Lawrence · Douglas County
PUBLIC HEALTH
Advancing Health for All

Douglas County Community Health Improvement Plan

2024–2029

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Letter from the Executive Director

of Lawrence-Douglas County Public Health

In 2023, our community developed a comprehensive picture of Douglas County's current health status via the 2023 Community Health Assessment by identifying health needs, issues, inequities, and factors that contribute to poor health outcomes for residents of Douglas County. The results of our 2023 Community Health Assessment indicate that we have a lot of work to do to ensure that Douglas County residents have abundant and equitable opportunities for good health. To put things into perspective, here is a small sample of the issues that were identified for Douglas County in our Community Health Assessment.

- 48.8% of Douglas County renters are cost burdened.
- Deaths due to overdose are rising in Douglas County.
- Hispanic, multiracial & Native American populations have statistically lower rates of insurance coverage.
- Black babies are more likely to be small for gestational age compared to white babies.
- 29% of Douglas County is within 1 mile of healthy food, compared to the Kansas average of 43.7%.
- 1 in 10 children live in poverty.

It's time to act.

I'm thrilled to introduce you to our 2024-2029 Community Health Improvement Plan, which is a long-term, systematic approach to address the results of our Community Health Assessment. The 2024-2029 Community Health Improvement Plan has specific focus areas that contain measurable outcomes to address access to health services, birth outcomes, food security, anti-poverty, behavioral health, and safe and affordable housing in Douglas County. The development of this plan would not be possible without the work of our staff, community partners and community members. Words are not able to describe how much I appreciate your efforts.

Throughout this letter, you will notice the words "our" and "we." When you see those words, know that YOU are included in that. Thank you for joining us on the journey to implement your 2024-2029 Community Health Improvement Plan!

Take care,

Jonathan Smith

Executive Director, Lawrence-Douglas County Public Health

Introduction

A **C**ommunity **H**ealth **I**mprovement **P**lan, or CHIP, is a strategic plan for health and well-being for a community. The Douglas County CHIP includes goals, objectives, and strategies for advancing equity and making meaningful progress in six key areas:

- **Access to Health Services**
- **Anti-Poverty**
- **Behavioral Health**
- **Birth Outcomes**
- **Food Security**
- **A Place for Everyone Housing**

Community Health Improvement Process

The community health improvement process is an iterative cycle which begins again every five years. Each cycle starts with a comprehensive community health assessment. The assessment uses multiple sources of data to describe community populations, characterize health status and behaviors, identify and describe notable health disparities and inequitable conditions, and elevate community assets for health.

The community health assessment leads to the selection of priority issues which will be the focus of the community health improvement planning efforts. Planning consists of convening multi-sector groups to complete the development of plan components. The following describes the timeline for the most recent community health improvement process cycle.

Timeline

2022

Community health assessment initiated

Community health data collection

2023

Analysis & report creation

Community listening sessions

CHIP priorities selected

CHIP conveners identified

2024

CHIP work groups assembled

Plan components developed

CHIP Launched

2025-2029

CHIP implementation & evaluation

CHIP Structure and Planning Process

Development of the CHIP was supported by a structure involving multiple partners. The graphic below describes the partnerships and structures key to this process.

The steering committee consists of community leaders and members which supported decision-making across all aspects of assessment and planning. Lawrence-Douglas County Public Health Staff provided resources, support, and assessment through all aspects of planning. Conveners identified and developed work groups which conducted planning activities, and will continue to exist to support implementation.

STRUCTURE

CHIP Steering Committee

A group of 20+ community leaders and members providing oversight to the community health assessment & planning process.

Lawrence-Douglas County Public Health

Staff from the Community Health and informatics teams provide backbone support for assessment and planning.

Work Groups

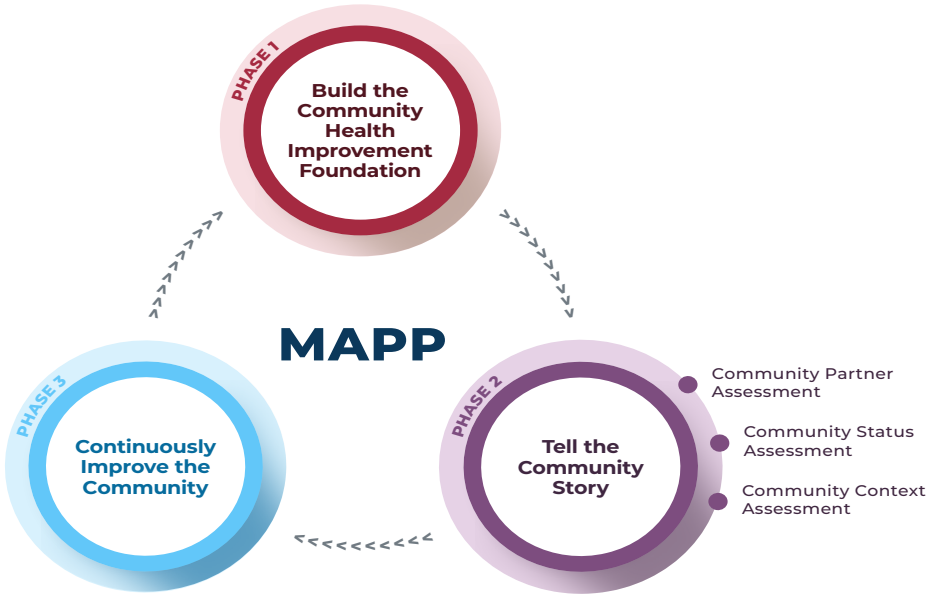
- Access to Health Services
- Anti-Poverty
- Behavioral Health
- Birth Outcomes
- Food Security
- Housing

