STATE OF KANSAS)
WYANDOTTE COUNTY)) SS SPECIAL SESSION, THURSDAY, SEPTEMBER 26, 2019
CITY OF KANSAS CITY, KS)

The Unified Government Commission of Wyandotte County/Kansas City, Kansas, met in Special Session, Thursday, September 26, 2019, with eleven members present: Bynum, Commissioner At-Large First District; Burroughs, Commissioner At-Large Second District; Townsend, Commissioner First District; McKiernan, Commissioner Second District; Murguia, Commissioner Third District; Johnson, Commissioner Fourth District; Kane, Commissioner Fifth District; Markley, Commissioner Sixth District; Walters, Commissioner Seventh District; Philbrook, Commissioner Eighth District; and Alvey, Mayor/CEO; presiding. The following officials were also in attendance: Doug Bach, County Administrator; Misty Brown, Deputy Chief Counsel; Carol Godsil, Deputy Unified Government Clerk; Alan Howze and Emerick Cross, Assistant County Administrators; Lynn Melton, Assistant to the Mayor; Terry Brecheisen, Director of Public Health; Terrie Garrison, Deputy Director of Public Health; Juliann Van Liew, Manager of Planning & Operations Division in the Health Department; Dr. Allen Greiner and Officer Jay Doleshal, Sergeant-at-Arms.

MAYOR ALVEY called the meeting to order.

ROLL CALL: Bynum, Burroughs, Townsend, McKiernan, Murguia, Johnson, Kane, Markley, Walters, Philbrook, Alvey.

NOTICE OF SPECIAL SESSION of the Unified Government of Wyandotte County/Kansas City, Kansas, to be held Thursday, September 26, 2019, at 5:00 p.m. in the 5th floor conference room of the Municipal Office Building for the Wyandot Behavioral Health Network Update, followed by the Board of Health Update.

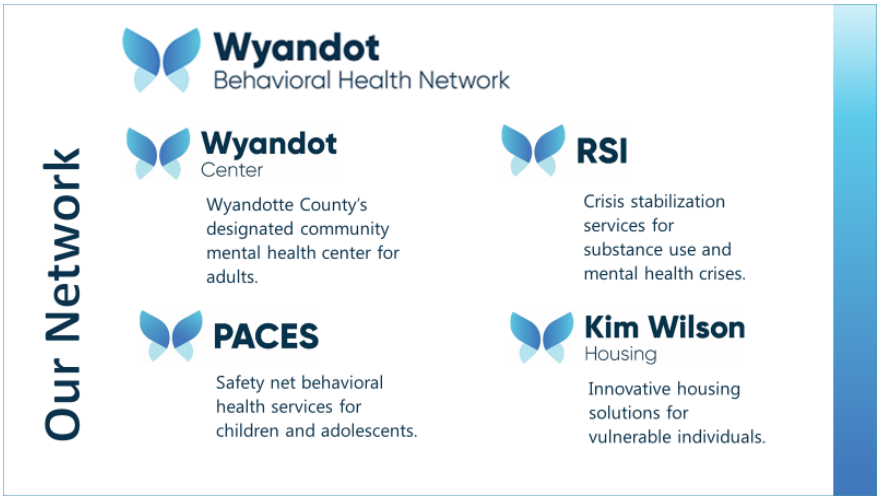
CONSENT TO MEETING of the governing body of Wyandotte County/Kansas City, Kansas, accepting service of the foregoing notice, waiving all and any irregularities in such service and in such notice, and consent and agree that we, the governing body, shall meet at the time and place therein specified and for the purpose therein stated.

Mayor Alvey said tonight we have two presentations. The first is an update from the Wyandot Behavioral Health Network. The second will be an update to us as the Board of Health.

Randy Callstrom, President/CEO Wyandot Behavioral Health Network, said as the local designated Community Mental Health Center I wanted to come and give you an update on the last year and what the Mental Health Center is doing and to let you know a little bit about what your investment and the return on that investment looks like. Just to put it out there, I'm not here to ask for anything. I'm just here to give you information. It could be a set-up for an ask later, no, I really think it's important to keep communication with the Commission open and transparent and I appreciate the opportunity to be here this evening.

You may have heard we did a little rebranding so I want to just talk for a minute about that. Formally Wyandot, Inc., we are now Wyandot Behavioral Health Network and I'll give you a little background of why we rebranded.

Last year we went through some strategic planning and contracted with a group called TeamTech to facilitate that process and did focus groups with our staff, with our consumers and clients, our Board members and the community, very importantly, our community stakeholders and funders. One of the things that we heard is that Wyandot, Inc. didn't mean anything to folks and they didn't understand the connection between all of the organizations within our network, didn't know there was this connection, etc.



Also, and this is very important, one day last year I was out of town attending a conference and I called back and I was talking to my assistant and she informed me there had been a visitor, a very important visitor, to meet with me that day and I regretted that I wasn't there. It happened to be the President/CEO of Wyandot, Inc. which is me. You may be aware of this, but there is a Wyandot County in Ohio and it is spelled with one T and no E and there is a food company, snack food company in Wyandot County, Ohio called Wyandot, Inc. which is fine. I actually knew there was this other entity, but we had actually never connected but their President/CEO was in Kansas City for his conference and was taking the opportunity to come by and meet us.

The important part of that, in today's modern world, is that if you go to an employer/employee website like Indeed or Glass Door and you're looking at reviews of Wyandot, Inc., you might be reading a review of our organization or you might be reading a review of the snack food company in Ohio and unless it mentions specifically the nature of the work or the state that it's in, you really can't tell the difference, although my assumptions of all the despairing comments about the CEO of Wyandot, Inc. is about the snack food company in Ohio.

Part of our rebranding was to have a name that described who we are and what we do, so it's little bit more self-descriptive and then, very importantly, we had—it was really important to distinguish ourselves from this other company in Ohio. So, that's why we did it. It's a longer name, I understand, but I think it accomplished our goals and I think it's important for you all to know that our Board was absolutely committed to keeping Wyandot in the name. That is our first and priority identity.

Within our network we have Wyandot Center which is actually the original organization dating back to 1953. That is the official designated Community Mental Health Center. PACES is

our children's serving mental health service agency. RSI is our crisis stabilization center and Kim Wilson Housing is our housing company.

Just a little background on the Community Mental Health System in America; the last piece of legislation that President Kennedy signed in 1963 was the Community Mental Health Center Act which created Community Mental Health Centers across the country and it really was the beginning of the institutional. The movement to help people living with mental illness moved from institutional care back into the community and the recognition that they are going to need, more intensive support, than was otherwise available to them.

Shortly after that, Wyandot Mental Health Center, as we were called back in the day, was designated as the Wyandotte County Community Mental Health Center and that's an official designation by the county.

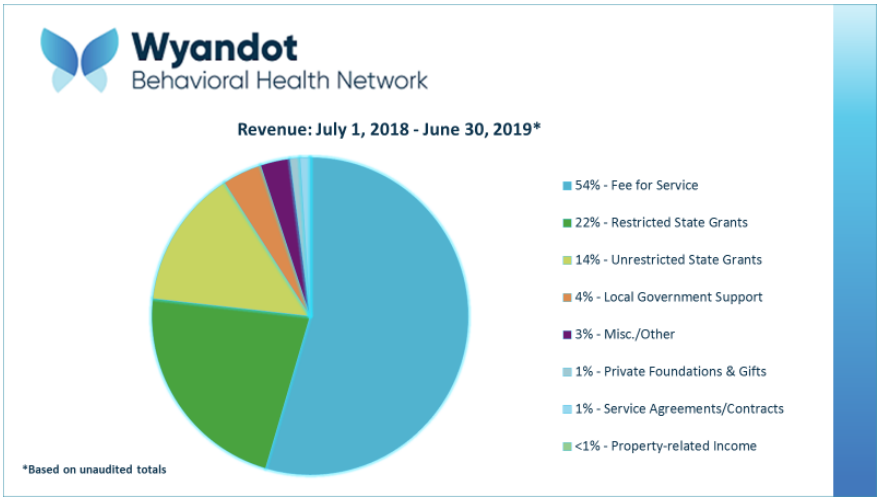
Across the state there are 105 counties and 26 Community Mental Health Centers serving from corner to corner, state line to state line, from north to south and east to west. There are a couple that are actual county departments; Johnson County Mental Health Center is a department of the Johnson County government. COMCARE in Wichita is part of the Sedgwick County government. Most of us are standalone self-standing non-profits like we are, but there is a formal relationship with the counties.

This last year, and our fiscal year runs from July 1 to June 30. We served just under 9,000 children and adults in Wyandotte County and took over 4,000 crisis calls and walk-in appointments.

Ninety-three percent of the folks that we serve are from Wyandotte County and the reasons that's not 100% is 1) are decide by design, serves people from Johnson County, although the large majority are from Wyandotte County, but it is designed to serve Johnson County. We also will take some contiguous county folks that come to our site, but also if someone has Medicaid or private insurance and they chose to come to us for their services, we also will see them as well, but it is a small number.

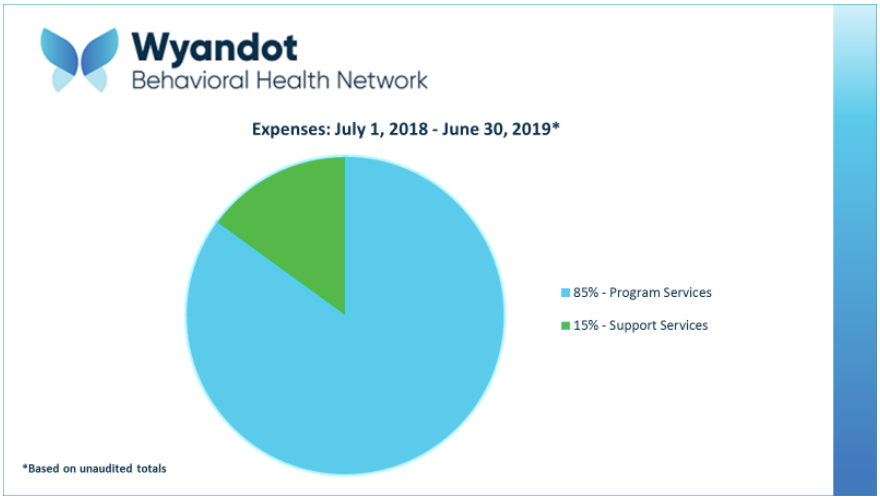
About half of the people that we serve are Medicaid eligible, 34% are uninsured and 60% live below the poverty line and I will talk about our funding here in just a minute, but the important thing about our funding streams is that even though 16% have either private insurance or Medicare,

that doesn't cover the services that we provide to adults living with severe mental illness or the services that we provide to children with severe emotional behavioral disorders in the community. Private insurance and Medicare will only pay for traditional outpatient therapy so our school-based services, our community-based and community support services are only funded really through Medicaid or the grant dollars that we receive from the state and the support that we receive from the Unified Government.



This is a breakdown and some of this data you should have in front of you, our annual report, and so this data is also in that report. A little over half of our gross revenue comes from fee for service that if we provide an hour of service, we get paid for that hour of service. About 22% comes from restricted state grants. These are grants that we receive from the state for a specific program. We do have some Homeless Outreach Grants from the state, we have an Early Intervention for Psychosis.

We're one of the two locations in the State of Kansas, us and Topeka, who have an Evidence-Based Program for early identification of psychosis and treating people who are having their first psychotic break. We have some unrestricted state grants and then 4% of the local government is how we are supported from the Unified Government and we're very appreciative of the support that we receive. There is the tax levy support as well as, and we will talk about this here in a little bit, some specific programs that we have in our justice involved mental health services that are funded through the UG as well.



Eighty-five percent of all the revenue that we receive goes back directly into the delivery of services and our programs and 15%, this last fiscal year, was for our support programs or our overhead and costs.

We don't do this alone. In the Wyandot Center Mission Statement, it talks about in partnership with the community. These are some of our key community partners, but it's by a longshot not an exhaustive list.

Wyandot Center serves adults.

We have everything from traditional outpatient therapy and psychiatry and case management services, but I really want to call your attention to a couple things. One is our Crisis Intervention Training. You may be familiar with this. It's commonly referred to as our CIT training. We've been doing this for seven or eight years now with partnership with many collaborators, but we have trained around 90% of law enforcement officers in the county, both KCK Police, Bonner Springs as well as the Sheriff's Department.

This last year we served over 4,500 adults and a little over 1,300 walk-in crisis situations.

One of the things that we think about in our mission, and our Vision Statement was on the first slide, and talked about healthy minds, healthy lives, and thriving communities is that we're not just here to serve the people that walk in our door. We really take to heart that we are the Community Mental Health Center and that our commitment is not only to serve people who seek us out for mental health services, but how do we reach out and better serve our community. One of those is the Frank Williams Homeless Outreach Center. We are open from 8:30 to 12:00 everyday down at 7th & Nebraska. Almost 1,600 folks who are living in homelessness last year came to Frank Williams. There they can get showers, they can have their mailed delivered there, they get street survival gear, we are also available to do mental health assessments and we are the hub for the Continuum of Care homeless count in Wyandotte County. So, there is a bi-state

community of care for those that are chronically homeless and this is the hub in Wyandotte County to count but also to put those individuals on the by name list so they are able to access housing when it becomes available.

