

**Lawrence-Douglas County Health Board
November 21, 2011**

Community Health Facility - 1st Floor Conference Room

5:00 p.m.

Agenda:

Approximate time: 1:50

1. Call to order, Shirley Martin-Smith.
2. Executive Session
23 minutes
3. Approval of minutes of October 17, 2011 meeting, Shirley Martin-Smith.
2 minutes
4. Approval of October 2011 monthly financial report, Jennie Henault.
5 minutes
5. Collective Impact – Erika Dvorske, CEO United Way
20 minutes
6. New Business (*action needed*).
30 minutes
 - a. 3rd Quarter Performance Scorecard, Dan Partridge
 - b. Performance Scorecard for 2012 Draft, Dan Partridge
 - c. Upcoming Board Appointments, Shirley Martin-Smith
7. Director's Report, Dan Partridge.
30 minutes
 - a. Community Health Assessment planning (Local PH System Assessment 12/9)
 - b. Determinants of Health video
 - c. Elevator Speech
 - d. Homeless Shelter conversation
 - e. Air Quality Report update
 - f. Complete Streets policy
 - g. Executive Reorganization Order
 - h. Legislative Forum (Planning meeting held Oct. 25th potential HD issue Kansans for Vaccine Rights)
 - i. Kansas Association of Counties and Kansas Association of Local Health Departments
 - j. Advisory Council orientation
8. Adjournment.

Next Regularly Scheduled Meeting Dates

Board Meeting – December 19, 2011

Future Business

Board Evaluation Tool

**Lawrence-Douglas County Health Department
October 2011 Notes for Financial Reports**

Income Statement

Revenues

- *Program fee revenue is \$6,569 higher than budgeted for the month. Compared to the same time period in 2010, immunization revenue is up \$5,000 (of which \$461 is related to collections from accounts over a year old and \$2,144 is related to collections from accounts over six months old), family planning income is up by \$700 (of which all \$700 is related to collections from accounts over a year old), child care licensing revenue is up \$900, pool fee income is up \$1,300, environmental health fees are down \$400, family based sexuality class revenue is down \$650. All other fees are comparable to last years' levels. Collection efforts resulted in \$1,165 from accounts over a year old and \$2,943 from accounts over six months old.*
- *State grant income for October is \$31,413 higher than budgeted. The majority of this is related to receiving the second installment of the Kansas Department of Health and Environment SFY2012 grant payments in October and in past years we have received them in September.*
- *Local/Private grant income is \$7,368 higher than budgeted for the month. This primarily relates to receiving \$5,608 from the Public Health Continuing Education grant through the Kansas Health Foundation for expenses incurred and we normally receive that payment in September.*

Expenses

- *Contractual expenditures are \$5,140 lower than budgeted for the month. Several line items are over budget for the month including health education/promotion for Breast is Best Social (B.I.B.S.) fliers and participant vouchers for the Perfect Fit store at Lawrence Memorial Hospital which will be offset with the United Methodist Health Ministry Fund/Kansas Public Health Association grant. The miscellaneous expense line is over budget for the month related to drive through flu expenses which will be offset with our Public Health Emergency local and regional grant funds.*
- *Commodities are \$14,021 lower than budgeted for the month. This primarily relates to purchasing cuvettes and paying for flu vaccine at different times of the year in 2011 compared to the same time periods as last year.*

Balance Sheet

General/Operating

- *Balance decreased \$37,622 to \$1,433,373 due to income & expenses (see above).*

Board Designated Fund

- *Balance increased \$266 to \$874,956 due to \$205 in interest earnings on the account and \$61 in interest earnings on the certificates of deposit.*

Kay Kent Public Health Service Award Fund

- *Balance increased \$7 to \$16,556 due to interest earnings.*

Funded Depreciation

- *Balance decreased \$1,328 to \$125,521 due to \$1,379 for the purchase of replacement computers and \$51 in interest earnings.*
- *I have included a list of the funded depreciation purchases that make up the Funded Depreciation Furniture & Equipment balance on the balance sheet.*

