Bob St. Peter: Hello, I'm Bob St. Peter. I'm a pediatrician and the former president of the Kansas Health Institute. Today is May 7th, 2026, and I'm in Hutchinson, Kansas to interview Kim Moore. Kim is a lawyer who was the long-time president of the United Methodist Health Ministry Fund here in Hutchinson. Thanks for joining us.

Kim Moore: It's great to be here.

BSP: This interview is part of the Kansas Oral History Project, exploring health issues in Kansas. The Kansas Oral History Project is a nonprofit corporation that collects and preserves oral histories of Kansans. The series is supported by donations from generous individuals and a grant from the United Methodist Health Ministry Fund. Our videographer is former State Representative Dave Heinemann. Kim, I look forward to our conversation.

KM: I'm looking forward to it as well, Bob.

BSP: So, we worked together for many years.

KM: Yes.

BSP: Tell me a little bit about your upbringing in Kansas and your early history.

KM: As it turned out, I kind of spotted myself around Kansas through my years. I grew up in a town called Longton, which is about thirty miles west of Independence and about 400 or 500 people. There were 13 in my high school graduating class. My early years were filled with fond memories of 4-H, some sports, working in the local bank, which my dad was the banker. I did that for six or eight years, just all the kind of things I think a rural kid in a small town was able to do.

BSP: And your dad was also a state legislator for a period of time.

KM: Yes. He got elected in the first election after the one-person, one-vote rule came into effect. So, he had like three-and-a-half counties that he represented. I was his campaign manager. I was a senior in high school. Then he went off to the legislature and left me to pump the oil lease, which was a disturbing event in my life. I enjoyed politics. I always assumed I would be in politics. Dad, I think didn't enjoy it so much, but I think he was really pretty good at it.

BSP: Maybe that partly influenced your decision to get a law degree eventually but first you went off to—

KM: I went off to Southwestern College, sixty miles away. I had not known there was a Southwestern College until the president of Southwestern was at the Kansas legislature lobbying for a program called the Kansas Tuition grant program, which was to provide state aid for every Kansas student that met certain income guidelines that went to a private college. I suppose that didn't get started until 1970. Dr. Strohl was up there lobbying, and my dad followed him out after the legislative hearing, and we discovered there was a United Methodist College sixty miles

from my doorstep. I went over there, and they were doing a model United Nations session that day. I fell in love with it. I met a guy named Mike Lennen who I've always looked up to, and we've become close friends. So, that's how I ended up at Southwestern, student body president a couple of years.

I really didn't have law school in my heart. I really wanted to teach political science, but for a variety of reasons, I went to Washburn Law School. I would say I enjoyed law school, but not as much as undergraduate. I think professional schools, it's a little hard to have that same level of attachment sometimes.

BSP: Yes. You have remained very engaged with Southwestern College over the years. I was wondering—you were student body president. That's how you got involved in the board activity when you were still in school.

KM: When I graduated and was headed to law school, I joined the Southwestern Board at age twenty-one.

BSP: That's pretty impressive.

KM: I was there until 1987, when I changed careers and came up here to do what we'll talk about with the United Methodist Health Ministry Fund. After law school, I clerked for a federal judge on the 10th Circuit Court of Appeals; he was nearing retirement. His name was Judge Delmas Hill. He was appointed by Truman to the Federal District Court. Clerking for a federal judge on the 10th Circuit meant that you got to help write draft opinions. We traveled within the circuit to hear cases, but it was mostly research work. When I left there, I joined a law firm in Wichita called—it was then called Foulston, Siefkin, Powers, and Eberhardt and probably had about thirty lawyers at the time.

BSP: What kind of law did you practice there? You were there about a decade.

KM: About a decade, yes. As usual, I didn't know what I really wanted to do but thought maybe banking law since I'd been raised in a banking family. I knew I didn't want to be a litigator. I walked in, and the next month, the person who did employee benefits walked out the door. They said, "I think you could learn employee benefits." That happened at the same time that a law called ERISA enacted in 1974 was now effective in 1976. I was immediately thrown into getting about 150 profit sharing and pension plans amended to comply with the new law.

BSP: I just want to make a comment about ERISA. That's a great example of a federal health policy that originally had no intention of really impacting health care in the US.

KM: Right.

BSP: It was employee retirement related legislation, but as it turns out, it's played a major role in how the health care systems developed in our country.

KM: You're right. Originally, nobody paid attention to the fact that it also covered health plans in a skimpy sort of way, but it was real. So, I also became interested in tax-exempt organization law and helped start a number of foundations and organizations. That was my core practice. Then I'd get pulled off into other things.

BSP: Was the work you did in the nonprofit—how did that tie into the potential move that you made next?

KM: I think it did. I think the good thing about knowing something about tax-exempt law was that my job at United Methodist Health Ministry Fund was so often going to involve starting up, paying to help organizations start up or expand or even occasionally join together, and it was always sort of helpful to have that legal background.

BSP: You went from the law firm to the United Methodist Health Ministry Fund. You were recruited as the executive director of that right out of the—

KM: "Recruited" would be a strong word. There was an ad put out for people to apply, and our bank had gotten into regulatory trouble. This was the 1980s. The interest rates were 18 and 21 percent. Anything that we made a loan on was worthless. The cattle were worthless. The oil was worthless. The land was worthless. Young, aggressive examiners were forcing you to mark loans to market rates. We weren't even computerized in our family bank.

So, I gave six years of my life trying to save that bank from the regulators. I eventually lost in 1992, but that experience made me believe, "I want to do something that I can be passionate about." I saw the possibility of the Health Ministry Fund for that to occur. I do feel like God was involved in that decision. I always felt like I finally answered the call that I refused to answer before. I came; I took a 60 percent cut in pay. I moved my family from Wichita to Hutchinson. We had three little kids. I guess we had three little kids. I'd been so busy practicing law, I'm not sure how much attention I paid. It was the one time in my life that I took a big risk, and I'm glad I did.

BSP: What was it about the opportunity that attracted you there?

KM: Well I've always been a United Methodist from confirmation, Southwestern's United Methodist-related institution. I taught Sunday School since I was a freshman in high school. I filled the pulpit on occasion. I saw the possibility for the church to put its view of the Kingdom of God and caring for the least and the lost into practical opportunities through that foundation. I don't want to say we operated from a spiritual frame of mind, but that was always I think behind the board and I as we worked forward.

BSP: We'll get into some of the work that you did when you were at the Fund. Tell us a little bit about the origin of the United Methodist Health Ministry Fund.

