, and more backgrounds into one community. In contrast, most rural towns in Kansas have little to no diversity in their population. With such a mix of backgrounds and cultures in Riley County, public health professionals must take into consideration every factor when working with individuals. My hope is that information gained through my interviews and through the *Chartbook* will assist professionals as they continue their important work in our community.

Being able to talk to public health professionals who work directly with the populations being discussed was a strength of this project. Their insight is invaluable and provides important direction for future research and possible policy development. A limitation was that there was no direct contact/interview/focus group with anyone experiencing the health inequities in question. While insight from health professionals is extremely valuable, individuals with direct exposure to these inequities would have helped to support any of the evidence that I have presented in this report. Another strength of this project is its relevance to Riley County and how data from the Kansas Health Institute was measured directly from the county and was able to describe adverse health outcomes for various populations in this community. Another weakness

was lack of quantitative data that was measured more recently. The most recent data from the Kansas Health Institute was from 2013 which is almost 5 years old now. More recent data will be necessary to ensure the relevance of the information in this report.

To make progress in reducing and eliminating health disparities and health inequities, health professionals and policy makers need to move beyond discussion of inequality and consider what is inequitable. Our attention should be focused on what is avoidable and preventable based on what we know now regarding determinants of health. Priorities should focus on what we do know regarding how to avoid a given disparity, what determinants of health are amendable, and how to make changes based on what we know. Given the context of our given population here in Riley County, efforts should focus on reducing known inequities, providing training regarding health equity to health professionals, and encouraging open and transparent dialogue among the community regarding these disparities and inequities. Health professionals need to move beyond a generalized understanding of minority populations and begin to more fully understand the individuals and populations at risk for adverse health outcomes.

Chapter 5 - Competencies

Student Attainment of MPH Foundational Competencies

Table 5.1 Summary of MPH Foundational Competencies

Number and Competency		Description
4	Interpret results of data analysis for public health research, policy or practice	I focused on translating data previously collected into readable graphs and presentations.
6	Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organization, community, and societal levels.	My research focused on health inequities in our own community and the possible reasons for these to exist.
18	Select communication strategies for different audiences and sectors	I developed a communication plan to be used by members of the coalition to make communication between members and the community more streamlined and efficient.
19	Communicate audience-appropriate public health content, both in writing and through oral presentation	Creating and posting online content for different audiences through Facebook, Instagram, and the website was a large portion of my internship.
21	Perform effectively on interprofessional teams	I served as both a general member of the coalition, as well as a member of the administrative support team.

Competency 4 – One of the first large projects I was able to work on during my time with the Flint Hills Wellness Coalition was creating presentations using data collected by the Kansas Health Institute. The data was collected throughout the entire state of Kansas from 1999-2013 and was published on March 1st, 2018 as *Chartbook: Racial and Ethnic Health Disparities in a Changing Kansas*. Data sets ranged from average income, unemployment rates, poverty rates, pregnancy rates, prenatal care, etc. and were broken down by individual county. Part of my responsibility was going through each data set and pulling any relevant information about Riley County. That data was then put into tables and then translated into more appealing visuals. This task gave me the opportunity to decipher what each piece of information meant and how this data can be used for future research, policy development, and public health practice. The presentation that I made was used during a conference call with Lawrence J. Panas, an analyst for the Kansas Health Institute and author of *Chartbook: Racial and Ethnic Health Disparities in a Changing Kansas.*

Competency 6 – The latter part of my time with the coalition focused on creating a health equity presentation. This was a culmination of what I previously knew about this topic, as well as new information collected along the way. Information was gained through a combined means of online research and interviews with Riley County Health Department Employees. Employees interviewed included Jennifer Green, Director of the Riley County Health Department; Earlisha Killen, Breastfeeding Consultant; Jan Scheiderman, Raising Riley; Breva Spencer, Maternal and Child Health; and Maria Baquero, Spanish Interpreter. These interviews were important in learning about aspects of public health in Riley County and helped me to begin deciphering data and learning possible explanations for health inequities present in Riley County. This presentation was made for the purpose of educating members of the coalition on health equity/inequity and to help us begin more conversations about how structural and racial biases and disparities can have drastic consequences for the health of populations.

Competency 18 – A large part of my experience with the coalition was helping the administrative team develop new ways to communicate with members of the coalition and with the community at large. The development of the communication plan was brought forward as a way to improve communication as a whole and in turn, create a more streamlined and efficient way of communicating. In order to make sure that the communication plan was something that was desired and needed, I met with members of each workgroup to discuss their opinions on the coalition, to hear their feedback on communication up to that point, as well as to discuss ways that they can be better supported by the administrative team. Our first goal with the communication plan was to improve internal communication between the administrative team, the workgroups, and members of the coalition. This included creating a new simplified meeting facilitation model, creating a Chair and Co-Chair position, and making face-to-face interaction a priority. The second goal of the communication plan was to raise awareness, support, and participation in coalition initiatives among the public. This included creating direct links to the coalition through our website and social media accounts, providing basic social media and communication training, and identifying communication specialists within each workgroup to engage with members of the community.

Competency 19 – One aspect that I wanted to focus on was reaching new audiences with information about the coalition and other features of community health. New forms of communication were developed and one that I have been able to continually maintain is our Instagram page. The coalition already had a Facebook page and utilized this form of communication frequently, but I wanted to use the Instagram page to reach a new audience and test out different forms of content. Content included highlights of individual workgroups, upcoming events, and meeting reminders. After searching for other similar Instagram pages, I only found a few that were poorly maintained and not up to date. My hope is that other people will be able to find our page, whether they be individuals or other wellness coalitions, and engage with us in that way. It was also important that we recognize the need for updated and accurate information on our website as well, and all workgroups were encouraged to send in updates as often as possible. It is my understanding that most people use our website as their first introduction to the coalition, so it was important that they be always be able to find up to date information.

Competency 21 – Performing on various interprofessional teams within the coalition was by far the most important aspect of my time with them. I regularly attended meetings with Julie Hettinger who is the Health Educator at the RCHD and Brandon Irwin who is the Community Organizer, as they were the two that advised me during my time with the coalition. I also attended meetings with the Administrative Support Team who worked behind the scenes to organize large coalition meetings, write and approve grants for the coalition, and made other administrative decisions. Another large aspect of my responsibilities was regularly interacting with each workgroup, meeting one-on-one with workgroup leaders, occasionally attending workgroup meetings, and passing on updates, wants, and needs to the administrative support team. Coalition meetings consist of community partners and individuals all over Riley County including but not limited to USD 383, Lafene Health Center, Pawnee Mental Health, Via Christi Health Center, City of Manhattan, ATA Bus, various entities within K-State, and more.

Table 5.2 MPH Foundational Competencies and Course Taught In

22 Public Health Foundational Competencies Course Mapping	MPH 701	MPH 720	MPH 754	MPH 802	MPH 818
Evidence-based Approaches to Public Health					
1. Apply epidemiological methods to the breadth of settings and situations in public health practice	x		x		
2. Select quantitative and qualitative data collection methods appropriate for a given public health context	x	x	x		
3. Analyze quantitative and qualitative data using biostatistics, informatics, computer-based programming and software, as appropriate	x	x	x		
4. Interpret results of data analysis for public health research, policy or practice	x		x		
Public Health and Health Care Systems					
5. Compare the organization, structure and function of health care, public health and regulatory systems across national and international settings		x			
6. Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organizational, community and societal levels					x
Planning and Management to Promote Health					
7. Assess population needs, assets and capacities that affect communities' health		x		x	
8. Apply awareness of cultural values and practices to the design or implementation of public health policies or programs					x
9. Design a population-based policy, program, project or intervention			x		
10. Explain basic principles and tools of budget and resource management		x	x		
11. Select methods to evaluate public health programs	x	x	x		
Policy in Public Health					
12. Discuss multiple dimensions of the policy-making process, including the roles of ethics and evidence		x	x	x	
13. Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes		x		x	
14. Advocate for political, social or economic policies and programs that will improve health in diverse populations		x			x
15. Evaluate policies for their impact on public health and health equity		x		x	
Leadership					
16. Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making		x			x
17. Apply negotiation and mediation skills to address organizational or community challenges		x			
Communication					
18. Select communication strategies for different audiences and sectors	DMP 815, FNDH 880 or KIN 796				
19. Communicate audience-appropriate public health content,	DMP 815, FNDH 880 or KIN 796				

both in writing and through oral presentation					
20. Describe the importance of cultural competence in communicating public health content		x			x
Interprofessional Practice					
21. Perform effectively on interprofessional teams		x			x
Systems Thinking					
22. Apply systems thinking tools to a public health issue			x	x	

Student Attainment of MPH Emphasis Area Competencies

Table 5.3 Summary of MPH Emphasis Area Competencies

MPH Emphasis Area: Physical Activity		
Number and Competency		**Description**
1	Population health	Examine and evaluate evidence-based knowledge of the relationship between physical activity and population health
2	Social, behavioral, and environmental influences	Investigate social, behavioral and environmental factors that contribute to participation in physical activity
3	Theory application	Examine and select social and behavioral theories and frameworks for physical activity programs in community settings
4	Developing and evaluating interventions	Develop and evaluate physical activity interventions in diverse community settings
5	Support evidence-based practice	Support public health officials and other community partners in the promotion of physical activity with evidence-based practices

Competency 1: Population Health - During my time in the MPH program, I was able to learn about different aspects of population health and how the health of entire populations can be affected by factors such as physical activity, access to services, socioeconomic status, environmental safety, disease prevention, and other health factors. Regarding physical activity, classes including KIN 612, KIN 614, KIN 655, and KIN 805 really stressed the importance of active populations in regard to short and long term health effects. The most crucial part to these classes were population based studies that looked at the association between physical activity levels in populations and their health outcomes. These studies helped me to understand the positive effects that physical activity can have on population health including rates of chronic

disease, life expectancy, cognitive function, and more. Understanding this relationship will be important as I transition into a career in public health and will be able to educate communities and populations about these positive effects. What really stood out to me in terms of physical activity and population health was comparisons between United States and other countries in terms of physical activity levels and health outcomes. These comparisons helped to me put into perspective how we rarely value physical activity and active lifestyles over convenience in our country as compared to other countries around the world.

Competency 2: Social, Behavioral, and Environmental Influences – Examining the relationship between the built environment, physical activity, and population health was integral to me understanding the dynamics between people and their surroundings, and how those surroundings can help or hinder a population's health. Most interesting was realizing how much of an influence a certain environment has on the health of a community, and what types of environments are ideal for a population to thrive. One important concept that I did learn was that there is not one "perfect" environment, and that an individual's success relies on a multitude of factors. What was most useful in understanding this concept was hands-on evaluations of a variety of neighborhoods, parks, etc. Evaluations utilized tools such as the Neighborhood Environment Walkability Score (NEWS), the Active Neighborhood Checklist (ANC), the International Physical Activity Questionnaire (IPAQ), and more. Most useful was understanding the importance of using valid and reliable tools to perform effective and consistent evaluations and audits of neighborhoods. After evaluations were conducted, analyses were performed to determine the effect certain neighborhoods and built environments had on the health of populations. This competency fits well with my research on health equity in our community and the importance in understanding how various environments and social norms can affect an individual's health.