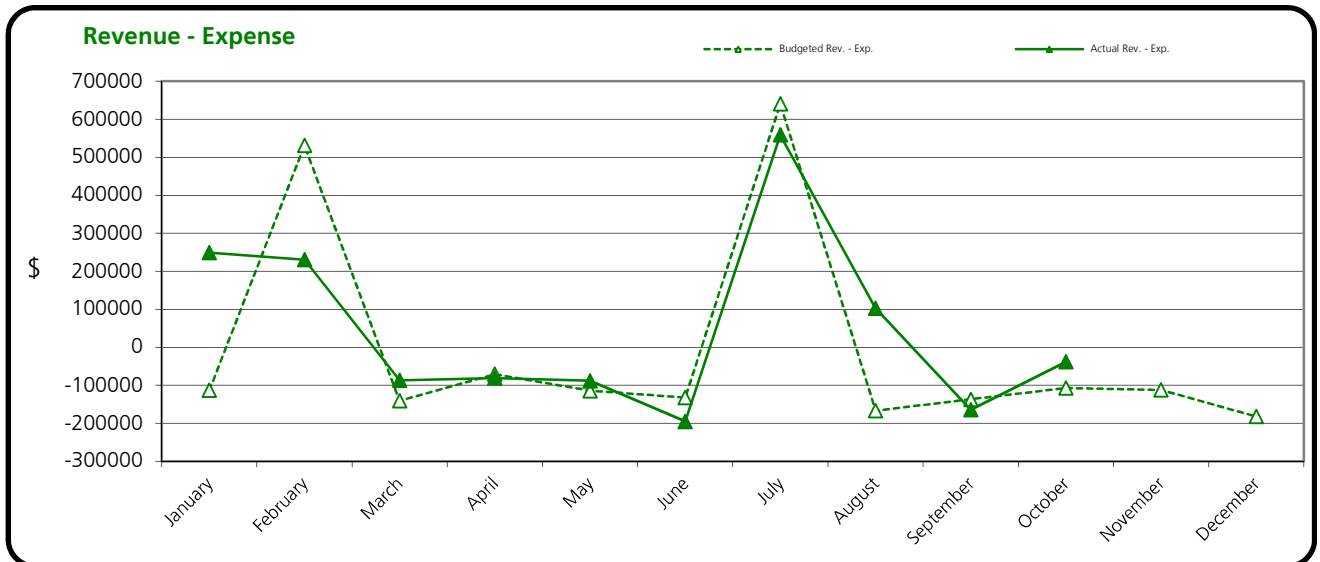
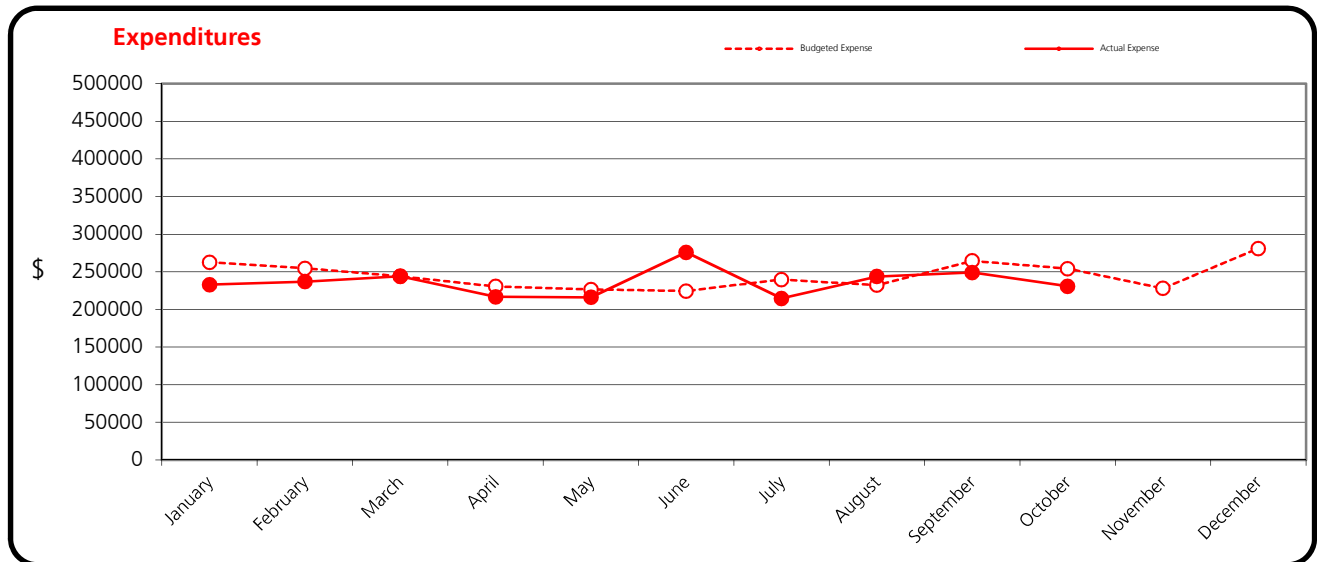
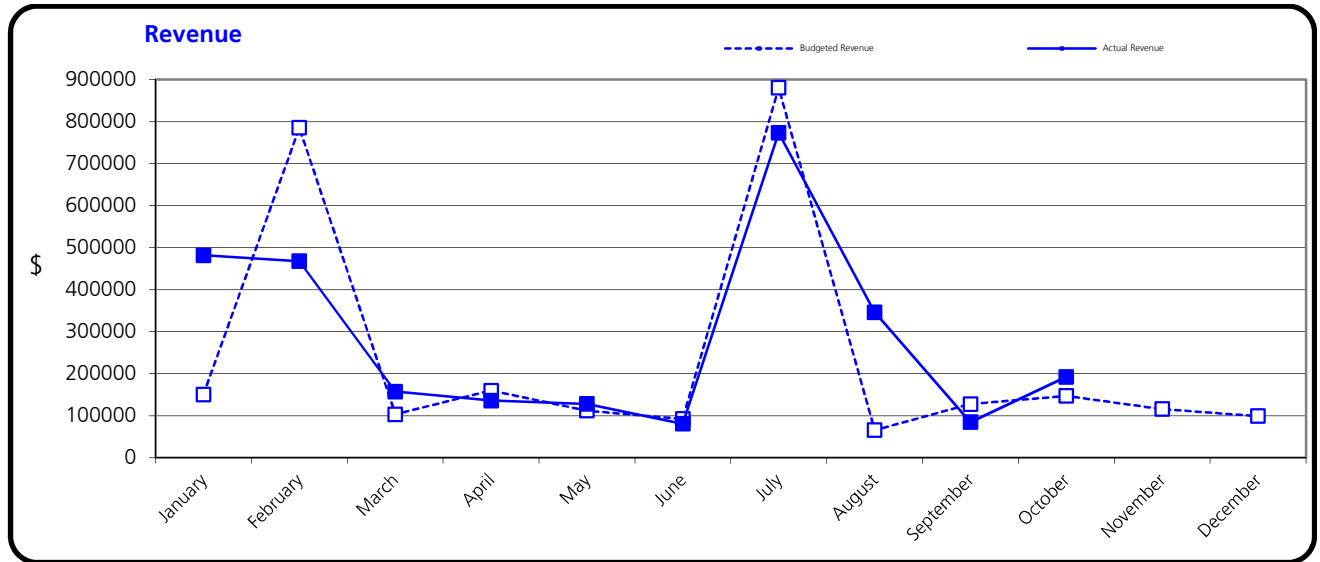
I have included a vendor payment listing for October.