We also have a tremendous partnership with law enforcement and the justice system here in Wyandotte County. We have our Behavioral Health Court that Judge Russell in collaboration with Wyandot Center started a couple years ago, Intensive Case Management that is embedded into Community Corrections. We have a co-responder that is embedded with the Kansas City, Kansas Police Department and then our jail and court liaisons. Those are all really critical to serving people living with mental illness who touch the juvenile or the adult justice system.

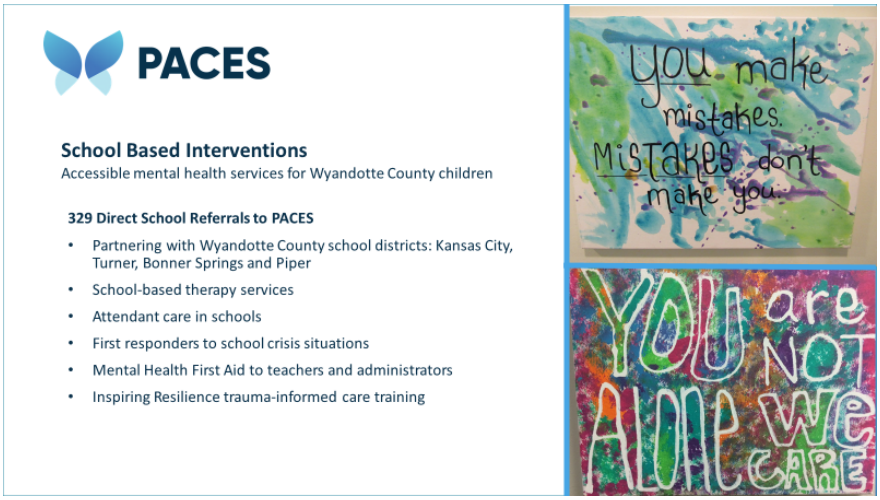
We're working really hard to help keep our folks that we are serving out of jail. Our jail liaison checks the bookings in the jail everyday to see who is involved in services or looking to see who might benefit from mental health services and connecting them up to services when they are released from the jail. I might point out, several of those positions are funded through the support of the Unified Government, so thank you for that.

PACES is our children's mental health organization and we provide a lot of the same services through PACES for traditional outpatient therapy, case management services for children with severe emotional disorder.

We also have great partnerships with our school districts, long-standing relationships particularly with the Kansas City, Kansas School District where we have mental health providers embedded into the alternative school, the Bridges Program, called the Wyandotte Academy where we have therapist and case management services that are provided on-site in the Bridges Program on a daily basis as well as crisis response to the school district. We also provide crisis services to the other school districts here in the county and then just this year, just starting, the Bonner Springs School District contracted with us to provide school social work services to the Bonner and Edwardsville schools.

This last year we served almost 3,000 children and their families with over 300 referrals directly coming from the Kansas City, Kansas schools.

Again, we are here not just to provide mental health services, but what other needs and the gaps in the community. Five years ago, we opened Robert's Place which is a children's emergency shelter here in Wyandotte County and serving children who are taken into police protective custody due to abuse or neglect. Each year we're serving over 450 Wyandotte County youth in Robert's Place.



I mentioned already the school-based services that we have.

RSI, this was the first crisis stabilization center in the State of Kansas.

Mayor Alvey asked could you go back to PACES. Is that an acronym for anything? **Mr. Callstrom** said technically yes. It's Parent Adolescent Child Empowerment Services which is way too long to say, but it's actually incorporated as PACES, Inc. so it's an acronym but legally it is PACES. **Mayor Alvey** said I thought maybe it had something to do with ACEs, Adverse Childhood Experiences. **Mr. Callstrom** said it's not, but that's a lovely play of words. I hadn't thought about that. I may use that if that's okay.

Mr. Callstrom said RSI launched five years ago in April. This was the first Crisis Stabilization Center in the State of Kansas. There are now a total of five including Wichita, Topeka, Salina, and Manhattan. Last year there was over 1,000 persons, that's unique individuals, that came to RSI and so this is over 1,000 individuals that either would have gone to jail, would have gone to the emergency room or not received any crisis mental health services at all and that's for a total of 1,600 visits or admissions.

I mentioned we're serving Wyandotte, Johnson, and then more recently, we started taking referrals from Leavenworth and Douglas Counties as well. There are three components to RSI. One is a Sobering Unit where they can stay for up 10 hours. It's usually about five hours. Most of those individuals are brought by law enforcement from either the law enforcement agencies in Wyandotte County or Johnson County. We have a Crisis Observation Unit that can serve up to 23

hours and then the Crisis Stabilization Unit where they can stay up to 10 days. This has been truly a godsend.

You may be aware there that there was a moratorium at Osawatomie State Hospital that went into effect in June of 2015, meaning only those individuals that are court ordered to the State Hospital are able to be admitted there and there is a waiting list that exists still every day. Today there was six individuals waiting to get into the State Hospital who already have been court ordered into treatment there. RSI has been a tremendous resource. This is really funded primarily by the state. Rainbow State Hospital was located here in Wyandotte County. You probably recall that and this was done originally through a grant.

The state approached the community saying if we took the State Hospital operating budget and put that into the community, what would you do and that's when Wyandot, Inc. at the time and Johnson County Mental Health Center and Heartland RADAC submitted an RFP response saying we would do these three services. We would have sobering, crisis observation, and crisis stabilization. We were awarded that grant money for $3.5M in 2015. That money is now actually a part of the budget line item for the Kansas Department of Aging and Disability Services and much to the work of our local representative, Kathy Wolfe-Moore and Senator Denning from Johnson County whose brother Frank was the Johnson County Sheriff at the time. As Senator Denning has said, Frank told him we needed to do it and he said okay, so we're appreciative of Frank and Senator Denning for that.

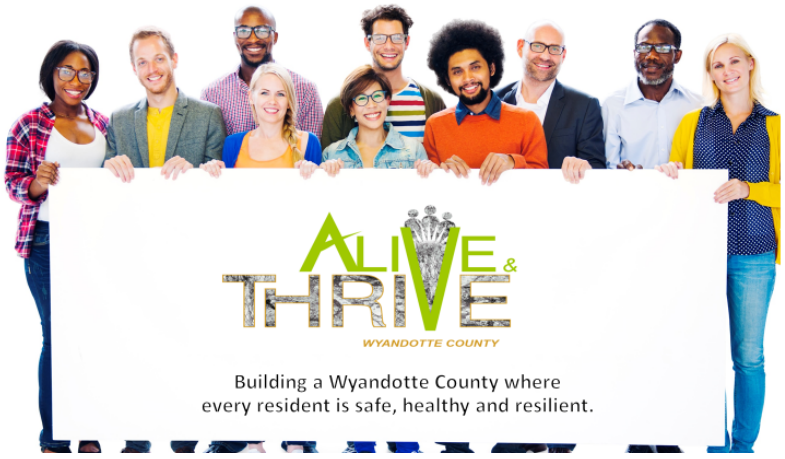
Over the last five years RSI has served over 4,500 unique individuals and prevented over 3,000 hospital admissions or jail bookings in Wyandotte and Johnson County.

In addition to our mental health services, as I've already mentioned, we are always looking at how we can better serve the community. Homelessness has a huge need and affordable housing in Wyandotte County continues to be a need. Kim Wilson Housing was born in 2009 to help fill some of those gaps and needs.

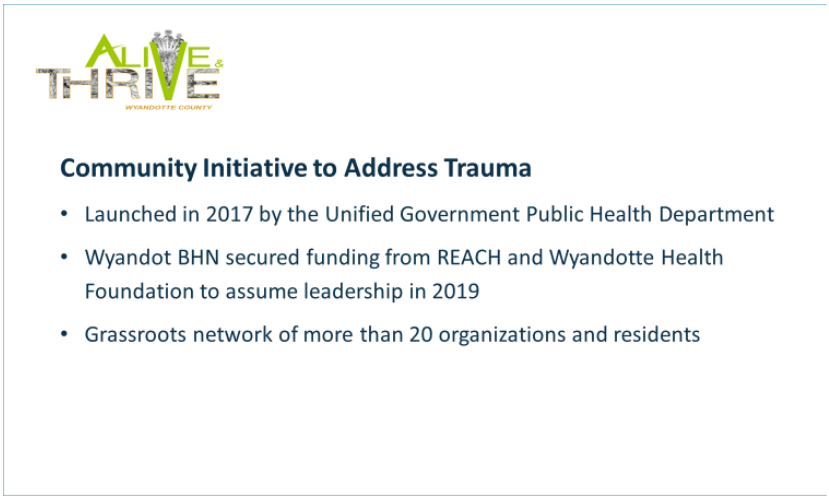
They offer permanent support of housing, so individuals who are living with severe mental illness can live successfully in the community but need on-site, and in some cases around the clock, supports available in order for that to open. They don't need to be institutionalized, they certainly don't need to be in jail or prison, but they need more intensive support in services to be successful, but also rental assistance and mediation services. What that means is mediation services with landlords. Landlords struggle in housing some of the folks that we are serving in the community.

Our staff is working as much with the landlords as they are with the individual clients to support the landlords, mediate when there's conflict either between the tenants or between the landlord helping make sure that the tenants are paying their rent, helping set-up those individuals with vouchers from the Kansas Housing Authority or through HUD.

This last year 440 individuals were served for housing services through Kim Wilson Housing and 197 are receiving permanent support in housing services.

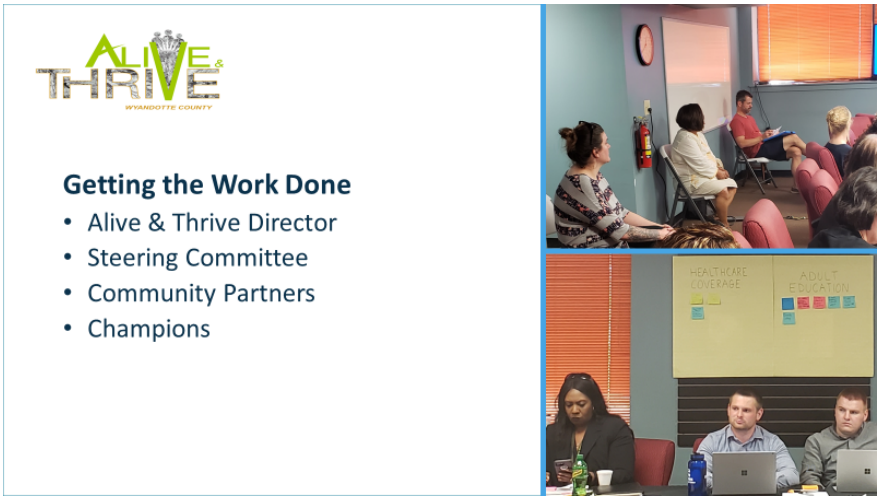


Alive & Thrive; you may be familiar with Alive & Thrive. This was actually born in 2018 under the Healthy Communities Wyandotte and then moved over under the Health Department. At the request of the Health Department we became the lead agency for Alive & Thrive beginning this last January.



While we are the lead agency, this is a community initiative. We're the lead agency, but we don't own it. This is a community-owned initiative. We assumed the leadership in January and immediately began working with over 20 organizations in the community and individual residents to really outline what are the needs to build resiliency in Wyandotte County.

To create awareness around the impact of trauma. Mayor, you mentioned the ACEs, Adverse Childhood Experiences, so the two primary goals of Alive & Thrive is to create awareness, to educate on the impact of trauma, and very critically, to help communities build resiliency to the impact of trauma. So, raising awareness, engaging, aligning & supporting.



The way we are approaching this is really through—we have an Alive & Thrive Director, Chandler Green; a steering committee made up of about 20 community partners that really is providing us strategic direction. But then, this is a road grassroots initiative. We really believe strongly, and this is really what the community is saying, is that the answers to resiliency needs to come from local neighborhoods, local faith groups, local community groups as a general rule. This is not us or anyone else saying this is what the community needs to do. This is bubbling up from the grassroots.

Just to say a little bit more about that, Chandler has started meeting with community groups and the first group that's engaging in the conversation is our faith community and this is an open group. It's certainly not a closed group, but we recognize the importance of the faith community in Wyandotte County and they touch a lot of folks throughout Wyandotte County and looking at how can we engage the leadership in the churches, but also the members within those churches and how can we support them in developing their own ideas on building resiliency.

At this point I would be happy to answer or entertain any questions that the Commission may have.

