I. Call to Order / Roll Call

II. Approval of standing committee minutes from July 21, 2014.

III. Committee Agenda

Item No. 1 - GRANT: HEALTHY COMMUNITY

Synopsis:
Request approval of an application submitted by MARC to the CDC for a Greater Kansas City Partnership for a Healthy Community Grant, submitted by Terry Brecheisen, Public Health. Wyandotte County will be a sub-recipient of this grant and will receive $160,000. Focus will be on good nutrition, physical activity, tobacco-free environments, and access to chronic disease prevention and management. No cash match. In-kind staffing support for Healthy Communities Wyandotte staff and Safe Routes to School Coordinator.

Tracking #: 140300
Item No. 2 - GRANT: TAKE CHARGE OF YOUR HEALTH

Synopsis:
Request approval of an application to the Healthcare Foundation of Greater Kansas City for a Take Charge grant in the amount of $256,082, submitted by Terry Brecheisen, Public Health. Healthy Communities Wyandotte, the YMCA and the Community Health Council will work together to create an integrated system that will educate Wyandotte County residents who are newly insured through the Affordable Care Act on how to use their insurance. No cash match. In-kind staffing support for Wyandotte Community Health staff and one Dietitian.
Tracking #: 140304

Item No. 3 - COMMUNICATION: BOARDS AND COMMISSIONS PROCESS

Synopsis:
Proposed improvements to the Boards and Commissions appointment process, submitted by Jody Boeding, Chief Legal Counsel, and Joe Connor, Interim County Administrator.
Tracking #: 140306

IV. Outcomes

Item No. 1 - Outcomes

Synopsis:
Add:
Innovation/open data
Social Services

Overview/discussion of the next phase.

AHS's outcomes presented at the following standing committee meetings:
Aug. 12, 2013
a. Education/Workforce Development. Maintain a collaborative working relationship with the various educational institutions and the business community to maximize community resources and enhance learning, college readiness, and career pathway opportunities in our community.
b. Healthy communities/recreation
c. Tax sales and local residence preference (completed)
d. Customer service
e. UGTV (completed)
Sept. 16, 2013
a. Workforce development update, presented by Sharon McMillan, Commissioners’ Liaison
b. Future tracking of goals and objectives for presentation and discussion

Jan. 13, 2014
a. Create searchable centralized online compilation of employment and educational resources by September 15, 2014.
b. Foster stronger relationships with Wyandotte County school districts by meeting with those districts at least twice a year beginning in 2014, and offering the same opportunities and partnerships to each school district. Commissioners representing areas within each school district should be invited to at least one of the two meetings.
c. Work with Board of Regents' personnel, school districts, and KCKCC to improve processes and increase the number of students signed up to use the SB155 Program by 10% per district by Fall 2015.
d. Research and identify our community's ten standout education and workforce development attributes to market to businesses as "star programs." Provide information about those programs on the centralized database and in our economic development materials by Fall 2015.

Mar. 24, 2014
Public Data Access
a. A brief discussion about the data and information.
b. A tour of a handful of UG web applications that allow public data access.
DOTMAPS www.wycokck.org/dotmaps
LANDSWEB www.wycokck.org/landsweb
APPRAISER PARCEL SEARCH www.wycokck.org/appraisal/publicaccess/
NRC E-LINK maui.wycokck.org/citizenaccess/
SPOTCRIME spotcrime.com/
c. A discussion about barriers to data use and strategies to overcome those barriers.

July 21, 2014
As requested by the County Administrator, discussion on the 311 operations with a presentation by Luke Folscroft, 311 Operations.

Tracking #: 120153 and 140238

V. Adjourn
The meeting of the Administration and Human Services Standing Committee was held on July 21, 2014, at 5:15 p.m., in the 5th Floor Conference Room of the Municipal Office Building. The following members were present: Commissioner Markley, Chairman; Commissioners Walker, Maddox, Kane and Philbrook. The following officials were also in attendance: Gordon Criswell, Joe Connor, and Jody Boeding.

**Chairman Markley** called the meeting to order. Roll call was taken and all members were present as shown above.

Approval of standing committee minutes from May 12, 2014. **On motion of Commissioner Kane, seconded by Commissioner Philbrook, the minutes were approved.** Motion carried unanimously.

Committee Agenda:

**Item No. 1 – 140219…GRANT: 1-2-3-4-5 FIT-TASTIC!**

**Synopsis:** Request approval to accept a $23,250 grant to subcontract with Children’s Mercy Hospital for Expanding the Healthy Lifestyles Initiative by implementing the Community Messaging Campaign, 1-2-3-4-5 Fit Tastic!, submitted by Terry Brecheisen, Interim Public Health Director. No matching funds required.

**Terry Brecheisen, Interim Public Health Director**, said this small grant is for us to continue, and to jump start, and to activate this healthy lifestyle program. It’s run through our Healthy Communities Wyandotte section of the Health Department. We will be the subcontractors for this. So, it’s to continue efforts that we’re already doing and to make them better, specifically, in a couple of schools and a couple of child care facilities.

One interesting thing about this grant I thought was that it’s from the Kansas Health Foundation is the money source on this. They will allow us to buy food, but if we want to buy...
food for anybody, we can’t buy donuts, cookies, candy, chips, full-fat ice cream or cake. So, if you want to come to our meeting, then we will have healthy snacks.

**Commissioner Maddox** said I wanted to ask, and I wrote this down, what will the grant funds go toward. **Mr. Brecheisen** said the grant funds are going to go toward supplies, educational materials, media kind of blitz things, and then compensating the schools and the child care facilities for the time and efforts and the materials that they need to promote this in those four facilities in particular, and then for general supplies after that. **Commissioner Maddox** said when you say four facilities, what facilities are they? **Mr. Brecheisen** said they’re going to be determined and the timeline on the grant is that they would be determined by the end of September. **Commissioner Maddox** asked have they already applied. **Mr. Brecheisen** said I would say no to that because the timeline has it for, you know, for September. So, we’re getting the money and so we haven’t identified the people before the money is here. **Commissioner Maddox** asked so how will people apply. **Mr. Brecheisen** said they’ll go through our Healthy Communities Wyandotte, so that’s through the Health Department.

**Commissioner Maddox** said the next I have is, what is the messaging campaign. **Mr. Brecheisen** said to promote the Fit Tastic! Healthy lifestyle behaviors. **Commissioner Maddox** asked but what does that look like. Is that signs? Is that newspaper articles? **Mr. Brecheisen** said yeah, it could be determined by the committee. The Healthy Communities Wyandotte has different committee groups and the committee that’s working on that is the Educational Action Team. They will work with our Health Department employees to develop those messages and those media things. It goes through December 2015, so I’m sure they’ll be working to get this professional so it looks good. Then we’ll get the professional help to develop those media campaigns.

**Action:** **Commissioner Kane** made a motion, seconded by Commissioner Philbrook, to approve and forward to full commission. Roll call was taken and there were five “Ayes,” Philbrook, Kane, Maddox, Walker, Markley.

*July 21, 2014*
Item No. 2 – 140220…GRANT: MARCH OF DIMES “BECOMING A MOM”

Synopsis: Request approval to accept a $20,000 grant from the March of Dimes to transition the Prenatal Department’s current Prenatal Education classes to the March of Dimes “Becoming a Mom” curriculum and expanding to reach patients communitywide, submitted by Terry Brecheisen, Interim Public Health Director. Match through Maternal Child Health Block Grant.

Terry Brecheisen, Interim Public Health Director, said at the Health Department, we already do educational classes for our prenatal clients at the Health Department. This is a grant from the March of Dimes for us to adopt their Becoming a Mom program which will change our five programs to six educational programs for prenatal clients. Then we will also take it into the community. Right now our prenatal classes are for our Health Department clients. This will expand it into the community and we’ll be looking for other locations where we can hold these educational classes. They can then tap into these through the March of Dimes program.

Commissioner Maddox said I wanted to know, what are the recruiting procedures when looking for other community groups to partner with. Mr. Brecheisen said the community, right now they had an idea of going to the Community College or some churches. They haven’t been identified yet. We’re starting at the Health Department and then we’ll proceed from there as some locations would become identified. So there’s no, we haven’t gone into there with specific contracts or agreements with anybody. There’s a chance we find a willing place then, and is a good location for the clients, then that could certainly be a possibility.

Commissioner Maddox said, Mr. Criswell, can you keep me updated as this grant moves forward in regard to whenever the locations are chosen or whatever groups you guys will be partnering with in the community after those locations are set so I can let people know how to apply for those programs. Mr. Brecheisen said it’s exciting to me that we’re going into the community, so the different locations where we go then that will be identified in the future. Now who gets to come to them, really, right now it’s only Health Department clients who are straight from the Health Department. But in the future, it could be anybody. It could just be anybody, referred through doctors’ offices or wherever. Commissioner Maddox said I guess the idea is just to know what locations are chosen to run those programs. Joe Connor, Interim Assistant

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County Administrator, said I think, Commissioner, if you have any ideas of locations, please get those to Terry on both of those grants that you’ve asked about the application process. If you have known entities that are interested, get the information to him sooner rather than later. Commissioner Maddox said okay. Mr. Connor said that’d be great.

Commissioner Philbrook said, Commissioner, I was just noticing as I was thumbing through here looking at this again, I thought I’d read in here something about that, and that information will be coming out through Wyandot, Inc. and District 500, and the Community College. All that stuff will be put out there in the open for people to see. So it’s going to be out there really hot and heavy. The school district does a great job on this.

Commissioner Walker asked how broad of an improvement in reaching the public do you think this will achieve, $20,000. I’m saying it seems like such a small amount. If I read the materials correctly, the primary amount seems to be focused on prenatal care and the rate of death in Wyandotte County, infant mortality, and the predominance of low birth rate and lack of prenatal care. It just seems to me I don’t know how much all collectively we’re putting in towards this through your budget and this $20,000. Any will help, but we need to be certainly aggressive in obtaining any money that’s available for these, not just this particular grant. Mr. Brecheisen said it’s a small startup. It’s allowing us to develop a relationship with the March of Dimes to use their program for Becoming a Mom. That’s an evidence-based program. We have our own program, but now we’re tapping into theirs.

Then the money, the $20,000, a lot of it’s used for incentives for the mothers to complete their classes. They’re given like tokens or incentive for each class that they complete. Then if they complete all of the classes then they get another incentive item of some nature. So, it’s for us to kind of learn the program ourselves and see what works and what doesn’t work. Then we’ll go from there.

Commissioner Walker asked how do you identify your target population. Generally, I assume, you have some overall statistics but this outreach, did I read correctly that like 30% in the first trimester get no prenatal care. Mr. Brecheisen said correct. Commissioner Walker asked how do you find those people and reach out to them and say, hey, come on, this isn’t about you. Mr. Brecheisen said right. We find them usually when they come into the Health
Department and they haven’t had the prenatal care. So we immediately get them into that. If they’re in the first or second trimester or whatever and that’s a sad deal. Hopefully, with this program, for the educational programs that they’ll be receiving from this, then the doctors will give us the referrals as soon as they find a pregnant lady, then they can refer to this new community education program. Because most doctors’ offices don’t provide the educational classes that the Health Department’s provided so now we can get those community clients into the Health Department’s prenatal education programs. It’s a win for all the ladies. How do we find them? Through referrals from the doctors’ offices and walk-ins straight into the Health Department.

**Action:** Commissioner Kane made a motion, seconded by Commissioner Philbrook, to approve and forward to full commission. Roll call was taken and there were five “Ayes,” Philbrook, Kane, Maddox, Walker, Markley.

Outcomes:
**Item No. 1 – 140238...PRESENTATION/DISCUSSION: 3-1-1 OPERATIONS**

**Synopsis:** As requested by the County Administrator, discussion on the 3-1-1 operations with a presentation by Luke Folscroft, 3-1-1 Operations

**Brett Deichler, Director of 3-1-1 Operations**, said I brought Mr. Luke Folscroft with me who works side-by-side with me daily down there on the administrative coordinating capacity. We want to talk a little bit tonight, the County Administrator asked us to come here to speak on behalf of 3-1-1 and to kind of define a little bit of what we do. I think everybody here has a pretty good idea about what we’re trying to do.
I thought I’d put a presentation together and talk about past, present and future just to kind of lay this thing out in a little more detail.
In the past, we obviously started this thing with formal commencement in February, 2008. I’ve listed some of the topics here as far as what the initial hardware/software configurations looked like and their general capacity and functionality. We have actually, it’s been some time since then, we’ve gone through the recession as well. We know that actually hurt a lot of offices, internal and external as well, and us included. We have actually sat back and utilized what we could with the original capacity of the software itself which was Microsoft CRM 3.0 and the unified telephone system which was a Cisco product.

Since that time, we’ve actually moved things forward a little bit. We had initial staffing with eight CSRs. We call our customer service representatives CSRs. We immediately went down to four during the recession which really cost us our ability to actually just answer the phone. If there’s one thing that’s really important with 3-1-1, answering the phone is paramount. We’re not just answering as an operator, we’re answering as a customer service rep. to basically solve that problem right there. We try to increase that first stop resolution right there and have a high resolution rate in the 80-90 percentiles. So we just don’t just pass that on like in the days of old when they had blue pages and you try to pass the buck and get it to the right person. We don’t want to do that. We are utilizing knowledge-based articles and things that like. We’re integrated with a lot of different things that we have initially put in there that allows us to really answer those types of things and gets you, if you have to, outside of our office to the right person the first time or to actually submit a work request order to someone such as Public Works, etc.

Presently we are on version 7.2 in the telephony side. Microsoft was moved to V4.0 which didn’t really give us a whole lot more dynamically speaking. It did give us a little bit, but like I said, we’re currently staffed at four on site. We are showing some of the call volumes here at the top of this page as well. We’re looking at 2008 and you can see that they have progressively gone up. We’re pretty stable right now. We’re at a little over 70,000 through May, so we’re still hanging tight right around 141, 51, and 60 in the thousands a year mark. It’s very important for us to be able to answer that phone and find out what the request is and then submit that request. More importantly, on the backside find out what it is that we did to resolve that request. It’s not just answering and passing it to someone for a verbal confirmation on the other end of the line, it’s about tracking performance. We’ll get into a little more of that.

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Talking about the future of 3-1-1, this excites me. We’ve looked for the last year and one-half to move the technologies forward. Cisco would now be a 10.0 release which dynamically by itself is very strong compared to where we are with the 7.2. Looking at some of the other things we have already currently is our current help desk is integrated with DOTS services as an example, and the knowledge-based articles we discussed earlier. Mr. Ben Blagg is our primary help desk personnel down there and he tries to get those things out daily. As you can see by the bottom of that last page, we take 4,000 and 5,000 call types a year just either internal or external to try to get things through just the Help Desk by itself.

As part of this new future proposal, we’re looking to do a mobile 3-1-1. Everybody’s doing it nowadays. It’s pretty simple. We just need to decide what that looks like. We’re also putting in external call connectors together as part of this hardware configuration for the future upgrade of 3-1-1. It will allow us to take and push that out to the streets and allow the constituent basically to take the old story, take a shot of a pothole, give us a GEO code so we know where it’s at and try to get that thing registered with us so we can track when it was in and follow through with what it took to actually kind of finalize that process too. At that end of that, we’re looking to upgrade our staffing as well meaning that we can probably stay with what I call onsite four CSRs at this point. It doesn’t mean that we’re going to be able to get to the telephones as quick as we did initially, but looking into the decentralized, offsite, meaning that

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people still in the City Hall complex here can actually come in, get trained. We’ve identified a handful of those in the past. We’re just looking to deploy that now and take what we call Tier 1 requests which are real simple, first line, front line things that they can answer. They don’t have to be a subject matter expert. We, in the Call Center, can still handle all of the SME requests as well as anything that goes out in grand detail to the NRC or is a further, more complex request.

Mobility, like I said, is a big deal for us. We built a mobile communication IVR that allows us to arrest the phones if we need to in the time of an emergency to on the fly take a canned recording and tell everybody that’s calling in what’s going on with the Unified Government. We can also push those operators’ connections in there even to a cell number at their house if they had to answer that. If we become the epa center of something done here and we have to move offsite, we can still push those phone calls off on the server to get back to our cell phones and those types of things. But the most important thing that we’re doing right now is getting to the reporting side looking at either an ad hoc or a customized reporting scenario. That is the heart of what we do.

We are more than just a call center. We’re a business operation center and looking at the business intelligence and the analytics behind that to drive and perform as a government which is why we’re all here talking about what we’re trying to do right now. We’re trying to solve problems. At the heart of customer service is the analytics. If we go into that last line, talking about Managing for Results, I put a special slide after this one here to talk a little more about this because I’ve been trained in this quite a few years ago from a guy that I think is probably the best MFR guy in the country.
It talks about down at the bottom of the collective information process and some of those things that go into that hopper up there when you start to look at the CSM and basically the Cisco products driving the connectivity and the technologies themselves, but you get down into that bottom bubble right there and you talk about managing for results and looking at basically a central repository or a data warehouse. The Unified Government, I’ve been preaching this for a long time, we’re going to have to someday sit back and try to collectively integrate what we have from an inoperable perspective to make sure that all the information we have that’s desperate right now gets into a central location so all of us here can speak one language and report out in real time what it is we’re trying to do on a daily basis and actually be as good as we can and maximize what we’re trying to get done.

When you look at these MFR processes here, it really does create smarter government, but you accurately collect the data and manage that data to something. It’s not just a matter of output. It’s a matter of what the outcomes look like and how effectively those things are in the cost relevance of providing that service.

Looking at the internal and external data sharing and transparency, or effectively manage towards specific outcomes, I mean, I don’t know what else to do with the call center besides that. It’s really why we were born. If we are just answering the phone and trying to pass that on, then we’re kind of missing what we were put there to do.

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The technology is coming around. We have already been approved in the budget to do this under a lease finance package over a five-year window. We’re working right now on a statement of work to get that finalized. We’re very close in doing that. We think this can work under the current budget proposal of what we’ve been assigned to do. The more important thing and the most exciting thing about all of this is actually automating these processes to find out how we can connect basically with the NRCs of the world, how we can wrap around and close things that we’re doing for the Public Works and those types of departments of the world and get out here and report these things back, both internally and externally, through transparency and have the mobility to do that when someone tries to get a hold of us.

Commissioner Maddox said on the last slide before that it said “Future,” I guess fixtures. How soon? It didn’t really say when. Mr. Deichler said we are looking to—we’ve pushed this back into this year. We were trying to actually deploy some of this last year in the fall of 2013. It didn’t happen. We had some restraints in regard to the telephone system and funding for that as a UG whole. Initially, we kind of built the whole telephone system that’s out there now from a 4.2 platform in Cisco up to where it was at 6.0 initially when we started. It kind of started us on an island but we created a sandbox for development which allowed the UG to migrate its whole telephone system into that box.

We wanted to do that again, Commissioner. We didn’t have the funding for that extra. So now what we’re doing is basically building an isolated phone system inside the Call Center again that will connect back out into the rest of the Unified Government until the Unified Government as a whole can bring its telephony network back up to where we will be. We’ll be basically operating in the most advanced telephone system that’s in the Unified Government once again. Hopefully that happens on a start, maybe this fall. We’re getting very close, hopefully by the end of August, to signing the contracts on the statement of work. If we can do that, I think we can commence on initial planning to seed the project. We’ve already kind of done some of that, and to get this thing out here. It shouldn’t take really very long. I think in a matter of a few months we can be through development and testing and then just roll into production. So, we’ve got the server set up and things like that to take care of it. Hopefully by the end of this year.
Commissioner Maddox said so you feel when the upgrades are made that there will be significant progress to the 3-1-1 current calling center. Mr. Deichler said without a doubt. The main focus is we, as an organization, have to drive our calls through there. We collect data at the front end. We’re a one stop resolution right there at the first call to try to get to that 90th percentile and push these things back out to the SMEs. I think everything that we gather, if we can utilize at least what we’re using in the CRM scenario as our primary data warehouse, we can pull a lot of data out of that thing from an analytical perspective and allow us to perform a whole lot better. I think it’s the mindset of the Unified Government to get on board to say start calling 3-1-1 because it starts and ends, really, right there. If we’re going to track these things, we’ve got to have a place to seed it and that’s really the best place to do it.

Commissioner Maddox said you spoke about tracking performance. Is there not a way to add in a survey for callers that they may take voluntarily upon the end of their call? Mr. Deichler said absolutely there is. We’ve worked on some of that with DOTS, too, for an internal perspective so far, and it can be done externally as well. That’s really pretty simple. We can add that on. It’s just a matter if they want to opt in to take that survey and we can get it back.

We also have an online 3-1-1 form right now that people fill out on the web that come in through the portal. We look to enhance that a little bit. It’s really pretty solid right now, but we can do anything we want because this external connector’s going to have a web portal to it. You can get into it from anywhere in the world. Commissioner Maddox said okay. Well, I know that was one thing that was important to me. When we did our community survey that was one of the things that the community spoke about. They had lots of issues with our current 3-1-1 system. So, to be able to track and know that we’re doing, that after the upgrades are made that it had been significant to have that survey at the end of the call, I think it is very sufficient for us.

