Instructions for Aid To Local (ATL) Document Completion

All Aid to Local documents (guidelines, instructions and application forms) are provided in Adobe format. Forms are "fillable:" information can be entered on the form, saved and submitted via email. The forms will require the use of the current version of Adobe Reader XI. For more information, visit www.adobe.com/products/reader.html

ALL AID TO LOCAL GRANT APPLICATIONS MUST BE RECEIVED BY MARCH 14, 2014.

Important! The "Application for Grant" form must be signed, dated and sent **via e-mail** to aidtolocal@kdheks.gov by March 14, 2014 by 5:00 p.m. Please indicate on the subject line the name of the applicant agency. If unable to email the signed document, it may be faxed to: 785-296-1231.

Contacts:

- For information regarding categorical program applications or requirements, contact the Program Manager as specified in each application.
- For information regarding forms, email aidtolocal@kdheks.gov or call Pat Behnke at 785-296-0425.

Grant Application Guidelines

1. One completed "Application for Grant" summary coversheet must accompany the completed Aid to Local Grant application for each applicant agency. See document for complete instructions.
    a. Note checklist in right column.
        i. All local health departments must submit a copy of the health department budget.
        ii. All local health departments must indicate local tax revenue on the "Application for Grant". Tax revenue should also be shown in the submitted budget
    b. All applicants (except applicants for Community-based Primary Care Clinic grants that are NOT local health departments) must complete the Personnel Allocation by Program table found in the Application for Grant form. See instructions on form. Note: The form will allow a sum greater than 100% - please be sure that no employee is shown as supported by grant funds at a level greater than 100%.
2. For individual program or categorical grants, visit the link for that program, found on the general Aid to Local webpage http://www.kdheks.gov/doc_lib/index.html
    a. Each categorical grant page includes general grant information and program requirements as well as links to required application documents.
    b. Example: Family Planning Grant
        i. Click on the "Categorical Grant Funds" link under "Forms to complete".
        ii. On the next page, in the list of categories at the bottom, click on "Family Planning".
        iii. Next, the link "Program Details" will open a document with full description of the program, the contact persons and contact details.
        iv. Click on "Program Request/Detail Budget" to access the actual application form. Complete and save.
        v. Note: "Grantees Share" indicates the dollar amount the local agency is providing for the program operations. "Requested Funds" is the total grant dollars being requested.
3. It is helpful to save each blank form to a folder on your computer before entering any data.
4. All local health departments should complete the application for State Formula and Public Health Emergency Preparedness.
5. **NEW -** When you have completed all forms (Application for Grant, including Personnel Allocation by Program, if required, State Formula Program Request and all Categorical Grant Funds) for the funds you are requesting, save forms, attach to an email and send to: aidtolocal@kdheks.gov. Please indicate on the subject line the name of the applicant agency.
6. Print out the "Application for Grant" form and have it signed and dated.
    a. Scan and send as an attachment to aidtolocal@kdheks.gov
    b. or fax to 785-296-1231.
7. All applicants will be notified by email that their documents were received.

Grant Application Guideline FY2015

Successful administration of grant funds requires that the organizations:

1. Comply with federal and state policies and regulations.
2. Bill KanCare or other third party payers for services provided to eligible clients. The project must develop and implement a cost-based sliding fee schedule. Funds generated from client fees or third party reimbursement will be used to support the maintenance of effort and/or expansion of services.
3. Implement an annual staff education plan which identifies education needs of existing staff and plans for upgrading provider skills in identified needs areas; includes a provision for attendance at annual KDHE updates in primary service areas; and, provides for orientation and in-service training of new staff.
4. Provide integrated services, client records and implement multi-program staff meetings.
5. If providing multi-county services provide each member county with a copy of the Grant Application Guidelines, completed application package, related program contact, Grant Reporting Instructions, and have on file a signed memorandum of agreement with each participating county.
6. Submit documentation of (a) progress in achieving objectives and (b) expenditures (quarterly Certified Affidavit of Expenditures). Documentation is used to understand public health needs and services in the state, and convey information and data to relevant federal and state agencies.
7. Maintain fiscal control and fund accounting procedures to ensure the proper disbursement and the accountability of grant funds. Cost center accounting should be established to document revenues and expenditures for each type of funding. The accounting system should reflect all receipts, obligations, revenues, and disbursements of grant and local funds.
8. Provide individual employee coverage for Workers Compensation, unemployment insurance, and social security. The agencies are also responsible for income tax deductions, other tax or payroll deductions, and providing any benefits required by law for those employees who are employed on behalf of the grant program.
9. Please submit all grant applications to Aid to Local, at aidtolocal@kdheks.gov by March 14.

A to Z Topic Listing

Community Health Systems Home
Aid to Local Grant
Data Resources
Governor's Public Health Conference
Kansas Public Health Directory
KDHE Statewide Population Health Call
KS-TRAIN
Local Public Health Regional Attendance Map
Public Health Connections
Public Health Resources
Regional Meetings/Calendar of Events
Staff Directory
Workforce Development

Categorical Grant Funds

These funds support more specific or targeted health service needs. Continued funding is not automatic. An annual application for each type of funding must be submitted to KDHE by the deadline.

The applicant must meet local matching requirements for each type of Categorical Grant Funds requested.

Successful administration of grant funds requires that the Local Health Agency:

a. Comply with federal and state policies and regulations.
b. Bill Medicaid or other third party payers for services provided to eligible clients. The project must develop and implement a cost-based sliding fee schedule. Funds generated from client fees or third party reimbursement will be used to support the maintenance of effort and/or expansion of services.
c. Implement an annual staff education plan which identifies education needs of existing staff and plans for upgrading provider skills in identified needs areas; includes a provision for attendance at annual KDHE updates in primary service areas; and, provides for orientation and in-service training of new staff.
d. Provide integrated services, client records and implement multi-program staff meetings.
e. If providing multi-county services provide each member county with a copy of the Grant Application Guidelines, completed application package, related program contact, Grant Reporting Instructions, and have on file a signed memorandum of agreement with each participating county.
f. Submit documentation of (a) progress in achieving objectives and (b) expenditures (quarterly Certified Affidavit of Expenditures). Documentation is used to understand public health needs and services in the state, and convey information and data to relevant federal and state agencies.
g. Maintain fiscal control and fund accounting procedures to ensure the proper disbursement and the accountability of grant funds. Cost center accounting should be established to document revenues and expenditures for each type of funding. The accounting system should reflect all receipts, obligations, revenues, and disbursements of grant and local funds.
h. Provide individual employee coverage for Workers Compensation, unemployment insurance, and social security. The agencies are also responsible for income tax deductions, other tax or payroll deductions, and providing any benefits required by law for those employees who are employed on behalf of the grant program.
i. Please submit all grant applications to aidtolocal@kdheks.gov by March 14 at 5:00 pm.

Categories

Child Care Licensing Program
Chronic Disease Risk Reduction
Community-Based Primary Care Clinic Grant
Family Planning
Healthy Families Services
HIV Prevention Program
Immunization Action Plan
Maternal & Child Health
Personal Responsibility Education Program (PREP)
Pregnancy Maintenance Initiative (PMI)
Ryan White
STI/HIV Disease Intervention/Prevention Services
Teen Pregnancy Targeted Case Management
WIC/ICP Collaborative
Public Health Emergency Preparedness

Return

Curtis State Office Building, 1000 SW Jackson, Topeka, Kansas 66612

State Formula

Program Purpose

State Formula (General Health) Funds are provided to local health departments to form the base for public health service support. These funds are intended to help insure that "adequate health services are available to all inhabitants of the State of Kansas." There are no specific program requirements at this time for this funding however all applicants who are local health departments must complete the "State Formula Program Request" questions.

Funding

Funding will be allocated to each local health department based on the formula contained in the Kansas Statutes Annotated (K.S.A. 65-241) applied to funds appropriated for this purpose by the current Legislature. The attached document (County Population and General Health Award) lists the amount that will be allocated to each health department based on that projected appropriation level. If the actual appropriation varies from that amount, a new allocation list will be prepared and distributed. County Population and General Health Award.

The statute authorizing the State Formula Grant, K.S.A. 65-241 et. seq., requires a Local Maintenance of Effort.

Local Health Department administrators should communicate with appropriate county officials to ensure that local maintenance of effort amounts are adequately and correctly certified.

Specific Program Information

a. Complete the "State Formula Program Request" form.
b. List the previous year Local Tax Revenue Amount on the "Application for Grant" summary page.

Additional Consideration

To be eligible to receive Formula Funding, a health department must:

a. Be a county, city-county, or multi-county department of health.
b. During the current year, receive and expend local tax revenue in accordance with attached KDHE maintenance of effort clarification memorandum.
c. Submit an application requesting funding, completing all questions on the "State Formula Program Request".

Reporting Requirements

a. No narrative report is required.
b. Submit the following information on a quarterly basis: A Certified Affidavit of Expenditures which will require reporting of total local tax and other non-state, non-federal revenue and expenditures.

Program Contact Person

Jane Shirley, Director, Local Public Health Program
785-296-1200
jshirley@kdheks.gov

Form: Program Request
County Population and General Health Award

References: Local Maintenance of Effort

2015

Kansas Chronic Disease Risk Reduction

Kansas
Department of Health and Environment

Contents

CHRONIC DISEASE RISK REDUCTION

Background

Chronic diseases account for roughly 75 percent of health care costs each year[1], based on national estimates in 2010 nearly $20 billion was spent in Kansas on chronic disease.[2] As states struggle to meet the staggering costs of health care, the most cost-effective interventions are frequently overlooked. Impressive achievements in population health are possible by reducing the prevalence of risk factors that underlie chronic disease and injury.

TOBACCO USE - Tobacco use is the leading cause of preventable death and disease in Kansas. Annually, cigarette use alone causes approximately 3,800 deaths in Kansas, costing more than $927 million in medical expenditures and $863 million in lost productivity from an experienced workforce that dies prematurely.[3] Additionally, youth continue to use tobacco at an alarming rate. Data from the 2011/2012 Kansas Youth Tobacco Survey (KYTS) reveal that 13.0 percent of high school students reported using cigarettes. The KYTS also indicates that 11.1 percent of high school male students in Kansas currently use smokeless tobacco. Data compiled by the Centers for Disease Control and Prevention (CDC) show that smoking prevalence among youth and adults declines faster as spending for tobacco control programs is increased. The risks of tobacco use extend beyond actual users. Secondhand smoke exposure increases the risk for lung cancer and heart disease.[4]

OBESITY- Obesity, defined as a body mass index $\geq$ 30 kg/m2, increases the risk for several chronic diseases including coronary heart disease, type 2 diabetes, certain cancers, stroke and osteoarthritis.[5] These conditions have their own promising practices to combat obesity, such as chronic disease self-management programs. In 2012, 29.8 percent of Kansas adults 18 years and older were obese.[6] The percentage of Kansas adults who were obese in 2012 was significantly higher among Kansans 25 years and older, persons with less than college education, those whose annual household income was less than $35,000 and those living with a disability. In addition, obesity is highly prevalent among Kansas adults with chronic health conditions.[6] For example 56.4 percent of Kansans with diabetes and 39.9 percent of Kansans with arthritis are obese.[6] In 2013, 28.9 percent of Kansas high school students in grades 9-12 were overweight or obese (16.3% overweight, 12.6% obese.)[7]

PHYSICAL ACTIVITY - Regular physical activity is associated with reduced risk of several chronic health conditions including coronary heart disease, stroke, type 2 diabetes and certain cancers.[8] Participating in physical activity also delays the onset of functional limitations,[9] prevents obesity[5] and is essential for normal joint health.[10] The U.S. Department of Health and Human Services' *2008 Physical Activity Guidelines for Americans* recommend that adults participate in at least 150 minutes a week of moderate-intensity aerobic activity, or 75 minutes a week of vigorous-intensity aerobic activity or an equivalent combination of moderate- and vigorous-intensity aerobic activity. The *Guidelines* also recommend that children and adolescents participate in at least 60 minutes of physical activity per day.

In 2011, 16.5 percent of Kansas adults 18 years and older met these physical activity guidelines.[11] The percentage of Kansas adults meeting current physical activity guidelines was significantly lower among females, Kansans 25 years and older compared to those aged 18 to 24 years, those with less than college education, those whose annual household income was less than $50,000, residents of less population-dense counties, those living with a disability and those with arthritis. In 2013, 71.7

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[1] The Power to Prevent, Call to Control: At A Glance 2009. Centers for Disease Control and Prevention website. 2009. Available at: www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm. Accessed December 14, 2012.
[2] U.S. Health Care Costs. Kaiser Family Foundation, Kaiser EDU website. 2012. Available at http://www.kaiseredu.org/issue-modules/us-health-care-costs/background-brief.aspx#footnote/. Accessed December 17, 2012.
[3] Smoking Attributable Morbidity, Mortality and Economic Cost. Centers for Disease Control and Prevention.
[4] U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.
[5] U.S. Department of Health and Human Services. Public Health Service; National Institutes of Health; National Heart, Lung and Blood Institute. Clinical guidelines on the identification, evaluation and treatment of overweight and obesity in adults. NIH Publication No. 98-4083; 1998.
[6] 2012 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.
[7] 2013 Kansas Youth Risk Behavior Survey. Kansas State Department of Education.
[8] U.S. Department of Health and Human Services. *2008 Physical Activity Guidelines for Americans.*
[9] Huang Y, Macera CA, Blair SN, Brill PA, Kohl HW, Kronfeld JJ. Physical fitness, physical activity, and functional limitations in adults 40 and older. *Medicine Science in Sports and Exercise.* 1998;30:1430-1435.
[10] Minor MA. Exercise in the treatment of osteoarthritis. *Rheum Dis Clin North Am.* 1999;25:397-415.
[11] 2011 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.

percent of Kansas high school students in grades 9-12 did not engage in recommended levels of physical activity (i.e. at least 60 minutes per day).[12]

NUTRITION - Research shows that eating at least two and a half cups of fruits and vegetables per day is associated with a reduced risk of many chronic diseases, including cardiovascular disease and certain types of cancer. A diet rich in fruits and vegetables can also help adults and children achieve and maintain a healthy weight.[13] In 2011, 41.4 percent of Kansas adults 18 years and older consumed fruit less than 1 time per day and 22.3 percent consumed vegetables less than 1 time per day.[11] The percentage of Kansas adults who consumed fruits or vegetables less than 1 time per day was significantly higher among males, adults 18-34 years old and those with less than a college level education.[11] In 2013, only 16.4 percent of Kansas high school students in grades 9-12 ate fruits and vegetables five or more times per day.[12]

RFP - This document is a request for proposals for local healthy community programs that include tobacco use prevention and control and may include community physical activity, nutrition and obesity prevention activities. This funding solicits program grant applications from communities to establish or continue tobacco control programs at the local level that are sustainable, accountable and eventually comprehensive as recommended by CDC's Best Practices for Comprehensive Tobacco Control Programs (October 2007). All applications must address tobacco, but work in physical activity or nutrition is optional. For any applicant, the number of proposed PAN activities must be less than the number of proposed tobacco prevention activities. This document provides background and guidelines for developing a full proposal and submission instructions. This is a competitive grant process, meaning that grants will be awarded based upon the quality and clarity of the proposed activities and achievability of proposed outcomes. Please follow the directions carefully. Applications will be scored based on adherence to the request guidelines.