Mayor Alvey said on the Alive & Thrive, when you talk about resiliency, describe what that looks like for an individual or for the community. **Mr. Callstrom** said if you think about, we all have a cup that gives us the ability to bounce back from the negative things that happen and we all have bad things that happen every day, but Adverse Childhood Experiences whether it's abuse, neglect, having a parent who is incarcerated or a parent who is living with mental illness or a parent who is addicted to substances, those are all parts of the ACEs. Those are all traumas and then there is the community trauma that witnessing violence that so many of our folks experience, all of those things drain us from our resiliency cup.

Building resilience is about how do we refill those cups. It can be support, it can be things like learning mindfulness and meditation, it can be when there is a violent act that happens in the community, how does the community rally around the victims of that violence or the witnesses to that violence. Those answers are best, I think, going to come from the community and how they can help fill the cups of their membership.

Mayor Alvey said I'm assuming that the other service programs you provide, the majority of your clients or customers have a score four or five or more. **Mr. Callstrom** said absolutely and we provide direct trauma treatment and that's really important. Some people need very specific evidence-based interventions around dealing with trauma, but it also takes the community as well. Some will get services through the Wyandot Behavioral Health Network, but there are other providers that are part of this process and part of the initiative as well.

Commissioner Philbrook said just briefly, because you mentioned ACEs, the scoring; could you just briefly mention what that is for those people that don't understand what that is out in television land? **Mr. Callstrom** said sure. The ACEs Study or Adverse Childhood Experience was a study done by Kaiser Permanente back in the late 1990s and it was a way of really linking physical health conditions with trauma. What they discovered is that there's 10 questions to the ACEs including abuse, neglect, parent with mental illness or substance abuse, parent who is incarcerated, etc.; that the more checks or the more ACEs that someone had, there was a direct correlation to their increase of their physical health. The more ACEs someone has, the more likely they are to experience heart disease, stress, anxiety, diabetes, cancer; we now know through a lot of research that there is a direct correlation between our mental health and mental wellness with our physical health as well.

Commissioner Philbrook asked can't you get on the internet and actually score yourself on that. Isn't there a mechanism to do that and I think a lot of us here would be surprised at our stress levels if we actually did that. **Mr. Callstrom** said sure. The ACEs is in the public domain as I believe.

Commissioner Townsend said, Mr. Callstrom, thank you for the work that your organization does. With regard to assisting—with respect to housing for some of your clients, could you go into that a little bit more; how specifically do you aid people in need of housing. Is it through vouchers, actually helping them find housing, just a little bit more specifically if you could talk about that. **Mr. Callstrom** said we work very closely with the Kansas City, Kansas Housing Authority in helping align vouchers with the folks that we're working with who are in need of housing. We also work with landlords who have project-based housing through HUD and then the Supportive Housing Services as well. We have a housing locator, so we have someone who is just designated to go out and recruit landlords to be willing to take people who living homelessness and specifically people who are living in homelessness who also have mental illness and helping them get connected with landlords that would be willing to work.

We're also working on projects to increase the availability of those housing services. We are working with a group called the Vecino Group which they develop supportive housing programs across the country. They are working something like 17 states now so it's a little premature to talk in detail about this, but we are in development of a project that we hope to submit for a (inaudible) tax credit this next year in 2020 to increase the availability of supportive housing

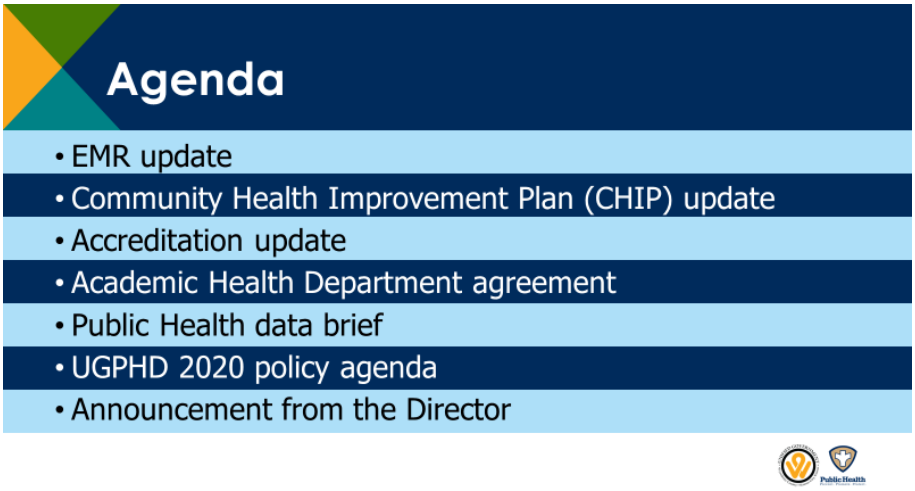
that would also have vouchers attached to it. It won't meet all the needs. The demand will always probably outpace the supply but those are some of the things that we are currently doing.

Mayor Alvey said thank you so much. We appreciate the report. **Mr. Callstrom** said thank you for your time and we do appreciate all the support that we get from the Unified Government and it's our pleasure to serve.

Mayor Alvey said we are convening as the Board of Health. (5:30 p.m.)

Doug Bach, County Administrator, said this is an update and the Health Department is here to give us a presentation on items that are going forward. I think they were here six months ago or somewhere around that timeframe and decided we wanted to come back.

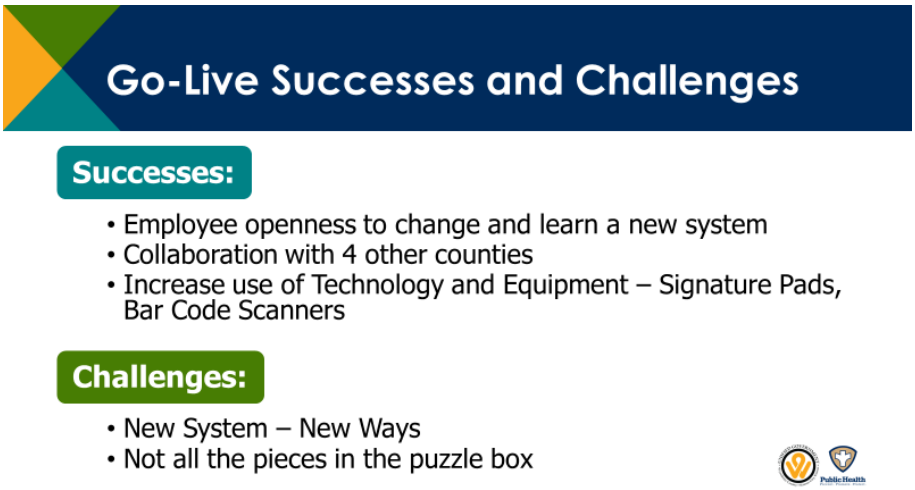
Terry Brecheisen, Director of Public Health, said six months ago we did meet with you and we decided, we meaning you and us, to meet every six months, so it's been six months, so here we are. We want to tell you everything about everything, but we have selected a few things for a robust agenda to cover this evening.



We would like to give you an update on our electronic medical records, the Community Health Improvement Plan, our Accreditation, and we are becoming an Academic Health Department in agreement with KU. We've got some statistics we want to share with you concerning public health in Wyandotte County and where do we go from here and what are we going to do in the future, so we have quite a bit of stuff.

With me today is Terrie Garrison, Deputy Director; Juliann Van Liew, Planning & Operations Coordinator; and Dr. Allen Greiner, Medical Advisor. We had one person that ended up in the emergency room today. She was going to be part of the presentation and couldn't make it. Terrie is going to give the first part of the presentation.

Terrie Garrison, Deputy Director, said thank you for having us tonight. My piece of it is talking about our new electronic medical records, the implementation phase of that and that occurred—we had training, we went with a program—we had been studying many EMR systems.



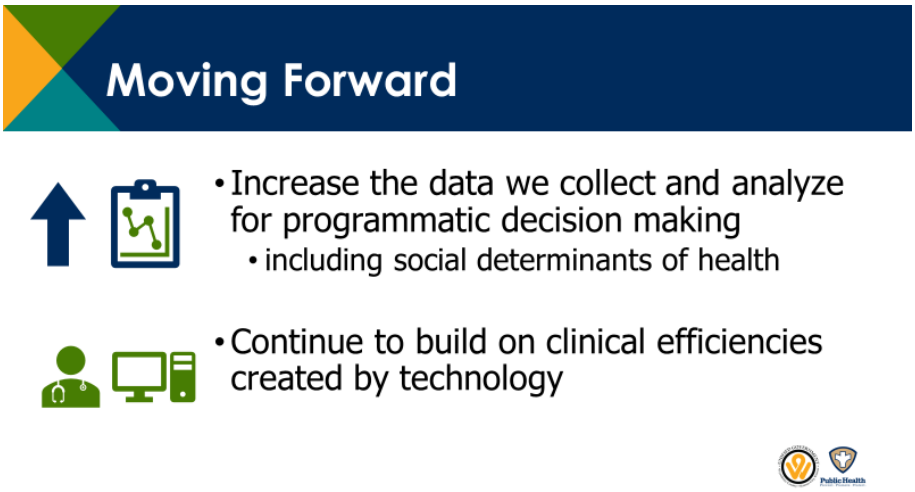
We finally decided on a company called Custom Data Processing, CDP for short. We had training with CDP at the end of June and went live on June 28th. It was very enlightening. Our employees were very open to the change and very interested in the training and learning the new system and everything which was very refreshing. We went together with, if you remember, there were five counties that went together on this process. We've all now have gone through all the training. All the five counties have gone through the training and four of the five counties have started going live with the system. We're continuing that collaboration and building those relationships and the system together which is very helpful.

We also increased the use of our technology and equipment. We started using bar scanners for our inventory of our supplies such as our immunizations and our medications. We're using signature pads so everything is electronic and we can pull it out that way, less papers, less trees that we're killing, so always a good thing.

Some challenges, of course, with a new system there are new ways of having to do business and that's always a challenge when you go through that and trying to build the system with four other counties and get everybody on the same page and looking at things the same way can always be a challenge. We're working through that. We have regular conference calls, regular meetings, webinars to go through some systems and say this is how we're using it, how are you

using it, what's the best way, so that we can have a consistent voice at the state level when things change at the state level which they inevitably will.

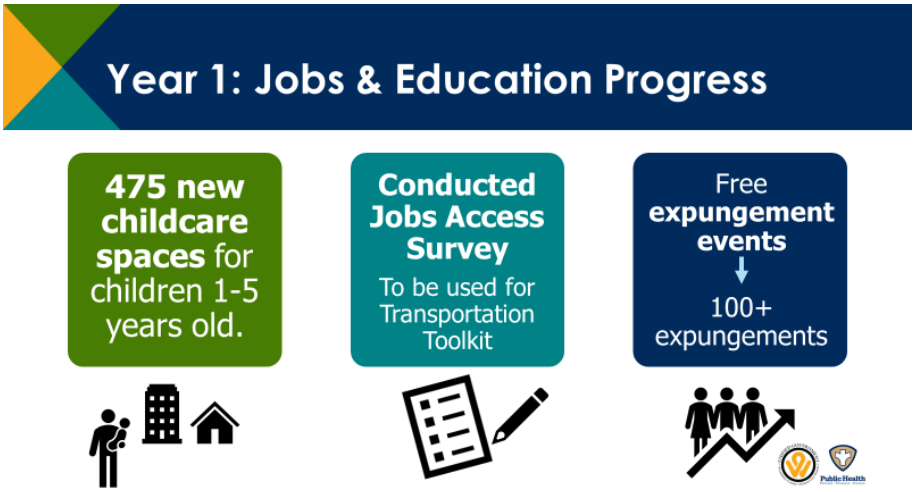
Some other challenges is, of course, there was not all the pieces at the same time. Like I said, we're building some of the different pieces so it wasn't ready to go out of the box and that has, again, presented some challenges for us as we move forward that we are working through.



Moving forward, our hope and our anticipation with this system is that we will be able to increase the amount of data that we collect and we can analyze to make good programmatic decision-making for our community and the individuals that we serve through the Health Department including doing some of the social determinants, looking at the housing, looking at food insecurities and some of those and being able to move that needle forward.

Also, to continue to build on the clinic efficiencies. The some that we have already mentioned like keeping inventory and being able to do inventory with our immunizations but continuing to improve in the efficiencies using technology as we move forward.

Juliann Van Liew, Planning & Operations Manager, said we're going to dive into an update on our Community Health Improvement Plan. We published this plan, as you probably remember, well probably not as well as I do, but exactly a year and one week ago so we're right at that one year mark. There is a tremendous amount that we could update you on, but what I want to do is spend time talking about the four pillar areas of our plan and what each of those areas have accomplished in their first year kind of at a high level and what their plans are for year two.



Our first team is the Jobs & Education Action Team. In year one they've had a lot of success. This was a group of folks who are already meeting as the Workforce Solutions Committee, so they had relationships built. The goal for five years for this team was to open 300 new childcare spaces and already in the first year, many of have already been implemented, but 475 have been

announced and are in the works so a great win there, not nearly meeting the need that we have, but moving us toward that.