Mr. Deichler said absolutely and I agree. There are two types of performance measures that’ll come out of 3-1-1. One will be how does 3-1-1 operate and perform as an entity in and of itself as well as the Unified Government by itself. I think that it’s important that when we do pop those surveys out that the people understand which one they’re looking at. Some of the limitations that we might expect in 3-1-1, how do we manage call volumes as an example. If we have four on-site CSRs and we used to be able to answer calls in 28 seconds, now sometimes people are on there for minutes at a time depending on if it’s a post-holiday Monday type of
situation, and they’re not very happy with those types of things. So it’s really relevant to get that survey out there and find out what their concerns are and manage to those outcomes.

I think we separate those two at the front where 3-1-1 is taking notes just like everybody else as another operational department just like anything else and we manage to those tasks more efficiently as we move forward as would the Unified Government as a whole.

Action: For Information Only.

Chairman Markley adjourned the meeting at 5:41 p.m.
MARC has applied to the CDC for a Greater Kansas City Partnership for a Healthy Community Grant. Wyandotte County will be a sub-recipient of this grant and will receive 160,000.00. The scope of the project will focus on improving opportunities for good nutrition by increasing environments with healthy food and beverage options; increasing physical activity; increasing tobacco-free environments, and increasing access to chronic disease prevention and management. No cash match, in-kind staffing support for Healthy Communities Wyandotte staff and Safe Routes to School Coordinator.

Action Requested:
Approval of application
BUDGET NARRATIVE

Mid-America Regional Council Community Services Corporation (MARC CSC)
Partnership for Improving Community Health (PICH)
Greater Kansas City Partnership for a Healthy Community

A. MARC CSC Personnel (Direct Labor)  

<table>
<thead>
<tr>
<th>Position</th>
<th>Hours to Grant</th>
<th>Chg to Grant</th>
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<tbody>
<tr>
<td>Salary - 1 FTE Project Manager</td>
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<td>Salary - 20% Public Affairs Coordinator</td>
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<td>Salary - 30% Com Development Director</td>
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<td>Salary - 30% Program Assistant</td>
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<tr>
<td>Salary – Intern</td>
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<td>Total</td>
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</tr>
</tbody>
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Job Description – Public Health Project Manager (Donna Martin, Project Manager/Principal Investigator):  
The Public Health Project Manager will be responsible for daily oversight of the grant;  
responsible will include overseeing the implementation of the project activities as described  
in the work plan, serving as the main point of contact for contractors and consultants and  
ensuring that their activities are being monitored. She will serve as principal investigator,  
overseeing the evaluation of the program, meeting with external community partners, and  
submitting reports as required to CDC.

Job Description – Public Affairs Coordinator (Laura Bogue):  
The Public Affairs Coordinator is a full-time position paid in part through the CDC grant. This  
person will be responsible for coordinating communication of the grant to the local and  
regional community; developing information for the agency website and to support local health  
department and project websites and to serve as a clearinghouse for information about the  
activities related to the PICH Grant, developing consistent messaging for printed materials and  
media exposure. Coordinator will work closely with communications consultant.

Job Description – Community Development Director (Marlene Nagel, program director):  
Marlene Nagel will serve as program director and will supervise staff and work with the  
Coalition, Children’s Mercy, the local public health departments, other grant partners and  
consultants in the program’s implementation and evaluation. This position is a full-time  
position paid primarily from other funds.

Job Description – Program Assistant (Traci Garcia Castells)  
The Program Assistant will be responsible for supporting the meetings; preparing contracts,  
budgets, and correspondence; working with safety net providers; and supporting evaluation  
activities. The position is a full-time position and paid primarily from other funds.
Job Description – Public Health Planner (to be hired)
The Public Health Planner will be responsible for supporting the overall grant, including program strategic objectives, communications, evaluation, reporting and support for the Coalition. This position is a full-time position paid by PICH funds.

Job Description – Intern
The graduate student intern will assist with data collection, GIS mapping and evidence-practice research. The intern is expected to work a total of 500 hours during the grant period.

B. Fringe Benefits
MRC’s Fringe Benefit Rate for Calendar Year 2014 is 48.9 percent for full-time employees and 7.65% for interns. The total fringe benefits for regular MARC employees are $68,710 and $497 for student intern.

C. Consultants
Total $504,000

Evaluation Consultants: $265,000
Nature of Services: Evaluator to work with MARC staff, the Coalition and PICH grant partners to implement the grant evaluation plan and assist with data collection, tabulation and interpretation. The evaluation work will be carried out with a team of skilled evaluators, all of whom have experience working with MARC and its partners. The team will be led by Dr. Eduardo Simoes, MD, MSc, DLSHTM, MPH Professor and Chair, Health Management and Informatics, University of Missouri School of Medicine. Other team members include Dr. Cheryl Gibson, Ph.D., Research Associate Professor, General and Geriatric Medicine, Department of Internal Medicine, Kansas University Medical Center; and Dr. Richard Suminski, Ph.D., MPH, FACSM, Associate Professor, Department of Physiology, Kansas City University of Medicine and Biosciences.
Method of Accountability: Scope of services will outline work to be performed; Project Manager and Principal Investigator will receive and review regular reports and schedule regular meetings/conference calls to review progress.

Communications Consultant: $100,000
Nature of Services: Develop overall brand and design year 1 communications program to support the PICH program strategies.
Method of Accountability: Scope of services will outline work to be performed; Project Manager and MARC Public Affairs Coordinator will receive and review regular reports and schedule regular meetings to review progress.

Project and Training Consultants: $69,000
Nature of Services: Provide training to local public health departments on assessments and technical assistance to school districts on implementing healthy eating and physical activity program strategies; training for local officials on public policy implementation; advice on program design and implementation by national consultants.
National technical assistance consultants: $30,000
Alliance for Healthier Generation training on school wellness policy implementation: $39,000
Method of Accountability: Scope of services will outline work to be performed; Project Manager will receive and review regular reports and schedule regular conference calls/meetings to review progress.

Community Organizations to Support Program Strategies’ Implementation $70,000
Nature of Services: Through a competitive RFP process, the Coalition will select up to 7 community organizations to receive funds to support program implementation.

<table>
<thead>
<tr>
<th>D. Equipment</th>
<th>Total $0</th>
</tr>
</thead>
<tbody>
<tr>
<td>E. Supplies</td>
<td>Total $500</td>
</tr>
</tbody>
</table>

Meeting supplies (folders, notebooks, flip charts, etc.) for Coalition meetings and workshops

<table>
<thead>
<tr>
<th>F. Travel</th>
<th>Total $4,500</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Region Travel</strong></td>
<td></td>
</tr>
<tr>
<td>$1,500 for airfare to attend CDC-sponsored conference(s) for the PICH grant program and a public health professional conference to present on the PICH work (3 trips)</td>
<td></td>
</tr>
<tr>
<td>$2,100 for hotel nights and meals for the three expected trips</td>
<td></td>
</tr>
<tr>
<td>$300 for ground transportation, airport parking</td>
<td></td>
</tr>
<tr>
<td>$400 for conference registration fees</td>
<td></td>
</tr>
<tr>
<td><strong>In-Regional Travel</strong></td>
<td></td>
</tr>
<tr>
<td>$200 for Mileage for use of personal car to meetings</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G. Other Direct Expenses</th>
<th>Total $114,563</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200 for courier/overnight delivery to send information to CDC and contractors</td>
<td></td>
</tr>
<tr>
<td>$80,000 for media buys (electronic, print media, social media) as determined by Communications consultant, grant partners and Coalition</td>
<td></td>
</tr>
<tr>
<td>$20,000 for printing for brochures, flyers, guidebooks and toolkits, assessment tools</td>
<td></td>
</tr>
<tr>
<td>$1,000 for meeting costs including conference call line charges, room rental for workshops</td>
<td></td>
</tr>
<tr>
<td>$500 for postage to mail surveys associated with evaluation of program strategies</td>
<td></td>
</tr>
<tr>
<td>$12,863 for office rent for program staff (The rent is calculated as a percentage of direct salaries – 8.5 percent in 2014)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>H. Indirect Costs</th>
<th>Total $69,622</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARC has an approved indirect cost allocation plan with US Health and Human Services. The approved rate for calendar year 2014 is 32.2 percent (Total salaries + fringe benefits x .322 = indirect costs).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I. Contractual Costs</th>
<th>Total $1,289,564</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARC CSC will partner with eight local public health departments, two hospitals with community programs and two not-for-profit organizations to carry out various program strategies. These partners are considered sub-recipients and include:</td>
<td></td>
</tr>
</tbody>
</table>
Local Public Health Departments
Cass County, Mo. Health Department $40,000
Clay County, Mo. Public Health Center $75,000
Independence, Mo. Health Department $100,000
Jackson County, Mo. Health Department $115,000
Johnson County, Kan. Dept. of Health and Environment $160,000
Platte County, Mo. Health Department $30,000
Wyandotte County, Kan. Health Department $160,000
Kansas City, Mo. Health Department $175,000

Each of the local public health departments will be involved in the program objectives involving schools, local governments, and parks and recreation departments. All but three will be involved in the multi-unit housing program strategy. Several will be involved in working with safety net clinics on expanding access to preventive clinical services. All will be involved in the infrastructure program strategies to strengthen and expand the Coalition, to communicate and engage the public and key audiences, to evaluate and monitor the program strategies, and to help with reports and information to the CDC.

Hospitals and Nonprofits
Children’s Mercy Hospital and Clinics $194,564
Truman Medical Center $40,000
Bike Walk KC $100,000
Kansas City Healthy Kids $100,000

Children’s Mercy Hospital and Clinics will play a lead partner role in helping to support the Coalition, communications and evaluation work. In addition, Children’s Mercy will lead work around the preventive clinical services program objectives and school wellness policies. Truman Medical Center will be involved in the preventive clinical services program objectives and training for safety net clinic staff. Bike Walk KC will focus its work around the physical activity program objectives and lead the work around Safe Routes to School. Kansas City Healthy Kids will focus its work around the nutrition program objectives and lead the work around local government financing for healthy food retail.

Matching In-Kind Contributions
MARC expects to secure additional in-kind match commitments for years 2 and 3 totaling over 30 percent of the total program budget.

Mid-America Regional Council Community Services Corporation $85,000
Funds from local foundation to support overall program and specific healthy eating/nutrition program strategies
<table>
<thead>
<tr>
<th>Agency</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children’s Mercy Hospital and Clinics</strong></td>
<td>$194,564</td>
</tr>
<tr>
<td>Funds from JR Albert Foundation and Kansas Health Foundation ($150,371) and in-kind match of $44,193 to provide staffing support, communications support and support from community organizations</td>
<td></td>
</tr>
<tr>
<td><strong>Wyandotte County, Kansas Health Department</strong></td>
<td>$61,000</td>
</tr>
<tr>
<td>In-kind staffing support for Healthy Communities Wyandotte staff and Safe Routes to School Coordinator</td>
<td></td>
</tr>
<tr>
<td><strong>Bike Walk KC</strong></td>
<td>$25,000</td>
</tr>
<tr>
<td>In-kind staffing support and other expenses for Safe Routes to School programming from the Health Care Foundation of Greater Kansas City and the UG/Hollywood Casino Fund at the Greater Kansas City Community Foundation.</td>
<td></td>
</tr>
<tr>
<td><strong>Independence, Mo. Health Department</strong></td>
<td>$39,770</td>
</tr>
<tr>
<td>In-kind staffing support, training for local government officials and supplies to support tobacco free, healthy nutrition and physical activity program objectives from local government dollars</td>
<td></td>
</tr>
<tr>
<td><strong>Johnson County, Kan. Department of Health and Environment</strong></td>
<td>$24,680</td>
</tr>
<tr>
<td>In-kind staffing support for tobacco free, healthy nutrition and physical activity program objectives from local government dollars</td>
<td></td>
</tr>
<tr>
<td><strong>KC Healthy Kids</strong></td>
<td>$100,000</td>
</tr>
<tr>
<td>In-kind staffing support, supplies, contractual to support healthy nutrition program objectives from foundation dollars</td>
<td></td>
</tr>
<tr>
<td><strong>Platte County, Mo. Health Department</strong></td>
<td>$42,500</td>
</tr>
<tr>
<td>In-kind support two Health Educators’ portion of salaries $40,000/annual</td>
<td></td>
</tr>
<tr>
<td>Marketing for Healthy Food &amp; Beverage options wall calendar @ $2,500-$3,000/year to distribute targeted health messages to the public</td>
<td></td>
</tr>
<tr>
<td><strong>Kansas City, Mo. Health Department</strong></td>
<td>$26,931</td>
</tr>
<tr>
<td>In-kind support for portions of 4 public health specialists (10% of 2 FTE, 4.4% of 1 FTE and 4.25% of 1 FTE)</td>
<td></td>
</tr>
</tbody>
</table>

**Total CDC Grant Request:** $2,198,967  
**Total In-Kind Match:** $599,445 (21.4%)  
**Total Budget Year 1:** $2,798,412
APPENDIX j: ABSTRACT
The Greater Kansas City Partnership for a Healthy Community (Coalition) will serve 6 counties in the Kansas City region, including Cass, Clay, Jackson, and Platte counties in Missouri, and Johnson and Wyandotte counties in Kansas, with a total population of 1.8 million. There are 44 census tracts in the designated geographic area that meet both CDC criteria of high poverty and low educational attainment. The population in these census tracts totals 111,660 persons. The Partnership is led by the Mid-America Regional Council Community Services Corporation with eight local public health departments, two hospitals and two nonprofit advocacy organizations leading the work. Chronic diseases have serious and negative impact on Greater Kansas City’s community health. In order to address that burden, the Coalition will focus on improving opportunities for good nutrition by increasing environments with healthy food and beverage options; increased physical activity and tobacco-free environments to decrease risks for chronic diseases. In addition, the Coalition will continue efforts to improve opportunities for prevention and management of chronic diseases. One of the biggest burdens driving the efforts in the Kansas City area is the high rate of obesity and diabetes. This warrants alignment of multiple agencies’ efforts to change policies and practices to support healthy eating and active living as well as the prevention, detection, early intervention and management of chronic diseases.

Schools are priority settings because of the number of children that can be reached; the opportunities these settings provide to reach and engage families to lower risks for chronic diseases in home and neighborhood settings; and the increased risk in terms of obesity rates observed when children enter school. Program strategies for school settings will address school wellness policy adoption and implementation; healthy local food procurement policies; and expansion of Safe Routes to School programs. Local governments are another priority setting for program strategies to reach both the general population and targeted neighborhoods through the adoption of policies to support healthy vending and concessions by area parks and recreation departments; implementation of Complete Streets policies to increase access for physical activity; adopting financing policies for healthy retail in target neighborhoods; and smoke-free policy adoption by local governments. The private sector has an important role in creating healthier environments as a priority setting, and a program strategy will address smoke-free multi-unit housing. The Coalition will increase opportunities for the prevention of chronic diseases by expanding safety net and WIC clinic locations that implement a Healthy Lifestyle Initiative protocol identifying and connecting at-risk patients to preventive services.

The grant provides an opportunity for the Partnership to strengthen community communication and engagement and program evaluation, as well as strengthen and expand the Coalition’s capacity to serve the metro area. The Coalition will ensure community input and engagement and fine tune strategies that are long-lasting, and build on existing community networks and assets. The Coalition's steady progress over the last three years has positioned it to broaden its impact and align approaches in a sustainable and effective manner. Through this application, the Coalition will further improve the region’s capacity to achieve desired outcomes. In the past, the Coalition has had limited evaluation capacity to track results. This application’s robust evaluation plan will help identify what is working and better direct resources to those activities that are having the most impact. The communication efforts and strategies will better equip the Coalition to address spark a community commitment to improving health and removing obstacles.
GREATER KANSAS CITY PARTNERSHIP FOR A HEALTHY COMMUNITY
APPLICANT: MID-AMERICA REGIONAL COUNCIL

NARRATIVE
I. Approach
a. Background
i. Designated Geographic Area: The Greater Kansas City Partnership for a Healthy Community (Coalition) will serve six counties in the Kansas City region, including Cass, Clay, Jackson, and Platte counties in Missouri, and Johnson and Wyandotte counties in Kansas. This area has a population just over 1.8 million. The region’s population has grown modestly over the past several decades, at about 1 percent per year. The region’s population is aging and becoming more diverse, and the poverty rate is increasing.

Demographic Characteristics

<table>
<thead>
<tr>
<th>County</th>
<th>Population 2013</th>
<th>% change (2010-13)</th>
<th>Non-white population 2012</th>
<th>Population below poverty level 2012</th>
<th>Adults w/ less than HS education 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass</td>
<td>100,641</td>
<td>1.2%</td>
<td>11,147</td>
<td>8,604</td>
<td>5,356</td>
</tr>
<tr>
<td>Clay</td>
<td>221,939</td>
<td>3.8%</td>
<td>38,571</td>
<td>19,636</td>
<td>12,724</td>
</tr>
<tr>
<td>Jackson</td>
<td>679,996</td>
<td>0.9%</td>
<td>251,875</td>
<td>125,803</td>
<td>47,186</td>
</tr>
<tr>
<td>Platte</td>
<td>93,310</td>
<td>4.5%</td>
<td>15,313</td>
<td>5,573</td>
<td>3,244</td>
</tr>
<tr>
<td>Johnson</td>
<td>566,933</td>
<td>4.2%</td>
<td>105,409</td>
<td>37,445</td>
<td>14,801</td>
</tr>
<tr>
<td>Wyandotte</td>
<td>160,384</td>
<td>1.8%</td>
<td>90,899</td>
<td>36,914</td>
<td>21,473</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,823,203</td>
<td>2.4%</td>
<td>513,214</td>
<td>233,975</td>
<td>104,784</td>
</tr>
</tbody>
</table>

While the region’s non-white population of 28% is somewhat less than that of the nation (36.7%), it still represents a large number — 513,214 people. At 13.6%, black non-Hispanics make up the largest non-white portion of the population, followed by Hispanics at 9%. There is a wide variance in racial makeup among the counties in the metro area. Wyandotte County has a majority-minority population, with 57.1% non-white. Jackson County is the second most diverse at 37.2%, or roughly the same percentage as the U.S.

About 13% of the region’s population lives below the poverty level, with the greatest concentrations in Wyandotte and Jackson counties. Over the past decade, the number of people living at or below the federal poverty level (FPL) increased by 35 percent regionally, with even greater rates of increase occurring in suburban counties — Cass County’s FPL population increased by 146% and Johnson County’s by 135%.

Nearly 105,000 adults have less than a high school education, with the highest rates of low educational attainment found in the portion of Kansas City, Missouri, that falls within Jackson County and in Wyandotte County, Kansas.

Life expectancy for males in the Kansas City region ranged from 71.6 to 79.3 years by county, compared to the U.S. average of 76.2 years. For females, life expectancy ranged from 77.9 to 82.9 years, with the U.S. averaging 81.3 years. Life expectancy for non-whites was three to six years lower than whites in the region’s most diverse counties (Jackson and Wyandotte).
Life expectancy for blacks in these two counties was one to four years lower than the national average. The major causes of death in 2010 in the metro area were heart disease (23.5%), cancer (23%), stroke (5.9%), and lower respiratory disease (5.8%).

<table>
<thead>
<tr>
<th>County</th>
<th>Number of Uninsured</th>
<th>Obesity Rate</th>
<th>Diabetes Rate</th>
<th>Tobacco Use</th>
<th>Physical Inactivity</th>
<th>Years of Potential Life Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass</td>
<td>12,314</td>
<td>33.3%</td>
<td>10%</td>
<td>23.8%</td>
<td>30%</td>
<td>1100/6935</td>
</tr>
<tr>
<td>Clay</td>
<td>25,461</td>
<td>27.8%</td>
<td>9%</td>
<td>22.8%</td>
<td>26%</td>
<td>2104/6278</td>
</tr>
<tr>
<td>Jackson</td>
<td>112,719</td>
<td>32.7%</td>
<td>9%</td>
<td>23%</td>
<td>25%</td>
<td>8485/8902</td>
</tr>
<tr>
<td>Platte</td>
<td>7,578</td>
<td>28.4%</td>
<td>9%</td>
<td>18.8%</td>
<td>27%</td>
<td>720/5251</td>
</tr>
<tr>
<td>Johnson</td>
<td>48,679</td>
<td>23.8%</td>
<td>7%</td>
<td>13.7%</td>
<td>18%</td>
<td>3603/4586</td>
</tr>
<tr>
<td>Wyandotte</td>
<td>41,021</td>
<td>37.9%</td>
<td>12%</td>
<td>25.3%</td>
<td>33%</td>
<td>2182/10125</td>
</tr>
</tbody>
</table>

Sources: MARC, Kansas City Regional Health Assessment Report, June 2013, RWJ County Health Rankings, LPHA Community Health Assessments.

There are 44 census tracts in the designated geographic area that meet both CDC criteria of high poverty and low educational attainment. The population in these census tracts totals 111,660 persons. There are 52 census tracts in the six county area with a poverty rate of 30 percent or more with a population of 171,145. There are 52 census tracts with at least 25 percent of adults with less than a high school population. The population for these tracts totals 132,163. These census tracts with both high poverty and low educational attainment include:
Jackson County, Mo.: 6, 7, 9, 10, 18, 19, 20, 21, 22, 34, 52, 54, 55, 61, 63, 96, 118, 153, 154, 155, 156, 160, 163, 164, 166
Wyandotte County, Kan.: 408, 410, 411, 412, 413, 415, 417, 418, 420.01, 420.02, 421, 422, 423, 424, 426, 427, 428, 439.03, 451.