The work groups followed a specific approach to move through the planning process. Staff derived this approach from the MAPP 2.0 process and integrated specific steps to support goals for the CHIP, including:

- Centering equity throughout the plan
- Ensuring required CHIP elements were included, and
- Striving for identification of feasible and transformational strategies to support progress on identified outcomes. The graphic below displays the steps undertaken by each work group.

1. **Work group development**
   a. Multi-sector partners
   b. People with lived experience
   c. Onboarding and group process
2. **Study and learning**
   a. Describing who is impacted and how
   b. Understanding root causes
   c. Learning about what other communities are doing
3. **Frame the issue; goal & objective development**
   a. Narrowing the focus of the issue to a framing that the group can wrap their arms around
   b. Identifying goals
   c. Selecting SMART and SMART+IE objectives
4. **Identification and prioritization of strategies**
   a. Identifying policy, system and environmental changes
   b. Identifying evidence-based actions
   c. Identifying strategies that work within the 4R+P framework for equity (Restore, Repair, Remediate, Restructure, Provide)
5. **Development of action steps and responsible partners**
   a. Develop action steps to support implementation with notes about specific implementation partners and timeline

Models Shaping CHIP Development



The efforts to shape the CHIP goals, objectives, and strategies were guided by two important models and frameworks.

Throughout the assessment and planning phases, the **Mobilizing for Action through Planning and Partnerships (MAPP) 2.0** model was used as the overall guiding framework. The MAPP 2.0 model articulates three distinct phases for undertaking the community health improvement process, and provides a structure for developing a CHIP which will support progress and learning. The MAPP 2.0 model provides supports for communities to center equity throughout their work.

Another important model which influenced the shaping of the CHIP is the 4R+P Health Equity Framework[1]. This framework describes how achieving health equity requires intentional action to address the systemic barriers to opportunities and resources established over time to make progress. The model provides concrete features for a strategy to have an impact equity.

1 Hogan, V.K., Rowley, D.L., White, S.B., & Faustin, Y. (2018). Dimensionality and R4P: A Health Equity Framework for Research Planning and Evaluation in African American Populations. Maternal and Child Health Journal, 22, 147-153.

Strategy Types

Icon Key

Throughout the plan, some strategies have been elevated with graphics to note when a strategy contains one or more of the 4R+P Health Equity Framework.

Remove: These strategies remove power imbalances and forces (i.e., racism, sexism, classism) that are adverse to health and embedded in societal institutions.

Repair: These strategies repair the damage of the past by acknowledging the role of past trauma wrought through policies and systems of exclusion.

Remediate: These strategies reduce exposures to negative elements while structural change is under development.

Restructure: These strategies call for structural changes (i.e., changes to social, economic, or educational rules and regulations) to stop production of risk and remove stressors or exposures.

Provide: These strategies provide education, care, resources, opportunities, and environmental supports so that easy, low-barrier choices are available to support and sustain health and well-being.

Overarching Policies & Intersecting Plans & Strategies

The CHIP planning process revealed a number of opportunities to optimize implementation of the CHIP through support of policies at the state or federal level or support for locally developed plans. In addition, there are strategies in the CHIP that intersect across goal areas and suggest opportunities to implement systems changes which may have impacts on multiple outcomes.

Overarching Policies

The CHIP aspires to bring about transformational change to improve population-level outcomes. It is important to acknowledge that the work occurring in Douglas County is influenced, directly and indirectly, by policies implemented at the state and federal levels. To increase the likelihood of local success, to the extent possible given the constraints of allowable activities, the CHIP Steering Committee, LDCPH, and CHIP partners will provide support, education, and encouragement for the following policies:

- **Medicaid (KanCare) Expansion:** This policy would enable local health organizations to leverage existing funding to provide care to underserved populations.
- **Expansion of SNAP and WIC enrollment and benefits:** These policies would provide much needed increased access to resources for food security, including expanded vouchers and new settings (e.g., farmer's markets) for obtaining healthy food.
- **Maximize the benefits of the Earned Income Tax Credit:** This policy work would support permanent adoption of federal eligibility expansions and extend the Earned Income Tax Credit to all eligible people in Douglas County and Kansas.