This team has worked the Mid-America Regional Council to conduct a Jobs Access Survey. This is really to help figure out how do we help folks in our community with transportation, get to the jobs that we know are available. It was largely geared at company's in the western part of our county and trying to figure out what their interest is in helping employees get to work for those who have specific workforce needs and what their interest is in coordinating with one another to meet that need.

We also worked closely with the DA's Office and the Kansas City, Kansas Community College on the expungement events that you probably heard about this summer which were very successful and we're hoping to do continuous rounds in the future.

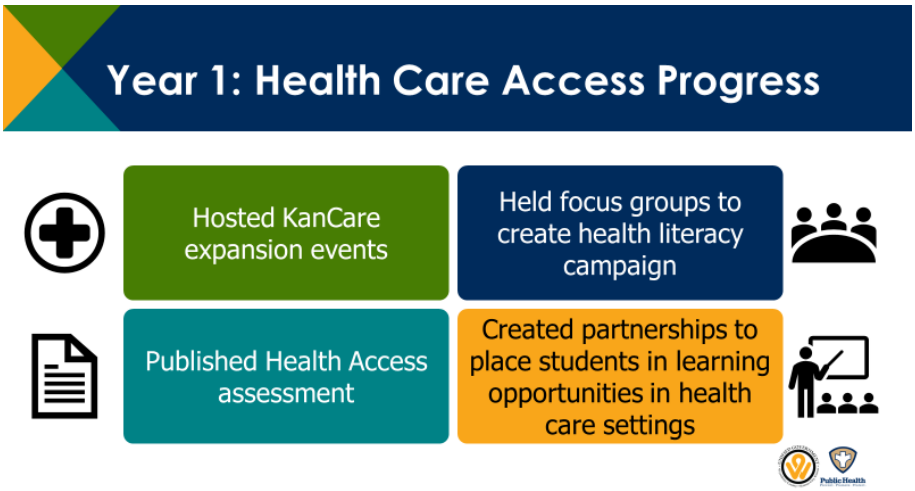
In year two, one of the main things that's gearing up, some of you were actually there last week, we kicked-off a faith-based partnership with a faith-based roundtable. There are a lot of opportunities there. We know we have a really robust faith-based community here in our county, so trying to figure out how to engage them in jobs and education, but in the CHIP as a whole.

There are some opportunities around transportation because many of them have fleets of vehicles as well as around childcare because many of them have spaces that could be opportunities for childcare centers.

Also, looking at increasing Business ESL. There's a big difference between the English that it requires to be fluent in your community and the business—or the English that you need to

be safe and productive in the workplace oftentimes. So, working with businesses to figure out what is that minimum amount of English that folks need and how can we really tailor ESL Programs so that we're meeting that need first before we're working on all the rest of the fluency stuff.

Lastly, they're working on implementing, for the first time in Kansas, although this is a national model, the Federation for Advanced Manufacturing Education, so continuing to try to be a place of strong manufacturing workforce in Wyandotte County.



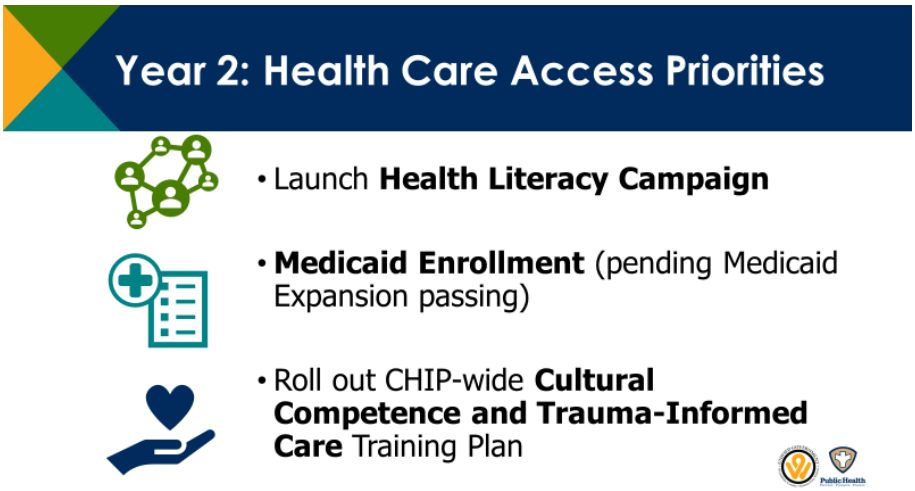
Our next team is the Health Care Access Action Team. We did a lot of work around KanCare Expansion during the legislative session. We all know how that went. We will be picking that work up again here shortly this fall. We held focus groups around a health literacy campaign that I will talk about in a moment.

We also published what we consider to be the most comprehensive and robust Health Access Assessment that's been done for Wyandotte County. We surveyed all the healthcare providers in our county and we also interviewed high-risk residents to better understand barriers to care. Not surprising, the largest barriers to care were cost for insurance, transportation, and language barriers, so it's really helping this team to hone in on those areas as we move forward.

Lastly, we've been working hard to match schools at different levels, high schools and post-secondary, with healthcare employers in the community. Healthcare is our largest affecter of the workforce in our community. That's not something that's likely to change, but what we need to make sure is that our Wyandotte County kiddos are ready to move into those jobs and a lot of

times what we're finding is the experience that they have with healthcare is that you can be a doctor or a nurse. Well, we know it goes beyond that. If it's the largest sector of our economy, then there are a whole bunch of other jobs. There is billing and coding, there's health administration, there's public health; so, figuring out how do we get students exposed as young as freshman in high school to the other parts of healthcare.

Then, kind of our secondary goal for that, how do we make sure that they know that their second language skills are really valuable particularly in the healthcare field in Wyandotte.



In year two, this team is gearing up to launch a Health Literacy Campaign. What this really is about, we've got a little bit of funding so we're really excited for this, one of the main indicators for health that's kind of used nationally is how many folks have a primary care provider or PCP. This is looked at—that's kind of a standard metric because it points to a lot of other things. If you don't have a primary care provider, you're much less likely to be able to manage your chronic conditions. You're more likely to end up in the emergency room, a whole host of things that you can imagine. This campaign will really be geared around helping folks understand what is the appropriate use of primary care, first and foremost, and secondly; where do you go to get care.

There is some misperception in our community that we don't have any healthcare providers and we certainly have a need for more, but there does exist a strong safety net health system in our community. You can call in and get an appointment within two to three days at several local clinics and so helping folks figure that out of what they should be doing and how to access it.

Secondly, Medicaid Enrollment, which we are hoping to begin working on. Like I said, we will be working toward the Medicaid Expansion in some advocacy efforts but hoping that passes even in the early parts of the session. There will be more than 10,000 folks around our county who need to get enrolled. Part of our job will be to help folks through what can be a pretty difficult and complex process.

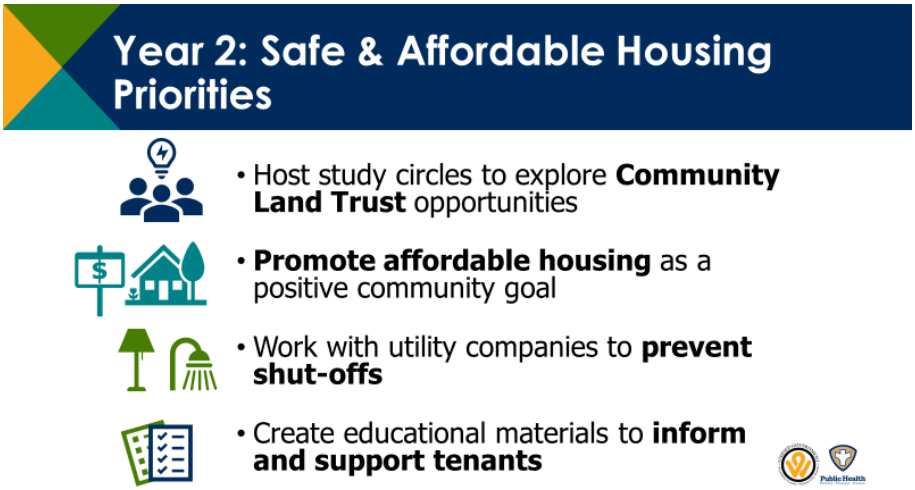
Lastly, this team is looking at rolling out a Cultural Competence and Trauma-Informed Care Training Plan. This is an exciting way that the CHIP teams are coordinating and collaborating with one another because this originally started out as a strategy only for healthcare access and as we started going down this path the other teams are going, we need this too. Cultural Competence and Trauma-Informed Care pertains just as much for employers in the business sector as it does for folks working on violence and folks working on housing, so a great opportunity for collaboration.

Our third team is a Safe & Affordable Housing Action Team. You may remember, this is a group that kind of started the furthest behind simply because they hadn't had a coalition before. There hadn't been a sustained way that folks from across the sector from contractors to tenant rights advocates have sit down at the table over a sustained period of time, so this year has seen a lot of relationship building. I think it was important to spend the time on that that was required in order for us to be able to move forward.

In addition to doing that, they've also had some wins. There is a Minor Home Repair Coalition pot of funds that wasn't fully being tapped into because we didn't have enough

contractors who could assist with that. We've really worked on increasing that number of contractors and this is really about helping largely the older segment of our population to be able to stay in their home. Safe and affordable housing isn't just about new housing stock, but how do we help folks who are in a home stay in a home.

This team also secured a grant and has hired a contractor to support this Action Team so we have some more stability and then in June I think some of you participated in the first Housing Summit in Wyandotte County that was held that brought together even a more robust group of stakeholders around housing.



Gearing up for year two, they are looking at delving further into the Community Land Trust issue, really figuring out what different sectors of housing they're looking for in this because there are a lot of parties that are interested, but there are a lot of ways a Land Trust could go.

Also, looking at promoting affordable housing as a positive community goal. A lot of us probably have a decent understanding of the negative connotation that exists when we say affordable housing. The research shows us that affordable housing is incredibly stabilizing both for families and communities, so starting to promote that and reducing that not in my backyard kind of stigma that can exist.

The team has been working really hard, especially with the contractors we have hired, to ramp up conversations with BPU and with others on preventing shut-offs. There's some real traction just because there are a tremendous amount of folks who are interested in this. That work is, hopefully, going to take off around the beginning of the year.

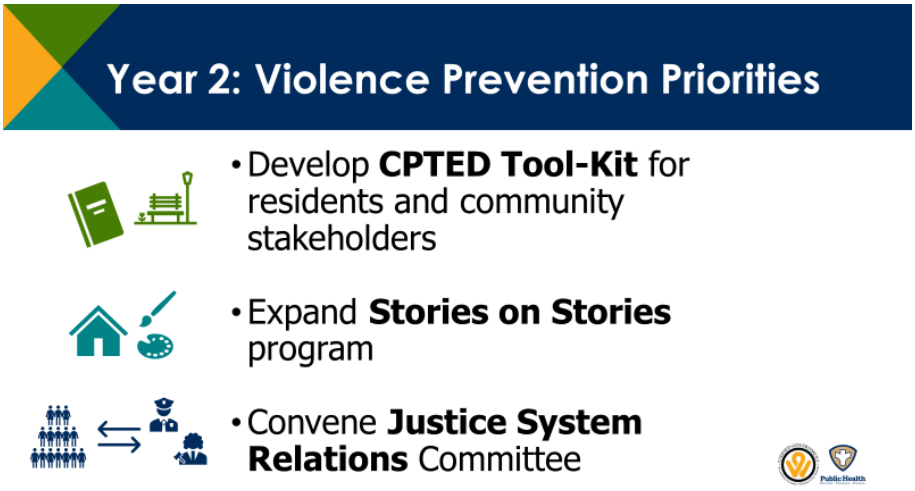
Lastly, this group is looking at figuring out a way to have a repository of information around supporting tenants and tenant rights information. If you're in this community and you're having a situation with your landlord, the advice that you're going to get is going to be really different depending on who you ask and what site you google. There is great information out there, but helping there be a central location, not just for residents to access, but so that our social service agencies are all getting the same message about what support exists for tenants.

Lastly, our Violence Prevention Action Team has been very busy. Most of you are familiar by now with the concept of CPTED or Crime Prevention Through Environmental Design. This team has really hone in on that. In year one they held a robust 40-hour training for a lot of community members and many Unified Government employees really helping us figure out how do we promote the reduction of violence through changes in our physical built environment. They've also created videos and brochures around that to support outreach efforts.

Just a couple weeks ago they finished their first pilot of the Stories on Stories Project, so stories as in art work on stories as in building, pretty catchy I thought, which is a fantastic way to reduce violence because not only—we know that beautifying neighborhoods reducing violence in and of itself. What this team has done specifically is not just commission artists to do this, but to engage the community so that at the end of this project you've not just reduced violence again through that beautification but through building a sense of community cohesion because people came together and designed the concepts together and implemented it together.

This team also started up a Youth Community Action Board. We know through the research that the best way to reduce youth violence is to have youth figure out they want to reduce youth violence and so working with the HEAT CAB and NBCCDC, has been putting that group together and there's a really engaged group of young people in our community that want to work on this.