KM: Well, the origin story kind of follows the same origin as the Kansas Health Foundation. In about 1984, the trustees of Wesley Medical Center in Wichita, which was affiliated with the United Methodist Church, Kansas West Conference, those trustees decided that they wanted to

sell the hospital, and there was sort of this rage going on in the country where you formed these foundations from the sale of hospitals.

So, they were going to take the existing Wesley Medical Endowment Foundation and put the proceeds in it from the sale to Hospital Corporation of America. There were United Methodists who were not very pleased with this idea of selling "our hospital," but through the years, the legal relationship had become less controlling in terms of the Church's control of that hospital. So, it was an open question whether the church could stop that sale.

I was first involved in this by a call from a group that wanted me to help them stop the sale of Wesley Hospital. I went to the meeting. There was a lot of anger and so forth. But eventually the annual conference met after doing a study, and by about a 3-2 vote approved the sale subject to thirty-million dollars of the proceeds coming to the Kansas West Conference, the United Methodist Church.

That money was to be paid out in ten-million dollar increments over three years from the Wesley Medical Endowment Foundation. I don't know that tracking all this money is any real importance, but for years, the Kansas Health Foundation would claim that the United Methodist Health Ministry Fund was their largest grantee. I think probably your organization and the Kansas Leadership Center has well surpassed thirty million dollars.

We were born as sort of a stepchild out of that whole process.

BSP: So, out of the proceeds of the sale, a larger portion went to the Wesley Foundation which evolved into the Kansas Health Foundation.

KM: Right.

BSP: And then a subset of that thirty million was to the United Methodist Health Ministry Fund.

KM: You got it.

BSP: What is the relationship between the Methodist Church and the Fund?

KM: Well, it was set up in a much more controlling sense. All the trustees had to be United Methodist. They all had to come from the Kansas West Conference. Some of this has changed, Bob, since I left eight years ago. But the idea was that we would focus on the western two-thirds of Kansas, which was that jurisdictional boundary for the Kansas West Conference. As we'll talk, that became a stressor because so many things that we wanted to get involved in were with state-level organizations. We pretty much got away from—we couldn't send money to your organization in Topeka. We pretty much got away from that as long as you were serving the whole state.

BSP: You were there a little more than thirty years. When I think of you and the United Methodist Health Ministry Fund, there are a number of really important topics that jump out including oral health, a safety net, rural health, access to care, early childhood in particular, and

intergenerational issues, hospice care, your work with the church, and your role in supporting mentoring programs.

KM: It may show that we weren't very good at having a narrow enough focus.

BSP: You were there a long time, and you touched on really important issues and played an important role in all of them.

KM: We didn't move year by year. Those moves were always after five years or ten years.

BSP: Tell me where the interest and focus on oral health issues came from and some of the work you did in that area.

KM: I think that came from hearing from low-income medical clinics how many people came in with oral health problems, and they couldn't deal with them. We occasionally would get calls from people seeking care, imagining that we could actually do something for them, and we really got a sense that in terms of the lower-income population of Kansas, there was just a dearth of services, and that prevention modalities were not being widely used.

BSP: Yes.

KM: The other thing was, it was a field where nobody was spending any money. So, we could take our dollars and have big impact in a field like that.

BSP: Which is one of the big strategic questions.

KM: That's a strategic idea that we always had to think about. If you think about, how do you move health care with three million dollars a year, or how do I eliminate poverty with three million dollars a year, it's just pretty hard to come up with good strategies. But with oral health, there was sort of a hunger to get something done.

BSP: I remember—I think I remember the name right—the Kansas Mission of Mercy.

KM: Yes.

BSP: Where you would bring volunteer dental care providers to certain locations and advertise them. I remember talking with you about you wanted to understand what impact they were having. The first one that you had, you had people camping out overnight, bringing family members to get in line to get free or reduced-price dental care. Talk about that.

KM: The Health Ministry Fund did—it was really the Kansas Dental Association and the Dental Charitable Foundation. We put money into that to get the mobile equipment that they would need to conduct that, and because we were so—we had our own internal Oral Health Initiative Committee that had many of these dentists on it. So, I found myself personally engaged with these kinds of activities.

I remember either the first or second one—I never remember if Pittsburg or Garden City was first or second—but at the Garden City one, my assignment was to let people in the gate. At 4:00 that morning, people were at the gate to get in, and the program wasn't even going to open until 7:00 or 8:00. It was snowing hard. It was an absolute blizzard-looking Western Kansas day, and those people were lined up to get in there to get that dental care, and I remember shutting the gate and turning dozens of people away.

One other story, you know, a lot of times people in the philanthropy—first of all, they get disconnected from what the real world is, but secondly, they don't see how the money actually does the good. They get written reports that people tell them the wonderful things that they're doing that use your money, but I would go to these Missions of Mercy and work them and eventually had groups from my church coming and working at these Missions of Mercy.

We were down at southeast Kansas, and I watched a young man from Thayer, another little town down there. I immediately could sort of identify with this kid. He came in the first two days with family members, shepherding them through the process. It was kind of a process, getting them in line, getting them comfortable, whatever, Grandma's brothers and sisters. The last Saturday morning, he came through, and I had talked to him every day. He was going to start at Washburn University in the fall, and on that Saturday morning after he had been through the dental services, he smiled at me and I realized that was the first time the kid had smiled. He had been maintaining the hard lips to cover up the fact that he had rotten front teeth.

I knew then we were doing something that mattered. While the service delivered from those Missions of Mercy was 600, 700 people, here we are dealing with a statewide crisis, what happened was they created so much public and political attention to the dental problem that it got to the point where every year the legislature would say, "What can we do to make this better" It was an incredible moment, and I think a lot of it happened because of that publicity about how many people that don't have dental care.

BSP: Were waiting in line in snowstorms and everything else.

KM: Driving hundreds of miles.

BSP: I remember that period of time, and it really was the work that you guys were doing along with the Dental Association and others to elevate oral health as an issue. And you dabbled a bit in water fluoridation as well. Maybe you want to skip that chapter.

KM: No, no. We'll hit water fluoridation. I would say probably as I look back, it wasn't by any means the biggest mistake the Health Ministry Fund ever made. I don't think it was a mistake. We increased the level of water fluoridation by about 9 percent of Kansans. We won a few. We lost very publicly in Wichita and McPherson, and Hutchinson. The Hutchinson thing really stung. I can't deny it. That was just really hard. It was close, too, 48-52 or 51-49.

BSP: Yes.

KM: But that was a piece of it, but the other thing, we funded sealant projects. Sealants were being underutilized. So, we literally—

BSP: That was for dentists and other—

KM: Hygienists, eventually.

BSP: Would put a hard plastic seal on the cracks in your teeth in the back to keep them from getting cavities.

