



*Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary*

DEPARTMENT OF HEALTH
AND ENVIRONMENT

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Division of Health

GRANT/CONTRACT APPLICATION GUIDELINES SYF 2009

Roderick L. Bremby, Secretary
Richard Morrissey, Acting Director of Health
January 14, 2008



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DEPARTMENT OF HEALTH
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M E M O R A N D U M

TO: Local Health Agencies
Other Grantees

FROM: Roderick L. Bremby, Secretary

DATE: January 14, 2008

REGARDING: Grant Application Guidelines and Grant Reporting Instructions SFY 2009

The Grant Application Guidelines and Grant Reporting Instructions for the following programs are enclosed for your review and submittal: General Health (Formula Grant), Primary Care Clinics, Child Care Licensing and Registration, Chronic Disease Risk Reduction, Maternal and Child Health, Family Planning, School Linked Services, Teen Pregnancy, HIV/STD (current contractors only), and Immunization Action Plan (IAP).

These instructions supersede all previous Grant / Contract Quarterly Report Instructions. You are advised to destroy all previous instructions and use these to ensure accurate and timely reporting which will permit a timely cash flow. These documents are also available on the Office of Local and Rural Health internet website: http://www.kdheks.gov/doc_lib/index.html

Three (3) complete copies of each of the grant applications, postmarked not later than Friday, March 14, 2008, should be mailed to:

**Kansas Department of Health & Environment
Office of Local & Rural Health
ATTN: Pat Behnke
Curtis State Office Building
1000 SW Jackson Ave, Suite 340
Topeka, KS 66612-1365**

Reporting instructions for grant programs which are not included in this packet and forms such as affidavits, etc. will be in the Grant/Contract Reporting Instructions SFY 2009.

Enclosure
pc: Richard Morrissey, Acting Director of Health

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GRANT GENERAL INFORMATION

Each year, the Kansas Department of Health and Environment (KDHE) makes federal and state funds available to local units of government and other eligible agencies to support public health services in local communities. The goal is to support services which maintain and improve the health of Kansas residents. There are two types of funding to local agencies:

1. **STATE FORMULA FUNDS** - General Health Services. These funds are available to local public health departments on a formula basis to support general health services. To be eligible for these funds, the Local Health Agency must be a county, city-county or a multi-county health department supported by sufficient local tax revenues and expenditures to meet the maintenance of effort requirements. (See memorandum in Form #6)
2. **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 under one cover.

OUTLINE OF SUBMITTAL REQUIREMENTS

STATE FORMULA GRANT

1. Submit a completed **APPLICATION FOR GRANT** (Form #1). Instructions for completing the application are on the reverse side of the form. The required copy of the 2008 Board of County Commission-approved County Health Department budget takes the place of the detailed budget form for the State Formula grant.

CATEGORICAL GRANTS (all other types of funding)

2. Submit a completed **APPLICATION FOR GRANT** (Form #1). Instructions for completing the application are on the reverse side of the form. One completed form is required as the cover sheet for each Local Health Agency application. Check the items submitted with the application.
3. Complete one **PROGRAM REQUEST** (Form #2) for each type of categorical funding requested. Instructions for completing the objectives are provided in the guidance materials.
4. Complete one **DETAILED BUDGET** (Form #3 or #4) for each type of categorical funding requested. Instructions for completing the budget are provided on the reverse side of the form.
 - a. Information about Matching funds from Local Health Agency
Some federal funds require state and local match. The amount of local match may vary from program to program. (See categorical program descriptions for required match.) The match amount must be equal to or greater than the minimum required match, and should reflect the Local Health Agency's total share of the grant program. Local funds spent by the Local Health Agency for travel, personnel, supplies, capital equipment, and "other" may be used as match. Indirect cost and contributions are acceptable as part of the local match **after the Local Health Agency has submitted an acceptable annual indirect cost proposal** to KDHE. Items included in the indirect cost computation cannot be included as direct cost items.
 - b. Other Budget Stipulations: Most federal grant awards have a fiscal year from October 1st to September 30th. When planning the program expenditures do not anticipate receiving more than 25% of the grant funding for the period July 1st through September 30th. The local match amount must be equal to or greater than the minimum required match for the same period. An excess match in the period starting October 1st cannot be carried back to offset an under-match for the period July 1st through September 30th.
5. Complete one **PERSONNEL ALLOCATION BY PROGRAM** (Form #14) for each Local Health Agency. This information must be in agreement with the detailed budget(s) filed with individual Program Form(s).
6. **COUNTY HEALTH DEPARTMENTS ONLY**
A copy of the 2007 Board of County Commission-approved County Health Department budget, including projected revenue and expenditures must be submitted with the grant application packet.

GRANT PROGRAMS

STATE FORMULA

1. 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.

2. FUNDING

Funding will be allocated to each local health department based on the formula contained in the Kansas Statutes Annotated (K.S.A.) applied to funds appropriated by the 2008 Legislature. A listing is attached that exhibits the amount that will be allocated to each health department based on that appropriation level. If the appropriation varies from that amount, a new allocation listing will be prepared. (See Form #5)

The statute authorizing the State Formula Grant, K.S.A. 65-241 et. seq., requires a local maintenance of effort. (See Form #6)

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

3. SPECIFIC PROGRAM INFORMATION

- a. List basic services to be provided with State Formula Funds.
- b. List the 2008 Local Tax Revenue Amount on the "Application for Grant" summary page.

4. 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 2008, receive and expend local tax revenue in accordance with attached KDHE maintenance of effort clarification memorandum. (See Form #6)
- c. Submit an application requesting funding.

5. REPORTING REQUIREMENTS

- a. No narrative reports are 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.

6. PROGRAM CONTACT PERSON

Shirley Orr, Director, Local Health
Office of Local & Rural Health
Curtis State Office Building
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365
Phone: (785) 296-1200
Fax: (785) 296-1231
Email: sorr@kdhe.state.ks.us

COMMUNITY BASED PRIMARY CARE CLINICS

1. PROGRAM PURPOSE

State General Funds are provided to assist in the development and operation of projects that focus on improving access to health care with an emphasis on community based primary health care services and projects that address health disparities. Grant funds are intended to make primary medical and dental care, prescription drugs and preventive health care services available, accessible, and affordable to underserved and vulnerable Kansas residents including persons eligible for HealthWave, Medicaid or other medical assistance programs operated by the State of Kansas.

2. FUNDING

Applicants for primary health care project grants are required to provide local support which meets the local match requirement of one dollar for each one dollar of funding awarded through this program. Grant requests for Primary Care Clinics (PCC), the Prescription Drug Assistance Program (PDAP) and Dental Programs (DP) may be combined in one application. Awards for each program are contingent upon the availability of funding.

Funding will be provided to clinics and health centers that:

- demonstrate a high level of need in their community,
- present a sound proposal to meet this need,
- demonstrate responsiveness to the health care environment of the service area, and
- have collaborative and coordinated delivery systems for the provision of health care to the underserved to the extent funding is available.

3. SPECIFIC PROGRAM INFORMATION

To obtain a packet of forms specific to the State Primary Care Clinic Program, please contact the Primary Care Office indicating that you plan to apply and forms will be provided to you. The completed application must be assembled in the following order:

- a. Face Page: APPLICATION FOR GRANT (Form #1) Record the total of all funds requested for Primary Care Clinics, Pharmacy Assistance and Dental Programs.
- b. Budget Forms: Primary Care Clinics, Pharmacy Assistance and Dental Program request for state funding in appropriate columns (Form #4)
- c. Personnel Allocation by Program (Form #14). This form is required from all agencies applying for grants from KDHE for more than one program area.
- d. Program Narrative
- e. Program Specific Health Plan and Business Plan Forms are available on the web at: http://www.kdheks.gov/doc_lib/index.html
- f. Written Agreements
- g. Letters of Support (not required for existing grantee renewal applications)

4. DEFINITIONS/DESCRIPTIONS OF SPECIFIC PROGRAM INFORMATION

- a. **Face Page:** Specify the clinical location(s) of your program if different from the address of the applicant. The form must be signed by the President/Chairman of the local health agency, clinic or health center governing board.
- b. **Grant Application Budget:** The **budget** is the financial plan required to achieve the overall management of the program. The plan for financing should be as accurate as possible so that few changes will occur to budget line items during the administration of the grant.
 - **Non-cash contributions** such as personnel time, space, commodities, or services, must be given a fair market value and documented in the applicant's accounting records. Costs associated with inpatient care are non-allowable.
 - Expenses:** (Budget detail as follows)
 - **Staff Personnel:** Staff Salaries and Benefits

List personnel according to a category (e.g., health professional/clinical personnel, prescription assistance, clerical, and administrative). Beneath the category "health professional/clinical personnel" each position should be listed separately by title and percent of full-time equivalency (FTE) employed as a primary care provider. Allocate the salary amounts to be paid from applicant's share and/or State Grant in the appropriate columns. Only regularly assigned personnel who receive salaries or wages should be included in the staff category. Include expenses of payroll taxes and employer-paid benefits. The value of volunteer personnel time may be listed in this category for purposes of local match.

Health professional/clinical staff includes physicians, all nursing personnel (RN, LPN, nursing assistants) nurse practitioners, physician assistants, psychologists, clinical social workers, dentists, dental hygienists, pharmacists, pharmacy assistants, and optometrists.

- **Contract Personnel:** are health professionals (similar to staff personnel listed above) who provide primary care services by special arrangement or contract. The full time equivalency (FTE) of the contracted person shown in the column marked "% time worked in a program."
- **Health Services:** includes payments made for services only, not personnel. Clearly explain the purpose of each contract and the specific contract deliverable. Categorize contract costs according to type (e.g., dental, optometric, laboratory, pharmacy, mental health, x-ray). Do not list non-patient care contracts in this category. Cost related to the contracted service may not be more than the fair market value. The applicant's share may not be more than the actual cost of the service for which the applicant has contracted. For example, the cost to report for donated (non-cash) laboratory services should be an amount agreed upon as the market value for those services.
- **Travel:** limited to in-state travel to primary care training and continuing education, including training to manage pharmacy assistance programs. Do not include salary expense. In this grant program, do not use state funds for out-of-state travel.
- **Supplies:** should be categorized according to type: Pharmaceuticals (prescription medications purchased by or dispensed from the clinic site). Include the cost/market value of donated sample medications as local match, if appropriate. Laboratory Supplies, Other Medical Supplies: (patient education materials, and clinical supplies directly related to patient services, e.g., (drapes, gloves, needles), and Office Supplies (clerical, financial, administrative and other operational supplies).
- **Capital Equipment:** List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Avoid budgeting for capital equipment with state funds without prior authorization from the Primary Care Office Director. If capital items purchased with the applicant's funds are to be credited toward the local match, they must be listed separately. Only major equipment items (costing more than \$5,000 per unit) need to be itemized with equipment costs and justifications. Items costing less than \$5,000 should be aggregated with a brief summary explanation.
- **Other (Including Indirect Cost)**
 - Itemize other direct costs.
 - Indirect costs or contributions are acceptable only as part of the local match, but the applicant must submit an annual indirect cost proposal which meets KDHE requirements. Items included in the indirect cost computation cannot be included as direct cost items. Indirect costs may include rent, utilities, general administration, accounting, etc.
- **Budget Summary:** The budget form will automatically total all budget categories in the appropriate columns on the summary sheet.

c. **Personnel Allocation by Program** (Form #14)

All Local Public Health Departments, as well as any other clinics and health centers applying for grants from more than one program, must complete the form identifying employees, position titles, salary, and time allocation by program. Instructions accompany the form.

d. **Program Narrative:**

Describe your organization's mission and history. Programs vary greatly in terms of mission, service area, range of services, client eligibility, and local project goals and objectives. Submit a brief written narrative describing the program, accomplishments or changes in the last grant year, new and ongoing partnerships, program goals and/or projections for the new grant year.

