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1.	NEW YORK/NEWARK	225	250	475
2.	CHICAGO	200	80	280
3.	DETROIT	140		140
4.	LOS ANGELES	125	250	375
5	WASHINGTON, DC	110		110
6.	PHILADELPHIA	100		100
7.	BALTIMORE	90		90
8.	DALLAS/FT. WORTH	75		75
9.	SAN FRANCISCO/OAKLAND	75	50	125
10.	HOUSTON	75	50	125
11.	ATLANTA	75		75
12.	NEW ORLEANS	60		60
13.	ST. LOUIS	50		50
14.	MEMPHIS	50		50
15.	CLEVELAND	50		50
16.	MIAMI		150	150
17.	SAN ANTONIO		100	100
18.	BROWNSVILLE/McALLEN		70	70
19.	EL PASO		50	50
20.	ALBUQUERQUE		50	50
21.	TUCSON	20	50	70
22.	TOPEKA	20	20	40
23.	ROXBURY/BOSTON	20	--	20
24.	DENVER	20	30	50
25.	INDIANAPOLIS	20		20
26.	BATON ROUGE	20		20
27.	JACKSON, MS	20		20
28.	HELENA	20		20
29.	RALEIGH	20		
30.	COLUMBUS	20		20
31.	COLUMBIA	20		20
32.	SEATTLE	20		20
33.	BATTLE CREEK	10		10
34.	KALAMAZOO	15		15
35.	GRAND RAPIDS	15		15
36.	PONTIAC	20		20
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Division of Health Improvement

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Director

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August 6, 1993

To: Kansas Health Foundation Advisory Committee
Robert St. Peter, M.D.
Edward B. Perrin, Ph.D.
✓Kristine M. Gebbie, MSN

William Turner, Ph.D., Consultant

Kansas Health Foundation Staff
Jack Davis, President
Marni Vliet, Senior Vice President
Donald Stewart, Vice President
Lynne Pringle, Grants Manager

Dear Colleagues:

The last of the individual Committee members' reviews of the July 20th draft report was received yesterday. Enclosed is a revised draft. I have tried to incorporate all of your suggestions.

At the end of the report there is a section III. Schedule. The enclosed draft completes the work defined in the first sentence of the section on Schedule. Our next task is to interact with the Foundation staff to make further modifications and refinements according to the needs of the Foundation. Our final report will be due in about six weeks.

Enclosed in this mailing is the report by Bill Turner, dated July 27, 1993. Bill's report is thought-provoking and warrants our attention. Does our report need a greater emphasis on minority health, on minority representation in the health professions, and in minority input to leadership? Should one of the proposed institute's decentralized centers be organized specifically around the issue of minority health? Does the tone of our report capture our collective view of the issue of minority health? Is our collective view adequate to the need? Have we been faithful to the concept of "improved health for all Kansans"? Your views on these topics is sought.

I will give each of you about 10 days to think about the report and related matters and then I will be in touch with each of you by telephone.

Respectfully submitted,

Alvin R. Tarlov, MD
Director, Division of Health Improvement and
Senior Scientist, The Health Institute
New England Medical Center

Professor of Medicine
Tufts University School of Medicine

Professor of Health Promotion
Harvard School of Public Health

ART:cdw
Enclosures

ADVISORY COMMITTEE TO THE KANSAS HEALTH FOUNDATION ON THE ESTABLISHMENT OF AN INSTITUTE TO IMPROVE HEALTH

Report of Site Visits in Kansas
July 12-14, 1993

The site visit team was comprised of four members of the Advisory Committee (Kristine M. Gebbie, Edward Perrin, Robert St. Peter, and Alvin Tarlov, Chairman) plus William Turner, Ph.D., a consultant selected for these visits. Dr. Turner is a rural sociologist and Associate Professor of Sociology at Winston-Salem State University, North Carolina.

A copy of the Committee's previous report submitted on April 29, 1993 is attached for ease of reference. In the April Report the Committee recommended the establishment of an institute for health data and policy analysis and made some preliminary suggestions as to its functions, organizational structure and governance, and location.

The purpose of the July 12th-14th meeting was to visit the various campuses of the Regent's institutions in the state of Kansas, hold discussions with key individuals at those sites to ascertain their strengths and degree of interest and how they might participate in the institute, and to obtain a cross-section of views on the appeal of the ideas implicit in the institute concept.

A copy of the group's itinerary is attached to this report. We visited the KU Medical Center in Kansas City; Kansas University at Lawrence; Kansas State University at Manhattan; Fort Hays State University at Hays; Kansas University Medical Center in Wichita;

and Wichita State University in Wichita. At most sites in addition to faculty members relevant to the institute concept we met with the senior academic officer and staff, including Chancellor Gene Budig in Lawrence, Mr. James Martin, President of the Kansas Endowment Association, Provost James R. Coffman, at Manhattan, Dean Virgil Howe at Fort Hays, Dean Joseph Meek at KU-Wichita, and President Eugene Hughes at Wichita State. In addition, we had separate evening meetings with State Senator Sandy Praeger, and State Assemblyman Henry Helgerson, each meeting lasting roughly two hours.

At each meeting we explained that the goal of the proposed institute is to improve the health of all Kansans. We emphasized that "improved health" would require a diversity of approaches. Formal medical care could have some important effects on the health of Kansans but medical care alone would be an insufficient tool to meet the institute's long-range objectives. We also discussed that the phrase "all Kansans" is to be interpreted literally and has implications for the reach of the institute's programs. We emphasized that the term "health" should be interpreted broadly to include not only those concepts associated with morbidity and mortality, but should also encompass some indicators related to health-related quality-of-life including how well people function in the home, in the neighborhood, and in the workplace with family, friends, and colleagues, as well as individuals' perception of and confidence in their own health, their sense of well-being, and their capacity to function fully.