- **Remove barriers to TANF:** Policies which remove barriers to TANF focus on extending eligibility from two to five years and remove punitive work reporting requirements. These policies would expand available resources to families who need resources the most.
- **Healthy School Meals for All:** This policy would support access to free, nutritious meals in qualifying schools, regardless of household income. This policy would eliminate school meal debt and reduce stigma and shaming, while ensuring access to healthy food.
- **Health in All Policies approaches and practices:** Adoption of Health in All Policies procedures ensures health and well-being are centered as important direct or indirect consequences of policy action.
- **Expanded funding models to support community health workers (CHWs):** These policies would expand inclusion of community health workers services into reimbursable models of care.
- **Support maintaining Home Rule authority to preserve opportunities for community driven solutions:** The CHIP contains strategies identified as important for communities. Preserving the ability of our local jurisdictions to support these actions is critical to success.

Intersecting Plans

It is important to note that organizations and institutions across Douglas County have strategic plans which compliment the goals of the CHIP. Amplifying and offering support for these plans can support the success of the CHIP. These plans include:

- **Adapt Douglas County: Climate Action and Adaptation Plan:** This plan articulates goals and strategies for mitigating and deepening resilience for climate change impacts. The plan includes strategies related to food access, behavioral health, and public health.
- **Transportation 2050:** Transportation 2050 (T2050) is the blueprint for the future transportation system of Lawrence, Eudora, Baldwin City, Lecompton, and unincorporated areas of Douglas County. T2050 sets regional goals and improvement recommendations for all modes of transportation (automobile, public transit, bicycle, pedestrian, etc.) to meet the region's future transportation needs through 2050.
- **Coordinated Public Transit and Human Services Transportation Plan:** Collects and analyzes meaningful organizational and consumer information to create a plan for future coordination and improvement of services in Douglas County.

Intersecting Strategies

CHIP work groups identified factors influencing each of the goal areas and related strategies for addressing those factors. Not surprisingly, it was often the case that some of the factors that influenced a challenge or barrier in one goal area also was noted in one or more of the other goal areas. As a result, a few strategies appear in multiple goal areas. We aspire to leverage shared interest around these intersecting strategies to create systems improvement that aid people living in Douglas County by creating greater opportunities to achieve health and reducing barriers to underused services and resources. These intersecting strategies are:

- **Creating or expanding Community Health Worker (CHW) or navigator services** which serve to connect people in Douglas County to needed resources and services for primary and prenatal health care, behavioral health services, childcare, food assistance, and housing.
- **Implementing transportation options** which reduce barriers to primary and prenatal health care, behavioral health services, and food resources and assistance.

Access to Health Services

Goal

To increase access to comprehensive, high quality health care services.

Overall Objectives

Objective 1

By 2028, increase the proportion of people with a usual primary care provider.

- From 47,450 to 52,195 for people seen by LMH Health
- From 12,466 to 13,712 for people seen by Heartland Community Health Center

Objective 2

By 2028, increase the proportion of people who get recommended evidence-based preventative health care.

- From 15,450 to 17,000 for people ages 45-75 who have fully met the USPSTF recommendation for colorectal cancer screening
- From 7,274 to 8,001 for women aged 50-74 who have had a mammogram within the past two years
- From 8,865 to 9,308 for women aged 21-65 who have had a pap test in the past three years

Objective 3

By 2028, reduce the number of patients who utilize the Emergency Department for routine, primary care services from 1,800 to 1,440.

Priority populations for advancing equity

To make progress on notable disparate outcomes, the access to health services efforts will focus on creating more equitable conditions for people who are uninsured or underinsured.

How we get there:

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Establish community-clinical linkages to care which supports greater access to primary and preventative health care

STRATEGIES

- Increase the number of new uninsured and underinsured patients into primary care to improve the health of individuals living in Douglas County.
- Increase the availability of community health workers at health care and community settings who support health care access.
- Establish community-based sites and collaborations to engage people in preventative care screenings.
- Explore collaborations with employers to create innovative approaches to support or incentivize employees seeking primary care and preventative services.
- Establish a process to ensure people using the ED for primary care services are connected to primary care providers.
- Improve health literacy by providing education and resources to assist people with navigating healthcare services.

Establish or expand supports which reduce barriers to accessing existing primary care options

STRATEGIES

- Establish formal pathways for people to be effectively referred for transportation services.
- Establish formal pathways for people to navigate other resources that impact social drivers of health.
- Explore innovative approaches to supporting families who need childcare in order to seek primary or preventative health care options.
- Research available educational resources for consumers related to obtaining health insurance (governmental and private).

Anti-Poverty

Goal

To improve the well-being of families in Douglas County by intentionally and simultaneously working to support children and adults in their lives together, recognizing that families in Douglas County come in all different shapes and sizes and that families can define themselves.

Overall Objective

Objective 1

By 2028, create policy, system, and environmental changes that results in the percentage of single female headed households experiencing poverty living below the ALICE threshold in Douglas County decreasing from 64% to 50%.

Priority populations for advancing equity

To make progress on notable disparate outcomes, the anti-poverty efforts will focus on creating more equitable conditions for single female headed households, children (prenatal through age five), and the care provider workforce.