1. Generally, the Program Narrative should be a detailed description of the community/target population(s) to be served and the applicant organization's plan for addressing the identified health care needs/issues of the community/target population.
2. Throughout the Program Narrative, reference may be made to exhibits and charts, as needed, in order to reflect information about multiple sites and/or geographic or demographic data. These exhibits and charts should be included as part of the attachments.

The following information provides a framework for the program narrative which should be organized using the following section headers:

Narrative Section I: Description of Community Needs: Patients to be Served

1. Applicant describes the service area(s)/community(ies) to be served by the project, including:
 - a. The population and area to be served.
 - b. The counties, Census tracts, minor civil divisions, schools/school districts, etc., (as appropriate) in the service area.
 - c. Any Medically Underserved Areas (MUA), Medically Underserved Populations (MUP), and Health Professional Shortage Areas (HPSA), as applicable.
2. Applicant describes the target population(s) for the clinic or health center (e.g., general community members, migrant/seasonal agricultural workers, residents of public housing, homeless persons, low-income school children, etc.), including:
 - a. The unserved, underserved and at-risk populations in the community.
 - b. The unique demographic characteristics of the target population (e.g., age, gender, insurance status, unemployment, poverty level, ethnicity/culture, education, etc.).
<http://www.kdheks.gov/chipr/homepage.html>
 - c. The relevant access to care and health status indicators of the target population/community, including the most common causes of mortality and the incidence and prevalence of chronic and infectious diseases. See "Data Links" at:
http://www.kdheks.gov/bhp/healthy_ks_comm/index.htm
3. Applicant identifies and describes the most significant barriers to care, gaps in services, significant health disparities, and major health care problems in the community that will be addressed by the clinic/health center. This should include a description of:
 - a. Any culturally specific characteristics that impact access to and the delivery of health care services.
 - b. Any relevant geographic barriers to care and other factors impacting access to care.
 - c. Any major and/or unique health care needs of the target population(s).

4. Applicant describes any significant changes over the past year in the service area or population being served (e.g., influx of refugee population or closing of major employer, etc.) impacting the need for services.
5. Applicant identifies any health care providers (including all other clinics/health centers and Federally Qualified Health Centers), resources and/or services of other public and private organizations within the proposed service area that are providing care to the target population(s). The applicant also evaluates the effectiveness of available resources and/or services in providing care to the target community/population.
6. Applicant projects how many people will be served and encounters will be generated.

Narrative Section II: Response to Fulfill Needs

1. Applicant describes the scope of the proposed project, including the proposed service delivery model.
2. Applicant demonstrates that the proposed model is most appropriate and responsive to the identified community health care needs (i.e., the service delivery plan addresses the priority access to care and health and social problems of the target population(s) for all the major life stages and for each special population to be served.) Examples: National Health Service Corps Site Development Manual: <http://nhsc.bhpr.hrsa.gov/resources/SRM-toc.asp> BPHC Self Assessment Tool: http://www.jointcommission.org/NR/rdonlyres/1657E26E-0D04-4F37-BD22-F7637F3C3DC3/0/bphc_self_report_tool.pdf
3. Applicant demonstrates that the required primary, preventive, and supplemental health services will be available and accessible to the target population without regard to ability to pay (i.e., applicant demonstrates that a schedule of charges for services has been established, as well as a corresponding schedule of discounts, based on a person's ability to pay for all persons below 200 percent of poverty).
4. Applicant demonstrates that the services will be culturally competent and linguistically appropriate.
5. Applicant demonstrates comprehensiveness and continuity of care for the project, including a discussion of the following:
 - a. Hours of operation that assure services are available and accessible at times that meet the needs of the population, including evenings and weekends as appropriate; and
 - b. Mechanism to assure professional coverage during the hours when the health center is closed.
6. Applicant demonstrates that the proposed clinical staffing pattern for the project is appropriate for the level and mix of services to be provided.
7. Applicant describes a plan for recruiting and retaining appropriate health care providers to achieve the proposed staffing pattern.

Narrative Section III: Program Evaluation

1. Applicant must demonstrate the following:
 - a. An operating quality improvement program that contains the ability to monitor and evaluate the quality and outcomes of the services provided, including an evaluation plan with specific time frames, measurable outcomes, and clear methods/action steps. Sample resource: <http://www.hrsa.gov/performance/protocol.htm#appendixa>
 - b. Tools and mechanism(s) by which the organization identifies and responds to the community and its needs (e.g., patient surveys, needs assessments, statewide data, and Census data). Sample resources: <http://bphc.hrsa.gov/patientsurvey/>
<http://www.ahrq.gov/ppip/manual/>
<http://www.qualitymeasures.ahrq.gov/browse/browsemeasures.aspx>

- c. The role of clients, community, staff and board of directors (and/or advisory board, where applicable) in establishing and evaluating the organization's objectives and priorities. Sample resource: <ftp://ftp.hrsa.gov/nhsc/resources/SRM-Chapter4.pdf>
- d. How strategic planning and program decision-making result from the evaluation of program effectiveness by management staff and the Governing Board/Advisory Board.
2. If applying for renewal of a state grant, provide a narrative and statistics describing current status of objectives listed in last year's application.

Narrative Section IV: Expected Impact

1. Applicant demonstrates and provides evidence of the community's support of the primary care clinic. Letters of support and Memoranda of Understanding (MOU) and/or a list of additional letters of commitment, MOUs, etc., on file at the clinic or health center.
2. Applicant demonstrates the extent to which it will increase access to care and eliminate major barriers to care for the medically underserved in the community/target population(s) to be served.
3. Applicant demonstrates the extent to which it will address the priority health care needs and reduce health disparities for the medically underserved in the community/target population(s) to be served.

Narrative Section V: Governance

1. Applicant must provide a copy of the signed bylaws. If a potential grantee has an advisory board rather than governing board, please explain why and how the advisory board functions along with a detailed description of the makeup of the board.
2. Applicant describes the structure of the board in terms of size, expertise, and how it represents the communities/populations served by the clinic or health center.
3. Applicant discusses the mechanism of continued board training, including training new governing board members in appropriate responsibilities and requirements of the primary care clinic grant.

Narrative Section VI: Health Care Plan

In general, this section should be used to outline goals and objectives related to health needs and issues of the target population. A template for the Plan may be found on the web at: http://www.kdheks.gov/doc_lib/index.html

During 2007, the Kansas Health Policy Authority engaged in a statewide planning process that resulted in the adoption of a set of 21 health reform recommendations for improving health and the delivery of health care in Kansas. The report and recommendations may be downloaded at: http://www.khpa.ks.gov/PressReleases/12-20-07KHPA%20Report_3Ps_UPDATED_122007_FINAL.pdf

The health care plan should be used as an ongoing monitoring and evaluation tool by both the grantee and KDHE. Please address the following:

1. Major health-related goals and objectives for each of the life stages and populations to be served. Sample resources: *Healthy People 2010* <http://www.healthypeople.gov/hpscripts/KeywordSearch.asp>
Healthy Kansans 2010 Objectives <http://www.healthykansans2010.org/>
Kansas Oral Health Plan: http://www.kdheks.gov/ohi/download/Kansas_Oral_Health_Plan.pdf
2. Improving performance, quality, and outcomes, e.g., quality improvement plan activities and clinical outcome measures.
3. Eliminating Health Disparities as appropriate for the target community/population, e.g., infant mortality, adult and pediatric immunizations, diabetes mellitus, cardiovascular disease, HIV infection, cancer prevention, asthma, hypertension, obesity. Ethnic Disparities Chart Book: <http://www.khi.org/s/index.cfm?aid=135>

4. The health care plan may also address, in narrative form, those issues that cannot be represented in table form.

Narrative Section VII: Business Plan

Please indicate what plans your center has to increase its income. Include what efforts have been made this past year to increase both the number of patients and income and how your center can become financially self-sufficient. A sample format is provided on the web at: http://www.kdheks.gov/doc_lib/index.html Include plans for attaining and maintaining long-term viability (i.e., future requirements for financial and other resources, space, personnel, capital, marketing, etc.) The Business Plan may also address, in narrative form, those issues that cannot be captured in the table format.

-end of narrative section-

5. WRITTEN AGREEMENTS

Supporting Agencies are the project partners who contribute non-cash donations. The clinic must have a written memorandum of agreement with these other agencies and make these available upon request by KDHE. If there are new supporting agencies not previously reported, please submit the new written memoranduma.

6. LETTERS OF SUPPORT

Letters of support for the original grant applications are kept on file with KDHE. Additional letters are not required for continuation grants.

7. ADDITIONAL CONSIDERATION

Fiscal control and fund accounting procedures must exist to assure the proper disbursement and accounting of funds for each grant. Bookkeeping accounts should be established and maintained reflecting all services, charges, receipts, obligations, and revenue, including non-cash contributions and disbursement of grants and local funds. The applicant is fully responsible for providing workers' compensation, unemployment insurance, and social security coverage. The applicant is also responsible for income tax deductions, and for providing any benefits required by law for those employees who are employed on behalf of the grant program.

Additional program and/or revised budget information may be requested after funds are awarded and prior to issuance of the contract to ensure that all KDHE requirements are met. Questions regarding the application process may be directed to Barbara Gibson, Director KDHE Office of Primary Care, at (785) 296-1200 or bgibson@kdhe.state.ks.us.

8. **GRANT EVALUATION:** Applications will be prioritized, based on the extent to which applicant addresses the following factors:
 - a. specific local health priorities;
 - b. need based on local data;
 - c. collaboration with other organizations in the proposed service area;
 - d. measurable outcomes; and
 - e. best practice or replicable model.

Other factors considered in granting awards:

- a. The level of requested support versus total budget.
- b. Amount of projected non-clinic grant revenue relative to the proposed plan and other Federal/State/local/in-kind resources applied to the project.
- c. Projected number of users and encounters funded by the requested grant.
- d. The total cost to the clinic/health center per user and encounter (using 2006 patient data).

9. REPORTING REQUIREMENTS

See instructions and forms for the Community Based Primary Care Clinic Program contained in the SFY 2009 Grant/Contract Reporting packet and on the internet at http://www.kdheks.gov/doc_lib/index.html

10. PROGRAM CONTACT PERSON:

Barbara Gibson, Director, Primary Care Office
Office of Local & Rural Health
1000 SW Jackson Ave, Suite 340
Topeka, KS 66612-1365
phone: (785) 296-1200
fax: (785) 296-1231
email: bgibson@kdhe.state.ks.us

CHILD CARE LICENSING AND REGULATION PROGRAM

1. PROGRAM PURPOSE

The purpose of the Child Care Licensing and Registration Program is to safeguard children from harm in out-of-home child care by:

- a. Increasing the state-wide availability of regulated homes and facilities that meet or exceed standards.
- b. Reducing predictable health and safety risks to children in child care and foster care.
- c. Providing consumer protection for children and families.
- d. Increasing public awareness regarding the need for quality child care and foster care.
- e. Increasing the timeliness of inspections and enforcement actions.

This includes children who are cared for in 24 hour residential care and in less than 24 hour day care.

2. FUNDING

- a. Availability - Awards will be based on a formula that includes the population of children under 15 years of age in the county based on 2000 US Census Bureau projections; number of child care cases as of February, 2008; and child care capacity as of February, 2008, surveyor qualifications and multi-county service areas. Payment may be held for failure to meet contract requirements.
- b. Maintenance of Effort Requirement - The federal child care funds may not supplant local and state public funds expended in the regulatory program. The local funds expended in the child care licensing program can not be used as a local match to meet other federal grant requirements.
- c. Priorities - Funds will be used to maintain and improve the regulatory program at the local level. Priority should be given to improving current service delivery including timeliness and quality of service delivery. Funds may be used for additional services needed to improve the regulatory program or to improve communication system between state and local units.