On some occasions we presented data that supports the view that the health of Kansans could well stand to be improved. We drew from reports in the 1991 Statistical Abstract of the United States; the 1993 Kids Count Data Book, a publication of the Annie E. Casey Foundation and the Center for the Study of Social Policy, that presents state-by-state profiles of child well-being; the 1993 Kansas Health Profile, a publication of the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; as well as a variety of sources that provide comparative data across the nations of the world. The data shows that among the 50 states Kansas rates 18th in percentage of low birth weight infants, 18th on infant mortality, 24th on child (age 1-14) death rate, 24th on teen (age 15-19) death rate. Kansas rates less favorably than the average state on motor vehicle deaths, and percentage of women receiving mammography to detect breast cancer. Only 40% of Kansans drink fluoridated water. Kansans are at about the national average on unintentional injuries (burns, falls, drownings, accidental poisoning, etc.) measles, suicide, work-related deaths, AIDS, breast cancer, diabetes, and percent smokers. Further, on most health variables the United States as a whole ranks 19th among 30 industrialized nations having advanced economies. From the perspective of relative rank among states and relative rank among nations, the Committee believes that the improvement potential for Kansans may be an added four years of life and an added six years of life without impairment of functional capacity.

FINDINGS

1. Substantial Resources Are Already in Place.

The Committee discovered that each institution we visited had skills, experience, and capacities that are unique, could be applied for the purposes of the institute, and could benefit the program substantively.

KU at Lawrence is one of the nation's largest and most successful research universities. Its Department of Health Services Administration, faculty in diverse fields relevant to health and policy analysis, its library, and its proximity and connectedness to the state government in Topeka, could be important to the realization of the institute's purposes.

The KU Medical Center in Kansas City has an emerging strength in epidemiology and preventive medicine. It could become an important asset to the public health capacity throughout the state (as has Michigan State University and Western Michigan University in their state) by its newly developed MPH program and early signs of collaboration with the State Department of Health and Environment.

The KU Medical Center in Wichita is the state's best bet for training of primary care physicians, although the school would have to take a much more aggressive approach to be successful in regard to training non-physician providers, rural health, minority health, public health and so forth. The leadership and senior faculty at

the Medical Center in Wichita presented an attractive idea of coupling training to a system of tracking and accountability for the deployment of primary care physicians to areas of greatest need throughout the state.

Kansas State University at Manhattan directs the Cooperative Extension Service, jointly funded by the U.S. Department of Agriculture, the State of Kansas, and county authorities. The Extension Service has employees in each of the 105 counties.

On site in each county is a minimum of one Cooperative Extension worker for agricultural production, and another for home economics. In the more populous counties the number of cooperative extension workers usually exceeds this number. There are plans for adding a third extension specialist, for health, a plan that in the minds of Committee members has substantial potential for a comprehensive health improvement program.

Each county has an elected board that works with the local Extension Service to assure that the appropriate services are provided in topic areas of greatest relevance and need. The administration of the Cooperative Extension Program is through five geographic areas, each area having a director and staff. All together, the Cooperative Extension Service employs 340 workers full time, approximately 75 of them at Kansas State University where the overall direction of the program for the whole state is headquartered.

It would be hard to imagine a more complete and widely accepted service that touches intimately every geographic area in

the state. There are some health-related services already provided by the Cooperative Extension. Mental health services are one example. The plans of the Cooperative Extension to add a larger health component to their work could become a key asset in achieving the goals of the institute. The Kansas Health Foundation's proposal to establish an endowed chair at Kansas State to concentrate on health services through the Extension program could give health in Kansas a big boost. The Cooperative Extension Service appears to be a treasure awaiting direction for health improvement.

In addition, we were told that a well-developed survey research and data collection capacity is in place at Kansas State. Further inquiry should be made to examine its suitability for helping to serve the larger data collection needs of the state.

The Dole Communications Center at Kansas State presents an opportunity using telemedicine to reach all parts of the state for continuing education of professionals, public education in health, medical consultation, networking for common purposes, and so forth.

Fort Hays State University has deep connections with rural Kansas, derives many or most of its students from those areas, and appears to be in its courses and outreach highly sensitive to the needs of the western half of the state. Its College of Health and Life Sciences has a large baccalaureate nurse training program and a large masters level nurse practitioner training program. This resource, already in place with years of experience and developed expertise, could become an even more valuable resource for the

state's health if it could be connected to other programs and coordinated with a larger plan to improve the health of all Kansans. In addition, Fort Hays State University has a well-developed telecommunication-assisted continuing nurse education program that on a regular basis reaches out to a half dozen junior colleges in the western part of the state. This very active program has formed the beginnings of what could become an interconnected network of nurses and nurse practitioners working in a coordinated way for a common purpose.

Fort Hays State appears to have an excellent collaborative arrangement with the local community hospital that is sophisticated in medical practice. In a joint undertaking with the hospital, Fort Hays State has training programs for radiological technicians, physical therapists, laboratory technicians, and perhaps some others. Additionally, a primary care practice was recently established at the hospital in which nurse practitioner students in training play a key role.

It appears that the nearby city of Nicodemas is not on Fort Hays State's agenda for health, but perhaps could be.

Wichita State University's College of Health Professions has the largest and perhaps the best allied health professional training program in the state. The most notable component is the baccalaureate physician's assistant program, unique in the state. Approximately 30 PAs are graduated each year, with a total of 500 having been graduated over the past 15 years. Although too many, in the opinion of the program's leadership, of the graduates join

highly specialized medical practices and too few select primary care, there was confidence that the program could be reoriented to yield a high proportion of primary care PAs. Again, the Committee was impressed with this already-existing structure that seems to be functioning well. The newly appointed President of the University could provide the needed leadership to direct the program to more fully address the state's needs. If coordination could be accomplished with other programs in the state within a comprehensive framework to improve health, Wichita State University could play a key role in the institute.

It should also be mentioned that a dental hygienist training program at Wichita State (the only one in the Regent's institutions) is another valuable resource. A nursing and nurse practitioner training program are in the planning stages.