About the Kansas Tobacco Use Prevention Program (TUPP)

The Kansas Department of Health and Environment's Tobacco Use Prevention Program[14] (TUPP) was established in 1992 and is the lead state program for comprehensive tobacco prevention and control. TUPP incorporates CDC's Best Practices for Comprehensive Tobacco Control Programs and uses approaches compatible with the Healthy People 2020 risk reduction strategies for tobacco use. A primary program function is to provide resources and technical assistance to community coalitions for development, enhancement and evaluation of state and local initiatives to prevent morbidity and mortality from tobacco use.

About the Kansas Physical Activity and Nutrition Program (PAN)

The mission of the Kansas Department of Health and Environment's Physical Activity and Nutrition Program is to increase the number of Kansas residents who have the knowledge, motivation and opportunity to make lifestyle choices that promote healthy eating and physical activity. PAN's mission is facilitated through state-level leadership and coordination that reaches into communities across the state.

Chronic Disease Risk Reduction (CDRR) Grant Overview

The purpose of this community grant program is to provide funding and technical assistance to communities to address chronic disease risk reduction through evidence-based strategies that impact tobacco use, physical activity and nutrition. Examples of these strategies can be found in the American Journal of Preventive Medicine's "The Guide to Community Preventive Services: Tobacco, Obesity, Physical Activity, Nutrition " (www.thecommunityguide.org), the National Association of County and City Health Officials' Recommendations for Comprehensive Tobacco Use Prevention Programs (http://www.naccho.org/topics/HPDP/tobacco/upload/Tobacco-Prevention-Learners-Guide.pdf) and The Community Health Promotion Handbook: Action Guides to Improve Community Health (http://www.cdc.gov/steps/actionguides). The grant program is structured to promote community program progress in five distinct phases:

[12] 2013 Kansas Youth Risk Behavior Survey, Kansas State Department of Education.
[13] U.S. Department of Agriculture and U.S. Department of Health and Human Services. *Dietary Guidelines for Americans, 2010*. 7th Edition, Washington, DC: U.S. Government Printing Office;2010.
[14] http://www.kdheks.gov/tobacco/

1. An initial planning phase,
2. Capacity building,
3. Implementation,
4. Sustainability and
5. Maintenance.

Each phase of the program requires the grantee to demonstrate increasingly comprehensive activities with associated short-term outcomes before advancing to the next phase.

Program Progress Phases

Funding is available at one of five program phases. Applicants must include tobacco programming to be eligible for obesity programming funding. All applications must include tobacco control activities, while obesity control activities are optional. Tobacco prevention funding is contingent upon appropriations by the Kansas State legislature. Physical activity and nutrition activity funding is contingent upon availability of funds.

Grantees are expected to advance sequentially and consistently through the progress phases, completing the requirements of each phase before advancing to the next. If necessary, a grantee may have a lapse in funding for one year. After the lapsed year, the grantee may re-apply at the highest phase attained or may choose to re-apply at a previous phase. A grantee may not advance phases during a lapse period. The program phases and estimated maximum lengths are outlined below. If not in the planning phase, a grantee may petition to remain in a phase longer than the maximum when circumstances provide a compelling rationale. In such cases, a separate petition document will be required in addition to the grantee's application. Planning grants are awarded for one year, after which the applicant must advance to capacity building or not be funded.

Planning (1 year maximum): Grant funds support completion of an approved community assessment tool, establishment of a functional tobacco prevention coalition, preparation for future participation in the Youth Tobacco Survey (YTS) and attendance at three state trainings. At least 0.25 full-time equivalent (FTE) (a minimum of 10 hours per week) must be dedicated to grant implementation.

Planning Phase Deliverables:

- Community chronic disease prevention plan based on community assessment results (i.e., CHANGE Tool Community Action Plan)
- Functional tobacco prevention coalition
- Attend the Annual CDRR Summit (counts as one of three required trainings)

Note: Activities proposed in the application are not considered when determining funding for Planning phase applicants.

Timeline and Staffing:

- Maximum of one year
- 0.25 FTE minimum
- 25 percent local match

See inset "Required of All Grantees."

Required of All Grantees:

Activities

1. Support state surveillance if requested.
2. Integrate Kansas Tobacco Quitline promotion into related tobacco control work.
3. Attend three approved trainings.
4. Host two Outreach Coordinator site visits during first and third quarters of grant year.
5. Complete semiannual educational letters to community leaders, decision-makers, or legislators (must be reviewed by KDHE Communications Coordinator). Planning grantees need only submit one letter after mid-year report.
6. Have staff or a coalition member attend TUPP technical assistance webinars.
7. Complete CHANGE Tool if most recent community assessment is five years old or older.
8. Complete CDRR Coalition Assessment every two years. See coalition assessment appendix.
9. Submit regular earned media reporting via online survey (http://www.surveymonkey.com/s/CDRREarnedMedia).
10. Complete mid and final year reports that follow evaluation guidance.
11. Complete one success story per approved program area per year: one for tobacco, one for PAN. See Success Story form. Does not apply to Planning phase.

Communication with TUPP

1. Inform Outreach Coordinator of ongoing grant activities including but not limited to media campaigns, youth events, coalition meetings, etc.
2. Submit all communications items (including legislative letters and other media) to KDHE Communications Coordinator for review at least two weeks prior to date needed.
3. Provide agenda to Outreach Coordinator two weeks prior to each coalition meeting.
4. Provide minutes to Outreach Coordinator after coalition meetings.
5. Provide quarterly fiscal reports to Outreach Coordinator.
6. Submit surveys to TUPP epidemiologist for review in advance of survey administration.

Capacity Building (3 years maximum): Grant funds support maintenance of a functioning coalition that meets at least quarterly, a concentrated focus of activities and outcomes on two tobacco prevention and control program goals integrated with disparate population activities, participation in the state level YTS if selected, and attendance at three state trainings. At least 0.25 FTE (a minimum of 10 hours per week) must be dedicated to grant implementation.

Capacity Building Phase Deliverables:

- Two approved tobacco control activities in different goal areas
- Functional tobacco prevention coalition that meets at least quarterly, but ideally monthly or bimonthly
- Optional: Physical activity and nutrition activities. The number of proposed PAN activities must be less than the number of proposed tobacco prevention activities. See appendix "Goal and Purpose of CDRR-PAN RFP activities."

Timeline and Staffing:

- Maximum of three years
- 0.25 FTE minimum
- 25 percent local match

See inset "Required of All Grantees."

Implementation (5 years maximum): Grant funds support tobacco control funding in all three tobacco control goal areas, quarterly coalition meetings, participation in the county and state level YTS if selected, and attendance at three state trainings. At least .5 FTE (a minimum of 20 hours per week) must be dedicated to grant implementation.

Implementation Phase Deliverables:

- At least three approved tobacco control activities, one in each goal area
- Functional tobacco prevention coalition that meets at least quarterly, but ideally monthly or bimonthly
- Optional: Physical activity and nutrition activities. The number of proposed PAN activities must be less than the number of proposed tobacco prevention activities. See appendix "Goal and Purpose of CDRR-PAN RFP activities."

Timeline and Staffing:

- Maximum of five years
- 0.5 FTE minimum
- 25 percent local match

See inset "Required of All Grantees."

Sustainability (5 years maximum): Grant funds provide for a functioning coalition, program activities and outcomes work in all three tobacco prevention and control program goals, participation in the county and state level YTS if selected, attendance at three state trainings, and funding replacement activities. Grantee is responsible for seeking external funding to enhance CDRR funds for sustaining and growing the local program with a 5 year goal of generating a match equivalent of two-thirds of the Sustainability Year 1 CDRR budget. To achieve this goal, grantees should aim to increase the match by 27 percent each year. Technical assistance will be provided to grantees to support their external funding applications. At least .5 (a minimum of 20 hours per week) FTE must be dedicated to grant implementation.

Sustainability Phase Deliverables:

- At least three approved tobacco control activities, one in each goal area
- At least one new external grant application
- Functional tobacco prevention coalition that meets at least quarterly, but ideally monthly or bimonthly
- Optional: Physical activity and nutrition activities. The number of proposed PAN activities must be less than the number of proposed tobacco prevention activities. See appendix "Goal and Purpose of CDRR-PAN RFP activities."

Timeline and Staffing:

- Maximum of five years

- 0.5 FTE minimum
- Meet increasing match requirements (see Match section below)

Progress Phases	Percentage of Total Match (minimum)	Percentage Total Match to be Cash (minimum)	Percentage of Total Program Cost that is Cash Match (minimum)
Planning	25%	0	0
Capacity Building	25%	0	0
Implementation	25%	0	0
Sustainability (Year 1)	25%	0	0
Sustainability (Year 2)	32%	22%	7%
Sustainability (Year 3)	40%	38%	15%
Sustainability (Year 4)	51%	51%	25%
Sustainability (Year 5)	65%	62%	40%

See inset "Required of All Grantees."

Maintenance (on-going): For grantees that have achieved sustainability, grant funds may be requested to provide for county and state-level data collection as requested, conference attendance and program marketing. At least .5 (a minimum of 20 hours per week) FTE must be dedicated to grant implementation. Maintenance grantees must be willing to serve as a mentor to other CDRR grantees as needed. When needed, mentors will be assigned to assist another grantee in the same CDRR region at the discretion of the regional Outreach Coordinator. Mentors will not be assigned more than two grantees to coach in any one year.

Maintenance Phase Deliverables:

- At least three approved tobacco control activities, one in each goal area
- Serve as a mentor when requested in identified areas of expertise
- Functional tobacco prevention coalition that meets at least quarterly, but ideally monthly or bimonthly
- Optional: Physical activity and nutrition activities. The number of proposed PAN activities must be less than the number of proposed tobacco prevention activities. See appendix "Goal and Purpose of CDRR-PAN RFP activities."

Timeline, Staffing and Match:

- Indefinite
- 65 percent match minimum
- 0.5 FTE minimum

See inset "Required of All Grantees."

Grant funds may NOT be used to:

1. provide meals,
2. provide direct services, individual or group cessation services,
3. provide direct patient care,
4. provide personal health services medications (NRT therapy),
5. provide patient rehabilitation,
6. supplant existing funding from Federal, State, or private sources,
7. directly enforce policies,
8. pay for an internship,
9. provide incentives and promotional items,
10. provide staff time for direct classroom instruction of students of any age,
11. lobby government entities, or
12. defray other costs associated with the treatment of diseases.

Eligibility

Eligible applicants are local health departments that are expected to serve as the project lead on behalf of the community. A local health department may designate a partner organization to serve as the lead agency. If a partner organization is to serve as the lead agency, the application must include a letter from the local health department stating that it has designated another agency to be the applicant. A consortium of counties may apply together under one application.

Match

All applicants applying for Planning, Capacity Building and Implementation grants must provide a minimum of 25 percent match for every dollar awarded. The 25 percent match may be in cash, in-kind or a combination of both from county and/or public and private sources. Sources of in-kind match may include: school programs, Safe and Drug Free Schools funds, Kansas Healthy Schools, Safe Routes to School, Sunflower Foundation Trails grant, Kansas Department of Transportation Enhancement grant and others as determined by the program director. Local funds that support existing evidence-based cessation program services and local funds provided for enforcement activities may also serve as local match. To lead a program towards sustainability, the match should increase each year. Please see the following diagram as an example of incremental increases in match goals:

Match Requirements

Progress Phases	Percentage of Total Match (minimum)	Percentage Total Match to be Cash (minimum)	Percentage of Total Program Cost that is Cash Match (minimum)
Planning	25%	0	0
Capacity Building	25%	0	0
Implementation	25%	0	0
Sustainability (Year 1)	25%	0	0
Sustainability (Year 2)	32%	22%	7%
Sustainability (Year 3)	40%	38%	15%
Sustainability (Year 4)	51%	51%	25%
Sustainability (Year 5)	65%	62%	40%

Sustainability Example

Progress Phase	CDRR Grant Funds	Match Amount	Cash Match Amount (minimum)*	Total Program Cost
Sustainability (Year 1)	$37,500	$12,500	$0	$50,000
Sustainability (Year 2)	$34,000	$16,000	$3,520	$50,000
Sustainability (Year 3)	$30,000	$20,000	$7,600	$50,000
Sustainability (Year 4)	$25,500	$24,500	$12,494	$50,000
Sustainability (Year 5)	$17,500	$32,500	$20,150	$50,000
Maintenance	$17,500	$32,500	$20,150	$50,000

*NOTE: Only a percentage of total match funds are cash amount (see table above). The remaining percentage of total match funds can be in-kind donations as listed previously.

Grant Timeline

March 2014	April	May	June	July	August
March 14, CDRR Grant application due		Award notices sent		July 1, Grant year begins, 25% of award funds distributed	
September	**October**	**November**	**December**	**January 2015**	**February**
September 1, revisions due Site Visit #1	October 1, 25% of award funds distributed			January 1, 12.5% of award funds distributed January 15, mid-year report and affidavit of expenditures due	February 15, 12.5% of award funds distributed
March	**April**	**May**	**June**	**July**	
	April 1, final 25% of award funds distributed Site Visit #2		June 30, Grant year ends	July 15, end of year report and final affidavit of expenditures due	

Application and Reporting

All applicants must complete mid-year and final reports. A "CDRR Activity Evaluation" form for each activity should be attached to the mid and final year reports. Forms for this purpose are provided by KDHE and include the "CDRR Grant Reporting Form" and the "Affidavit of Expenditure." These forms are located in the Reporting Guidelines or online at http://www.kdheks.gov/doc_lib/index.html and should be used for reporting program progress. Additionally, the grantee will be required to participate in two formal site visits during the first and third quarters of the fiscal year. Revisions to the first grant application, if required, are due before receipt of the second disbursement of grant funds.

The Final Report and Affidavit of Expenditure for the period of July 1, 2014 – June 30, 2015 will be due no later than July 15, 2015. When submitting Final Reporting information, send a copy of the final affidavit of expenditures to Kshaughnessy@kdheks.gov. Also send a copy of the affidavit as well as the final report to your Outreach Coordinator.

KDHE's Responsibility to Grant Recipient

1. Presence at coalition meetings and other events if requested.
2. Provide assistance during the grant writing process.
3. Provide technical assistance for evaluation and media.
4. Schedule first and third quarter site visits to check progress with grant activities.
5. Guidance through processes that require state agency oversight (Internal Review Board (IRB), media approval, etc.).
6. Provide technical assistance with finding alternative funding sources in Sustainability Phase.