3. SPECIFIC PROGRAM INFORMATION

- a. Application: Agencies applying for SFY 2009 grant funds will follow the application process outlined in the Grant Application Instructions.
- b. Services: During SFY 2009 some services currently requiring paper format will be performed electronically using e-mail, the updated computer database (CLARIS) and other technologies. Surveyor access to email and internet service is required. All the regulatory field work is to be conducted at the local county level in accordance with the Child Care Facility Policy and Procedure Manual. This includes the following regulatory services:
 - (1) Pre-application activity: providing an orientation for prospective child care providers at least monthly, more often as needed and upon demand if less than one inquiry per month is received.
 - (2) Inspection activity: conducting surveys and related tasks involving professional decision-making necessary to determine compliance with statutes and regulations.

- (3) Complaint activity: conducting all required activity related to intake and investigation of complaints concerning illegal child care or regulation violations and related tasks involving professional decision-making.
 - (4) Community outreach activity:
 - (a) Establish the local health agency as the primary contact for applying for child care, reporting concerns of poor child care practices or violations of regulations, and for reporting illegal child care.
 - (b) Participate with other agencies and organizations in the coordination of child care services at the local level including the referral of public requests for child care facility availability to Kansas licensed day care resource and referral agencies, and presentations to the public to promote community awareness of the importance of regulation and quality child care.
- c. Program Assurances: By applying for funds, contractors agree to meet the following requirements:
- (1) Strengthen compliance through the consistent administration of the child care licensing laws and regulations.
 - (a) Provide regulatory activity in accordance with the Child Care Facility Policy and Procedural Manual.
 - (b) Participate in child care facility surveyor and grant training provided by KDHE, Child Care Licensing and Registration Section. Minimum participation is 3 of the 4 Quarterly Regional Meetings and 5 clock-hours of KDHE, CCLR Administrator Approved in-service training that is child care and/or regulatory directed and that relates directly to the work of a child care facility surveyor.
 - (c) Complete the Child Care Facility Surveyor Qualifications for each licensing surveyor or assistant surveyor currently employed by the local program. (Form #15) Where qualification requirements for Child Care Facility Surveyor(s) are at or upgraded to the professional level they will be maintained. Where surveyors are qualified at the special technical level, qualification requirements will be maintained or increased. Where Child Care Facility Surveyor duty assignments have been "grandfathered in" below the special technical level, they may be maintained for the incumbent. New surveyors must be qualified at the professional or special technical level.
 - (d) Participate with KDHE staff in assessing consistency and quality of surveying.
 - (2) Improve timely and effective service delivery that is customer friendly in the child care regulatory program. Contractors will achieve a 90% or higher timeliness of inspections in SFY 2009. Multi-county contracts are encouraged for counties serving a small number of child care facilities.
 - (3) Support the development of a high quality child care system through community partnerships.
- d. Grant Application Budget. The budget is the financial plan required to achieve the overall management of the program. The plan for financing should receive serious consideration so that few changes will occur to budget line items during the administration of the grant.

Expenses: (Budget detail as follows)

- **Staff Personnel: Staff Salaries and Benefits**
List personnel according to a category (e.g., a child care facility surveyor, clerical, administrative). Beneath each category, each position should be listed separately by title and percent of time employed in the child care licensing and registration program. Allocate the salary amounts to be paid from local health agency share and/or State Grant in the appropriate columns. Only regularly assigned personnel who receive salaries or wages should be included in the staff category. List expenses of payroll taxes and employer-paid benefits separately.
- **Travel**
Include in-state travel necessary to carry out the child care regulatory program. Include Child Care Facility Surveyor training and continuing education travel expenses in this category. Do not include salary expense.
- **Supplies**
Categorize supplies according to type: i.e., Office Supplies. Do not include a cost (value) for donated items.
- **Capital Equipment**
Capital Equipment is defined as items costing \$500 or more and having a useful life greater than one year. Avoid budgeting for capital equipment using Grant Funds. If capital items purchased with local health agency funds are to be used toward the local match, each item must be listed separately and a justification for the use of the item must be included. If the item is shared with another program, only the percentage of use for the child care regulatory program is allowable.
- **Other (Including Indirect Cost)**
Itemize other direct costs. Indirect costs are acceptable only as part of the local match, but the local health agency must submit an annual indirect cost proposal which meets KDHE requirements. Items included in the indirect cost computation cannot be included as direct cost items. Indirect costs may include rent, utilities, general administration, accounting, etc.
- **Budget Total**
Carefully check the mathematics before submitting the budget.

4. REPORTING REQUIREMENTS

- a. Quarterly program reports are required to document progress in meeting program objectives, regulatory activity and program improvement, and to provide statistical information.
- b. Quarterly Certified Affidavit of Expenditures are required to document the use of federal, state and local funds in the child care regulatory program.

5. STAFF QUALIFICATIONS

- a. In cases where the local agency employs both Child Care Facility Surveyors and Assistant Surveyors, job descriptions and minimum requirements for the positions are to be attached to the application. Child Care Facility Surveyor duties shall include initial licensed day care home surveys, all complaint investigations, all child care center/preschool and 24-hour care survey visits and orientation training. Assistant Surveyor duties include routine re-licensing inspections for day care homes; routine compliance checks; and assisting the Child Care Facility Surveyor in their surveyor duties. Assistant Surveyor duty assignments will require completion of a post high school professional technical education or training program, with course work in a health related

field, public health, child development, behavioral sciences, or home economics and related work experience with children and families.

- b. The bonus for contractors with a Child Care Facility Surveyor(s) meeting the requirements at the Professional Level will be prorated per percentage FTE. The minimum bonus will be \$250 and the maximum will be \$1,000.

6. PROGRAM CONTACT PERSON

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MATERNAL AND CHILD HEALTH SERVICES

1. PROGRAM PURPOSE

Maternal and Child Health (MCH) programs promote the development of local systems of health care for pregnant women, children ages 0 to 21, and their families. Fundamental to MCH programs are services that are family-centered, community-based, collaborative, comprehensive, flexible, coordinated, and culturally competent and developmentally appropriate.

2. FUNDING

Continuation Grants: Highest priority is to continue funding of local agencies that demonstrate progress toward specific objectives, meet program requirements and participate in education updates. A 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.

New Grants: Awards for new projects are subject to the availability of funds and community needs assessment.

Match: 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.

Local MCH Services: Applicants should adhere to a service plan that utilizes 50% of the funds for services to pregnant women and infants and 50% for children and adolescent services.

3. SPECIFIC PROGRAM INFORMATION

Application: Follow the KDHE SFY 2009 Grant Application Guidance

Services: MCH grants address priorities identified in the federally required 5 year MCH state needs assessment called MCH2010. Go to <http://www.kdheks.gov/bcyf/index.html> or refer to MCH program manual to access MCH2010.

MCH2010: Each local grantee agency will provide services in order to address the following State priorities identified in MCH2010:

- a. Pregnant Women and Infants
 - Increase early & comprehensive health care before, during & after pregnancy
 - Reduce premature births and low birthweight
 - Increase breastfeeding
- b. Children & Adolescents
 - Improve behavioral/mental health
 - Reduce overweight
 - Reduce injury and death

Program Goal and Outcome Objectives: Families that have a regular source of healthcare in a medical home are receiving services that are family-centered, community-based, collaborative, comprehensive, flexible, coordinated, culturally competent and developmentally appropriate. With a medical home, early identification and intervention for women, infants, and children may improve health outcomes. Therefore, the SFY 2009 Goal for MCH services is: All pregnant women, infants, children and adolescents served by the MCH local agency will have an identified medical home that consists of a provider as a regular source of care and an identified payor source. For more information on Medical Home, go to the American Academy of Pediatrics Kansas Medical Home Webpage at <http://www.medicalhomeinfo.org/states/state/kansas.html>.

To meet this goal for all clients served in MCH programs, grantee agencies must work towards the following outcome objective:

Medical Home Indicator

- Increase the % of pregnant women and infants, children and adolescents who do not have access to a "Medical Home" (regular source of care and an identified payor source) from ____%(current data) to ____% (projected improvement) by June 30, 2009.

Please see worksheet Form #18 in the Forms. Please submit completed worksheet page with your application.

In addition, the local grantee agency will address **at least one** outcome objective from each of the following two groups:

1) Pregnant Women and Infants

- **First Trimester Prenatal Care indicator**
Increase the % of pregnant women served by the MCH local agency that receive prenatal care in the first trimester of pregnancy from ____% (current data) to ____% (projected improvement from planned local agency intervention) by June 30, 2009.
- **Tobacco Screening indicator**
Increase the % of pregnant women served by the MCH local agency screened for tobacco use from ____%(current data) to ____% (projected improvement from planned local agency intervention) by June 30, 2009.
- **Tobacco Cessation indicator**
Decrease the % of pregnant women served by the MCH local agency who use tobacco products from ____% (current data) to ____% (projected improvement from planned local agency intervention) by June 30, 2009.
- **Breastfeeding Initiation indicator**
Increase the % of pregnant women served by the MCH local agency that initiate breastfeeding from ____% (current data) to ____% (projected improvement from planned local agency intervention) by June 30, 2009.
- **Breastfeeding Duration indicator**
Increase the number of women who breastfeed their infants through six months of age: from ____% (current data) to ____% (projected improvement from planned local intervention) by June 30, 2009.

2) Children and Adolescents

- **Behavioral and Mental Health Screen indicator**
Increase the number of children and adolescents served by the MCH local agency who are screened for healthy mental and behavioral health functioning and referred if indicated from ____% (current data) to ____% (projected improvement from planned local intervention) with referral to community mental health services for identified needs by June 30, 2009.
- **Overweight and Obesity Screening indicator**
Increase the number of children and adolescents served by the MCH local agency screened for body weight and body mass index from ____% (current data) to ____%

(projected improvement from planned local intervention) with referral to appropriate nutrition counseling and medical services for children 2 to 18 years of age with weight percentiles and BMI \geq 85 percentile by June 30, 2008.

(Hagan JF, Shaw JS, Duncan PM, eds. 2008. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition. Elk Grove Village, IL: American Academy of Pediatrics).

- **Injury and Death Prevention indicator**

Increase the numbers of children age 0 – 21yrs that receive injury prevention education from ___% (current data) to ___% (projected improvement from planned local intervention) using education in the form of anticipatory guidance on child and adolescent safety by June 30, 2009.

SFY 2009 Process Objectives:

Maternal Child Health Level of Service	Level A Information and Referral Only	Level B Care Coordination and Management	Level C Comprehensive Care Coordination and Service Provision
Pregnant Women and Infants	Outreach and family support to pregnant & postpartum women with referral services only to outside care for social worker, dietician and medical prenatal/postnatal services. Provide infant immunizations only.	Outreach and family support to pregnant women with Case Management Services by a Nurse, Social Worker, and Dietician with referral linkage only to Medical prenatal/postnatal services to a specific clinic or private physician. Provide health assessments for infants.	Outreach and family support to pregnant & postpartum women (HSHV or other) with Case Management Services by a Nurse, Social Worker, and Dietician, plus Medical prenatal & postnatal services. Provide preventive health care, education and services to infant, and provide case management services to any chronic health condition.
Children and Adolescents	Provide immunizations only	Provide health screenings, immunizations, and physical assessments with referral to services and follow-up to children 1 – 21 yrs. of age.	Provide preventive health care education, promotion, and services to children 1 – 21 yrs. of age including health screenings, immunizations, physical assessments with referral and follow-up and case management services of children with chronic health conditions

***Please indicate Level of Service and number to be served in the application.

In SFY 09, Level (A, B, or C) ___ services will be provided to # ___ pregnant women.

In SFY 09, Level (A, B, or C) ___ services will be provided to # ___ infants (0-1yr.)

In SFY 09, Level (A, B, or C) ___ services will be provided to # ___ children (1 – 9 yrs).