KM: Yes, sealants. They weren't being used. They weren't being reimbursed adequately by Medicaid. Many dentists just didn't do it. So, we made a push to get more kids in. We literally paid dentists a set amount, $50, to put on sealants. They had a campaign. They'd do 100 kids a day. The Public Health Department, schools, whatever. We had those for two or three years, and then we convinced Medicaid to pay better.

BSP: I think the evidence that the sealants reduced the number of cavities kids get is very strong.

KM: Right. Then you pick up on fluoride varnish, which was a harder problem because nobody was doing that. The idea that oral health disease is really a bacterial issue. I'm sure they knew that, but they tend to treat it like you ate too much candy.

BSP: What we didn't understand back then was the connection to chronic inflammation in the gums with lots of things like premature birth, heart disease even that are associated with that chronic inflammation. I give the Fund and you and the work that that group did tremendous credit for raising the profile of oral health issues.

KM: And Oral Health Kansas became a coalition, and I think it's continued to do good work with the ups and downs of policy in Kansas.

BSP: Let's move to another big area that you guys were involved in, and that's supporting what we typically call the safety net system. First of all, tell us a little bit about what is the safety net from your perspective. How do you view the safety net?

KM: Well, from my view, the safety net is a group of programs that provide access to health care services to people who are unable to afford them or who are otherwise unable to access them—transportation.

BSP: They can be generally a clinic.

KM: Typical, a clinic. We start with the free clinic, and you move up until you're a federally qualified health center, and you're getting a government grant, and the sophistication and the demands move up. When we started in 1988 funding some of those programs, I noticed—I was reviewing this the other day for something else. Their productivity would be 500 patient visits a month, or 600 patient visits a month. They'd have a volunteer doctor who was there two or three

days a week. They'd have a nurse there two or three days a week. They had no access to prescriptions, for referral for specialty care, no dental, no mental health probably.

BSP: Yes.

KM: No vision care. Occasionally, they'd have that actually. The Lions [Clubs International] would come in and provide that occasionally. They were very small and financed really just by donations and grants. One of those programs, the United Methodist Health Clinic that we nurtured for years through all kinds of trouble, is now called Grace Med in Wichita—

BSP: And they have an office in Topeka.

KM: They have an office in Topeka; I think McPherson maybe also. They were producing 130,000, 150,000 patient visits a year. Mexican American Ministries down in Garden City was a true start-up for us. We started it with a $100,000 a year grant, kept doing that for five or six years. Eventually, we convinced Penney Schwab to move it to a federally qualified health center. It took a lot of convincing and others—it wasn't just us convincing her. And now they're producing tens of thousands of visits. You could tell the same story about Krista Postai and Jason Wesco in Pittsburg.

BSP: Southeast Kansas.

KM: I looked, and that network of low-income clinics now has twenty-four members, and the vast majority of them are federally qualified health centers based on my quick look.

BSP: Another amazing story of you applying leverage and strategically using the funds you have to move an issue forward.

KM: Occasionally it worked. Occasionally.

BSP: Yes. This may come up multiple times in the conversation, but we have Kansas has not expanded Medicaid yet. We're one of ten states that hasn't expanded Medicaid.

KM: There's still ten that haven't?

BSP: There are a few of those that have other programs. They're not formally Medicaid extension.

KM: I thought we were even rarer.

BSP: It depends on if you're looking at some of those state-specific programs like Wisconsin has things like that. Where was I going with that? People will argue that you can support the safety net. People don't need insurance. You can build and support the safety net. What do you think of that argument?

KM: First of all, Medicaid expansion will help you build the safety net. They're not some kind of exclusive strategies. The Medicaid expansion would probably do more for those twenty-four clinics than any other single group of providers. So many of their patients are just beyond the current Medicaid limits in Kansas.

The other thing I'd say is "When do we care about people's dignity?" The good thing is, I believe these safety net clinics now, the way they look, the way they're organized, I think people would feel good going in there to get medical care. Back in the days when we were doing it, these were a little bit shoestring, limited. But I think to be able to take yourself to the provider of your choice because you are a human being instead of because you are rich enough or still lucky enough to have employee health insurance or old—matters.

BSP: A lot of the clinics really focus on trying to be sensitive to community needs, providing culturally appropriate care, those sorts of things.

KM: I think you're right. They have in many times pioneered this whole patient-centered kind of approach to medicine, have been in those clinics because they have to to be effective.

BSP: Yes.

KM: If they're not aware that a person's going home to a place where they're not going to have good nutrition, if they're not aware that they don't have adequate shelter, what good does it do to treat? So, they've had to deal more holistically with health, I think.

BSP: I agree. Those clinics play a critical role in the system. I like your comment that Medicaid expansion would be a way to support the safety net system.

KM: It might help save rural hospitals.

BSP: Yes. The clinics may be more directly affected.

KM: I think they would be more directly affected.

BSP: Many of these safety net clinics, but not all of them, are in rural parts of the state. You guys got very engaged in the issue of rural health in Kansas, and the Fund continues to be very involved in that area. Talk a little bit about your—

KM: I think the Fund has done way better work in that area since I left than when I was there.

BSP: No cause and effect.

KM: No cause and effect maybe. Sometimes on these things, the time is better.

BSP: Yes.

KM: With health care, we always devolve that down immediately to saving rural hospitals. I think it's a huge, huge mistake we make in trying to figure out the solution to rural health care that it necessitates saving rural hospitals. The truth is most of those rural communities want their hospitals saved. I don't doubt that. But the question is, "Is that really the way to deliver effective, accessible health care in most rural areas?"

We've been hearing for years that we have all these rural hospitals about to close. Well, they haven't in Kansas, really. It's been the next tier of hospitals. It's been the independents and the Fort Scott's, just about critical access that have seemed to be more at risk to me. I don't know if I could prove that statistically.

BSP: Let me just explain. If you're small enough to be a critical access hospital, then you can get some supplemental financial support.

KM: It's called cost-based reimbursement.

BSP: Right, but the hospitals that are a little bit bigger than that don't qualify.

KM: Right.

BSP: They've been more financially challenged.

KM: And yet they're not as challenged as the others.

BSP: I don't disagree at all with your observation of "Is the hospital really the linchpin of what these communities need?" But we were talking to someone you know, Benjamin Anderson—

KM: Yes.

BSP: There are some very innovative hospitals in rural communities that are engaged in a broad set of activities that support community health.

KM: Right. I think part of the issue has been to determine what is a model hospital for rural areas based on the size of the community. The critical access hospital model really worked well for several decades, but as we've continued to have rural population shrinkage, the volumes have gotten very, very low. It's been very hard to access specialty services in those communities.