LAWRENCE-DOUGLAS COUNTY HEALTH DEPARTMENT

INCOME AND EXPENSE STATEMENT

FOR THE PERIOD OF 10/01/2011-10/31/2011

	Current Period Actual	Current Period Budget	YTD Actual	YTD Budget	Annual Budget
Revenues					
City Operating	\$0	\$0	\$514,313	\$514,312	\$514,312
City Health Insurance	\$0	\$0	\$134,616	\$134,616	\$134,616
County Operating	\$0	\$0	\$715,000	\$715,000	\$715,000
County Health Insurance	\$16,249	\$16,827	\$162,697	\$168,270	\$201,924
County Mill Levy Aging	\$0	\$0	\$10,000	\$10,000	\$10,000
Contract Services	\$1,277	\$1,167	\$48,796	\$11,669	\$14,003
Program Fees	\$37,328	\$30,759	\$297,651	\$276,686	\$345,555
Federal Grant	\$0	\$0	\$5,000	\$5,000	\$5,000
State Grant	\$125,310	\$93,897	\$877,048	\$733,247	\$833,430
Local/Private Grant	\$11,682	\$4,314	\$64,435	\$53,841	\$63,470
Interest	\$596	\$17	\$9,322	\$168	\$200
Other Revenue	(\$1)	\$0	\$10,205	\$0	\$0
Net Revenues	\$192,441	\$146,981	\$2,849,083	\$2,622,809	\$2,837,510
Expenses					
Gross Salaries & Wages	\$144,761	\$149,252	\$1,432,889	\$1,487,383	\$1,786,311
Payroll Related Expenses	\$50,821	\$50,707	\$513,406	\$511,607	\$627,500
Total Payroll Expenses	\$195,582	\$199,959	\$1,946,295	\$1,998,990	\$2,413,811
Contractual Service Expenses					
Total Contractual Service Expenditures	\$18,258	\$23,398	\$183,693	\$182,544	\$224,351
Commodities					
Total Commodities Expenditures	\$16,869	\$30,890	\$209,720	\$219,680	\$241,262
Total Expenses	\$230,709	\$254,247	\$2,339,708	\$2,401,214	\$2,879,424
Other Expense					
Capital Equipment	\$0	\$0	\$21,185	\$31,500	\$31,500
Transfer to Funded Depreciation	\$0	\$0	\$0	\$0	\$31,741
Transfer to Bd Designated Fund	\$0	\$0	\$0	\$0	\$0
Total Other Expense	\$0	\$0	\$21,185	\$31,500	\$63,241
Net Income (Loss)	(\$38,268)	(\$107,266)	\$488,190	\$190,095	(\$105,155)



**LAWRENCE-DOUGLAS COUNTY HEALTH DEPARTMENT
BALANCE SHEET
AS OF 10/31/2011**

Assets

Current Assets

Cash	1,432,663
Petty cash / change fund	710
Board Designated Fund Balance	515,507
Board Designated Fund Certificates of Deposit	359,449
K Kent Public Health Serv Award	16,556
Funded Depreciation	125,521
Total Current Assets	<u>2,450,406</u>

Property, Plant & Equipment

Fixed Assets	433,126
Less - Accumulated Depreciation	(350,264)
Total Property, Plant & Equipment	<u>82,862</u>

Total Assets 2,533,268

Liabilities and Net Assets

Net Assets

Operating Fund Balance	1,000,156
Reserves/Restricted Fund Balances	1,017,033
Contributed Capital	27,889
Net Income	488,190
Total Assets	<u><u>2,533,268</u></u>

**2011 Funded
Depreciation Purchases**

**For the period ending
October 31, 2011**

Month	Purchased	Price
Year End 2010	balance of purchases made	86,903
Feb	phone system	31,435
Apr	phone system analog interface	439
Jul	SQL & Windows 2008 server licenses	5,127
Aug	3 replacement computers	2,768
Sep	2 replacement computers	1,525
Oct	2 replacement computers	1,379
	Balance of Purchases	129,576

Stanford SOCIAL INNOVATION REVIEW

Collective Impact By John Kania & Mark Kramer

Stanford Social Innovation Review
Winter 2011

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Collective Impact

LARGE-SCALE SOCIAL CHANGE REQUIRES BROAD CROSS-SECTOR COORDINATION, YET THE SOCIAL SECTOR REMAINS FOCUSED ON THE ISOLATED INTERVENTION OF INDIVIDUAL ORGANIZATIONS.

BY JOHN KANIA & MARK KRAMER

Illustration by Martin Jarrie

The scale and complexity of the U.S. public education system has thwarted attempted reforms for decades. Major funders, such as the Annenberg Foundation, Ford Foundation, and Pew Charitable Trusts have abandoned many of their efforts in frustration after acknowledging their lack of progress. Once the global leader—after World War II the United States had the highest high school graduation rate in the world—the country now ranks 18th among the top 24 industrialized nations, with more than 1 million secondary school students dropping out every year. The heroic efforts of countless teachers, administrators, and nonprofits, together with billions of dollars in charitable contributions, may have led to important improvements in individual schools and classrooms, yet system-wide progress has seemed virtually unobtainable.

Against these daunting odds, a remarkable exception seems to be emerging in Cincinnati. Strive, a nonprofit subsidiary of KnowledgeWorks, has brought together local leaders to tackle the student achievement crisis and improve education throughout greater Cincinnati and northern Kentucky. In the four years since the group was launched, Strive partners have improved student success in dozens of key areas across three large public school districts. Despite the recession and budget cuts, 34 of the 53 success indicators that Strive tracks have shown positive trends, including high school graduation rates, fourth-grade reading and math scores, and the number of preschool children prepared for kindergarten.