How we get there:

Strategy Type Key

Remove | Repair | Remediate | Restructure | Provide | Intersecting Strategy

Strengthen the economic assets available to people in Douglas County

STRATEGIES

- Establish a community-wide intake and referral communication solution that is responsive, timely, outcomes focused and assists community agencies in meeting the needs of vulnerable adults and children.
- Conduct a Guaranteed Income Pilot Program targeted to serve low-income women with children or expecting a child in Douglas County.
- Develop a countywide community navigator and/or health worker program that increases the number of eligible, low-income single, female-headed households utilizing SNAP or WIC benefits in Douglas County from 10% to 50%.

Improve affordability of early childhood education and development opportunities

- By 2029, increase the average monthly earnings for female childcare service industry (NAICS) employees from $1,898 to $3,841.
- By 2029, Increase the number of licensed childcare providers accepting DCF benefits from 51 to 77.

STRATEGIES

- Establish a Douglas County employer-based and funded childcare subsidy program with public and private employers.
- Create annual priority public policy agenda and advocacy network that improves or removes systemic barriers faced by agencies and clients that engages state and federal agencies and elected officials in necessary programmatic and policy changes.
- Establish a community-wide childcare scholarship fund that match up to 33.3% of all high-quality childcare slots needed for children under 6 years with parents in the family in the labor force.
- Establish a countywide childcare subsidy community navigator position to increase the number of qualifying families enrolled and accessing Department for Children and Families childcare subsidies.

How we get there (cont):

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Increase available post secondary and employment pathways

- By 2029, increase the average monthly earnings for female childcare service industry (NAICS) employees from $1,898 to $3,841.
- By 2029, increase the rate of youth students enrolled in Career Technical Education (CTE) and/or apprenticeship programs in Douglas County from 150 to 400.
- By 2029, increase the rate of adult students enrolled in Career Technical Education (CTE) registered apprenticeship programs in Douglas County from 138 to 220.

STRATEGIES

- Expand Early Childhood Apprenticeship Program in partnership with Peaslee Tech and the Children's Community Center.
- Establish a youth student and educator-led coalition to support local and countywide programming and initiatives to connect students with CTE and apprenticeship programs.
- Establish an adult student, employer, community partner and educator-led coalition to support local and countywide programming and initiatives to connect adult students with CTE and apprenticeship programs, and support program completion.

Behavioral Health

Goal

An integrated system of behavioral health care that serves the whole person, their whole life, so they can realize their full potential.

Overall Objectives

Objective 1

Promote integration of housing and behavioral health services to achieve Functional Zero for chronically homeless individuals and households by 2029.

Objective 2

Decrease the age-adjusted suicide mortality rate from 14.3 to 12.8 per 100,000 population by 2029.

Objective 3

Reduce the drug overdose mortality rate from 15.4 to 10.4 per 100,000 by 2029.

Objective 4

By 2029, reduce chronic absenteeism rates in Douglas County to less than 10%.

Priority populations for advancing equity

To make progress on notable disparate outcomes, the behavioral health efforts will focus on creating more equitable conditions for people who are uninsured or underinsured, people who experience co-occurring serious mental illness and substance use disorders, people who are chronically experiencing homelessness, people who are justice-involved, people who are Black, people who are Indigenous, people who are Latino, people who are LGBTQ+, people who are 10-19 years of age, and people who are 65 years of age or older.

How we get there:

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Prioritize prevention

- By 2026, conduct a comprehensive Substance Use Needs Assessment in Douglas County.
- By 2028, increase community utilization of My Strength to 12,000 users.
- By 2029, reduce Douglas County chronic absenteeism rates by 10%.
- By 2029, reduce Tobacco use by adults from 32.9% in 2023 to 25% in 2028.
- By 2029, reduce the percent of Douglas County youth who report no perceived risk of harm from the use of vaping products from 6.5% in 2022 to 5% by 2028.
- By 2029, reduce the percent of youth who report low perceived risk of harm from drug use from 47.6 percent in 2021 to 42 percent by 2028.

STRATEGIES

- Obtain current baseline data from 2018-2023 to clarify and quantify metrics related to the goals listed above.
- Create a chronic absenteeism workgroup and establish a systematic data-backed plan.
- Expand the scope of Engage Douglas County to include truancy and relationship violence in addition to substance use, and suicide prevention.
- Increase the number of harm reduction interventions in Douglas County by 25%.
- Expand the implementation of Sources of Strength to include all Douglas County Secondary Schools.
- Expand the implementation of PAX Good Behavior Game and Sources of Strength in Douglas County elementary and preschool settings.
- Integrate Bert Nash WRAP workers and DCCCA Prevention Specialists into the Sources Of Strength and PAX staffing models.
- Establish performance-based measures to inform local prevention investments.
- Identify additional baseline data sources beyond Kansas Communities that Care (KCTC).

How we get there (cont):

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Improve access to care

- By 2026, achieve a 20% increase in client retention within the Medication Assisted Treatment (MAT) program.
- By 2028, maintain an overall MAT client retention rate of at least 50%, ensuring that patients remain engaged in their recovery process for up to 12 months.
- By 2029, reduce cancellation and no-show rates for psychiatric services by 15%.
- By 2029, increase patient satisfaction with access to psychiatric and medical services by 20%.