BSP: And many of those hospitals around the state have one or two patients a day on average in their hospital.

KM: Yes.

BSP: Small.

KM: And yet the Medicare reimbursement will permit that at some level. I'm sure it's still tough, very tough. So, the Health Ministry Fund, we started before I left to try to engage with seven or

eight western Kansas hospitals in kind of a learning community to talk about what would—I had this theory if we could somehow develop collaborative structures of rural hospitals, maybe that was a path forward.

BSP: FQ—federally qualified health centers have that collaborative community input model.

KM: Right. My theory was especially if we could get hospitals that weren't competing with each other to work together on administrative structures, on whatever, governance, whatever, that that might be a way to kind of keep that full critical access hospital structure going if we could develop collaborative arrangements or multiple critical access hospitals under one organization, whatever.

That was not going very well when I left the Fund. We were also talking to the Kansas Hospital Association about an even more streamlined model, which would be mostly emergency room, day clinic, maybe pharmacy, certainly great emergency services. That would be the critical element so that people could be moved upstream easy and quick. And that came to happen, I think, with the Health Ministry Fund's leadership post me and the Kansas Hospital Association and our legislative delegation. And they have that available, and I think a few hospitals have taken advantage of that.

BSP: Yes, that's great. You've talked about the financial strain on many of the hospitals. Where do you think we're headed with rural hospitals? Maybe this Rural Emergency Hospital designation that you're talking about will catch on. Where are we headed? What are the biggest challenges ahead for rural health care providers in our state?

KM: Well, having the health professionals in those areas is a huge challenge certainly.

BSP: The workforce issues keep coming up.

KM: They just keep coming up. I think a lot has been—there's a sense in Kansas that the rural parts of the state are ignored in Topeka. They've always had this sense—I grew up in one of these areas. I know how this feels. But I will tell you in all thirty-one years of the Health Ministry Fund, I don't believe that I ever went to a conference, workshop, or planning meeting that half of the time we didn't spend on rural issues.

The problem is, they are so difficult. When I grew up, Elk County had over 5,000 people. Today, the last time I saw a census report, it was 2,500. How do you ever catch this? How do you have a structure that is accessible that yet has almost no volume? That's the question we keep having to ask. And I think telemedicine is going to come in. I think better emergency services are going to be essential because we're going to have to move people more miles, and probably some of these streamlined versions can help. But I haven't answered your question because if I could, I'd still be working.

BSP: Take another thirty-one years.

KM: Yes, at least.

BSP: There is an opportunity that we have right now around the Rural Health Transformation grant.

KM: Yes.

BSP: On one hand, the feds cut several tens of billions of dollars from reimbursement to rural hospitals, but they did supplement a fifty-billion-dollar amount to try to support the transformation of the health care in rural parts of the county. I know Kansas has been very engaged in putting together a proposal, has a couple of hundred million dollars to work with rural providers around the state. I'm sure that the Fund is still involved in that.

KM: I'm sure they are involved in that. It matters, too, if a whole gob of your board members come from rural areas.

BSP: So, the Fund has typically had a lot of rural—

KM: I would have to admit, I don't know why I'm doing this on tape, that I was always sort of skeptical of our ability to save rural hospitals at the Health Ministry Fund because giving away three million dollars a year, I didn't see how I was going to turn that boat. The only way I think is the way that the Hunt Fund has continued to work, and that is advocacy around new models and new reimbursement techniques.

BSP: Yes.

KM: Because going in and trying to—the fact that they'd like to have a new x-ray machine—we just couldn't, we didn't have that kind of money.

BSP: Yes, it's a lot of money in one way, but in the context of—

KM: The whole Medicaid budget, what do they say? A rounding error?

BSP: Yes. So, we've talked about safety net and rural health. Sort of stepping back on an even broader picture than that, thinking about health care reform in the health care system, tell me about the work that the Fund did over the years in that area.

KM: Well, now we'll move from successes into something else. I was looking the other day. I had forgotten this. Others in the room may know of something called Health Insurance Purchasing Cooperatives that were a passing fad at one time that I grabbed a hold of. We had a relationship where we formed the Kansas Alliance for Health.

BSP: Out of Great Bend?

KM: No. That was the finishing touch to our effort. We formed this, and I'm embarrassed to say I can't remember the name of the person we were working with at the time. We organized this group, and we were going to have a purchasing exchange. The Wichita Chamber of Commerce

had opted it for their plan for small businesses. We only had Wesley Hospital, and I was trying to convince St. Francis [Hospital] to come on board.

This gets to a really silly personal story. I had an appointment with the head sister at St. Francis for Tuesday after Memorial Day in 1999, and we went down to Longton, and my dad dropped over dead that night. I never had the appointment with because then there was some kind of federal money coming to Kansas that Sandy Praeger was running through, and instead of choosing us, she chose the group in Great Bend to be the state health purchasing alliance. So, our whole effort in the end was just impossible.

That was a negative, and I don't think it was a good long-term strategy. I think you still have the problem of cherry-picking and aging insured base. So, that was one that went down in flames.

I think other things we were more successful on were where we supported navigation to get people enrolled in the Affordable Care Act. I think that ended up being a pretty successful endeavor. For several years, we were the center of a program called the Caring Program for Children. We actually managed all of that money and made grants for it and took grants from other people. And Blue Cross had a program that for $200 a year, they'd insure a child. That was very successful. We had thousands of kids enrolled in that program. And then SCHIP came in, and we didn't need that program.

BSP: State Children's Health Insurance Program.

KM: Right.

BSP: And we called it HealthWave in Kansas when it was first implemented.

KM: Yes, thank you.

BSP: Now KanCare, a part of KanCare.

KM: I think that led into the Kansas Health Policy Authority. Do you think that's right? What sprung the Kansas Health Policy Authority? I couldn't remember. They stole Andy Allison from you.

BSP: They did. That's true. But Bob Day was the first director of it. Governor Sebelius was putting together a health reform set of initiatives, and the Republicans that controlled the legislature, but both Chambers wanted to have an alternative to put forward to the governor's agenda. The Health Policy Authority sort of arose out of that. We can get to that maybe another time.

KM: We ended up being involved in that. We paid $300,000 for a big Schramm study that came back about how you'd use all the existing federal tools and insure more Kansans. Do you remember this?

BSP: Oh, I remember. We had a couple of rounds with—he was an actuary who came and helped sort of model how these—

KM: I think we did it in coordination with you guys. You didn't do that part of the study.

BSP: Talk about the successes when you bring us in.

KM: I'll have to think about that.