Competency 3: Theory Application – Brazil et al. (2005) notes the importance of integrating theory into research and practice because it improves methodology and can encourage stronger collaboration between decision-makers. Integrating theory into practice can also create new expectations for improvements in public health and provide a framework to understand the complex relationship between resources, implementation, and outcomes (Brazil et al. 2005). Theory essentially provides us with the understanding for why people behave in certain ways and helps us design effective programs to change behaviors. When a solid understanding of theory is reached, behavior can be understood, explained, predicted, and changed. I was able to apply my knowledge of theory development in my classes through various hands-on projects and assignments. For example, In KIN 805 I was able to review a

theory-based intervention and assess how effectively the researchers used this theory for their intervention. I was then able to discuss the strengths and weaknesses of theory-based interventions and how effective they are when it comes to behavior change. In KIN 655 I was able to work on a project that focused on using theory to develop our own intervention. My target population was worksite wellness and I developed an intervention based on a known theory that would help to improve the physical activity participation in that population. These classes influenced my perception of incorporating trusted theories into practice and how necessary it is to produce valid and reliable results.

Competency 4: Developing and Evaluating Interventions - The development and evaluation of interventions was highly stressed in almost every course specific to the physical activity emphasis area. In KIN 614 and KIN 610, I was able to develop interventions relating to the built environment, food insecurity, neighborhood safety, health equity, and more. Developing interventions for such a variety of different health concerns forced me to step beyond my comfort and explore areas of interest that I might not otherwise have. The development of each of these interventions was meticulous, calculated, and well thought out. We had to consider every factor when developing each portion of our interventions and programs. While program development was important, just as important was evaluation. Evaluations were done from beginning to end and held each of us accountable to make sure that the development of our interventions was held to the highest standard possible.

Competency 5: Support Evidence-Based Practice - Supporting the efforts of public health officials and other partners in the community was an important aspect of my time in the MPH program, as well as my time with the Flint Hills Wellness Coalition. One of my goals within the coalition was to help promote community events that supported physical activity, nutrition, health, and wellness. Understanding the best available practices and current research is crucial and was a topic of discussion at many meetings within the coalition. Being a group that functions strictly from grants, it is important that any money spent on a project or event is spent wisely. Understanding the best evidence available, incorporating preferences of the community, and prioritizing valid evidence was important in every decision being made. In MPH 720 we were able to conduct interviews with various health professionals who work in a variety of careers within the health field. Each student was able to conduct their own interview and then the rest of the class was able to listen to every interview and learn about their practice and the issues that many populations are facing when it comes to our healthcare system. The assessment of policies, organizational system, and practices taught me how to understand basic trends in our healthcare system, as well as how different populations are impacted by their

access to healthcare. Each interviewee stressed the importance of incorporating evidence-based practice into their own personal practice and how applying strong, valid evidence is necessary to continue to improve. These professionals worked in a variety of healthcare settings but each one came back to the same message that it takes both clinical expertise and client values to be successful.

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Appendix

FHWC COMMUNICATION PLAN

info@flinthillswellness.org
www.flinthillswellness.org

WHY

This communication plan offers a framework for communication between members of the coalition and communication with the community at large

The coalition can also benefit from an increased presence in the online community by

- Circulating updated and correct information about the coalition and related events to the community and surrounding areas
- Spreading awareness and educating members about each of the coalition work groups
- Building capacity of the coalition and its presence in the community
- Demonstrating support for existing community groups and organizations

GOALS

Goal 1 – Improve internal communication between the administrative team, the workgroups, and members of the coalition

- Create Chair and Co-Chair position at coalition level
- Create a simplified meeting facilitation model
    - Members will come to meetings prepared with updates, questions, and asks for the groups
- Continue to improve internal communication structure
    - Face to face communications
        - Monthly coalition administrative support team meetings
        - Monthly coalition meetings
        - Monthly workgroup meetings
- Electronic communication will be through e-mail

Goal 2 – Raise awareness, support, and participation in coalition initiatives among the public

- Create direct links from the coalition to the community
    - Coalition website
    - Social media accounts
- Identify and train communications specialists within each workgroup

Appendix Figure 1: Communication Plan

- Provide basic social media training
- Train members on how to create effective messages
  - E.g. how and when to post to reach target audiences
- Outline various forms of social media and outreach methods to reach members of the community

TARGET AUDIENCES

Our target audience includes the community at large with special focus on those who may be facing health inequities including rural community members, senior citizens, low income families, etc.

COMMUNICATION "HOW TO'S"

Select Communication Channels

- Facebook – Build capacity and engagement
- Instagram – Educate and inform
- Newsletters – Information heavy
- Website – Main source of information

How to Post

- Posts on any platform (social media, websites, etc.) should be clear and concise
- Posts should include all necessary and pertinent information
- One member of each workgroup should be designated to post on various social communication platforms themselves OR contact the current coalition intern with all information for their desired post
- To post or update information on the FHWC website, please contact Brian Tesene at tesene@outdoorresources.com and CC coalition e-mail at info@flinthillswellness.org
- To post on FHWC Instagram, please contact the current coalition intern with all information. All information can be sent to Lexi (coalition intern) at lexizavala@gmail.com to be used on social media.
- To post on FHWC Facebook, either contact the current coalition intern or info@flinthillswellness.org. All workgroup communication specialists should be given admin access to the Facebook page.

What Posts Should Contain

- Posts should contain all important information related to topic or event

2

Appendix Figure 1 continued: Communication Plan

- Posts should also contain at least one photo related to the post itself. Photos should be high quality and appropriate to the post.

COMMUNICATION TOOLS AND GUIDELINES

Facebook

- Facebook is a good platform to reach a lot of people through a single post
- These posts should contain all pertinent information to whatever event or topic that the post is regarding
- If at all possible, please share and encourage members of the FHWC to share our posts so as to reach a larger audience
- Examples of what to post on Facebook include:
    - Events happening in or around the community
    - FHWC sponsored activities
    - Articles or journals related to the FHWC or its individual workgroups
- Because our presence on Facebook is still growing, posts on Facebook should be limited to 3-5 per week. This will increase engagement without overwhelming members of our group on Facebook
- Facebook can be used to educate and inform – by doing this, we hope to engage interaction with our page and increase knowledge and awareness about the coalition and the work that we're doing

Instagram

- Instagram is the newest social media platform for the FHWC and we hope to engage and interact with a different type of audience here
- Instagram posts will be limited to 3 per week
- We will utilize both normal posts as well as Instagram stories to inform and educate our followers about who we are, the work that we're doing, and any other information provided by individual workgroups
- Examples of what to post on Instagram include:
    - Upcoming events around the community
    - Education information regarding any of our individual workgroups
    - CHIP progress
    - Member spotlights

Website

3

Appendix Figure 1 continued: Communication Plan

- The website is the all-encompassing information hub for all things regarding the coalition
- This is most likely the first place that interested members will look for information regarding the coalition
- The website should be updated weekly with new information, meeting dates, event dates, workgroup updates, CHIP progress, and interested member information

SOCIAL MARKETING AND WHY IT'S IMPORTANT

- Social marketing is typically defined as a program-planning process that applies commercial marketing concepts and techniques to promote voluntary behavior change. Social marketing facilitates the acceptance, rejection, modification, abandonment, or maintenance of particular behaviors by groups of individuals, often referred to as the target audience.
- It tries to transform people's perception and behavior for the benefit of society as a whole
- Social marketers know it is not possible to be "all things to all people." Rather, marketing differentiates populations into subgroups or segments of people who share needs, wants, lifestyles, behavior, and values that make them likely to respond similarly to public health interventions.

4

Appendix Figure 1 continued: Communication Plan

Riley County Health Disparities Data

Developed by the Flint Hills Wellness Coalition based on *Chartbook: Racial and Ethnic Health Disparities in a Changing Kansas*

Presented by:

Lawrence John Panas, Ph.D. | Kansas Health Institute

March 1st, 2018

Appendix Figure 2: Chartbook Data Presentation

Population Distribution

Figure A1. Population by Race/Ethnicity in Riley County, 2016

Race/Ethnicity	Population	%	Female	Male
Non-Hispanic White	57,678	78.6%	47.5%	52.5%
Non-Hispanic African American	5,478	7.5%	42.3%	57.7%
Non-Hispanic American Indian/Alaska Native	487	0.7%	49.5%	50.5%
Non-Hispanic Asian/Pacific Islander	3,978	5.4%	50.4%	49.6%
Hispanic, Any Race	5,722	7.8%	44.4%	55.6%

Percentages are calculated based on the total population of each racial/ethnic group

Source: KHI analysis of data from the National Center for Health Statistics' Vintage 2016 Bridged-Race Postcensal Population Estimates.

Appendix Figure 2 continued: Chartbook Data Presentation

Age Distribution

Age Distribution and Median Age of All Kansasns by Geographic Area in Riley County, 2016									
Race/Ethnicity	Total	Age 0-4	Age 5-12	Age 13-17	Age 18-24	Age 25-44	Age 45-64	Age 65+	Median Age
All	73,343	5.9%	7.3%	3.8%	32.2%	27.5%	14.5%	8.8%	25.3
White	57,678	5.4%	6.7%	3.5%	32.6%	25.9%%	15.6%	10.4%	25.7
Non-Hispanic African	5,478	7.8%	10.3%	5.5%	32.3%	29.9%	11.1%	3.1%	23.7
Non-Hispanic American	487	5.5%	10.7%	6.6%	28.7%	30.6%	14.8%	31.0%	24.6
Non-Hispanic Asian/Pacific	3,978	6.2%	6.8%	3.5%	30.1%	37.3%	12.7%	3.4%	25.9
Race	5,722	9.6%	11.1%	5.5%	30.1%	33.8%	7.6%	2.3%	24.4

Percentages are calculated based on the total population of each racial/ethnic group

Source: KHI analysis of data from the National Center for Health Statistics' Vintage 2016 Bridged-Race Postcensal Population Estimates.

Appendix Figure 2 continued: Chartbook Data Presentation

Educational Attainment

Educational Attainment for All Riley County Adults Age 25 Years and Older by Gender, 2015						
	All		Male		Female	
Race/Ethnicity	Less Than HS	College	Less Than HS	College	Less Than HS	College
All	4.9%	44.9%	4.4%	44.6%	5.4%	45.3%
White	3.7%	46.5%	3.3%	46.1%	4.3%	46.9%
African American	10.5%	29.7%	7.3%	27.4%	14.5%	32.8%
American Indian/Alaska Native	12.2%	32.2%	10.4%	54.8%	13.9%	9.6%
Asian/Pacific Islander	9.1%	63.7%	5.7%	65.3%	12.2%	62.4%
Hispanic	10.9%	26.2%	14.3%	25.9%	6.6%	26.7%
Races	6.4%	36.0%	4.6%	45.2%	10.1%	17.6%

Percentages are for the population with less than high school (HS) education or college or greater (bachelor's degree, graduate degree or professional degree). Percentages will not sum to 100 percent when combined.