The population in these census tracts are 49.5% male; 50.5% female. The population is 25.5% white; 31.7% Black; 36.5% Hispanic; and 6.3% other races. By age, 10.6% is under age 5; 20.9% 5-17 years; 4.0% 18-21 years; 13.0% 22-29 years; 13.5% 30-39 years; 12.5% 40-49 years; 11.3% 50-59 years; and 12.7% 60 years and older.

A map showing the location of these target areas is included in Appendix K.

**ii. Chronic Disease Burden.** Using 2009 CDC estimates, all but one county in the bistate Kansas City region had age-adjusted obesity rates (for adults over 20 years) greater than 25%. Johnson County’s rate was 23.6%. Half of the counties had rates greater than 30%, including Wyandotte County at 37.9%. Higher rates of obesity are associated with higher rates of diabetes and heart disease. CDC data indicates that between 2004 and 2009 every county in the Kansas City area experienced an increase in obesity rates. Clay County saw only a modest increase, 3.4%, while Wyandotte County’s obesity rate increased by 35.4%. Diabetes rates increased in every county, with Johnson County growing the slowest, 6.7%, and Wyandotte the fastest, 50%. These increasing rates, compounded with the current high rates of diabetes — greater than 9% in five of the six counties — illustrate a clear burden.

While adult tobacco use has been declining throughout the region, rates remain high in most counties, with the highest rates in Wyandotte and Cass counties. The Missouri and Kansas Student Surveys show a range of youth tobacco use, from a low of 5.4% in Johnson County using cigarettes in the past 30 days to a high of 9.9% in Jackson County.
The prevalence of health insurance is one indicator of access to health care. In 2008, 12.4% of the population in the region was uninsured. By 2011, this figure had increased to 13.6%, or 265,938 individuals. Uninsured rates range widely across counties, from Johnson County’s 8.9% to Wyandotte County’s 26.1%. Another measure of medically vulnerability is the combined total of those who are uninsured or on Medicaid. This number rose from 455,239, or 23.6% of the regional population in 2008, to 527,223, or 26.7% of the population in 2011.

The health status of the region’s population is also affected by the metropolitan area’s physical form, including suburban community design and limited public transportation and active transportation options. The prevalence of adults with no leisure-time exercise or physical activity during the past 30 days, based on the population-weighted percentage of adults interviewed for the BRFSS, shows that nearly a quarter of area adults have a sedentary lifestyle, with no major changes since 2002. Johnson and Wyandotte counties — the area’s most affluent and poorest counties, respectively, record the greatest differences among area counties in access to care and leisure-time exercise.

According to the Kansas City University of Medicine and Biosciences Score 1 for Health initiative, a 2011-2012 sample of 12,328 children from kindergarten through fifth grades found that the percentage of children in the Kansas City area who were overweight was 18.6% and who were obese was 22.3%. (1) Kansas City area obesity rates among children ages 2–5 and 6–11 were reported at 11%, while the rate for children ages 12–19 was 15%.

**b. Problem Statement.**

Chronic diseases have serious and negative impact on Greater Kansas City’s community health. In order to address that burden, the Coalition will focus on improving opportunities for nutrition, physical activity and tobacco-free environments to decrease risks for chronic diseases. In addition, the Coalition will continue efforts to improve opportunities for prevention and management of chronic diseases. One of the biggest burdens driving the efforts in the Kansas City area is the high rate of obesity and diabetes. This warrants alignment of multiple agencies’ efforts to change policies and practices to support healthy eating and active living as well as the prevention, detection, early intervention and management of chronic diseases. While gains have been made in decreasing tobacco use in the region, smoking rates remain high. The Coalition will address this risk by expanding clean-indoor air efforts that benefit non-smokers and providing cessation prompts and reinforcements for smokers.

Given the strong influence of social determinants on health in low-income, low-education regions, particularly in Wyandotte County, Kansas, and Jackson County, Missouri, the Coalition will emphasize adoption of evidence-based implementation strategies that are locally relevant and integrated into existing systems to function efficiently. Coalition capacity will be structured to ensure community input and engagement and fine tune strategies that are long-lasting, not disruptive, and build on existing community networks and assets.

Schools are priority settings for strategies to address poor nutrition and physical inactivity because of the number of children that can be reached; the potential of policy and practice shifts to improve the food and fitness environments of children in schools and impact life-long practices; the opportunities these settings provide to reach and engage families to lower risks for chronic diseases in home and neighborhood settings; and the increased risk in terms of obesity rates observed when children enter school.
Many changes and coordinated efforts at the individual, home, community and system levels are essential to reverse the burden imposed by chronic diseases in the Kansas City area. It is no small task to make these changes at all levels. While efforts to address this burden are increasing, the approaches are not yet at a sufficient scale to have the impact needed to reduce risks and prevalence of chronic diseases within the community. Complex community problems require new approaches, new governance systems, and careful navigation around challenges.

The Coalition's steady progress and growing insights over the last three years have positioned it to broaden its impact and align approaches in a sustainable and effective manner. Through this application, the Coalition will further improve the region’s capacity to achieve desired outcomes. In the past, the Coalition has had limited evaluation capacity to track results. This application's robust evaluation plan will help identify what is working and better direct resources to those activities that are having the most impact. Another challenge to current efforts is the inertia exhibited by individuals, agencies and complex systems, which challenge our ability to achieve community health. The communication efforts and strategies employed through this application will better equip the Coalition to address this problem by sparking a community commitment to improving health, to challenging obstacles such as policies that are unfriendly to good health and behaviors that are not conducive to good health; to increase opportunities to be physically active; to create a culture willing to acknowledge the conditions that stand in our way and motivated to take positive actions toward improved health.

c. Purpose

This grant will enable Greater Kansas City and the Healthy Lifestyles Initiative Coalition to further its efforts to create a “healthy community” by implementing sustainable, evidence-based and community-based improvements that address tobacco use and exposure, poor nutrition, physical inactivity and limited access to chronic disease prevention. The applicant and Coalition will build on current efforts throughout the six-county, bistate region to address priority needs defined in recent community health assessments, reaching 75 percent of the population through policy and environmental change while targeting specific program objectives to priority populations and target areas.

The grant will enable Mid-America Regional Council (MARC) and its many community partners, including hospitals, local public health departments, local governments, and nonprofit organizations, to create environments that support health and healthy behaviors through strengthened alignment of efforts led by the multi-sector Coalition. MARC, with support from evaluation and communications contractors, will create community health metrics to track outcomes and launch a community health campaign through its established communications network to reduce risks for chronic diseases, including heart disease, diabetes, stroke and obesity, in the metro area.

d. Three-Year Outcomes

The Coalition will address all four risk factors and achieve the following outcomes from its work over the next three years:

1.0 The Coalition will increase the number of people with greater access to environments with healthy food or beverages from 54,910 to 856,905 by September 2017.
2.0 The Coalition will increase the number of people with greater access to physical activity opportunities from 1,083,269 to 1,174,203 by September 2017.
3.0 The Coalition will increase the number of people with greater access to tobacco-free environments from 1,413,948 to 1,433,948 by September 2017.
4.0 The Coalition will increase the number of people with greater access to opportunities for prevention of chronic diseases through clinical and community linkages from 15,000 to 47,000 by September 2017.
5.0 The Coalition will increase the number of infrastructure components supporting the community health activities from one to four by September 2017.

**e. Strategies and Activities – See Appendix A: CAP and Appendix B: Logic Model.**

**1.0 Increase Environments with Healthy Food and Beverage Options**

Healthy eating is essential to lower risks for obesity and chronic diseases that afflict large numbers of adults and youth in our region. The Coalition will increase the number of schools, parks and recreation departments, and neighborhoods that provide healthy food and beverage options. Through these three venues, the initiative can reach much of the population and increase the number of people with improved access to healthy foods and beverages. Dietary guidelines clearly outline the foods and dietary practices that are foundational to health and prevention of obesity and chronic diseases, but drastic changes in the nation’s food system, food and eating environments in recent decades make it difficult to meet those standards (2). While food may be readily accessible in many settings and neighborhoods, much of it falls into the unhealthy food category — energy-dense foods, many of which consist of refined grains and high levels of sodium, fats and/or sugars and low in nutrients (2). These foods, when consumed in excess, contribute to chronic disease risk.

High poverty neighborhoods are significantly less likely to afford access to supermarkets offering fresh fruits and vegetables. In the heart of one of the country’s richest agricultural regions, Kansas and Missouri rank 23rd and 7th, respectively, among the 50 states in food insecurity. In Wyandotte County, 20.5% of the population is food insecure; in Jackson County, the rate is 19.1%. Grocery store access is low in these high risk areas. Low-income residents also have more limited access to large grocery stores — 13.6% in Wyandotte County and 6.6% in Jackson County.

Schools play a central role and are a targeted setting for the Coalition’s efforts. They work to create healthy environments that promote student learning, support student health, and prevent long-term chronic disease. Moreover, students typically consume 30–50% of their total calories at school, making schools a significant source of nutrition, particularly for people who are food insecure. Unfortunately the school food environment is radically different that it was a few decades ago, with high-calorie, low-nutrition foods available throughout the day. While important changes are being implemented on a national basis, including improvements in school meal standards and requirements for school wellness policies, there are challenges to implementing those new standards and policies in metro area schools, as documented in a recent assessment conducted of school policies and practices.

Parks and Recreation Departments also have a significant impact. They control food options in multiple public venues. Parks often set a standard for recreational eating, and for the busy family it is important to have healthy options in this venue.
1.1 Increase the number of school districts that implement recommended policies to improve food and beverage environments from six to 12 with an estimated reach from 40,338 to 80,677 in year 1. This objective will increase the number of school districts that implement at least one of eight recommended policies to improve food and beverage environments. Activities will focus on increasing the number of school districts that have written and implemented policies in one of the following priority areas: encourage staff to be role models for healthy behaviors; engage families to provide information and/or solicit input to meet district wellness goals; restrict marketing of unhealthful choices; regulate vending machines, school stores, and food service a la carte; regulate food served at class parties and other school celebrations; ensure adequate time to eat; and regulate food sold for fundraising at all times (not only during the school day). These priorities were identified in an assessment of written school wellness policies conducted in 2012 by the Kansas University Medical Center (KUMC), which is one of the current evaluators, in collaboration with Children's Mercy. Children's Mercy will coordinate these activities and oversee a contract with the Alliance for a Healthier Generation to provide training to local public health and community agencies and school staff. Pre and post-environment inventories will be conducted by local public health agency staff at selected school sites in participating school districts. Communication efforts will focus on the value of these policies and engaging staff and parent support. In year 2, it is estimated that an additional two school districts will implement one of these policies; in year 3, it is estimated that an additional four school districts will implement one of these policies for an estimated total of 18 school districts that have policies to improve food and beverage environments at the end of this project period.

1.2 Increase the number of school districts that implement healthy local food procurement policies. This objective will focus on increasing the number of school districts participating in farm to school programs from 6 to 10 to increase opportunities to access healthy food at lower cost reaching as estimated 26,962 residents. KC Healthy Kids will lead this program, working with the local public health departments to recruit school districts, particularly in target neighborhoods and where free and reduced price meal populations are greatest; assess policy and practice goals; conduct baseline surveys and focus groups; and work with local farmers to identify locally-grown foods to be used in school settings. KCHK will provide training and technical support to school districts. Communication tactics will be designed for two school audiences: 1) school boards & school administrators, and 2) food service personnel to broaden awareness of the policy benefit and commitment to support implementation.

1.3 Increase the number of Parks and Recreation Departments that implement healthy food retail policies. This objective will focus on activities to increase access to healthy food and beverages through adoption of healthy vending and concession policies. Increasing the availability of healthier food and beverage choices will help encourage patrons of park facilities to eat healthier. This strategy will build on current work funded through the Community Transformation Grant program in Jackson County and efforts led by the Johnson County Department of Health and Environment on healthy vending and concessions with support from private foundation funds. The Coalition will work with local parks and recreation departments (in five counties and 38 cities) to assess vending machines and concessions; provide model contracts and tools; conduct training and offer technical assistance; and engage community groups to encourage support for healthy food retail policies. The communications strategies will
include tactics to raise awareness of healthy eating in area parks and recreation facilities. In year 1, the Coalition will increase the number of Parks and Recreation departments with healthy food retail policies from 1 to 3, affecting an increase in population with greater access to healthy food from 116,830 to 471,864. By the end of year 3, it is expected that an additional 10 local parks and recreation departments would have adopted policies.

1.4 Increase the adoption of policies that establish incentives and supports to food retailers to locate in underserved neighborhoods (Year 2). Foundational work will be done in year 1 to support this objective, which will focus on activities to increase the number of jurisdictions that implement policies establishing incentives and supports to encourage food retailers to locate in underserved areas. The city of Kansas City, Missouri, and the Unified Government of Wyandotte County/Kansas City, Kansas, will be targeted for the year 1 activities. This work will focus on assessment of current policies and writing a model policy for use in the metro area. KC Healthy Kids and local public health departments will prepare information on model policies, in consultation with local officials and through the review of best practices from communities across the country, and establish a plan of action by year 2. Policy adoption by these two local governments would affect 623,439 residents, which is planned to occur in year 2.

2.0 Increase Physical Activity Opportunities

The Coalition will work to increase physical activity opportunities by promoting the implementation of school wellness policies to improve physical activity opportunities in school settings; enhancing infrastructure that supports active transportation, including biking, walking and public transportation; and enhancing safety (personal and traffic) in areas where persons are or could be active. These program strategies will target population-wide improvements as well as target areas where greater health disparities exist. The program strategies will increase the number of people with improved access to physical activity opportunities from 1,082,269 to 1,174,203 persons.

The proportion of children and adults who are obese has significantly increased because of changes in environments. Schools have decreased the amount of physical education and recess time offered, and neighborhood changes make it more difficult for many children to walk to school or be active outside of school. As a result, fewer children are able to achieve 60 minutes per day of physical activity. Students' physical activity habits and weight status are unlikely to change without strong and linked school and community-based programs and policies. Adult risk factors are also due, in part, to limited opportunities for physical activity, such as the lack of safe accessible bicycle and pedestrian facilities in many neighborhoods and communities. In the Kansas City area, 12 local governments have passed Complete Streets policies, but many require technical support to implement policies that will in a more supportive environment for walking and bicycling.

2.1 Increase the number of school districts that implement recommended policies to improve physical activity opportunities within school environments. This objective focuses on activities to increase the number of school districts (from 11 to 15) that have written and implemented policies in one of the following priority areas: regular physical activity breaks are provided for students during classroom time, not including PE and recess; restricting physical activity is not used as punishment; and daily recess is provided in elementary schools. This objective has the potential to reach 26,892 area students in year 1. These priorities were identified based on an assessment of written school wellness policies conducted in 2012 by the Kansas University
Medical Center (KUMC), one of the current evaluators, in collaboration with Children’s Mercy and with guidance from the Healthy Schools Committee. Model policies, implementation guides and parent fact sheets for each of the three priority physical activity policies are currently being finalized to support schools’ implementation of these policies. Training provided by the Alliance for a Healthier Generation will focus on those in target neighborhoods and those serving larger proportions of students eligible for free and reduced price lunch. Pre and post-environment inventories will be conducted by local public health agency staff. Communication efforts will engage staff and parents. In year 2, it is estimated that an additional three school districts will implement one of these policies; in year 3, it is estimated that an additional two school districts will implement one of these policies for an estimated total of 20 school districts that have policies to improve physical activity opportunities at the end of this project period.

2.2 Increase the number of communities that have implemented at least one element of their established Complete Street policy. The Kansas City region is a low-density, auto-oriented area, with an extensive road and highway system. Opportunities for physical activity and active transportation are limited by a lack of connected bike and pedestrian systems. Twelve communities (three counties and nine cities) have adopted Complete Streets policies, but there is a need to support implementation in those communities and to encourage more cities and counties to adopt and implement policies. This objective will increase from 7 to 12 the number of communities that have implemented at least one Complete Streets policy element and enhance the region’s infrastructure to support active transportation. This objective has the potential to increase persons supported by Complete Streets policy implementation by 90,934 in year 1. In year 1, Bike Walk KC and MARC will provide technical assistance to communities that have adopted policies to develop or advance implementation plans, resulting in additional miles of bicycle and pedestrian facilities; advance implementation of the region’s Complete Streets policy by supporting its use in the selection of transportation investments; provide training and technical assistance to encourage the adoption and implementation of Complete Streets policies in more communities; and train local officials on conducting bicycle counts for selected facilities and developing procedures for pedestrian counts. MARC and Bike Walk KC will also conduct public outreach to encourage area residents to engage in active transportation to support healthy lifestyles, building on existing work to promote Bike to Work Month, International Walk to School Day, National Trails Day and other opportunities for physical activity. Additional technical support will be offered in years 2 and 3 to increase the number of local governments with adopted policies and implementation steps advanced.

2.3 Increase the number of schools that implement Safe Routes to School policy. The Safe Routes to School (SRTS) program will expand its reach (from 25 to 37 schools) and enhance safety in areas where persons could be active. This objective has the potential to reach 6,912 residents around schools in year 1. Many school children face challenges in walking or bicycling to school due to traffic or personal safety concerns. Bike Walk KC, local public health departments, Children’s Mercy Hospital and other partners will identify 12 schools in target neighborhoods to expand the region’s SRTS program in year 1, with an emphasis on elementary schools. Following an assessment of current adoption of the SRTS program by selected schools, a train-the-trainer program will be implemented to offer training and technical assistance to school staff, parents and other volunteers and support adoption of the SRTS program. Additional schools would be targeted for years 2 and 3.
3.0 Increase Tobacco- and Smoke-Free Environments

In the six targeted counties in the Kansas City metro area, as in the states of Missouri and Kansas, four of the five leading causes of death are heart disease, cancer, cerebrovascular disease (stroke), and chronic lower respiratory diseases (including chronic bronchitis, emphysema, and asthma). These diseases are attributable in part to smoking or exposure to secondhand smoke. Tobacco use remains the most preventable cause of death and disease in the United States. Unlike lifestyle choices that primarily affect the person choosing the particular behavior (i.e., eating unhealthy food), smoking is a behavior that significantly affects both smokers and the non-smokers living, working and playing around them. In many cases, non-smokers are some of the most vulnerable in our population. The objectives to increase access to tobacco-free environments will build on previous work in the Kansas City region. Many jurisdictions in the area already have indoor air ordinances to protect people in most public buildings, including restaurants and bars, but some ordinances could be strengthened. The Coalition will assess where new smoking-related ordinances may be feasible or where there is opportunity to strengthen existing policies. In addition, activities will expand current smoke-free multi-unit housing efforts in the region. In February 2014, the Housing Authority of Kansas City adopted a smoke-free policy that will be fully implemented by January 2015. Additional work will be done to educate and assess other multi-unit housing complexes within the metro and encourage smoke-free living environments as a norm. Through these program objectives, the number of people with increased access to tobacco free environments will increase from 1,413,948 to 1,443,948 by year 3.

3.1 Increase the number of jurisdictions with new or enhance smoke-free ordinances. While approximately 80% of the population lives in local jurisdictions that are already covered by state or local indoor air ordinances, there are still over 50 municipalities with no clean indoor air protections. In addition, many existing ordinances have gaps; for example, some ordinances exempt casinos or other specified public places and other ordinances do not cover some of the recent nicotine delivery technologies such as e-cigarettes. For this objective, local public health agencies will take the lead to encourage interested local jurisdictions to identify gaps that might exist in their indoor air policies, priorities for action and key stakeholders to engage, and establish action plans that outline the most viable way to close those gaps through local ordinances. In year 1, it is expected that two additional local governments will adopt one or more policies to address smoke-free environments affecting 19,500 residents.

3.2 Increase the number of smoke-free multi-unit housing complexes. This objective will increase the number of people protected from secondhand smoke in their living environments by helping multi-unit property owners adopt smoke-free policies. An estimated 35% of the occupied housing units in the six-county Kansas City metro are rental units and an estimated 30% of the population rent. Approximately 44% of the rental units in the metropolitan area are located in structures that have five units or more (108,605 units). Evidence from the building industry indicates that non-smokers living in the same complex as smokers are at risk of secondhand smoke exposure due to the transfer of smoke throughout a building. For many renters, particularly low-income renters, finding smoke-free rental housing can be a significant challenge. The Coalition will encourage multi-unit housing complexes, both public and private, to consider adopting smoke-free policies. Assessment activities will measure existing support for smoke-free policies in housing complexes. Air quality monitoring (pre and post policy) will
be offered to complexes that are interested in changing their policies. Educational activities will highlight the dangers of smoking and secondhand smoke from multiple different viewpoints, targeting complex owners/managers and residents. In year 1, it is expected that an additional 4 multi-unit rental housing complexes affecting 600 residents will adopt indoor smoke-free policies.