Time did not permit visits to other institutions and organizations. We would benefit from dialogue with the Governor's office, the Farm Bureau, the Machinists Union, the American Association of Retired Persons, NAACP, the Urban League, the state nursing, medical and dental societies, the state-wide association of journalists, the extensively developed junior college system throughout the state, and grass-roots organizations and other entities that should be considered as contributors to a program to improve health.

Special note should be made of an oversight on the Committee's part in not examining dental health and dental health services throughout the state. Dental disease has been found by some

researchers to be responsible for more disability than any other single medical condition. Dental health should be among the high priority topics for the institute.

2. Enthusiasm for the Concept.

Everyone we met in every place we visited, as well as everyone we spoke to on our previous visit, expressed a genuine enthusiasm for the concepts and goals of the institute. Everyone grasped the concepts of health and its improvement, the need for data, and the role their program could play. There appears to be an environment that is ready to embrace and implement a widespread program to improve health.

3. Need for Data.

The Committee found a universal expression of the need for more health data to guide educational programs and legislative initiatives. Most educators said that they require more complete data to allow them to shape their programs to better meet the needs of the state. The two legislators emphasized this need.

4. Desire for Collaboration.

At every site the leadership expressed a desire to collaborate with other institutions and organizations in their work.

5. Need for Connectedness.

Almost everyone had some level of familiarity with other

programs around the state. However, almost everyone commented that there is a need to connect and integrate these various programs in order to enhance their effectiveness in meeting the health needs of the state. The present lack of coordination was a recurrent lament.

6. Racial and Ethnic Issues Not Easily Discussed.

At almost every site the Committee attempted to stimulate a discussion of racial and ethnic issues pertaining to health in Kansas. In all discussions, with one exception, there appeared to have been a lack of practice and a general reticence to discuss minority issues in depth. There appears to have been little attention directed to racial and ethnic issues since the Kansas Initiative of 1989, a document that dealt specifically with this issue. Race and ethnicity are important health issues, not only for the minority population but for the majority as well. The importance of race and ethnicity should rise for attention on the list of priorities of the institute.

7. A Cooperative Structure is Required.

It was difficult to envision that any one of the already existing academic campuses within the state could by itself provide the leadership to harness existing resources throughout the state into an integrated and coherent multi-decade effort to improve the health of all Kansans. An organizational structure and governance

policy needs to be carefully considered and designed to achieve the institute's purposes.

The need for a cooperative and integrated approach to health improvement appears to the Committee at this point in its deliberations to require that the leadership center of the institute's program be perceived as non-aligned and neutral. It is essential that each participating organization sense a shared ownership of the purposes and strategies of the program and that a sense of real participation by all involved parties be created.

8. Need for Leadership.

The leadership of each university or each college we visited appeared purposeful and energetic with respect to its own program. However, overall there appears to be an absence of knowledgeable, vigorous, and sustained leadership appropriate for comprehensive health programs designed to cover the whole state. Each program appears to be fulfilling its own stated mission without a state-wide integrated concept of health and its determinants and without a comprehensive master plan for the state.

9. Evidence of the Kansas Health Foundation's Influence.

Everywhere we visited we found evidence of the Foundation's programs and leadership. This might be summarized as follows: Among all organizations and institutions in the state that came to our attention the Kansas Health Foundation currently stands alone

in its capacity to provide the leadership to develop a comprehensive program to improve the health of all Kansans.

INTERPRETATION OF FINDINGS

1. Timing.

An enthusiasm and readiness to move on issue pertaining to the health of all Kansans appears to have already developed throughout the State of Kansas. Legislative interest in health and health reform, academic interest in preparing for the future health system, and the Foundation's existing investment in primary care, health data, and public health comprise a strong base for action. The timing appears to be just right for the development of the institute.

2. Foundation's Leadership.

The Foundation's leadership, already evidenced around the state, is required for this undertaking. The Kansas Health Foundation has a reputation for boldness, seriousness of purpose, and fairness and its leadership is respected. The Foundation can readily convene, collect, coordinate, and redirect disparate resources, and provide the necessary stimulus until self-perpetuating health leadership arises for the state.

3. Existing Resources.

Many of the resources needed for a comprehensive program to improve the health of all Kansans are already in place in a variety of locations throughout the state. The availability of these resources increases the probability that the undertaking will be successful. There is not a need to create totally new resources for every component of the institute's program. Building on existing resources will be efficient and more likely to gain acceptance.

4. Need for a Non-aligned Organizational Structure, Governance, and Location

Care in selecting a site for the institute and the institute's organizational structure and governance is crucial to the successful integration of existing resources and to the ultimate success of the undertaking. The institute cannot be seen as captive of or subordinate to any one academic or service organization, or branch of government.

5. Minority Health

With twelve or more percent of the state's population being minority, and with little evidence that the Kansas Health Foundation's 1989 Report <u>The Kansas Initiative</u> has stimulated action toward minority health, it appears that new initiatives will be required in this regard.

RECOMMENDATIONS

I. Establish a Kansas Health Institute.

The Committee is unanimous in its view that the Foundation should provide the leadership and funds to develop an institute for the purpose of improving the health of all Kansans.

A. Functions

The following functions describe the intended activities of the institute:

1. **Facilitate the Development of Appropriately Linked Systems:**

   - **A state-wide health data system**
   - **A public health system**
   - **A primary care system**
   - **A rural health system**
   - **A health promotion and disease prevention system**

The Committee believes that the institute should not operate these systems. Rather, the institute's function should be to facilitate, encourage, and cooperate in the development of the systems that ultimately should become permanent features of the appropriate governmental and private sector institutions. In the beginning it may be necessary for the institute to play a larger role, but in most or all cases these systems should be integrated into and sustained by other institutions.

2. **Health Policy Research**
3. **Policy-oriented Data Analyses**
4. **Policy analysis**

The institute should prepare to provide continuing analysis and interpretation of data and health care trends for the Legislative and Executive Branches of the state government. Examples exist in other states (Washington, for one) where a standing policy analysis unit funded by the state government is in place at the university.