Source: KHI analysis of data from the U.S. Census Bureau's American Community Survey 2015 (2011-2015) 5-Year Estimates.

Appendix Figure 2 continued: Chartbook Data Presentation

Births to All Mothers with Less than HS Education

Births to All Riley County Mothers with Less than High School Education, 1999-2013

	1999-2003		2004-2008		209-2013	
Race/Ethnicity	Count	%	Count	%	Count	%
All	339	7.3	350	7.1	303	5.5
Non-Hispanic White	253	7.2	226	6.1	183	4.5
Non-Hispanic African American	35	7.3	37	9.6	23	6.1
Non-Hispanic American Indian/Alaska Native						
Non-Hispanic Asian/Pacific Islander			10	4.3	6	2.3
Hispanic	45	13	59	14	76	13.8

Rates are for three five-year periods

Source: Kansas Department of Health and Environment, data from combined years 1999-2003, 2004-2008 and 2009-2013.

Appendix Figure 2 continued: Chartbook Data Presentation

Per Capita Income and Median Household Income

Per Capita Income (in 2015 Infaltion-Adjusted Dollars) by Population Group in Riley County, 2015

All	Non-Hispanic White	African American	American Indian/Alaska Native	Asian	Hawain/Other Pacific Islander	Some Other Race	Two or More Races	Hispanic, Any Race
$23,992	$26,319	$19,997	$23,623	$15,666	$16,547	$11,583	$11,792	$14,128

Median Household Income (in 2015 Inflation-Adjusted Dollars) by Population Group in Riley County, 2015

All	Non-Hispanic White	African American	American Indian/Alaska Native	Asian	Hawain/Other Pacific Islander	Some Other Race	Two or More Races	Hispanic, Any Race
$44,437	$46,142	$47,893	$22,517	$30,675		$33,958	$40,444	$33,583

Source: KHI analysis of data from the U.S. Census Bureau's American Community Survey 2015 (2011-2015) 5-Year Estimates.

Appendix Figure 2 continued: Chartbook Data Presentation

Unemployment Rate

Unemployment Rate in Riley County by Population Group and Gender, 2010 and 2015

	All	Non-Hispanic White	African American	American Indian/Alaska Native	Asian	Native Hawaiin/Other Pacific Islander	Some Other Race	Two or More Races	Hispanic, Any Race	Male	Female
2010	4.5%	4.1%	8.4%	0.0%	0.9%	0.0%	32.7%	6.0%	8.3%	4.1%	3.4%
2015	5.8%	5.3%	9.3%	35.1%	5.5%	0.0%	2.8%	11.2%	6.2%	5.6%	5.4%

Source: KHI analysis of data from the U.S. Census Bureau's American Community Survey (ACS) 2010 (2006-2010) 5-Year Estimates and the U.S. Census Bureau's ACS 2015 (2011-2015) 5-Year Estimates.

Appendix Figure 2 continued: Chartbook Data Presentation

Riley County Residents Below Poverty

All Riley County Residents Below Poverty by Gender, 2015

	All		Male		Female	
Race/Ethnicity	Count	%	Count	%	Count	%
All	14,922	22.5%	7,227	21.0%	7,695	24.2%
Non-Hispanic White	11,357	22.1%	5,563	20.9%	5,794	23.4%
African American	790	19.1%	334	15.0%	456	24.0%
American Indian/Alaska Native	135	41.9%	69	51.1%	66	35.3%
Asian/Pacific Islander	1,053	34.3%	533	40.2%	520	29.8%
Some Other Race	345	41.7%	25	9.8%	320	55.9%
Two or More Races	532	19.3%	343	20.0%	189	18.3%
Hispanic	1,177	22.9%	457	16.8%	720	29.8%

Source: KHI analysis of data from the U.S. Census Bureau's American Community Survey 2015 (2011-2015) 5-Year Estimates.

Appendix Figure 2 continued: Chartbook Data Presentation

Renter Occupied Households with Gross Rent at 30% of Income

Percent of Renter-Occupied Households with Gross Rent at 30 Percent (or Greater) of Their Income by Race/Ethnicy in Kansas, 2000 and 2010

	All	Non-Hispanic White	African American	American Indian/Alaska Native	Asian/Pacific Islander	Some Other Race	Two or More Races	Hispanic, Any Race
2000	46.50%	48.20%	40.50%		29.30%		39.50%	42.60%
2010	55.40%	57.50%	40.80%		22.40%		65.70%	71.40%

Percentages are for householders in rented households with gross rent as 30 percent (or greater) of their income and do not sum to 100 percent

Source: KHI analysis of data from the U.S. Census Bureau's 2000 Census and the U.S. Census Bureau's American Community Survey 2010 (2006-2010) 5-Year Estimates.

Appendix Figure 2 continued: Chartbook Data Presentation

Households with No Vehicle

Percent of Households with No Vehicle by Race/Ethnicity in Riley County, 2000 and 2010

Non-Hispanic White		Non-Hispanic African American		Non-Hispanic American Indian/Alaska Native		Non-Hispanic Asian/Pacific Islander		Non-Hispanic Some Other Race		Non-Hispanic Two or More Races		Hispanic, Any Race	
2000	2010	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010
4.5%	4.3%	5.4%	10.2%	-	-	6.2%	10.3%	-	-	8.6%	0.0%	3.9%	4.0%

Percentages are for households without vehicles and do not sum to 100 percent

Source: KHI analysis of data from the U.S. Census Bureau's 2000 Census and the U.S. Census Bureau's American Community Survey 2010 (2006-2010) 5-Year Estimates.

Appendix Figure 2 continued: Chartbook Data Presentation

Pregnancy Rates for All Mothers Age 10-19

Pregnancy Rates (Age 10-19) for All Mothers in Riley County, 1999-2013						
	1999-2003		2004-2008		209-2013	
Race/Ethnicity	Count	%	Count	%	Count	%
All	541	20.8	476	18.8	417	16.7
Non-Hispanic White	414	18.6	345	16.6	274	14
Non-Hispanic African American	71	37.9	56	28.7	52	23
Non-Hispanic American Indian/Alaska Native	6	29.1				
Non-Hispanic Asian/Pacific Islander	8	12	6	6.9		
Hispanic	40	36.6	47	33.3	57	28.4

Rates are per 1,000 female age-group population for three five-year periods.

Source: Kansas Department of Health and Environment, data from combined years 1999-2003, 2004-2008 and 2009- 2013.

Appendix Figure 2 continued: Chartbook Data Presentation

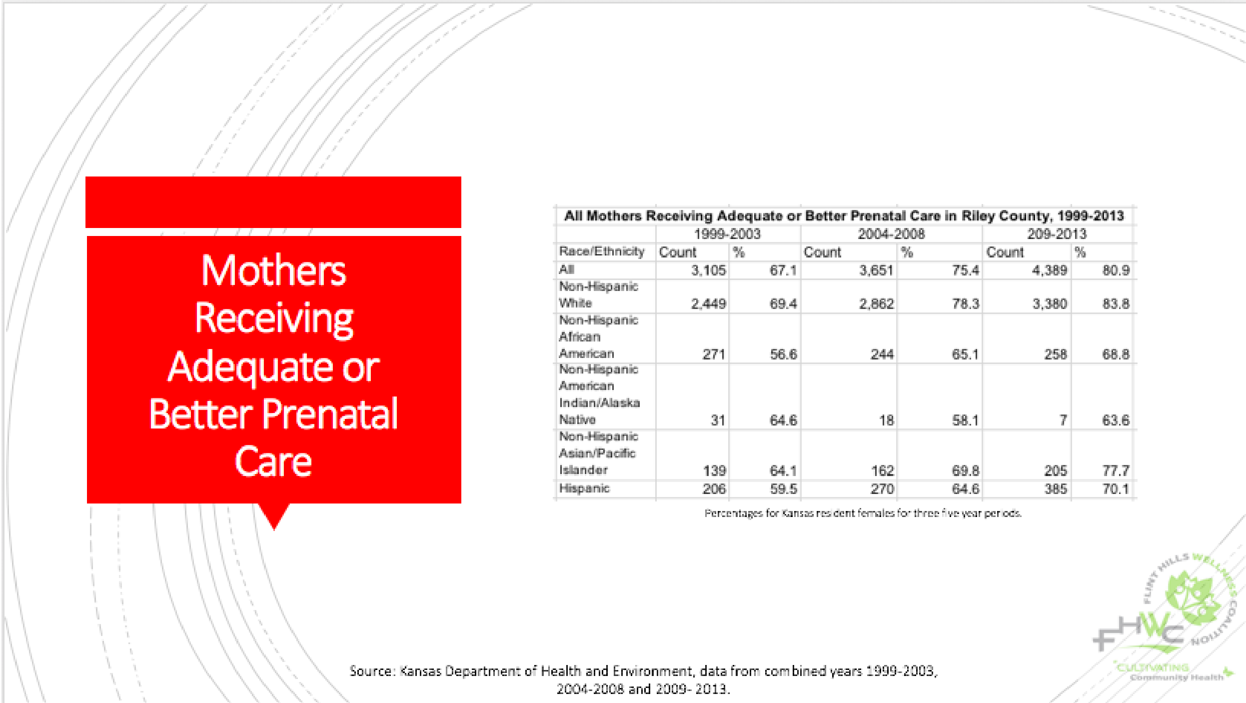
Pregnancy Rates for All Mothers Age 15-19

Pregnancy Rates (Age 15-19) for All Mothers in Riley County, 1999-2013						
	1999-2003		2004-2008		209-2013	
Race/Ethnicity	Count	%	Count	%	Count	%
All	536	28.8	473	25.3	412	23.1
Non-Hispanic White	411	25.4	343	21.6	271	18.7
Non-Hispanic African American	71	61.1	55	44	51	37.4
Non-Hispanic American Indian/Alaska Native						
Non-Hispanic Asian/Pacific Islander	8	20.8	6	10.6		
Hispanic	39	52.7	47	54.1	57	47.7

Rates are per 1,000 female age-group population for three five-year periods.

Source: Kansas Department of Health and Environment, data from combined years 1999-2003, 2004-2008 and 2009- 2013.