BSP: You talked a little bit about kids. You brought that up a couple of times. One of the really important things being a pediatrician, and I remember the work that you guys did was around early childhood and not just medical services but social and behavioral health. Talk a little bit about that whole set of activities that you were involved in.

KM: Well, again, I would say that we did some degree of research and determined that frankly, very young children were not getting very good mental health in the broadest sense, the emotional support, young mothers, everything from maternal depression, avoidance, and prevention, and care to the children.

BSP: And young kids don't stay in their pajamas in bed all day and not go to work. They exhibit depression and stress and anxiety in very different ways that are hard to recognize sometimes.

KM: And in some cases, the families are having trauma. They do have functional families but there's still a lot of trauma in the household. Unless you're having some kind of assistance with those children, they're going to internalize that trauma for the rest of their lives.

BSP: Yes.

KM: We just felt like the mental health group in Kansas was not serving that population very well.

BSP: If I remember right, the focus was to help health care professionals and others to be able to recognize and diagnose these signs of—

KM: Maternal depression, make referrals, have on your staff at a mental health center somebody who's comfortable working with infants. We've found a treatment approach called ABC, which dealt with really bonding between parents and child that was like a ten-session thing that seemed like it was very effective, and we pushed getting people trained in how to do that technique. We ended up having to do that through standalone programs which was not the way I wanted to do it. I wanted to incorporate it into baskets of other services.

BSP: Were you working with the Academy of Family Physicians?

KM: Yes, we had them. We always found the pediatricians easy to work with. Then I guess what ended up becoming I think the best outcome out of the whole program is we started doing research on breastfeeding and discovered that it was almost like some of the stuff in oral health.

If we just do it, there are lifetime health benefits. But lots of cultural reasons that breastfeeding was not being done by many, many mothers, particularly in the African American community. Breastfeeding rates were very low.

So, we started this program with our friends at the Kansas Hospital Association to develop breastfeeding-friendly hospitals.

BSP: So, you got involved in work around breastfeeding.

KM: Yes. One of the better strategies there was to get hospitals more engaged in preparing moms to breastfeed when they took the children home. There was kind of a national effort to have certain things in position in hospitals that were known to help do that.

So, we took a group of twenty Kansas hospital nurses over to Cameron, Missouri, where they had already developed that kind of a program. We took them on a bus and had a two-day trip out of this to see how they did it and brought them home. Then we started saying, "Here are the criteria, and we will certify you as a breast-friendly hospital if you'll meet these criteria" and the program just took off. Suddenly, we were managing a program instead of just giving away money.

BSP: I can tell you from personal experience, my wife is a professional woman. I'm a pediatrician. We struggled getting our firstborn, our daughter, to figure that out. You think it's just something that is going to naturally happen. It takes some work.

KM: It does, and so eventually we encouraged the development of local breastfeeding coalitions who would undertake projects to have more employer-friendly or more breast-friendly workplaces who would help young mothers be aware of the benefits of breastfeeding. The formula industry is pretty good at pushing their product. But I think that has really been a success.

BSP: Let me go back to something you talked about around the stress and the trauma in families. There's a term that people throw around now called "adverse childhood experiences" or ACEs. I know that's something that has informed a lot of the work that you guys have done. What have we learned about ACEs, and how has that been something that you guys have addressed in your grantmaking?

I think we've learned that it's not touchy-feely. It is real stuff, and it has real consequences. Part of the problem is, we have to have health care professionals again look beyond their normal toolbox to try to address this broader problem. This treatment modality called ABC that we found in Connecticut was very good at that because bonding is critical to minimizing the effects of poverty and other kinds of trauma in a household if you have good parent/child bonding. That was probably our primary way to go after ACEs.

BSP: I know we sat in the same conferences many times as the science around understanding how those chronic stress situations actually affect the laying down of neurons in young

children's brains. There are periods of time early in their life where once those pathways have been established, it's impossible to change them.

KM: Pretty tough.

BSP: Again, it exhibits itself through poor emotional regulation and social interaction and aggressive behaviors as kids begin to grow.

KM: Then we're going to fall into discussing holistic health if we're not careful, Bob, which I know is just kind of an old term now that people kind of turn up their nose at, but I still believe that you deal with the whole individual always.

BSP: Yes.

KM: That there are spiritual components as well as emotional and physical and social. I think the Fund was always good at understanding that. I think we often got off on single kinds of modalities, treatments that didn't do it.

BSP: That includes oral health and mental health and vision care, and things like that sort of not being considered as mainstream medical care, so to speak. Let me ask also about childcare, which is a really important issue for families who have young working parents and want to know their kids are in a safe place where they're going to learn some skills. You did some work in the childcare area.

KM: I guess I just opened that up by saying as I have looked back over some of the documents, some of these things that happened inside the Health Ministry Fund, there were a lot of difficult decisions made to get there. For instance, is childcare health? Why are we funding babysitting? Please understand that's not how I viewed childcare.

BSP: But that's the conversation at the board level.

KM: Yes, that's the conversation at the board level that you have. Of course, again, it went back to what you just so well-articulated around the development of the brain. We were learning that all of these early experiences are critical to the long-term human capacity of health.

Then, frankly, the economic issues of childcare. I mean, again, so often it was low-income people who were having to have substandard childcare. We made, I assume, some low hundred number of quality improvement grants for childcare. That was sort of our entry point.

BSP: To develop some standards.

KM: Yes. If they don't have any playground, then we buy a playground. It was sort of that kind of approach. We repossessed a playground once from a failed childcare center. That was interesting.

So, many of these childcare centers are just hand-to-mouth operations. I'm talking centers now. We were also making these grants to individual providers, which was a little bit trickier legally. We would not accept a hospital's physical conditions the way we accept physical conditions for environments where we put our youngest children. It is amazing how as a culture, we just said, "Well, it's a low-paid career. It's a low-paid operation, and the way it is."

So, we were trying to help people understand that they needed to have standards, and in some cases, a little money could help them get to those standards.

BSP: Yes. There's a lot of emphasis on self-sufficiency of families. If both parents are having to work and you have young kids, a lot of emphasis on having children and supporting children, and you have that conundrum.

KM: I noticed this year the legislature I think formally enacted an Office of Early Childhood. Again, I hope the goodness of the idea gets translated into the practical reality because for years, I've wanted to have the home visiting programs of Kansas under some kind of single umbrella. I just felt like, "Why do we have a home visitation program that's for abused and neglected children, and we have a home visitation program to help meet educational standards? We have a home visitation program to help pregnant and delivered moms? Why don't we have a home visiting program?" I can never understand that.

BSP: Another intervention that's been shown to be very cost effective.

KM: Very cost effective, yes.