In SFY 09, Level (A, B, or C) ___ services will be provided to # ___ adolescents (0 – 21 yrs)

Health Promotion and Education

Community education and outreach activities should be based on an assessment of community needs and available resources and have both implementation and evaluation components. Each MCH funded program must provide for community education programs to: a) enhance community understanding of the objectives of Maternal Child Health care and services; b) inform potential clients of the availability of community resources and services; and c) encourage continued participation by persons to whom MCH services may be beneficial.

Program Requirements

1. The local grantee agency will develop and have on file written program policies and procedures that are based on program standards and guidelines as in Section 3, SPECIFIC PROGRAM INFORMATION above.
 - Income and family size of all MCH clients must be determined at least annually.
 - A sliding fee scale with a minimum of four equal increments must be established and implemented for all MCH services provided.
 - Agencies will submit client encounter data by a paper Client Visit Record (CVR) or by electronic means at least bi-monthly.
 - Grantees will provide at least 20% of the families visited in the clinic or home setting with a client satisfaction feedback postcard. The family completes the card and mails it to KDHE. The survey card will be returned to the local health agency for program self-evaluation.
2. Maximize Third Party Revenue: The local grantee agency will use a billing system to maximize revenues from 3rd party sources including Medicaid.
3. Compliance Monitoring: Monitoring/Site Visits are conducted and technical assistance will be provided to all MCH grantees by KDHE MCH program staff. A corrective action plan for issues identified during the said visit will be established and implemented.

A 5% penalty of total grant award amount will be assessed for delinquent year-end reports beyond August 15th.

4. For multi-agency grants only, the delegate agency shall provide each agent/subcontractor with a completed grant application, contract, and reporting instructions, and to 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.

Continuing Education

- An Individual Professional Development Plan (IPDP) or other system of documenting educational updates will be maintained on all MCH professional staff members at each agency.
- Orientation to MCH services will be provided for all new MCH staff at the annual Maternal and Child Health Conference.

- At least one local agency MCH professional staff will attend the annual Maternal and Child Health Conference. Attendance at this conference is highly recommended for all MCH staff.
- Newly hired Healthy Start Home Visitors (HSHVs) will attend the Kansas Home Visitation Training within the first six months of employment.
- All HSHVs will attend the Fall Regional HSHV training and one statewide conference of the local agency's choice.

4. REPORTING REQUIREMENTS

Refer to the KDHE "SFY 2009 Grant/Contract Reporting Instructions."

5. PROGRAM CONTACT PERSONS

Brenda Nickel, Child Health
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FAMILY PLANNING

1. PROGRAM PURPOSE

The goal of Family Planning is to provide individuals the information and means to exercise personal choice in determining the number and spacing of their children, prioritizing services to low-income and high risk individuals.

2. FUNDING

- a. Continuation Grants - Highest priority is to continue funding of local agencies that consistently meet contract objectives and requirements, and participate in education updates. A second priority is to provide funding equal to at least 90% of the previous year's base award and to allocate the remaining 10% based on performance/need data. In the event additional funds are received at the state level, they will be distributed to local agencies based on performance/need data. The amount of funding the local agency requests in the grant application should be based on cost to provide services, not the amount received in the previous year.

Based on 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. 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.

- b. New Grants - At this time, funding is expected to be available to support only those projects currently in existence.
- c. Match - Local matching funds must be equal to or greater than 40% of grant funds awarded. Program revenues may be utilized to meet the match requirement.
- d. Program Revenue - Local agencies must establish a schedule of fees for services and supplies based on guidelines contained in the Manual (see 3.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 federal funds, projected fee collections, Title XIX, and third party reimbursements plus any unexpended revenue carryover (prior grantees only) from the previous year's budget.

3. SPECIFIC PROGRAM INFORMATION

- a. Application - Follow the KDHE "SFY 2009 Grant Application Guidance" instructions. The application budget must include expenses for staff to attend education updates.
- b. Services - See "Program Guidelines for Project Grants for Family Planning Services," DHHS and also the KDHE "Children, Youth, and Families Health Services Manual, Vol. IV, 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 (OPA) 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. SFY 2009 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.

SFY 2009 Process Objectives: In setting your objectives for SFY 2009, 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) 2007 to # ___ in CY 2008.
 - 3) Increase the number of low-income (below 150% poverty) Users receiving services from # in CY 2007 to # ___ in CY 2008.
 - 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 3.b. above. As appropriate, Local Health Agency will have on file current ARNP protocols 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 DSI training needs assessment and 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. REPORTING REQUIREMENTS

Refer to the KDHE "SFY 2009 Grant/Contract Reporting Instructions."

5. PROGRAM CONTACT PERSONS

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SCHOOL AND PUBLIC HEALTH NURSE COLLABORATIVE PRACTICES

1. PROGRAM PURPOSE

The goal of the School and Public Health Nurse Collaborative Practice is to strengthen interdependence of school and public health nurse practice to more efficiently provide population-based services to preschool and school age children and their families, utilizing public health practices and collaborative partnerships within communities.

2. FUNDING

Eligible applicants are Local Health Departments in Kansas. Funding is available to plan the creation or expansion of integrated health promotion, preventative services, and coordination of child preventive health programs and services within local community health systems, utilizing specifically, school nurses, public health nurses, and the medical home office staff. Guidance on possible collaborative projects is available by contacting the program contact person listed below.

Match Local matching funds must be equal to or greater than 30% of grant funds awarded.

3. SPECIFIC PROGRAM INFORMATION

- a. Application: Follow the KDHE "SFY 2009 Grant Application Guidance" instructions.
- b. Services: It is the intent of this initiative that this grant will be used for the purpose of expanding or enhancing collaborative partnerships between school health services and public health departments to target the health needs of children who attend school programs. Information to assist in developing a collaborative initiative and outcomes for this grant may be developed addressing the MCH 2010 Priorities for Children and Adolescents:
 - Improve behavioral/mental health
 - Reduce overweight
 - Reduce injury and death

Address any of the health issues outlined and presented in the Kansas Maternal and Child Health 2004 Annual Summary found at

http://www.kdheks.gov/bcyf/download/MCH_2004_Annual_Summary.pdf.

This document provides a brief overview of the Kansas goal, definition, significance of the health issue, and Healthy People 2010 Objectives when available.

- c. SFY 2009 Outcome Objectives: The School and Public Health Collaborative Practices grantee will address the following:
 - Increase the capacity of school nurses and public health nurses to identify local public health systems that serve as resources in communities so that regional and community health concerns for young children and school-age children may be identified and addressed in a timely fashion.
 - Identify and utilize resources available to school and public health staff providing the nurses with the tools to conduct assessment, provide quality services, impact positive outcomes, explore possible resources to generate financially sustainable programs, and influence policy development for populations served through collaboration of all community members.
 - Develop a community-based system to actively seek out collaborative partnerships with other health professionals in local communities and develop viable and sustainable partnerships to assure delivery of health services to all children.

* The applicant must address each of the following areas in a written plan:

- 1) **School Collaboration and Planning: Current Status**
 - Identify current status of grants, existing community assets, local community initiatives addressing health of children 0 – 21 years of age, resources available for children and families within your region.
- 2) **Statement of Needs:**
 - Define the numbers and characteristics of the children you will serve, as well as the setting(s) identifying gaps in the coordination and delivery of health services to children and families in your community.
- 3) **Target Plan:**
 - Explain why children and families will benefit by this collaborative project.
 - Name the school nurse / district and medical home office whose involvement is critical for your idea to work.
- 4) **Performance Target:**
 - Specify the collaborative target activity(s) you are committed to achieving with the school nurse(s) and other health professionals within your community and what changes will occur for children.
 - Describe how you will verify that your performance targets were achieved and how you will evaluate their effectiveness in influencing change within your community.
 - Specify critical milestones (steps) that will be achieved to reach your stated performance target.
 - Specify your proposed school nurse(s) or district / medical home office(s) collaboration activity and key features indicating the important and distinct functions of your activity(s) / service(s).

4. REPORTING REQUIREMENTS

Refer to the KDHE "SFY 2009 Grant/Contract Reporting Instructions."

5. PROGRAM CONTACT PERSON

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COMMUNITY-BASED TEENAGE PREGNANCY REDUCTION PROJECTS

1. PROGRAM PURPOSE

The goal of Community-Based Teenage Pregnancy Reduction Projects is to reduce teen pregnancy rates and help teens achieve their full potential through a positive youth development approach in various and select State localities where teenagers are most at-risk for pregnancy (K.S.A. 65-1,158).

2. FUNDING

Continuation Grants: Highest priority for SFY 09 is to continue funding of local agencies that demonstrate progress toward specific objectives. A 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.

New Grants: As funding becomes available, new grants will be awarded. At this time, funding is expected to be competitive in SFY 2011.

Match: Local matching funds must be equal to or greater than 30% of grant funds awarded.

3. SPECIFIC PROGRAM INFORMATION

- a. **Application:** Follow the KDHE "SFY 2008 Grant Application Guidance" instructions.
- b. **Services:** Refer to Improving the Health of Adolescents & Young Adults: A Guide for States and Communities (CDC, 2004), The National Campaign to Prevent Teen Pregnancy web site: http://www.teenpregnancy.org/resources/reading/pdf/What_Works.pdf, and the KDHE Children, Youth and Families Health Services Manual, Vol. V, Teen Pregnancy.
- c. **SFY 2008 Outcome Objective:**
 - The number of teens the program will serve.
 - Number of community members that will be trained.
 - Outcome measures specific to your community.
 - Measure for the intervention effectiveness, in terms of reduction of pregnancy rates for the community.
 - Measure of the processes of the interventions.
- d. **Program Protocols:** Refer to 3.b. above and the technical assistance packet provided by KDHE.
- e. **Culturally Competent:** The applicant must be culturally competent and can provide culturally competent services. In cases where its clients are limited English Proficient (LEP), the applicant must address LEP needs, e.g., identify non-English speaking clients, and establish program requirement to meet LEP interpreter needs.
- f. **Other:** Incorporate the following into the application, budget, and program plans. The project will:
 - 1) Demonstrate local support of school board, parents, physicians, other health care providers, and other community agencies through the development and support of an advisory group.
 - 2) Grantees will identify funding they receive and existing teen pregnancy programs in their communities and coordinate efforts to reduce duplication of services.
 - 3) Grantee will attend annual training workshop provided by the KDHE program manager and include travel expenses to cover a maximum of two trips to Topeka.

- g. Evaluation Program evaluation shall be conducted on a state level by KDHE. Evaluation process which will involve a review of process measures (numbers served) and outcomes (3.c. above).

4. REPORTING REQUIREMENTS

Refer to the KDHE "SFY 2009 Grant/Contract Reporting Instructions."

5. PROGRAM CONTACT PERSON

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TEEN PREGNANCY CASE MANAGEMENT

1. PROGRAM PURPOSE

The goals of Teen Pregnancy Case Management (TPCM) are to: 1) reduce long-term welfare dependency by teen parents; 2) reduce the negative economic, health, educational, vocational and social consequences for teens and their children; 3) increase levels of self sufficiency and goal-directedness of teens relevant to their own futures and that of their children and 4) delay the birth of the second child until completion of goals related to basic education/training.

Though teen pregnancy rates continue to decline for Kansas, the disparities among ethnic and racial groups (particularly Hispanic and Black youth), are increasing and remain higher than rates for Caucasian youth. Services must address the needs of these disparate populations.

2. FUNDING

Continuation Grants: Highest priority is to continue funding of local agencies that demonstrate progress toward specific objectives.

New Grants: At this time, funding is expected to be available to support only those projects currently in existence.