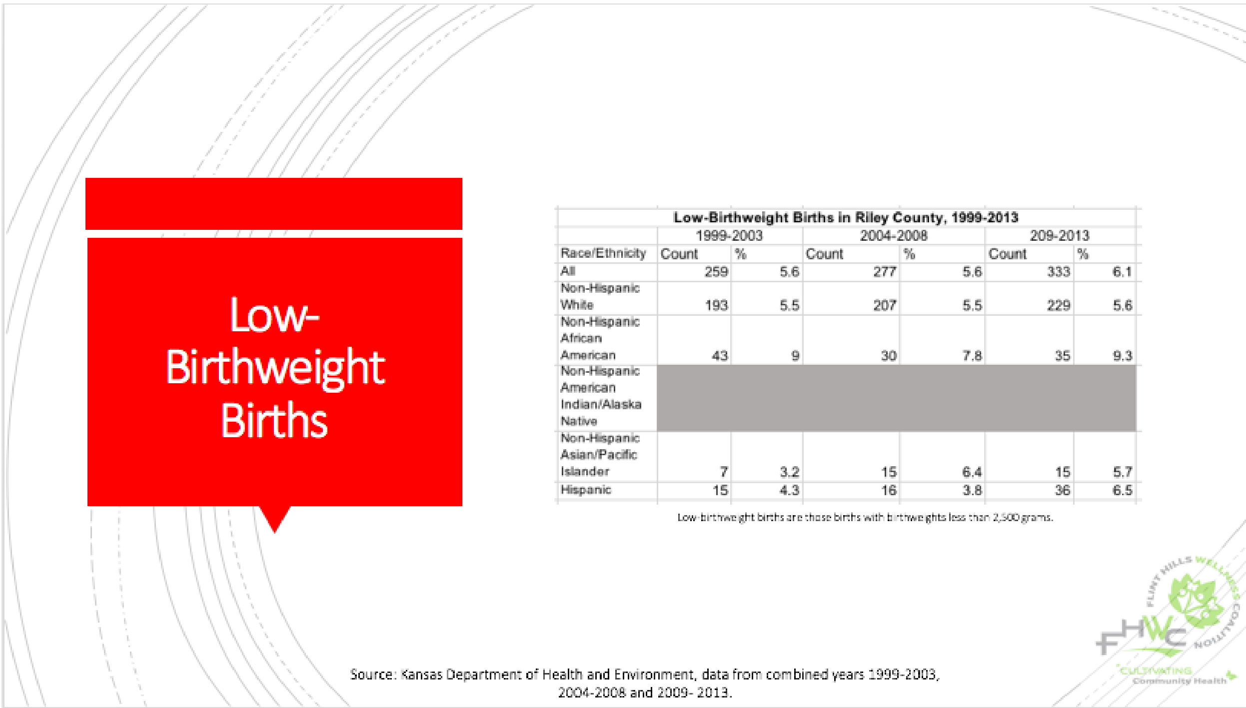
Appendix Figure 2 continued: Chartbook Data Presentation



All Mothers Receiving Adequate or Better Prenatal Care in Riley County, 1999-2013						
	1999-2003		2004-2008		209-2013	
Race/Ethnicity	Count	%	Count	%	Count	%
All	3,105	67.1	3,651	75.4	4,389	80.9
Non-Hispanic White	2,449	69.4	2,862	78.3	3,380	83.8
Non-Hispanic African American	271	56.6	244	65.1	258	68.8
Non-Hispanic American Indian/Alaska Native	31	64.6	18	58.1	7	63.6
Non-Hispanic Asian/Pacific Islander	139	64.1	162	69.8	205	77.7
Hispanic	206	59.5	270	64.6	385	70.1

Percentages for Kansas resident females for three five year periods.

Appendix Figure 2 continued: Chartbook Data Presentation



Low-Birthweight Births in Riley County, 1999-2013						
	1999-2003		2004-2008		209-2013	
Race/Ethnicity	Count	%	Count	%	Count	%
All	259	5.6	277	5.6	333	6.1
Non-Hispanic White	193	5.5	207	5.5	229	5.6
Non-Hispanic African American	43	9	30	7.8	35	9.3
Non-Hispanic American Indian/Alaska Native						
Non-Hispanic Asian/Pacific Islander	7	3.2	15	6.4	15	5.7
Hispanic	15	4.3	16	3.8	36	6.5

Low-birthweight births are those births with birthweights less than 2,500 grams.

Appendix Figure 2 continued: Chartbook Data Presentation

Premature Births

	Premature Births in Riley County, 1999-2013					
	1999-2003		2004-2008		209-2013	
Race/Ethnicity	Count	%	Count	%	Count	%
All	359	7.7	444	9	469	8.6
Non-Hispanic White	279	7.9	353	9.4	336	8.2
Non-Hispanic African American	43	9	31	8.1	33	8.8
Non-Hispanic American Indian/Alaska Native						
Non-Hispanic Asian/Pacific Islander	13	6	16	6.8	17	6.4
Hispanic	20	5.8	33	7.8	60	10.8

Premature births are births that occur under thirty-seven weeks' gestation

Source: Kansas Department of Health and Environment, data from combined years 1999-2003, 2004-2008 and 2009- 2013.

Appendix Figure 2 continued: Chartbook Data Presentation

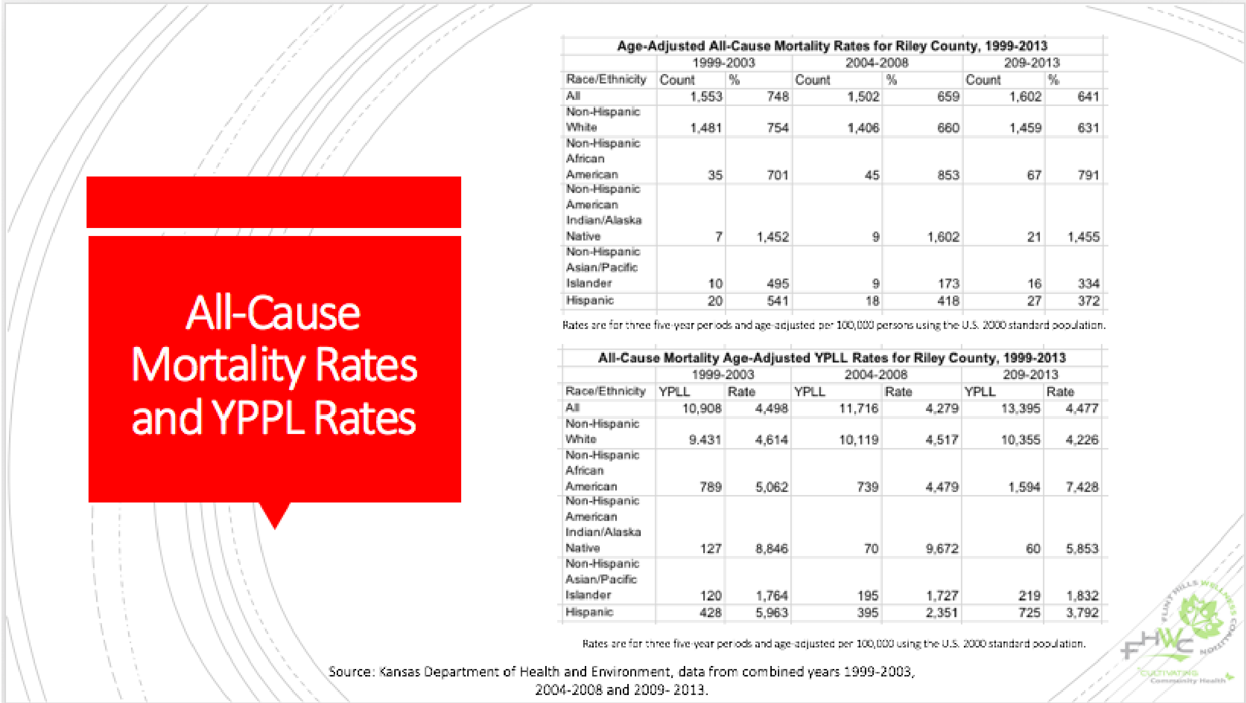
Infant Mortality Rates

	Infant Mortality Rates in Riley County, 1999-2013					
	1999-2003		2004-2008		209-2013	
Race/Ethnicity	Count	%	Count	%	Count	%
All	19	4.1	28	5.7	34	6.2
Non-Hispanic White	17	4.8	23	6.1	22	5.4
Non-Hispanic African American					6	15.9
Non-Hispanic American Indian/Alaska Native						
Non-Hispanic Asian/Pacific Islander						
Hispanic						

Rate per 1,000 live births

Source: Kansas Department of Health and Environment, data from combined years 1999-2003, 2004-2008 and 2009- 2013.

Appendix Figure 2 continued: Chartbook Data Presentation


All-Cause Mortality Rates and YPPL Rates

Age-Adjusted All-Cause Mortality Rates for Riley County, 1999-2013						
	1999-2003		2004-2008		209-2013	
Race/Ethnicity	Count	%	Count	%	Count	%
All	1,553	748	1,502	659	1,602	641
Non-Hispanic White	1,481	754	1,406	660	1,459	631
Non-Hispanic African American	35	701	45	853	67	791
Non-Hispanic American Indian/Alaska Native	7	1,452	9	1,602	21	1,455
Non-Hispanic Asian/Pacific Islander	10	495	9	173	16	334
Hispanic	20	541	18	418	27	372

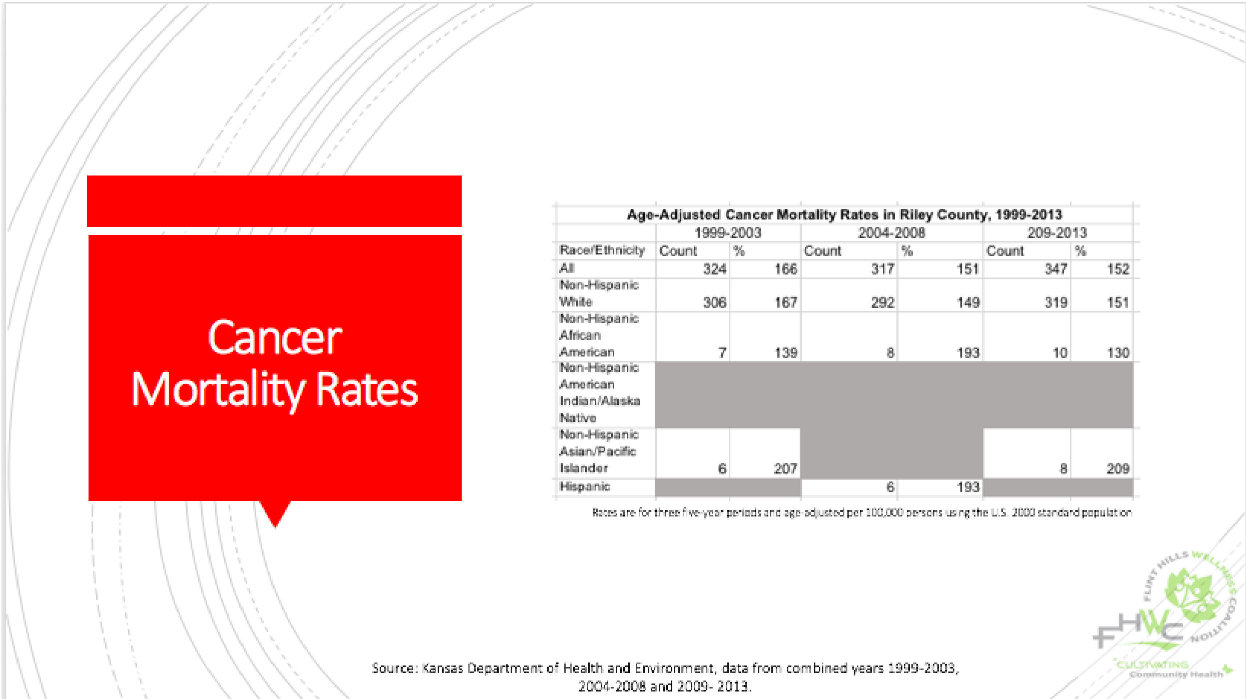
Rates are for three five-year periods and age-adjusted per 100,000 persons using the U.S. 2000 standard population.