4.0 Increase Opportunities for Prevention of Chronic Diseases

More than 60 percent of adults and an estimated 41 percent of children in the Kansas City metro area are overweight or obese. Alarmingly high rates of obesity are seen in Wyandotte County (37.9%), and Jackson County (33.7%). Individuals who are obese are at risk for a number of associated co-morbidities that include, but are not limited to, elevated blood pressure, asthma, dyslipidemia and type II diabetes. However, identification of weight problems and subsequent intervention often occur too late, only once these co-morbid conditions begin to present. This strategy will expand the existing Healthy Lifestyles Initiative (HLI) model to safety net clinics and to WIC agencies. The HLI model incorporates assessment, preventive counseling, and referral for appropriate follow-up services. Several Kansas City clinics have begun incorporation of the HLI model successfully into their protocol and electronic health records (EHR) systems. In addition several WIC agencies have enrolled as HLI partners and are ready to implement this model. This objective focuses on providing training and supports to help with the uptake of that model into safety net clinic and WIC practices.

In a community-wide health needs assessment survey, Children’s Mercy Hospital found that only 16.5% of parents of obese children had been told in the past year by a school or health professional that their child was overweight. In another Children’s Mercy 2013 assessment, primary care providers identified key barriers to initial detection and treatment, including inadequate time, training, resources and referral options for community support. Children’s Mercy worked closely with its primary care clinics to successfully implement a Healthy Lifestyle Model (HLI) for best-practice healthy weight and behavior assessment, including a protocol for follow-up healthy weight plans and further treatment or referral as needed. The model embraces the use of communication strategies to increase awareness of healthy behaviors, and is based on Kansas City’s experience in a national initiative, Collaborate for Healthy Weight (3).

These objectives focus on providing training and supports to help with the uptake of the HLI model in safety net clinic serving both adults and children and WIC agencies. During year 1, as a manageable first step, the Coalition will focus collaborative efforts on weight status and behavior assessment, as these elements are foundational to chronic disease prevention and treatment. Efforts will also focus on creating a referral and linkage system between the primary care clinics and community programs. Children’s Mercy created a database with over 250 food, nutrition, physical activity, and weight management services within the metro area. We will create criteria for which programs should be included and a process for the referral system for piloting by the beginning of year 2. This work will make sure that appropriate programs are included, including the newly launched Diabetes Prevention Program operated by the YMCA in the Kansas City area. Work done in year 1 will determine priorities to continue to incrementally build a systems approach in year 2 and beyond. By the end of year 3, the Coalition will have increased the number of people with increased access to opportunities for prevention of chronic diseases through clinical and community linkages from 15,000 to 47,000.
4.1 Expand clinic locations that implement the existing Healthy Lifestyles Initiative protocol previous implemented in CMH clinics from one to six in year 1, from six to 12 in year 2, and to 14 by the end of year 3. It is estimated that an additional 7,185 residents will be affected in year 1. This objective will focus on enhancing safety net providers’ capacity to assess, provide preventive counseling, detect and intervene earlier to prevent or manage obesity and co-morbid conditions, and ensure adequate follow-up and referral to programs such as those offered by the YMCA as needed. The activities include engagement, technical assistance, and tracking what’s working and what barriers need to be overcome. Children’s Mercy (CMH) will be the lead partner, and will engage staff at individual clinic locations. CMH will assess current practices and provide technical assistance and training. A community messaging campaign will reinforce opportunities for physical activity and nutrition. CMH will lay a foundation during year 1 for activities to be done in years 2 and 3 to build a systems approach. Coalition members will conduct an assessment of activities and identify action priorities that will help incrementally build a system. Efforts will focus on creating a referral and linkage system between the primary care clinics and community programs.

4.2 Increase the number of WIC clinics that implement the existing Health Lifestyles Initiative model for assessment, follow up and referral for obesity from zero to six affecting 5,330 young children in year 1. Prevention efforts must start early, especially in relation to nutrition and physical activity behaviors and weight status. An estimated 11% of children 2–4 years of age served by metro WIC agencies are obese. Expanding the HLI model to WIC agencies will allow the Coalition to reach vulnerable low-income children and their families at an earlier stage for prevention. This objective will focus on enhancing WIC agencies' abilities to assess, provide preventive counseling in a standardized manner, and refer to clinical and community services as warranted. Training and technical assistance will be provided to WIC agency staff on incorporation of the HLI model into their practices. The community messaging campaign will reinforce opportunities for physical activity and nutrition. In addition, action will be taken to determine interest and recruit grocery stores that redeem WIC vouchers to be active partners in the community messaging campaign. Year 2 activity will focus on expanding the number of WIC sites participating in the HLI model on the Missouri side of the metro, exploring the feasibility of changing the electronic data system of the Kansas WIC program, and evaluating the impact of messaging. By the end of year 3, it is expected that 15 clinics serving 13,326 young children will benefit from this program objective.

5.0 Increase Infrastructure Components Supporting Community Health Activities
There is currently a strong base of organizational capacity to support the work of the Coalition and accomplish the objectives of this application. The lead applicant, MARC CSC, has considerable experience in convening community partners, supporting coalitions, and administering large grant programs. The base of support and involvement in the Coalition will be expanded in the next year to support the work for a broader region. The infrastructure components will be expanded or developed over the three years, including staffing and coalition support, communications, evaluation, and sustainability.

5.1 MARC, in coordination with Children’s Mercy will increase infrastructure elements to support the coalition in its implementation of the community action plan from one to five elements: 1) support regular coalition meetings that engage participation from all sectors and geographic areas; 2) increase staff and contract support to carry out the work of this grant and
Coalition, 3) expand Coalition membership and linkages; 4) implement a new governance structure to enhance collaboration, and 5) deploy community engagement processes. Dedicated staff will provide support to the Coalition with regular meetings, and complete an update of the Coalition charter to include a broader purpose. In year 1, approximately 500 staff from the Coalition’s 75 members will be engaged in the work.

5.2 Increase the number of communication strategies from 0 to 5 in order to increase the reach of the community health brand and messages to 911,602 or about half of the metro population by the end of year 1. The Coalition will test and launch a new community health brand, strengthen its integrated communications network, and provide partner training on deployment of the communication approaches. The communications campaign will be organized around a theme that will appeal to the media and galvanize community agencies and their constituents. This theme will present a call to action – precise and strategic actions for individuals and institutions — to help make the Kansas City metro the healthiest in the country. The communications campaign will not only use advertising, collateral materials and social media, but also inspire a grassroots campaign and commitment to the healthy community cause. The campaign theme will engage people through the use of a question, Who says it can’t be done?, with the “it” being good health. The campaign will counter the inertia and encourage our commitment — as a community — to the improvement of good health by challenging obstacles that include policies unfriendly to good health, lack of opportunities to be physically active, behaviors that don’t reinforce good health; a culture unwilling to acknowledge honestly those qualities; and conditions that stand in our way. Coalition members will be given training and communications kits to help them understand how to use the campaign, and plans to execute the campaign with the constituencies they represent. Paid media will serve supplement the grassroots campaign. All materials will be available on one website for accessibility by all partners. MARC will communicate regularly, at least once every three months, to Coalition members and other key stakeholders. Two success stories will be published by the end of year 1. The communications infrastructure will also be designed to provide targeted messages to key audiences for each program objective focused on tobacco-free living, healthy nutrition, increased physical activity and improved preventive clinical services. Regular communications will be provided to Coalition members and to local officials to keep them apprised and engaged in the program over the three years. The communications objective will enable the Coalition to reach 75% of the area population by the end of year 3.

5.3 Increase the number of evaluation initiatives from 1 to 6. MARC CSC will establish evaluation contracts to create the performance measurement and evaluation system and start evaluation functions, conduct evaluation training for Coalition members, and compile annual results and recommendation reports by the end of year 1. These activities will carry on through years 2-3.

5.4 Sustain the Coalition beyond the grant three-year time frame by establishing the Planning and Fiduciary Subcommittee; strengthening the Coalition’s charter, and raise additional in-kind and financial support for the program. MARC CSC will secure funds to meet match requirements during year 1 for year 2 activities, increasing each year to a goal of at least 30 percent by year 3. By the end of the grant period, the Coalition will create an updated strategic plan for the years 2018–2021 and secure revenue support to sustain these efforts and implement the plan.
II. Evaluation and Performance Management

a. Evaluation support and b. Evaluation capacity

Evaluation Plans. MARC, local health departments, and other community collaborators have chosen four interventions for evaluation: access to healthy foods and beverages, physical activity opportunities, smoke-free or tobacco-free environments, and opportunities for prevention of chronic diseases. For each of the interventions, we describe the evaluation design for a selected strategy, including the setting, instruments and measures, and sampling plan. The data analysis plan follows the methodology section. A more detailed description of the instruments to be employed, data collection procedures, and statistical calculations for sample size estimates are included in Appendix F. The Evaluation Plan Template may be found in Appendix G.

1. Healthy Foods and Beverage Access: Implement evidence-based strategies to increase access to environments with healthy food or beverage options.

School Environment

All public school districts within the six-county area will be included. There are 490 school buildings with 332 elementary, 87 middle and 71 high schools in the 6-county region.

<table>
<thead>
<tr>
<th>County</th>
<th># Districts</th>
<th>Buildings</th>
<th>2013-2014 Enrollment</th>
<th>Number Free/Reduced Lunches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass</td>
<td>10</td>
<td>40</td>
<td>18,313</td>
<td>7,054 (38.5%)</td>
</tr>
<tr>
<td>Clay</td>
<td>6</td>
<td>63</td>
<td>39,858</td>
<td>14,280 (35.8%)</td>
</tr>
<tr>
<td>Jackson</td>
<td>12</td>
<td>153</td>
<td>88,504</td>
<td>46,730 (52.8%)</td>
</tr>
<tr>
<td>Platte</td>
<td>4</td>
<td>27</td>
<td>14,995</td>
<td>4,103 (27.4%)</td>
</tr>
<tr>
<td>Johnson</td>
<td>6</td>
<td>149</td>
<td>91,872</td>
<td>23,598 (25.7%)</td>
</tr>
<tr>
<td>Wyandotte</td>
<td>4</td>
<td>58</td>
<td>28,827</td>
<td>23,647 (82.0%)</td>
</tr>
<tr>
<td>Totals</td>
<td>42</td>
<td>490</td>
<td>282,369</td>
<td>119,412 (42.3%)</td>
</tr>
</tbody>
</table>

Collection of School Policies. For this intervention, we will use the results from a 2012 assessment of 46 school districts for baseline values. KUMC research staff will obtain policy information through contact with officials for each school district.

Review of Policies. Research team members will assess existing policies to determine their quality, specifically related to comprehensiveness and strength of nutrition and physical activity environments. Each policy will be analyzed using the Wellness School Assessment Tool developed by the Robert Wood Johnson Foundation, which provides a standard method for the quantitative assessment of school wellness policies. Total comprehensiveness and strength scores will be calculated for each school district. The WellsAT scores for each school district will be used to assess baseline, follow-up measures and change from baseline to follow-up to determine if comprehensiveness and strength of policies have improved.

Online/Written Surveys. We will adapt the survey used by Woodward-Lopez and colleagues (2010) to determine the benefits of and challenges to following school wellness policies. This 24-item survey includes questions about needs, practices, barriers, and perceptions regarding competitive foods, foods of lower nutritional value and school wellness policy implementation. A sample of 470 teachers and 480 parents/guardians will provide results representative of the
target population. Multiple strategies will be used to enhance survey response rates. Survey results will help to determine what activities may be needed for policy consideration.

**Focus Group Discussions.** During the first year, we will invite teachers and parents to participate in separate focus group discussions. We will hold sessions in each of the six-counties, with approximately 10 to 15 teachers/parents invited to each discussion. A moderator’s guide will be developed to learn more about the benefits of and challenges to the implementation of the new wellness policies. Parents of children in elementary, middle, and high school schools will be invited to participate.

**Parks and Recreational Center Environment**

Data collection will involve both pre- and post-inventories and intercept interviews. We will assess the total number of parks and recreation departments that have implemented healthy vending policies for their food retail (i.e., vending and concessions.) The evaluation measures for the vending machine and concessions will include review of current policies at baseline and in year 3 to determine the presence/absence of food retail policies that address healthy vending and concessions. We will determine if food retail policies are present, and if so, we will assess if the policies address sodium, sugar and fat content of vending and concession items.

**Observational Assessment of Vending And Concessions.** During on-site assessments, we will collect a categorical listing of items sold, using standardized forms, and quantify change in the degree of compliance with the healthy vending/concession policy. The nutrient profile of each item will be determined using Nutrition Data System for Research, packaging information, menu recipes or product manufacturer websites.

**Intercept Interviews.** Using intercept interviews, we will determine the food/beverage items customers are purchasing from vending/concessions at parks and recreational centers. Additionally, during these observations we will assess whether any visible media messages in the vending/concession areas encourage healthier eating or inform consumers about caloric nutritional values. Sample size estimates for the number of intercept interviews to be conducted will be determined by county.

2. **Physical Activity Opportunities:*** Implement evidence-based strategies to increase the number of individuals with increased access to physical activity opportunities.

**School Environment**

For this strategy, the assessment will determine the number of school districts in the six-county area that have implemented the recommended Healthy Schools’ policies regarding physical activity (PA). Further, the strength and comprehensiveness of those policies will be determined using the WellSAT.

**Review of School Policies.** For each district, we will examine whether school wellness policies address regular PA opportunities during classroom time, not including minutes allocated for PE.
and recess. Additionally, we will assess if the school districts’ policies address not using PA as punishment. We will evaluate change from baseline to follow up for all school districts as described in the nutrition policy evaluation.

**Online/Written Surveys.** The survey to be administered to teachers and parents for the Healthy Food and Beverage Access will include questions about PA opportunities available to students, in what different ways the number of minutes of PA required throughout the day are achieved and how often PA is incorporated into the school day. Survey items will also inquire about the level of support by school staff and parents to support these physical activity guideline policies and the perceived benefits and challenges to schools to implement these policies.

**Focus Group Discussion.** The same sample of teachers and parents invited to participate in discussions about school nutrition policies will be asked about PA policies. The moderator’s guide will include questions about the benefits of and challenges to the implementation of the PA school wellness policies. Parents of children in elementary, middle, and high school schools will be invited to participate.

**Complete Streets**
We will determine the number of Complete Streets projects that have been built in each jurisdiction (i.e., projects built that meet at least basic level standards) by employing an inventory of Complete Streets projects in the six-county area.

**Observations.** We will conduct pedestrian and bicycle counts, using an observational method to determine the number of individuals using sidewalks/streets for walking and bicycling. Total minutes of walking and bicycling done by residents within and outside their neighborhood will be measured with the RESIDEs Neighborhood Physical Activity questionnaire, which is a subjective evaluation of walking. To determine the effect of a Complete Street policy on walkability and bikeability, we will employ the PIN3 Neighborhood Physical Activity Questionnaire, which assesses street-level characteristics that are related to walking and bicycling.

**Resident Surveys.** To determine residents’ perceptions of the built environment, we will survey 6 neighborhoods per condition and 35 households per neighborhood at each data collection point, using the Environmental Features of the Neighborhood (EFN) (Suminski et al, 2013), 2006), which provides a summary score ranging from 0 (poor perceptions) to 10 (good perceptions).

**3. Smoke-Free or Tobacco-Free Multi-Unit Housing:** Implement evidence-based strategies to increase access to smoke-free or tobacco free environments.

**Multi-Unit Housing**
The number of multi-unit housing complexes with five or more units in the six-county area is estimated to be 108,605 or 39% of all multi-unit housing complexes. Based on this estimate, we have determined the number of owners/managers of multi-unit housing complexes to be surveyed as a representative sample of the target population, shown in the table below.

**Manager/Resident Survey.** Instruments will include a survey of managers and residents that was originally administered as a part of the Community Transformation Grant project. Survey responses will be used to assess the prevalence of existing smoke-free or tobacco-free policies,
interest in developing smoke-free housing policies and the manager’s/owner’s willingness to participate in the intervention and other surveys. Based on the number of affirmative responses to survey residents by owners/managers, we will determine the best sampling strategy to gain residents’ current general health and smoking status, knowledge of smoke-free policies, and support for these policies within multi-unit housing complexes. Additionally, we will include questions related to the impact of secondhand smoke on residents’ daily living activities.

<table>
<thead>
<tr>
<th></th>
<th>Renter-occupied 5 units or more</th>
<th>Final N*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnson County</td>
<td>38,050</td>
<td>168</td>
</tr>
<tr>
<td>Wyandotte County</td>
<td>8,278</td>
<td>36</td>
</tr>
<tr>
<td>Cass County</td>
<td>1,087</td>
<td>5</td>
</tr>
<tr>
<td>Clay County</td>
<td>12,207</td>
<td>54</td>
</tr>
<tr>
<td>Jackson County</td>
<td>44,033</td>
<td>194</td>
</tr>
<tr>
<td>Platte County</td>
<td>4,950</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total Units</strong></td>
<td><strong>108,605</strong></td>
<td><strong>479</strong></td>
</tr>
</tbody>
</table>

*Based on response rate = 80%

4. **Chronic Disease Prevention:** Strategy: Implement evidence-based strategies to increase the number of individuals with increased access to opportunities for prevention of chronic diseases. The Healthy Lifestyle Initiative (HLI) is designed to increase individuals practicing healthy lifestyles and at a healthy weight in the Kansas City area. The HLI model uses consistent messaging, assessment and counseling strategies to increase awareness of current nutrition and physical activity behaviors and support improvements in those behaviors to support a healthy weight. HLI partners use the 12345 Fit-Tastic Messages which promote 1 hour or more of physical activity, 2 hours maximum of screen time, 3 servings of low or nonfat milk or yogurt, 4 servings of water, not sugary drinks, and 5 servings or more of fruits and vegetables. The 12345 Fit-Tastic messages are an adaptation of an evidence-based strategy developed by Maine Youth Overweight Collaborative (MYOC) in partnership with the Maine Chapter of the American Academy of Pediatrics (http://www.nichq.org/about/nichq_news_archive.html?id=7). Also, HLI partners use standardized and established weight assessment as defined by the National Quality Forum (www.qualityforum.org/WorkArea/). The chronic disease prevention strategy focuses on expanding the number of clinics and WIC agencies that use the HLI model.

**Evaluation:** We will use the RE-AIM framework to evaluate the reach, effectiveness/efficacy, adoption, implementation and maintenance of this model in these settings (Glasgow, Vogt, & Boles, 1999). RE-AIM is a framework to evaluate research translation to practice and to better evaluate the public health impact of an intervention. The RE-AIM elements are described elsewhere (www.re-aim.org). The HLI indicators will be monitored, measured and summarized monthly, and consolidated twice a year from baseline to end of three-year project. Indicators to be monitored are briefly described below after a definition of the RE-AIM elements they represent (See Appendix F for detailed description of measurement, data sources and sub-indicators):

1) Reach refers to the number and characteristics (representativeness) of individuals who participate in a given program/intervention.
Indicator 1.1 - Percent of the target population (geographic area and/or partner audience) reached by the message. This includes numbers exposed in participating settings and audience reach of media used.

2) Effectiveness refers to the impact or effect observed from the program/intervention.

Indicator 2.1 - Number of primary care settings that improve processes to assess weight status of all patients. Weight assessment sub indicator is that for children and Adolescents-national standardized measure (NQF 0024)-reflects the % of patients 2-17 years of age who had an outpatient visit and who had evidence of BMI percentile documentation;

Indicator 2.2 - Number of primary care settings that improve processes to counsel all patients. Counseling sub indicator is the % of those assessed that received nutrition/physical activity counseling[i];

Indicator 2.3 - Number of primary care settings that improve processes to follow up all patients. Follow up sub indicator is the % of those counseled that received follow-up with 12 months.

3) Adoption refers to the number and characteristics (representativeness) of settings or staff members who initiate the program/intervention.

Indicator 3.1 - Percent of partners that enroll on-line that adopt HLI framework as indicated by completion of work plan, staff training, and evaluation report

4) Implementation refers to how the program protocol is followed and how the program is established at the organization or setting level.

Indicator 4.1 - Percent of programs that are taking actions to implement the HLI approaches in their setting;

Indicator 4.2 - Percent patients/those screened (primary care and partners conducting health screenings) that have weight status assessed using standardized process (BMI/BMI percentile and 5 behaviors)

Indicator 4.3 - Percent of patients who receive an assessment, which have been engaged in developing individualized plan to attain /maintain healthy weight

Indicator 4.4 - Track progress toward new policy or environmental changes that support healthy weight within the partner's setting

5) Maintenance refers to the extent to which the program becomes part of the routine practices of the organization or practitioners.

Indicator 5.1 - Number of partners that implement the HLI work plan and continue reports after 12, 24, 36 months from date the work plan is submitted

Data Collection: The RE-AIM evaluation model is feasible because all indicators are being monitored through systems developed by MARC partners. Indicator data availability is presented by RE-AIM elements: 1) Reach and Adoption - Partners enroll in HLI through the online system and this information is collected in an Excel spreadsheet managed by Children's Mercy; 2) Effectiveness information is currently available from Children's Mercy's and Truman Medical Center's primary care clinics through their electronic medical record systems; while two Federally Qualified Health Care Centers provide information through their medical record systems; 3) Currently implementation information is only being collected at Children's Mercy's primary care clinics through their electronic medical record system. Efforts are being established to collect this information at other participating settings such as Truman Medical
Center’s primary care clinics and WIC settings. The Missouri state WIC electronic data system captures this data for their WIC agencies.