Application Format and Instructions

Applications that do not follow the instructed format will be considered non-responsive.
Below are instructions and guidelines for each section of the application. Please direct any questions to your Outreach Coordinator.

Grant Application PDF	**Cover Sheet** The cover sheet requires information about the organization submitting the proposal including contact information for the legal applicant, project contact and fiscal contact. **Executive Summary** The Executive Summary should include the essential elements of the proposal and give the reviewers a brief, yet complete overview of the project. Briefly describe the following key concepts contained in the main body of the proposal: the need for and rationale behind the program, goals, major program activities, and organizational capacity. *Grant Writing Tip: The Executive Summary should be written last after working through the program activities and evaluation forms and budget forms.* **Community Profile Form** The Community Profile Form requires the applicant to describe the community to be served. This description must include population demographic information, identified disparate population(s) and summarize the most recent CHANGE Tool Community Action Plan (not applicable to Planning Grantees). In the absence of a CHANGE Tool Community Action Plan, applicants may attach the results of a previously approved community assessment and write a detailed narrative describing community needs and strengths as well as anticipated barriers to proposed activities. All grantees are expected to complete the CHANGE Tool. Applicants operating under a community assessment plan that is less than five years old may delay implementation of the CHANGE tool until after the five year anniversary of their last assessment. **Sustainability and Maintenance** Sustainability and Maintenance phase applicants have additional expectations. See the Program Progress Phases.

Coalition Membership PDF	**Program Coalition Membership Form** A functional coalition is a requisite for successful community-based chronic disease prevention. Please complete the Program Coalition Membership Form and have each participant sign to indicate their support for the grant application. Sectors of community support are provided as a guideline to composition of an optimal community coalition for chronic disease risk reduction. Applicants are encouraged, but are not required to have an organization represented in every sector. Applicants should include all sectors with direct relevance to selected goals and outcomes. Each sector may have multiple participants. A minimum of five active sectors are required for the coalition to be considered functional.
Planning Phase PDF	**Planning Phase Requirements** Planning Phase Applicants must provide evidence of community readiness for chronic disease risk reduction by completing the following forms: A. Connection Map B. Identifying Linkages Between Community Priorities and Tobacco Control C. Types and Levels of Partnerships If funding allows, consideration may be given to extending the planning phase for applicants who encounter mitigating difficulties, but demonstrate sufficient progress toward activity completion.
Activity Evaluation PDF	**Program Activities and Evaluation** At least two or more community-based activities addressing at least two different tobacco control goal areas are expected of Capacity Building phase applicants and beyond. Use the Activity Evaluation form once for each proposed activity. For each proposed activity, applicants will describe the activity and build an evaluation plan. The CDRR Activity Evaluation form should be reproduced as necessary for all proposed activities. Instructions for completing each section of the form are in the CDRR evaluation appendix along with examples of how the Activity Evaluation form has been used in the past. *Grant Writing Tip: Use your CHANGE Tool Community Action Plan (or other community assessment) to justify your activities. State how these activities will meet local needs.* *Grant Writing Tip: Process indicators should come from your Action Steps. Impact indicators should be related to your objective. See examples.*
Detailed Budget PDF	**Detailed Budget** The detailed budget is an itemized list of expenses that support the proposed program. Instructions for completing the detailed budget are included on the form.

CDRR Budget PDF	

Staffing Plan and Budget Justification

These directions are specific to CDRR. For general aid-to-local budget information see the Budget section below.

A. Staffing Plan Form
   a. List the Position Name for each proposed staff member, the staff member's name and credentials, and provide a brief explanation of the scope of duties for this position related to the program. The staffing plan should reflect the organizational capacity to complete the program activities and evaluation through an appropriate amount of FTE. Minimum FTE requirements as specified for each program phase must be dedicated to the program.
   b. Grant funds for staffing are to be used for grant coordination and activity implementation through local health educators/outreach workers.
   c. No more than 10 percent of administrators' salaries may be funded by CDRR.

B. Salary Worksheet
   a. Complete an Employee Salary Calculation for each staff person to be paid by grant funds.
   b. Supplanting existing resources for staff salaries is prohibited. In the case that existing staff is to be paid from grant funds, the applicant must demonstrate avoidance of supplanting existing funds in the Budget Justification.

C. Budget Justification Form
   a. Provide line item budget with justification consistent with selected goals and outcomes, planned activities and time frame of the project ending June 30, 2015.

Budget

Budget forms and instructions may be downloaded from http://www.kdheks.gov/doc_lib/index.html.
Funds may be used for salary, travel, registration fees, supplies, advertising (requires prior approval from TUPP Communication Coordinator to ensure statewide coordination), consultation, facility rental, equipment rental, speakers/presenters, educational materials and other reasonable costs associated with the program's activities.

Funds may not be used to replace existing agency funding sources, provide inpatient services, purchase capital equipment or purchase food. Communities are encouraged to get partner contributions for food, which may be used as matching funds. The Kansas Department of Health and Environment funds cannot be used to supplant existing funding. Applicants may not use these funds to supplant funds from Federal, State or private sources.

Matching funds may be cash, in-kind or donated services or a combination of these made directly or through donations from private entities. Cash matches are required to increase yearly for programs in the Sustainability Phase. Please consult the regional Outreach Coordinator for assistance in determining the amount of cash match required for a specific program. The applicant must document all costs used to satisfy the matching requirements. Program resources may be used for consultants, staff, survey design and implementation, data analysis, or other expenses associated with surveillance and evaluation efforts to fulfill the match requirement.

Review Procedures

Grant applications will be reviewed by a team of outside consultants and state program staff. Each regional Outreach Coordinator will present the grant applications from his/her region to the team for consideration. Applicants will benefit in the review process by working closely with the regional Outreach Coordinator to refine the application prior to submission to ensure that the Outreach Coordinator can present the application strongly. Outreach Coordinators will not score grants from their assigned region during the review process. When available, the applicant organization's performance and compliance as a CDRR grantee during the past two fiscal years is considered and discussed when scoring and ranking grant applications.

Applications will be initially reviewed by state program staff for completeness and responsiveness. Incomplete applications and applications that are non-responsive will not advance through the review process. Applicants will be notified if the application did not meet submission requirements.

Although not an exhaustive list, reviewers look for the following qualities in "good" applications:

- Does the community profile demonstrate the chronic disease-related strengths, weaknesses and barriers faced by the community?
- Does the applicant demonstrate they have a functioning, diverse community coalition or the capacity to develop a strong coalition capable of carrying out chronic disease risk reduction interventions?
- Are the proposed activities aligned with evidenced-based strategies as described in the RFP?
- Do the proposed activities effectively integrate any paid or earned media into policy, systems and environmental activities, thus avoiding stand-alone media campaigns?
- Are the proposed activities logically organized and likely to result in a positive impact on demonstrated community needs?
- Are the objectives and indicators proposed by the grantee feasible, measurable and demonstrative of activity progress and success?
- Are the staffing and budget sections sensible and justified by the proposed activities?
- Is the application complete, of high overall quality and clearly and persuasively written?

To answer these questions, reviewers award points for different parts of the application. Applications are reviewed by at least three review team members who can allot a maximum number of points as follows:

MAXIMUM POINT DISTRIBUTION FOR PLANNING APPLICANTS

Community Profile: includes community demographics and community assessment status and planning.	28%
CDRR Community Readiness: includes the Connections Map, Community Linkages and Types and Levels of Partnerships.	44%
Staffing: clearly defined staff roles and how they are related to completing planning phase activities.	16%
Budget: staff time and other expenses should be justified by grant activities and described in sufficient detail.	12%

MAXIMUM POINT DISTRIBUTION FOR NON-PLANNING APPLICANTS

Community Profile: includes community demographics, community assessment results and status, and coalition membership.	26%
Program Description: includes proposed activity evaluation plans.	60%
Staffing: clearly defined staff roles and how they are related to completing required and proposed activities.	7%
Budget and Budget Justification: staff time and other expenses should be justified by grant activities and described in sufficient detail.	7%

Funding preference will be given to those applications in Capacity Building, Implementation, Sustainability and Maintenance with highest scores. Planning Grants will be scored separately to eliminate competition barriers for new applicants.

Anticipated Award Announcement Date - Awards will be announced approximately June 1, 2014.

Award Administration Information - Successful applicants will receive a Letter of Award and Grant Contract from the Kansas Department of Health and Environment. The first disbursement of grant funds may be expected on or before July 31, 2014. Any requested revisions to program activities, evaluation and/or budgets must be completed before the second disbursement of grant funds. Grant activities will be expected to start on July 1, 2014, and continue through June 30, 2015.

Unsuccessful applicants will receive notification of the result of the application review by mail.

Mid and Final Year Reporting Requirements

All applicants must complete mid-year and final reports. Forms for this purpose are provided by KDHE and include the "CDRR Activity Evaluation" form, the "Grant Reporting Form" and the "Affidavit of Expenditure." The Activity Evaluation should be partially completed as part of the CDRR application. For each approved CDRR activity, the Activity Evaluation form should be updated and turned in along with the Grant Reporting form and Affidavit of expenditure at mid and end of year.

These forms are located in the Reporting Guidelines or online at www.kdheks.gov/doc_lib/index.html and should be used for reporting program progress. Reporting forms may change during the grant period, in which case grantees will be notified. Additionally, the grantee will be required to participate in two formal site visits taking place in the first and third quarters of the fiscal year. Revisions to the first grant application, if required, are due before receipt of the second disbursement of grant funds.

The Mid-year report and Affidavit of Expenditures for the period of July 1 through December 31, 2014, will be due no later than January 15, 2015.

The Final Report and Affidavit of Expenditure for the period of July 1, 2014 – June 30, 2015 will be due no later than July 15, 2015. When submitting your Final Report, send one copy to your Outreach Coordinator and a second copy to:

Kevin Shaughnessy
Kansas Department of Health and Environment
Purchasing and Grants Management Office
1000 SW Jackson, Suite 570
Topeka, KS 66612-1368
785-296-1507
kshaughnessy@kdheks.gov

Summary of Required Forms

Application
CDRR Detailed Budget
CDRR Budget
CDRR Application
CDRR Activity Evaluation Plan (one for each activity)
Coalition Members
Planning Phase

Mid and Final Year Reporting
Affidavit of Expenditure
CDRR Grant Report
CDRR Activity Evaluation Plan (one for each activity)

Appendices

Physical Activity and Nutrition Activities Scope and Guidance

Evaluation Guidance

Evaluation Examples

- CDRR Activity Evaluation Examples: Exemplary Evaluation Plans
- CHANGE Tool Evaluation Plan Format

Reference Documents

- CDRR Short-Term Outcome Codes

CDRR Coalition Self Assessment Instructions and Tool

Goal and Purpose of CDRR-PAN RFP Activities

The Physical Activity and Nutrition (PAN) program strives to help create and support environments that make it easier for all Kansas residents to make healthy food choices, be physically active, and achieve and maintain a healthy weight. The PAN program emphasizes systems and environmental changes to support individuals in adopting and sustaining healthy lifestyles.

In addition to supporting the PAN mission, this funding opportunity seeks to address the following:

- Build capacity within communities to address obesity and chronic disease
- Increase skills within communities to plan, implement and evaluate evidence-based interventions using a social marketing planning approach and the Social Ecological Model, with a focus on systems and environmental changes
- Address one of the strategy areas (below)
- Address one or more of CDC's six target behaviors for obesity prevention (as they relate to the strategy area(s) selected from the list below)
    - Increase physical activity
    - Increase consumption of fruits and vegetables
    - Decrease the consumption of sweetened beverages
    - Increase breastfeeding initiation, duration and exclusivity
    - Reduce the consumption of high energy dense foods
    - Decrease screen time
- Address health disparities and health inequities
- Build sustainability for local and state program to address obesity
- Leverage other funding and resources

The PAN program recognizes that communities and coalitions are at various levels of readiness to address obesity. Based on your coalition's current capacity, some of the strategies below may already have been completed, may take more than one grant year or may not be applicable.

Example PAN strategy areas for local coalitions:

- **Active Community Environments** (promoting and supporting physical activity through changes to the built environment)—examples include:
    - Improving safety for bicyclists and pedestrians
    - Promoting active transportation and transit use
    - Safe Routes to School
    - Bike/walk trails and connectivity
    - Joint use agreements
    - Increasing access to recreation facilities and open spaces including parks and community gardens

- **Breastfeeding Support**—examples include:
    - Encouraging breastfeeding support in the workplace with private rooms and flexible scheduling for breast milk pumping and storage
    - Facility policy and environmental changes for breastfeeding-friendly childcare facilities
    - Maternity care practices that support breastfeeding exclusively and duration

- **Food environments**—examples include:
    - Farm to school or institution
    - Competitive pricing strategies of healthy food
    - Farmers' market/farm stands

- Use of electronic benefit transfer machines
- Community gardening
- Point-of-decision labeling for healthy eating
- Encouraging convenience stores to offer more fruit and vegetables
- Increasing access to community supported agriculture

- **School Wellness**—examples include:
  - Active school strategies (active classrooms, active recess, joint use agreements, Safe Routes to School)
  - Staff wellness
  - Improve access and pricing of healthier foods
  - Farm to school

- **Worksite Wellness**—examples include:
  - Comprehensive wellness programs
  - Comprehensive prevention benefits
  - Promoting physical activity by providing breaks
  - Providing access to facilities that promote physical activity
  - Promoting alternative transportation
  - Providing healthy food options in vending, cafeterias and meetings
  - Point-of-decision signs for healthy eating and physical activity

- **Other**: If your coalition wishes to implement strategies in an area other than those listed, provide evidence of need and a well-developed plan to implement strategies.

Important Notes*

PAN activities cannot equal or exceed the total number of tobacco activities, i.e. if your application has a total of three proposed tobacco activities, proposed PAN activities must be less than three.