All-Cause Mortality Age-Adjusted YPLL Rates for Riley County, 1999-2013						
	1999-2003		2004-2008		209-2013	
Race/Ethnicity	YPLL	Rate	YPLL	Rate	YPLL	Rate
All	10,908	4,498	11,716	4,279	13,395	4,477
Non-Hispanic White	9.431	4,614	10,119	4,517	10,355	4,226
Non-Hispanic African American	789	5,062	739	4,479	1,594	7,428
Non-Hispanic American Indian/Alaska Native	127	8,846	70	9,672	60	5,853
Non-Hispanic Asian/Pacific Islander	120	1,764	195	1,727	219	1,832
Hispanic	428	5,963	395	2,351	725	3,792

Rates are for three five-year periods and age-adjusted per 100,000 using the U.S. 2000 standard population.

Source: Kansas Department of Health and Environment, data from combined years 1999-2003, 2004-2008 and 2009- 2013.

Appendix Figure 2 continued: Chartbook Data Presentation


Cancer Mortality Rates

Age-Adjusted Cancer Mortality Rates in Riley County, 1999-2013						
	1999-2003		2004-2008		209-2013	
Race/Ethnicity	Count	%	Count	%	Count	%
All	324	166	317	151	347	152
Non-Hispanic White	306	167	292	149	319	151
Non-Hispanic African American	7	139	8	193	10	130
Non-Hispanic American Indian/Alaska Native						
Non-Hispanic Asian/Pacific Islander	6	207			8	209
Hispanic			6	193		

Rates are for three five-year periods and age adjusted per 100,000 persons using the U.S. 2000 standard population

Source: Kansas Department of Health and Environment, data from combined years 1999-2003, 2004-2008 and 2009- 2013.

Appendix Figure 2 continued: Chartbook Data Presentation

Premature Births

Premature Births in Riley County, 1999-2013						
	1999-2003		2004-2008		209-2013	
Race/Ethnicity	Count	%	Count	%	Count	%
All	359	7.7	444	9	469	8.6
Non-Hispanic White	279	7.9	353	9.4	336	8.2
Non-Hispanic African American	43	9	31	8.1	33	8.8
Non-Hispanic American Indian/Alaska Native						
Non-Hispanic Asian/Pacific Islander	13	6	16	6.8	17	6.4
Hispanic	20	5.8	33	7.8	60	10.8

Premature births are births that occur under thirty-seven weeks' gestation

Source: Kansas Department of Health and Environment, data from combined years 1999-2003, 2004-2008 and 2009- 2013.

Appendix Figure 2 continued: Chartbook Data Presentation

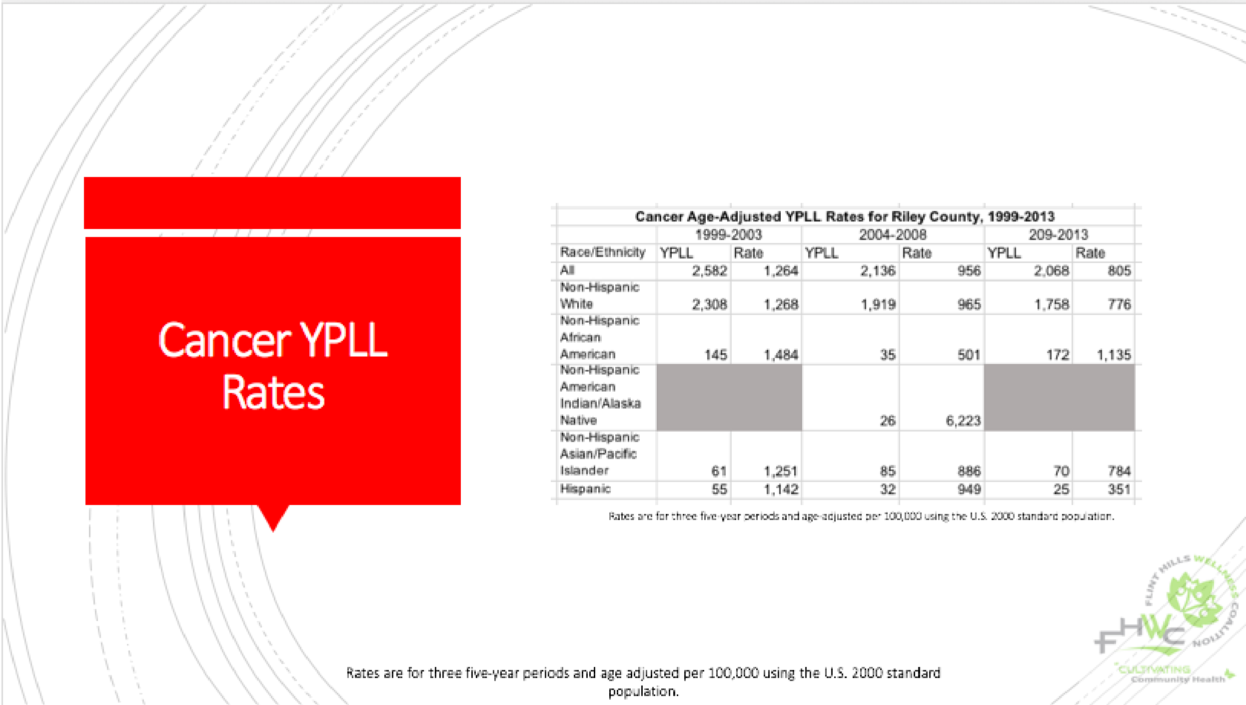
Infant Mortality Rates

Infant Mortality Rates in Riley County, 1999-2013						
	1999-2003		2004-2008		209-2013	
Race/Ethnicity	Count	%	Count	%	Count	%
All	19	4.1	28	5.7	34	6.2
Non-Hispanic White	17	4.8	23	6.1	22	5.4
Non-Hispanic African American					6	15.9
Non-Hispanic American Indian/Alaska Native						
Non-Hispanic Asian/Pacific Islander						
Hispanic						

Rate per 1,000 live births

Source: Kansas Department of Health and Environment, data from combined years 1999-2003, 2004-2008 and 2009- 2013.

Appendix Figure 2 continued: Chartbook Data Presentation

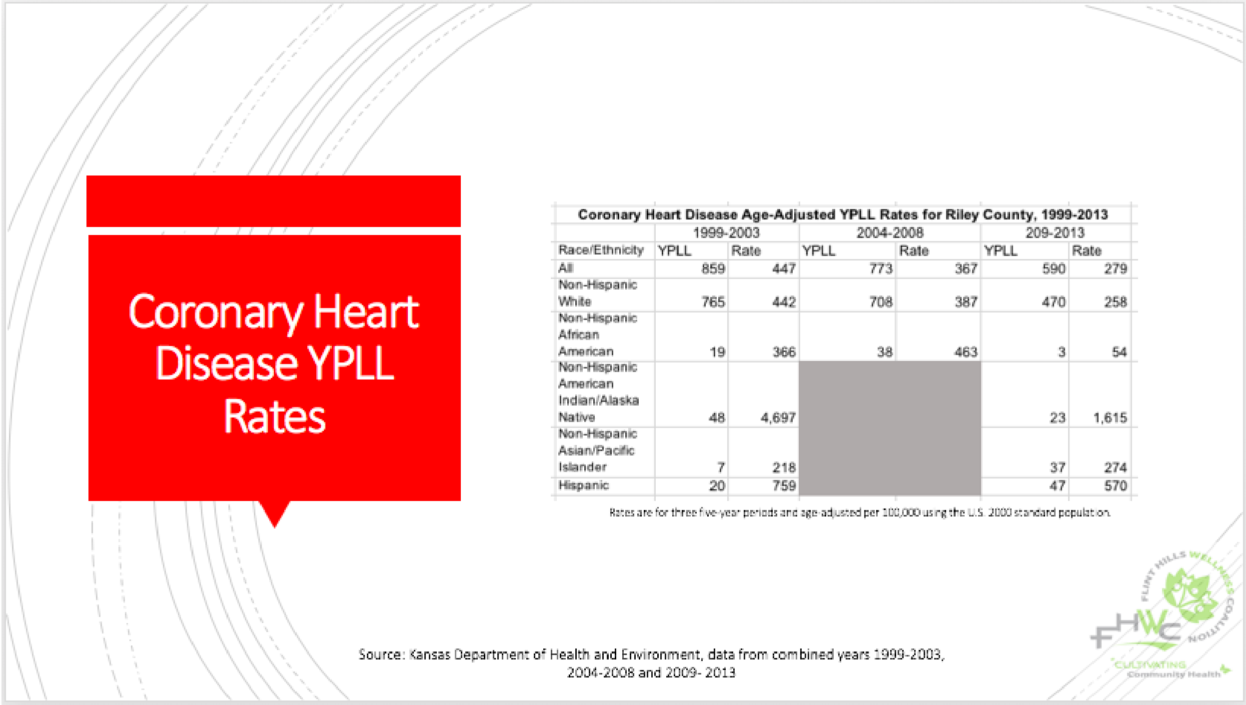


Cancer Age-Adjusted YPLL Rates for Riley County, 1999-2013

	1999-2003		2004-2008		209-2013	
Race/Ethnicity	YPLL	Rate	YPLL	Rate	YPLL	Rate
All	2,582	1,264	2,136	956	2,068	805
Non-Hispanic White	2,308	1,268	1,919	965	1,758	776
Non-Hispanic African American	145	1,484	35	501	172	1,135
Non-Hispanic American Indian/Alaska Native			26	6,223		
Non-Hispanic Asian/Pacific Islander	61	1,251	85	886	70	784
Hispanic	55	1,142	32	949	25	351

Rates are for three five-year periods and age-adjusted per 100,000 using the U.S. 2000 standard population.