We will evaluate indicator’s change from baseline to follow up times in two ways. First, because we can measure electronic health records derived indicators monthly (e.g., number of healthy behavior/weight assessment) we will generate a time-series analysis of the indicator, including at least 6 months before and 6 months after HLI three-year grant period. Second, we will generate yearly estimates for the other indicators to calculate percent change in proportions reaching desirable (expected) levels every year, and the cumulative change in the three year grant period. Except for partner’s enrollment-related indicators, other indicator data is large enough for precise estimates of change with approximately 15,000 children seen annually for well child visits.

**Statistical Analysis.** We will summarize sample demographics and all outcome measures globally and by targeted group, using descriptive statistics such as means and standard deviations for continuous variables and counts and percentages for categorical variables. Bivariate tests will be performed to examine difference between baseline and end of grant period, as appropriate. Statistical significance will be determined at 0.05 alpha level and all analyses will be conducted using SAS version 9.3. We will code and organize qualitative data using ATLAS.ti (version 5.2) software. Coding will facilitate content analysis of particular topics and identification of common themes. The basic unit of analyses for the qualitative analyses will be quotes (parents, school staff, stakeholders) from the transcriptions that represent participants’ views and experiences.

**Data collection, data entry and data management.** The partners and the evaluation consultants have extensive experience in data entry, data checking, and quality control from previous and current projects. Data will be categorized and entered into separate tables within a relational database. At logical time points, the data will be checked for outliers and normalcy. Questionable data (e.g. >3 standard deviations from the mean) will be re-checked for accuracy and re-entered if necessary. All checked data will be archived and saved to a secure server. To facilitate data base management, entry, and storage, we maintain a dedicated room for this purpose. All personnel who enter data are blind to condition. All key personnel at the University of Kansas Medical Center have current Human Subjects/HIPPA certificates.

**III. Applicant’s Organizational Capacity to Implement Approach**

**a) The lead applicant agency** is the Mid-America Regional Council Community Services Corporation (MARC CSC), the 501c3 subsidiary of the Mid-America Regional Council (MARC). MARC is the Metropolitan Planning Organization (MPO) and association of city and county governments serving the bistate Kansas City region, including nine counties and 119 cities. (Six of these counties are included in this grant as the geographic area representing areas of greatest health disparities and the majority of the region’s population). Formed in 1972, MARC is governed by a 33-member board of directors composed of city and county elected officials. MARC also has over 40 policy, technical and advisory committees overseeing its work and providing important and diverse stakeholder involvement. MARC’s role is to build a stronger
regional community through leadership, planning and action. MARC CSC was formed in 2004 to enable MARC to serve the region with a broader set of community programs and services. MARC’s role is to build a stronger regional community through leadership, planning and action. MARC’s annual budget is $65 million, with approximately 75 percent from federal grant sources and the remainder from state and local government dollars, private foundation grants and earned income. MARC’s financial services department manages over 150 grants at any given time and has received recognition annually from the Government Finance Officers Association for its quality accounting and reporting systems. MARC CSC was formed in 2004 to enable MARC to serve the metropolitan region with a broader set of community programs and services. MARC has a proven track record in meeting CDC and other federal agency reporting requirements, financial accounting and reporting, and management benchmarks such as those required by the FOA.

MARC has successfully worked with its local governments, diverse stakeholders and active coalitions to serve the geographic area designated for this grant. As the Metropolitan Planning Organization (MPO), MARC prepares the region’s long-range transportation plan, and works with state and local government officials, transit agencies and others to determine how federal and state transportation funds will be spent in the metro area. MARC’s transportation planning work includes efforts to build a stronger public transit system for the region, and to increase opportunities for active transportation through bicycling and walking. Through MARC’s transportation program, a regional Complete Streets policy was adopted in 2012, and criteria used to evaluate projects for federal transportation funds through the regional programming processes has been revised to implement the Complete Streets policy. MARC is now working with policy officials and professionals to select investments for $51 million in federal transportation funds using Complete Streets’ policy criteria.

MARC and its many grant partners provide direct support to disadvantaged populations with documented burdens of the risk factors to be addressed through this PICH grant. MARC has worked with the community to expand high quality early education services over the past 20 years, and serves as the grantee for Mid-America Head Start, serving 2,800 children and their families in Clay, Jackson and Platte counties. MARC works through its Metropolitan Council on Early Learning to increase the quality of early learning programs across the bi-state metro area. MARC is the Area Agency on Aging for the five Missouri counties in the region, providing an array of services for low-income older adults. MARC operates a Regional Health Care Initiative, working with safety net clinics, public health agencies, hospitals, behavioral health organizations and others to expand access to health care for uninsured and underinsured. MARC has worked with the region’s safety net providers as they move to become medical homes for their patients, and to focus on chronic disease prevention particularly around high blood pressure and diabetes. MARC played an important role over the past nine months to promote enrollment in the federal Health Insurance Marketplace. MARC provides support for a regional Homelessness Task Force, and is working with community stakeholders to design and implement a more unified system of services, including those that improve health outcomes for homeless persons and families. The eight local public health departments, Bike Walk KC, KC Healthy Kids, Children’s Mercy and Truman Medical Center all provide services that assist populations with high documented burdens of chronic diseases, conditions and risk factors.
MARC works with local governments to promote sustainable development, and successfully completed a three-year HUD-funded Creating Sustainable Places program that resulted in innovative corridor land use plans for six priority transportation corridors. The plans outline land use investments that communities should encourage to enable economic and social opportunity for residents and land use designs that enable active living. MARC is working to train local officials and offer technical assistance to ensure the appropriate use of the technical tools to support sound sustainable planning and the integration of public health into land use and development policies and project decisions.

MARC has a Government Training Institute (GTI), which offers a variety of training programs, workshops and webinars to over 8,000 local officials and other stakeholders annually. The training includes open enrollment classes in computer and business skills, facilitation, customer service, and a range of technical subjects. MARC has used the GTI to organize and deliver training on transportation, land use, sustainable development and public health subjects, including complete streets and health impact assessments. This training capacity will be utilized to educate local officials and other key stakeholders to advance policy change in tobacco exposure, poor nutrition and limited access to physical activity risk factors as well as capacity building for local health departments and local governments to work with a diverse coalition and communicate with the public and key audiences.

MARC and its partners in this grant have all implemented evidenced- and practice-based PSE strategies that lead to community wide improvements. Among the accomplishments have been adoption of Complete Streets policies by MARC at a regional level and by local cities and counties; adoption of smoke-free policies under the CTG grant; adoption and implementation of school wellness policies for proper nutrition; and advances in increasing access to preventive clinical services. MARC and its partners will dedicate adequate staff in sufficient number and with sufficient expertise to successfully administer, manage and monitor the grant program.

i. **Coalition Support:** MARC is actively engaged in Coalition that will lead the Greater Kansas City Partnership for a Healthy Community (Coalition), which links a broad spectrum of partners that are transforming health in the metro area. The Coalition was established in 2011 and has a diverse membership, including representatives from over 65 community development, community organizations, health care facilities, faith-based organizations, schools, business organizations and others. MARC provides infrastructure supports for a number of working groups linked with the Coalition, including the Metropolitan Health Officials of Greater Kansas City Area (MOHAKCA), the Safety Net Provider Collaborative and the Jackson County Community Transformation Grant (CTG) Leadership Council. Infrastructure supports for the Coalition have been provided by Children’s Mercy Hospital’s Healthy Lifestyles Initiative. A Memorandum of Understanding (Appendix I) between MARC and Children’s Mercy on behalf of the HLI Coalition outlines the leadership roles that the Coalition will provide for this grant over the next three years. Children’s Mercy will serve as a subcontractor on this application and work in tandem with MARC to support the Coalition’s plan implementation, communication, evaluation and coalition needs. In addition, there are 12 metro groups linked within the Coalition, described in Appendix C: Evidence of Organizational Capacity.

MARC has been involved in recent community processes to develop Community Health Assessments for Kansas City, Clay County, Independence and Jackson County in Missouri, and
Johnson County, Kansas. Five local public health departments and two hospitals, Children’s Mercy Hospital and Truman Medical Center (partners in this grant application), have prepared community health assessments in the past two years and identified priority health needs based on the findings. In addition, MARC prepared a regional health assessment in 2013. The health problems addressed in this application are metro priorities, as illustrated in the table below.

### Community Health Needs Assessments Completed Since May 2011

<table>
<thead>
<tr>
<th>Public Health Agencies &amp; Jurisdictions</th>
<th>Date</th>
<th>Identified as Priority Issue</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Poor</td>
</tr>
<tr>
<td>Cass County Health Department (MO)</td>
<td>2013</td>
<td>x</td>
</tr>
<tr>
<td>Independence City Health Department (MO)</td>
<td>2013</td>
<td>x</td>
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<tr>
<td>Platte County Health Department (MO)</td>
<td>2013</td>
<td>x</td>
</tr>
<tr>
<td>Johnson County Health &amp; Environment (KS)</td>
<td>2011</td>
<td>x</td>
</tr>
<tr>
<td>Wyandotte County Health Department (KS)</td>
<td>2012</td>
<td></td>
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<tr>
<td>MARC Regional Health Assessment</td>
<td>2013</td>
<td></td>
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<tr>
<td>Hospitals — Metro Area Reach</td>
<td></td>
<td></td>
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<tr>
<td>Children's Mercy Hospitals &amp; Clinics (regional)</td>
<td>2013</td>
<td>x</td>
</tr>
<tr>
<td>Truman Medical Center (MO)</td>
<td>2013</td>
<td>x</td>
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<tr>
<td><strong>Totals (7 CHNAs completed in last 2 years)</strong></td>
<td><strong>4</strong></td>
<td><strong>3</strong></td>
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**ii. Evaluation Support.** Evaluation activities led by three subcontractors represent a total of **12 percent of the grant budget**. The University of Missouri School of Medicine Department of Health Management and Informatics, under the leadership of Eduardo Simoes, MD, will provide technical oversight and consultation for the evaluation plan. Dr. Simoes was appointed as the department chair in 2012. Prior to that time he served as director of the Prevention Research Centers Program Office in the CDC’s Division of Adult and Community Health for nine years. He was previously chief epidemiologist for the Missouri Department of Health and Senior Services, where he served from 1996 to 2003. The University of Kansas Medical Center (KUMC) will also serve as a locally based evaluation subcontractor. Dr. Cheryl Gibson, Ph.D., Research Associate Professor, General and Geriatric Medicine, Department of Internal Medicine, Kansas University Medical Center, will serve as a principal evaluator. She is currently conducting evaluation of the Jackson County CTG efforts and has experience supporting the Coalition with evaluation of program outcomes. Dr. Richard Suminski, Ph.D., MPH, FACSM, is Associate Professor, Department of Physiology, Kansas City University of Medicine and Biosciences, will lead evaluation of the Complete Streets’ program strategy. Additional information on their backgrounds is included in the Appendix D, Bios.

Both MARC and Children's Mercy Hospital (CMH) have strong evaluation capacity that will support and sustain evaluation efforts of the Coalition. Children’s Mercy, in collaboration with the University of Kansas, conducted evidence-based, comprehensive studies of the assessment...
of behavior, nutrition and physical activity interventions on prevention and treatment, the
development and analysis of public policy pertaining to pediatric obesity, and the development
of programs to engage communities. Children’s Mercy is creating an evaluation framework for
the Healthy Lifestyle Initiative to track results and expand the reach, adoption, implementation
and effectiveness of the HLI strategies. MARC has a Research Services Department with senior
researchers skilled in using secondary data and primary data collection to support various
agency programs, and Geographic Information Systems’ capacities, enabling GIS tools to be
available for all MARC programs. MARC’s Research Services Department produced a regional
health assessment in 2013, *Kansas City Regional Health Assessment Report*.

**iii. Communication Support.** Communication activities represent a total of **10% of the grant
budget and 17% of in-kind supports**. These funds will support a portion of subcontract(s) with
one or more communication firms to design and test the brand, and compile and implement
the communication plan. A portion of the funds will be used to support coordination of these
efforts by MARC’s public affairs staff. MARC’s public affairs office has a staff of eight
professionals, including a webmaster overseeing MARC’s website and numerous program
websites. The public affairs' staff will oversee the Coalition brand management, website
content and design, collateral material development, technical tools, purchase of print and
electronic media, and use of social media. MARC will oversee the communications work in
collaboration with Children’s Mercy.

Strategic consultation on the communication campaign will be provided on an in-kind
basis by David Westbrook, senior vice president of strategy and innovation, Children’s Mercy.
Westbrook founded the Corporate Communications Group, one of the nation’s leading
communications and public relations firms which he led for 34 years. Westbrook played a
leadership role in creating a nationally recognized regional #1 question campaign launched in
April 1997. It successfully engaged individuals and organizations to use the question "Is it good
for the children?" as a litmus test for decisions. Through the use of grassroots engagement and
advertising, general awareness of the #1 Question was built throughout the community.
A recently awarded foundation grant will support the launch of the HLI nutrition and physical
activity message campaign targeting the highest-risk community in Wyandotte County in 2015.
These efforts will link with the Coalition’s broader community health communication campaign,
brand and rallying cry and will leverage existing equity in HLI messages.

MARC has led regional communications initiatives focused on community and systems
change in areas of air quality, water quality, transportation safety, information for older adults,
reducing exposure to secondhand smoke, early education, and active transportation. MARC
also supports the Regional Area Public Information Officers network, a rich communications
network that will be used to disseminate community health plans, messages and calls to action.

**b) Community coalition**

**i. History:** The Coalition links community efforts that have been active for over 15 years and
represents diverse constituencies, including health care, business, public health, nonprofit
organizations, schools and local governments. One challenge to implementing broad-based
community interventions is building a truly collaborative approach to plan, acquire and align
resources, advocate for policy and environmental changes, and evaluate implementation and
outcomes. This challenge requires new approaches, and Coalition leaders have invested in a concerted planning process during the last six months to align efforts to address the health needs of the community.

MARC provides support for many of the groups linked through the Coalition including MOHACKA, the Safety Net Provider Collaborative and the CTG Council. Children’s Mercy provides support for the HLI. The infrastructures supports that have been built for this initiative over the last two years will be transitioned to support the broader reach of the Coalition. The Coalition has over 68 members representing community agencies and programs. The Greater Kansas City Food Policy Coalition, supported by KC Healthy Kids, has been in existence since 2010. In 2011 the Healthy Schools Committee was created as a means to consolidate the efforts of several groups around school settings including those of Children’s Mercy Weighing In and the Food Policy Coalition. All of these efforts are being linked under the Coalition to carry out the Community Action Plan. Representative groups and coalitions linked in the Coalition structure are shown in the following table (not inclusive of all groups).

Table 2: Greater Kansas City Partnership for a Healthy Community – Coalition History

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<tr>
<td>MOHACKA</td>
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<td>Clean Indoor Air Metro KC</td>
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<td>KC Health Commission</td>
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<td>Mother and Child Health Coalition</td>
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<td>Children’s Mercy Weighing In (2008)</td>
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<td>Greater Kansas City Food Policy Coalition (2007)</td>
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<td>Safety Net Provider Collaborative (2007)</td>
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<td>Healthy Communities Wyandotte (2009)</td>
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<tr>
<td>Healthy Lifestyle Initiative</td>
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<tr>
<td>Healthy Schools Committee</td>
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Members of the Coalition participated in the first round of the National Initiative for Children’s Healthcare Quality (NICHQ), Collaborate for Healthy Weight (4) in 2011-12. This initiative was a pioneering effort that used a multi-sector learning collaborative to develop, test, and disseminate an integrated change package of six promising evidence-based clinical and community strategies to prevent and treat obesity for children and families. Collaborate for Healthy Weight led to reframing approaches — starting on a small scale; doing rapid tests of strategically chosen ideas; modifying approaches based on results of the initial tests; and expanding in scale and scope with increasing confidence in the approach. The HLI was created based on the successes of this pilot. Since 2012, concerted effort has been invested in securing
resources to expand and establish infrastructure supports for community partners to adopt the HLI system strategies.

**ii. Coalition Operations.** The groups highlighted in the above table have clear documentation of regular meetings representing efforts that cross multiple sectors and engage multiple partners throughout the metro Kansas City area. The HLI Working Group process outlined below illustrates our capacity and infrastructure to support coalition business and implement the collective goals of the Coalition. When HLI efforts first started in 2011, the Coalition met bi-weekly to coordinate plans and implementation, secure resources and track progress. The initial roster of membership included representatives of a health plan, CMH, the YMCA of Greater Kansas City, KC Healthy Kids, the Kansas City, Missouri, Health Department and the Ivanhoe Neighborhood Association. The group outlined strategies, milestones, timelines and supports needed. Regular communication was critical to the progress. Team members participated in learning collaborative sessions and received training and technical assistance on coalition building and community and clinical evidence-backed strategy implementation from national experts. Progress and successes were regularly presented to other national teams, partner organizations and other community coalitions and other working groups.

The coalition developed a community message campaign to increase awareness of healthy eating and physical activity behaviors through active engagement of community partners and formative research with high risk groups in 2011-12. During 2012, upon completion of the *Collaborate for Healthy Weight* pilot, the group transitioned to the HLI Working Group, and created a charter and short and long-term objectives to guide the work. (Appendix C) Coalition support was initially provided by existing CMH staff but a small grant awarded in 2012 allowed CMH to hire an additional staff person to support the working group. During 2013, educational materials were developed to support community messages. The core set of educational items were translated and made available in Spanish. Over 500 professionals were trained on the HLI strategy framework and over 100 have attended “boot camp” trainings to develop a work plan for their programs to incorporate the HLI strategies, including messaging and policy/ environmental change. A dedicated website was created in 2013 and is currently being enriched through funds secured in 2013.

Currently, 68 metro-area organizations participate in the Coalition: 13 from the government sector, representing public health agencies, university extension, parks and recreation directors, and MARC; 13 from health care settings such as safety net clinics, private primary care settings, and hospitals; and 42 from community settings, including schools, early childhood settings, worksites, YMCAs, foundations, libraries, and grocery stores. As the coalition efforts have grown in scope and scale, resources are being invested from secured grants to create a formal governance structure and community engagement process. Extensive work has been done during the last six months to create a means for the coalition to increase collaboration. The community-based guiding committee, governance structure, and a community engagement process will be in place by November 2014. This effort is being built to evolve as the community health needs and issues evolve. The Guiding Committee’s functions include 1) engage community partners to expand collective reach and align efforts, 2) interpret and apply evaluation findings to improve approaches, 3) update plans, 4) advocate for policy changes, and 5) acquire and align existing resources to implement plans.
iii. Kansas City Successes. MARC CSC was the recipient of the CDC Community Transformation Grant for Jackson County, Missouri, and through this support has made progress on policy and environmental change to address chronic disease prevention with three public health departments in the county. The program has implemented evidence-based strategies to address chronic disease risk factors related to tobacco use or exposure, poor nutrition, physical inactivity, and limited access to opportunities for chronic disease prevention that have or are leading to community-wide improvements. MARC has addressed tobacco-free living through smoke-free indoor (multi-unit housing) and outdoor settings (smoke-free parks); and healthy eating through a Healthy Corner Store program, community gardens and healthy vending initiatives. The program is also focused on preventive clinical services with area safety net providers and a safe and supportive built environment promoting greater availability of bicycling and walking infrastructure through the CTG grant. MARC has developed a robust data system for program evaluation which will be part of the base for these efforts. The 68 metro programs that have enlisted in the HLI collectively reach approximately 50 percent of the current metro population. Collaborative efforts resulted in the following successes:

- Children’s Mercy implemented a new weight/behavior assessment using a standardized protocol in primary care settings serving high risk children. From Aug 2012 through Dec 2013, 14,188 children were seen in these clinics; 12,635 received assessments and approximately 60% of those seen during the last six months of 2013 received customized counseling on their nutrition and physical activity behaviors. This process has been embedded in the electronic medical record and is now a standardized practice at Children’s Mercy primary care clinics.
- The Missouri WIC Program made modifications in its electronic system to capture assessment questions in a manner so results on behaviors can be compared across settings in the Kansas City area.
- $500,000 was secured from 3 different funding sources to support efforts through 2016.
- Messages were disseminated at 17 community events with over 17,000 reached. Four earned media opportunities were secured during 2013. In addition, the messages were used by two agencies that conduct school screenings, reaching 20,000 children.