STRATEGIES

- Implement critical system and process changes to support increased access to Medicated Assisted Treatment (MAT) services.
- Define clear MAT program objectives that align with organizational goals, including increasing client retention and better understanding of MAT offerings among staff and community partners.
- Implement critical system and process changes to improve access to psychiatric and medical services.
- Develop and implement automated reminders and scheduling policies.
- Ensure smooth and timely care transitions following a crisis, with an emphasis on reducing the time between discharge and follow-up care.
- Assign care coordinators or Community Health Workers to track patient engagement and follow up on missed appointments, ensuring patients remain connected to care.
- Expand options for accessing outpatient treatment services through introduction of group therapy and peer support, offering evening and weekend outpatient treatment options, expanding same-day or walk-in appointment availability, implementation of care coordinators, and integration of transportation services.

How we get there (cont):

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Increase supportive housing

» The content for this section of the plan overlaps in its entirety with the A Place for Everyone Plan. Please see the A Place for Everyone section of this report for the plan components.

Integrate lived experience

» By 2027, expand the peer workforce and increase the number of employed peer support specialists, certified peer mentors, recovery coaches, and peer first responders by 50%.

» By 2028, establish a clubhouse model to support community members living with mental illness and co-occurring substance use disorders and offer members a wide array of opportunities to achieve their full potential.

STRATEGIES

» Obtain baseline peer workforce data 2018-2023.

» Advocate to expand state funding and payer sources for peer support across the system of care.

» Secure funding to sustain a Consumer Run Organization (CRO) in Douglas County.

» Secure startup funding to design, develop, and implement a clubhouse model for Douglas County.

» Continue to implement “Peer First” response models.

» Integrate lived expertise representatives on all workgroups related to the Behavioral Health Focus Area of the Community Health Plan.

» Continue to build the peer support workforce in Douglas County by developing a cadre of highly trained peer specialists, recovery coaches, and peer mentors to exercise leadership across Douglas County’s behavioral health system of care.

» Identify future settings and partners for embedded peer support including CASA, KVC, STA Care Center, LMH Birthing Center, and Lawrence Community Shelter.

» Identify future settings and potential partners to integrate peer support in youth settings such as VanGo, Douglas County School Districts, Be More Like Claire, O’Connell.

» Identify strategies to expand embedded peer support at the Treatment and Recovery Center and supportive housing sites, within human service agencies, and among pre and post crisis and outpatient treatment teams such as Assertive Community Treatment (ACT), Assisted Outpatient Treatment (AOT), Homeless Response Team (HRT), Mobile Response (MRT), and Intensive Care Coordination (ICC).

How we get there (cont):

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Optimize the behavioral health crisis response system

- By 2029, increase the number of 911 calls referred to an alternative mobile crisis response team by 10% annually.
- Reduce the number of people who present at the emergency department in behavioral health crisis from 3,152 in 2023 to 2,364 in 2029.
- By 2029, reduce the percentage of booked individuals at the Douglas County Jail with serious and persistent mental illness (SPMI) by 5%.
- By 2029, increase the percentage of TRC patients who complete an outpatient follow up visit after discharge from 65% to 75%.
- By 2029, increase the number of Familiar Faces referrals who consent to share information and engage in care coordination and treatment by 10% annually.

STRATEGIES

- Establish a Douglas County Crisis System Coalition to provide system oversight, inform a process of continuous quality improvement, and increase community engagement and utilization of the behavioral health crisis response system.
- Reconfigure the structure and membership of the Douglas County CIT Council and expand the council's scope beyond training to provide a collaborative forum for system stakeholders to improve communication, share and review data, identify shared concerns, and solve problems.
- Integrate all crisis system entities on the My Resource Connection (MyRC) data sharing platform and increase training and utilization of MyRC by all covered entities by 50%.
- Integrate 988 and the deployment of Alternative 911 Emergency Response teams by aligning the Douglas County crisis line and mobile response deployment with the Emergency Communications Center.
- Identify sustainable strategies to expand the availability of alternative emergency response teams such as police co responders, Mobile Integrated Health, and Homeless Response to 7 days per week.

How we get there (cont):

Strategy Type Key

Remove

Repair

Remediate

Restructure

Provide

Intersecting Strategy

Implement Zero Suicide

- By 2029, decrease the age-adjusted suicide rate from 14.3 to 12.8 per 100,000 population.
- By 2029, reduce the number of Emergency Department visits that involve a suicide attempt from 167 in 2023 to 125 in 2028.
- By 2029, reduce the percentage of people who died by suicide and were seen within the prior year by a health care provider in a Zero Suicide agency from 65% (in 2022) to 45%.

STRATEGIES

- Implement Zero Suicide to fidelity in all Douglas County health care partners.
- Establish a Zero Suicide Coordinator position at Lawrence Douglas County Public Health.
- Update the Douglas County Suicide Report in 2024 to establish baseline data from 2018-2023.
- Establish a Douglas County Fatality Review Board.
- Expand the implementation of Sources of Strength to include all Douglas County Secondary Schools.
- Expand the implementation of PAX Good Behavior Game and Sources of Strength in Douglas County elementary and preschool settings.
- Continue annual percent studies to measure progress and identify opportunities for continuous quality improvement.