5. Training Health Services Research Professionals

Considering the wide array of health-related research needed to provide an empiric base for the Kansas initiative it would appear wise that a small post-doctoral or post-masters fellowship training program be developed. The training and research topics should be specifically tailored for the needs of Kansas. Trainees, beyond their basic educational and intellectual qualifications, should be selected for the high likelihood that they will remain in Kansas to work for the overall goals of the program.

6. Coordination

A principal function of the institute will be to create an overall master plan for health improvement, discover existing resources and develop new ones when needed, and integrate and coordinate these resources throughout the state. This coordination function should include the universities, junior colleges, public school programs, the State Department of Health and the Environment and other state agencies, the Cooperative Extension Program, the Farm Bureau, physician, nurse, and dental organizations throughout the state, hospitals, community health centers, the organized

workforce, grassroots organizations, the media and other organizations that can play a role in health improvement.

7. Consultation

The institute, and its associated structures, will have a level of expertise suitable for providing consultative services to participating organizations throughout the state. When the expertise is not at hand within the institute, responsibility should be taken to locate the appropriate consultative resource elsewhere and help make it available to the requester.

8. Leadership Development

It will be necessary to mobilize existing leaders to develop leadership capacity across the state. The need to develop leadership for comprehensive health improvement might be in some segments of higher education as well as in private organizations and at the community level.

B. Organizational Structure and Governance

To carry out the functions listed above the Committee believes that a central institute headquarters with numerous decentralized programs is the preferred structure. The headquarters staff might consist of an institute director plus three or more other professionals and support staff. In addition to providing leadership in the development of a master plan and coordinating the statewide enterprise to achieve the institute's objectives, the professional staff should be of a caliber to direct data collection, analysis, research, and alternative policy

formulations. The institute's associated decentralized programs would be in various Regent's institutions, state agencies, and private sector organizations. For example, health services data analysis and health policy analysis might be assigned to KU in Lawrence, the development of an integrated strategy for primary care, including the training of primary care physicians and their deployment, at KU Medical Center in Wichita, the training of nurse practitioners at Fort Hays and physicians assistants at Wichita State, the development of a new health services system through the Cooperative Extension Program would be at Kansas State University, and cooperation in the development of a sound public health infrastructure would be a major responsibility of the KU Medical Center in Kansas City. Data collection should become a larger responsibility of the State Department of Health and Environment, but Kansas State University and other institutions might participate. Community organizations such as the Farm Bureau, labor unions, the media, and junior colleges likewise could be encouraged and supported to assume specific functions in their areas of strength and interest. The specific task assignments listed above are not meant to be definitive, but are presented simply to illustrate the decentralized concept of the Institute. Alternative assignments and flexibility should be encouraged.

At this time it seems to the Committee that the best way to achieve cooperation, integration, comprehensiveness, and respect would be to establish the institute as an independent entity with a seven-member board of directors, two of whom would be from the

Kansas Health Foundation. The board of directors should have responsibility for the hiring of the director, setting broad policy directions, appointing the members of the advisory committees, and overseeing the fiduciary matters of the institute.

The final authority for the search and appointment of the institute director should be with the institute's board of directors. However, since the director in almost all instances should have a faculty appointment, most likely at Kansas University, a parallel process should be conducted by the University faculty and administrative staff during the search and recruitment process. The two processes must be coordinated.

A large institute Advisory Committee which includes all the stakeholders in the undertaking should be established. This committee would be advisory to the director and would meet about twice a year to provide feedback and advice. The institute advisory committee should have a small elected administrative structure to prepare the agenda and to help make the meetings efficient and to foster communication between meetings.

There should be a legislators' liaison committee to provide a structure for regular communication between the institute director and the Kansas State Legislature. It was suggested that this committee could be comprised of the President of the state Senate, the Speaker of the House, their respective counterparts in the other political party, and the Governor. The Committee took no position on this particular configuration.

It was also suggested at one site that a committee comprised of the academic officers of the Regent's institutions be established to provide regular interactions with the institute director. The Committee does not take a position on this suggestion.

C. Site

The Committee believes that the Lawrence campus provides the best location for the headquarters of the institute. The university's resources in Lawrence in research, policy, and allied disciplines, the availability of its first-rate library, and the proximity to and interaction with the state Legislature makes Lawrence the preferred site for the institute's headquarters.

A letter of agreement or similar document between the Regents and the institute could define the relationship, especially those elements that confer independence of the institute under its own board of directors, while allowing for appropriate interaction with the University in Lawrence for research, faculty appointments, and other academic purposes. It should also be possible to use the administrative structure of the University for the conduct of some management functions of the institute. The University Press seems to be a model of site, governance, and collaboration on an equal footing that is relevant to the proposed institute.

D. A Building

The size of this undertaking, the importance of its purpose,

the requirement for broad interactions, the desirability for high visibility, and the long-term nature of the undertaking suggest that a separate building be acquired or developed to house the institute's central functions.

II. Long-Range Time Frame

An undertaking of this nature will require the Foundation's continued leadership, and the Foundation's financial resources over an extended period of time. From the beginning, the institute should seek alternative sources of funding, particularly for those developments that rightfully belong in state government agencies. Over ten years the institute might become self-sustaining from a variety of resources. Nonetheless, the Committee recommends that a ten-year Foundation commitment be understood from the beginning.

III. Schedule

The Committee intends to work within itself over the next couple of weeks to improve this report. Thereafter, we hope to interact with the Foundation staff in making further modifications. We are prepared to make additional visits to the Foundation, or to elsewhere in Kansas, if that appears appropriate. We intend to have a final draft document by the first week in October if that meets the Foundation's needs. A meeting of the Committee at the Foundation in Wichita has been scheduled for October 10-12, 1993. The Committee is prepared to meet on those days if the staff so desires.