Why has Strive made progress when so many other efforts have failed? It is because a core group of community leaders decided to abandon their individual agendas in favor of a collective approach to improving student achievement. More than

300 leaders of local organizations agreed to participate, including the heads of influential private and corporate foundations, city government officials, school district representatives, the presidents of eight universities and community colleges, and the executive directors of hundreds of education-related nonprofit and advocacy groups.

These leaders realized that fixing one point on the educational continuum—such as better after-school programs—wouldn't make much difference unless all parts of the continuum improved at the same time. No

single organization, however innovative or powerful, could accomplish this alone. Instead, their ambitious mission became to coordinate improvements at every stage of a young person's life, from "cradle to career."

Strive didn't try to create a new educational program or attempt to convince donors to spend more money. Instead,

through a carefully structured process, Strive focused the entire educational community on a single set of goals, measured in the same way. Participating organizations are grouped into 15 different Student Success Networks (SSNs) by type of activity, such as early childhood education or tutoring. Each SSN has been meeting with coaches and facilitators for two hours every two weeks for the past three years, developing shared performance indicators, discussing their progress, and most important, learning from each other and aligning their efforts to support each other.

Strive, both the organization and the process it helps facilitate, is an example of *collective impact*, the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem. Collaboration is nothing new. The social sector is filled with examples of partnerships, networks, and other types of joint efforts. But collective impact initiatives are distinctly different. Unlike most

collaborations, collective impact initiatives involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants. (See “Types of Collaborations” on page 39.)

Although rare, other successful examples of collective impact are addressing social issues that, like education, require many different players to change their behavior in order to solve a complex problem. In 1993, Marjorie Mayfield Jackson helped found the Elizabeth River Project with a mission of cleaning up the Elizabeth River in southeastern Virginia, which for decades had been a dumping ground for industrial waste. They engaged more than 100 stakeholders, including the city governments of Chesapeake, Norfolk, Portsmouth, and Virginia Beach, Va., the Virginia Department of Environmental Quality, the U.S. Environmental Protection Agency (EPA), the U.S. Navy, and dozens of local businesses, schools, community groups, environmental organizations, and universities, in developing an 18-point plan to restore the watershed. Fifteen years later, more than 1,000 acres of watershed land have been conserved or restored, pollution has been reduced by more than 215 million pounds, concentrations of the most severe carcinogen have been cut sixfold, and water quality has significantly improved. Much remains to be done before the river is fully restored, but already 27 species of fish and oysters are thriving in the restored wetlands, and bald eagles have returned to nest on the shores.

Or consider Shape up Somerville, a citywide effort to reduce and prevent childhood obesity in elementary school children in Somerville, Mass. Led by Christina Economos, an associate professor at Tufts University’s Gerald J. and Dorothy R. Friedman School of Nutrition Science and Policy, and funded by the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, Blue Cross Blue Shield of Massachusetts, and United Way of Massachusetts Bay and Merrimack Valley, the program engaged government officials, educators, businesses, nonprofits, and citizens in collectively defining wellness and weight gain prevention practices. Schools agreed to offer healthier foods, teach nutrition, and promote physical activity. Local restaurants received a certification if they served low-fat, high nutritional food. The city organized a farmers’ market and provided healthy lifestyle incentives such as reduced-price gym memberships for city employees. Even sidewalks were modified and crosswalks repainted to encourage more children to walk to school. The result was a statistically significant decrease in body mass index among the community’s young children between 2002 and 2005.

Even companies are beginning to explore collective impact to tackle social problems. Mars, a manufacturer of chocolate brands such as M&M’s, Snickers, and Dove, is working with NGOs, local governments, and even direct competitors to improve the lives of more than 500,000 impoverished cocoa farmers in Cote d’Ivoire, where Mars sources a large portion of its cocoa. Research suggests

that better farming practices and improved plant stocks could triple the yield per hectare, dramatically increasing farmer incomes and improving the sustainability of Mars’s supply chain. To accomplish this, Mars must enlist the coordinated efforts of multiple organizations: the Cote d’Ivoire government needs to provide more agricultural extension workers, the World Bank needs to finance new roads, and bilateral donors need to support NGOs in improving health care, nutrition, and education in cocoa growing communities. And Mars must find ways to work with its direct competitors on pre-competitive issues to reach farmers outside its supply chain.

These varied examples all have a common theme: that large-scale social change comes from better cross-sector coordination rather than from the isolated intervention of individual organizations. Evidence of the effectiveness of this approach is still limited, but these examples suggest that substantially greater progress could be made in alleviating many of our most serious and complex social problems if nonprofits, governments, businesses, and the public were brought together around a common agenda to create collective impact. It doesn’t happen often, not because it is impossible, but because it is so rarely attempted. Funders and nonprofits alike overlook the potential for collective impact because they are used to focusing on independent action as the primary vehicle for social change.

ISOLATED IMPACT

Most funders, faced with the task of choosing a few grantees from many applicants, try to ascertain which organizations make the greatest contribution toward solving a social problem. Grantees, in turn, compete to be chosen by emphasizing how their individual activities produce the greatest effect. Each organization is judged on its own potential to achieve impact, independent of the numerous other organizations that may also influence the issue. And when a grantee is asked to evaluate the impact of its work, every attempt is made to isolate that grantee’s individual influence from all other variables.