Other Kansas City area successes are highlighted in Appendix C, Evidence of Organizational Capacity of Applicant to Implement the Approach. MARC and its partners and through the leadership of the Coalition have the experience in working together and substantial capacities to support the implementation of the program strategies to address chronic disease throughout the six county geographic area and target areas included in this grant proposal over the next three years.
Staff Request for Commission Action

Type: Standard
Committee: Administration and Human Services Committee

Date of Standing Committee Action: 9/15/2014
(If none, please explain):

Proposed for the following Full Commission Meeting Date: 10/2/2014

Confirmed Date: 10/2/2014

On Going

Date: 9/2/2014
Contact Name: Terry Brecheisen
Contact Phone: 573-6707
Contact Email: ljenicke@wycokck.org
Ref: Department / Division: Public Health

Item Description:
A request for $256,082.00 has been made to the Healthcare Foundation of Greater Kansas City for a Take Charge grant. Healthy Communities Wyandotte, the YMCA and the Community Health Council will work together to create an integrated system that will educate Wyandotte County residents who are newly insured through the Affordable Care Act on how to use their health insurance. The system will also connect residents to the YMCA's weight loss program and pre-diabetes programs.

No cash match, in-kind staffing support for Wyandotte Community Health staff and one Dietitian.

Action Requested:
Approval of application.

Publication Required

Budget Impact: (if applicable)

Amount: $
Source:
☐ Included In Budget
☑ Other (explain) Grant funding request
ABSTRACT

Take Charge of your Health Wyandotte (Take Charge) will create an integrated system that educates Wyandotte County residents who are newly insured through the Health Insurance Marketplace on how to access and utilize health care in an appropriate and sustainable way. A secondary component will integrate healthy lifestyle education and referrals into that support system. This proposal builds on the successful work of Enroll Wyandotte, a collaborative effort of Wyandotte County-based organizations that assisted individuals through the Health Insurance Marketplace in 2013-2014. The target population for this program is uninsured residents who make contact with Enroll Wyandotte. The population is low-income, low health literacy, and linguistically diverse, with a high prevalence of obesity and diabetes. Take Charge intends to serve 900 individuals in 2015.

$256,082 is requested from the Health Care Foundation for program expenses including salary, supplies, training and other direct program expenses resulting from this collaborative work.

Basic Take Charge program processes
1. Assist clients in health insurance enrollment
2. Refer clients to Take Charge appointment
3. Educate clients in health insurance and system literacy, healthy lifestyles, screenings and referrals to community resources
4. Healthy lifestyle behavior interventions as appropriate

The Take Charge program seeks to increase knowledge, capacity, and self-efficacy of new health care consumers. They will understand what the health care system offers, believe it is of benefit to them, understand the need to take action for their own benefit, and utilize the resources that exist within the system.
DISCUSSION OF NEED (up to 10 points)

This proposal addresses two major needs in the Wyandotte area health care system:

1. Lack of an integrated system that supports Wyandotte residents, both insured and uninsured, in accessing the health care system in an appropriate and sustainable way.
2. Lack of a system that integrates healthy lifestyle choices and other social determinants of health into health care.

This proposal builds on the successful work of Enroll Wyandotte, a collaborative effort of Wyandotte County-based organizations that assisted over 900 individuals through the Health Insurance Marketplace in 2013-2014. Enroll Wyandotte learned first-hand how low health literacy level is in the community and how critical the need for follow-up assistance is after enrollment. Many residents obtained health insurance for the first time and demonstrated great lack of knowledge of the health care and insurance systems. Through personal follow-up by Enroll Wyandotte staff, it was discovered that residents often had received insurance cards in the mail but did not know what to do next. This was corroborated by anecdotal reports from local safety net clinics, which reported seeing clients “boomerang” back into the safety net system after they saw little personal benefit from monthly premium payments. Enroll Wyandotte understood the need for an integrated system for follow-up and education at the time, but did not have the staff and resources to create one.

Wyandotte County residents are on the average very unhealthy, suffering from some of the highest rates of obesity and diabetes in the KC Metro and state of Kansas. The ACA has increased national focus on integrating healthy lifestyle choices into health care, but there is little community infrastructure in place to efficiently refer health consumers to these services.

To address these needs, we are asking for support from the Health Care Foundation to pick up where last year’s efforts left off. We have an opportunity to educate new enrollees in health care navigation and healthy lifestyles resources. If we do not take this opportunity, we expect that many may stop paying health insurance premiums, never find a primary care provider, utilize the health care system in an inefficient way, and continue with unhealthy behaviors that could be prevented through timely intervention. If this is the case, much of the benefit of the historic expansion of health coverage through the ACA will be lost. By proactively increasing recent enrollees’ healthcare system knowledge, we can play a crucial role in reducing the uninsured and underinsured population in Wyandotte County.

Get to Know Wyandotte County
According to the Robert Wood Johnson Foundation’s County Health Rankings (See Table 1), Wyandotte County ranks the lowest in many parameters that support a healthy lifestyle. This county of 160,000 has ranked lowest in the state in the County Health Ranking’s social determinants of health indicators since its inception in 2010. The rates of poverty, education, health insurance and health care, diabetes, and obesity are all worse than the state average and much worse than neighbor Johnson County, the healthiest and wealthiest county in Kansas. The population of Wyandotte County is roughly 5% of the state’s population of 2.9 million, yet Wyandotte County contains 10% of uninsured Kansans (est. 365,000)¹. The majority of Wyandotte County’s population is between the ages of 19-64 (61%), and non-white (approx..30% Latino/Hispanic; 25% African-American²).

¹ kff.org/uninsured/state-indicator/total-population-2/
² United States Census Bureau, http://quickfacts.census.gov/qfd/states/20/20209.html
Table 1: Wyandotte Co. Health Indicators Compared with Neighboring Johnson Co. and Kansas

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Wyandotte County</th>
<th>Johnson County</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with diagnosed diabetes</td>
<td>15.5</td>
<td>6.5</td>
<td>9.4</td>
</tr>
<tr>
<td>Estimated rate of pre-diabetes&lt;sup&gt;3&lt;/sup&gt;</td>
<td>48</td>
<td>20</td>
<td>29</td>
</tr>
<tr>
<td>Adult population with a medical home or usual source of care</td>
<td>60.1</td>
<td>75.7</td>
<td>72.8</td>
</tr>
<tr>
<td>Adults living below poverty level</td>
<td>17.7</td>
<td>5.3</td>
<td>11.2</td>
</tr>
<tr>
<td>Adults who are sedentary</td>
<td>33.4</td>
<td>17.9</td>
<td>24.5</td>
</tr>
<tr>
<td>Adults with health insurance</td>
<td>69.2</td>
<td>88.4</td>
<td>82.3</td>
</tr>
<tr>
<td>Adults who are obese</td>
<td>38.8</td>
<td>22.6</td>
<td>29.6</td>
</tr>
<tr>
<td>High school graduation</td>
<td>68</td>
<td>90</td>
<td>83</td>
</tr>
<tr>
<td>Adults who reported consuming vegetable less than 1 time per day</td>
<td>26.3</td>
<td>18.3</td>
<td>22.3</td>
</tr>
<tr>
<td>Inadequate social support</td>
<td>26</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Median household income ($)</td>
<td>39,163</td>
<td>75,139</td>
<td>51,273</td>
</tr>
<tr>
<td>Language other than English spoken at home</td>
<td>24.0</td>
<td>11.3</td>
<td>10.9</td>
</tr>
</tbody>
</table>

Source: Kansas City Health Matters: http://kchealthmatters.org/

The traditional path to healthcare, paved by a quality education leading to gainful employment with health benefits, is less common for Wyandotte County residents than elsewhere in the state. There are little or no federal or state resources dedicated to connecting medically underserved residents to health insurance, primary, and preventive care. As a result, residents often avoid seeking any medical care at all until it becomes an emergency, or seek primary care in the Emergency Department, amplifying costs to the entire system. A great effort is required to change this behavior pattern; ACA enrollment, retention and use can meet this need.

1. PROJECT DESIGN

The goal of the Take Charge of Your Health program is to create an integrated system that:

1) Supports Wyandotte residents, both insured and uninsured, in accessing health care in an appropriate and sustainable way.
2) Integrates healthy lifestyle education and referrals into that support system

Take Charge of your Health Wyandotte (Take Charge) is a program model that has been created as a result of a planning process between the Unified Government of Wyandotte County/Public Health Dept., Enroll Wyandotte, and the YMCA of Greater Kansas City. Each of these partners individually see the repercussions of gaps in health care reform and therefore see the collective benefit of working together to improve health.

The target population for this program is uninsured residents who make contact with Enroll Wyandotte. The Enroll Wyandotte team aims to create Marketplace accounts for approximately

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1,800 individuals in the Nov 2014-Feb 2015 enrollment period. It is estimated that approximately 50% of the total 1,800 individuals will attend a Take Charge appointment, or 900 individuals served during this project in 2015. The data table presented in the Statement of Need reflects the health characteristics of the target population. The population is low-income, low health literacy, and linguistically diverse, with a high prevalence of obesity and diabetes.

Recruitment for the Take Charge program will take place within the context of the successful Enroll Wyandotte program. Enroll Wyandotte has two means of client intake. One is self-referral (walk-ins), and the other is by referral from a community organization such as the Health Department, YMCA, safety net clinics, neighborhood associations, public libraries, etc. This network of existing partners was successful in assisting 900 residents through the Marketplace application last year, and doing outreach to over 4,000 residents. These partners and processes will be utilized for the new Take Charge program. Clients will be retained in the Take Charge program via an intensive follow-up schedule monitored by staff hired through this grant.

Wyandotte’s large refugee population will require more tailored recruitment strategies. Refugees arrive in the United States with special health care needs related to their countries of origin and from many years of living in a refugee camp. They have little understanding of how the health care system works in the United States, which is confusing even for many native born citizens. The need for preventive health care and impact of lifestyle choices on health are often new concepts for refugees. The current largest resettled refugee populations are Chin, Bhutanese, and Karen, all peoples from Southeast Asia. The key partner in recruiting and retaining this special needs population will be Catholic Charities.

The basic program process is listed in Figure 1, and charted in detail in Appendix A: The Take Charge Process Diagram. The Enroll Wyandotte team will guide these individuals through the Marketplace enrollment process. Individuals who successfully obtain health insurance either via the Marketplace or KanCare will be referred to a Take Charge appointment. At this appointment, individuals will receive guidance on how to navigate the health care system and how to use health insurance, basic non-invasive screenings, healthy lifestyle education, and referral to appropriate resources including primary care and other community resources.

Individuals who do not qualify for a Marketplace plan or KanCare will also be referred to a similar, but separate Take Charge appointment that includes the same health curriculum, screenings, and referrals offered to the newly-insured population, but focuses on the Kansas City Safety Net system.

The Take Charge program will integrate a new and highly valuable resource in the area. This is an evidence-based program adapted from the CDC’s National Diabetes Prevention Program, designed to prevent individuals diagnosed with prediabetes from progressing to diabetes by empowering them to make lasting lifestyle changes to improve their overall health. The YMCA’s weight loss program, Y Weight, will also be offered to individuals that are not prediabetic but have elevated body mass indices. These two programs are specifically integrated into the Take

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4 Catholic Charities of NE Kansas resettlement statistics, 2008-2014
Charge program because of the disease burden in Wyandotte County, in which 15.5% of adults have diagnosed diabetes (KS 8.5%) and 38.8% of adults are obese (KS 29.6%).

Description of Project Model/Intervention & Supporting Evidence Base/Best Practice:

<table>
<thead>
<tr>
<th>Type</th>
<th>Duration</th>
<th>Scope of Services</th>
<th>Units of Services</th>
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<tbody>
<tr>
<td>Staff Training</td>
<td>Quarterly</td>
<td>YMCA staff will conduct the following trainings for EW and UGPHD staff and volunteers * Motivational Interviewing and Readiness for Change (Stages of Change) * Cultural Lenses training</td>
<td>Two 2.5 hour Motivational Interviewing trainings and two 8 hour Cultural Lenses training, with 15 in each training</td>
</tr>
<tr>
<td>Recruitment &amp; Assistance with the Health Insurance Marketplace</td>
<td>ACA Open Enrollment (Nov-February) Ongoing as people experience “qualifying life events”⁶</td>
<td>Individuals are referred into the system through multiple points of access through EW community partners EW does regular follow up calls to check completion status and will register them for their group appointment.</td>
<td>EW staff meet with individual to open a marketplace account in Healthcare.gov, provide them with knowledge and assistance to complete the enrollment process as well as establishing a primary care provider</td>
</tr>
<tr>
<td>Group Education</td>
<td>Feb-December regularly scheduled group appointments offered regularly at either UGPHD or YMCA location. Goal is that they attend a group appointment within 30 days of opening a marketplace account with EW.</td>
<td>Newly insured (or those that remain uninsured) attend one of two sessions (Newly Enrolled or UGPHD/ Safety Net services) and receive information on how to use their insurance/safety net services, basic health screenings, and information about community lifestyle behavior programs for which they qualify. Also conduct a screening form identifying other basic needs</td>
<td>36 group appointments with 25 attendees each, delivered by a team of bilingual EW staff, public health, and YMCA representatives. Individuals receive USPSTF screening recommendations, blood pressure, BMI Calculation and pre-diabetes risk test.</td>
</tr>
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</table>

⁶ Qualifying life events involve a change in status that allows individuals to enroll in the marketplace outside of open enrollment times. They include marriage, the birth of a child, or loss of other coverage.
| Data Collection & Evaluation | Ongoing | Work with consultant to create Take Charge electronic health record
Identification of third party evaluator to finalize survey tools and measures of effectiveness.
Outcome measurement and evaluation protocol as described in logic model (Appendix B) and Evaluation section | EHR created at UGPHD
Follow-up call questions
Pre and post-surveys |
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</tr>
</thead>
<tbody>
<tr>
<td>Follow-Up Support</td>
<td>At regular intervals following Marketplace application</td>
<td>Take Charge Coordinators following up to ensure primary care provider appts are completed and that premiums are paid</td>
<td>Follow-up calls and appointments</td>
</tr>
</tbody>
</table>
| Capacity Building | Ongoing | Creation of Take Charge Advisory Committee to discuss issues of shared concern (i.e. planning, evaluation, training opportunities, measurement) as well as identify opportunities for new projects.
Student Projects | Quarterly meeting of Advisory Committee
Student projects (to include translation of materials, creation of voice overs for Take Charge presentation, data entry, follow-up assistance) in partnership with Kansas Health Institute |

**Evidence base**

Our intervention is:

- **Aligned with the Triple Aim**: Addresses problems before the need for acute care
- **Informed by research**: Guided by evidence on health literacy, health behavior theory and the Triple Aim approach.
- **Adaptive**: We have incorporated practical learnings of Enroll Wyandotte, the UG-PHD’s Healthy Communities Wyandotte and the YMCA’s experiences with implementing evidence-based/informed lifestyle interventions with the target population.

While there are evidence based principles and tools for increasing individuals’ health literacy; there is less available evidence for how to best increase individuals’ health *insurance* literacy.

The Agency for Healthcare Research and Quality published an Evidence Report/Technology Assessment in March, 2011 as an update to a 2004 Review of health literacy research that explores the relationship between health literacy and health outcomes. Social support and

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health care system characteristics played a role in the magnitude of the relationship between health literacy and adherence. Health literacy can potentially mediate the effects of education, income and urbanicity on health outcomes. Knowledge, patient self-efficacy and stigma may be the mediating factors according to four studies reviewed by AHRQ as part of this update. The Take Charge partners have proven capacity in implementing effective health literacy strategies and uses messaging strategies proven resonate with all demographics and increase enrollment. Enroll Wyandotte has used trained volunteer Certified Application Counselors (CACs) to help the newly insured make their first office appointment with their provider. Additionally, the Take Charge planning team has been working with Catholic Charities’ Refugee and Migrant Services to put plans in place for how to serve more immigrant and refugee populations through translation of materials created for Take Charge group appointments.

Providing social support and a sense of community is a key strategy of the YMCA’s Healthy Living work and for how we help increase knowledge and self-efficacy on the path to sustained behavior change. The Y’s approach to supporting behavior change is grounded in several evidence-based health behavior change theories and models, including the Health Belief Model, the Stages of Change (Transtheoretical Model), Social Cognitive Theory, and theories of Social Networks/Social Support. The YMCA trains its healthy living staff in motivational interviewing (MI). MI builds on the stages of change, focusing on supporting change in a way that meets individuals where they are and is consistent with each person’s own values. The YMCA will train public health staff and Enroll Wyandotte assisters in these techniques.

In the mid-1990s the NIH funded the Diabetes Prevention Program (DPP), a multi-center randomized clinical trial which found that a lifestyle intervention was more effective than the drug metformin or a placebo for preventing type 2 diabetes. In the trial, lifestyle interventions reduced the number of type 2 diabetes cases by 58% during the three year trial period (71% reduction for adults 60 and older). Researchers at the Indiana University School of Medicine and the YMCA of Greater Indianapolis replicated these results using a group format trained by a trained Y Lifestyle Coach that decreased the cost per participant by almost 75%. This valuable resource will be offered to all individuals identified as pre-diabetic through screening efforts.

Results

- Individuals will establish a primary care provider and gain increased knowledge and capacity of how to use the health care system to stay healthy
- Individuals better understand why they should utilize strategies/resources available within the community (e.g. preventive, primary care, disease management)
- Individuals demonstrate increased self-efficacy in terms of their health (motivation to act on those strategies to improve their individual health behaviors or those of their family)
- Creation of an integrated system (process outcome)
- Long Term: Improved Health


Theory of Change

• Theory of Change
  o The Take Charge program seeks to increase knowledge, capacity, and self-efficacy by creating a system where, because of its seamless integration, individuals that enter into the system through multiple ways understand what it offers, believe it is of benefit to them, understand that they have to do something about it to make changes for their own benefit, and take action utilizing the resources that exist with the system.

• Theory of Action
  o Take Charge program will achieve that change by developing delivering a culturally relevant curriculum that expands upon basic health literacy information to incorporate health insurance literacy and empowers individuals to fully utilize primary care and other community based services. We will also provide screenings that provide basic health assessment data as well as a screening and referral system for social service needs.
  o Build strong referral pathways between organizations.

Triple Aim

• Better Health – As a result of Take Charge, health care users will experience increases in knowledge and self-efficacy about utilizing preventive and health care services, resulting in lifestyle behavior change and improved health. Including screening services as part of the initial appointment will help individuals better understand their personal health status and how the various parts of the system can help improve that status.

• Better Care- As a result of Take Charge, individuals will be made aware of common health risks and indicators that can be prevented and/or managed through coordinated care, and lifestyle behavior change programs available through community resources. Empowered by new understanding, and supported by trained and equipped assistants familiar with concepts of motivation, individuals can take charge of their families’ health, and see value in the medical home concept as opposed to emergency room services.

• Lower Cost – there are multiple opportunities for cost savings within this integrated model. While there is not an easy way to calculate such savings, we are making the assumption that as a result of Take Charge, we are helping people understand pathways to prevention and comprehensive medical care available outside of the emergency room and before expensive acute care becomes necessary. That alone will save the system money. In addition, by developing effective referral pathways between partners, each entity doesn’t have to work so hard on its own to reach constituents.

Cultural Competence
All the partners in Take Charge have extensive experience working with diverse cultures. The YMCA of the USA, of which the YMCA of Greater Kansas City is a Training Partner YMCA, has a sanctioned Cultural Lenses 1-day training. All staff hired through this grant, as well as any staff and volunteers of EW and/or the UGPHD will be trained to reinforce culturally sensitive practices. In addition EW typically recruits volunteers from within the target population, including refugee populations (e.g. Mung, Nepalese, Iraqi and Burmese).

Progress of existing projects
The Take Charge program is a new program built upon the enrollment assistance work of Enroll Wyandotte. Enroll Wyandotte has been financially supported by grants from the REACH Health Care Foundation, Health Care Foundation of Greater Kansas City, Sunflower Foundation, and in-kind contributions by the Community Health Council and the UGPHD. Enroll Wyandotte
successfully assisted 900 Wyandotte County residents complete applications in the Health Insurance Marketplace, and did public outreach to 4,000 during the first open enrollment period. They discovered through follow-up after enrollment, and through conversations with safety net providers, that many newly insured had no idea how to use their insurance. This realization led to the unique partnership that is the Take Charge program.

Collaboration and Community Integration/Coordination:

<table>
<thead>
<tr>
<th>Partner Organization</th>
<th>Role, Key Skills &amp; Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unified Government Public Health Department</td>
<td>Lead grant applicant; respected institution in the community; 90+ staff (including dietician and clinical staff); 30,000 unique patients per year; space for programming</td>
</tr>
<tr>
<td>Healthy Communities Wyandotte</td>
<td>HCW is a coalition whose support staff is housed in the UGPHD; will build partnerships and facilitate close relationship between UGPHD and Community Health Council; 50+ cross-sector community partners; strong support of the Mayor</td>
</tr>
<tr>
<td>Community Health Council of Wyandotte County</td>
<td>Will provide major staff support for Take Charge; expertise in serving uninsured; experience coordinating Enroll Wyandotte; relationship with Wyandotte Co. hospitals and clinics; experience community organizing with Latino and Black communities</td>
</tr>
<tr>
<td>YMCA of Greater Kansas City</td>
<td>Will provide referrals to Take Charge, train staff, and deliver evidenced-based healthy lifestyles programs; leader in healthy lifestyles promotion; long tradition of working in Wyandotte County; communication support</td>
</tr>
</tbody>
</table>

It is often said that “necessity is the mother of invention” and in Wyandotte County, the same could be said of collaboration. For more than a decade, the Unified Government of Wyandotte County has been using its position to convene health improvement stakeholders to think strategically about how to address the socially-complex problems related to health and healthcare. From the envisioning of the Community Health Council, which was formed in 2003, to the envisioning of Healthy Communities Wyandotte in 2010, the leadership from the Unified Government has helped foster both the spirit of collaboration and the sense of urgency which shapes our respective undertakings. Both the Community Health Council and Healthy Communities Wyandotte form the operational nucleus which is Enroll Wyandotte. Enroll Wyandotte is a grassroots, collaborative community effort of neighborhood and community leaders, as well as several community-based organizations that aims to inform, educate and assist as many Wyandotte County residents as possible with accessing benefits from the Affordable Care Act. These two organizations share staff, volunteers, office space and project software, as well as practice shared decision-making and evaluation. The YMCA is an anchor institution that not only is the County’s top wellness provider but is also a leader in forming collaborative efforts around addressing health disparities in Wyandotte County.