Birth Outcomes

Goal

Improve the health of mothers, families, parents and infants by reducing racial and ethnic differences in birth outcomes.

Overall Objectives

Objective 1

By 2029, reduce the rate of fetal death rates at 20 or more weeks gestation from 6.1 per 1,000 births to 2.0 per 1,000 births.

Objective 2

By 2029, reduce the rate of fetal death rates at 20 or more weeks gestation among Black families from 6.1 per 1,000 births to 2.0 per 1,000 births.

Objective 3

By 2029, reduce the rate of low birth weight births from .8 per 1,000 births to .5 per 1,000 births.

Objective 4

By 2029, reduce the rate of low birth weight births among Black mothers and pregnant people from 1.5 per 1,000 births to .5 per 1,000 births.

Objective 5

By 2029, increase the proportion of mothers and pregnant people who receive early and adequate prenatal care from by 5% (Baseline under development.)

Objective 6

By 2029, increase the proportion of Black mothers and pregnant people who receive early and adequate prenatal care by 5% (Baseline under development.)

Objective 7

By 2029, reduce the rate of infant mortality infants from 6.1 per 1,000 births to 2.5 per 1,000 births.

Objective 8

By 2029, reduce the rate of infant mortality among Black infants from 10.0 per 1,000 births to 2.5.

Objective 9

By 2029, reduce the five-year average of unintentional Sudden Unexpected Infant Deaths (SUID) during sleep from 4 to 0.

Priority populations for advancing equity

To make progress on notable disparate outcomes, the birth outcomes efforts will focus on creating more equitable conditions for Black babies and mothers and pregnant people.

How we get there:

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Increase access to prenatal and postnatal care for Black mothers and pregnant people

STRATEGIES

- Expand referrals and connections to services for Black mothers and pregnant people by facilitating systems change between and among health care and human service providers.
- Explore how community health workers or care navigators may increase early and adequate access to prenatal care.
- Explore the viability of group prenatal care models to serve the needs of pregnant people and increase access to prenatal care.

Increase adoption of approaches and practices which center cultural humility

STRATEGIES

- Encourage adoption of organizational policies by health care and human service organizations which require staff to complete annual education regarding cultural humility, implicit/ racial biases of medical (and other) care teams.
- Work with Douglas County to adopt a policy requiring organizations which receive service funding to adopt organizational policies which require staff to complete annual training regarding cultural humility and implicit bias.

How we get there (cont):

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Establish collaborative, multi-sector processes to identify and implement policy and systems changes to address birth outcomes

STRATEGIES

- Create a fetal infant mortality review (FIMR) board to identify changes to systems, programs, and policies.
- Evaluate the possibility of creating a maternal mortality review committee.
- Establish a Community Action Team and/or Subcommittees focused on Birth Outcomes that extends the progress of the initial CHIP Birth Outcome Committee.
- Integrate data-driven decision-making approaches to CHP and FIMR groups.

Prevent sleep-related sudden unexpected infant deaths in Douglas County

STRATEGIES

- Coordinate policy, system and environmental changes to implement research-based safe sleep recommendations across community organizations.
- Organize 10 crib clinics per year with pre/post evaluation.
- Educate healthcare professionals to use sleep-related suffocation language to clarify for parents that in most sleep-related deaths, children do not die from unexplained reasons but due to positional asphyxia and other forms of suffocation/strangulation.
- Form a Douglas County Breastfeeding Coalition to encourage and support the benefits of human milk consumption, including as a protective factor against sudden unexpected infant deaths.

Food Security

Goal

Reduce food insecurity and hunger in Douglas County.

Overall Objective

Objective 1

By 2029, food insecurity in Douglas County will decrease from 11.5% to 10.5%.

Priority populations for advancing equity

To make progress on notable disparate outcomes, the food security efforts will focus on creating more equitable conditions for low-income single female headed households, older adults, and people living in rural areas.

How we get there:

Strategy Type Key

Remove | Repair | Remediate | Restructure | Provide | Intersecting Strategy

Improve awareness and communication regarding food assistance programs to reduce stigma

- By 2029, increase participation rate of students for free and reduced lunches from 36.9% to 38.4%.
- By 2029, increase the percent of households with one or more people 60 years and older utilizing Supplemental Nutrition Assistance Program (SNAP) benefits from 24.5% to 26%.
- By 2029, increase the number of households utilizing WIC benefits from 1258 to 1400.

STRATEGIES

- Support school district (Lawrence, Eudora, Baldwin City, Perry-Lecompton) efforts to reduce application barriers and increase the number of families that complete the free and reduced meals application.
- Support organizations serving people 60 years and older to reduce application barriers and increase the number of eligible seniors that complete the SNAP application.
- Support organizations serving single, female-headed households to reduce barriers and increase participation of WIC services.

Improve organizational capacity and food choice

- By 2029, increase the percent of households with one or more people 60 years and older utilizing Supplemental Nutrition Assistance Program (SNAP) benefits from 24.5% to 26%.
- By 2029, increase the number of households utilizing WIC benefits from 1258 to 1400.