In short, the nonprofit sector most frequently operates using an approach that we call *isolated impact*. It is an approach oriented toward finding and funding a solution embodied within a single organization, combined with the hope that the most effective organizations will grow or replicate to extend their impact more widely. Funders search for more effective interventions as if there were a cure for failing schools that only needs to be discovered, in the way that medical cures are discovered in laboratories. As a result of this process, nearly 1.4 million nonprofits try to invent independent solutions to major social problems, often working at odds with each other and exponentially increasing the perceived resources required to make meaningful progress. Recent trends have only reinforced this perspective. The growing interest in venture philanthropy and social entrepreneurship, for example, has greatly benefited the social sector by identifying and accelerating the growth of many high-performing nonprofits, yet it has also accentuated an emphasis on scaling up a few select organizations as the key to social progress.

Despite the dominance of this approach, there is scant evidence that isolated initiatives are the best way to solve many social problems in today’s complex and interdependent world. No single organization is responsible for any major social problem, nor can any single

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TYPES OF COLLABORATIONS

Organizations have attempted to solve social problems by collaboration for decades without producing many results. The vast majority of these efforts lack the elements of success that enable collective impact initiatives to achieve a sustained alignment of efforts.

Funder Collaboratives are groups of funders interested in supporting the same issue who pool their resources. Generally, participants do not adopt an overarching evidence-based plan of action or a shared measurement system, nor do they engage in differentiated activities beyond check writing or engage stakeholders from other sectors.

Public-Private Partnerships are partnerships formed between government and private sector organizations to deliver specific services or benefits. They are often targeted narrowly, such as developing a particular drug to fight a single disease, and usually don't engage the full set of stakeholders that affect the issue, such as the potential drug's distribution system.

Multi-Stakeholder Initiatives are voluntary activities by stakeholders from different sectors around a common theme. Typically, these initiatives lack any shared measurement of impact and the supporting infrastructure to forge any true alignment of efforts or accountability for results.

Social Sector Networks are groups of individuals or organizations fluidly connected through purposeful relationships, whether formal or informal. Collaboration is generally ad hoc, and most often the emphasis is placed on information sharing and targeted short-term actions, rather than a sustained and structured initiative.

Collective Impact Initiatives are long-term commitments by a group of important actors from different sectors to a common agenda for solving a specific social problem. Their actions are supported by a shared measurement system, mutually reinforcing activities, and ongoing communication, and are staffed by an independent backbone organization.

organization cure it. In the field of education, even the most highly respected nonprofits—such as the Harlem Children's Zone, Teach for America, and the Knowledge Is Power Program (KIPP)—have taken decades to reach tens of thousands of children, a remarkable achievement that deserves praise, but one that is three orders of magnitude short of the tens of millions of U.S. children that need help.

The problem with relying on the isolated impact of individual organizations is further compounded by the isolation of the nonprofit sector. Social problems arise from the interplay of governmental and commercial activities, not only from the behavior of social sector organizations. As a result, complex problems can be solved only by cross-sector coalitions that engage those outside the nonprofit sector.

We don't want to imply that all social problems require collective impact. In fact, some problems are best solved by individual organizations. In "Leading Boldly," an article we wrote with Ron Heifetz for the winter 2004 issue of the *Stanford Social Innovation Review*, we described the difference between *technical problems* and *adaptive problems*. Some social problems are technical in that the problem is well defined, the answer is known in advance, and one or a few organizations have the ability to implement the solution. Examples include funding college scholarships, building a hospital, or installing inventory controls in a food bank. Adaptive problems, by contrast, are complex, the answer is not known, and even if it were, no single entity has the resources or authority to bring about the necessary change. Reforming public education, restoring wetland environments, and improving community health are all adaptive problems. In these cases, reaching an effective solution requires learning by the stakeholders involved in the problem, who must then change their own behavior in order to create a solution.

vision for change, one that includes a common understanding of the problem and a joint approach to solving it through agreed upon actions. Take a close look at any group of funders and nonprofits that believe they are working on the same social issue, and you quickly find that it is often not the same issue at all. Each organization often has a slightly different definition of the problem and the ultimate goal. These differences are easily ignored when organizations work independently on isolated initiatives, yet these differences splinter the efforts and undermine the impact of the field as a whole. Collective impact requires that these differences be discussed and resolved. Every participant need not agree with every other participant on all dimensions of the problem. In fact, disagreements continue to divide participants in all of our examples of collective impact. All participants must agree, however, on the primary goals for the collective impact initiative as a whole. The Elizabeth River Project, for example, had to find common ground among the different objectives of corporations, governments, community groups, and local citizens in order to establish workable cross-sector initiatives.

Funders can play an important role in getting organizations to act in concert. In the case of Strive, rather than fueling hundreds of strategies and nonprofits, many funders have aligned to support Strive's central goals. The Greater Cincinnati Foundation realigned its education goals to be more compatible with Strive, adopting Strive's annual report card as the foundation's own measures for progress in education. Every time an organization applied to Duke Energy for a grant, Duke asked, "Are you part of the [Strive] network?" And when a new funder, the Carol Ann and Ralph V. Haile Jr./U.S. Bank Foundation, expressed interest in education, they were encouraged by virtually every major education leader in Cincinnati to join Strive if they wanted to have an impact in local education.¹

Shifting from isolated impact to collective impact is not merely a matter of encouraging more collaboration or public-private partnerships. It requires a systemic approach to social impact that focuses on the relationships between organizations and the progress toward shared objectives. And it requires the creation of a new set of nonprofit management organizations that have the skills and resources to assemble and coordinate the specific elements necessary for collective action to succeed.

THE FIVE CONDITIONS OF COLLECTIVE SUCCESS

Our research shows that successful collective impact initiatives typically have five conditions that together produce true alignment and lead to powerful results: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone support organizations.

Common Agenda | Collective impact requires all participants to have a shared

Shared Measurement Systems | Developing a shared measurement system is essential to collective impact. Agreement on a common agenda is illusory without agreement on the ways success will be measured and reported. Collecting data and measuring results consistently on a short list of indicators at the community level and across all participating organizations not only ensures that all efforts remain aligned, it also enables the participants to hold each other accountable and learn from each other's successes and failures.