Web Resources:

--Safe Routes to School
http://www.saferoutesinfo.org/
http://www.ksdot.org/burTrafficEng/sztoolbox/default.asp
http://www.safekidskansas.org/downloads/WalkingSchoolBusGuide.pdf

--Complete Streets
http://www.smartgrowthamerica.org/complete-streets
http://www.opkansas.org/Resident-Resources/Traffic-Calming-Program
www.completestreets/webdocs/cs-brochure-policy.pdf
www.completestreets.org/changing-policy-elements/
www.walkscore.com
http://www.walkableamerica.org/checklist-walkability.pdf
http://www.med.upenn.edu/beat/onlinetraining.shtml

--Community Garden/School Garden
http://www.letsmove.gov/community-garden-checklist
http://www.healthiergeneration.org/uploadedFiles/For_Schools/1_SnacksMeals/GardenTK.pdf

--Farmers' Markets
http://www.extension.purdue.edu/extmedia/EC/EC-739.pdf
http://kansasruralcenter.org/

http://www.capitalcitywellness.org/download/Wellness_Toolkit_Booklet.pdf
http://extension.oregonstate.edu/catalog/pdf/sr/sr1088-e.pdf

--School Wellness
http://www.jointuse.org/
http://activeclassroom.volusia.k12.fl.us/
http://www.aahperd.org/letsmoveinschool/
http://www.letsmove.gov/
http://www.choosemyplate.gov/
http://www.farmtoschool.org/
http://www.fns.usda.gov/cnd/F2S/Default.htm.
http://www.schoolempwell.org/
http://www.cdc.gov/healthyyouth/policy/

--Breastfeeding
http://www2.aap.org/breastfeeding/healthProfessionaIsResourceGuide.html
http://www.kansaswic.org/breastfeeding/
http://www.kansaswic.org/breastfeeding/worksite_support_for_breastfeeding.html
www.cdc.gov/breastfeeding/index.htm

--Worksite Wellness
http://www.cdc.gov/sustainability/worksitewellness/
http://wichita.kumc.edu/kansas-worksite-wellness.html

--Food Environments
http://www.naccho.org/advocacy/positions/upload/09-11-Menu-Labeling-Trans-Fat-Salt.pdf
http://www.centertrt.org/content/docs/Intervention_Documents/Intervention_Templates/KP_Menu_Labeling_Template.pdf
http://www.bphc.org/programs/cib/chronicdisease/healthybeverages/Forms%20%20Documents/toolkit/HealthyBeverageToolkitFinal.pdf
http://www.banpac.org/healthy_vending_machine_toolkit.htm
http://www.fitpick.org/
http://www.nems-v.com/
http://www.med.upenn.edu/nems/

--Parks
http://www.arlingtonva.us/Departments/ParksRecreation/scripts/programs/SmokeFreeParkInitiative.aspx
http://tobaccoeval.ucdavis.edu/documents/2.2.16solano.pdf
http://www.krpa.org/
http://kaboom.org/take_action/play_day

CDRR Evaluation Guidance

CDRR evaluation plans are expected to be demonstrably effective, clear, plausible, concise, backed by community support and aligned with state CDRR programmatic guidance and evidence-based practice. This guidance and the evaluation plan examples are provided to aid the applicant in meeting these criteria.

Evaluation is often conceptually separated between process and impact, or outcome and evaluation. Depending on what your activity involves, you may not be able to fill in the impact portion of an activity, but you can always provide process evaluation information.

1) Process Evaluation: assesses the activity process – tangible outputs within your sphere of control.
   a) **Number** of things you did or produced.
2) Impact Evaluation: assesses the changes that can be attributed to a particular intervention. Measured by comparing your achievement against stated objectives.
   a) **Proportion** of your target population or target group you influenced.

Fields

1) Activity Number
   a) The number you assign this activity. If you have three activities you can number them 1, 2 and 3. This is to ensure we can differentiate similar activities.
2) Agency Name: the name of the organization to which the CDRR grant was awarded.
3) SMART Objective
   a) The activity objective is the primary, measurable purpose of the activity. In addition to the criteria below, the measure included in the objective (e.g. - "proportion of County X family practices using a Quitline fax-referral system") should be explicitly measured and included as an impact indicator. An activity can have many indicators, but it should have only one objective.

      SMART Objectives are….
      Specific **M**easurable **A**ttainable **R**elevant/**R**ealistic **T**ime-bound

      To construct a SMART Objective you will need:

      1. A target group and population (An objectively defined target. By geography? Age? Sex?)
      2. A direction of change (increase or decrease)
      3. A magnitude of change (pre measure and the expected post measure)
      4. A unit of measurement (proportion, count, other?)
      5. A time-bound (end of grant period)
      6. What we are measuring (what are you trying to change?)

      By June 30th, 2011,[5] increase[2] the proportion of[4] County X family practices[1] using a Quitline fax-referral system[6] from 0% to 25%[3].

4) Activity Name: a meaningful name you give an activity.
5) Short Term Outcome Number
   a) Reference the appendix "Short Term Outcomes." Select ***one*** short term outcome for each activity and put the corresponding number (i.e. "1.6") on the evaluation plan. The short term outcome you select is the ultimate goal of your activity – your objective and impact indicators should be closely related to the short term outcome.
6) MAPPS Strategy
   a) Select the appropriate MAPPS strategy from the drop-down menu for your activity. Reference the appendix "MAPPS Interventions for Communities Putting Prevention to Work" for examples of activities and their corresponding MAPPS strategy.
7) CHANGE Sector: select the appropriate CHANGE Sector from the drop-down menu for your activity. Reference the CHANGE Tool for further guidance.

8) Target Population
   a) The end user. Your target population is the people you hope to influence and in whom you will see outcomes.
9) Target Organizations
   a) Intermediaries through which you impact your target population. With a policy/system/environment intervention, this is what typically appears in your objective. Examples:

      A specific group of schools

      A specific group of health clinics/health care providers

      A specific group of downtown businesses
10) Action Steps
   a) Action Steps are the concrete steps you must take to complete your activity. Most of your Action Steps should be easily converted to Process Indicators.

      1. Develop Principal Questionnaire.

      2. Contact USD 123 Principals.

      3. Distribute Principal Questionnaire.

      4. Follow up with USD 123 Principals.

      5. Collect questionnaires and assess school needs.

      6. Use results to promote policy changes at schools without comprehensive tobacco policies.

      7. Provide technical assistance to schools interested in changing tobacco policies.
11) Activity Narrative
   a) The Activity Narrative is your opportunity to concisely describe, in plain language, what you plan to do and why. Reference your community assessment to describe the setting and justify your activity.
12) Process Indicators
   a) Measure the progress of your activity. Should be easily categorized into pre-intervention, intervention and post-intervention categories.
      i) Have no time bound
      ii) Have no direction
      iii) Have no magnitude of change
      iv) Can be measured at multiple points in time

      For the above Action Steps, the corresponding Process Indicators might be…

      1. Questionnaire developed.

      2. Number of USD 123 Principals contacted.

      3. Number of questionnaires distributed to USD 123 Principals.

      4. Number of unresponsive USD 123 Principals reminded to return survey.

      5. Number of questionnaires collected and assessed.

      6. Number of schools provided questionnaire results.

      7. Number of schools provided technical assistance to change tobacco policies.

13) Data Sources
   a) Each indicator measurement must come from somewhere.
14) Data Collection
   a) How will you collect the indicator measurement?
15) Timeframe
   a) Is it an ongoing data collection or is there a pre and post measurement? When will the pre measurement be completed and when will the post measurement be completed? For Process Indicators, look at the corresponding Action Steps and estimate when those will be completed.
16) Communication Plan
   a) Other than your mid and final year report to KDHE, how else will you distribute/use this evaluation information?
17) Staff Assigned

a) Who is ultimately responsible or completing the work? These can be coalition members, community partners, staff, etc.

18) Impact Indicators
    a) Measure the impact of your activity. Should be related to (or actually *are*) your objective and short term outcome. See example activity evaluation plans.
        i) Have no time bound
        ii) Have no direction
        iii) Have no magnitude of change
        iv) Can be measured at multiple points in time

CDRR Activity Evaluation Examples

CDRR Activity Evaluation

State Fiscal Year: 2013

Submit Form

This Activity Report is for: Grant Application

Activity Number: 2 Short Term Outcome Number: KOI 1.7 Strategy: Access CHANGE Sector: School

Agency Name: Johnson County Department of Health and Environment

Counties: Johnson

Activity Name: Private High Schools Comprehensive Tobacco-Free Grounds Policies

SMART Objective: By June 30th, 2013 increase the proportion of private high schools in Johnson County reporting the implementation of 100% tobacco-free policies from 2 of 9 to 3 of 9.

Target Population: Students (approximately 3000+), faculty, staff and visitors of Johnson County private high schools

Target Group: Johnson County private high schools (N=9) and policy makers (approximately 85 trustees, directors, principals, etc.)

Activity Narrative: Usage bans are a proven MAPPS strategy. Currently most private school report that tobacco use is not allowed on school property, but have no formal written policy. By sharing information among institutions about the number and types of written tobacco-free grounds policies that are in place it is hoped that schools will move toward more comprehensive and more formal written policies. Over time this strategy should help to further reduce the smoking rates of youth and school personnel at these institutions.

Action Steps:

1. Contact Johnson County private high schools
2. Update policy information in Private School Tobacco-free Policies Spreadsheet
3. Determine schools with no or insufficient tobacco-free policies
4. Identify a champion on the school boards with the help of coalition members.
5. Use champion to help identify and recruit 5 - 10 school patrons and youth groups to assist with educating key policy makers.
6. Provide technical assistance to schools moving forward with policy creation

	Process Indicators	Data Sources	Data Collection	Timeframe	Staff Assigned	Measure
	What type of measure you need?	Where you will get the data on selected indicator?	How will you get the data?	When will you collect data?	Who will ensure this gets done?	Indicator Measure
Add Line	Number of private high schools contacted	Private School Tobacco Free Policies Spreadsheet	Calls, e-mails and meetings schools to obtain current tobacco policy	September 2012	CDRR staff/Erin, coalition members and JCHD interns	*
Add Line	Number of policies from private high schools reviewed	Private School Tobacco Free Policies Spreadsheet	Review and abstraction of current private high schools tobacco free grounds policies	September 2012	CDRR staff/Erin, coalition members and JCHD interns	*

Add Line	Number of schools with no policy in place assessed	Private School Tobacco Free Policies Spreadsheet	Review and abstraction of current private high schools tobacco free grounds policies	September 2012	CDRR staff/Erin, coalition members and JCHD interns	*
Add Line	Number of schools requiring additional policies assessed	Private School Tobacco Free Policies Spreadsheet	Review and abstraction of current private high schools tobacco free grounds policies	September 2012 - June 2013	CDRR staff/Erin, coalition members and JCHD interns	*
Add Line	Number of policies drafted/finalized for schools with no or insufficient policies	Private School Tobacco Free Policies Spreadsheet	Review and abstraction of current private high schools tobacco free grounds policies	September 2012 - June 2013	CDRR staff/Erin, coalition members and JCHD interns	*
Add Line	Number of identified youth groups to assist with educating policy makers	Private School Tobacco Free Policies Spreadsheet	coalition members with help of identified champion will contact youth group	September 2012-June 2013	CDRR staff/ coalition members and JCHD interns	*
Add Line	Number of school patrons recruited to help assist with educating policy makers	Private School Tobacco Free Policies Spreadsheet	coalition members with help of identified champion will school patrons to help	September 2012 - June 2013	CDRR staff/ coalition members and JCHD interns	*

	Impact Indicators	Data Sources	Data Collection	Timeframe	Staff Assigned	Pre Measure	Post Measure
Add Line	Proportion of private high schools implementing 100% tobacco-free policies	Excel Spreadsheet/log of Private Schools	Calls, e-mails and meetings with school policy makers	July 2012 - June 2013	CDRR staff/Erin	2/9	pending
Add Line	Proportion of private high schools that have improved current tobacco-free policies	Excel Spreadsheet/log of Private Schools	Calls, e-mails and meetings with school policy makers	July 2012 - June 2013	CDRR staff/Erin	1/8	pending
Add Line	Proportion of private high school policy makers who express support for 100% tobacco-free school grounds policies verbally or by administrative action	Excel Spreadsheet/log of Private Schools	Calls, e-mails and meetings with school policy makers, meeting minutes	July 2012 - June 2013	CDRR staff/Erin	0/85	pending

	Progress Entry Date	Progress Entry
Add Progress		

CDRR Activity Evaluation

State Fiscal Year: 2013

Submit Form

This Activity Report is for: Grant Application

Activity Number: 01 Short Term Outcome Number: KOI 3.7 Strategy: Social Support/Services CHANGE Sector: Work Site

Agency Name:	Lawrence-Douglas County Health Department
Counties:	Douglas County
Activity Name:	Quitline Promotion by WorkWell Lawrence
SMART Objective:	By June 2013, increase the number of SFY Quitline callers from Douglas County users who heard about the Quitline through an employer from 2 calls to100 calls.
Target Population:	Workers that smoke and are employed by organizations represented on the WorkWell Lawrence Leadership Team (N=1642) [11,986 workers x 13.7% smoking rate]
Target Group:	Douglas County employers who participate in the WorkWell Lawrence Leadership Team (N=21)

Activity Narrative:

The smoking rate in Douglas County is 13.7%. The quitline utilization dashboard reports indicate that the quitline's unique individual reach in Douglas County is at 0.74% for 2011 (below the target reach of 2.0%).

Quitline utilization could be significantly increased by targeting workers that smoke and are employed by organizations represented on the WorkWell Lawrence Leadership Team. WorkWell Lawrence is an initiative of LiveWell Lawrence managed by K-State Research and Extension-Douglas County. The WorkWell Lawrence Leadership Team is a coalition of 21 Douglas County employers working to improve their employee wellness programs. Four of the largest county employers within Douglas County participated in the CHANGE Tool and are represented on the WorkWell Lawrence Leadership Team. The CHANGE Tool revealed that each of these employers currently implements a tobacco cessation referral system for employees that smoke. However, Douglas County quitline employer-based quitline referrals average less than 1 per month. (According to quitline reports, only 2 referrals have been made by Douglas County employers since July 2011).

According to the 2009 NAQC Issue Paper, "Increasing Reach of Tobacco Cessation Quitlines: A Review of the Literature and Promising Practices," current and anticipated budget cuts for tobacco control programs should be met with less expensive quitline promotion strategies like news media coverage, healthcare provider referral networks and websites, which should also be considered as tools to increase quitlines' reach. Several states have found great success with building referral programs designed to refer smokers to the quitline from natural settings like their health provider's office and community organizations. It follows that employer-based referral programs could also be an effective strategy to increase quitline calls.

To improve the employer referral rate, the Health Department will work with the WorkWell Lawrence Leadership Team, which represents more than 10,000 employees from 21 local employers. A Learning Collaborative (LC) approach, based on public health quality improvement theory, will be used to strengthen the collective capacity of WorkWell Lawrence Leadership Team members to implement policy and system changes to their tobacco cessation referral systems in order to increase calls to the telephone quitline from users who heard about the quitline through an employer. The Health Department will work with the WorkWell Lawrence Coordinator to recruit members for a quitline learning collaborative, provide those members training on the Plan-Do-Study-Act model of quality improvement and provide ongoing consultation during three PDSA cycles. Additionally, online advertising targeting Douglas County residents will be used to further raise awareness of the quitline in the community-at-large to support efforts of Douglas County employers. According to the 2009 NAQC Issue Paper, "Increasing Reach of Tobacco Cessation Quitlines: A Review of the Literature and Promising Practices," online advertising has great potential to reach smokers trying to quit. The Health Department will work with the CDRR Communications Coordinator to plan this complimentary online advertising campaign.