The Committee wishes guidance from the Foundation as to whether the Committee should prepare separate reports on any of the following topics:

1. An explicit description of the specific data that should be collected for a modern health data system.

2. A more detailed and explicit definition of health.

3. An essay on the determinants of health, specifically including the role of medical care, and the role of other initiatives.

4. A specific set of recommendations regarding minority health and minority participation in all inter-related health initiatives to be undertaken by the institute.

5. Would a general formulation of a comprehensive strategy to improve health be useful?

6. Others.

July 27, 1993

RECEIVED
JUL 28 1993
By FAX @

ADVISORY COMMITTEE TO THE KANSAS HEALTH FOUNDATION
ON THE ESTABLISHMENT OF AN
INSTITUTE TO IMPROVE HEALTH

Report of Site Visits in Kansas (July 12-14, 1993)

Review of Report

Draft Dated July 20, 1993
by
Alvin R. Tarlov, MD
Advisory Committee Chairman

Review/Comments
-by-

William H. Turner,PhD
Consultant to the Advisory Committee

5821 Brookway Drive Winston Salem, North Carolina 27105 (919) 744-5611

July 27, 1993

Review/Comments on Draft of July 12-14 Report to KHF from Advisory Committee on Proposed Health Institute

Alvin R. Tarlov, MD
from
William H. Turner, PhD

Introduction

I have combined my understandings of the April 7-dated Report to the Foundation (especially the Institute objectives, page 4), specifically: "*...to foster the development of a comprehenstve system of health services for the rural (as well as urban) populations...*" and "*to foster the use of community organization methods to activate broad collaborations among the various participants in a health improvement endeavor.*" This is reflected off my background as a rural sociologist and a community organizer and collaborations facilitator.

My review of the present draft also extends from the context of the *conceptual framework* established in the April document: "*...social determinants of health, including health behaviors, family and neighborhood characteristics, educational and economic opportunities, and macrosocial features including the economy, class, racial and gender distinctions that create inequalities.*"

In the July 20 document, your reference to the discussants' reaction to the Advisory Committee's attempts to stimulate a discussion of racial and ethnic issues pertaining to health was both **clear and straightforward** : ("*...there appeared to have been a lack of practice*

and a general reticence to discuss minority issues").

The Kansas Initiative--distributed in January 1989--confronted the objectives and the conceptual framework dealt with in the April Report and "*Finding #6*" of the July draft Report (*Racial and Ethnic Issues Not Really Discussed*) are all mutually-reinforcing. The Initiative (see pages 26-27) underscores these concerns under "*Problems Facing Special Populations.*" In Kansas' most prosperous and fastest region (Northeastern Kansas), the Initiative noted that "Downtown Kansas City, Kansas lies in a depressed area of the city," and "[in Southeastern Kansas] the economy is depressed, in part due to the decline of the coal mining industry," (12). To these I add the common feature of the April and July Reports, as well as in each of the July meetings: your consistent reference to the transcendent goal of the proposed institute: "*...to improve the health of all Kansans.*" These concerns constitute the focus of my background as a rural sociologist and community development/collaboration facilitator. As consultant to the Committee, these cross cutting issues would have been part of my analysis, but, clearly, the Committee and its precursors have engaged these concerns for at least since 1989. In that sense, the "*lack of practice and a general reticence to discuss minority issues*" is retrogressive. The Committee's need to argue that the "*importance of race and ethnicity should assume an appropriate place for attention in the list of priorities of the institute* begs a question that has already been deliberated. Our experiences and the literature informs us that the inequalities in health status between rural (non racial/ethnic group) Kansans and urbanites, i.e., "all Kansans"--a purely economic variable--will supplant that *appropriate place*.

In Kansas, therefore, "*Special Populations*" are Elders, African Americans, Hispanics and Native Americans, Southeast Asians, and Rural inhabitants. Together these comprise a very large number of people and the critical mass of underserved people whose morbidity, mortality, life expectancy, functional capacity, and health-related quality-of-life account for the State's relative ranking among states.

The remainder of this review/commentary follows the flow of the July Report Draft.

Findings

1. The KU Medical Center in Kansas City, as an asset to the public health capacity throughout the state, would benefit from the model in Michigan: Western Michigan University and the Michigan State University Kalamazoo Center for Medical Studies have a federally-funded project that provides multidisciplinary health care and interdisciplinary team care training in selected underserved rural areas of the state. Occupational therapy, speech pathology, social work, gerontology, and physician assistant programs are all involved.

The KU Medical Center in Wichita as "*best bet for training of primary care physicians*" must "get ahead of the curve" (with Foundation support) to restructure graduate medical education from the hospital-based focus to include more ambulatory training sites in rural areas, including nurse practitioners, physician assistants, and certified nurse midwives. Foundation-support for health care policy, regulations, and research on delivery models that encourage and allow experimentation with innovative delivery models (multispecialty group

practices in rural areas) should be top priorities at KUMC/KC and KUMC/W. Both campuses, insofar as minorities are concerned, should be encouraged to take the lead increasing the ranks of minority health professionals. The health problems that afflict minorities and rural Kansans stem from a combination of unemployment, poverty, poor living conditions, and inadequate education. These problems are exacerbated by the slow growth in the relatively small pool of trained minority health professionals, (Fickenscher and Lagerwey-Voorman, 1992:135-140 ; Chance, 1993:7).