It may seem impossible to evaluate hundreds of different organizations on the same set of measures. Yet recent advances in Web-based technologies have enabled common systems for reporting performance and measuring outcomes. These systems increase efficiency and reduce cost. They can also improve the quality and credibility of the data collected, increase effectiveness by enabling grantees to learn from each other's performance, and document the progress of the field as a whole.²

All of the preschool programs in Strive, for example, have agreed to measure their results on the same criteria and use only evidence-based decision making. Each type of activity requires a different set of measures, but all organizations engaged in the same type of activity report on the same measures. Looking at results across multiple organizations enables the participants to spot patterns, find solutions, and implement them rapidly. The preschool programs discovered that children regress during the summer break before kindergarten. By launching an innovative "summer bridge" session, a technique more often used in middle school, and implementing it simultaneously in all preschool programs, they increased the average kindergarten readiness scores throughout the region by an average of 10 percent in a single year.³

Mutually Reinforcing Activities | Collective impact initiatives depend on a diverse group of stakeholders working together, not by requiring that all participants do the same thing, but by encouraging each participant to undertake the specific set of activities at which it excels in a way that supports and is coordinated with the actions of others.

The power of collective action comes not from the sheer number of participants or the uniformity of their efforts, but from the coordination of their differentiated activities through a mutually reinforcing plan of action. Each stakeholder's efforts must fit into an overarching plan if their combined efforts are to succeed. The multiple causes of social problems, and the components of their solutions, are interdependent. They cannot be addressed by uncoordinated actions among isolated organizations.

All participants in the Elizabeth River Project, for example, agreed on the 18-point watershed restoration plan, but each is playing a different role based on its particular capabilities. One group of organizations works on creating grassroots support and engagement among citizens, a second provides peer review and recruitment for industrial participants who voluntarily reduce pollution, and a third coordinates and reviews scientific research.

The 15 SSNs in Strive each undertake different types of activities at different stages of the educational continuum. Strive does not prescribe what practices each of the 300 participating organizations should pursue. Each organization and network is free to chart its own course consistent with the common agenda, and informed by the shared measurement of results.

Continuous Communication | Developing trust among nonprofits, corporations, and government agencies is a monumental challenge. Participants need several years of regular meetings to build up enough experience with each other to recognize and appreciate the common motivation behind their different efforts. They need time to see that their own interests will be treated fairly, and that decisions will be made on the basis of objective evidence and the best possible solution to the problem, not to favor the priorities of one organization over another.

Even the process of creating a common vocabulary takes time, and it is an essential prerequisite to developing shared measurement systems. All the collective impact initiatives we have studied held monthly or even biweekly in-person meetings among the organizations' CEO-level leaders. Skipping meetings or sending lower-level delegates was not acceptable. Most of the meetings were supported by external facilitators and followed a structured agenda.

The Strive networks, for example, have been meeting regularly for more than three years. Communication happens between meetings too: Strive uses Web-based tools, such as Google Groups, to keep communication flowing among and within the networks. At first, many of the leaders showed up because they hoped that their participation would bring their organizations additional funding, but they soon learned that was not the meetings' purpose. What they discovered instead were the rewards of learning and solving problems together with others who shared their same deep knowledge and passion about the issue.

Backbone Support Organizations | Creating and managing collective impact requires a separate organization and staff with a very specific set of skills to serve as the backbone for the entire initiative. Coordination takes time, and none of the participating organizations has any to spare. The expectation that collaboration can occur without a supporting infrastructure is one of the most frequent reasons why it fails.

The backbone organization requires a dedicated staff separate from the participating organizations who can plan, manage, and support the initiative through ongoing facilitation, technology and communications support, data collection and reporting, and handling the myriad logistical and administrative details needed for the initiative to function smoothly. Strive has simplified the initial staffing requirements for a backbone organization to three roles: project manager, data manager, and facilitator.

Collective impact also requires a highly structured process that leads to effective decision making. In the case of Strive, staff worked with General Electric (GE) to adapt for the social sector the Six Sigma process that GE uses for its own continuous quality improvement. The Strive Six Sigma process includes training, tools, and resources that each SSN uses to define its common agenda, shared measures, and plan of action, supported by Strive facilitators to guide the process.

In the best of circumstances, these backbone organizations embody the principles of adaptive leadership: the ability to focus people's attention and create a sense of urgency, the skill to apply pressure to stakeholders without overwhelming them, the competence to frame issues in a way that presents opportunities as well as difficulties, and the strength to mediate conflict among stakeholders.

FUNDING COLLECTIVE IMPACT

Creating a successful collective impact initiative requires a significant financial investment: the time participating organizations must dedicate to the work, the development and monitoring of shared measurement systems, and the staff of the backbone organization needed to lead and support the initiative's ongoing work.

As successful as Strive has been, it has struggled to raise money, confronting funders' reluctance to pay for infrastructure and preference for short-term solutions. Collective impact requires instead that funders support a long-term process of social change without identifying any particular solution in advance. They must be willing to let grantees steer the work and have the patience to stay with an initiative for years, recognizing that social change can come from the gradual improvement of an entire system over time, not just from a single breakthrough by an individual organization.

This requires a fundamental change in how funders see their role, from funding organizations to leading a long-term process of social change. It is no longer enough to fund an innovative solution created by a single nonprofit or to build that organization's capacity. Instead, funders must help create and sustain the collective processes, measurement reporting systems, and community leadership that enable cross-sector coalitions to arise and thrive.