BSP: All of this work that you did through the Fund, I know that you also got involved and became chair of the Kansas Children's Cabinet.

KM: Right.

BSP: Tell me what in the heck is the Kansas Children's Cabinet, and what does it do?

KM: That's a good question. Some legislators wisely set up the tobacco money coming to Kansas to benefit children. I know that was a controversial thing versus giving all the money to tobacco prevention, but we set it up for kids. It was set up to be, I believe, an endowed organization where they would save money and build up a permanent endowment that would sustain it once the twenty or twenty-five years of the tobacco funding ended. I think that money got raided repeatedly.

BSP: There were tens of millions of dollars.

KM: Tens of millions of dollars. So, today, it has really not operated on an endowed basis. There's very little in the endowment. It operates on what hasn't been raided out of the tobacco settlement, as I understand it.

BSP: Yes.

KM: So, this happened after I retired from the Health Ministry Fund. As we were talking, I've been retired eight years. What has happened is that it has become sort of an ongoing funding source for a number of programs. When you set up something to be a funding source, you have to make critical decisions about "Are we going to be an ongoing funder for a very few things? Are we going to be a funder that is going to preserve most of our capital to address something new that comes up and never be the long-term funder of very much?"

The decision had been made a long time before I got there that we had these programs that are absolutely 90 percent dependent on us to stay open that are doing very good work. I think it's less a laboratory than the legislature really intended. I think they thought they were going to fund cutting edge programs that changed over time and was the point at which there were consolidated efforts and especially making all of these multiple funding streams seamless.

We left out one thing that I'll just mention, and it was called the Corporation for Change. The Health Fund, it was at that time, Bob, really where the Health Fund really got into children's work because of some of our friends at the state level who had conceived of this idea of all of these disparate funding streams are not being effectively used. Let's work at pulling those funding streams together, and let's give local communities more power and initiative to spend what is a really large pot of money.

BSP: It's divided into all of these different silos.

KM: Children with disabilities, abused and neglected children, the school lunch program, on and on and on. There are all of these funding streams. And I really bought into that because at the same time, there was a movement around the country to have a one-stop shop for services, the belief that that would improve access, would improve people getting the totality of assistance they needed versus all this. It fit the moment.

So, we became the staff for the Reno County Planning Council for Children and Families. For three years, I turned out a Reno County Children's budget where we had gathered from every agency, state and local, the money coming to Reno County was being spent. My administrative assistant, we had three of us on staff at the time, she was so glad when we quit doing that. It was a huge—you would have just laughed at the things I did. I would have to say, "Well, I think about a third of this is for children." I had to make gross decisions.

But you got aware of where the money was going, which was part of this whole corporation, to at least know where the money is going. Regrettably, the political winds changed. I was in a conference when the question was, "We need to take the school lunch money and feed people." I immediately knew we were dying in the water. Immediately, the educational establishment just lost all—they'd always been suspicious of this. This combining of money was not to their liking.

BSP: Yes.

KM: So, that whole effort went away, which I hated. We spent a huge amount of human effort, not so much money but human effort, and we announced that one-half of our grant money would only be spent on projects consistent with the Corporation for Change.

BSP: That concept of streamlining programs and funding streams to reduce some of the inefficiencies of having so many redundant structures and stuff is a popular one.

KM: Isn't it appealing?

BSP: Yes, but it's very difficult as you found out.

KM: Right.

BSP: I would say a big part of the work that you guys did was with congregations themselves, both with the members of a congregation and the clergy. Obviously, I'm assuming that has to do with your connection to the United Methodist Church.

KM: Yes.

BSP: Talk about that as a grant-making area.

KM: Well, it was always an area of promise and problem from my view. I believed that there were great possibilities for people of faith to express their faith in service to others in the broadest sense of health ministry. I didn't think it was just—

BSP: Not a small vision.

KM: Sort of the idea, when I first came into the health ministry fund was that health was medicine. Health equals medicine.

BSP: Yes.

KM: So, the church, what they've traditionally done is set up hospitals. That's how they had addressed that health issue. But we sort of believed that social health, emotional health, helping people get access to physical health, and prevention could be things that people of faith could without being a trained professional help with. That was the concept.

BSP: I remember going to a conference that you put on at Southwestern College—

KM: That's a good place.

BSP: You had ministers from all over the Methodist conference, and you invited some non-Methodist religious—

KM: We were that open? That's good.

BSP: You were. I went with the pastor of my church.

KM: Really?

BSP: Yes.

KM: I remember the meeting.

BSP: It was a two- or three-day meeting where you were trying to educate pastors from around the church on this concept. Did they get the message? Did they pick it up?

KM: Some did. Today, the conference has their own minister of health who assists as an advocate, ministers with their health issues, a fully ordained person. She happens to attend my Sunday School class that I teach. I mean, the whole idea that we've got that clergy health needs unique attention. I fought that for a long time. I will admit that I—and it comes with the history—when the Health Ministry Fund was formed, they stood up on annual conference to get it approved and listed all of the things the Health Ministry Fund could do with this huge amount of money it was going to receive. I wasn't at that annual conference, but I read the report. One of the things they said was they'd pay for clergy health insurance.

So, one of the battles that I faced—it went on for three years—the bishop came and asked our board. The bishop was a member of our board and asked our board to commit a half million dollars a year to paying for the clergy's health insurance. And my board by more than a three-fourths vote said, "No, thank you." And that battle went on through three votes, and it got shot down more and more every time because we knew that once we got into that thicket, it would just consume us.

BSP: Yes.

KM: But the idea of clergy wellness, I was—I had this defense mechanism for treating clergy as a special group that I always had to overcome. But eventually you saw that I did overcome it.

BSP: Yes.

KM: We had this. We had special programs for clergy, and then we moved into what we called the Healthy Congregations phase where we encouraged local churches to develop health teams and undertake primarily prevention-related activities—healthy exercise—

BSP: Supporting the health of members of the congregation.

KM: Or the community, whatever they wanted to do. And at the same time, the idea of so-called parish nurses became popular. We sponsored the first conference for parish nurses in Kansas. There was a period, I looked up—AI tells me that it might be 130 of them now, but there's no real record. It's not a specialty where they're registered anywhere. But those are very hard to sustain as paid positions by local churches. But the idea of a health team, the Health Ministry Fund I think has eighty-five churches now that have those health teams, and they provide them

special grants for various activities like developing community gardens, undertaking summer feeding programs, various things. They're kind of one of those things where there's a spirit in a church and a spark because of two or three people, and that may last five years, and then it goes away. But they've been pretty successful.

BSP: Great. Say something about hospice. I know you guys were very engaged in hospice efforts, too.