Kansas State's well-entrenched Cooperative Extension Service proffers the best occasion to impact on rural Kansans and minority groups--wherever they are located. The CES must transpose and adapt its effective work to urban venues and link with the essential access community hospitals (EACHs) and rural primary care hospitals (PCHs) in effectuating its plans for adding health as a specialty. Urban (community-based) extension specialists (aka health advocates) are necessary. KSU can be an important link in providing more "midlevel" practitioners (e.g., nurse practitioners, physicians, certified nurse midwives) to practice semi-independently at rural sites remote from physician preceptors, (Alpha Center, 1993:6). The Dole Communications Center stands as Kansas' answer to on-line telemedicine with wide-ranging impact on rural health care. KSU's "*well-developed survey research and data collection capacity*" (in anticipation of the institute's work) should be encouraged to begin immediately to address some of the "problems with current data collection and research efforts" as they relate to minority health: (a) extant data sets tend

treat minority populations as homogeneous entities (i.e, Asians, Hispanics) without recognition that these broad categories cover many heterogeneous groups, nationalities and cultures; (b) the lack or research and research tools which have been "normed" on minority populations, i.e., many research findings, based on white populations, may not be relevant for minority groups: are there different biological responses, cultures, values, and beliefs that might impact upon findings. Often, policy makers must "refit" findings to minority populations; and, among others, (C) it needs to be assured that KSU has a baseline data base on minority and rural populations in order that can inform decisionmaking and policy alternatives. It will be very difficult for the institute to set priorities without reliable, consistent, and "normed" baseline data on the rural and minority populations of Kansas. There is more and more emphasis on prioritization and health care rationing. Absent adequate baseline data for minority populations, how will such decisions be made?

Fort Hayes State University should be encourage to link with nearby Nicodemas, Kansas as part of an experiment in working in a unique rural African American community. Even as the Advisory Committee was visiting the region, the Wichita Eagle/Beacon (July 18) was running a series of articles on this enclave of blacks. Senator Dole has gone on record to "*resuscitate Nicodemas*", and FHSU and the Foundation should explore ways to link with Nicodemas, e.g., recruit blacks interested in health care careers to FHSU. I have written to Don Stewart about this idea. FHSU's institutional capacity with rural students supports its potential to actively recruit blacks into its baccalaureate nurse and nurse

practitioner programs as well as expansion of programs that train midlevel providers for rural settings.

I believe the Committee needs to be much more specific about "*other institutions and organizations.*" I am especially keen on specifying community-based (grassroots) organizations. As for African American advocacy groups, e.g., the NAACP, Urban League, et.al., there are other, lesser-known (likely church-based) groups that must be identified, bought to the table, and represented in the mix of "*other institutions and organizations and other entities*". These include social service agencies that serve underserved communities; such as public welfare (AFDC) food stamps/WIC, tribal councils, United Way, community action agencies, public housing, community health clinics, mental health clinics, drug treatment facilities. The Foundation/Institute must be familiar (on the front end) with key community businesses patronized by targeted populations, such as grocery and clothing stores, beauty parlors/barber shops, restaurants, pharmacies, taverns and bars. A list of community leaders; such as clergy/pastoral care, local minority legislators, city and county commissioners, youth leaders (including gang leaders), business owners, sports figures and coaches, teachers, school counselors and principals, agency directors, leaders of community groups, musicians, and media specialists (deejays) and highly-visible "personalities," (Randall-Davis, 1989:16).

Under **Need for Data**, please refer to comments above made in conjunction with KSU's data collection capacity. This is especially keyed to your comment: "*Most educators*

said that they require more complete data to allow them to shape their programs to better meet the needs of the state."

5. Need for Connectedness Intraprofessional dependence, networks and consortia. should be the operative phrases for the proposed institute. The Foundation would benefit from study of the W K Kellogg Foundation-sponsored program: Affordable Rural Health Coalition (ARCH). Community leaders from a broad array of community institutions, including government, religion, health care, education, commerce, and the dominant economic contributor to the community, will recognize their interdependence and work together to meet local health care needs if provided support for such collaboration, (Ludtke and Ahmed, 1990).

6. Racial and Ethnic Issues Not Easily Discussed Unequivocally, the discussants and key organizers at the universities must be prodded/educated to the primacy of this concern. Social marketing targeted to special populations and geographical locales should be domain and originating assumptions in the work of the institution--especially in the context of (public) health promotion. There is no need to *remake the wheel* on this since we know much about Kansas' need to improve minority health status. Among other things, the present Report should recommend that the institute include in its work a call for (a) outreach campaign to disseminate information and education materials specially tailored to the individual minority sectors; (b) new approaches to delivering and financing health services to minority groups: (c) strategies to improve the availability and accessibility of health professionals to minority communities; (d) improved data collection; and (e)

establishment of a targeted research agenda. Indeed the 1985 Report of the Secretary's Task Force on Black and Minority Health (1985) was an outgrowth of Secretary Margaret Heckler's concerns to implement research and programmatic agendas from the Office of Minority Health, (Heckler, 1985). Such a special office for this initiative is implied in your conceptual framework (explained in the April Report to the Foundation). Further, discussants and key persons (including the Foundation Board) must be proactive about the concerns of minority populations, e.g., "*...there is a distinctive, coherent, persistent African American perspective, frame of reference, world view, and cultural ethos that is evident in the behavior, attitudes, feelings, life styles, and expresstve patterns...transmitted from one generation to the next, this world view provided them a way of interpreting reality and relating to others and a general design for living,*" (Dancy, et.al., 1990:1).

The work of the Foundation and the proposed institute will meet with resistance and have little legitimacy in minority communities unless strategies for working with culturally a distinct and diverse citizenry are in place long before the institute goes on-line. Minority communities have a long history of *'outsiders*" (however well-meaning) coming into their communities to "rescue" their members from some inherent dangers. Thus, the sooner such communities are represented in the planning and implementation stages of this work, the better. Minorities resent outsiders (even persons like me) receiving funds for working with their members while the community itself suffers from economic stressors. They do not wish to be told what their problems are and how to solve them. The Foundation should

develop linkages to foster community pride and self-determination by providing technical assistance and funding that ***enable*** communities to help their own people. In minority communities, there are sufficient numbers of intelligent and committed people who are in the best positions to know their communities and to provide culturally appropriate interventions since they know the beliefs, values, attitudes, and behaviors of community members. The best such a person as myself might do is to assist the Foundation to deal with these obstacles by facilitating communications and collaborations between the network of institute discussants and indigenous persons in minority groups to design and staff programs specifically tailored to meet the institute's objectives in minority and rural communities. Is a needs assessment centered around leadership identification and coalition-building ("town meetings/focus groups"), on the model of the Kansas Initiative warranted (see page 28)? Is a KHF "Developing Comprehensive Health Services for Special Populations in Kansas" (modeled on the KHF RFP on Rural Health Services) necessary? What use can be made of the KU African American alumni network, as a start?