Action Steps:

- Provide quitline information and materials to members of WorkWell Lawrence Leadership Team
- Recruit four employers from the WorkWell Lawrence Leadership Team to participate in a Learning Collaborative (LC) approach, a quality improvement method that uses multiple Plan-Do-Study-Act (PDSA) cycles to spread, adopt and adapt best practices across multiple settings
- Work with the CDRR Communications Coordinator to plan and conduct an online quitline advertising campaign using Douglas County targeted web presences such as WellCommons.com, LJWorld.com, Lawrence.com and KUSports.com (Douglas County web properties managed by The World Company)
- Provide training on the Learning Collaborative (LC) approach to members of the WorkWell Lawrence Quitline Learning Collaborative
- Attend the North American Quitline Consortium (NAQC) 2012 conference on August 13th and 14th in Kansas City, Missouri
- Promote the quitline to Douglas County employers through sponsorship of the September 19, 2012 WorkWell Lawrence Symposium featuring keynote speaker WELCOA President Dr. David Hunnicutt
- Complete an assessment of the proportion of WorkWell Lawrence Leadership Team employers that provide insurance coverage for cessation treatment
- Complete three PDSA cycles, reporting results to WorkWell Lawrence Leadership Team members at monthly meetings
- Track the number of policy and system changes implemented by WorkWell Lawrence Leadership Team employers to improve their tobacco cessation referral systems in order to increase calls to the telephone quitline from users who heard about the quitline through an employer
- Communicate results to CDRR Outreach Coordinator via the Success Stories template as well as publishing results to the WorkWell Lawrence group page on WellCommons.com and the WorkWell Lawrence website as well as the LiveWell Lawrence group page on WellCommons and the LiveWell Lawrence website
- Communicate results to Douglas County employers via presentations to three employer groups, including Douglas County Community Health Improvement Project (CHIP), which has historically supported tobacco use prevention and control initiatives and the Lawrence-based Jayhawk Chapter of Society Of Human Resource Management (SHRM).
- Report monthly to the WorkWell Lawrence Leadership Team on the number of calls to the telephone quitline from users who heard about the quitline through an employer

	Process Indicators	Data Sources	Data Collection	Timeframe	Staff Assigned	Measure
	What type of measure you need?	Where you will get the data on selected indicator?	How will you get the data?	When will you collect data?	Who will ensure this gets done?	Indicator Measure
Add Line	Number of WorkWell Lawrence Leadership Team members introduced to quitline and provided materials	WorkWell Lawrence Leadership Team monthly meeting summary and attendance records	Review of meeting summary and attendance records	Data will be collected from July 2012 through June 2013	WorkWell Lawrence Coordinator	*
Add Line	Number of employers from WorkWell Leadership Team recruited to participate in the WorkWell Lawrence Quitline Learning Collaborative	Completed Learning Collaborative roster	Review of roster	July 2012	WorkWell Lawrence Coordinator	*
Add Line	Number of unique Impressions Served to Quitline media via The World Co.	The World Company campaign reports	Review the The World Company campaign reports	Data will be collected from July 2012 through June 2013	Communications Coordinator	*
Add Line	Number of WorkWell Lawrence Quitline Learning Collaborative members that attend Learning Collaborative training	Training attendance records	WorkWell Lawrence Quitline Learning Collaborative members will sign in on a training attendance form created by the Community Health Planner	August 2012	Assistant Director and Community Health Planner	*

	Impact Indicators	Data Sources	Data Collection	Timeframe	Staff Assigned	Pre Measure	Post Measure
Add Line	Number of staff that attend the North American Quitline Consortium (NAQC) 2012 conference	Conference registration and travel reimbursement documentation	Review of conference registration and travel reimbursement documentation	August 2012	WorkWell Lawrence Coordinator and Community Health Planner	*	
Add Line	Sponsorship of the 2012 WorkWell Lawrence Symposium	Sponsorship registration documentation, symposium materials and photographic documentation of displays at symposium	Review of sponsorship registration documentation, symposium materials (for presence of logo and quitline information) and symposium photographs	September 2012	Community Health Planner	*	
Add Line	Proportion of WorkWell Lawrence Leadership Team employers that provide insurance coverage for cessation treatment	Survey of all WorkWell Lawrence Leadership Team employers as regards to insurance coverage for cessation treatment	Review of survey results to calculate proportion of WorkWell Lawrence employers providing insurance coverage for cessation treatment	August 2012	WorkWell Lawrence Coordinator	*	
Add Line	Number of PDSA cycles and reporting results to WorkWell Lawrence Leadership Team	WorkWell Lawrence Leadership Team monthly meeting summary and attendance records	Review of meeting summary and attendance records	Data will be collected from September 2012 through June 2013	WorkWell Lawrence Coordinator and Community Health Planner	*	
Add Line	Number of published PDSA cycle results	Success Stories sent to CDRR Outreach Coordinator and published on WellCommons, WorkWell Lawrence and LiveWell Lawrence websites	Record of email to CDRR Outreach Coordinator and Review of WellCommons, WorkWell Lawrence and LiveWell Lawrence websites	Data will be collected from September 2012 through June 2013	Communications Coordinator and Community Health Planner	*	
Add Line	Number of policy or systems changes implemented to increase quitline referrals	Policy and system changes implemented will be tracked on an PDSA log	Review of PDSA log	Data will be collected from September 2012 through June 2013	WorkWell Lawrence Coordinator and Community Health Planner	*	
Add Line	Number of completed presentations provided to Douglas County employer groups	Community Health Planner will keep records and progress notes	Community Health Planner will report progress through regular supervision meetings	Data will be collected from September 2012 through June 2013	Community Health Planner	*	
Add Line	Number of reports to WorkWell Lawrence Leadership Team on the number of calls to the telephone quitline from users who heard about the quitline through an employer	WorkWell Lawrence Leadership Team monthly meeting summary and attendance records	Review of meeting summary and attendance records	Data will be collected monthly from July 2012 through June 2013	Community Health Planner	*	

Add Line	Number of calls to the telephone quitline from users who heard about the quitline through an employer	Monthly Kansas Tobacco Quitline Reports	Track the monthly Employer/Worksite metric for Douglas County on the How Heard About by County Report	Data will be collected monthly from July 2012 through June 2013	Community Healthy Planner	2	*
Add Line	Proportion of employers participating in the WorkWell Lawrence Leadership Team that have implemented policy or systems changes to increase quitline referrals	Policy and system changes implemented will be tracked on an PDSA log	Numerator = Denominator = Number of employers represented on the WorkWell Lawrence Leadership Team	Data will be collected from September 2012 through June 2013	WorkWell Lawrence Coordinator and Community Health Planner	0	*

	Progress Entry Date	Progress Entry
Add Progress		* Describe progress on the activity, including barriers and successes.

CDRR Activity Evaluation

State Fiscal Year: 2013

Submit Form

This Activity Report is for: Grant Application

Activity Number: 1 Short Term Outcome Number: KOI 3.9 Strategy: Social Support/Services CHANGE Sector: School

Agency Name: City - Cowley County Health Department

Counties: Cowley

Activity Name: Tobacco Cessation

SMART Objective: By June 30, 2013 increase the percent for Cowley County college student health services with a Kansas Tobacco Quitline/Tobacco Cessation referral system, including paper, digital and fax referrals, from 0% (0 of 2) to 100% (2 of 2).

Target Population: Approximately 4000 Adults and Young Adults on Campus

Target Group: Student Health Services at Cowley and Southwestern Colleges (N=2)

Activity Narrative: Throughout the grant year the City - Cowley County Health Department CDRR Program will advocate policy change and clinical procedure implementation aligned with 5A's programming to local college student health services to 1) identify campus tobacco users; 2) ensure tobacco cessation educational materials are provided, and 3) offer tobacco cession service referrals (paper, electronic & fax) to the Kansas Tobacco Quitline (1-800-Quit-Now). Also, the Program will advocate incorporation of the Kanquit.org web link on the target institutions respective websites for greater accessibility.

Action Steps:

1. The City - Cowley County Health Department will post the Kansas Tobacco Quitline and Kanquit information and links to its website.
2. Consult with TUPP Cessation Coordinator to provide education to student health services from both colleges.
3. College student health service staff and Cowley County CDRR Staff will receive 5 A's Training from the TUPP Cessation Coordinator
4. Gather system change documentation including additional Patient/Provider Kansas Quitline referral forms. Digital, paper and fax referrals will be utilized.
5. Contact college leadership and representatives with support from Clean Air Cowley Coalition
6. Clean Air Cowley leadership will meet with Student Health Service to plan implementation of policy change, clinical procedure change and use of referral forms.
7. Post link to Kansas Tobacco Quitline information and kanquit.org on respective college websites.
8. Implement policy change, clinical procedure change, including resource materials and use of referral forms.
9. Consult with TUPP Cessation Coordinator from KDHE to evaluate implementation of policy and procedure implementation.
10. Gather data of referrals offered by Student Health Services each month.

	Process Indicators	Data Sources	Data Collection	Timeframe	Staff Assigned	Measure
	What type of measure you need?	Where you will get the data on selected indicator?	How will you get the data?	When will you collect data?	Who will ensure this gets done?	Indicator Measure
Add Line	Date KTQL information posted to CCHD website	KDHE/ KTQL Web links	CCHD Web	Monthly	CCHD Admin	*
Add Line	Number of meetings with TUPP cessation coordinator	Meeting notes / call log	Discussion	per event	CDRR Coordinator	*

Add Line	Number of meetings with Clean Air Cowley County Coalition	Meeting Minutes	QL Discussion	Quarterly	CDRR Coordinator	*
Add Line	Number of contacts per school with college leadership and representatives	Meeting minutes / call log	Discussion	per event	Clean Air Cowley County Coalition	*
Add Line	Number of colleges that approve adding/improving tobacco cessation systems	Meeting minutes / call log	Discussion	Approval by October 31, 2012	CDRR Coordinator	*
Add Line	Number of meetings with Student Health Services	Internal documentation: meeting notes	Discussion	Completed prior to December 31, 2012	CDRR Coordinator	*
Add Line	Number of colleges that post KTQL information/links on their websites	KDHE/ KTQL Web links	CCHD Web	Monthly	CDRR Coordinator/ Clean Air Cowley County Coalition	*
Add Line	Number of QL reports collected to monitor progress	QL reports from TUPP Cess. Coord	Electronic Record	Monthly	CDRR Coordinator	*
Add Line	Number of CCHD Staff that complete 5 A's Training	Training sign in	Review sign in	October 1, 2012	CDRR Coordinator / CCHD Admin	*
Add Line	Number of College Health Service Staff that complete 5 A's Training	Training sign in	Review sign in	October 1, 2012	CDRR Coordinator / CCHD Admin	*

	Impact Indicators	Data Sources	Data Collection	Timeframe	Staff Assigned	Pre Measure	Post Measure
Add Line	Proportion of Cowley Co. college health organizations with student KTQL referral systems in place	College Policies	Review current policies	Monthly	CDRR Coordinator	0	*
Add Line	Average number of monthly KTQL calls from Cowley Co.	QL Reports	Electronic Record	Monthly	CDRR Coordinator	0	*
Add Line	Average number of monthly KTQL calls from Cowley Co. from young adults (age 18-24)	QL Reports	Electronic Record	Monthly	CDRR Coordinator	0	*

	Progress Entry Date	Progress Entry
Add Progress		* Describe progress on the activity, including barriers and successes.

CDRR Activity Evaluation

State Fiscal Year: 2013

Submit Form

This Activity Report is for: Grant Application

Activity Number: 2 Short Term Outcome Number: PAN 4.2 Strategy: Access CHANGE Sector: Work Site

Agency Name: City - Cowley County Health Department

Counties: Cowley

Activity Name: Lactation Areas at Work Sites

SMART Objective: By June 30, 2013, increase the proportion of targeted work sites that provide a lactation area for employees from 0% (0 of 5) to 100% (5 of 5).

Target Population: Women Employees of five local businesses: (N = 105)

Target Group: 5 Local businesses identified by the Breastfeeding Advocates of Cowley County coalition --2 major employers: Rubbermaid and General Electric; and 3 main street businesses within Cowley County.

Activity Narrative:

We will implement a lactation area project at five work sites -- Rubbermaid, General Electric and 3 main street businesses within Cowley County -- to educate employees about the benefits of breastfeeding, educate policy makers, decision makers, and wellness teams about the benefits of encouraging employees to breastfeed babies, and how to implement a lactation area for employees who choose to continue to breastfeed after returning to work from maternity leave. We will provide trainings for Human Resource Managers, and wellness teams using the Business Case for Breastfeeding model and will assist wellness teams in planning and implementing a lactation area in each of the businesses that meets or exceeds the minimum standards set by federal law. We will measure change in provision of lactation areas through the implementation of a phone or electronic survey of participating work sites. Environmental Change in the form lactation areas provided & Policy Change in the form of implementing federal standards will be assessed.

Kan. Stat. Ann. § 65-1,248 provides that it is the public policy of Kansas that a mother's choice to breastfeed should be supported and encouraged to the greatest extent possible and that a mother may breastfeed in any place she has a right to be. Federal requirements in the Patient Protection and Affordable Care Act, H.R. 3590, on March 23 and the Reconciliation Act of 2010, H.R. 4872, on March 30, 2010 also speak to provisions for breastfeeding mothers at work sites. Among many provisions, Section 4207 of the law amends the Fair Labor Standards Act (FLSA) of 1938 (29 U.S. Code 207) to require an employer to provide reasonable break time for an employee to express breast milk for her nursing child for one year after the child's birth each time such employee has need to express milk. The employer is not required to compensate an employee receiving reasonable break time for any work time spent for such purpose. The employer must also provide a place, other than a bathroom, for the employee to express breast milk, that is shielded from view and free from intrusion from co-workers and the public. The federal requirements shall not preempt a state law that provides greater protections to employees.

Breastfeeding Report Card 2011, United States: Outcome Indicators (CDC) show that Kansas has a higher rate of ever breastfed infants than the national rate (75.4% vs 74.6%) but breastfeeding rates are below national levels at 6 months (41.0% vs 44.3%) and at 12 months (21.6% vs 23.8%). In addition exclusive breastfeeding rates are lower at 3 months (33.5% vs 35.0%) and significantly lower at 6 months (10.6% vs 14.8%). The 10.6% exclusive breastfeeding rate at 6 months is well below the Healthy People 2020 goal of 25.5%. These statistics indicate that in Kansas new mothers initiate breastfeeding following the birth of their babies at a higher rate but are less likely to breastfeed (especially exclusively) at 3 months, 6 months, and 12 months--in other words when they return to work after maternity leave. Increasing the number of community employers who provide lactation areas and encourage employees to breastfeed will increase the number of employees who breastfeed their babies after returning to work, thus reducing the children's risk for obesity and other health related disorders such as diabetes.