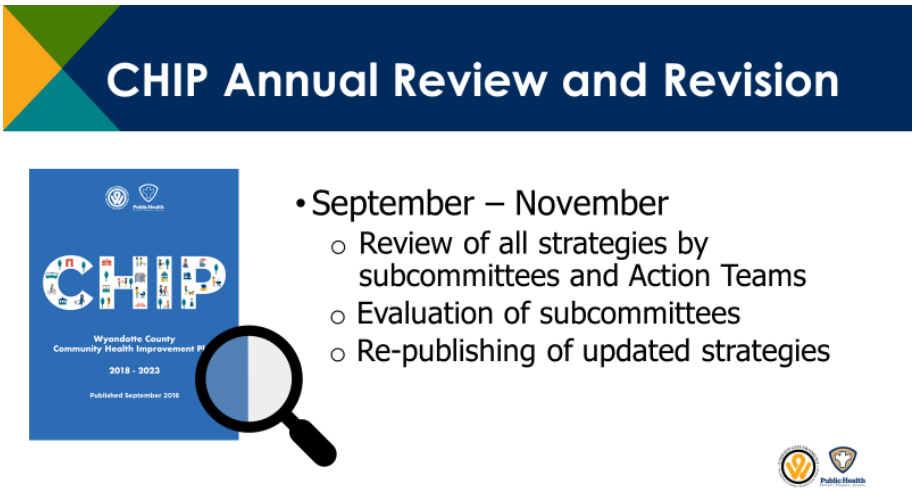
Lastly, starting up a Hospital-Based Violence Intervention Program, so we know that folks, especially young people, who are admitted to the emergency department from having suffered some sort of violence are very likely to either experience it again the next year or to become perpetrators themselves. Putting an intervention in place with someone who is like a community health worker who is from their community, that stays with them and becomes a mentor for them and really provides this way of intervening and hoping to, if you're looking at it from an epidemiological model, stop the spread of disease, stop that perpetuation and that cycle. It's been a great partnership with KU and the Thrive Violence Prevention Project.



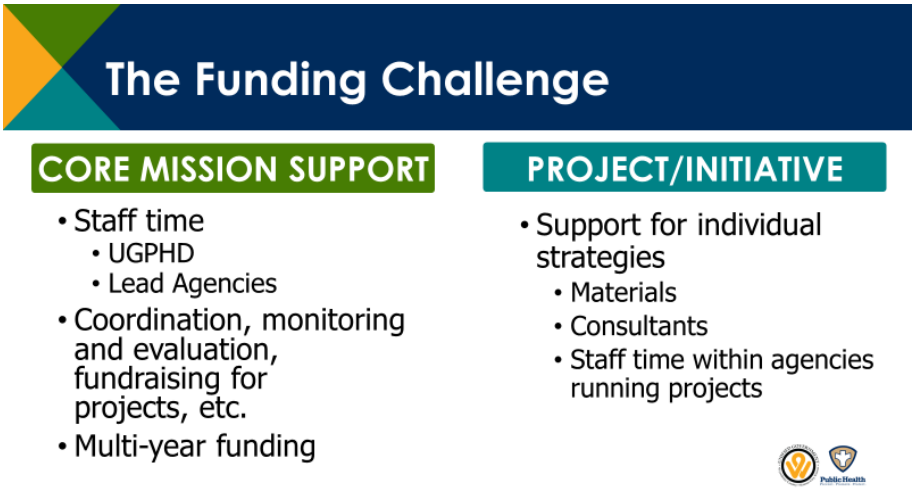
For year two, the Violence Team is looking to continue their CPTED work specifically by creating a tool-kit so we have a robust group of neighborhood organizations in our community and we need to tap into that. As those neighborhood groups are working on considering their built environment, making sure they have the tools that they need to work on violence prevention.

Expanding the Stories on Stories, we will really be using—Rosedale was a great pilot, but we need to be getting into the most high-risk neighborhoods that experience the highest rates of violent crimes, so expanding that.

Taking a closer look at Justice System Relations. We've had great involvement from the PD and Sheriff's Office and others in the CHIP. Its been a great partnership that's helping build relationships, but we need a team that's looking at this more closely. I think this plays out in the community survey that we do every couple of years, that this is consistently seen as something that could be improved, so working on ramping that up.



A couple more things on the CHIP before we move out of this. Right now, we're undergoing a year-one annual and evaluation so in about six weeks you will see kind of an updated year-two CHIP. It's meant to be a living, breathing document. The strategies that we selected more than a year ago some of them we know now after a years' worth of learning, aren't exactly appropriate for our community or they need to be tweaked or they were preempted at the state or something like that. The vast majority of strategies will stay in the plan as they are but some of them will be modified and I think that's appropriate as we go to continue to have an actual plan that reflects the work on the ground.



I want to spend one more minute talking about the Funding Challenge. So, something like a Community Health Improvement Plan uses a collective impact model which is essentially a hub and spoke model. So, at the core you have the Health Department and the four lead agencies who are leading these Action Teams and then you have a whole bunch of partners that are kind of spreading further out. Work like this requires an incredible amount of collaboration and coordination and that collaboration and coordination requires staff time.

We think of funding for the CHIP in two different buckets. That core mission support, which is often times that really unsexy work of monitoring and evaluation, fundraising, setting the meetings, leading the meetings, harping on people in between the meetings to actually do the things. All that kind of stuff and so we're working really hard to try to raise this core mission support that we need and I'm going to give you a sense of how much we're looking for. Again, like Randy, we're not asking for money today, but I do want to lay it out there for you, and specifically looking for multi-year funding. It's really difficult, as you can imagine, to hire new staff to work on this when you're looking down the road at only a years' worth of stability.

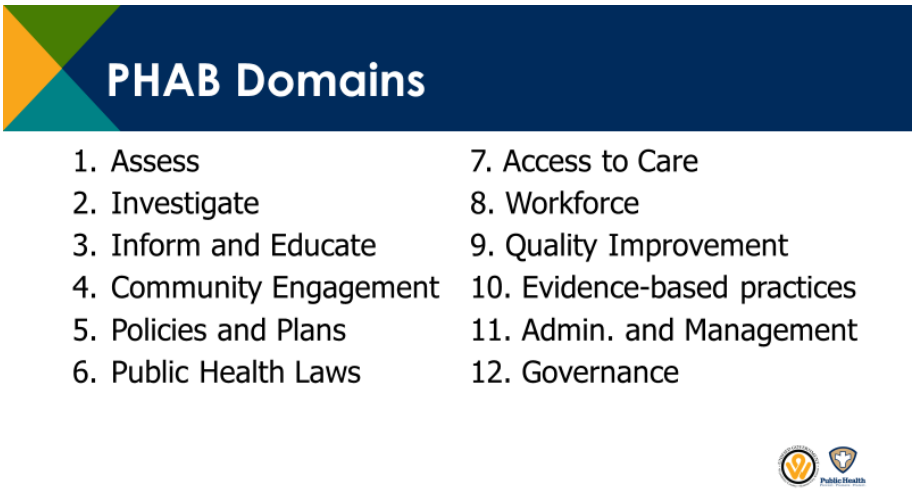
The second pot of funding is a Project/Initiative funding that's going to these actual projects or strategies so that a Health Literacy Campaign, for example, the money for the printing and the bus ads and all of those things; that's a little bit easier to raise because funders like to see the photos of the concrete things that were done. They don't really like the photo of the staff person sitting at their desk scheduling meetings so you can imagine.

To wrap up this CHIP part; to give you an idea of what something on this scale costs, we estimate that annually the four lead agency's that are leading these Action Teams with us and the Health Department have a collective need of $314,000 and that's, again, for that Core Mission support.

We've raised through the Wyandotte Health Foundation providing us with a generous grant and then through a little bit of money from the Health Department, but mostly from many of you in this room, giving us a portion of your Casino Grant Fund. Thank you very much. The $50,000 match that was required in order to get that $90,000 from Wyandotte Health Foundation, so we've secured $140,000 all of which this first portion will go to the lead agencies because we really think they need to be prioritized which leaves us with an annual need still for year two of $174,000 which seems like a lot but divided a couple of ways really isn't so much.

Last week we just hosted four community area foundations for a CHIP breakfast so we're working hard to build those relationships and trying to get more money in the door for this.

I'm going to segway into a quick Accreditation Update. Hopefully, you all saw the communication that came out from us in July saying that we submitted for accreditation which is, quite frankly, fantastic. I'm very proud of us. It's more work than I think we can even describe.



Just to give you a little bit of a reminder, these are the domains and kind of the topic areas that we had to meet documentation requirements for, so it's very broad. It covers, not the acutely clinical work of the Health Department, but every single other thing that we do from policies to governance to quality improvement.

So, collectively through these 12 domains we had to submit 350 pieces of unique documentation and we did so in July. We've also completed what they call a Completeness Review, the second step and now we're really looking down the pipeline toward our March Site Visit. The exact date hasn't been set but we know it will be in March.

Later this month I'm leading my team through a mock site visit to really help staff get familiar with what this is going to be like. Our site visitors of whom there are three from across the country will be reviewing all 350 pieces of those documentations this winter. In February when I return from leave, we will be getting the rest of the folks ready for the site visit.

Just so you have an idea of what that means, the site visit includes a department tour, an interview with our Director, interviews with our staff, a CHA/CHIP and a strategic planning interviews, and

then meeting with community partners which of whom we obviously get to select and then lastly a meeting with our governing entity.

This is really what we're looking for some help on in terms of accreditation. We're required—we can't complete our site visit without having at least two members of the Board of Health or Commission, more ideally three, participate in this with us. We will be making a formal ask through the Commission Liaison here in the coming weeks to try and get some commitment from a few of you in the room. To give you an idea, I'm talking a handful of hours here.

In February, I will prep you with a practice interview which will take an hour or two and the site visit itself is also an hour or two interview. You are not required to know the policies, procedures and programs of the Health Department in and out to participate in this. That's not the kind of interview it is. You need to be able to speak to the relationship between the Board of Health and the Health Department and generally between the Commission and other departments in the Unified Government and then be able to speak a little bit to if you've had any personal project relationship with staff as well as the general direction the Health Department is going. It's really that high level relational kind of interview questions. You will be hearing from us. Please get excited. We would love to see you there.

I'm going to segway into the topic of an Academic Health Department. I'm really excited to announce this. Doug Bach signed this Memorandum of Understanding just a couple weeks ago. I included that Memorandum of Understanding in your handouts in case you're somebody who wants to go home and read all that fine text. I'm going to walk us through the general kind of overall components.

This is an agreement, not a binding contract, there is no money involved, but a Memorandum of Understanding between us as a Health Department and the University of Kansas School of Medicine Department of Population Health.

The purpose of an Academic Health Department is to marry public health practice, which we do every day in the Health Department, with public health academia and research and make sure that the two are connecting. Both to help give support on their end to expose their students

and their staff to public health practice but really to help us make sure that as public health practitioners, we are using the most up-to-date research and information to implement effective interventions in our community.

This relationship will be overseen by an Advisory Committee that has staff from the Health Department and from KU and the seventh member being our Medical Officer. These other six areas are the components that exists in this relationship. The first being faculty and staff exchanges so this can look like Health Department staff guest lecturing for them and then it also looks like their staff coming to the Health Department participating in workflow improvement and strategic planning in public health ethic review cases and things like that. So, getting access to the expertise on their staff generally.

Access to Technical Resource; as of today, the Health Department does not have any paid access to peer reviewed literature which is really unfortunate, and in our defense, it's quite expensive to get access to these things. It's imperative, again, that if we want to implement evidence-based practice, we need to know the evidence-base so we're working with KU to figure out how we can either get it at a very, very low cost or I'm hoping, free access to their best library system most physically, but more importantly, electronically to get access to all that great information.

Thirdly, Technical Assistance and Consultation; they have a team of folks who are working on specific focus areas. For example, infant mortality or tobacco research or these sort of topic areas and as we are implementing programs or evaluating our programs, having the ability

to get technical assistance from folks who have expertise in that topic area will be invaluable. That will be a great asset for us.

Student Activities; we've hosted students for many years at the Health Department which is obviously a bonus for them at KU but it's also a bonus for us in a couple of ways. It's a way we're building our future Public Health Workforce. A lot of our workforce is going to retire in the next five years so trying to think ahead and really think about how do we nurture that and how folks leaving an MPH Program wanting to work in the Health Department which often isn't their first thought. Those students also provide much needed capacity especially for someone like me who can delegate things and really, I can increase my workload substantially by having access to students.

Research Collaboration; we've undertaken over the years several research projects at the Health Department, but there is room for a lot more of that and for us to have an actual research agenda that we're looking at figuring out the most pressing health topics in Wyandotte that we don't have great data for and figuring out how do we participate in being data collectors and analyzers.