Appendix Figure 2 continued: Chartbook Data Presentation

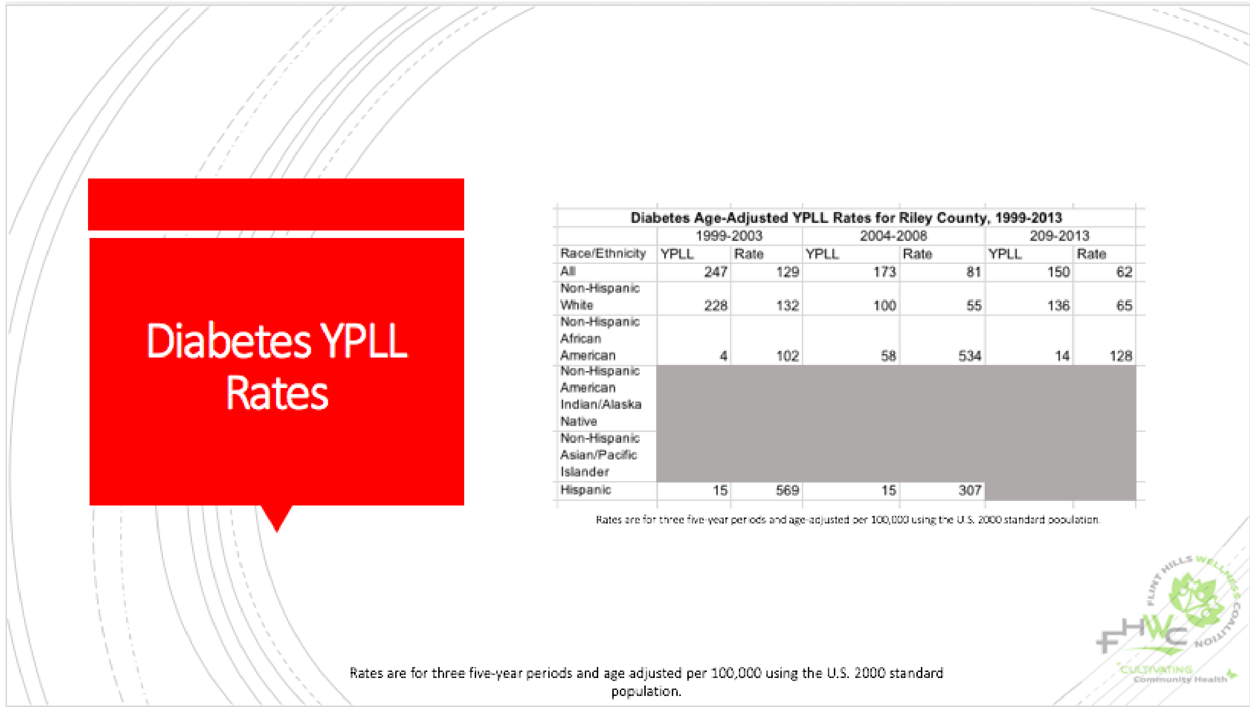


Coronary Heart Disease Age-Adjusted YPLL Rates for Riley County, 1999-2013

	1999-2003		2004-2008		209-2013	
Race/Ethnicity	YPLL	Rate	YPLL	Rate	YPLL	Rate
All	859	447	773	367	590	279
Non-Hispanic White	765	442	708	387	470	258
Non-Hispanic African American	19	366	38	463	3	54
Non-Hispanic American Indian/Alaska Native	48	4,697			23	1,615
Non-Hispanic Asian/Pacific Islander	7	218			37	274
Hispanic	20	759			47	570

Rates are for three five-year periods and age-adjusted per 100,000 using the U.S. 2000 standard population.

Appendix Figure 2 continued: Chartbook Data Presentation

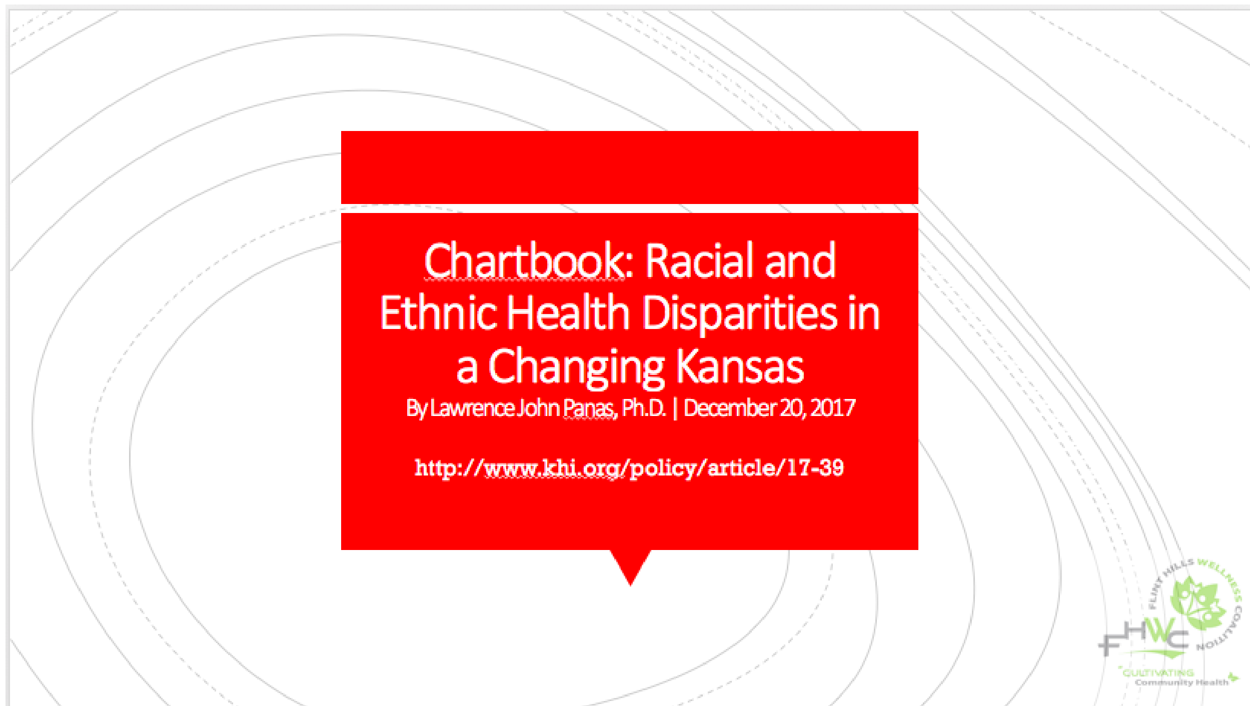


Diabetes Age-Adjusted YPLL Rates for Riley County, 1999-2013

	1999-2003		2004-2008		209-2013	
Race/Ethnicity	YPLL	Rate	YPLL	Rate	YPLL	Rate
All	247	129	173	81	150	62
Non-Hispanic White	228	132	100	55	136	65
Non-Hispanic African American	4	102	58	534	14	128
Non-Hispanic American Indian/Alaska Native						
Non-Hispanic Asian/Pacific Islander						
Hispanic	15	569	15	307		

Rates are for three five-year periods and age-adjusted per 100,000 using the U.S. 2000 standard population.

Appendix Figure 2 continued: Chartbook Data Presentation



Appendix Figure 2 continued: Chartbook Data Presentation

Advancing Health Equity in Riley County

And addressing root causes

Appendix Figure 3: Health Equity Presentation

Objectives

- Define health equity
- Discuss trends in health and health disparities in Riley County
- The next steps

Appendix Figure 3 continued: Health Equity Presentation

Before we go further...why does it matter?

Appendix Figure 3 continued: Health Equity Presentation

What is Health?

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

World Health Organization 1948

Appendix Figure 3 continued: Health Equity Presentation

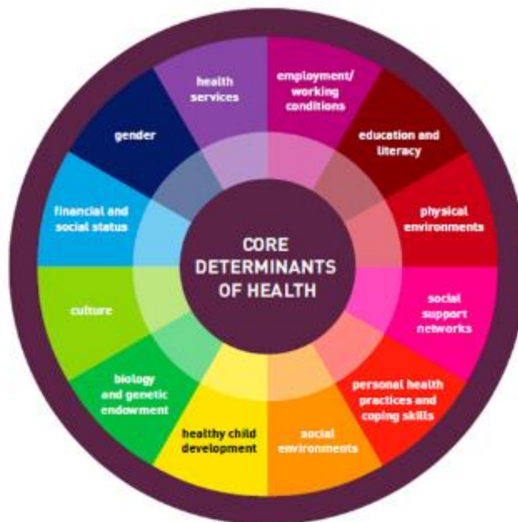
What is Public Health?

"Public health is what we, as a society, do collectively to assure the conditions in which (all) people can be healthy"

-Institute of Medicine (1988),
Future of Public Health

Appendix Figure 3 continued: Health Equity Presentation

Factors that determine health



- Social environments
- Healthy child development
- Biology and genetics
- Culture
- Financial and social status
- Gender
- Health services
- Employment / working conditions
- Education and literacy
- Physical environments
- Social support networks
- Personal health practices and coping skills

World Health Organization, Health Impact Assessment

Appendix Figure 3 continued: Health Equity Presentation

Factors included among the social determinants of health are indeed modifiable and they can be influenced by social, economic, and political processes and policies.

Appendix Figure 3 continued: Health Equity Presentation

Public Narrative - Why is it important?

"It's defined as a leadership practice of translating values into action, based on the fact that values are experienced emotionally. Narrative is the discursive means people use to access values that equip them with the courage to make choices under conditions of uncertainty."

Appendix Figure 3 continued: Health Equity Presentation

Asking the right questions about assumptions helps change the narrative about what creates health

- ❑ *What do we value most in our community?*
- ❑ *What is the public "narrative" in Riley County regarding health?*

Appendix Figure 3 continued: Health Equity Presentation

Health Equity

"Health equity means that everyone has a fair and just opportunity to be healthier"

Triple Aim of **Health Equity**

- Implement a Health in All Policies Approach With Health Equity as the Goal
- Expand Our Understanding of What Creates Health
- Strengthen the Capacity of Communities to Create Their Own Healthy Future

Implement Health in All Policies

Strengthen Community Capacity

Expand Understanding of Health

Appendix Figure 3 continued: Health Equity Presentation

Health Inequity

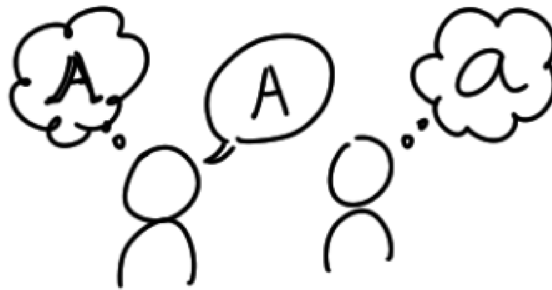
Health inequities are systematic differences in the health status of different population groups. These inequities have significant social and economic costs both to individuals and societies. It arises from the social, economic, environmental, and structural disparities that contribute to intergroup differences in health outcomes both within and between societies.