This is a shift that we foreshadowed in both "Leading Boldly" and our more recent article, "Catalytic Philanthropy," in the fall 2009 issue of the *Stanford Social Innovation Review*. In the former, we suggested that the most powerful role for funders to play in addressing adaptive problems is to focus attention on the issue and help to create a process that mobilizes the organizations involved to find a solution themselves. In "Catalytic Philanthropy," we wrote: "Mobilizing and coordinating stakeholders is far messier and slower work than funding a compelling grant request from a single organization. Systemic change, however, ultimately depends on a sustained campaign to increase the capacity and coordination of an entire field." We recommended that funders who want to create large-scale change follow four practices: take responsibility for assembling the elements of a solution; create a movement for change; include solutions from outside the nonprofit sector; and use actionable knowledge to influence behavior and improve performance.

These same four principles are embodied in collective impact initiatives. The organizers of Strive abandoned the conventional approach of funding specific programs at education nonprofits and took responsibility for advancing education reform themselves. They built a movement, engaging hundreds of organizations in a drive toward shared goals. They used tools outside the nonprofit sector, adapting GE's Six Sigma planning process for the social sector. And through the community report card and the biweekly meetings of the SSNs they created actionable knowledge that motivated the community and improved performance among the participants.

Funding collective impact initiatives costs money, but it can be a highly leveraged investment. A backbone organization with a modest annual budget can support a collective impact initiative of several hundred organizations, magnifying the impact of millions or even billions of dollars in existing funding. Strive, for example, has a \$1.5 million annual budget but is coordinating the efforts and

increasing the effectiveness of organizations with combined budgets of \$7 billion. The social sector, however, has not yet changed its funding practices to enable the shift to collective impact. Until funders are willing to embrace this new approach and invest sufficient resources in the necessary facilitation, coordination, and measurement that enable organizations to work in concert, the requisite infrastructure will not evolve.

FUTURE SHOCK

What might social change look like if funders, nonprofits, government officials, civic leaders, and business executives embraced collective impact? Recent events at Strive provide an exciting indication of what might be possible.

Strive has begun to codify what it has learned so that other communities can achieve collective impact more rapidly. The organization is working with nine other communities to establish similar cradle to career initiatives.⁴ Importantly, although Strive is broadening its impact to a national level, the organization is not scaling up its own operations by opening branches in other cities. Instead, Strive is promulgating a flexible process for change, offering each community a set of tools for collective impact, drawn from Strive's experience but adaptable to the community's own needs and resources. As a result, the new communities take true ownership of their own collective impact initiatives, but they don't need to start the process from scratch. Activities such as developing a collective educational reform mission and vision or creating specific community-level educational indicators are expedited through the use of Strive materials and assistance from Strive staff. Processes that took Strive several years to develop are being adapted and modified by other communities in significantly less time.

These nine communities plus Cincinnati have formed a community of practice in which representatives from each effort connect regularly to share what they are learning. Because of the number and diversity of the communities, Strive and its partners can quickly determine what processes are universal and which require adaptation to a local context. As learning accumulates, Strive staff will incorporate new findings into an Internet-based knowledge portal that will be available to any community wishing to create a collective impact initiative based on Strive's model.

This exciting evolution of the Strive collective impact initiative is far removed from the isolated impact approach that now dominates the social sector and that inhibits any major effort at comprehensive, large-scale change. If successful, it presages the spread of a new approach that will enable us to solve today's most serious social problems with the resources we already have at our disposal. It would be a shock to the system. But it's a form of shock therapy that's badly needed. ■

Notes

- 1 Interview with Kathy Merchant, CEO of the Greater Cincinnati Foundation, April 10, 2010.
- 2 See Mark Kramer, Marcie Parkhurst, and Lalitha Vaidyanathan, *Breakthroughs in Shared Measurement and Social Impact*, FSG Social Impact Advisors, 2009.
- 3 "Successful Starts," United Way of Greater Cincinnati, second edition, fall 2009.
- 4 Indianapolis, Houston, Richmond, Va., and Hayward, Calif., are the first four communities to implement Strive's process for educational reform. Portland, Ore., Fresno, Calif., Mesa, Ariz., Albuquerque, and Memphis are just beginning their efforts.