Match: No local match is required

3. SPECIFIC PROGRAM INFORMATION

- a. Application: Follow the KDHE "SFY 2009 Grant Application Guidance" instructions.
- b. Services: Refer to "Children, Youth and Families Health Services Manual, Vol. V, Teen Pregnancy" (KDHE) and "Improving the Health of Adolescents & Young Adults: A Guide for States and Communities" (CDC, 2004) for service standards and guidelines.
- c. **SFY 2009 Process Objectives:** All programs will address the following process objective: Provide case management services to ____# adolescents ages 10-21. Of these adolescents, ____# (projected improvement from planned program intervention) will be new clients.
- d. **SFY 2009 Outcome Objectives:** The following are the primary objectives for the TPCM program:
 - 90% of clients will delay the birth of their second child until after completion of their basic education or vocational goals.
 - 90% of the program participants will have reduced welfare dependency upon successful completion of the goal plan.
 - All adolescents receiving case management services that are referred to outside agencies (for medical, educational, or vocational etc) will receive services from the referral agencies.

In addition, the grantee will address *two* additional outcome objectives from the following:

- 90% of pregnant clients participating in the program will receive adequate prenatal care.
- All clients will be enrolled in a basic education program as indicated by school verification within six months after their enrollment in case management.

- 100% of teen parents and their children will participate in well child preventative health programs that will include teaching parent(s) importance of completing periodicity health assessments (Kan Be Healthy / EPSDT) and immunizations.
- 100% of teen parents will have demonstrated adequate parenting capacity at time of exit from TPCM services as evidenced by TPCM report of absence of confirmed Social and Rehabilitation Services (SRS) for child abuse and neglect.

4. PROGRAM REQUIREMENTS

Refer to the Manual in 3.b. above.

5. CULTURALLY COMPETENT

The applicant must be culturally competent and can provide culturally competent services. In cases where its clients are limited English proficient (LEP), the applicant must address LEP needs, e.g., identify non-English speaking clients, and establish program requirements to meet LEP interpreter needs.

6. EVALUATION

Program evaluation shall be conducted on a State level by KDHE. The evaluation process will involve a review of process measures (number served) and outcomes (prevention of second pregnancy and percent achieving health, educational and vocational goals).

7. REPORTING REQUIREMENTS

Refer to the KDHE "SFY 2009 Grant/Contract Reporting Instructions."

8. PROGRAM CONTACT PERSON

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HIV/AIDS

1. PROGRAM PURPOSE

- a. Purpose of the Grant Program: the HIV/AIDS Section of the Kansas Department of Health and Environment (KDHE), Bureau of Disease Control and Prevention receives funding from the Centers for Disease Control and Prevention (CDC), Health Resources Services Administration (HRSA) and from the State of Kansas to conduct HIV/AIDS activities. Some of the funds are earmarked to provide services through local health departments and community-based organizations. These services include (HE/RR) HIV/AIDS Health Education and Risk Reduction (#13 health departments), and HIV (CTR) Counseling, Testing and Referral (#14 health departments). Advancing HIV Prevention (#36 community based organizations) and Ryan White Case Management (#33).

Grantees are to write objectives designed to meet the needs of the program under which they receive funds. Quarterly fiscal reports are required under each contract, as well as quarterly activity reports for HERR contracts and Ryan White Case Management. In addition, under the CTR contracts, all reporting of pre and post-test counseling information must be up to date (reported within two weeks of service) and ongoing through the reporting periods. Activity reports are to be sent to the appropriate manager in the AIDS section or through electronic reporting systems as established for each form. Fiscal reports (Certified Affidavit of Expenditures) are submitted to KDHE, Division of Management and Budget, ATTN. Kevin Shaughnessy.

- b. Background

Programs offered by the HIV/AIDS Section are designed to provide primary prevention services for those persons who are at highest risk for HIV infection, including partners of positives, men who have sex with men, injection drug users, sex/needle sharing partners of these individuals and those who are the sex/needle sharing partners of HIV-infected individuals.

2. FUNDING

- a. Availability

Applications for funding to support HIV/AIDS contracts should be submitted for continuation of current contracts only. In the current cycle, ALL contracts will be continuation and the process indicated in this document will apply. Federal and state funding is expected to remain at present levels.

HE/RR grantees (#13 health departments) are required to submit for approval prior to the start of the grant period a month-by-month work plan outlining activities designed to achieve grant objectives. Work plans are dynamic and can change per guidance based upon federal and KDHE guidance. All grantees are required to submit a budget for approval prior to the start of the grant period and during the grant period for proposed changes.

- b. Match Requirement

At this time, a match is not required for grants with the HIV/AIDS Section. The HIV/AIDS Section reserves the right to require grantees to provide a match. A resource inventory of other funding sources is required of all community-based organizations receiving competitive funding in association with Health Education and Risk Reduction (HE/RR) funding. A request for this will come under a separate cover letter from the HIV/AIDS Section.

3. SPECIFIC PROGRAM INFORMATION

The scope and focus of grants awarded under the auspices of the HIV/AIDS Section are determined by mandates of HIV/AIDS Section funding sources as well as by decisions that are made at KDHE in conjunction with community planning processes. Each program varies greatly in terms of the service area, project goals and objectives, and evaluation. Some contracts are required to be competitive on a multi-year cycle. Details of each grant are sent to applicants at the time of application.

4. REPORTING REQUIREMENTS

Fiscal reports (Certified Affidavit of Expenditures) are submitted to KDHE, Division of Management and Budget (ATTN. Kevin Shaughnessy).

HE/RR (#13 health departments) contractors must continue to submit quarterly HIV/HERR reports and stay up to date with required reporting. All interactions will be with designated HIV prevention consultant/contracts managers in accordance with program policies and procedures. Reports must include a description of activities conducted under each objective of the contract with pertinent required measurable outcome data. All contractors must submit Quarterly Certified Affidavits of Expenditures.

5. PROGRAM CONTACT PERSONS

Health Education/Risk Reduction Contract (#13) Questions:

Marc Shiff, MPA 785-296-8596
Bureau of Disease Control and Prevention
Operations and Services Director
mshiff@kdhe.state.ks.us

Shirlene Small, MPH 316-337-6136
Community Partnership Consultant
ssmall@kdhe.state.ks.us

HIV Counseling, Testing, and Referral Contract (#14) Questions:

Jennifer VandeVelde 785-296-6544
HIV/STD Testing Director
jvandeve@kdhe.state.ks.us

IMMUNIZATION ACTION PLAN

1. PROGRAM PURPOSE

The purpose of the Immunization Program is to reduce the incidence of vaccine preventable diseases by increasing the number of people receiving age-appropriate immunizations.

- a. Healthy People 2010 Objectives include: Achieve and maintain vaccination coverage levels for universally recommended vaccines among young children. Target: 90% among children aged 19-35 months.

Increase the proportion of children who participate in fully operational population-based immunization registries. Target: 90% of children under age 6yrs.

- b. Background: Since 1993, IAP funds have been awarded to every Local Health Department and some community agencies. Since 1999, State Aid to Local funding has supported IAP activities.

IAP is a Federal and State funded supplemental immunization program that supports the assurance of immunization services within each of the 105 counties through provider education and VFC provider recruitment activities, service delivery to the underserved and uninsured populations, public education, and assessment of immunization coverage.

In order to qualify for federal funding through the Centers for Medicare and Medicaid Services (CMS) for immunization registry development, a 50% match with state funding must be identified. Activities funded through the IAP Aid to Local program that result in electronic documentation of immunization activity for integration with the Kansas Immunization Registry will help demonstrate state support of registry activity.

- c. Purpose of the Grant Program: The purpose of this Grant Program is to increase immunization rates through improved documentation of immunization services, education of immunization providers and support of the provision of immunizations in a child's medical home.

2. FUNDING

- a. Availability - Grant awards will be distributed on SFY 2009 Aid to Local Appropriations. Applications for funding will be accepted from all Local Health Departments and other agencies that have received IAP funds since 1993.

Awards will be population-based with available funding from the State General Fund (\$350,000) and the federal Centers for Disease Control and Prevention Immunization Grant (\$200,000).

- b. At this time, a match is not required for IAP grants.
- c. Funds may not be used to supplant or replace existing agency funding sources.

3. SPECIFIC PROGRAM INFORMATION

- a. Application - Follow the KDHE "SFY 2009 Grant Application Guidance," and complete the Program Request (Form #2) and Detailed Budget (Form #3) forms.
- b. SFY 2009 Objectives - The application must, at minimum, set one of the following objectives, with strategies to accomplish the objective:

- Objective I: The Local Health Department (LHD) will attain a 90% immunization rate for the 4:3:1:3:3:1 (4DTaP:3Polio:1MMR:3Hib:3HBV:1Varicella) series for all 2 year olds receiving LHD services. Strategies will include:
 - 1) Reminder/recall of patients needing immunizations
 - 2) Bi-monthly quality assurance of immunization practices through the use of CoCASA software
 - 3) Staff education regarding immunization practices via one or more of the following activities:
 - a) Immunization Program annual conference
 - b) CDC satellite teleconferences or webcasts
 - c) Other immunization related educational offerings
 - 4) Provide linkage between WIC services and immunization service access
 - a) Assure access to immunization services during WIC clinics
 - b) Provide follow-up on referrals to the child's medical home for WIC clients w/incomplete immunizations
 - 5) Participate in the *Immunize Win a Prize* project
 - Objective II: The LHD will assure progress towards the target 90% immunization rate for the 4:3:1:3:3:1 series for all 2 year olds in the county by providing educational offerings to private providers within the LHD jurisdiction. Offerings may include:
 - 1) *Maximizing Office Based Immunizations* (MOBI) curriculum developed by the KsAAP and KDHE
 - 2) Marketing/demonstration of the VFC Program
 - 3) Vaccine administration and vaccine storage and handling
 - 4) Utilizing CoCASA as a quality assurance tool
 - Objective III: The LHD will assure progress toward the 95% target rate of children less than 6 years of age within the LHD jurisdiction participating in KWebIZ who have two or more immunizations. Strategies may include:
 - 1) Inclusion of all LHD client immunization data in KWebIZ via either
 - a) Direct data entry into KWebIZ or
 - b) Indirect data entry via an electronic interface between the LHD's patient management system and KWebIZ
 - 2) Marketing of KWebIZ to private providers
 - 3) Facilitation of KWebIZ user initial training or ongoing training by acting as a host site or training event coordinator
 - Objective IV: The County of birth will attain a 90% immunization rate for the administration of the Hepatitis B birth dose. Strategies will include:
 - 1) Advocating enrollment as a VFC provider for Universal Hepatitis B vaccine program for all birthing hospitals in the county. ****{LHDs providing VFC HepB vaccine to birthing hospitals in their jurisdiction are ineligible to apply for funding associated with Objective IV.}**
 - 2) Providing educational materials regarding the HepB birthdose and other childhood immunizations during LHD family planning clinics.
- c. Priorities
- Applications containing one or more of the suggested strategies for each of the stated objectives will be given priority.
 - Each objective with adequate strategic documentation will qualify the applicant for 25% of the population based funding available for that county.

4. REPORTING REQUIREMENTS

- Quarterly, submit Certified Affidavit of Expenditures
- Bi-annually, submit a progress report of activities toward objectives.

5. PROGRAM CONTACT PERSON

Sue Bowden, Director
Immunization Program
Bureau of Disease Control and Prevention
(785) 296-0687

CHRONIC DISEASE RISK REDUCTION

1. PROGRAM DESCRIPTION

BACKGROUND

Chronic diseases account for roughly 75% of health care costs each year, over \$10 billion per year in Kansas. As states struggle to meet the staggering costs of providing health care to those in need, the most cost-effective interventions to lessen the growing burden of chronic disease and injury are frequently overlooked. Tremendous achievements in health are possible by reducing the prevalence of risk factors that underlie chronic disease and injury. In fact, 33% of all deaths are attributable to three modifiable health-damaging behaviors: tobacco use, lack of physical activity and poor eating habits.