Timeline

<table>
<thead>
<tr>
<th>Activity</th>
<th>2014</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Enrollment Period: November 15-February 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awards Announcement: December 10</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing Take Charge Advisory Team meetings</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
2. EVALUATION
Monitoring and evaluation with a focus on effectiveness and sustainability is an important part of the Take Charge project. Enroll Wyandotte enjoys a relationship with the University of Kansas Work Group for Community Health and Development to provide comprehensive evaluation for their scope of services. If funded, the Take Charge project will identify an agency to investigate whether the program as a whole or parts of the program are effective in increasing the capacity of individuals to use health insurance to access a primary care provider and/or the safety net system. This evaluation will also provide insight to stakeholders who may have an interest in sustaining the Take Charge program as outlined in the sustainability section of this proposal.

Many specific details are outlined in the logic model and outcomes measurement framework, attached as Appendix B. Methods of measuring success are outlined below:

- Health insurance literacy pre- and post-tests. The American Institutes for Research (AIR) is working to develop an objective tool that measures health insurance literacy. The preliminary tool is currently in testing phase to establish validity and reliability. If funded, the Take Charge team will use this validated tool if it is available or will work with the AIR group to develop a tool that incorporates the most appropriate elements to measure program effectiveness.\(^\text{10}\)

- Standardized questions asked in follow-up calls to Take Charge clients. Take Charge staff, students, and volunteers will be doing extensive follow-up with Enroll Wyandotte clients to ensure they attend group education classes, find a primary care doctor,

continue with payments if insured, and are utilizing services in a sustainable way. Results from the follow-up calls will shed light on client attitudes about health insurance and group education classes, allowing Take Charge to improve as it matures.

• Take Charge pre/post surveys and follow up call scripts will include questions selected from YMCA lifestyle behavior program surveys that address readiness for change and self-efficacy concepts.

3. ORGANIZATIONAL PROFILE & CAPACITY

Organization’s Profile
The mission of the UGPHD is to monitor and assess health status indicators to identify community health problems, and to promote and encourage healthy lifestyle behaviors. The UGPHD is centrally situated within the Wyandotte County public health system, seeing more than 30,000 unique clients per year. Almost all of these clients are low-income, and the population is diverse, reflecting the majority-minority demographic in Wyandotte County. Along with providing safety net care, disease control, and health education services to the community, the UGPHD has taken a leadership role in improving the social determinants of health through the Healthy Communities Wyandotte (HCW) initiative. This project is in-line with the UGPHD’s mission to improve health access and healthy lifestyles, important determinants of health.

Organization Capacity:
UGPHD partnered with the Health Council last year to assist UGPHD client families in completing health insurance applications on-site. The UGPHD was the largest Enroll Wyandotte site, and all its relevant sub-departments gained experience educating clients about new health insurance options and directing them to the enrollment room on the 1st floor of the building. HCW played a coordinating role in that learning process, and its staff will be present for year two of enrollment.

The Community Health Council was the staff backbone for Enroll Wyandotte in its first year. They worked with the UGPHD’s linguistically and culturally diverse client base, encountering and working through every possible issue with the fledgling Marketplace. In addition, UGPHD and Health Council staff trained over 100 volunteers to provide culturally competent enrollment assistance to the uninsured. The staff performed with such distinction, and so many volunteers were mobilized, that the Wall Street Journal sent a reporter to profile the Enroll Wyandotte effort. Additionally, Kansas City, KS was one of only two cities in HHS Region VII recognized by President Obama for our proactive response to the Marketplace release.

The YMCA is recognized national leader in promotion and provision of healthy lifestyle programming. The Greater Kansas City YMCA is one of 130 YMCAs nationally that are deploying the Diabetes Prevention Program (DPP), developed off of the CDC’s evidenced-based National Diabetes Prevention Program. Additionally, the UGPHD and the YMCA have a close working relationship: YMCA Wyandotte leadership serve on the Steering Committee of Healthy Communities Wyandotte, and Healthy Communities Wyandotte staff have collaborated with the YMCA on several CDC REACH grants. With two active sites, the YMCA is a visible and accepted leader in Wyandotte County.

An advisory body including key UGPHD, Healthy Communities Wyandotte, YMCA, and Health Council staff will be formed to make key decisions during this program pilot. Day-to-day supervision will be provided by the Enroll Wyandotte Coordinator (Health Council) and the

Healthy Communities Wyandotte Coordinator (UGPHD). Evaluation for Enroll Wyandotte in the first year was provided by the KU Work Group for Community Health and Development, and this will continue into year two.\(^\text{12}\)

**Staffing**

**Take Charge Coordinators**

These 2 individuals will assist in curriculum development, coordinate and host the Take Charge educational classes, and do one-on-one outreach to Enroll Wyandotte clients to ensure participation and retention. These staff will dedicate 100% of their time to the grant (2.0 FTEs total) and will be new hires. It is important that these individuals are bi-lingual, energetic, patient, good communicators, and able to deliver culturally competent services to individuals with limited knowledge of the health care system.

**Jessica Velazquez, YMCA Diabetes Prevention Program Coordinator**

Jessica will work with clients who are screened in the Take Charge classes and identified as at risk for diabetes. She will assist them through a curriculum that meets evidenced-based standards as defined by the CDC. 50% of her salary will come from other grant sources, and 50% is requested from HCF. Jessica has a bachelor’s in Communication, an Associate’s degree in Exercise Science and has 3 years of experience as a YMCA Healthy Living Director. She speaks functional Spanish. She has been trained by the YMCA of the USA in the YMCA Diabetes Prevention Program curriculum.

**Jerry Jones, Executive Director, Community Health Council of Wyandotte County**

Jerry will assist in governance, evaluation, and partnership development for Take Charge. He will contribute 10% of his time in-kind to the project. Before his role at the Health Council, Jerry worked for a decade to organize the Black faith community in Kansas City around health issues.

**Lucia Jones, Enroll Wyandotte Coordinator, Community Health Council of Wyandotte**

Lucia will directly supervise all Take Charge staff and will work in multiple settings to ensure partners understand and sign on to the referral systems necessary for Take Charge to successfully function. Lucia is a masterful coordinator, and was able to build support for enrollment in both the Spanish-speaking and English-speaking communities in Wyandotte. Before becoming EW Coordinator, Lucia was an ER nurse for 8 years. She will be the key link between Enroll Wyandotte and Take Charge, and will be devoting 50% of her time in-kind.

**Wesley McKain, Healthy Communities Wyandotte Coordinator, Unified Government Public Health Department**

Wesley will contribute 10% in-kind of his time to this project. He will serve in a coordinating and assistance role with Enroll Wyandotte staff at the UGPHD enrollment site. He will be the primary liaison between Enroll Wyandotte and the UGPHD. As HCW Coordinator, Wesley leads a coalition of 50+ organizations that includes the Mayor’s office. He was instrumental in the initial planning, mobilizing, and fundraising that ensured the success of Enroll Wyandotte.

**Sue Martin, Dietician, Unified Government Public Health Department**

Sue has been the Health Department’s Dietician for 18 years, counseling patients from every language and background in diet & nutrition. She has a deep knowledge of community perceptions about healthy lifestyle behavior change. She will review health eating with clients during the screening and educational process, and work with YMCA staff to facilitate training for

\(^\text{12}\) Their nationally known Online Documentation and Support System was developed over a 20 year period specifically to track inputs and outcomes in complex, multi-stakeholder community health projects.
UGPHD employees in readiness for change and motivational interviewing. She will be devoting 10% of her time in-kind to this project.

Julie Alsup, Program Innovation and Resource Director, YMCA of Greater Kansas City
Julie will contribute 5% of her time to this project in-kind. She will serve in a coordinating and assisting role with YMCA healthy living programs and the grant partners and serve on the Take Charge Advisory Committee. Julie is the YMCA’s grants director and expert in establishing partnerships to improve or develop new programming for residents of Kansas City.

4. COST
Much of the work proposed by the Take Charge program is uncharted territory. To this point, the major focus of the ACA has been enrollment. The Take Charge project takes the next step in addressing the challenges created by the complex health care system in the United States. An extensive literature review revealed very little information related to proven cost savings related to this specific work. The US Department of Education estimates that only 12 percent of adults have proficient health literacy, and this low health literacy costs the US economy an estimated $106 to 236 billion annually. Despite this lack of specific data, there are several elements the program addresses that will likely lead to cost savings.

- Building capacity of individuals who obtain health insurance to understand the importance of maintaining that coverage.
- Increasing the capacity of both insured and uninsured individuals to understand the importance of and access to primary care and preventive screenings, and avoid unnecessary ER visits.
- Increasing the capacity and opportunity for Wyandotte residents to make healthy lifestyle choices and achieve the recommended levels of physical activity will improve the health of the community and decrease the reliance on the health care system in general.

Diabetes and obesity are two major health care cost drivers, and play a major role in morbidity and mortality in Wyandotte residents. Diabetes costs average $20,000 per year in the advanced stages, while prevention costs average only $3,700 per year. The Take Charge program provides resources specifically targeted to individuals affected by these conditions to prevent disease progression and potentially treat and discontinue the conditions all together.

5. SUSTAINABILITY
Monitoring and evaluation with a focus on effectiveness and sustainability is an important part of the Take Charge project. If funded, the advisory team will identify an agency to complete this evaluation and investigate whether the program as a whole or parts of the program are effective in increasing the capacity of individuals to use health insurance to access a primary care provider and/or the safety net system. Over the 12 month grant period the advisory team will identify stakeholders who would have an interest in elements of the Take Charge project and develop strategies to address sustainability. Potential interested stakeholders include:

---

14 Center for Health Care Strategies. “Health Literacy Implications of the Affordable Care Act.” November 2010. Available at: http://www.iom.edu/~media/Files/Activity%20Files/PublicHealth/HealthLiteracy/Commissioned-Papers/Health%20Literacy%20Implications%20of%20Health%20Care%20Reform.pdf
Area foundations: Several foundations have supported many of the efforts related to enrollment, support of the safety net system, and health promotion and disease prevention in Wyandotte’s vulnerable populations.

Health insurance providers (public and private): The more knowledge of and access to health promotion and disease prevention resources enrollees have, the greater potential they have to lead healthy, active lifestyles and avoid many chronic diseases, therefore costing the insurance provider less. Additionally, insurance providers may have an interest in supporting and/or providing a program that enables clients to understand the health insurance process and how to access the system in a sustainable and non-wasteful manner.

Hospitals: Uninsured individuals are often a major cost driver for hospital systems.

Safety net clinics and other primary care providers: Primary care providers have an interest in building capacity of clients to take charge of their own health, increasing the health literacy and improving the overall health of their clients.

Public health agencies: The more engaged individuals are in their health, the higher the chance of healthier behavior, leading to improved health outcomes in individuals and the population as a whole.

YMCA: The YMCA Diabetes Prevention Program is the first lifestyle intervention to be a covered benefit among certain insurance plans. Projects like Take Charge can introduce new payers to the idea of including prevention programs like this as covered benefits, creating an earned income stream for the YMCA to sustain and grow the program.

6. Diversity & Cultural Competency (up to 10 points)
Understanding the importance of being culturally and linguistically competent, the Unified Government Health Department has a strong history of providing vital and continuous leadership for diversity issues in the Wyandotte County community. In addition to recruiting and hiring an ethnically diverse staff (current composition of the staff is 22% African American, 19% Latino and 55% Caucasian), UGPHD strives to partner with a variety of community-based agencies that represent the Latino, Black and Asian populations.

This project’s success will largely depend on our ability to bridge Kansas City’s historical legacies of deprivation and discrimination by promoting a fully inclusive coalition. The Enroll Wyandotte project includes important organizations working to empower communities of color in Wyandotte County, including the Latino Health for All Coalition, El Centro Inc., and the Historic-Northeast Midtown Association. Coalition leadership also reflects the diversity in the community. Jerry Jones, Executive Director of the Community Health Council, is an African-American with a decade of health organizing experience in the black faith community. Lucia Jones, Enroll Wyandotte Coordinator, is Latina and effectively built partnerships with the Mexican Consulate, El Centro Inc., and Hispanic neighborhood leaders in the last enrollment period.

The YMCA of Greater Kansas City is committed to diversity and inclusion. In 2013, the Board of Directors approved the creation of a Diversity, Inclusion and Global Council with the following mandate: The Y strives to ensure access, inclusion and engagement for all to reach their personal potential and live life to the fullest. We will ensure that all segments of society feel welcome as participants, members, associates and volunteers. This mandate created a council that will help oversee strategies to achieve key outcomes around diversity and inclusion. The Y regularly monitors and creates subsequent recruitment and retention plans to support our Diversity & Inclusion strategies.
Attendees will receive:

1. How-to guide on the health insurance and finding a doctor
2. Personalized USPSTF screening recommendations
3. Blood pressure measurement, BMI calculation, diabetes screening form
4. Health risk assessment: Simple 7 from American Heart Association?
5. Description of active living opportunities offered by the YMCA to anyone;
   readiness for change screening; brief nutrition/exercise counseling
6. Low cost primary care clinic list (involve FQHCs for easy referral?)
7. Additional resources as needed

Specific additional follow-up

- Known diabetes
  - Appropriate PCP referral and YMCA opportunities as appropriate (Y weight, coaching connection)

- Pre-diabetes
  - Appropriate PCP referral and YMCA DPP Program

- BMI 25 or greater, no pre-diabetes
  - Appropriate PCP referral and YMCA opportunities as appropriate (Y weight, coaching connection)
- Refers newly-enrolled to "first appointment"
- Refers those who remain uninsured to UG-PHD services
- Refers uninsured to Enroll Wyandotte

Enroll Wyandotte

- Screens and refers individuals to appropriate YMCA programming
- Provides active living expertise and program enrollment at "First Appointment"
- Trains UG-PHD staff in readiness for change screening, motivational interviewing

Integrated System

Marketplace Insurers: BKBC-KC, Coventry

Enrollment presence at YMCA events

Refers uninsured to Enroll Wyandotte

Improved Health Outcomes

Cost Savings and System Sustainability

Enrollment presence at YMCA events

Refers uninsured to Enroll Wyandotte

Refers uninsured to Enroll Wyandotte

Refugee Coverage

FQHCs

KanCare Health Homes

UG-PHD

YMCA
## Outcome Measurement Framework – Take Charge of Your Health Wyandotte

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicator</th>
<th>Data Source</th>
<th>Data Collection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved knowledge to use the health care system in a sustainable way</td>
<td>The number of people that complete the Take Charge appointment</td>
<td>Organizational records</td>
<td>Follow up calls by EW Staff and Take Charge Coordinators</td>
</tr>
<tr>
<td></td>
<td>The number of people that demonstrate a change in knowledge of health insurance literacy</td>
<td>Attendance/sign in Surveys</td>
<td>Pre/Post survey</td>
</tr>
<tr>
<td>Increased awareness and access to preventive care recommendations available in the community</td>
<td>The number of people that complete screening forms</td>
<td>Referrals Enrollments</td>
<td>Screening Forms YMCA ActiveNet system</td>
</tr>
<tr>
<td></td>
<td>The number of people enrolled in the YMCA healthy lifestyle programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased self-efficacy of individuals in terms of their health</td>
<td>The number of people continue to pay their premiums after 6 months</td>
<td>Follow up Calls</td>
<td>Regular follow up calls by EW Staff and Take Charge Coordinators with select questions.</td>
</tr>
<tr>
<td></td>
<td>The number of people that have completed their primary care provider visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creation of sustainable Take Charge partnership</td>
<td>The number of advisory committee meetings</td>
<td>Minutes of meetings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of collaborative grant proposals written</td>
<td>Collaborative products/ processes developed</td>
<td></td>
</tr>
</tbody>
</table>
## Logic Model – Take Charge of Your Health Wyandotte

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Initial Outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long-term outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCF Funding and in-kind support from partners ($350k)</td>
<td>Take Charge Advisory Team meetings</td>
<td>Number of and attendance to Advisory Team meetings</td>
<td>Creation of partnership between UG-PHD, Enroll Wyandotte, and YMCA to develop integrated system from coverage to care.</td>
<td>Individuals better understand why they should utilize resources available within the community (i.e. preventive, primary care, management) - perceived importance</td>
<td>Better health: increased preventive screenings, increased primary care visits, decreased obesity, decreased diabetes, increased exercise, increased healthy eating</td>
</tr>
<tr>
<td>Curriculum: CMS Coverage to Care, YMCA/CDC Diabetes Prevention Program, YMCA Y Weight, YMCA Coaching Connection</td>
<td>Hiring and training required staff</td>
<td>Number of system sustainability stakeholder meetings</td>
<td>Improved knowledge and capacity, use health insurance, obtain primary care appointment, and use health care system in a sustainable way.</td>
<td>Individuals demonstrate increased self-efficacy in terms of their health (motivation to act on those strategies to improve their individual health behaviors or those of their family)</td>
<td>Better care: integrated and sustainable system to build capacity of individuals to access the healthcare system appropriately.</td>
</tr>
<tr>
<td>Grant-funded staff: 2.0 FTE Take Charge Program, 0.5 YMCA DPP Program</td>
<td>Curriculum development</td>
<td>Number of Take Charge class attendees</td>
<td>Increased awareness of preventive care recommendations available at no cost with insurance</td>
<td>Sustainability of Take Charge</td>
<td>Lower cost: decreased emergency department visits, increased health promotion and disease prevention will save chronic diseases costs later, increased capacity of individuals to take charge of own health results in a healthier population and less health care costs.</td>
</tr>
<tr>
<td>In-kind staff: 0.10 FTE Healthy Communities Wyandotte, 0.10 UGPHD Nutritionist, 0.50 Enroll Wyandotte Coordinator</td>
<td>Take Charge classes</td>
<td>Number of pre/post surveys</td>
<td>Increased awareness and access to community healthy eating and active living resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location (all in-kind): UG-PHD, YMCA</td>
<td>Individual follow-up</td>
<td>Number of follow up phone calls</td>
<td>Increased knowledge and capacity of individuals with prediabetes to adopt healthy behaviors to prevent progression to diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child care costs</td>
<td>Referral to YMCA programs and other community resources</td>
<td>Number of individuals confirmed to have made a PCP visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Translation services</td>
<td>Data entry, tracking, analysis</td>
<td>Number of YMCA DPP, Y Weight, Coaching Connection attendees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enroll Wyandotte outreach activities</td>
<td>Student projects</td>
<td>Number of student projects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Translation of some curriculum into major refugee languages</td>
<td>% of individuals who maintain or lose weight, achieve recommended levels of physical activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meetings with system stakeholders to develop program sustainability plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project monitoring and evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Net Revenue

Total funding from the Foundation and other sources as follows:

<table>
<thead>
<tr>
<th>Source</th>
<th>SECURED (S)</th>
<th>PENDING (P)</th>
<th>HCF</th>
<th>Other</th>
<th>In-Kind</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Foundation (HCF)</td>
<td>S</td>
<td>P</td>
<td>$256,082</td>
<td>$0</td>
<td>$0</td>
<td>$256,082</td>
</tr>
<tr>
<td>In-Kind</td>
<td>S</td>
<td>P</td>
<td>$0</td>
<td>$0</td>
<td>$45,660</td>
<td>$45,660</td>
</tr>
<tr>
<td>REACH Health Care Foundation</td>
<td>S</td>
<td>P</td>
<td>$0</td>
<td>$25,000</td>
<td>$0</td>
<td>$25,000</td>
</tr>
<tr>
<td>Humana Foundation</td>
<td>S</td>
<td>P</td>
<td>$0</td>
<td>$18,000</td>
<td>$0</td>
<td>$18,000</td>
</tr>
<tr>
<td>UG-Hollywood Casino Grant Fund</td>
<td>S</td>
<td>P</td>
<td>$0</td>
<td>$8,250</td>
<td>$0</td>
<td>$8,250</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>$256,082</td>
<td>$51,250</td>
<td>$45,660</td>
<td>$352,992</td>
</tr>
</tbody>
</table>

### Benefits and Payroll Taxes

The project will pay the following benefits and payroll taxes for the above staff (e.g., FICA, Health, Dental, Life Insurance, etc.):

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit % rate of total salary expense (e.g., 20%)</th>
<th>HCF</th>
<th>Other</th>
<th>In-Kind</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Council benefit package</td>
<td>25.00%</td>
<td>$20,000</td>
<td>$6,500</td>
<td>$1,600</td>
<td>$28,100</td>
</tr>
<tr>
<td>YMCA package for DPP staff</td>
<td>23.60%</td>
<td>$4,248</td>
<td>$0</td>
<td>$4,248</td>
<td>$8,496</td>
</tr>
<tr>
<td>YMCA benefits for Y-Weight part-time</td>
<td>13.68%</td>
<td>$547</td>
<td>$6,500</td>
<td>$547</td>
<td>$1,600</td>
</tr>
<tr>
<td>Total Benefits and Payroll Taxes</td>
<td></td>
<td>$24,248</td>
<td>$6,500</td>
<td>$6,395</td>
<td>$37,143</td>
</tr>
</tbody>
</table>

### Other Direct Expenses:

(e.g., Training Expenses, Consulting Fees, etc.)