KM: Thank you for letting me tell the mythic story—I call it the mythic story of the Health Ministry Fund. When, you think about a foundation, most people only know the fully formed foundation. When the Kansas Health Foundation came into being, that was the start of a whole different kind of philanthropy that had never been in Kansas before. So, instead of what we might call responsive grantmaking where you just say, "Tell us what you need, and we'll see if we are interested."

BSP: A charity, almost.

KM: A charity kind of funding, right. And partly the idea that the foundation isn't able to conceive of a future that it wants to have happen. It's going to let somebody else decide what that future is. The Kansas Health Foundation from the very beginning decided they were going to create a biomedical research mecca in Kansas, and they were going to do that and made a bunch of grants

BSP: That was their early vision.

KM: That was their early vision. They found out they probably weren't big enough to do that, and Kansas was going to be difficult to have that happen, I think.

So, for us, when we opened, I knew nothing. I mean, I helped form foundations. I knew about them. But we opened the door and people started sending us letters of inquiry. I had forty-nine waiting for me when I walked in the door, and most of them were from United Methodist groups who wanted a million dollars. They wanted to make sure they asked for enough. And I thought we were giving away one-and-a-half million a year, five percent of the corpus. They thought we might just give it all away and go out of business, I guess.

I look back at some of those early grants we made and I just shudder. I just shuddered when I was doing it the other day. There was a slow learning process. At first, we get all of these applications come in. Then we start thinking because we're funding mostly throughout the whole state but particularly in the west. Well, when that CASA Program came in and asked us for money, we gave them $5,000 a year for two years. Now, this CASA program from another town where another trustee lives is asking for money for $20,000 a year for three years.

BSP: CASA is—

KM: Court Appointed Special Advocate.

BSP: That work with children in the foster care system.

KM: Right. So, early on, we agreed to fund something like that as health. That was our first grant. But the problem was, we'd get these requests that were kind of similar, but how do you treat them?

BSP: Yes.

KM: If you fund one CASA program in Kansas, how am I going to turn down five others? Before I know it, I'm a CASA funder. I didn't mean to be particularly.

So, what the lawyer did, me, was I would develop a funding policy when we'd get two or three, and I'd say, "This looks like the way we could spend money most effectively and still maintain money so you have a decision to meet new opportunity." So, we're going to pay for COMPEER. We're going to start a Compeer program. We're going to pay all of their budget the first year, most of their budget the second year, whatever. It was all written down. Everybody got treated the same. Consistency was—I think that is the hobgoblin of little minds, but consistency was very important to me, and I think to the trustees.

So, we got a very few requests to fund hospices. This was in 1989. We'd been in operation two years.

BSP: So, there wasn't a lot of conversation going on around hospices prior to that?

KM: No. We'd finally gotten a couple of requests. My grants committee chair for the first eleven years had been executive director at Reno County Hospice. She was a nurse. So, I was always getting on to her for conflicts of interest. Anyway, that's not quite true.

So, we got these requests, and they were, "Would you give us $3,000 so we can deliver pain medicine next year?" or "Would you give us $5,000 so we can pay for this nurse to drive out to these two adjoining counties for hospice?" These hospices tended to be a very part-time person or totally volunteer who depended solely on donations.

Well, my grants committee chair knew there was something called the Medicare Hospice Benefit. But to get the Medicare Hospice Benefit, you had to be a certified provider. You had to meet certain standards. A part-time nurse with a clergy person who tagged along once in a while wouldn't quite meet those reimbursement standards. And you wouldn't have the administrative capability to file the bill anyway.

BSP: Right.

KM: There were four Medicare certified hospices in Kansas. I think they were all in northeast Kansas, but I could be wrong. They wanted to form a state association, and they wanted to move Kansas into the Medicare certified hospice column in a big way. They thought people all over the state should have hospice care when they're dying and have bereavement care after the death.

So, we started talking to them. We listened to them. So, I wrote a funding policy, and the funding policy was that we would pay—I don't know that it said how much—but we were thinking $100,000 or so to start up or expand the existing hospices into regional Medicare certified programs because I did not believe that we could have 105—

BSP: Each county.

KM: Each county having its hospice. They would never have the volume. They just wouldn't be able to support themselves. So, we announced this, this state association. We give them a fairly big grant, $300,000. That was a big grant for us to help hospices make this move. And I got no applications. A year went by. I had no applications. This wonderful thing we were prepared to do.

So, I talked to a woman named Donna Bales who ought to be given sainthood. Donna said, "Well, they just don't think they can do it. They can't get the person. If they have to cover three counties, they can't possibly get the person there within thirty minutes the way Medicare requires. They can't have this full range of palliative care that you've got to deliver. There's no way they can do it." And I said, "Well, is nobody in a rural area doing this?" She said, "Oh, yeah, they're doing it all kinds of other places." I said, "Where are they doing this well?" She said, "The entire state of Kentucky has ever acre covered with Medicare-certified hospice care." I said, "Okay, pick ten or fifteen people, and we're going to fly them down" to a town that she knew near Louisville, Kentucky, "and we're going to have a two or three-day seminar on how you do this."

We loaded up these people who were volunteers and part time, people who loved their work, and we took them down to Kentucky, and the first two days, they were just going, "We've heard all this. We could never deal with the paperwork. We'd never be able to do it. "The last night of this seminar, we have a panel, three local hospice leaders. The third one says how wonderful and what it's meant to the people in this poor, low-income area to be able to have their dying people taken care of and to be able to receive consolation, good pain management so they're not dying with pain. And where was this? In the Appalachian Mountains. "And we in the snowstorms, we'd go up the mountains. We go down the mountains. We go through the passes. We get there in thirty minutes, and it has changed the lives of so many people in our part of the state to have that service."

We came back. The applications came in. How could they argue that in Dodge City, they couldn't drive over a flat piece of ground for forty miles and get the nurse there? Literally, within a year, we had started about eight hospices. We had expanded several others, and we had every county in Kansas at least claimed to have hospice care. The National Hospice Association gave us the Funder of the Year award nationally, and that was pretty heady stuff for a little foundation guy, four- or five-years in.

But that changed the whole direction of our foundation because from then on, we could conceive hopefully with people who were well into the field we were talking about like the hospice leadership of what a future might look like, and we could say, "That's what we're funding toward." So that's our mythic story.

BSP: That one's in the victory column.

KM: That was a victory. And I feel that oral health was in the victory column.

BSP: That's awesome. So, two overarching things I want to ask you about. You mentioned Kansas Health Foundation, the Fund, other foundations. Kansas has a lot of health foundations. At one point in time, I believe that we had on a per capita basis more health philanthropic dollars than any state in the country. A couple of other states now have had big conversions and stuff.