Tobacco use is the single most preventable cause of death and disease in our society. Annually, cigarette use alone causes approximately 3,900 deaths in Kansas annually, costing more than \$927 million in medical expenditures and \$863 million in lost productivity from an experienced workforce that dies prematurely. The risks of tobacco use extend beyond actual users. Nearly nine out of ten nonsmoking Americans are exposed to environmental tobacco smoke (ETS), increasing their risk for lung cancer and heart disease.

Data show that the implementation of comprehensive tobacco control programs produces substantial reductions in tobacco use. The Centers for Disease Control and Prevention (CDC) recommends that states establish tobacco control programs in local communities that are comprehensive, sustainable, and accountable. The goal of a comprehensive tobacco control program is to reduce disease, disability, and death related to tobacco use.

Similarly, obesity has been identified as a strong risk factor for the development of diabetes and cardiovascular disease and some cancers. Studies have demonstrated that increases in body mass index (BMI) at the population level foreshadow increases in the prevalence of diabetes, coronary disease and hypertension. Kansas has not escaped the epidemic. Since 1992, the prevalence of obesity has increased by 77% among adults, with more than 62% now considered overweight or obese (BMI >25) and 26% considered obese (BMI > 30). Obesity and its co-morbidity causes approximately 3,700 deaths per year in Kansas. It is estimated that obesity costs Kansans \$657 million/year, of which \$143 million is in Medicaid expenditures. If current trends continue, by 2020 one in every four dollars spent on health care will pay for obesity-related treatments.

PURPOSE

The purpose of the community grant program is to provide funding and technical assistance for communities to address chronic disease risk reduction through evidence based strategies that impact nutrition, physical activity and tobacco use. These strategies can be found in the American Journal of Preventive Medicine's "*The Guide to Community Preventive Services: Tobacco Use Prevention and Control, Reviews, Recommendations and Expert Commentary*" and can be found at www.kdhe.state.ks.us/tobacco and the *Community Guide to Physical Activity and Nutrition* www.thecommunityguide.org. Another resource is the National Association of County and City Health Officials' *Recommendations for Comprehensive Tobacco Use Prevention Programs* that can be found at www.kdheks.gov/tobacco. Funding is available at one of three levels to accomplish the following:

- a. Build and sustain capacity at the local level to address unhealthy eating practices, physical inactivity and tobacco prevention and control through Chronic Disease Risk Reduction (CDRR) Grants.

- b. Expand existing CDRR activities within the community that specifically impact tobacco use and develop a plan to implement these strategies through enhanced tobacco use prevention funding.
- c. Implement Comprehensive Tobacco Use Prevention and Control program that reflects Best Practices for Tobacco Control and Prevention.

2. ELIGIBILITY

Eligible applicants are local health agencies who are expected to serve as project lead on behalf of the community. If the health department wishes to designate a partner organization to serve as the local lead agency, the application must include a letter from the local health department stating that it has designated another agency to be the applicant and a letter from the designee indicating their consent to do so. A consortium of counties may apply together under one application.

3. FUNDING

Funding for the Chronic Disease Risk Reduction grant program is provided through several sources, including the Centers for Disease Control and Prevention, and the Children's Initiatives Fund, by appropriation of the Kansas State Legislature and approval of the Governor. Communities will be selected through a competitive application process for funding beginning in state fiscal year 2009 (July 1, 2008 – June 30, 2009). Exact funding levels for the program will be determined in the spring of 2008.

Level A grant applicants are eligible to apply for a maximum of \$14,999.

Level B grant applicants are eligible to apply for more than \$15,000, and the requested amount should be based upon community need.

Level C grants will be based on the amount necessary from all sources combined to implement Best Practices for Tobacco Control and Prevention.

Grant funds must be used for focused strategies to change systems, develop and implement policies, change the environment in which tobacco use, physical inactivity and poor eating practices occur, and impact population groups rather than individuals.

To this end grant funds may NOT be used to provide the following:

- direct services, individual or group cessation services
- direct patient care
- personal health services medications (NRT therapy)
- patient rehabilitation
- supplant existing funding from Federal, State or private sources
- direct enforcement of policies
- staff time to provide direct classroom instruction of students
- or other costs associated with the treatment of diseases.

Due to limited availability of funding, applicants are encouraged to prioritize appropriate amount of funds to assure staff time to support accomplishment of the strategies as proposed.

4. MATCH

All applicants must provide a 25% match for every dollar awarded. The 25% match may be cash, in-kind, or a combination from county and /or public and private sources. In-kind match may include: school programs, Safe and Drug Free Schools funds, Coordinated School Health, Safe Routes to School, Sunflower Foundation Trails grant, Kansas Department of Transportation Enhancement grant etc. Local funds that support existing cessation program services and local funds provided for enforcement activities may serve as a local match as well.

5. REQUIRED PROGRAM COMPONENTS

The following program grant components should be addressed through activities that are appropriate for the selected funding level. For convenience, a chart summarizing the required grant components for each funding level is included.

- a. Training - A list of approved workshops will be available from Outreach Coordinators or at the Office of Health Promotion's TUPP website at www.kdheks.gov/tobacco. See chart for training requirements associated with each funding level.
- b. Coalition - All applicants must support and maintain a coalition of state and local partners to build and sustain capacity at the local level to address chronic disease risk reduction. All funded communities must document that coalitions meet at least quarterly by providing agendas. Minutes should be sent to respective Outreach Coordinators within fifteen days of the meeting. Additional meetings are encouraged as needed to accomplish objectives. The Outreach Coordinator must be notified in advance of each coalition meeting by phone, fax, or email. Evidence that youth coalitions are integrated into the community coalition will be a strong factor in the evaluation of applications.
- c. Quitline Promotion - All applicants must agree to promote the Kansas Tobacco Quitline through local efforts. Local efforts should include promoting the Quitline via health care providers and encouraging the use of provider reminder systems. Kansas Tobacco Quitline logos, promotional items, and monthly reports will be available through the Tobacco Use Prevention Program Outreach Coordinator and the Kansas Department of Health and Environment website.
- d. Policy Initiative - The requirements for initiating policy change are described in the chart summarizing the required grant components for each funding level that can be found on page 40.
- e. Media - All applicants must agree to arrange all earned and paid media strategies with the Tobacco Use Prevention Program staff to ensure coordination with the statewide media campaign. All media must be approved by the TUPP Outreach Coordinator and/or Media and Policy Coordinator.
- f. Sharing Session - All applicants must plan to implement a Sharing Session for partners and community leaders during the fiscal year. The goal of a sharing session is to educate and engage community members, especially decision-makers, in coalition efforts and accomplishments around tobacco, physical activity and nutrition. The format of a sharing session can take many forms - please refer to www.kdhe.state.ks.us/tobacco for examples.
- g. Partner Collaboration - Partnerships should include statewide and local organizations, voluntary health organizations, youth, universities, local health departments, Regional Prevention Centers, community-based organizations, statewide and local coalitions, medical community, and community decision makers. Working with partners includes capacity building with those organizations through technical assistance, training and education activities.

Priority will be given to applicants who are able to document a partnership with School Health Councils in conjunction with the Coordinated School Health Program if applicable.

The Level A and B partner collaboration requirements are described in the chart summarizing the required grant components. Level C grant applicants must submit at least five letters of commitment from those coalition members or organizations whose work is essential for completion of the grant strategies; that clearly define the level of commitment from the organization; contacts and memorandum of understanding; membership lists; active participation in meetings documented through local coalition meeting minutes; clear role definitions for

partners; active participation in statewide and local planning including media campaigns, tobacco control plans, and conferences.

h. Physical Activity/Nutrition

All applicants must address physical activity and/or nutrition strategies at the local level. Physical activity and nutrition strategies must be aligned with the tobacco prevention and control strategies of the grant. Activities identified will lead to an increase in physical activity and/or the consumption of more fruits and vegetables at the local level.

i. Comprehensive Tobacco Prevention and Control Plan

Level A CDRR Grant:

Applicants are not required to develop a Comprehensive Tobacco Prevention and Control Plan, but strategies that are proposed must be Best Practices.

Level B CDRR Grant

First time applicants should include a description of the process that the coalition will use to develop a Comprehensive Tobacco Prevention and Control Plan. Applicants who have previously been funded should have a completed plan and describe implementation steps for priority components.

Level C CDRR Grant:

Applicants will implement a five-year Comprehensive Tobacco Prevention and Control Plan demonstrating active participation of local partners. The Comprehensive Plan should reflect all anticipated tobacco prevention and control activities in the community. The five-year Comprehensive Tobacco Prevention and Control Plan should include a description of evidence-based program and policy strategies in response to data determined needs, a logic model linking activities to outputs and short-term and intermediate outcomes using (specific, measurable, achievable, relevant, and time bound) program objectives, program evaluation activities including a summary and time-line for data collection and analysis activities. Program components that address counter-marketing and strategic use of media advocacy, as well as paid media will be linked to statewide media campaigns. Evidence of readiness to implement a comprehensive program should be documented by inclusion of a description of how the plan was developed and the submission of a plan that is consistent with the activities described above.

6. PROGRAM EVALUATION

All applicants must coordinate surveillance and evaluation activities with the Tobacco Use Prevention Program evaluation plan and Kansas LEAN (Leadership to Encourage Activity and Nutrition) evaluation efforts. The local evaluation plan will be based on the CDC Logic Models for Tobacco Control and Community Guide for Physical Activity and Nutrition. For tobacco use prevention consult CDC resources on Key Outcome Indicators that can be used to monitor and evaluate local level tobacco control programs for additional information.

STAFF TIME

Identify or hire staff with the appropriate competencies to manage a chronic disease risk reduction program. Performance will be measured by evidence that the local lead agency has dedicated human resources to administer and manage the program effectively. Evidence of the intent to provide ongoing training for staff should be demonstrated by budgeting for staff participation in State sponsored training, meetings and conferences and other continuing education opportunities approved by the Office of Health Promotion.

Level A CDRR Grant:

A minimum of 25% of a Full Time Employee (FTE) is required. A FTE is considered an employee who works 40 hours per week. To be eligible for funding an employee must dedicate a minimum of 10 hours per week. No more than 2 employees may be designated to meet the 25% FTE requirement. Other staff involved may serve as match.

Level B CDRR Grant:

A minimum of 50% of an FTE is required to receive funding. To be eligible for the grant, an employee must dedicate a minimum of 20 hours per week. No more than 2 employees may be designated to meet the 50% FTE requirement. Other staff involved may serve as match.

Level C CDRR Grant:

A minimum number of staff would be 2 FTEs including one FTE Program Manager and 0.5 FTE for administrative support, and 0.5 FTE for youth empowerment. Staff should have knowledge and skills in: program development, coordination and management; fiscal management; leadership development; tobacco control and prevention content; cultural competence; public health policy including analysis, development and implementation. The Program Manager and the administrative support position should be FTEs within the local lead agency. Other positions may be FTEs or may be contracted to another agency/organization. The size of the population may dictate a revised staffing formula.

7. REPORTING REQUIREMENTS

All applicants must complete a Mid-Year and Final Report. Forms provided by KDHE include the "Reporting Form", "Affidavit of Expenditure", and "Community Partner Event Form" and can be located in the Reporting Guidelines Booklet and should be used for reporting. History of non-compliance with guidelines and reporting requirements will be considered in determining funding levels. Community Partner Event Forms are to be submitted electronically within the month the event occurred. Forward a copy to the Media/Policy Coordinator and Outreach Coordinator.