Lastly, I think what's most important to me is Workforce Development. So, figuring out how to tap in to the folks at KU to help us build a customized training plan, in-person training for our staff on a number of things. There is a large portion of our workforce at the Health Department who was either never formally trained in public health or was trained in it many years ago. This is to say nothing against any of those folks who do a great job, but more to say that it's part of our responsibility as an employer to provide the training and opportunities that they need to be effective in their job. I see this as working towards that.

Commissioner Johnson said can you just drill down one more level and kind of give us a sense of how you all will do this. I'm just trying to get a sense of how that's going to operate on a daily basis. **Ms. Van Liew** said it will mostly go through the Advisory Committee and we're setting up, probably bi-monthly, we're trying to figure out how frequent of meetings, where we will have an agenda that covers these topics and we will set actionable goals for each of these six topics of what we want to cover for year one I'll say. I'm hoping we can build out a longer term plan than that, but at least for year one, and so this Advisory Committee will really be the folks who go back to staff, figure out what workforce development needs do we have, what research interest do we

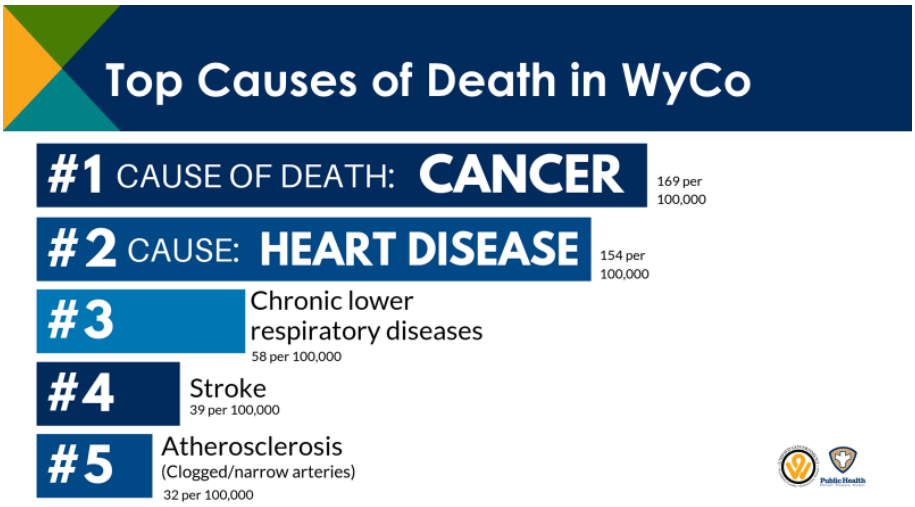
have and bringing that back to the Advisory Committee who will make decisions on what we prioritize and then be responsible for that kind of implementation piece. It is a little fuzzy. I have never done this before either. There is, truthfully, these are becoming more and more prevalent throughout the country, but there is no specific model that's best practice yet, so we're kind of out with those folks who are trying to figure it out. The MOU is based off of what we've found to be a couple of really great examples and some folks we've talked to who it's working well for. We've done as much research as we can, but the implementation will be interesting.

Commissioner Johnson said that makes absolute sense just from a conceptual perspective. I'm glad to see that you all are doing that. **Ms. Van Liew** said I really glad too and I really think it's nod to KU. We've heard in the last few years their interest in becoming more invested in public health in the community and I think some of us feel we haven't seen it. To their credit, I think this is a great way. When I look at this, we're getting a lot more than we're giving truthfully, so I see it as a great investment on their end in Wyandotte and in public health.

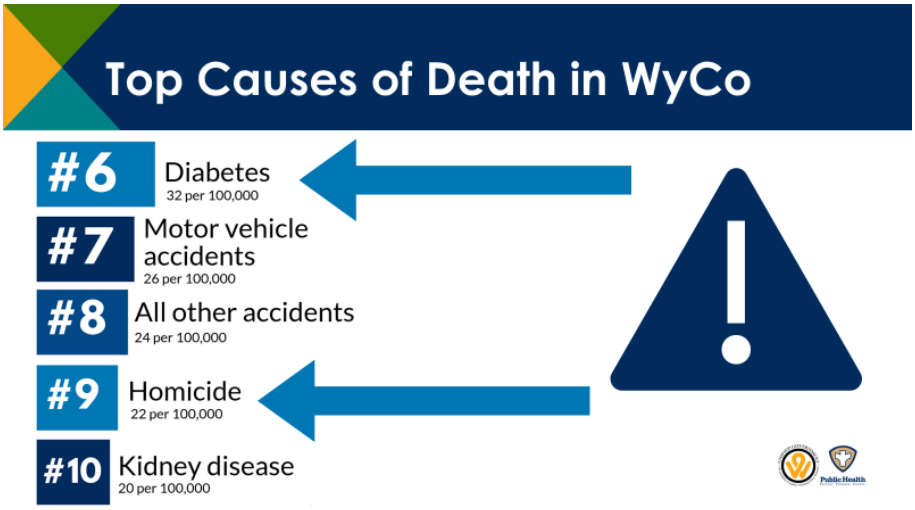
Mr. Van Liew said as Terry mentioned, unfortunately our Epidemiologist who is not here this evening, so you get to continue to listen to me. I did help with a lot of this data and I'm familiar with it, but I'm not the expert that she would have been. Feel free to ask question some of which I may respond with I will get back to you.

There are several handouts in the papers in front of you that have a lot of this included for you to take with you and some additional information as well. I just want to make sure you can follow along with those if you're interested. I want to kind of introduce the idea of a public

health data brief as something that will be a continuous part of our journey together, so I think it's really important as a Board of Health that we're keeping abreast of the most important public health data that we're kind of graveling with at the Health Department on a continual basis. I think it's our job to make sure that we put this data in front of you, so I'm hoping this can become a routine part of these convenings.

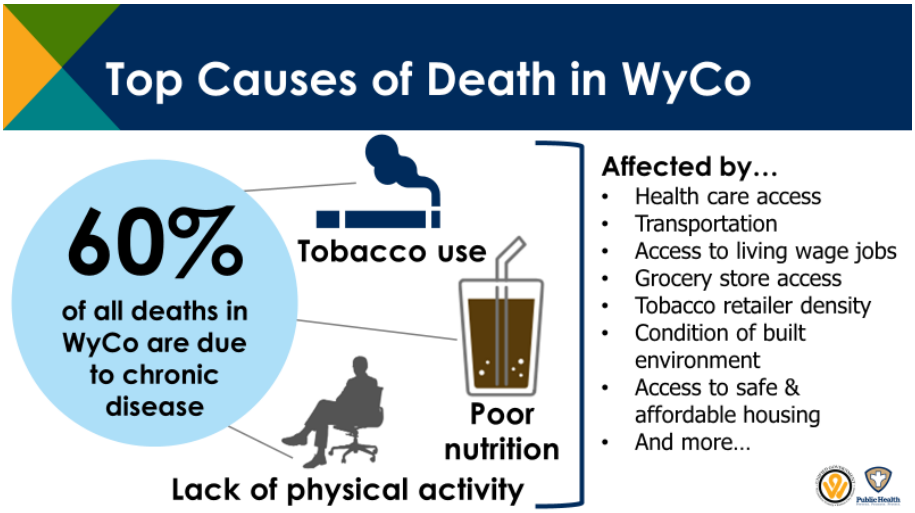


Tonight, what we would like to talk about first and foremost are the top causes of death in Wyandotte. There are some things that are unsurprising in here and some things are surprising in here. Cancer and heart disease are #1 and #2 causes of death in Wyandotte. That's not surprising. This is what you would expect to see, it's what you see in a large majority of counties in the State of Kansas and, frankly, around the country. Our rates aren't fantastic, but this is pretty standard and not an abdominally.

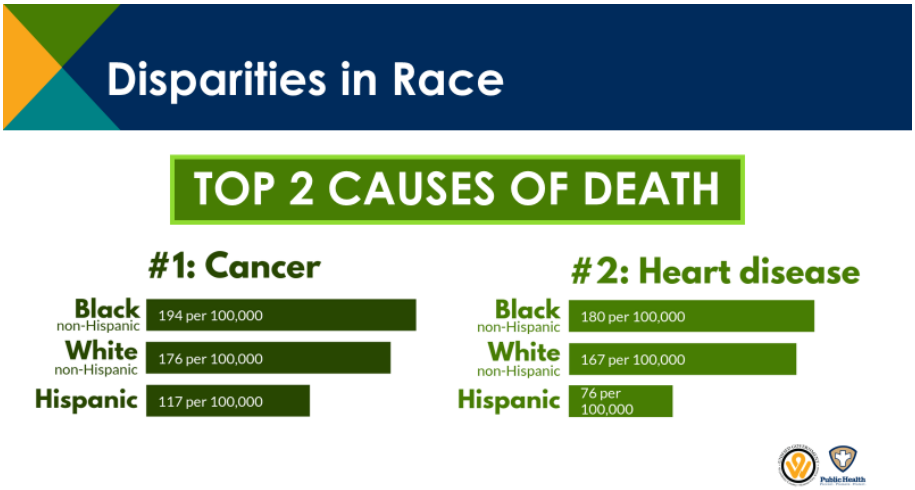


What is concerning, if you look further down the page of the handout in front of you, is #6, diabetes and # 9 homicide. When you look at something like diabetes, we don't actually have tremendously higher rates of diabetes than other counties, but we have a higher rate of death from diabetes in Wyandotte County. What we think this really speaks to is a lack of access to care. You don't die from diabetes if you have access to a medical provider, if you can afford your insulin, and if you manage it right. This is one of those things that should not be on our top causes of death and it's one of the reasons why one of the four pillars of our Community Health Improvement Plan is Access to Care because this is something we should be able to move off of this top causes of death, frankly, in the next five years if we put some concerted effort into it if we expand Medicaid, if we get folks transportation, and those sorts of things. This is one I'm hoping to see move. It's one of those we're keeping our eye on.

Then # 9, Homicide. I know we all know that violence is a concern in our community. It's rare to see homicide in a top 10 causes of death list for a county, quite frankly, throughout the country, but in Kansas especially, very rare. This is something we also want to keep our eye on and, hopefully, watch fall off of this list in the coming years or decades. I'm going to talk a little bit more about violence in just a moment.



But before I do that, just to point out that of those top causes of death, 60% of those are due to chronic disease. This is a national trend. This isn't an abdominally either. Those are largely due to what we think of as modifiable health behaviors, tobacco use, poor nutrition, lack of physical activity and it is true that those are modifiable health behaviors. What's even more true and what we know more and more about today is that those potentially modifiable behaviors are affected by so many more things than we previously realized. So that transportation, that access to a living wage job, having grocery stores near you, how many tobacco retailers are near our kiddos schools; all of these things are actually more important and the things, we as a Health Department and as a community, need to be thinking about if we want to move the number on those chronic disease deaths.

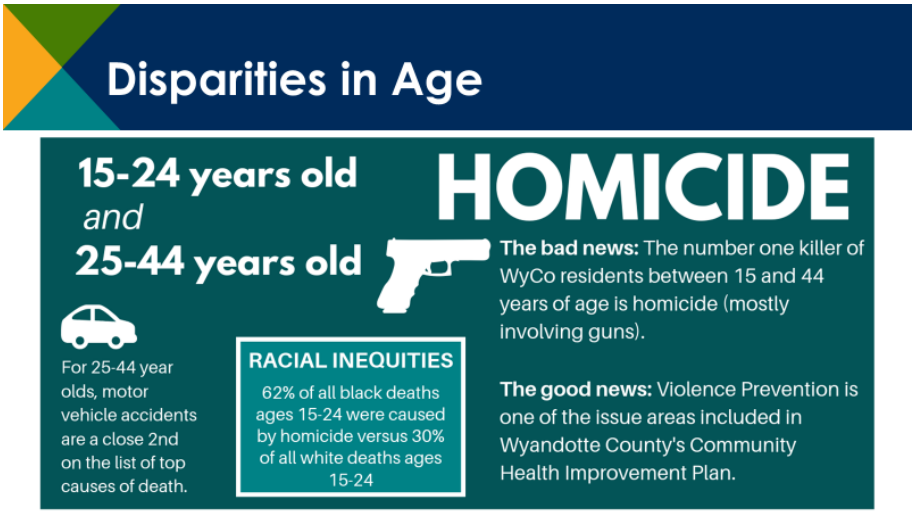


A little more about top causes of death. We want to talk a little bit about disparities because this is really where the good information lies. Things like cancer and heart disease are not distributed evenly. You can see here that our Black non-Hispanic population has higher rates in both cancer and heart disease than Whites who have higher rates than Hispanics which I think is often fascinating to folks. They are surprised to see Hispanic are below White. There are a lot of factors that go into this including culture practices around accessing care, all of those things, but the important thing is that we realize this isn't distributed equally and that there are things that we can do within community's to kind of move these numbers.

Also, I want to talk about disparities in two other areas. One of them being homicide which I mentioned. For the White population in Wyandotte County, homicide did not make the top 10 leading causes of death. If you were Hispanic though, it's the fourth leading cause of death and for Black the fifth leading cause of death. That's a tremendous disparity. Blacks have four times higher rates of homicide as White folks.