KM: It's hard to beat those billion-dollar ones. They're out there.

BSP: Tell me about the role of philanthropy and your engagement. You were also on the board of the national organization of health-related philanthropies, Grantmakers in Health. You were on that national board for several years.

KM: That was some of the most fun I ever had. I looked forward every year to the Grantmakers in Health Conference because when you're doing this, you're sort of isolated in a way, and it was just so important to me, and we always took board members with us to the Grantmakers in Health because I sort of liked to grade myself. I sort of wanted to know, "How are we doing?" You know, we're small. We're dinky, but how are we doing with what we have? I jotted down Kansas Health Foundation formed in '85. We were formed in '86, '87ish. Wyandotte came on in '97. That was not much of a change to the environment because they only funded in Wyandotte County.

BSP: Right.

KM: So, really from 1986 until Sunflower—

BSP: And all of those were hospital sales until Sunflower. And that came out of the attempted sale of Blue Cross and Blue Shield of Kansas.

KM: That may be when I first met Joan Wagnon and Kathleen Sebelius. We funded a little grant to oppose that merger. The Reach Foundation in 2003, the now Health Forward, Greater Kansas City I think 2003 as well.

BSP: Yes, same year.

KM: But for thirteen years, from '87 to 2000, we were the only funder for health care in Kansas because the Kansas Health Foundation would not fund health care.

BSP: Health care services.

KM: Health care services.

BSP: Right.

KM: And they made a big deal about that. Their program officers, if I called over and said, "Do you guys want to join us"— "We don't do health care." They only did health, and that did not include health care.

We had lots of opportunities. That changed some when Sunflower—which all the others were bigger than we are, but Wyandotte. That changed, but what happened was, the leaders of all of these foundations, a little bit less on Greater Kansas City because they fund in four counties in Kansas, but they're housed in Kansas City.

BSP: Focused on the Missouri side more.

KM: But we formed kind of a group, and we got together every quarter to talk about big issues, things we wanted to do together, and we developed really great relationships. I would say now that all six of those health foundations operate more strategically than responsively although there is a real move in health philanthropy to not do that.

BSP: To be more responsive to the quick requests for money versus a long-term strategic investment.

KM: Yes. Don't substitute your judgment for the people doing that work.

BSP: When I think of the work that you did over the years with the safety net, building up the safety net, building up the hospice system, raising awareness of early childhood issues and behavioral—those are longer term, strategic activities. It would be hard to do that in a purely responsive manner.

KM: I've often said it's not easy to figure out what you should fund, but the hardest thing inside the foundation is saying no. If you don't have really strong guardrails around what you're doing, things will just be dissipated.

BSP: Yes. I want to close by sort of a big question, a big-picture question. You and I both overlapped a long time of our careers in Kansas. During that time, if we talk about state health rankings, I'm sure you're very familiar with the America's health rankings that looks at how states compare to each other. At a high point back in 1991, Kansas ranked as the 8th healthiest state in the country.

KM: Really? I didn't remember that.

BSP: Yes.

KM: Wasn't that the Kansas Health Foundation's goal that we be the #1 ranking?

BSP: They've adopted something similar now, but from a high of about #8 in 1991, we fell down to as low as 33rd. Now we're back up a little bit, about 27th or so, but we've had a larger decline than any other state in the country in terms of our relative health ranking.

KM: In spite of having all of these philanthropic resources.

BSP: Yes. What do you think is behind that trend? Again, it's not that Kansans are less healthy than other states. It's that we haven't been gaining as much, as quickly as other states. They're making bigger gains quicker than we are in some of the things that are measured typically. How do you think on that?

KM: Well, I think I'm not a Libertarian. I believe that those kinds of things are in part because government is no longer playing the role government needs to play to secure health and economic progress for its citizens. You can't have a backing away from public health measures that are proven scientifically. You can't have the continued underfunding of those institutions that are dealing with the difficult human problems in our midst. You can't have an "up by your bootstraps" philosophy if you want to have a healthy, prosperous citizenry.

I don't know why we are so adverse in Kansas to investing in our people. I just find it amazing. We will invest in any kind of business scheme that comes along. We will invest in any kind of moral guidance that we think the public needs, but we're not willing to invest dollars back into our citizens, our children, our youth, our people with handicapping conditions. Everything is done sort of begrudgingly and with more worry about abuse than success. I think that whole attitude affects these things, Bob.

BSP: Yes.

KM: Versus what could government do, the question is, "What could government stop doing" constantly. I am no Socialist. I am no politically correct liberal, but I do believe that progress in Kansas has always comes from the center, and it's always been solid. I think we've strayed away from that at our heart.

BSP: I hear in your comments a view of health in this very broad way that we've been talking about. You're not talking about necessarily hospital—

KM: Now we're spending on the KU Med Center. No, I'm not at all.

BSP: You're talking about all of these community, social, family, education opportunities, sorts of supports.

KM: Yes. We get these reports on the Happiness Scale of people. In many of those countries, the tax rate is higher than ours, but we're fixated on the tax rate constantly. It is always a public/private partnership that secures it. The private sector many times cannot go to scale with what needs to be done. It takes public resources, government leadership to make that happen.

BSP: I think that's a very sober assessment of things. I don't know if I want to end on that note there. Is there anything we haven't talked about that you'd like to bring up?

KM: I would just say whoever might ever listen to this, I don't know who you may be, but throughout 90 percent of my career, I was always pleased to say, "I'm from Kansas." People have a stereotype about Kansas. I found when I was at Grantmakers in Health, participating on panels that—

BSP: This national group.

KM: A national group, I could keep up with the conversation. I found that many times, we were doing pretty good when the oral health funders would get together and see the kind of progress we were making, I usually felt pretty good. What was our Medicaid system covering? How were we taking care of children? We've had all kinds of problems in early childhood or children-related services, but they've all been because we're working in a very difficult area as far as I'm concerned.

So, anyway, I guess I always felt like Kansas, unbeknownst to the rest of the world, was a pretty good place to be and that we had this sense of true humanity and progress. Then things started changing politically, and we saw these kinds of things you're talking about with how we ranked against other—I never thought we were going to catch Minnesota. There are always a few places that you knew. I think there's still hope because I think the Kansas that we know is still alive and well. Things will turn from this moment, and we're going to find that deep down, those values that have all been important to us are going to be there and succeed. So, I'll be happy. I'm trying to end on a happy note.

BSP: Well, we'll end there. Thank you, Kim, for the time you spent today, and all that you've done for our state over the years.

KM: It's been a pleasure. Thanks.

[End of File]