STRATEGIES

- Develop a countywide community navigator and/or health worker program.
- Expand fresh (local) food options and availability in established and new markets, convenience stores, food pantries and school districts.
- Expand mobile food markets (i.e. Just Food Cruising Cupboard) and farmers' markets to increase access in Eudora, Baldwin City, and Lecompton.

How we get there (cont):

Enhance transportation supports for accessing food

» By 2029, decrease the percentage of households living less than 1 mile (roughly a 15-minute walk) from a full-service grocery store from 22.% to 20%.

STRATEGIES

» Expand mobile food initiatives to reach people 60 years and older and single, female-headed households.

» Strategically locate full-service grocery stores to create accessible and equitable neighborhoods.

» Implement the Lawrence Pedestrian Plan and Regional (Eudora, Baldwin City, Lecompton) Pedestrian Plan.

» Implement the Adapt Douglas County: A Climate Action and Adaptation Plan (Goal 3 - Enable low-carbon modes of transportation while improving access to everyday needs).

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

A Place for Everyone Housing Plan

The A Place for Everyone Housing Plan is a comprehensive strategic plan to resolve homelessness. The planning occurred outside the CHIP planning efforts, but is an issue critical importance for community health. Thus, it is incorporated fully into the CHIP. The following is a summarized version.

Goal

By 2028, we will create a system that achieves functional zero through policy, system, and environmental changes resulting in all Douglas County residents having access to the fundamental human right of safe, accessible, attainable, and affordable housing, and in which homelessness is a rare and brief occurrence.

Priority populations for advancing equity

To make progress on notable disparate outcomes, the A Place for Everyone efforts will focus on creating more equitable conditions for the following:

- Individuals experiencing chronic homelessness
- BIPOC individuals/households experiencing or at-risk of homelessness
- LGBTQ+ individuals/households experiencing or at-risk of homelessness
- Families with children younger than 18
- Single-parent, female-headed households
- Justice-involved/formerly incarcerated residents
- Individuals with Intellectual and Developmental Disability (IDD) in institutional setting
- Low-income seniors
- Transitional youth, unaccompanied minors, and youth aging out of foster care
- Individuals with substance use disorder (SUD) and severe and persistent mental illness (SPMI)
- Survivors of domestic violence, human trafficking, and/or stalking
- Immigrant individuals/households
- Individuals with English as second language
- Individuals with disabilities

How we get there:

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Equity and Inclusion

- By 2024, define a clear set of equity goals that will inform all areas of this plan.
- By 2024, prioritize equity in community education resources.
- By 2024, establish ongoing roles in this work for people with lived experience.
- By 2025, use data to track success and sustainability.
- By 2026, focus on equity in policy and budget decisions.
- By 2026, target systemic inequities to increase diverse homeownership.
- By 2027, promote best practices that improve diversity and equity for all service providers.

STRATEGIES

- Support a shared vision of equity between all local agencies and government with a shared terminology list.
- Determine four data performance measures that tie directly to equity goals and action steps.
- Highlight equity in all community education resources and communication, with improved collaboration and availability of easy-read resources.
- Establish ongoing roles for individuals with lived experience to inform planned strategies, including an advisory board and opportunities for paid work.
- Develop a decision-making model that targets and reduces racial disparities by prioritizing funding for projects with an equity focus.
- Identify policies that reduce the risk of homelessness, increase accessibility and uplift historically marginalized populations; target systemic inequities and increase diverse homeownership.
- Create long-term Diversity, Equity and Inclusion training and assessments for all levels of organization and government.

How we get there (cont):

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Systems

- By July 2024, achieve quality data through the Built for Zero framework.
- By April 2024, launch a dashboard for real-time homelessness and housing data specific to Douglas County.
- Increase participation in the Homeless Management Information System and Coordinated Entry System by 20%.

STRATEGIES

- Collaborate among partners within the Homeless Management Information System and promote resource and service tracking.
- Build a Built for Zero-specific report and dashboard and share it with the community.
- Identify agencies who serve the unhoused population that are not able to use the Homeless Management Information System and create a plan for data integration for the dashboard.
- Develop key performance indicators to utilize for public education.
- Conduct a Housing Study through the Kansas Housing Resources Corporation.
- Increase Lawrence and Douglas County representation at Continuum of Care Homeless Management Information System Steering Committee meetings.
- Make the Homeless Management Information System accessible for all homeless targeted programs and housing services throughout the community to review, input data and pull reports.

How we get there (cont):

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Affordable Housing

- By 2028, increase the supply of affordable rental housing units by 1,500.
- By 2028, increase the supply of affordable homeownership units by 200.
- By 2028, increase the supply of accessible and affordable units by 100.
- By 2028, increase the supply of affordable units for families with minor children by 500.
- By 2028, establish policy and system changes that realign power imbalances that currently prevent access to, or development of, affordable housing.