World Health Organization, 2017

Appendix Figure 3 continued: Health Equity Presentation

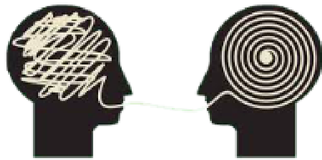
Two Common Themes

- Interviews conducted with Public Health professionals in Riley County
- Two common themes arose from interviews
  - Inequity as a function of misunderstanding
  - Inequity as a function of miscommunication



Appendix Figure 3 continued: Health Equity Presentation

Inequity as a Function of Misunderstanding



- Understanding the differences and uniqueness of individuals utilizing services
- Are we listening to them?
- Can't generalize a population - everyone has individuals needs
- Getting to know people on a personal level - becoming a familiar and trustworthy face
- Stories on a national level
  - Shalon Irving

Appendix Figure 3 continued: Health Equity Presentation

Inequity as a Function of Miscommunication

- Creating a safe environment for non-English speaking individuals
- Information understandable at all educational levels
- Resources and facilities accessible to all - recognizing needs of all populations
- Adapting resources
- Are we doing enough?
  - Look from a different perspective

Appendix Figure 3 continued: Health Equity Presentation

Population by Race/Ethnicity in Riley County, 2016

Non-Hispanic White – 78.6%

Non-Hispanic African American – 7.5%

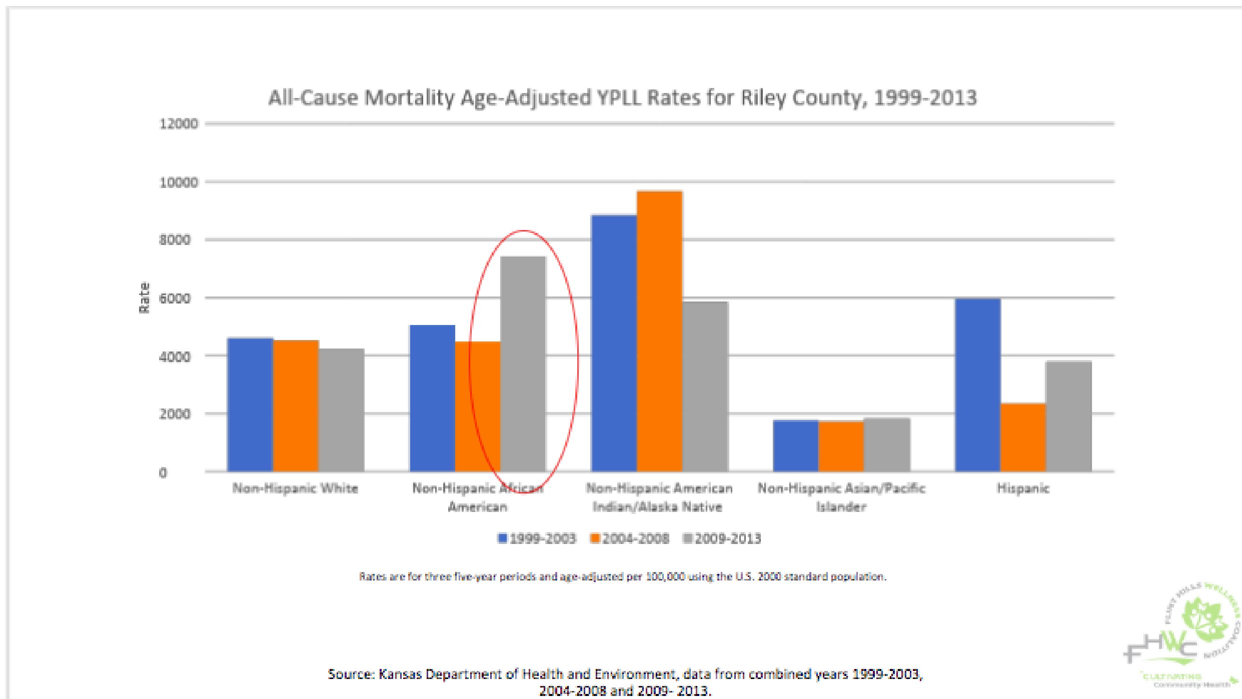
Non-Hispanic American Indian/Alaska Native- 0.7%

Non-Hispanic Asian/Pacific Islander – 5.4%

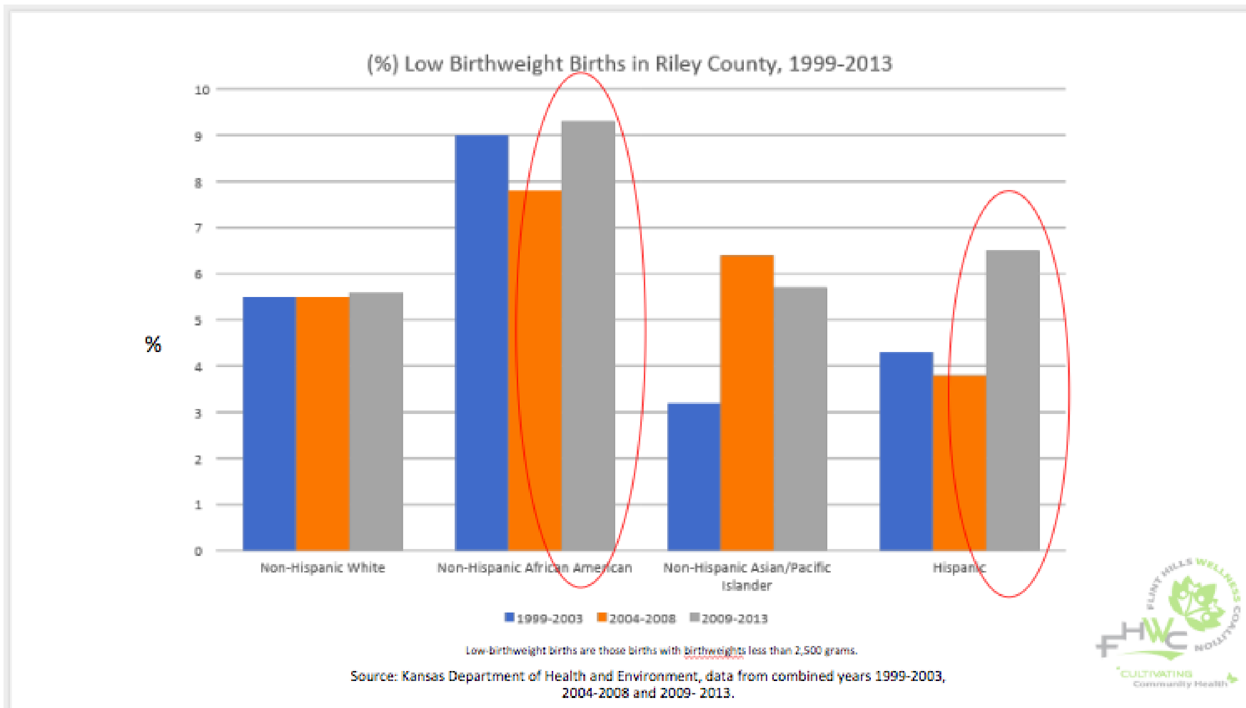
Hispanic/Any Race – 7.8%

Source: KHI analysis of data from the National Center for Health Statistics' Vintage 2016 Bridged-Race Postcensal Population Estimates.

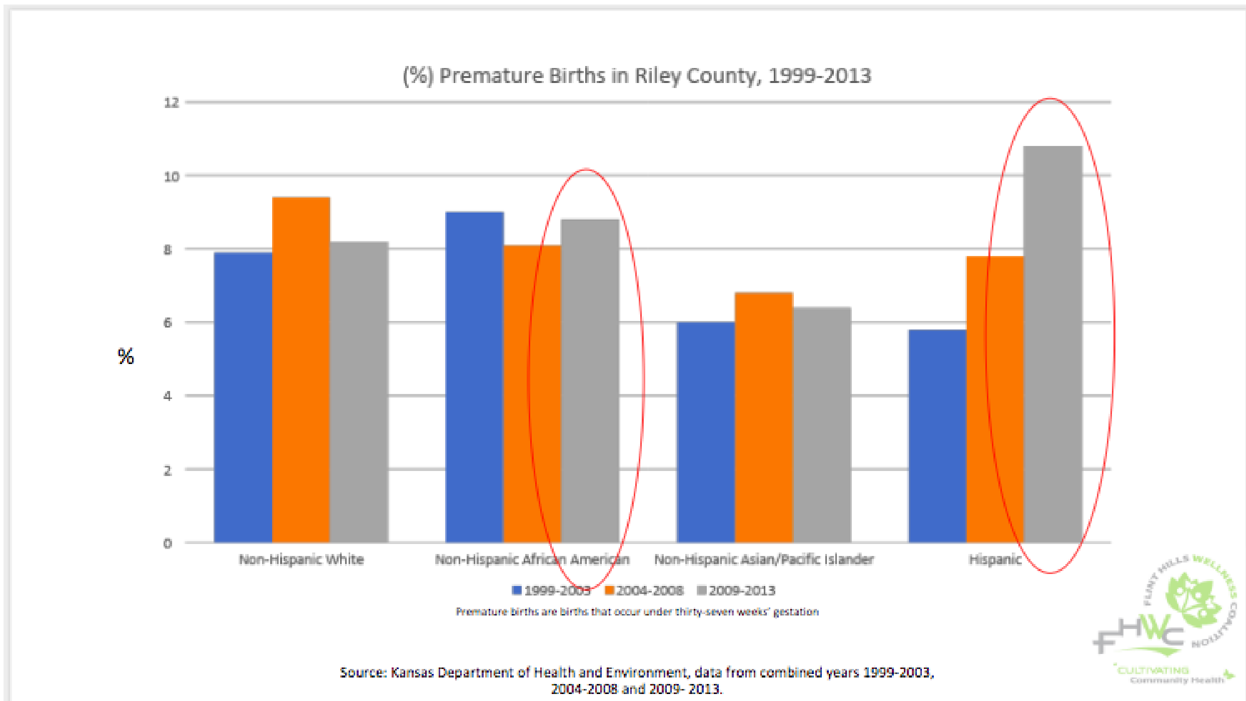
Appendix Figure 3 continued: Health Equity Presentation