Action Steps:

PRE-INTERVENTION
1 Consult with the KDHE Nutrition Educator to better provide education to identified Employers and Chambers of Commerce (Winfield and Arkansas City)
2 Contact target businesses, arrange for and present project to leadership on lactation areas and policies.
3 Schedule and provide Business Case for Breastfeeding training for policy makers, decision makers, and employee wellness teams.
4 Seek written approval of project for each business. (Policy Change)
INTERVENTION
5 Determine appropriate lactation area at each business and basic components for lactation areas that are needed.
6 Request funding for needed items for the lactation area from businesses, donations, or other community sources.
7 Purchase or procure items needed.
8 Schedule and hold a work day to set up the lactation area at each location. (Environmental Change)
POST INTERVENTION
9 Follow-up project with phone survey to business contacts to determine/assure completion of lactation areas.
10 Record all activities and data in Lactation Project Log.
11 Report progress and results to all appropriate entities.

	Process Indicators	Data Sources	Data Collection	Timeframe	Staff Assigned	Measure
	What type of measure you need?	Where you will get the data on selected indicator?	How will you get the data?	When will you collect data?	Who will ensure this gets done?	Indicator Measure
Add Line	PRE-INTERVENTION 1 Number of target businesses contacted.	CDRR coordinator will build a spreadsheet tool to serve as Lactation Project Logs of all contacts made with county businesses.	Data for indicator will be extracted from the Lactation Project logs.	July through September of 2012	CDRR coordinator is responsible for organizing the overall project, recording all gathered data in the project logs and reporting.	#
Add Line	PRE-INTERVENTION 2 Number of project presentations made on lactation areas and policies.	Number will be recorded in the project logs.	Number will be extracted from Lactation Project Logs	July through September of 2012	CDRR coordinator and coalition partners will make presentations to county employers/ decision makers	#
Add Line	PRE-INTERVENTION 3 Number of Business Case for Breastfeeding trainings scheduled for policy makers/decision makers, and wellness teams.	Number of trainings scheduled will be recorded in Lactation Project Logs.	Number will be extracted from Lactation Project Logs	September through November of 2012	CDRR coordinator, coalition partners, and any interested community members will assist the training	#
Add Line	PRE-INTERVENTION 4 Number of Business Case for Breastfeeding trainings provided for policy makers/decision makers, and wellness teams.	Number of trainings held will be recorded in Lactation Project Logs.	Number will be extracted from Lactation Project Logs	September through November of 2012	CDRR coordinator, coalition partners, and any interested community members will assist the training	#

Add Line	PRE-INTERVENTION 5 Number of participants to Business Case for Breastfeeding trainings	Number of training participants will be gathered from sign-in sheets at trainings and recorded in Lactation Project Logs.	Number will be extracted from Lactation Project Logs	September through November of 2012	CDRR coordinator will record data, extract, and report all results to KDHE & coalition partners.	*
Add Line	PRE-INTERVENTION 6 Number of educational materials distributed.	Number of materials distributed will be recorded in Lactation Project Logs.	Number will be extracted from Lactation Project Logs	September through November of 2012	CDRR coordinator will record data, extract, and report all results to KDHE & coalition partners.	*
Add Line	PRE-INTERVENTION 7 Number of sites approving project implementation.	Number will be recorded in Lactation Project Logs	Number will be extracted from Lactation Project Logs	October through November of 2012	CDRR coordinator will gather & record data for reports	*
Add Line	INTERVENTION 8 Number of appropriate lactation areas identified and lists made of needed items to meet standards.	Number will be recorded in Lactation Project Logs	Number will be extracted from Lactation Project Logs	November 2012	County Admin, Health Dept. Coalition Partners, wellness team members, HR managers, and maintenance staff will collaborate.	*
Add Line	INTERVENTION 6 Number of materials purchased or received as donations	Number will be recorded in Lactation Project Logs	Number will be extracted from Lactation Project Logs	November through December 2013	CDRR coordinator will gather information and record in logs.	*
Add Line	INTERVENTION 7 Number of work days scheduled and held to set up lactation areas.	Number will be recorded in Lactation Project Logs	Number will be extracted from Lactation Project Logs	December 2012 through February 2013	County Admin, Health Dept Coalition Partners, wellness team members, HR managers, and maintenance staff will assist.	*
Add Line	POST-INTERVENTION 8 Number of administrators/coalition partners contacted to determine project completion.	Number will be recorded in Lactation Project Logs	Number will be extracted from Lactation Project Logs	March through April 2013	CDRR coordinator will gather & record data for reports	*

Add Line	POST-INTERVENTION 9 Number of lactation areas completed.	Number will be recorded in Lactation Project Logs	Number will be extracted from Lactation Project Logs	March through April 2013	CDRR coordinator will gather & record data for reports	*
Add Line	POST-INTERVENTION 10 Number of Entries/Data recorded in Lactation Project Log	Number will be recorded in Lactation Project Logs	Number will be extracted from Lactation Project Logs	June 2013	CDRR coordinator will gather & record data for reports	*
Add Line	POST-INTERVENTION 11 Number of reports completed and sent to appropriate entities.	Number of reports submitted will be recorded in coalition minutes and project logs	Number of reports submitted will be extracted from coalition minutes and project logs.	July 2012 through June 30, 2012	CDRR coordinator will submit reports.	*
Add Line						*
Add Line						*
Add Line						*

	Impact Indicators	Data Sources	Data Collection	Timeframe	Staff Assigned	Pre Measure	Post Measure
Add Line	1) Proportion of target businesses that provide a lactation area for employees.	Data from coalition partners and Lactation Project Logs.	Baseline data has previously been gathered from county coalition partners through normal communications.	July 1, 2012 through June 30, 2013.	CDRR Coordinator will assist partners, record data, extract data, and report project results	0%	*
Add Line	2) Proportion of targeted female employees with access to a designated, sanitary, private lactation area for employees.	Data from coalition partners and Lactation Project Logs.	Baseline data has previously been gathered from county coalition partners through normal communications.	July 1, 2012 through June 30, 2013.	CDRR Coordinator will assist partners, record data, extract data, and report project results	0%	*

	Progress Entry Date	Progress Entry
Add Progress	*	* Describe progress on the activity, including barriers and successes.

CDRR Activity Evaluation

State Fiscal Year: 2013

Submit Form

This Activity Report is for: Grant Application

Activity Number: 03 Short Term Outcome Number: PAN 4.2 Strategy: Access CHANGE Sector: School

Agency Name: Lawrence-Douglas County Health Department

Counties: Douglas County

Activity Name: Farm to School

SMART Objective: By June 30, 2013, increase the percent of Douglas County school districts with a policy on the inclusion of locally grown foods in school food service programs from 0% (0 of 3) to 33% (1 of 3).

Target Population: Students enrolled in Douglas County school districts (N=14,356)
(1,423 [Baldwin City - USD 348] + 1,559 [Eudora - USD 491] + 11,374 [Lawrence - USD 497])

Target Group: Douglas County school districts (N=3), USD 348=6 schools, USD 491=4 school, USD 497=20 schools.

Activity Narrative:

As part of the SFY2012 CDRR program, the Lawrence Douglas County Health Department(LDCHD) began working with Lawrence Public Schools (USD497), in partnership with LiveWell Lawrence, to improve availability of mechanisms for purchasing foods from farms. In support of this objective, the Health Department drafted a local foods policy as part of a pilot program at Schwegler Elementary School. The policy, along with a basic farm food safety checklist for produce sales to institutions, was adopted by the principal at Schwegler Elementary School in November 2011. The policy supports the purchase of locally grown food for approximately 300 students served each day. On February 13, 2012, the Lawrence Board of Education received a report from the Lawrence Public Schools Coordinated School Health Council that highlighted, among other student and staff wellness activities, the pilot program at Schwegler Elementary School. The board welcomed the report but did not direct district staff in regards to expanding the farm to school pilot.

Because the local foods policy was not adopted district-wide, work still remains to be done. As was noted in the SFY2012 CDRR Activity Evaluation Form, results from the CHANGE evaluation tool indicate gaps in the community-at-large sector in areas related to both the nutrition policy level as well as nutrition environment level with scores of 48 and 49, respectively. Within the school sector, while the average scores are relatively high for nearly all modules (greater than 70), specific questions at the school level related to the provision of school gardens is mixed. Furthermore, while a number of schools in the Lawrence school district have begun a school garden, use of the produce as part of the school lunch program has been decided on an individual school basis rather than as a district-wide policy.

Over the last several years Lawrence and Douglas County have had significant leadership growth in the areas of nutrition policy and environment through the work of Live Well Lawrence (which includes initiatives such as a School Gardens Project, the LiveWell EatWell Restaurant Challenge and the Farm to School pilot program), Coordinated School Health Council, and more recently the formation of the Douglas County Food Policy Council. The coalition is well positioned to continue making progress toward district-wide adoption of a local foods policy.

LDCHD and LiveWell Lawrence will work with Douglas County Food Policy Council and other stakeholders to educate school policy makers on the Farm to School initiative. A public education campaign using WellCommons will be developed for public awareness and support for Farm to School. WellCommons is a community journalism website with a full time health reporter. The site relies on active participation of community members for keeping blogs and posting articles related to health. Lawrence Douglas County Health Department will provide technical assistance to Lawrence Public Schools staff to draft a policy for using locally grown foods district wide.

Support of the local foods policy will be provided at Lawrence Board of Education Meetings when the policy is considered.

Action Steps:

- Schedule appointments with Lawrence Public Schools staff to assess the current stage of evaluation of the farm to school pilot and development of a district-wide local foods policy
- Schedule appointments with Douglas County Food Policy Council staff and leadership to assess current interest in collaborating to advocate for a district-wide local foods policy
- Identify resources for model policies and best practices
- Develop a Farm to School stakeholder committee with local foods policy advocates and advisors
- Work with CDRR Communications Coordinator to develop a public education campaign to inform the public about the issue and the farm to school concept using WellCommons
- Work with Lawrence Public Schools staff to provide support and technical assistance to achieve a draft district-wide policy on using locally grown foods in school food service programs
- Present in support of the draft local foods policy at the Lawrence Board of Education when the policy is considered

	Process Indicators	Data Sources	Data Collection	Timeframe	Staff Assigned	Measure
	What type of measure you need?	Where you will get the data on selected indicator?	How will you get the data?	When will you collect data?	Who will ensure this gets done?	Indicator Measure
Add Line	Number of scheduled appointments with Lawrence Public Schools staff	Spreadsheet log of appointments with LPS staff	Community Health Planner will maintain spreadsheet log of appointments with dates, times, LPS staff members involved and notes	Data will be collected from July 2012 through June 2013	Community Health Planner	#
Add Line	Number of scheduled appointments with Douglas County Food Policy Council staff and leadership	Spreadsheet log of appointments with DCFPC staff and leadership	Community Health Planner will maintain spreadsheet log of appointments dates, times, DCFPC staff and leadership members involved and notes	Data will be collected from July 2012 through June 2013	Community Health Planner	#
Add Line	Number of resources for model policies and best practices	Spreadsheet of resources for model policies and best practices	Community Health Planner will maintain spreadsheet of resources for model policies and best practices	Data will be collected from July 2012 through June 2013	Community Health Planner	#
Add Line	Number of members of Farm to School stakeholder committee of local foods policy advocates and advisors	Farm to School stakeholder committee roster	Community Health Planner will maintain and review the Farm to School stakeholder committee roster	Data will be collected from July 2012 through June 2013	Community Health Planner	#
Add Line	Number of articles posted on WellCommons that educate the community on Farm to School initiatives and concepts	Spreadsheet log of Farm to School articles posted on WellCommons	Community Health Planner will maintain log of Farm to School articles posted on WellCommons	Data will be collected from July 2012 through June 2013	Community Health Planner	#

Add Line	Number of meetings with Farm to School stakeholder committee of local foods policy advocates and advisors	Spreadsheet log of committee meetings and announcements	Community Health Planner will maintain log of committee meetings and announcements	Data will be collected from July 2012 through June 2013	Community Health Planner	*
Add Line	Date of completion of a draft district-wide Farm to School policy for consideration by the Lawrence Board of Education	Draft district-wide Farm to School policy document	Community Health Planner will maintain a copy of the draft district-wide Farm to School policy document	Data will be collected from July 2012 through June 2013	Community Health Planner	*
Add Line	Number of unique visits to WellCommons articles	WellCommons usage metrics	Solicitation of data from WellCommons health reporter	Data will be collected from July 2012 through June 2013	Community Health Planner	*

	Impact Indicators	Data Sources	Data Collection	Timeframe	Staff Assigned	Pre Measure	Post Measure
Add Line	Proportion of Douglas County school districts covered by a Farm to School policy that integrates locally grown food into meals offered to students	Lawrence Board of Education meeting minutes	Community Health Planner will present in support of the local foods policy at the Lawrence Board of Education meeting when the policy is considered	Data will be collected from July 2012 through June 2013	Community Health Planner	0 of 3 Douglas County school districts	*
Add Line	Proportion of Douglas County schools covered by a Farm to School policy that integrates locally grown food into meals offered to students	K-12 Report website maintained by Kansas State Department of Education	Lawrence Board of Education meeting when the policy is considered	Data will be collected from July 2012 through June 2013	Community Health Planner	0 of 30 Douglas County schools	*
Add Line	Proportion of Douglas County public school students covered by a Farm to School policy that integrates locally grown food into meals offered to students	K-12 Report website maintained by Kansas State Department of Education	Lawrence Board of Education meeting when the policy is considered	Data will be collected from July 2012 through June 2013	Community Health Planner	0 of 14,356 Douglas County students	*

	Progress Entry Date	Progress Entry
Add Progress		* Describe progress on the activity, including barriers and successes.

CHANGE Tool Evaluation Plan Format

Goal #: Provide community assessment for [*community name*].

Objective #: By June 30, 2011, complete CHANGE Tool for [*community name*].

Activity: CHANGE Tool for [*community name*].