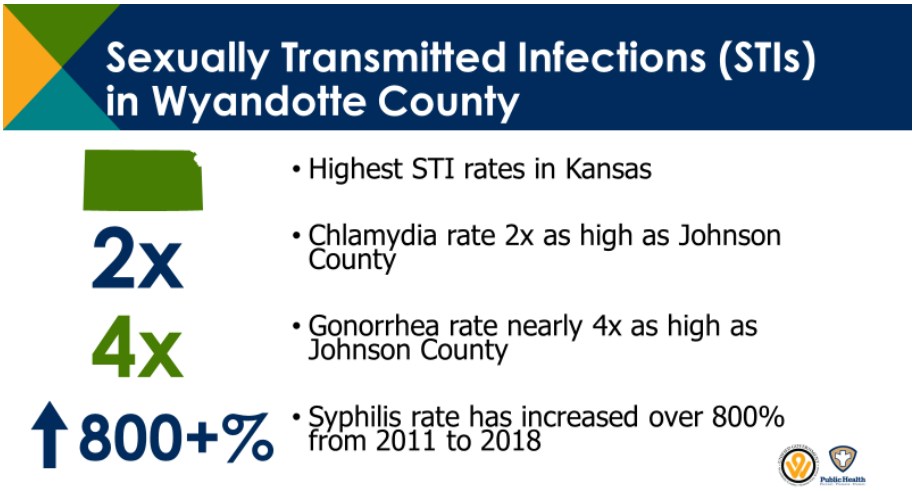
If you look at suicide, it's reversed. For Whites—suicide is not on the list of our countywide top 10, but if you look at Whites alone, it is the #10 leading cause of death and it's creeping up in communities around Kansas and around the country on top 10 lists so we're not alone in that. It didn't make the top 10 leading cause of death for Hispanics or Blacks. So, really looking at these two issues side by side I think is fascinating because we often think as disparities moving in one direction or another. Oftentimes with people of color experiencing the worst health outcomes, but something like suicide shows us this isn't always the case. It really illustrates our

need to dive into the data on a more routine basis to see these nuisances and figure out how to best intervene.

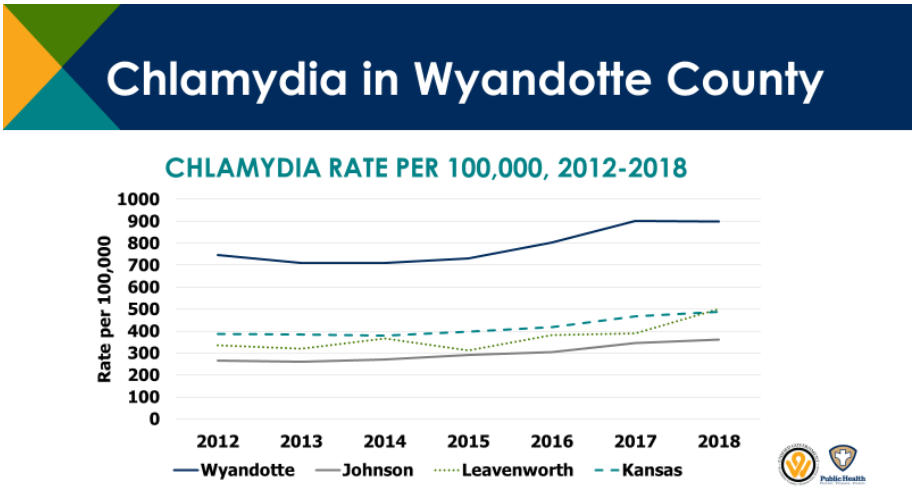


One more nod to this data before we move to our next topic. I want to talk a little bit about homicide. Some of you might know this, I didn't know this until about a month ago and I've been losing sleep over it, if you are between the age of 15-44 in our county, you are more likely to die because someone else killed you than anything else. That, quite frankly, freaks me out. That's a problem. I know you know that's a problem. I'm still surprised about it every time I look at it. It's something that is rare. I haven't seen data like this in other communities, 62% of all Black deaths for folks 15-24 were caused by homicide versus only 30% of all White deaths, 30% is way too high, but 62% is off the charts. This is one of those areas where I'm hoping you will see the Health Department pick up its game a little bit.

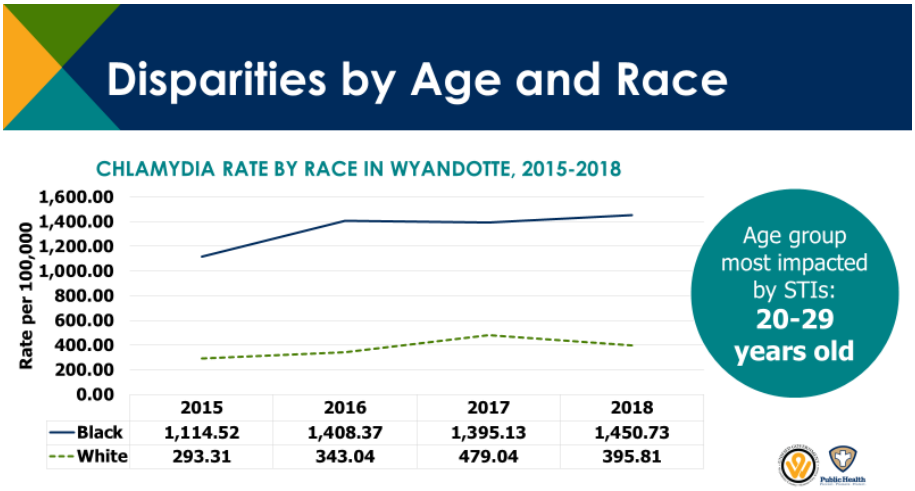
We're interested in some new violence prevention strategies, figuring out how we can play in the sandbox a little bit more. I'm very glad that violence prevention is a piece of our Community Health Improvement Plan, but I think there's a role specifically for an organization like a Health Department and I will speak to that a little bit more when we talk about policy.



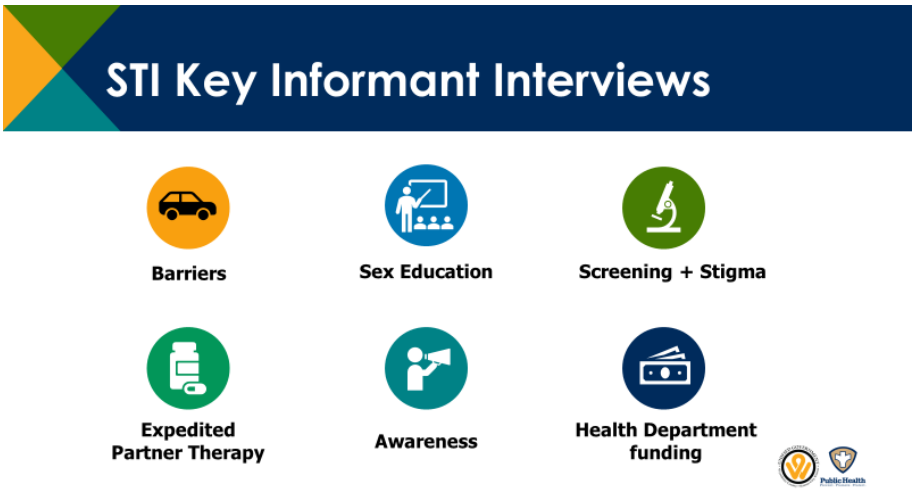
We have one other data specific topic before I move on and that's Sexually Transmitted infections in Wyandotte County. We have an STI crisis. It's bad. We have the highest rates of STIs in the State of Kansas. Double rates of Johnson County in Chlamydia. Our rates are four times as high for Gonorrhea. Our Syphilis rate, which is really a problem, long-term it can lead to infertility and a whole host of health issues, has increased 800% from 2011 to 2018. This is a serious health issue in our community.



You can see here compared to Leavenworth, Johnson Counties in Kansas, we're just consistently staying. It's not a change over the last decade, but we're consistently staying much higher. These are rates, just for those of you that don't look at data all the time, we are able to compare across populations. We use rates and the rate for STIs is almost always at per 100,000 individuals.



Just to harken back to the disparities conversation for one moment, Black folks in our community are experiencing much, much higher rates of STIs than our White population or non-Hispanic White population. STIs, as I'm sure you can imagine, generally impact the age between 20-29 years old most often, not surprising.



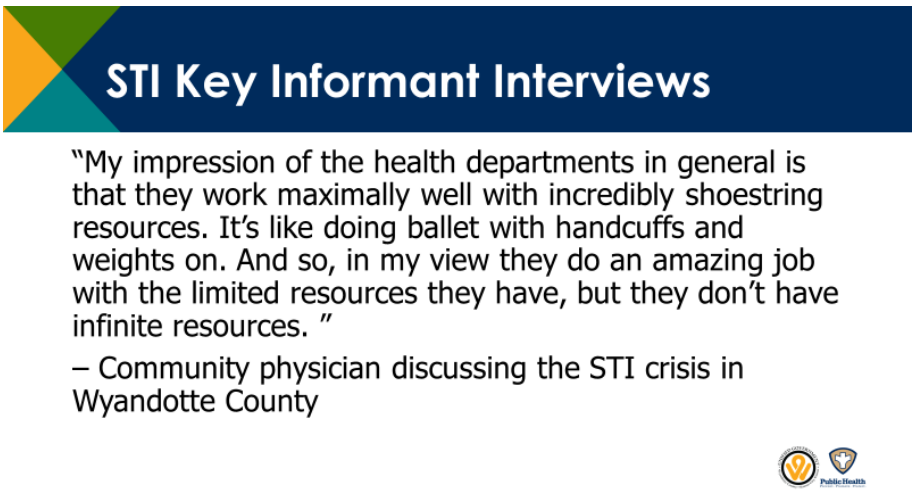
We delved into all of that quantitative data this spring at the Health Department and then we wanted to get some quantitative data as well to back it up. So, we did some Key Informant Interviews with folks who are providing STI related services in our community. A lot of our Safety Net Clinics, folks at KU, etc. to ask them about this problem, what they were seeing, what their thoughts were, and here are some of the things that we heard.

First of all, barriers, unsurprising. We heard a lot about transportation barriers, folks being able to get to services, so they're worried they're just seeing the number of people present

to them for testing that should be and they are correct. We heard a lot about lack of Sex Ed. Both having Sex Ed at all as well as the quality of Sex Ed. We heard about difficult time for folks getting screening and a lot about the stigma, not just of having STI, but the stigma of even going somewhere to get screening. Even going into that waiting room and asking to be screened for something like this, that's not a barrier that's unique to us by any means. That's something we need to keep working on nationally.

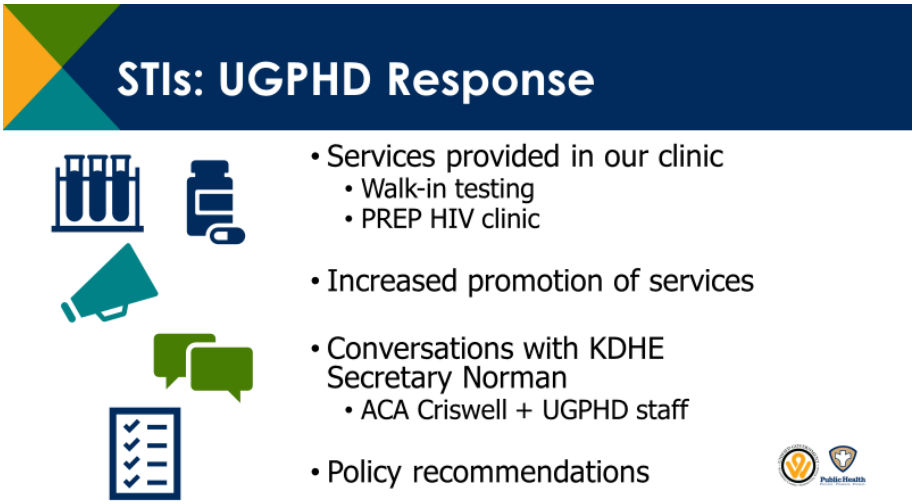
We heard about Expedited Partner Therapy which I'm going to touch on when we talk about policy in a minute. We heard a lot about awareness. (A) just lack of awareness in terms of how do you protect yourself and, (B) lack of awareness around what services exists both within the Health Department and within the community.

Then, a surprising number of respondents mentioned the lack of Health Department funding. I think it was known by some of our partners that we lost some funding in the Health Department a couple of years ago and that is showing especially in these numbers that are not slowing down.



This is what we heard from some partners. I particularly like this quote from a community physician who said "My impression of the Health Departments in general is that they work maximally well with incredibly shoestring resources. It's like doing ballet with handcuffs and weights on." I was like yes, that's how we feel at work every day. But saying that we do a great job with the limited resources we have, but we don't have infinite resources and I think this is

really the case. There are things we can do without the resources and then there are things we can't do.