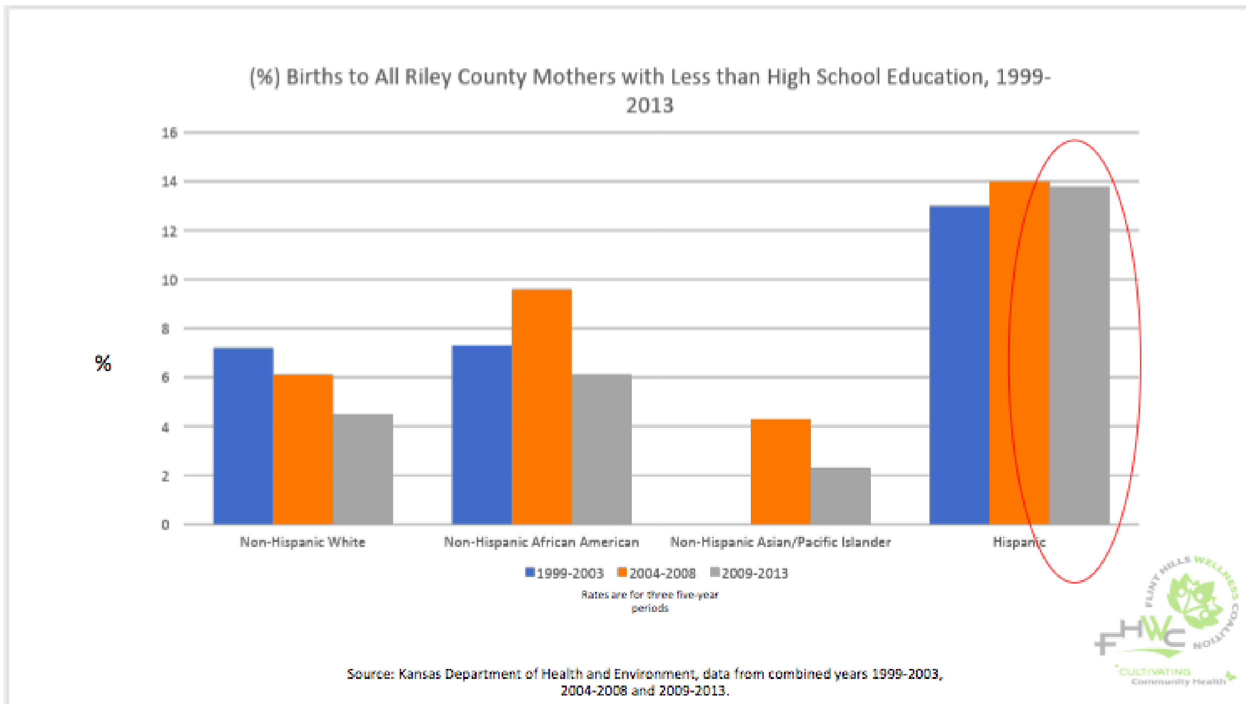
Appendix Figure 3 continued: Health Equity Presentation



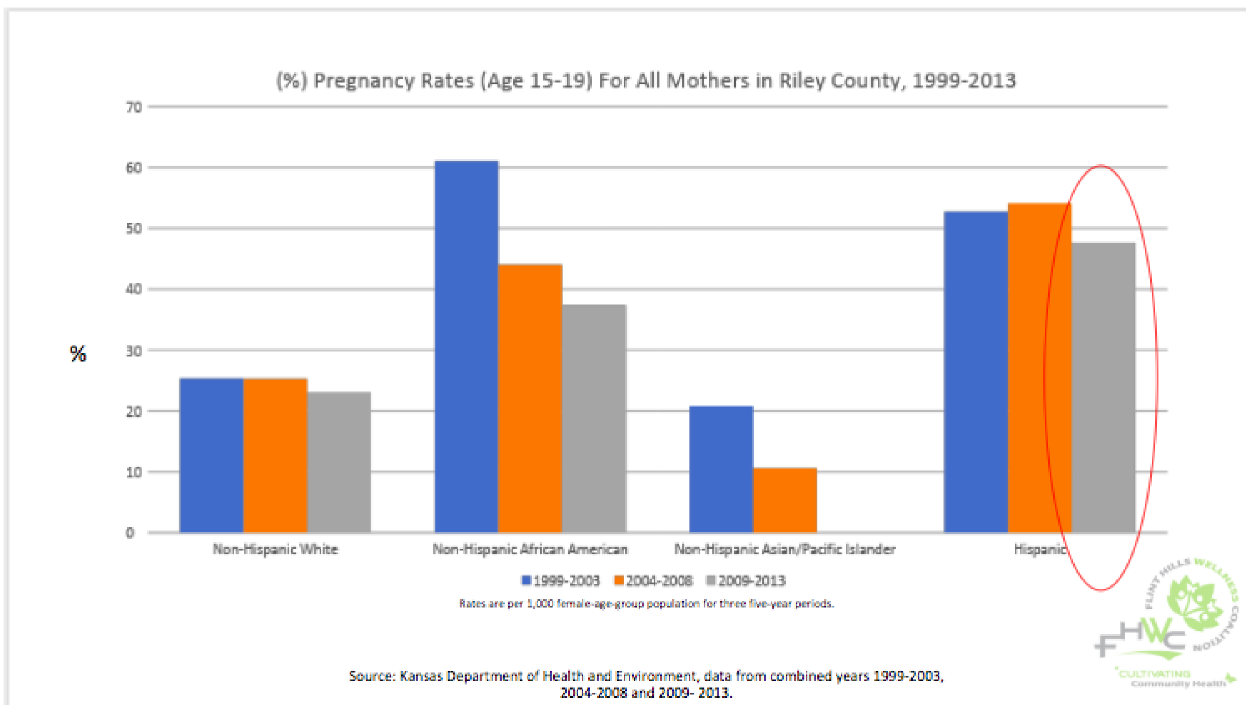
Appendix Figure 3 continued: Health Equity Presentation



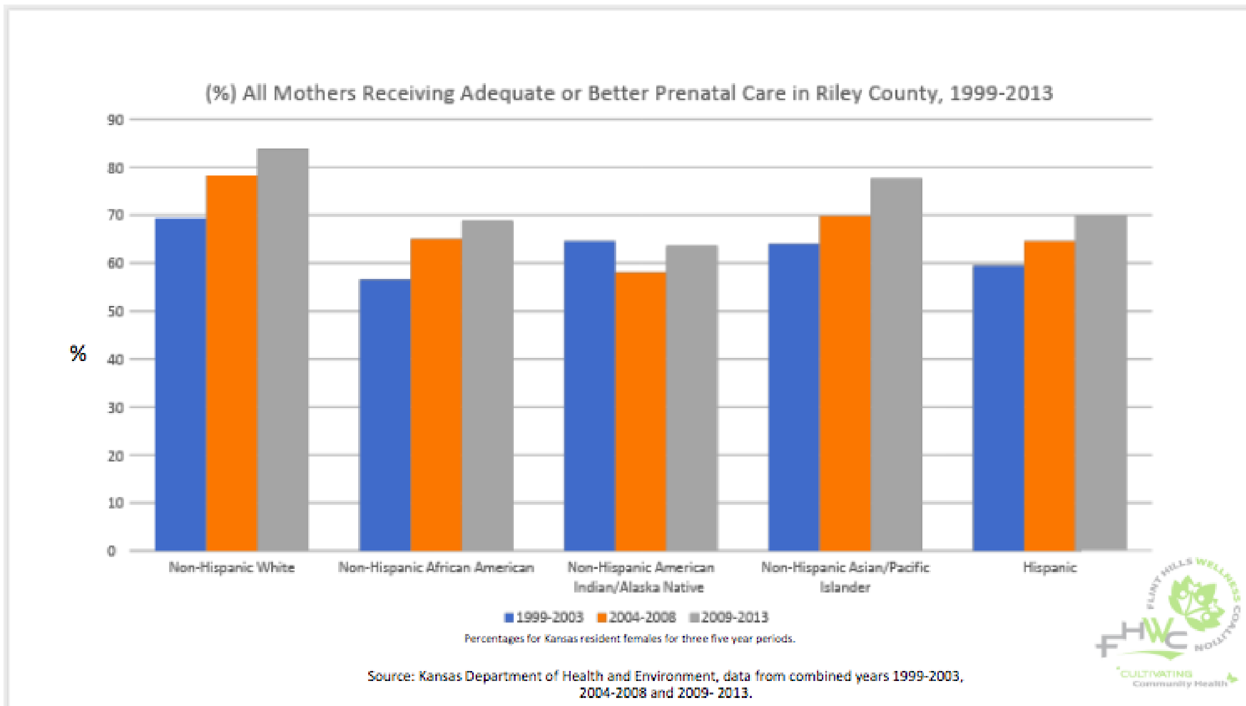
Appendix Figure 3 continued: Health Equity Presentation



Appendix Figure 3 continued: Health Equity Presentation



Appendix Figure 3 continued: Health Equity Presentation



Appendix Figure 3 continued: Health Equity Presentation

A community effort - what's our narrative?

Health – and health equity - are created in the community by people working together to create just economic, social and environmental conditions that promote health.

FLINT HILLS WELLNESS COALITION

FHWC

CULTIVATING Community Health

Appendix Figure 3 continued: Health Equity Presentation

What needs to be done?

In education?
In housing?
In transportation?
In employment?
In public safety?
In the physical environment?

Appendix Figure 3 continued: Health Equity Presentation

To create change we need...

Public understanding – of what creates health

Public agenda – create expectation that we can and will address these conditions

Public/political will – to make tough choices- accountability for policies, programs

Appendix Figure 3 continued: Health Equity Presentation

Maternal Health – Interview Guide

Describe your role at the Riley County Health Department?

-

What populations do you primarily work with?

-

What are the most common issues the women/families that you work with face?

-

Do you believe that health disparities / health inequities exist in Riley County? In Manhattan, KS?

-

What do you believe are some underlying issues for why we might be seeing women face these disparities or inequities?

-

What are your thoughts on the data presented by the KHI on maternal health outcomes?

-

What conclusions or connections that you draw from the data?

-

What health services or resources are available to these populations?

-

Any concluding thoughts regarding health inequity, health disparities, or the KHI data?

-

Appendix Figure 4: Sample Interview Guide

Appendix Figure 5: FHWC Instagram Page

fh_wellness
Manhattan, Kansas

Liked by **sam__bond**, **n8faflick** and **6 others**

fh_wellness Our vision is a healthy, equitable, resilient community and our mission is to bring together residents of Riley County to take collective action to address health inequity through system and policy change. Our project to enhance health equity in Riley County is funded by the Kansas Health Foundation and the Healthy Communities Initiative. For more information on this project, visit our website at flinthillswellness.org/advancing-health-equity-in-

Appendix Figure 5 continued: FHWC Instagram Page

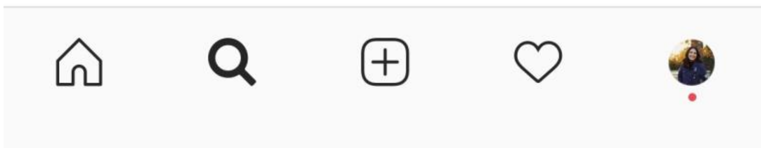
fh_wellness
Northview, Manhattan

Liked by **sam__bond**, **earth_to_brandon** and **14 others**

fh_wellness Community. In. Action. The Greater Northview Action Team (GNAT) is working hard to improve the community around them. Interested in the work that they're doing? Stop by their meeting this Thursday to learn more about ways to get involved! For more information, DM us or search for the Northview Action Team on Facebook.

View 1 comment

AUGUST 20



Appendix Figure 5 continued: FHWC Instagram Page