1. Assemble the Community Team
2. Develop Team Strategy
3. Review all 5 CHANGE Sectors
4. Gather Data
5. Review data gathered
6. Enter data
7. Review consolidated data
8. Build the Community Action Plan

	Indicator	Data Sources	Data Collection	Timeframe	Data Analysis	Communication Plan	Staff Assigned
	1) Community Team assembled.	Completed team roster/list of team partners.	Review of team roster		Count of team members		
	2) Team strategy developed	Meeting minutes	Review of meeting minutes.		Final vote on team strategy		
	3) 5 CHANGE sectors reviewed	Meeting minutes	Review of meeting minutes.		Completed review of all 5 CHANGE sectors		
	4) Community data gathered.	To be determined (TBD) by Community Team	TBD		TBD		
	5) Community data reviewed in meeting	Meeting minutes	Review of meeting minutes.		Community data reviewed in meeting		
	6) Community data entered into excel file	CHANGE Sector Excel File	Review of Excel File		Assess completeness of Excel File		
	7a) CHANGE Summary Statement Created 7b) Sector data grid completed 7c) CHANGE Strategy Worksheets Completed 7d) Community Health Improvement Planning Template completed	CHANGE Summary Statement, Sector grid, Strategy Worksheets and Community Health Improvement Planning Template	Review of specified data sources		Assess completeness of specified data sources		
	8) Community Action Plan completed	Community Action Plan document	Review of Community Action Plan		Assess completeness of Comm. Action Plan		

CDRR SHORT-TERM OUTCOME CODES (Key Outcome Indicators (KOI))

GOAL AREA 1: PREVENTING INITIATION OF TOBACCO USE AMONG YOUNG PEOPLE

1.6 Increased knowledge of, improved anti-tobacco attitudes toward and increased support for policies to reduce youth initiation

1.7 Increased anti-tobacco policies and programs in schools

1.8 Increased restriction and enforcement of restrictions on tobacco sales to minors

1.9 Reduced tobacco industry influences

GOAL AREA 2: ELIMINATING NONSMOKERS' EXPOSURE TO SECONDHAND SMOKE

2.3 Increased knowledge of, improved attitudes toward, and increased support for the creation and active enforcement of tobacco-free policies

2.4 Creation of tobacco-free policies

2.5 Enforcement of tobacco-free public policies

GOAL AREA 3: PROMOTING QUITTING AMONG ADULTS AND YOUNG PEOPLE

3.7 Establishment or increased use of cessation services

3.8 Increased awareness, knowledge, intention to quit, and support for policies that support cessation

3.9 Increase in the number of health care providers and health care systems following Public Health Service (PHS) guidelines

3.10 Increased insurance coverage for cessation services

GOAL AREA 4: REDUCE THE BURDEN OF OBESITY IN YOUTH AND ADULTS

4.1 Increase physical activity

4.2 Improve nutrition

CDRR Coalition Self-Assessment Instructions

CDRR programming relies on engaged, highly functional coalitions to implement chronic disease risk reduction interventions. Coalitions can leverage local resources and capitalize on local partners and relationships to achieve goals that would be near-impossible for one or two individuals working alone. Coalitions, however, require work to create and maintain. To facilitate the health of coalitions associated with the CDRR program, the CDRR grant requires completion of the CDRR Coalition Self-Assessment every other year.

The CDRR Coalition Self Assessment is designed to improve coalition organization and functionality. It does this by identifying coalition strengths and weaknesses, which are used by CDRR Outreach Staff to facilitate discussions about coalition improvements. The assessment provides a general picture of a coalition's stage of development and may point out areas in which technical assistance, training or other support is needed.

This assessment is not a test. There are no right or wrong answers and there is no personally identifying information requested on the questionnaire. To get the most out of the assessment, it is important that each question be answered honestly and by as many coalition members as possible. A coalition assessment can only "fail" if it does not result in coalition improvement.

When your coalition is ready to conduct a coalition assessment, contact your Outreach Coordinator to schedule an assessment date. It is recommended that you schedule an assessment in the first half of the grant year to give your Outreach Coordinator sufficient time to analyze results and report back to the coalition.

The Coalition Self-Assessment Process:

1) Discuss the assessment with your coalition and pick a couple possible dates to have the assessment.
2) Contact your Outreach Coordinator and decide on a date to have the assessment.
3) Your Outreach Coordinator will attend the designated coalition meeting and administer the assessment.
4) Your Outreach Coordinator collects, aggregates and analyzes the results of your assessment.
5) At another meeting later in the grant year, your Outreach Coordinator will present the results of the coalition assessment and facilitate a discussion about the results and how the information can be used.

A to Z Topic Listing

- Community Health Systems Home
- Aid to Local Grant
- Data Resources
- Governor's Public Health Conference
- Kansas Public Health Directory
- KDHE Statewide Population Health Call
- KS-TRAIN
- Local Public Health Regional Attendance Map
- Public Health Connections
- Public Health Resources
- Regional Meetings/Calendar of Events
- Staff Directory
- Workforce Development

Public Health Emergency Preparedness

Program Purpose

The goal of the Preparedness Program is to protect the health and safety of Kansans through efforts to mitigate, prepare for, respond to, and recover from natural disasters, infectious disease, terrorism, and mass casualty emergencies. Those that wish to participate in the Preparedness Program are responsible for:

- Health and medical planning and response within their communities
- Planning and participating in local level exercises which test public health preparedness capabilities
- Participation in their local healthcare coalition

Funding

Preparedness funding is contingent upon the availability of Federal funds from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. The State Agency determines the base award to the Local Agency each year based on a population formula. Local health departments that wish to redirect some of their preparedness funding to their public health region may do so and must submit a Redirection Request Form, usually in May.

Program Detials

All programmatic details, work plan requirements, and guidance may be found at Grant Application Documents. Questions may be directed to Jamie Hemler at jhemeler@kdheks.gov or (785) 296-5529.

Return

Curtis State Office Building, 1000 SW Jackson, Topeka, Kansas 66612

Family Planning

Funding

Based on the availability of State or Federal funds, the State Agency determines the base award to the Local Agency on the 3-year average of unduplicated number of Family Planning Users.

Funding is also subject to legislative and policy priorities. The Kansas Legislature established two priorities related to contracting for the delivery of family planning services for State Fiscal Year 2015 (beginning July 1, 2014): First priority to public entities (state, county, and local health departments and health clinics); and, if any moneys remain, then, Second priority to non-public entities which are hospitals or federally qualified health centers that provide comprehensive primary and preventative care in addition to family planning services.

Local Agency continuation grants are funded equal to at least 80 percent of the previous year's base award and the remaining 20 percent of funds may be allocated based on performance data. The amount of funding a local agency requests in the grant application should be based on cost to provide services.

In the event additional funds are received at the state level, they will be distributed to local agencies based on performance/need data. At such time that the Local Agency's unduplicated number of Family Planning Users for a 3-year average falls below 50, the State Agency may discontinue funding the Local Agency. The State Agency reserves the right to modify in its sole discretion, the funding criteria used in the award process. Funding is also subject to legislative and policy priorities.

Match – Local Agency matching funds must be equal to or greater than 40 percent of grant funds awarded. Program revenues may be utilized to meet the match requirement.
Program Revenue – Local agencies must establish a schedule of fees for services and supplies based on guidelines contained in the Manual (see b. below). Funds generated from any of these will be used to support the maintenance/expansion of family planning services. These funds will be carried forward from year to year. The grant application budget for family planning must reflect the total program budget including grant funds, projected fee collections, Title XIX, and third party reimbursements plus any unexpended revenue carryover (prior grantees only) from the previous year's budget.

Specific Program Information

A. Application – Follow the KDHE "SFY2015 Grant Application Guidance" instructions. The application budget must include expenses for staff to attend education updates. In order to advocate for increased funds, documentation is necessary to reflect pharmaceutical expenses on the detailed budget.
B. Services – See the Department of Health and Human Services' (DHHS) "Program Guidelines for Project Grants for Family Planning Services," and the "Kansas Health Services Manual, Family Planning/Women's Health."
    1. Each project must assure that skilled personnel, equipment and medical back-up services are available to provide the required services.
    2. Each project will have an advisory committee to review and approve family planning informational and educational materials, and provide guidance in the development, implementation and evaluation of the project.
    3. Each project must provide for community education programs to:
        a. enhance community understanding of the objectives of the project;
        b. inform potential clients of the availability of services; and
        c. encourage continued participation by persons to whom family planning may be beneficial. Community education and outreach activities should be based on an assessment of community needs, and have both implementation and evaluation components.
    4. Each project must handle Family Planning pharmaceuticals purchased through the Office of Pharmacy Affairs 340B Drug Pricing Program in compliance with that program's guidelines.

5. For delegate agencies whose subcontractors are purchasing Family Planning pharmaceuticals for their clients through the Office of Pharmacy Affairs (OPA) 340B Drug Pricing Program there must be a mechanism in place that allows for allocating a proportional amount of the grant award to the subcontractor(s) in order to meet the OPA expectation that Title X Family Planning covered entities receive grant funds for clinical services.

C. SFY2015 Outcome Objective: All client records with Pap test results showing epithelial cell abnormalities (ASC or more severe) will have documentation of client notification, and appropriate referral and/or follow-up recommendations within 6 weeks of the date the Pap smear was read. SFY2015 Process Objectives: In setting objectives for SFY2015, please review the latest data available from the state data system. The applicant must set objectives in each of the following areas:
   1. Provide family planning services to #___ Users.
   2. Increase the number of high-risk (age 19 & under) Users receiving services from #___ in Calendar Year (CY) 2013 to # ___ in CY 2014.
   3. Increase the number of low-income (at or below **100 percent** poverty) Users receiving services from #___ in CY 2013 to #___ in CY 2014.
   4. Remain in compliance with clinical indicators on semi-annual reporting forms.

D. Program Protocols: The Local Health Agency will develop and have on file, written local program policies and procedures for services to be provided based on program standards and guidelines contained in the Manual in b. above. As appropriate, the Local Health Agency will have on file current APRN protocols and authorization for collaborative practice as required by the Kansas State Board of Nursing.

E. Other:
   1. The Local Health Agency will provide for orientation and training of new staff. Staff will participate in the annual KDHE Family Planning update.
   2. Onsite monitoring and technical assistance visits are conducted by the State Agency. A corrective action plan for issues identified during the said visit will be established and implemented.
   3. For multi-agency grants only, the delegate agency shall provide each agent/subcontractor with a completed grant application, contract, and reporting instructions, and will have on file a signed memorandum of agreement with each agent/subcontractor which includes provisions for record keeping and providing matching funds if required. A copy of the signed memorandum of agreement with each agent/subcontractor shall be on file with the State Agency.
   4. For the Local Agency and its agents or subcontractors who are providing required core Family Planning services off-site, a copy of the signed agreement between the provider(s) and the Local Agency shall be on file with the State Agency.

Reporting Requirements
Refer to the KDHE "SFY2015 Grant/Contract Reporting Instructions."

Program Contact Persons

Christina Flyntz, Family Planning Administrative Consultant
785-296-1205
cflyntz@kdheks.gov

Ruth Werner, Family Planning Director
785-296-1304
rwerner@kdheks.gov

Form required: Program Request and Detailed Budget

STI/HIV Disease Intervertion/Prevention Services

Funding

Applications for funding to support STD/HIV Disease Intervention/Prevention Services should be submitted for continuation of current contracts only. Award amounts will be contingent on federal funding availability and amounts. Awards will be initiated upon receipt of an amended budget based on the actual amount of the award unless award is equal to the requested amount. At this time, a match is not required for these grants. The STD and HIV Sections reserve the right to require grantees to provide a match.

Reporting Requirements

All grantees must submit quarterly Certified Affidavit of Expenditures.

Program Contact Person

David M. Owens, MPH
Disease Intervention Program Manager
Bureau of Disease Control and Prevention
785-291-3655
dowens1@kdheks.gov

Maternal and Child Health Services Program Purpose

Funding

A. First priority is to continue funding of local agencies that demonstrate progress toward specific objectives, meet program requirements and participate in education updates. Second priority is to provide funding equal to at least 90% of the previous year's award and to allocate the remaining 10% based on performance/need data.
B. Awards for new projects are subject to the availability of funds and identified maternal and child health needs resulting from a recently completed community needs assessment.
C. Local matching funds must be equal to or greater than 40% of the grant funds requested and awarded. Local program revenues may be utilized to meet the match requirement.
D. Applicants should adhere to a service plan that utilizes 50% of the funds for activities and services directed to pregnant women and infants including materials for outreach and support and 50% of the funds for activities and services directed to children and adolescents within the community to promote health.

Specific Program Information

A. Follow the KDHE SFY 2015 Grant Application Guidance.
B. MCH grants address priorities identified in the current federally required 5-year MCH state needs assessment called MCH 2015. Refer to the 2012 Biennial Summary, MCH 2015 or the MCH Program Manual.
C. Each local grantee agency will provide services in order to address the following State Priorities identified in MCH 2015:
   - Pregnant Women and Infants
     1. All women receive early and comprehensive health care before, during and after pregnancy
     2. Improve mental health and behavioral health of pregnant women and new mothers
     3. Reduce preterm and low birthweight births, and infant mortality
     4. Increase initiation, duration and exclusivity of breastfeeding
   - Children and Adolescents
     1. All children and youth receive health care through medical homes
     2. Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs
     3. All children and youth achieve and maintain healthy weight

SFY 2015 Program Request Form Template

A. The template enables local agencies to copy/paste information. It may be helpful to compose narrative information in a Word document first, then copy and paste into the template form.
B. Healthy Start Home Visitor (HSHV): Check “yes” or “no” whether the local MCH program will include Healthy Start Home Visitor services to support MCH program objectives during 7/1/14–6/30/15. A HSHV works in tandem with professional nursing staff in providing outreach and family support to pregnant women and mothers/families with newborns up to approximately one year postpartum. HSHV services are to be woven throughout the constellation of MCH health promotion and prevention services provided to pregnant/postpartum women and their infants. However, a HSHV is distinct from other home visiting services that a local MCH grantee agency may provide using nurses, social workers, or other professionals. Guidelines for HSHV services are in Section 410 of the MCH Program Manual.
C. Service Numbers: In the boxes provided, insert estimated total numbers to be served of pregnant women, infants, and children and adolescents during 7/1/14–6/30/15.
D. Program Objectives: Check at least **four** MCH 2015 State Priorities to address local needs during 7/1/14–6/30/15 - **two** from the Pregnant Women and Infants population group and **two** from the Children and Adolescents population group. The selections are to be based on local community health needs assessment data. For each selected priority, provide the following narrative information in the associated text box:

a. Specific objective to address the priority.
b. Justification of local needs.
c. Planned strategies, activities, and/or work plan to address the need and objective.
d. Staff responsible and roles.
e. Collaborative partners and roles.
f. How outreach will be provided in the local community(ies).
g. How the strategies and activities will be integrated with other efforts or programs within the agency, partners, community level efforts, etc. Include how care coordination will be facilitated to assure services for the population's nursing, social service, nutrition, behavioral health, oral health and medical needs will be comprehensively addressed.

E. Measurement Indicators: Check at least **four** indicators that will be measured and reported during 7/1/14–6/30/15. There should be a minimum of one indicator to measure each identified priority/objective. Selections may be made from the list provided on the form (and in Section 8 below) and/or additional indicators may be proposed (see "Optional/Additional Indicators" box on the form). For each indicator, provide the following narrative information in the associated text box:
   a. How it will be measured (e.g., data to be collected, source, collection plan, documentation, timeframes, etc.)
   b. How progress will be assessed (e.g., baseline, comparison, improvement, etc.)
F. Requested Funds: In the box provided, insert the total amount of MCH funds requested.
G. All objectives and indicators should be written using the S.M.A.R.T. format (**S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime-Based). MCH staff will assist any grantees requesting assistance in writing objectives or indicators on an individual, as-needed basis.