Recommendations Section

4. Coordination Can we call for a KHF Advisory Board on the Health Status of Minority Group Kansans? As for institutions of higher education other than four-year formats, we need to be much more knowledgeable than we are about the role of certain community colleges and grassroots organizations. What do we know about the total demographics of minority groups enrollment in all sectors of higher education in the state.

Would such information help planning insofar as "feeder" relationships between community colleges and four-year and graduate programs. Do we need a profile of African American, Hispanic, Asian American, and Native American grassroots organizations in Kansas?

6. Leadership Development The proposed ten-year commitment of the Foundation to the institute ought include such a component to identify, train, and place leaders from the distinct minority populations. It would not hurt the Foundation's image and commitment to diversity and equality should it identify and hire staff in the office and include minority group members on its Board.

7. Organizational Structure and Governance. At Wichita State, I noticed a photograph of Mr. Robert Caldwell among the Kansas Board of Regents. And, there should be minority and rural representatives on all advisory committees that are charged to oversee the work of the institute.

A priority outcome of the collaboration between the Kansas State Legislature and the institute should be to encourage allocation of training funds to assure adequate supply of primary care providers for rural areas.

Suggested Readings/References

National Health Policy Forum Issue Brief (#575) "Minority Health: Breaking Down the Barriers." 1991

The Kansas Initiative "Developing a Health Promotion Agenda", Wesley Foundation, January 1989.

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Alpha Center. Health Care Reform in Rural Areas. Conference Summary Paper. March 1993. Robert Wood Johnson & Arkansas Department of Health.

Chance, Kenneth B. "Health Reform With More Black Doctors," in Focus, journal of the Joint Center for Political and Economic Studies. March 1993

Randall-David, Elizabeth. Strategies for Working with Culturally Diverse Communities and Clients. USDHHS & Bowman Gray School of Medicine. June 1991.

Dancy, Joseph, et.al. Health Promotion for the Rural Black Elderly: A Program Planning and Implementation Guide. Center for Rural Elderly, University of Missouri-Kansas City and W K Kellogg Foundation. 1990.

Fickenscher, Kevin and Mary Lagerwey-Voorman. "An Overview of Rural Health Care," in Improving Health Policy and Management. The Baxter Health Policy Review, Health Administration Press, Ann Arbor, MI. 1992.

Tarlov, Alvin R. "Advisory Committee Report to the Kansas Health Foundation on the Establishment of an Institute to Improve Health," April 1993 and July 1993.

R. L. Ludtke and K. Ahmed. "ARCH: Networks for Change: A Symposium on New Approaches to Rural Health Care." Grand Forks, ND: Center for Rural Health. University of North Dakota School of Medicine, 1990.

Comments on Draft of July 12-14
Report to KHF from Advisory Committee on Proposed Health Institute
Tarlov from Turner
July 27, 1993

Dr. Tarlov:

I note below a few typing errors from the July Report draft. Headings from the Report are not counted as lines.

Page #	Line #	Word/Item (to insert/change to...)
1	5	Associate Professor of Sociology
3	14/15	the percentage of...
3	23	to the improvement of...
4	5	largest and most
4	10	the
6	20	State
7	2	delete "and"
8	14	legitimate and implement
10	2	"...and governance policy"
12	13	data
15	6	become
15	24	help make the meetings

11/5/93

Steve:

I'm still clearing out my boxes. This is material for the mtg. w/ William Turner if it has been scheduled.

Thx
Retina

TO: Kria Gebbia

RELIGION

National Baptist Confab In New York Sets Record With 45,000 Participants

T. J. Jemison

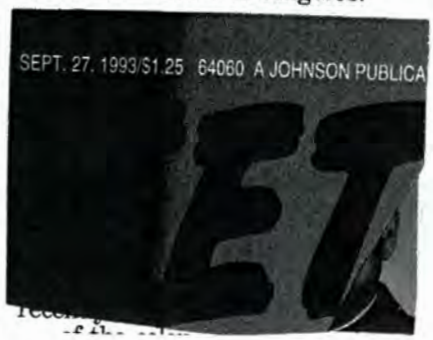
Members of the National Baptist Convention, the largest Black association in the world, recently converged upon New York City for their 113th annual convention, which attracted more than 45,000 participants, making it the biggest conference the city has ever hosted.

The four-day convention surpassed the 1992 Democratic National Convention which attracted 40,000 guests to the Big Apple. The convention of Baptists was expected to mean $25 million in revenue for New York City.

Highlights of the convention included a dinner in the New York Hilton Grand Ballroom to salute the Rev. T. J. Jemison, who heads the denomination. He announced he will step down as head of the denomination next year and will not try to amend the denomination's constitution in order to serve another term.

In addition, while the denomination has been reluctant to officially get involved with the crusade against AIDS, convention officials announced they were uniting to raise funds for churches and secular groups in the battle against the dread disease.

The convention agreed to encourage its pastors to get involved on the Black Leadership Council on AIDS which will be established in 17 metropolitan areas across the U.S. The church-based AIDS groups will be set up in Baltimore, Philadelphia, Washington, Chicago, Newark, Jersey City, N.J., Detroit, Boston, Atlanta, Houston, Miami, New Orleans, Memphis, St. Louis, Indianapolis, Cincinnati and Los Angeles.



William H. Turner
5821 Brookway Drive
Winston-Salem, NC 27105

Turner & Associates Consultants

September 27, 1993

Dear Kris:

Me again! Nothing urgent! I know you have much on your plate; but, I simply had to bring to your attention the attached feature from a recent issue of Jet magazine.