- Mid-Year Report and Affidavit of Expenditure for the period of July 1 - December 31, 2008 and submit no later than January 15, 2009. Utilize "Grant Reporting Form Guide".
- End of the Year Report and Affidavit of Expenditure for the period of January 1 - June 30, 2009 and submit no later than July 15, 2009. Utilize "Grant Reporting Form Guide".
- Send one copy of the Reporting Form and Affidavit of Expenditure to your Outreach Coordinator (See Tobacco Use Prevention Program District Map).
- Send one copy of the Reporting Form, the original Affidavit of Expenditures and one copy of the Affidavit of Expenditures to:

Kevin Shaughnessy
Kansas Department of Health and Environment
Purchasing and Grants Management Office
1000 SW Jackson Ave., Suite 570
Topeka, KS 66612-1368

Chronic Disease Risk Reduction
Required Program Components By Funding Level

Required Program Components	Level A \$0 - \$14,999	Level B \$15,000 and above	Level C Utilize "Level C Funding Worksheet"
Trainings	One staff and/or coalition member must attend three approved trainings, with two focusing on tobacco	One staff and/or coalition member must attend three approved trainings, with two focusing on tobacco	Three staff and/or coalition members must attend three approved trainings, three TFKC meetings, and Kansas Public Health Association conference.
Coalition	Quarterly meetings with Minutes and Agendas	Quarterly meetings with Minutes and Agendas	Quarterly meetings with Minutes and Agendas
Quitline Promotion	Required	Required	Required
Clean Indoor Air and/or Youth Access Policy Initiative	Not required, but due to the competitive nature of the grant, are strongly encouraged to do so. The initiative must be community wide.	Required to address at least one objective for clean indoor air or limiting youth access to tobacco products. It should be addressed on the attached "Action Plan" as a SMART Objective. The initiative must be community wide.	Required to address at least one objective for clean indoor air and/or limiting youth access to tobacco products. It should be addressed on the attached "Action Plan" as a SMART Objective.
Media	Must be approved by OHP TUPP Staff and complement statewide media plan	Must be approved by OHP TUPP Staff and complement statewide media plan	Must be approved by OHP TUPP Staff and complement statewide media plan
Sharing Session	Required	Required	Required
Partner Collaboration	At least 5 partner signatures on "Signatures of Support" Form	At least 5 partner signatures on "Signatures of Support" Form	At least 5 letters of commitment from partners.
Physical Activity/Nutrition	Must address and be aligned with tobacco prevention and control efforts	Must address and be aligned with tobacco prevention and control efforts	Must address and be aligned with tobacco prevention and control efforts
Comprehensive Tobacco Prevention and Control Plan	Not required	Draft of a Plan required. First time Level B applicants must include a plan on how this will be developed by the coalition	Required
Program Evaluation	Required	Required	Required
Staff Time	.25 FTE minimum	.50 FTE minimum	2 FTE's minimum
Reporting	Mid-Year Report and End of the Year Report and Affidavits of Expenditure, Community Event Forms, and Grant Reporting Form Guide	Mid-Year Report and End of the Year Report and Affidavits of Expenditure, Community Event Forms, and Grant Reporting Form Guide	Mid-Year Report and End of the Year Report and Affidavits of Expenditure, Community Event Forms, and Grant Reporting Form Guide

PROPOSAL CONTENT

Each proposal and its attachments needs to be type written and include the following components in the stated order, with **pages numbered consecutively beginning with page 1, including all Forms and Budget:**

- **Application Cover Sheet:** Cover sheet provided as a form.
- **Table of Contents:** Include page numbers of proposal and appendices, consecutively numbered from page 1 to the end of all appendices.
- **Executive Summary:** Provide a narrative, not to exceed one doubled-spaced page, describing the community in which tobacco control activities have been conducted, including barriers and supportive factors; accomplishments; anticipated needs; plans to address the Program Goals. Indicate major areas of future program focus.
- **Program Narrative:** Provide a Program Narrative of no more than 5 double spaced pages for the Level A grant, 10 double-spaced pages for the Level B grant, and 20 pages for the Level C grant following the outline in this section.

Program narrative should include the following components:

- a. Description of Community – A description of the **local lead agency**, its role in the community coalition, and its fiscal safeguards. If the applicant is not the County Health Department, include organizational capacity and previous experience with tobacco prevention and cessation efforts. A letter from the local health department must be included as an appendix stating that it has designated the applicant agency as the local lead agency.

Provide a description of the **local coalition**, including the time it has been in existence, the leaders of the coalition, previous accomplishments, and experience with chronic disease risk reduction/tobacco use prevention and cessation. The emphasis should be on previous successful collaborations or evidence of the capacity for successful collaborations. A list of coalition members should be included in the appendix.

Provide a description of the **community to be served**, including geographic boundaries, size of the population, types and percentages of minorities or other special populations (as this relates to tobacco use or targeting by the tobacco companies), and level of community support.

Only Level B applicants should include a description of the **community's readiness** for a comprehensive tobacco control program. Include other initiatives undertaken to date and their results, commitments obtained from various entities in the community, experience with data collection and program evaluation, and other factors, which demonstrate community readiness.

- b. Background and Need – Provide a description of the **community need** including gaps in service. Include data that demonstrate the scope of the problem. Also describe:
 - existing policies at the local level, including significant changes in community regarding tobacco free workplaces.
 - progress toward reducing the burden of chronic disease and tobacco use major physical activity, nutrition, and tobacco control activities conducted in the community.
 - successes and challenges of current program.
- c. Infrastructure and Program Management – Provide a description of:
 - current staff and plans to develop a staffing pattern consisting of qualified program and administrative staff.

- how program staff and coalition members will have access to opportunities for professional training.
 - how the staffing pattern will enable sharing of information, resources, and materials.
- d. Staffing Plan – Indicate who will be responsible for the strategies. Include position descriptions (no more than two pages each) in an appendix. Assure that position descriptions show the program components to be addressed by each member of staff (can be one component or more than one). Supplantation of existing resources for staff salaries is not allowed, so if existing staff is to be paid from the grant, applicant must demonstrate how supplantation has been avoided. Include key staff whose services will be donated in-kind to the program by the applicant agency or coalition members (and specify that they will not be paid with grant funds). Whether paid or donated in-kind, if the name of the individual to fill the position is known, that individual's resume, if available (no more than two pages) should be included in an appendix. In the case of multiple staff being donated to the project but only working minimal hours, the applicant may focus on descriptions of the key staff in the interests of space, and then just list others whose time will be donated. For paid staff, no more than two individuals can account for the staffing time requirement.
- e. Sustainability Plan – (for examples, please visit: <http://www.kdheks.gov/tobacco/>). Address how you plan to sustain this program in your community through seeking additional funding sources, policy change, sharing sessions with decision makers, training for community and coalition members, strategic planning, developing a Comprehensive Tobacco Prevention and Control Plan, etc. This may include plans to submit applications to other funders, willingness of local coalition members to assume responsibility for certain components, or other plans. This should address how you will involve local businesses, foundations, and organizations to assure continuance of tobacco control program if funding from KDHE were no longer available. Describe how all physical activity and nutrition activities will be integrated into tobacco prevention and control activities.
- f. Surveillance and Evaluation – The proposal should provide and describe:
- plans for evaluation and list the tracking systems used and/or needed at the State and local level.
 - any surveillance and evaluation activities currently being undertaken.
 - involvement of stakeholders or advisory group in the development of an evaluation plan.
 - barriers and proposed methods to overcome them.
 - unmet evaluation needs and plans to address them.
 - the baseline data currently available, and to be collected (and how it will be collected), and subsequent measures of the program.
 - the applicant's understanding of an effective evaluation program, including outcomes (such as the rate of youth or adult smoking as measured by a standardized survey), process measures, and the community changes which are necessary for achievement of the goals.
- g. Comprehensive Tobacco Prevention and Control Plan – Level B and Level C Grant Applicants Only
Level B grant applicants should include as a form, a draft of a Comprehensive Tobacco Prevention and Control Plan for their community. First time Level B grant applicants must include a plan of the process that the coalition will use to draft a Comprehensive Tobacco Prevention and Control Plan.

Level C grant applicants must provide a copy of their five-year comprehensive tobacco control plan and describe how the plan was developed. If a comprehensive tobacco control plan is in draft form, describe how the plan will be completed and the expected completion date. Describe the process by which the plan will be updated. Indicate who will be responsible for monitoring progress of plan implementation.

- h. Collaboration and Partnerships – Provide a description of:
- plans to develop, strengthen and maintain partnerships and coalitions through linkages with other local governmental, and non-governmental entities. Specify partner organizations and the purpose of those partnerships.
 - current coalition members and plans to recruit new members.
 - plans to identify new partners including proposed partners and purpose of partnerships.
 - plans to maintain and strengthen representation and participation by groups identified as experiencing tobacco related health disparities.
 - how partners' roles will complement each other as part of the overall effort. Strengthen stated collaboratives by having strongest partners submit letters of support.

Level C grant applicants only should:

- provide at least five letters of commitment as forms demonstrating activities, roles, responsibilities, and/or commitment of funds or other resources.
 - describe communication methods and channels used to inform and solicit information from partners.
 - describe barriers in communicating with partners.
 - describe plans to improve communication.
- i. Community Mobilization – Describe existing strategies for community mobilization, including funded organizations and level of funding, policy-focused activities, and collaboration with partners, and participation in coalitions. Also describe unmet needs and plans to address them.
- j. Trainings and Technical Assistance – Provide a description of:
- trainings attended in past three years and future training opportunities.
 - how staff and community coalition members' training and technical assistance needs will be determined and met.
 - activities and how they contribute to advancing the program goals and objectives.
 - barriers and methods used to overcome them.
 - identify unmet needs and plans to address them.
- k. Information Exchange – Provide a description of:
- how local lead agency personnel communicate and exchange information with Federal, State, regional and local chronic disease and tobacco control personnel in government and partner organizations.
 - participation in and collaboration with State, regional and national organizations and the benefits accrued.
 - how communication will occur with partners across the State, such as submitting abstracts, presentations at trainings, and participation in conference calls.
 - plans to collaborate with KDHE, TUPP including participation in regional meetings and workgroups, utilization of the Internet to communicate, and dissemination of information
 - participation in the Tobacco Free Kansas Coalition.
 - barriers and methods to overcome them.
 - unmet needs and plans to address them.
- l. Action Plan - Include action plan information in the narrative to best explain the goals of the community's tobacco prevention and control program. Describe how tobacco use prevention, physical activity and nutrition will be integrated on the Action Plan form.

- **Action Plan:** Please include the following information, using the attached Action Plan form.
Objectives must be stated in measurable terms that include measurement and timeline. When writing long-term, intermediate, short-term, and annual objectives, use specific, measurable, achievable, relevant, and time-bound (SMART) objectives. For each of the goal areas in the annual Action Plan, indicate key strategies and activities. For each activity, include the target group, lead role, timeline, and evaluation indicators. Approved strategies and measures of outcomes can be found at www.kdheks.gov/tobacco.

- a. Tobacco Use Prevention Goals and Objectives - Objectives must be stated in measurable terms that include measurement and timeline. Provide specific **evidence-based strategies** designed to lead to accomplishment of the goals and objectives. For Level C grants only, the application must address all seven components of the National Association of County and City Health Officials (NAACHO) recommendations for Best Practices for Local Tobacco Use Prevention. These seven components include: 1) Community Mobilization; 2) School Programs; 3) Counter-Marketing; 4) Cessation programs for youth and adults; 5) Enforcement; 6) Administration and Management; 7) Surveillance and Evaluation.

Prevention of Initiation of Tobacco Use Among Young People. Provide a description of:

- activities at the State and local level, including activities that are evidence-based and promote policy interventions.
- activities to promote tobacco-free policy in schools.
- barriers and identify methods to overcome them.
- unmet needs and plans to address them.

Eliminating Non-Smokers' Exposure to Environmental Tobacco Smoke. Provide a description of:

- activities to advance toward policy development at the local level, identify and eliminate disparities, collect and analyze data, conduct counter-marketing.
- interaction with activities undertaken by State and local coalitions/task forces and partnerships barriers and identify methods to overcome them.
- unmet needs related to environmental tobacco smoke and plans to address them.