Program Requirements

A. The local grantee agency will develop and maintain written program policies and procedures that are based on program standards and guidelines as in Section 3, "Specific Program Information" above.
   (1) Income and family size of all MCH clients must be determined and documented at least annually.
   (2) A sliding fee scale with a minimum of four increments must be established and implemented for all MCH services provided. This program does not require the fee scale to slide to zero.
B. Agencies will submit client encounter data by a paper Client Visit Record (CVR) or by electronic means **at least once a month**.
C. Grantees will provide at least 20% of the families visited with a client satisfaction survey card. Survey cards may be mailed individually or collected and sent to KDHE prior to the end of each quarter. An electronic summary will be returned to the local health agency for program self-evaluation.
D. The local grantee agency will use a billing system to maximize revenues from third party sources including Medicaid.
E. Compliance Monitoring/Site Visits are conducted and technical assistance will be provided as needed to MCH grantees by KDHE MCH program staff. An improvement plan will be jointly developed to address issues as identified during the monitoring site visit.
F. A 10% penalty of total grant award amount will be assessed for delinquent year-end reports beyond August 15th.
G. For multi-agency grants only, the local grantee agency shall provide each agent/subcontractor with a completed grant application, contract, and reporting instructions and will have on file a signed memorandum of agreement (MOA) with each agent/subcontractor which includes provisions for record keeping and providing matching funds if required. **A copy of the signed MOAs shall be submitted to Jamie Klenklen, MCH Administrative Consultant, at KDHE no later than April 15**.

Continuing Education

A. An Individual Professional Development Plan or other system of documenting educational updates, such as KS-TRAIN, will be maintained for all MCH professional staff members at each agency.
B. Training on MCH services is provided for MCH staff and Administrators at the annual Governor's Public Health Conference including a MCH 101 pre-conference session. Important updates are provided that benefit MCH staff and administrators therefore attendance is strongly encouraged. All new MCH program staff and administrators are required to attend.
C. Newly hired Healthy Start Home Visitors (HSHVs) will attend the Kansas Home Visitation Training within the first six months of employment.
D. All Healthy Start Home Visitors will attend the Fall Regional HSHV training and one statewide conference of the local agency's choice. Attendance at the Governor's Public Health Conference is highly recommended for all Healthy Start Home Visitors. If the HSHV position is vacant, the supervisor must attend.

Reporting Requirements

Refer to the KDHE "SFY 2015 Grant/Contract Reporting Instructions."

Measurement Indicators

- Number of (women, infants, children and adolescents) served by the local MCH program who receive health care through medical homes.
- Number of women served by the local MCH program who receive prenatal care in the first, second, or third trimester.
- Number of pregnant women and new mothers served by the MCH program screened for (depression, substance use, tobacco use, behavioral disorders, etc.).
- Number of infants with low birth weight born to women served by the local MCH program.
- Number of women served by the local MCH program who breastfed their infants for (3, 6 or 12) months.
- Number of women served by the local MCH program provided "Safe Sleep" education.
- Number of children and adolescents who receive preventive education on use of (alcohol, tobacco and other substances).
- Number of children and adolescents served by the local MCH program with BMI's less than the 85th percentile.
- Number of births by adolescents age 10-19 years served by the local MCH program.
- Number of children and adolescents served by local MCH program who receive preventive safety education (car passenger, fire, home, etc.).
- Number of children and adolescents served by local MCH program screened and/or referred for oral health issues.

References

Children and Families website: www.kdheks.gov/c-f/index.html

MCH Block Grant website: www.kdheks.gov/c-f/mch.htm

Population Health Impact Pyramid:
www.idph.state.ia.us/adper/common/pdf/healthy_iowans/health_pyramid.pdf

MCH Program Manual: http://www.kdheks.gov/c-f/downloads/MCH_Manual.pdf

Program Contact Persons

Jamie Klenklen, MCH Administrative Consultant 785-296-1234 jklenklen@kdheks.gov

Joe Kotsch, Perinatal Health Consultant 785-296-1306 jkotsch@kdheks.gov

Jane Stueve, Child, Adolescent, & School Health Consultant 785-296-7433 jstueve@kdheks.gov

Form required: Program Request and Detailed Budget

STI/HIV Prevention Program

Program Purpose

This program is designed to support Comprehensive HIV Prevention Programs in accordance with the Centers for Disease Control and Prevention's (CDC) National HIV/AIDS Strategy (NHAS). This funding is provided to nonprofit community-based organizations and local health departments to support prioritized HIV testing and HIV prevention services to reach at-risk populations. Based on recent HIV epidemiologic data, the priority at-risk populations for HIV prevention in Kansas are currently identified as: men who have sex with men (MSM), African-American heterosexual women, injection drug users (IDU), youth ages 15 to 24, and other high risk individuals (those with a recent STD, TB, or hepatitis infection and the incarcerated population).

Funding

Applications for funding to support Comprehensive HIV Prevention Programs should be submitted for continuation of current contracts only. Applicants must demonstrate the ability to have achieved a 0.10 percent positive rate for calendar year 2012 to successfully be awarded funding. Award amounts will be contingent on federal funding availability and amounts. Awards will be initiated upon receipt of an amended budget based on the actual amount of the award unless award is equal to the requested amount. At this time, matching funds are not required for grants with the STI/HIV Section. The STI/HIV Section reserves the right to require grantees to provide matching funds in the future.

Program Details: Program details, application requirements and program staff contact information can be found on the attached document.

Forms required:

Community HIV Prevention Application
Opt-Out HIV Testing Application

Personal Responsibility Education Program (PREP)

Funding

Only agencies that received funding in SFY 2013 are eligible to apply for SFY 2014 funding. Funding is based on KDHE receiving appropriated funds from the Administration for Children, Youth and Families.

Specific Program Information

Program models conducted under PREP must contain at least 3 of the 6 adulthood preparation topics which include healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success and healthy life skills. Agencies may not change their approved program model, venue and/or targeted youth populations without approval by KDHE.

Reporting Requirements

Funded agencies are to submit a quarterly narrative and financial affidavit. Data from program models should be entered using the database provided by KDHE.

Staff Qualifications

All staff performing program models must be trained in the specific program model and also completed the HIV, STD and Viral Hepatitis course (on-line) as well as the HIV Prevention and Behavior Change (live) prior to conducting programming. KDHE must approve the hire of individuals to be paid out of the PREP grant.

Program Contact Person

Phil Griffin
PREP Coordinator
785-296-8893
pgriffin@kdheks.gov

Jennifer Vandevelde
STI/HIV Section Chief
785-296-6544
jvandevelde@kdheks.gov

Additional Required Forms (please scan and attach)

- Organization Chart for PREP Project
- Resume or CV (for all budgeted positions)
- Agency and/or Venue Bullying Policy
- Budget Narrative (using categories from detailed budget)

Other Form

- PREP Application and Detailed Budget

Immunization Action Plan Funding

IAP is a Federal and State funded supplemental immunization program that supports assurance of immunization services and activities for:

- Immunization education for all ages
- Effective vaccine delivery and documentation
- Assessments of child and adolescent immunization coverage rates

Grant awards will be distributed through SFY 2015 Aid to Local Appropriations. Applications for funding will be accepted from LHDs who have been previously awarded funding. Awards will be population-based and determined on availability of funds from the State General Fund (up to $247,000) and the Federal Centers for Disease Control and Prevention Immunization Grant (up to $285,000).

A. At this time, a match is not required for IAP grants.
B. Funds may not be used to supplant or replace existing agency funding sources.
C. Funds may not to be used for license/maintenance fees for systems for immunization information documentation.
D. Funds may not be used for the purchase of vaccines.
E. Applications will be considered for funding based on implementation of strategies and completion of objectives in the previous project period.

Specific Program Information:
Application - Follow the KDHE "SFY 2015 Grant Application Guidance," and complete the Program Request and Detailed Budget form. Applicants must include the objectives and strategies to be implemented on the Program Request Form.

SFY 2014 Objectives – The application must, at minimum, describe one or more strategies to accomplish each objective to qualify for the full amount of population based funding. Applications will be considered for funding based on implementation of strategies, completion of objectives and reporting in the previous project period.

Healthy People 2020 Objectives include:

1) Achieve and maintain vaccination coverage levels for universally recommended vaccines among young children and adolescents.

Target-Children 24-35 months of age

A. 80% vaccine coverage rate for the 4:3:1:3:3:1:4 series (DTaP4, IPV3, MMR1, HIB3, HepB3, Var1, PCV4).
B. 90% vaccine coverage for each single antigen in the series mentioned above by two years of age.

Target-Adolescent 13-18 years of age

A. Vaccine coverage for the following antigens: Tdap1 80%; Var2 90%, MCV1 80%, HPV3 80%(females only)

IAP Objectives:

Objective 1: The Local Health Department (LHD) will attain a 90% immunization rate for **each** vaccine antigen in the 4:3:1:3:3:1:4 series (DTaP4, Polio3, MMR1, Hib3, HEPB3, Varicella1, PCV4) by 2 years of age AND 80% coverage for a complete series by 2 years of age.

Objective Strategies include:

A. At a minimum, perform quarterly immunization assessments for the 24-35 month olds through the use of CoCASA (Comprehensive Clinic Assessment Software Application).
B. At a minimum, quarterly send Reminder/Recall notices to 24-35 month olds needing

immunizations.

C. Inactivate or "MOGE*" according to the KIP Childhood MOGE criteria
D. Provide immunization education to local physician clinics
E. Provide linkage between Women, Infant and Children (WIC) services and immunization services by providing immunization services during WIC clinics
F. Provide follow-up on referrals to the child's medical home for WIC clients with incomplete immunizations
G. Document the number of referrals made during the reporting period

Objective 2: The LHD will assure progress towards the Healthy People 2020 target of 80% compliance for each ACIP recommended adolescent vaccination: Tdap1, Varicella2, MCV1, HPV3 (females only).
Objective Strategies include:

A. Offer educational opportunities for school districts to improve school immunization requirements
B. Educate community partners about recommended adolescent immunizations
C. Offer educational opportunities for private providers and school nurses regarding the importance of delivery of all recommended adolescent vaccines when adolescents receive required immunization for school
D. At a minimum, perform the CoCASA Adolescent Coverage Report quarterly using the expanded ages of 13-18 yrs olds to ensure protection with all of the following antigens: Tdap1, Var2, MCV1, HPV3 (females)
E. Inactivate or "MOGE" according to KIP Adolescent MOGE Criteria
F. Implement and maintain an effective adolescent reminder/recall system

Objective 3: The LHD will assure progress toward the recording of immunization histories in KSWebIZ for 95% of children less than 6 years of age and 90% of adolescents 13-18 years of age.
Objective Strategies may include:

A. Inclusion of all LHD client immunization data in KSWebIZ through direct data entry into KSWebIZ
B. Inclusion of all LHD client immunization data in KSWebIZ through indirect data entry via an electronic interface with the LHD's patient management system
C. Marketing of KSWebIZ to private providers and community partners
D. Facilitation of KSWebIZ user's initial training or ongoing training by acting as a host site or training event coordinator

Objective 4: The LHD will assure lifespan immunization services for individuals of all ages within the LHD's jurisdiction.
Objective Strategies will include:

A. Offer immunization learning opportunities for childcare facility staff and school nurses
B. Conduct community influenza vaccination clinics
C. Document staff education regarding immunization practices via one or more of the following activities:
    a. Immunization Program annual conference
    b. CDC webcasts or other immunization related educational offerings

Reporting Requirements
Quarterly certified Affidavit of Expenditures and a Bi-annual progress report of activities toward objectives per the award.

Program Contact Person
Patti Kracht, RN Immunization Program
pkracht@kdheks.gov

Form required: Program Request and Detailed Budget

*MOGE – "Moved or Gone Elsewhere

WOMEN, INFANT, & CHILDREN (WIC) / IMMUNIZATION COLLABORATION PROJECT

PROGRAM PURPOSE

The purpose of this grant program is to expand existing collaboration between Women Infant and Children programs and immunization services with specific interventions designed to improve immunization rates by providing vaccination services onsite or referring WIC eligible children for immunization services in their medical home.

GRANT BACKGROUND

In 2005, the Governor's Blue Ribbon Panel on Immunizations noted: "A regular schedule of immunizations is recommended for children from birth to two years of age, which coincides with the period in which many low-income children participate in the Women, Infants, and Children Program (WIC). Studies have found significantly improved rates of childhood immunization and of having a regular source of medical care associated with WIC participation." Beginning in 2003, the Kansas Immunization Program provided federal funding for a Medicaid Immunization Linkage project in Sedgwick County. That project dramatically increased rates. In conjunction with the Governor's Panel recommendations, in 2004 the project was expanded to four counties designated by the program targeting the largest WIC service areas with the lowest immunization rates (Ford, Finney and Wyandotte LHDs). In 2008, the program expanded to include four more counties as a result of a state appropriation for WIC-Immunization linkage services (Cherokee, Saline, Seward and Shawnee LHDs). There are now 8 counties funded for the project.

FUNDING

A. Availability - Grant awards will be distributed on SFY 2015 Aid to Local Appropriations. This is not a competitive application opportunity. Applications for funding are solicited from Cherokee, Finney, Ford, Saline, Seward, Sedgwick, Shawnee and Wyandotte LHDs. Awards will be made with available funding from the State General Fund (up to $200,000) and the federal Centers for Disease Control and Prevention Immunization Grant (up to $165,000).
B. At this time, a match is not required for the WIC Collaboration Project Grant.
C. Funds may not be used to supplant or replace existing agency funding sources.
D. Funds may not to be used for license/maintenance fees for systems for immunization information documentation

SPECIFIC PROGRAM INFORMATION

a. Application--Follow the KDHE "SFY 2015 Grant Application Guidance," and complete the Program Request and Detailed Budget forms.
b. SFY 2015 Objectives – Applications will demonstrate strategies to accomplish the following objectives:
    Objective I: Demonstrate that the WIC staff can interpret the ACIP Childhood recommended and minimum interval schedule.
        a) Immunization assessment and education will be provided at each WIC encounter until the child is fully immunized. Assessment will include a review of the vaccinations that are coming due or overdue.

    Objective II: Electronically document immunization records for WIC clients in the Kansas immunization registry (KSWebIZ) via electronic interface with PHClinic (Cherokee, Ford, Saline, Seward and Sedgwick, Shawnee) or Netsmart Insight (Finney and Wyandotte).
    Objective III: Follow-up on referrals made for needed immunizations.

Objective IV: Increase immunization coverage of WIC eligible children

a) Evaluation of immunization coverage rates of children that receive WIC services by performing CoCASA assessment on a quarterly basis.
b) Perform reminder/recall for WIC children due or past due for immunizations.
c) Coordinate with the immunization staff to participate in incentive projects to ensure that WIC eligible children are age appropriately vaccinated.

c. Priorities

1) Applications will be solicited from targeted counties.
2) Applications will be considered for funding based on implementation of strategies, documentation of objectives completion for the previous project period and on availability of fund.

Patti Kracht R.N. Professional Education/AFIX Manager
Immunization Program
Bureau of Disease Control and Prevention
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Forms required: Program Request Detailed Budget