The cut lines I 've highlighted underscores the ***pre-existing*** structure through which the we can implement the ideas I wrote to you about in mine of August 26.

I tender here also a brief on a company with which I am now affiliated as Director of Social Marketing. As you know, public health messengers are finding it increasingly necessary to promote ideas within culturally-sensitive contexts. SMSi--a major player in assisting product consumer companies to increase market share in ethnic markets (***"African Americans are not black white people!"***) is allowing me and some associates to develop ideas to market ***social products*** (i.e., information) in African and Hispanic communities. We're negotiating with Kellogg now to help them with a few projects. As you will note here, SMSi's major conduit to reach millions of African- and Hispanic Americans is through its **Church Family Network™**. It works.

And, all we need to do is (1) sit with the major players in the National Baptist Convention, (2) develop AIDS information packets, and (3) use the SMSi network to distribute the information. Eric Lincoln is but a phone call away from all of the major African American church demoninational leadership. Let's strike while the iron is hot!

Speaking of which, I have about ten in the fire right now. As usual, I'm excited, proactive, and awaiting your call. I can do the legwork. You get the table for folk to come around.

Continued best bidding.

Sincerely,

William H. Turner

Ms. Kristine Gebbie
Director
National AIDS Policy Office
200 Independence Avenue, Suite 738G
Washington, DC 20201

Enclosures

Health Policy Programming: Design & Evaluation

Social Marketing

Community Development

Diversity Issues

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William H. Turner, PhD President

Kris Gebbie (9/27/93)

Ethnic Marketing Report

William H. Turner
5821 Brookway Drive
Winston-Salem, NC 27105

1991

Marketing to Ethnic America

Companies Vying for Piece of $300 Billion Pie

WINSTON-SALEM, NC — Segmented Marketing Services, Inc. (SMSi) is quickly changing the face of marketing forever. The services they offer are literally being pounced on by America's top manufacturers. What is their secret ?

They have the *know-how* to cleverly lead companies through the ethnic marketplace.

Today, urban-based Blacks, Hispanics and Asians account for nearly 30% of the total U.S. population. With the rapid growth in these communities and the increased spending power they are enjoying, companies are faced with an escalating challenge in reaching these special consumer groups - whether it is called targeted, micro, segmented, or ethnic marketing.

Understanding will be the secret to taking advantage of the strategic opportunities necessary to attract and retain this superb market potential. And since 1978, SMSi has specialized in helping companies look for new profit centers or protect their market share in targeted communities.

Their client list is a Who's Who of Fortune 500 companies: Coca-Cola, Colgate-Palmolive, Johnson Publishing, Kraft General Foods, Proctor & Gamble, Quaker Oats, Revlon, Richardson-Vicks, RJR/Nabisco, Soft Sheen Products, Warner-Lambert, Wrigley ... just to name a few!

THE CORNERSTONE of the company's marketing efforts is The Church Family Network™, through which gift bags, filled with samples and coupons, are distributed. It provides marketers with an unusual opportunity to ***sample*** their products in a very special environment. Targeted to Black and Hispanic consumers it reaches millions of families in markets of major concentration for these two important population segments. In the past three years, over 50 million samples and coupons were distributed through the network.

SMSi's other services include:

- **Product Sampling**
- **Promotion Design & Execution**
- **Retail Merchandising**
- **Market Research**

The company was founded 13 years ago by Sandra Miller Jones, a native of Winston-Salem, who worked as a marketing executive for The Quaker Oats Company. While at Quaker, she realized that marketers were missing important in the Black consumer market, which has an annual purchasing power of nearly $300 billion.

SMSi's PARTNERS - Winston-Salem's Sandra Miller Jones is chairman of the company she founded 13 years ago in Chicago . Lafayette Jones (left), is president and Rodney Lawrence is executive vice president.

SHE SET HER SIGHTS on finding a cost-effective way to promote products to limited groups of people. The gift bags, filled with samples and coupons for a variety of brands, were the solution. The rest, as they say, is history.

Lafayette Jones, Mrs. Jones husband, joined SMSi as a partner in 1988 and is now president of the company. As a marketing manager for Hunt-Wesson, he created very successful strategies for Orville Redenbacher Gourmet Popping Corn and Hunt's Manwich ("A sandwich is a sandwich, but a Manwich is a meal "). His vast experience also includes working at other corporate giants such as Lever Brothers, General Foods, Pillsbury and Johnson Publishing (*Ebony & Jet* magazines and Fashion Fair cosmetics). He also founded the American Health & Beauty Aids Institute (AHBAI), the trade association of Black haircare companies.

In 1990, the Joneses recruited another partner from Chicago, Rodney Lawrence, the executive vice president. Lawrence's prolific career has included marketing positions at Sears, McDonald's, Leo Burnett Advertising, Johnson Publishing, and Soft Sheen Products (Care Free Curls & Optimum).

IT IS EASY TO SEE that this professional management team, and the superb staff they guide, are setting the stage for much success in the future. "We show our clients how to grasp strategic - *and very profitable* - opportunities," says Lafayette Jones. "We help them understand that it is no longer safe or reliable to *bank* on past success. They must realize this *now* - and seek ways to become well-informed - if they are to be competitive in the future."

But not only is SMSi intent on making profits for itself and its clients, it is eager to make a reinvestment in the community, as well. According to Jones, "We are very strong on returning dollars to the Black community. By providing employment opportunities, using minority vendors and supporting community programs, we are fullfilling our responsibilities as entrepreneurs - and as Americans."

To find out more about this exciting company and the unique marketing options they offer, contact SMSi.

per Bill Turner

SMSi

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Bringing companies and families together in a very special way.™

BRT-91

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Director, Adolescent AIDS Program
Albert Einstein College of Medicine
Montefiore Medical Center

Retime —
what ever happened
to effort to get meeting
scheduled with
William Turner (from
a No. Carolina Univ - interested
in church involvement)