Promoting Quitting Among Young People and Adults. Provide a description of:

- activities and strategies to collaborate to promote science-based cessation services and policies disparities and strategies to reduce them.
- strategies to interact with cessation including counter-marketing, policy development, and implementation, and population-based and systems change strategies.
- barriers and methods to overcome them.
- unmet needs and plans to address them.
- methods to include the health care community.

The Identification and Elimination of Tobacco-Related Disparities in Specific Populations may be incorporated into the other three goals.

Include the process for identifying and eliminating tobacco-related disparities and a description of:

- data sources used.
- the county population demographics.
- rationale for addressing tobacco-related disparities in specific population groups specific strategies.
- initiatives to build capacity and infrastructure among disparately affected population groups.

- b. Physical Activity and Nutrition Goals and Objectives - The Centers for Disease Control Division of Nutrition and Physical Activity has established four major program areas to be addressed in the reduction of obesity. They include: 1) increasing physical activity; 2) promoting breastfeeding; 3) increasing consumption of fruits and vegetables; 4) reducing television-viewing time. This grants program will support best practice strategies for two national goals: increasing physical activity and increasing consumption of fruits and vegetables.

Use of grant funds is limited to informational, environmental and policy approaches to address physical activity and nutrition on a community wide level. See www.thecommunityguide.org/pa. All grantees will be expected to use the KDHE Community Partner Event Form to report activity related to physical activity and/or fruit and vegetables consumption under the scope of this grant.

- **Logic Model:** For planning and evaluation of prevention programs, logic models depict the presumed causal pathways that connect program inputs, activities, and outputs with short-term, intermediate, and long-term outcomes. To evaluate the progress made by chronic disease programs toward long-term outcomes, applicants are required to use the Tobacco Use Prevention Program logic models developed by CDC to identify activities, outputs, and outcomes that show success towards reaching the long-term tobacco use prevention goal. These logic models can be found in CDC's Key Outcome Indicators. Grantees should propose outputs and outcomes that reflect a change from the community's respective baseline. All program strategies and activities should relate to the logic model for each of the program goals. There is one logic model per goal addressed, i.e. a maximum of three models (cessation, initiation, and environmental tobacco smoke).

The following example is for eliminating nonsmoker's exposure to secondhand smoke.

Inputs: Health Department and Partners

Activities: Policy, counter-marketing, community mobilization

Outputs: complete education efforts to introduce policies

Outcomes:

Short-Term: Level A: Increased Knowledge

Level B: Create Policies, Enforcement

Intermediate: Enforcement of Policies

Long-term: Reduce exposure, reduce consumption, reduce morbidity, decrease disparities.

- **Budget Summary, including match and budget justification:** Show computations for all line items, and give explanations for each item in the budget. There is no page limit for the Budget Justification. The Budget Summary is provided as a form and can be found at http://www.kdheks.gov/doc_lib/index.html. Provide a twelve-month budget, line item budget and justification consistent with the stated objectives, planned activities, and time frame of the project, ending June 30, 2009.

Funds may be used for salary, travel, registration fees, supplies, advertising (requires prior approval from KDHE staff to ensure statewide coordination), consultation, facility rental, equipment rental, speakers, 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. Grantees with written approval from an Outreach Coordinator may purchase food upon special request for youth events and sharing sessions. Communities are encouraged to get partner contributions for food, which may be used as match. The Kansas Department of Health and Environment, Tobacco Use Prevention Program funds cannot be used to supplant existing funding. Applicants may not use these funds to supplant funds from Federal, State or private sources.

Identify matching funds. Matching funds may be cash, in-kind or donated services or a combination of these made directly or through donations from public or private entities. 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. These activities may fulfill the match requirement.

Level A and Level B applicants should include a plan for at least one staff or coalition member to attend a minimum of three trainings. Level C applicants should include travel for a minimum of three staff/coalition members or selected representatives to attend each of three CDRR required trainings per year and three Tobacco Free Kansas Coalition Meetings per year, as well as the Kansas Public Health Association Meeting. Estimate round trip mileage, \$40 registration fees, lodging and meals.

For Level C Grant Applicants Only

In Kansas, most communities are addressing tobacco control issues at some level. Communities applying for Level C grant funding should identify and describe components that are currently funded through other sources. Level C grant funding will be based on the amount necessary to achieve a funding level of at least a minimum level of per capita support as defined by Best Practices for tobacco prevention and control. To assist applicants in determining the amount for which your community is eligible to apply, worksheets are available at www.kdhe.state.ks.us/tobacco for easy computation of the funding request that is appropriate for the geographic target population. Instructions follow the worksheet and technical assistance is available by calling the Outreach Coordinator for the Tobacco Use Prevention Program in your district. Contact information can be found at www.kdhe.state.ks.us/tobacco.

In applying for a Level C grant, applicants may subcontract parts of the proposal to other local agencies and organizations. When possible, subcontractors should be identified in the grant proposal, including the specific tasks they will perform and the method of selection. Position descriptions relative to this proposal should also be included in the narrative and the appendices, as listed above for the applicant agency. If a subcontractor has not been identified, the scope of the subcontract should be outlined in the proposal, as well as the types of organizations that are anticipated to be a subcontractor. The method of selection for subcontractors must be included in the application. On the Budget Sheet, the total funding for all subcontracts combined should be included in the line "Subcontracts." The budget justification must include the following: Contractor, Date, Method of Selection, Scope of Work, Budget and Accountability.

- **Memorandum of Understanding from County Health Department (if applicable)**
- **Application Checklist (Submit in the following order)**
 - Application Cover Sheet
 - Table of Contents
 - Executive Summary
 - Program Narrative
 - Action Plan
 - Budget Summary
 - Memorandum of Understanding if applicable
 - Signatures of Support Form
 - List of the local coalition members, including individuals' names, agency affiliations or constituency they represent.
 - Position descriptions for key staff
 - Resumes of key staff (if available)
 - Salary Worksheet, form #11

- Logic models
- Copy of all tobacco related ordinances/policies for the county (i.e.: worksite policies, school policies, college, university, community college policies, city/county building policies, hospital policies, etc.). If applicant has submitted these in the past, only new policies should be provided.
- Level B & C only – Five year comprehensive tobacco prevention and control plan. First time Level B applicants may include a description of the process that the coalition will use to develop the plan.
- Level C Funding Worksheet: Provided as a form for *Level C grant applicants only*. The form for your use can be found at: www.kdhe.state.ks.us/tobacco .
- At least five letters of commitment from local coalition members whose work is essential for completion of the grant strategies, specifying the commitment which the coalition member is making to the program.

TECHNICAL ASSISTANCE TO APPLICANTS

Health Promotion Outreach staff are available to answer additional questions. If you require additional information or have questions, contact Carol Cramer, Program Manager of the Tobacco Use Prevention Program at ccramer@kdhe.state.ks.us or 785-368-6308.

SUBMISSION OF PROPOSALS

Proposals for the Chronic Disease Risk Reduction Grant must be received before the close of business on March 14, 2008. The proposal should be mailed to:

Pat Behnke
Kansas Department of Health and Environment
Office of Local and Rural Health
1000 SW Jackson Ave., Suite 340
Topeka, KS 66612-1365

Please return your CDRR application as part of the Aid-to-Local application packet. In addition, please mail two copies of your CDRR application to your Tobacco Use Prevention Program Outreach Coordinator.

REVIEW PROCEDURE AND AWARD OF GRANTS

A review panel will be assembled consisting of KDHE staff and independent reviewers knowledgeable about nutrition, physical inactivity and tobacco use prevention and cessation. Applicants whose proposals are selected for funding will be notified about May 2008 and all grant programs will begin on July 1, 2008 and end June 30, 2009.

EVALUATION CRITERIA

Applications received will be reviewed utilizing a Technical Review process. Total possible points = 100.

- **Executive Summary** (not scored, but required for review)
- **Program Narrative** (Total Points: 40)
 - a. **Background and Need**
The extent to which the applicant describes Background and Need in Application Content.
 - b. **Infrastructure/Program Management/Staffing Plan**
The extent to which the applicant describes staffing plan including personnel, dedicated staff to project goals, etc.
 - c. **Sustainability Plan and Integration**
The extent to which the applicant describes current local efforts to build capacity, partners involved, training efforts, etc.

- d. **Surveillance and Evaluation**
The extent to which the applicant clearly describes the capacity to conduct adequate evaluation, experience and how local surveillance will be conducted.
 - e. **Collaboration and Communication with Partners**
The extent to which the applicant describes specific communication and interaction with partners at local, state and regional levels.
 - f. **Local Programs/Community Mobilization**
The extent to which the applicant describes specific current proposed programs as well as plans to coordinate with state and local partners, such as the Tobacco Free Kansas Coalition, regional and state coalitions.
 - g. **Training and Technical Assistance**
The extent to which the applicant demonstrates capability of attending approved training workshops recommend by the OHP and provides the means for coalition members to participate, as well as share community training with other communities.
- **Action Plan** (Total Points: 50)
The extent to which the action plan is based on the comprehensive plan and includes SMART objectives and Best Practices strategies. The action plan will be complete including strategies, target population, lead role, timeline, and evaluation indicators. Emphasis will be placed on the population-based effectiveness.
 - **Logic Model** (Total Points: 10)
All program strategies and activities should relate to the national logic model for each of the tobacco program goals. There is one logic model per tobacco goal addressed, i.e. a maximum of three models (cessation, initiation, and environmental tobacco smoke). Evaluation measures for nutrition and physical activity goals are outlined in the resource materials provided at www.kdheks.gov/tobacco

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

1. PROGRAM PURPOSE

The purpose of this program is to increase the number of children less than 5 years of age with age-appropriate immunizations who are accessing WIC services.

a. 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, the project was expanded to four counties designated by the program targeting the largest WIC service areas with the lowest immunization rates.

b. Purpose of the Grant Program

The purpose of this program is to expand existing collaboration between Women Infant and Children programs and immunization services with specific interventions designed to improve immunization rates.

3. FUNDING

- a. Availability - Grant awards will be distributed on SFY 2009 Aid to Local Appropriations. This is not a competitive application opportunity. Applications for funding will be solicited from targeted Local Health Departments with large populations of WIC clients.

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 \$170,000).

- b. At this time, a match is not required for WIC/IMM grants.
- c. Funds may not be used to supplant or replace existing agency funding sources.

4. SPECIFIC PROGRAM INFORMATION

- a. Application - Follow the KDHE "SFY 2009 Grant Application Guidance," and complete the Program Request (Form #2) and Detailed Budget (Form #3) forms.

- b. SFY 2009 Objectives – Applications will demonstrate strategies to accomplish the following objectives:

- 1) Objective I: Train WIC staff regarding immunization record assessment
- 2) Objective II: Electronically document immunization records for WIC clients in the Kansas immunization registry (KSWebIZ).
- 3) Objective III: Follow-up on referrals made for needed immunizations
 - a) Objective IV: Perform reminder/recall for WIC children due or past due for immunizations

c. Priorities

- 1) Applications will be solicited from counties containing the largest proportion of WIC clients.
- 2) Applications will be solicited from counties with immunization rates in need of the most improvement

5. REPORTING REQUIREMENTS

- a. Quarterly, submit Certified Affidavit of Expenditures

- b. Quarterly, Submit quarterly evaluation report to KDHE that includes:
 - 1) Immunization rates of WIC clients
 - 2) Number of referrals made
 - 3) Number of referrals returned with immunizations administered or not administered
 - 4) Number of follow-up interventions
 - 5) Type of intervention made
 - 6) Number of WIC staff educated

PROGRAM CONTACT PERSON

Sue Bowden, Director
Immunization Program
Bureau of Disease Control and Prevention
(785) 296-0687

APPENDIX

FORMS