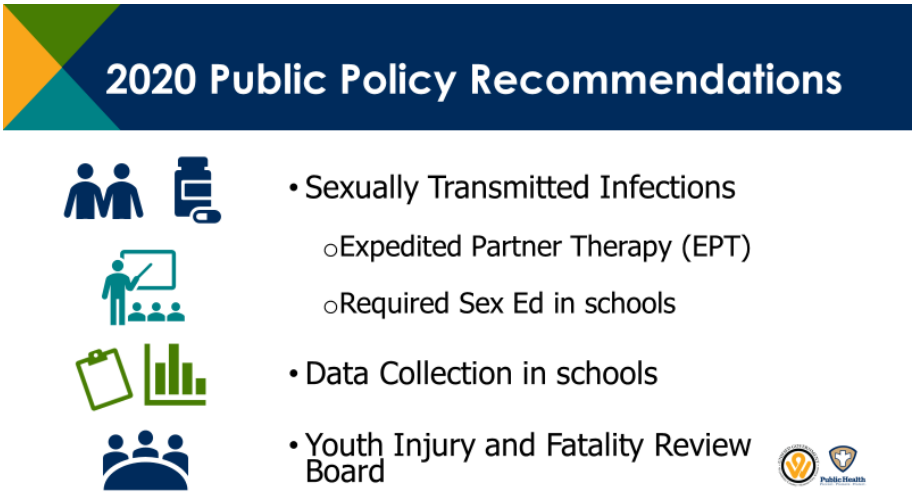


Some of the things that we are doing is continuing to provide robust very strong services in our clinic, so we have provided and we will continue to provide walk-in testing to folks, making sure folks get treated. We have the first Health Department PREP HIV clinic in the State which is doing incredible work. We've increased promotion of our services after hearing about what the key informants had to say in their interviews. We've elevated this conversation up through legislators, up through the Kansas Department of Health & Environment, Gordon Criswell is helping us have those conversations with Health Department staff. Really trying to help get on the radar of those who do hold some of the purse strings in Kansas to try to get some of that funding back.

Lastly, there comes a point around STIs in which you can't make a lot of headway without making some policy changes.

I'm going to give a couple of updates on some policy recommendations. Obviously, Mike Taylor will come before you, I believe in November, like he does every year with his recommendations that he's gathered from different departments around the 2020 Unified Government Policy Agenda. There are a few things you're going to see come before you that I would just like to give you some context and some information about so that you're not seeing it for the very first time and you have an understanding of what it is.

The Health Department Policy Agenda is the last thing in your packet in front of you. We're not going to go through all the items in there. We just want to go through a few that I think it could help for you to have some more information on.



As it relates to sexually transmitted infections, this is obviously a priority for us. Our first policy recommendation is that we put specifically into State Statute Expedited Partner Therapy. If you're

not familiar, Expedited Partner Therapy is a practice of when someone comes into the Health Department and screens positively for an STI, we give them a script for whatever medication they need, but we also give them a second one to take home to their partner. What this does is reduce the barrier of that second partner having to be convinced to come in in the first place, having to be tested, having to get their own script, all of that. It really takes a whole bunch of barriers away from treating that second person.

Again, it's looking at it from an epidemiological perspective of it makes no sense to send someone home, have them get well, have them have sex with someone who still has the disease and see them right back in a month. It's commonsense, it's basic and 45 of the 50 states in the United States, this is written explicitly in the State Statute as being allowed and encouraged and most Health Departments put out guidelines for—I'm sorry, State Health Departments put out guidelines for practitioners on how to do this, the most effective way possible.

Our State Statute does not explicitly disallow this, but what we hear from key informants is that they're not comfortable doing it because it's not specifically allowed and when you're talking medical licenses, that's understandable. We need it explicitly put into Kansas State Statute that this is allowed and encouraged and then we need guidelines on how folks can do it. This is one of the ways we think we can be most impactful on moving the needle on STIs.

The second thing, we're quite aware of how controversial it is and of the uphill battle it would take to get this accomplished, but we don't feel like we would be doing our job at the Health Department if we weren't advocating for required Sex Ed in schools. This is something that's being done around the country. All the research bears out that having Sex Ed in schools (A) does not, like people would want to tell you, increase young people having sex, but it actually decreases both sexually transmitted infection rates and also teen pregnancy rates which we happen to have the highest of in Kansas as well. If we want to work on both of those really important issues, required Sex Ed in schools is something that we really need to seriously consider getting behind.

Some schools in Wyandotte County are doing this. Some of them are doing it well, some of them are doing it through the Health Department. We only have one person who does this. They can't be in all the schools, we don't have the time or the money or the personnel. The idea of behind getting it written in policy at the state level is, obviously, that we would get a line item with it and would provide a little bit of funding and a little bit of help to help schools do this and

help them do it well because there is curriculum that's really good and there's curriculum that's not so good as you can imagine for Sex Ed.

This is something we're putting out there and we hope you consider. We know it's controversial, but truthfully, it's one of the ways, again, like Expeditated Partner Therapy that we could actually move the needle on something like this crisis of STIs.

Two other things we want to draw your attention to before we wrap up, Data Collection in schools. It's really difficult, and I've kind of harped into this a couple of times throughout this presentation, to do good public health, if you don't have good public health data. Two years ago, the legislation made a change to State Statute whereby if you're going to survey kids in school, your parents have to actively opt in.

Previously, they had to actively opt out. What that means is that when we're—not we, usually these are ran out of Kansas Department of Health & Environment, when they're doing a survey to ask about exposure to sex or drugs or to something like vaping, which we do not have good data on right now, or exposure to violence; any of these things when we're trying to survey students to get good data, we're starting to get really poor data. It's not representative samples anymore. The number of students who are responding are going down and the type of parent that returns an opt in sign-in sheet is a specific type of parent, so we're getting a self-selected group of folks who are responding to this. If I'm going to ask you about vaping, I'm going to get really different answers than if I had a representative sample.

There was a bill that went in front of the House in this previous session that we think will get some traction if we get some other municipalities and other Health Departments to get behind it. It's really imperative for us and if we want to take on things like violence related to youth especially or like the upcoming vaping situation, we've got to work on something like this.

Lastly, we would like to advocate for a Youth Injury and Fatality Review Board. Around the country all 50 states have a Youth Fatality Review Board and it is their mandate written into their own state laws that they look at all the cases of youth and they define youth differently in different states, but it's often 0-18 that happens over a course of a year to identify trends and concerns in how youths are dying in their community and too oftentimes to issue a report sometimes with recommendations and sometimes not. That exists at our state level out of our Attorney General's Office. We have a Kansas Youth Fatality Review Board, two-thirds of states; however, also have local municipality review boards. We do not.

The advantage of a local Fatality Review Board is, as you can imagine, you get data specific to your own population. Right now, the State Fatality Review Board issues a report every fall. It's completely unhelpful. I'm sure you can understand that the reasons that youth are dying in Wyandotte are different than the reasons youths are dying in southwest rural Kansas. When you put all that data into one big report, it doesn't mean anything for us anymore. We need our own data, we need our own experts at the table who are working with youth in our county to look at that data to show us the trends and provide recommendations.

We're advocating for adding to the State Statute that mandates a State Fatality Review Board to either mandate or at least specifically allow local Fatality Review Boards and the reason we're looking at a policy response to this is because of the data.

To do a robust review of this kind of situation of youth fatalities, you need access to medical records, public safety records, education records, all these things that tells the full story of why our youth are dying. It's really hard and it should be really hard to get that data, so we at the Health Department have vital stats data, but that only gives us a line item of why the person died, where, when, how old they were; we don't have the context that can come with all this other more robust data. If it were explicitly allowed in State Statute, we could write in a provision that would allow for the convener of this board, which could be a local municipality, it could be somebody else in the community, to have access to that data. Obviously, it's for very specific purposes, etc. We could figure all that out.

The other thing I want you to note in there is that we're advocating for a Youth Injury and Fatality Review Board. We can learn just as much, if not more, from injuries or those near misses as we can from fatalities. What we would really like to see is explicit legislation around both Injury and fatality Review Boards at the local level.

Commissioner Townsend said I thought the cancer was the worst thing, but things kind of went downhill after that. **Ms. Van Liew** said it's not uplifting. **Commissioner Townsend** asked do you happen to know, and I'm not trying to put you on the spot, what the current posture of Sex Education being taught in USD 500. Is it taught in the schools currently? **Ms. Van Liew** said yes, it is in USD 500. **Commissioner Townsend** said that is good to hear. **Ms. Van Liew** said it is just us having limited staff time at the Health Department to be able to get to all the schools. USD 500 has been very welcoming and opening and are supportive of it.

Commissioner Townsend said the other question I had went back to the statistic on cancer. Though it's not shown here, this is back on about page 14, the slide that was entitled Top Causes of Death in WYCO and cancer was #1. Do you have any data that more specifically says under that, that breast cancer is #1, colon cancer is #2, anything—**Ms. Van Liew** said we do and I can get that to you. I don't want to speak to it because I don't want to misspeak. Colon cancer is certainly up there, prostate is up there, breast cancer is up there. I don't think it is the highest but it's certainly up there in the top few, but we can certainly do a breakdown and send out something similar to this if you have an interest in that. Yes, we do have access to that data.

Commissioner Townsend said I think it was this past summer that the Health Department participated at the swimming pool on 10th & Quindaro with a breast cancer screening free and since we have the public audience available, who can use the services of Wyandotte County Health? **Ms. Van Liew** said in terms of breast cancer screenings? **Commissioner Townsend** said in terms of any type of treatment assisting for breast cancer screenings, being checked for the STDs, anything, who can qualify for that? **Ms. Van Liew** said anyone. **Commissioner Townsend** said without regard to economic income or—**Ms. Van Liew** said yes, we serve everyone.

Ms. Garrison said as far as it depends on what services they need. According to the US Preventive Task Force we would do clinical breast exams at certain ages and then screening mammograms at certain ages unless they have a high-risk family history or a genetic predisposition to breast cancer. As far as the mobile mammogram bus, that is ran by Diagnostic Imaging and we work very closely with them. We have a breast health navigator that works with them that where ever the bus is within Wyandotte County, she is. So, when clients come if they can't afford it, don't have insurance, she signs them up for a program through the state called Early Detection Works which will pay for up to the point of diagnosing breast cancer. Once they diagnose, if they are citizens, then they can apply for treatment funds through the State of Kansas. There are State of Kansas Treatment Funds so they will get a medical card that will help pay for any treatments. There is an age as to when mammograms should start. Prior to that if we suspect something, we can do ultrasounds but there is a process to that.

Commissioner Townsend said with some of the other circumstances and maladies that you talked about, is age and income considered if someone needed treatment. Going back to the ages that were noted for STD 20-29 years old, that group seems to be the most impacted. Could

someone who is in that age range come to you for assistance if they do not have medical care? **Ms. Garrison** said yes and the treatment we get the medications for treatment through the 340B Pharmacy Program and then it comes through the state. **Commissioner Townsend** asked what would that mean for the person. Would the treatment be free for them? **Ms. Garrison** said it's free to them. We administer it, but it's free to them.

Mr. Bach said it was noted there were 475 new daycare childcare spaces built this year. **Ms. Van Liew** said not all built but announced. Some of them built. I pushed back on Greg for that too. **Mr. Bach** said if those come in, what is your estimated percentage that we still have unmet? **Ms. Van Liew** said oh my gosh, very high. I can get the numbers for you, but we're talking thousands of spots still. **Mr. Bach** said that's my understanding, that what we have is only around 30% of what the need is. Is that how you're seeing it? **Ms. Van Liew** said yes, I would say at least below 50%. It's what we often talk about, 40-45%, but certainly we're not touching the iceberg yet.

Ms. Van Liew said we have one last piece here, an announcement from our Director, Terry Brecheisen.

Mr. Brecheisen said thank you Juliann for providing that information and substituting for Elizabeth. Thank you, Commissioner Burroughs and Dr. Greiner, for meeting with us with Secretary Lee Norman in attempts to get back our Disease Intervention Specialist position to provide services through our Sexually Transmitted Disease Division. We really want that and it wouldn't have been possible without Commissioner Burroughs interventions on that and help on that and Dr. Greiner's too, so thank you guys very much.

I'm leaving. After 43 years I'm leaving and this is my last Board of Health meeting with you. My last day is December 11th. It's been a wonderful ride here in the Unified Government. I've been the Director for 5 years of the Public Health Department. I enjoyed it. I'm walking confidently out and I will turnaround and waive good-bye. I'm really excited about retiring. I'm excited about leaving here happy and it's just been very enjoyable. I wanted to tell you good-bye. I may not be at a standing committee meeting. We are applying for some grants that I might have to come and see some of you before December 11th but it's just been a wonderful ride for me and I wanted you to know that I was leaving.

MAYOR ALVEY ADJOURNED
THE MEETING AT 6:30 p.m.

_____
Carol Godsil
Deputy Unified Government Clerk

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