STRATEGIES

- Develop a long-term affordable housing plan.
- Provide a grant subsidy for new development or rehabilitation of desired unit types.
- Acquire parcels and units for the community land trust and future affordable housing development.
- Provide recommendations for City code updates that allow for affordable housing development.
- Establish the tenant's right to legal representation in Douglas County.
- Enforce the City's protection against source of income discrimination.
- Establish a City of Lawrence vacant and dilapidated structure registry.
- Establish an incentive program for affordable housing development.
- Establish funding resources.
- Develop a plan for ongoing community engagement re: affordable housing.
- Develop programs that increase racial equity in affordable housing access and land ownership.

How we get there (cont):

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Supportive Housing

» By 2027, increase the number of permanent supportive housing units by 120 units dedicated to these groups:

a. Chronically homeless individuals (+30 units)

b. Chronically homeless families (+2 units)

c. Homeless individuals aged 55+ (+50 units)

d. Justice-involved individuals (+20 units)

e. Child-welfare involved families (+10 units)

f. Homeless individuals aged 17-23 (+8 units)

» By 2027, increase the number of transitional housing units dedicated to homeless individuals with substance use disorders or mental illness by 15 units.

STRATEGIES

» Develop a five-year supportive housing Capital Improvement Plan.

» Establish sustainable funding resources.

» Establish a community supportive housing case management program.

» Design and develop emergency, non-congregate shelter services.

» Design a curriculum to build community buy-in and trust for supportive housing.

How we get there (cont):

Strategy Type Key

- Remove
- Repair
- Remediate
- Restructure
- Provide
- Intersecting Strategy

Emergency Shelter and Services

- By 2024, enhance the regional coordinated entry system of agencies and access points to provide triage, diversion and care coordination to those at risk of — or currently experiencing — homelessness.
- By 2026, establish a street outreach team to serve unsheltered homeless individuals.
- By 2027, reduce the Douglas County Point-In-Time count for unsheltered individuals by 50%.
- By 2027, provide women and families with immediate access to low-barrier emergency shelter services for up to 65 beds.
- By 2027, establish a homeless community outreach and day center facility.

STRATEGIES

- Define programmatic and operational expectations for community organizations to provide emergency shelter services.
- Develop policy framework to build trust and accountability with our community.
- Define and develop the Pallet Shelter Village program.
- Expand street outreach services.
- Establish a community severe weather and disaster response and recovery emergency shelter plan for houseless individuals.

A Call to Action

The Community Health Improvement Plan provides strategic direction for the health and wellbeing of our community. During the planning process, members of the community came together and convened various groups that were key drivers in developing the priorities outlined in this plan. With community at the heart of this Community Health Improvement Plan, key stakeholders, coalitions, and agencies will continue to have an opportunity to work together to improve the health of Douglas County residents.

While this Community Health improvement Plan would not be possible without the collaboration of our stakeholders and partners, everyone, including you, has a role to play in improving the overall health and wellbeing of our community.

We hope that you are encouraged to collaborate with us over the next five years as we move towards a healthier Douglas County, together.

Definitions

Anti-Poverty

Refers to government or non-government initiatives designed to reduce poverty and provide aid, resources, or opportunities to those living in poor conditions. Source: Douglas County CHIP Anti-Poverty Team

ALICE Households

Asset Limited, Income Constrained, Employed (ALICE) – earning above the Federal Poverty Level yet struggling to afford basic expenses. Source: United for ALICE

Food Insecurity

The level of uncertainty or anxiety that individuals and families experience concerning their ability to obtain enough food including reduced quality and variety, due to a lack of resources. Source: Douglas County Food Policy System

Food Security

A community where all residents have access and resources to obtain, grow or produce culturally significant, nutritionally-rich food and a well-balanced diet through an equitable and sustainable food system. Source: Douglas County CHIP Food Security Team

Health Equity

Everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. Source: Robert Wood Johnson Foundation

Lived Experience

People with lived experience are those directly affected by social, health, public health, or other issues and by the strategies that aim to address those issues. This gives them insights that can inform and improve systems, research, policies, practices, and programs. (US Department of Health and Human Services Methods and Emerging Strategies to Engage People with Lived Experience)

Poverty

Occurs when an individual or family lacks resources to provide life necessities, such as food, clean water, shelter, and clothing. It also includes a lack of access to such resources as health care, education, and transportation. Source: American Academy of Family Physicians

Acknowledgments

The CHIP planning efforts were successful because of the collaborative efforts and contributions of many individuals and organizations which worked to undertake significant work. The CHIP team would like to acknowledge and express gratitude to everyone involved in this work. The table list many involved. Any omissions are unintentional.

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- Charles Shively, Just Food
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- Gabby Boyle, Sexual Trauma & Abuse Care Center
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- Ginny Barnard, Live Well Douglas County
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- Monica Dittmer, Eudora Schools Foundation
- Pantaleon Florez III, Maseualkualli Farms
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Lastly,

The Lawrence-Douglas County Public Health and the University of Kansas Medical Center Community Health and Informatics teams contributed substantively to the work of creating the CHIP, including:

- Vicki Collie-Akers
- Sara Obermeier
- Enrique Ortiz
- Shelby Ostrom
- Dee Kinard
- Patrick Bircher