<table>
<thead>
<tr>
<th>Item</th>
<th>HCF</th>
<th>Other</th>
<th>In-Kind</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student/Volunteer Stipends</td>
<td>$19,200</td>
<td>$0</td>
<td>$0</td>
<td>$19,200</td>
</tr>
<tr>
<td>Child Care</td>
<td>$960</td>
<td>$0</td>
<td>$0</td>
<td>$960</td>
</tr>
<tr>
<td>Food at events</td>
<td>$5,400</td>
<td>$0</td>
<td>$0</td>
<td>$5,400</td>
</tr>
<tr>
<td>Bus vouchers</td>
<td>$2,700</td>
<td>$0</td>
<td>$0</td>
<td>$2,700</td>
</tr>
<tr>
<td>Printing</td>
<td>$2,000</td>
<td>$0</td>
<td>$0</td>
<td>$2,000</td>
</tr>
<tr>
<td>Translation services</td>
<td>$2,000</td>
<td>$0</td>
<td>$0</td>
<td>$2,000</td>
</tr>
<tr>
<td>Food for staff meetings</td>
<td>$720</td>
<td>$0</td>
<td>$0</td>
<td>$720</td>
</tr>
<tr>
<td>Electronic health record technical assistance</td>
<td>$3,000</td>
<td>$0</td>
<td>$0</td>
<td>$3,000</td>
</tr>
<tr>
<td>200 individuals to complete Y Weight</td>
<td>$30,000</td>
<td>$0</td>
<td>$15,000</td>
<td>$45,000</td>
</tr>
<tr>
<td>6 DPP Programs (10 individuals each)</td>
<td>$17,160</td>
<td>$8,250</td>
<td>$0</td>
<td>$25,410</td>
</tr>
<tr>
<td>YMCA room rental space</td>
<td>$0</td>
<td>$0</td>
<td>$1,320</td>
<td>$1,320</td>
</tr>
<tr>
<td>YMCA Motivational Interviewing and Cultural Lenses trainings</td>
<td>$2,250</td>
<td>$0</td>
<td>$0</td>
<td>$2,250</td>
</tr>
</tbody>
</table>

Total Other Direct Expenses                   | $85,390  | $8,250| $16,320 | $109,960 |

### Equipment & Supplies:

Insert Types of Equipment/Supplies

<table>
<thead>
<tr>
<th>HCF</th>
<th>Other</th>
<th>In-Kind</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

Total Equipment/Supplies                      | $0       | $0     | $0     | $0     |
<table>
<thead>
<tr>
<th><strong>Net Revenue</strong></th>
<th><strong>Revenue</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>SUBTOTAL</td>
<td>$211,638</td>
</tr>
<tr>
<td></td>
<td>$58,750</td>
</tr>
<tr>
<td></td>
<td>$42,055</td>
</tr>
<tr>
<td></td>
<td>$312,443</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Evaluation</strong></th>
<th><strong>HCF</strong></th>
<th><strong>Other</strong></th>
<th><strong>In-Kind</strong></th>
<th><strong>Total</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total costs to evaluate the project.</td>
<td>$21,164</td>
<td>$0</td>
<td>$0</td>
<td>$21,164</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Indirect Expense</strong></th>
<th><strong>HCF</strong></th>
<th><strong>Other</strong></th>
<th><strong>In-Kind</strong></th>
<th><strong>Total</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indirect expense represents the project’s share of Overhead Expenses (rent, phone, library, etc.) and Administrative Costs. Applicants must limit the HCF portion of Indirect Expense to 10% of the Direct Expenses of the project represented by the sub-total above.</td>
<td>$23,280</td>
<td>$0</td>
<td>$3,605</td>
<td>$26,885</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Total All Expenses</strong></th>
<th><strong>HCF</strong></th>
<th><strong>Other</strong></th>
<th><strong>In-Kind</strong></th>
<th><strong>Total</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$256,082</td>
<td>$58,750</td>
<td>$45,660</td>
<td>$360,492</td>
</tr>
</tbody>
</table>
The Enroll Wyandotte Coordinator is funded in full with a grant from the REACH Health Care Foundation.

Humana Foundation: the YMCA DPP Director is partially funded by grant from Humana.

Hollywood Casino: The YMCA received a grant to support 20 uninsured Wyandotte County individuals to participate in DPP.

Take Charge Coordinators: will assist in curriculum development, coordinate and host the educational classes, and do one-on-one outreach to Enroll Wyandotte clients to ensure participation and retention. Enroll Wyandotte expects to assist residents in completing 1,800 marketplace applications in the 2014-2015, and that 900 of these will participate in Take Charge program.

YMCA DPP Coordinator - 50% of the Diabetes Prevention Program Coordinator will come from other grant sources, and 50% is requested from HCF. This individual will work with clients who are screened in the Take Charge classes and identified as at risk for diabetes. They will assist them through a curriculum that meets evidenced-based standards as defined by the CDC.

Weight bilingual specialist: Part-time hourly support for the Y-weight program, in the amount of $4,000.

Dietician - The UGPHD Dietician will 10% of staff time to review health eating with clients during the screening and educational process, and work with YMCA staff to facilitate training for UGPHD employees in readiness for change and motivational interviewing.

Community Health Council Director - Will assist in governance, evaluation, and partnership development for Take Charge. He will contribute 10% of his time to the project.

Enroll Wyandotte Coordinator - The EW Coordinator will supervise all Take Charge staff and will work in multiple settings to ensure sign on and understand referral systems into Take Charge of Your Health Wyandotte. She will contribute 50% of her time to this project.

UGPHD HCW Coordinator - The Healthy Communities Wyandotte Coordinator, an employee of the UG Public Health Department, will contribute 10% of his time to this project. He will serve in a coordinating and assistance role with Enroll Wyandotte staff at the UGPHD enrollment site. He will be the primary liaison between Enroll Wyandotte and the UGPHD.

YMCA Program Innovation and Resource Director: will contribute 5% of her time to this project. She will serve in a coordinating and assistance role with YMCA healthy living programs and the grant partners and serve on the Take Charge Advisory Committee.

Health Council benefit package: The Take Charge Coordinators will be employed by the Community Health Council and receive the standard benefit package for their employees ($20,000 total). The $6,500 of Other represents the donated portion of the Enroll Wyandotte Coordinator's benefit package, and the $1,600 is the donated portion of the Community Health Council Director's benefits.

YMCA package for DPP staff: 50% requested from HCF, 50% provided by other grants.

Benefits for Y-weight part-time: Fringe benefits supplied by another grant.

Food for staff meetings: $6/person x 10 people x 12 meetings.

Technical assistance: Technical assistance for NetSmart changes to facilitate improvement to the referral system.
- Insert any additional/clarifying comments re: your Revenue entries here.

$225/mon is $225; Y-weight charges $150, a $75 subsidy. $75 x 200 individuals = $15,000.

Program: $429/person x 10 people x 6 classes = 60 total DPP slots. 20 slots are donated in-kind.

Donated space: 12 of the Take Charge orientation classes will be held at the YMCA. Space is donated in-kind. Normal charge for space is $110 x 12 = $1320.

Trainings: $25 per person x 20 people x 4 trainings (2 motivational interviewing and 2 cultural lenses). Also a $250 trainer fee.

Equipment/Supplies - Please attach list of equipment purchases, including prices and quantities, to your application!
Staff Request for Commission Action

Tracking No. 140306

- Revised
- On Going

Type: Standard
Committee: Administration and Human Services Committee

Date of Standing Committee Action: 9/15/2014

Proposed for the following Full Commission Meeting Date: 9/25/2014

Confirmed Date: 9/25/2014

Date: 9/3/2014
Contact Name: Jody Boeding
Contact Phone: 5069
Contact Email: jboeding@wycokck.org
Ref: Legal
Department / Division:

Proposed improvements to the Boards and Commissions appointment process.

Action Requested:
Request approval.

Publication Required

Budget Impact: (if applicable)
Amount: $
Source:
- Included In Budget
- Other (explain)

File Attachment File Attachment File Attachment
Boards and Commissions

Proposed Improvements to the Appointment Process

The goal of this report is to provide the Administrator’s office with recommendations for improvements to the board and commissions appointment process for the Unified Government of Wyandotte County/Kansas City, Kansas.
Introduction:

In response to a directive from the County Administrator’s office to develop 1) a list of current members and vacancies 2) communication/reporting mechanism for board/committee activities and 3) a plan for providing staff support for all boards and commissions, the Clerk’s office has analyzed our current boards and commission process and, based on that review, it was determined that certain improvements might be desired with respect to the following:

I. Role of the Commission Liaison
II. Defined Appointment Terms and Process for Filling Vacancies
III. Standardized Nomination Application
IV. Department Staff Support
V. Implementation
I. Commission Liaison

- Maintains a list of all boards/commissions and positions which contains requirements and terms

- Examine and report on alternatives to the current appointment process, including regularizing terms of service, rules which prevent stalemates on appointments such as current vacancies and rules that address service under expired terms

- Examine and report on other reforms to the appointment process which may include the consolidation of appointments
II. Defined Appointment Terms & Processes for Filling Vacancies

Terms & Vacancies

- Currently all appointments are made to specific terms, ranging from 1 to 4 years. These terms are prescribed by state statute, ordinance or resolution.
- Where possible, the Commission will standardize the date of appointments for all positions via ordinance and resolution amendments.
- The start date for the terms of board or commission members will begin on June 1<sup>st</sup> of an odd-numbered year.
- Appointees whose terms have expired will continue to serve until a new appointment is made. When a new appointment is made, the term will be only for the remainder of the term as if the appointment had been made upon the expiration of the previous term.
- The Commission can designate staff to develop a slate of eligible candidates for boards/commissions.
III. Recruitment and Standardized Application Process

Recruitment

- All vacancies will be posted for a minimum 30-day period to allow interested members of the public to apply and be considered; however, this requirement can be modified to meet the needs of the Board of Commissioners.
- Vacancies will be advertised in the following manner:
  - Posting to the Board of Commissioners’ websites
  - Posting to the Liveable Neighborhoods’ websites
  - Posting on Facebook
  - Posting to UGTV billboard
  - Posting to UG’s E-news source letter
  - Posting to the Citizen publication
  - Posting to Nextdoor (social platform for neighborhoods)
- The Commission Liaison will maintain an interest file of unsolicited applications for review and consideration. Unsolicited applications will be retained for a period of two years and then purged.
- After approval by the Board of Commissioners, the Liaison will notify each nominee of their appointment in writing which provides details on the orientation program (date, time and location) as well as information about specific board/commission to which he/she is appointed. Along with contact information of the chair and vice-chair.

Standardized Application

- A standard application form will be submitted for each appointment.
- The applicant form will solicit information for all applicants;
  - Basic contact information
    - Full name
    - Home address
    - Home phone number
    - Cell phone number
    - Email address
    - Business address and contact information
o Identification of the boards/commissions for which application is being made
o Brief explanation on the purpose for seeking appointment

Note: Persons reappointed to the same board/commissions need not submit an application; the copy of original application will be included in briefing material.

➢ The standard application form will be made available to the public through posting to the Unified Government website
➢ Information from the standard application form, except for the applicant’s name, will be deemed private, personally-identifiable information and will be maintained solely for internal use and will not be made available to the public.
➢ Supplemental material may be submitted together with the standard application form, which may include a resume, interest letter or other information provided by the applicant.
➢ The Liaison shall keep the official records related to the appointment process, including: the official membership rosters for all boards/commissions, nomination papers, and other records that may be required.
➢ The staff support for each board/commission shall file copies of the meeting agendas, minutes, annual reports and other documents with the Clerk’s Office and such documents shall be made available to the public.

Routing & Review

➢ When an application for appointment or nomination is received, the Liaison will verify that the applicant/nominee is eligible for the specific appointment per applicable statutes, resolutions, ordinances or other governing policies or regulations.
➢ A preliminary appointment memorandum shall be prepared and submitted to the appointing commissioner. The memorandum will include the following:
  ▪ The name of the nominating or submitting Commissioner
  ▪ The date of the nomination or submission
  ▪ The name and primary contact information of the candidate
  ▪ The position for which the candidate is being considered or has applied
  ▪ The term of office for the position and dates of service
  ▪ A copy of the standard application form and other supplemental information provided by the candidate
  ▪ A current membership roster of the specific board/commission to which nomination is being proposed
Other information submitted by the nominating member

Preliminary Review by Commissioners

- Copies of the preliminary appointment memorandum (and all attachments) will be distributed to the appointing commissioners.
- The preliminary appointment memorandum will include a review date (a period of seven business days) and a statement indicating that if no concerns are raised in the initial review process by that date, then the nomination will be automatically processed as an item for the next agenda review provided no other applications were submitted.
- If more than one application is submitted for the same appointment, the commissioner will evaluate qualifications and submit recommendation for the next agenda review.

Orientation

- The Liaison, in cooperation with the County Administrator and specific agencies/departments, will develop and implement an orientation program for newly appointed members of boards/commissions.
- The orientation program will be mandatory for all new appointments and will be scheduled at a specific time of each month.
  - Individuals who are appointed to a board/commission may be seated prior to attending the orientation process if the regular date for the orientation has been missed in the cycle of processing appointments.
  - Individuals who are reappointed to the same position or the same board/commission need not take part in the orientation program, but may do so at their discretion.
  - Alternative arrangements will be made for those who cannot attend a regularly scheduled orientation session.
- As part of the orientation program, appointees will receive:
  - A copy of a standard “job description” for volunteer board/commission member positions.
  - Information which describes expectations for voluntary services, attendance policies and indemnification matters.
  - A written description of the board/commission, developed in coordination with the applicable resolutions, ordinances or statute.
  - A current membership roster for the board/commission to which appointed.
  - Other information specified by the Board of Commissioners.
IV. Department Staff Support

Agency/Department Staff Support

- For general appointments, each agency/department will be responsible for and connected to an appointed board/commission and may make recommendations for potential nominations and submit names of individuals for consideration to the Board of Commissioners. (See Appendix A)
- For qualified positions, the agency/department responsible for and connected to that board/commission shall be responsible for submitting names of qualified candidates to the Liaison. The Liaison shall maintain a list of individuals for review and consideration by the chairman/department in making such nominations.
- Each agency/department associated with an appointed board/commission shall ensure that a copy of the bylaws, policies and procedures, and other operational rules for the specific board/commission are filed with the Liaison. In addition, a copy of each agenda, all minutes and other related documents shall be filed with the Liaison. All such information shall be classified as public records and shall be made available to the public for inspection and copying as provided under the Kansas Open Records Act.
- Each agency/department responsible for supporting a board/commission shall designate at least one staff member to serve as the contact to the Liaison of the Board of Commissioners who shall be responsible for facilitating timely communication, providing regular updates on membership and board/commission activities.
- The Liaison shall provide copies of the following to the staff supporting each board/commission:
  - Each annual and monthly vacancy report
  - Each preliminary appointment memorandum to Commissioners and final appointment memorandum for nominations affecting that specific board/commission
  - Each confirmation letter for appointments by Board of Commissioners
  - A copy of the membership roster each time it is updated
  - A copy of any notice or other communication to the specific board/commission or which is made to all boards/commissions
  - A copy of standardized meeting minute guide
  - Minutes will be uploaded to the website
Resignations

- Resignations are required to be made in writing and filed with the Unified Government Clerk and the Commission Liaison. In the absence of a written resignation by the appointee, the executive director of the agency/department head may make the written resignation to the Liaison. The resignation shall be effective on the date of filing with the Liaison or as stated.
- The Liaison shall provide a copy of any written resignation to the Board of County Commissioners and also to the affected agency/department via the designated staff contact person.
- Resignations shall be considered final and effective when filed with the Liaison, and a vacancy thereafter exits on the board/commission.

Forfeitures

- Under Unified Government ordinance and resolution, unless otherwise required by federal, state, or local law, any person appointed to a board/commission by or under the authority of the Unified Government shall be deemed to have forfeited such office upon failing to attend three consecutive meetings without providing prior notice of an intended absence to the chairperson of the board/commission.
- The forfeiture is automatic without any further action by the Commission.
- The chairperson shall report the name of the person to the Unified Government clerk.

Vacancies

- The Liaison shall prepare and distribute in January and in May of each election year a report of all existing and anticipated vacancies for the coming year and shall issue monthly status reports.
- When a term expires or a vacancy exists for any reason, notice shall be given and the recruitment and posting process will be initiated.
- When an appointment is made to fill an unexpired term, the appointment shall be made for the remainder of the original unexpired term.
- It shall be the general policy of the Board of Commissioners that all appointments shall serve until a successor is appointed by official action (if still qualified); however, the appointing Commissioner shall act to recommend the appointment of a new member or to reappoint existing members to definite terms in order to avoid confusion and administrative difficulties with the appointment process.
In cases where a vacancy has not been filled (or a reappointment made) by a Commissioner within 60 days of the vacancy notice, the department head shall be empowered to make the nomination for the appointment/reappointment for that position in order to expedite the appointment process and ensure a full slate of members on all appointed boards/commissions.

Board/commission members who miss three consecutive, unexcused meetings shall be deemed to have forfeited their position. The agency/department contact person shall notify the Liaison, who shall notify the Commissioner and open the recruitment process.
## Appendix A

<table>
<thead>
<tr>
<th>Boards/Commissions</th>
<th>Agency/Department</th>
<th>Appointments by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol &amp; Drug Fund Advisory Board</td>
<td>Public Safety Business Office (PSBO)</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Area Wide Advisory Council on Aging Wyandotte/Leavenworth</td>
<td>Area Agency on Aging</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Board of Building &amp; Fire Code Appeals</td>
<td>Fire Department/Code Enforcement</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Casino Grant Fund Review Committee</td>
<td>Administrator</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Advisory Committee on Disabilities Issues</td>
<td>None</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Golf Advisory Board</td>
<td>Parks &amp; Recreation</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Housing Authority</td>
<td>None</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Human Relations Commission</td>
<td>None</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Landmarks Commission</td>
<td>Planning &amp; Zoning</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Law Enforcement Advisory Board</td>
<td>Police Department</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Library Board (Wyandotte County)</td>
<td>Finance/Legal</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>UG Board of Park Commissioners</td>
<td>Parks &amp; Recreation</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Planning Commission/Board of Zoning Appeals</td>
<td>Planning</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Rental License Appeals Board</td>
<td>Rental License</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Self-Supported Municipal Improvement District (SSMID) Advisory Board</td>
<td>Finance</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Area Transportation Authority</td>
<td>Transportation</td>
<td>Mayor</td>
</tr>
<tr>
<td>Community Corrections Adult Advisory Board</td>
<td>Community Corrections</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Homeless Coalition</td>
<td>Mayor</td>
<td>Mayor</td>
</tr>
<tr>
<td>Jail Population</td>
<td>Sheriff</td>
<td>Mayor</td>
</tr>
<tr>
<td>Juvenile Corrections Advisory Board</td>
<td>None</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Mayor’s Council against Domestic Violence</td>
<td></td>
<td>Mayor</td>
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<tr>
<td>Regional Homeland Security (RHSCC) Transit Coordinating Council (TTPC)</td>
<td></td>
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<tr>
<td>Solid Waste Management Committee</td>
<td></td>
<td></td>
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<tr>
<td>Tree Board</td>
<td>Parks &amp; Recreation</td>
<td>Administrator</td>
</tr>
<tr>
<td>Development Review Committee</td>
<td>Building Inspection</td>
<td>UG Departments/BPU</td>
</tr>
<tr>
<td>Ethics Commission</td>
<td>Legislative Auditor</td>
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<tr>
<td>Public Building Commission</td>
<td>Finance</td>
<td>Mayor/Commission</td>
</tr>
<tr>
<td>Convention &amp; Tourism Advisory Board</td>
<td>Administrator</td>
<td>Mayor/Administrator</td>
</tr>
<tr>
<td>Economic Opportunity Foundation</td>
<td></td>
<td>Inactive</td>
</tr>
<tr>
<td>Operation Brightside</td>
<td>Public Works</td>
<td>Inactive</td>
</tr>
<tr>
<td>T-Bones Uncommitted Recreation Fund (TURF)</td>
<td>Parks, Finance</td>
<td>Inactive</td>
</tr>
<tr>
<td>Wyandotte County Developmental Disabilities Organization Advisory Board</td>
<td></td>
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</table>