Performance Scorecard

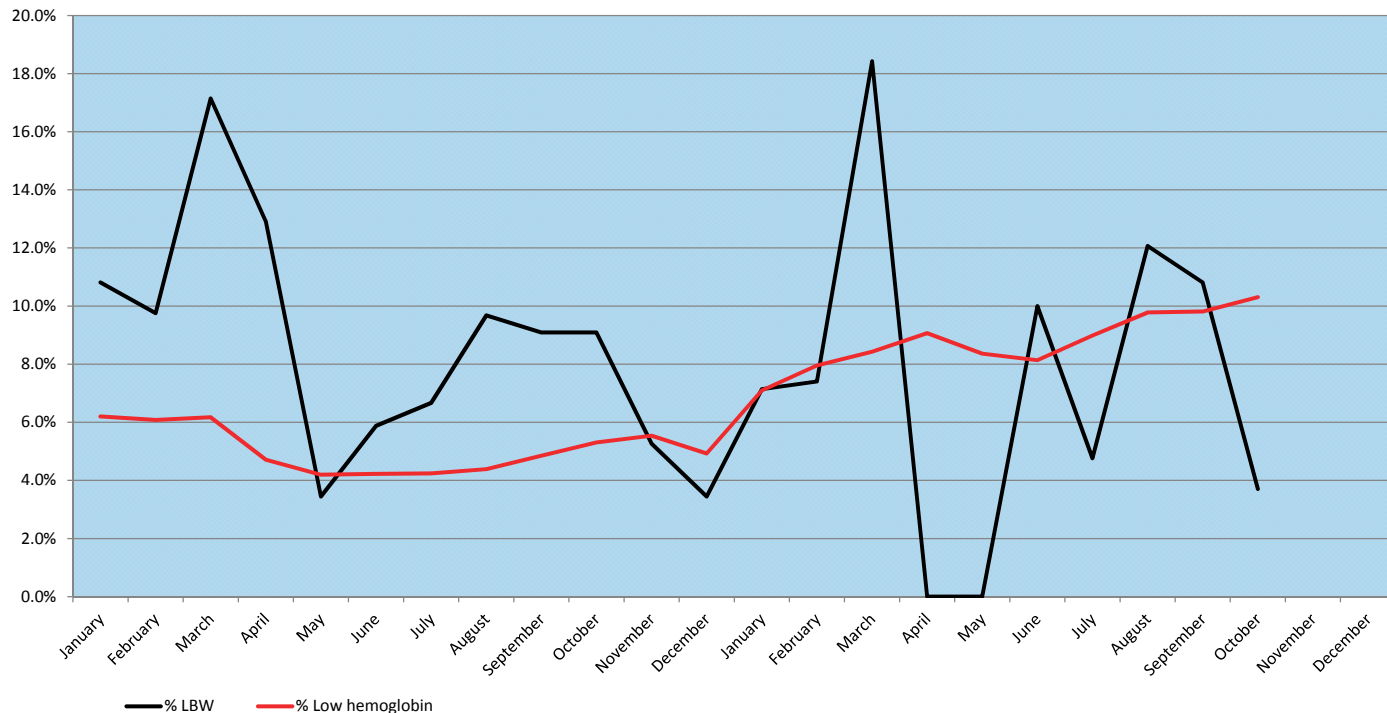
Program	Data Source	Target	2009	2010	2011			09-10 Trend
					1Q	2Q	3Q	
WIC								
1 % of WIC women delivering an infant weighing < to 2500 grams	KWIC	≤6%	6.4%	8.8%	11.2%	2.7%	9.5%	↑
2 % of children at high risk for low hemoglobin level	KWIC	≤9%	7.1%	5.1%	7.8%	8.5%	9.5%	↓
3 % of WIC children 2-5 YO who are overweight (≥ 95% BMI for age)	KWIC	≤7%	10.2%	10.2%	10.6%	10.2%	10.2%	↔
4 % of WIC Infants who breastfed for a minimum of 6 months	KWIC	≥30%	32%	28%	28%	23%	26%	↓
5 % of Douglas County infants utilizing WIC services	KWIC/KS Vital Stat.	N/A	39.4%	37.4%	33.3%	35.2%	34.6%	
6 \$ Value of WIC checks redeemed in DG Co	KWIC	N/A	\$963,001	\$957,165	\$242,817	\$255,788	\$269,084	
Project LIVELY								
1 % of services clients connected to	Access	≥90%	95%	98%	96%	98%	99%	↔
2 % of clients receiving a home visit at a frequency appropriate to their need	Access	≥90%	98%	99%	100%	100%	99%	↔
3 % of clients contacted within 3 business days of referral	Access	≥90%	99%	100%	100%	100%	99%	↔
4 % of clients satisfied with Project LIVELY services (once annual)	Access	≥95%	95%	95%	97%	NA	NA	↔
5 % of community partners satisfied with Project LIVELY services (once annual)	Access	≥95%	97%	91%	100%	NA	NA	↓
Clinic Services								
1 % of family planning clients age 15-25 testing positive for Chlamydia	KDHE	≤5%	5.0%	6.1%	3.3%	4.6%	3.6%	↑
2 % of 2-year old clients completing the primary immunization series	CO-CASA	≥84%	79%	84%	81%	80%	76%	↑
3 % of communicable disease case investigations initiated within 24 hours	Epi Log	100%	99%	99%	100%	100%	99%	↔
Child Care Licensing								
1 Rate of enforcement action taken in Douglas County (suspensions/fines/revocations) (# per 100)	CLARIS	≤ 0.5/qtr or 2/yr	0.73	3.64	0.39	0.40	0.00	↑
2 % of complaint investigations initiated within 5 business days	Access	100%	100%	100%	100%	100%	100%	↔
3 Rate of reportable accidents (# per 10,000 child care days)	Access	0.03	0.06	0.06	0.06	0.03	0.01	↔
Environmental Health								
1 Septic System failure rate (# per 1,000)	FoxPro	≤1	0.4	0.6	0.1	0.4	0.3	↑
2 % of well samples testing positive for fecal coliform bacteria	FoxPro	≤5%	2%	20%	7.7%	6.9%	16.7%	↑
3 % of recreational water facilities closed	FoxPro	≤3%	3.6%	5.4%	1.3	9.2	11.2	↑
4 % of environmental complaint investigations initiated by the next business day	Access	≥90%	100%	100%	74%	77%	70%	↔
Emergency Preparedness								
1 Technical Assistance Review (TAR) Score (once bi-annual)	TAR	≥65	82	NA	NA	NA	NA	↓
2 % of command staff contacted within 60 minutes of initiation of call down	Training Log	≥95%	86%	69%	90%	90%	54%	↓
3 % of all staff contacted within 90 minutes of initiation of call down	Training Log	≥80%	89%	58%	80%	86%	70%	↓
4 % of new staff having completed basic ICS training with the first 6 months of employment	Training Log	100%	100%	67%	100%	100%	NA	↓
5 % of all staff who have completed all required Incident Command System (ICS) training	Training Log	≥90%	91%	94%	98%	99%	97%	↔
Healthy Families Douglas County								
1 Premature Birth Rate (% of MCH infants born at < 37 weeks gestation)	Perinatal Outcome Report	≤7.6%	5.4%	0.0%	0.0%	0.0%	0.0%	↓
2 Low Birth Weight (% of MCH infants born at < 2500 grams)	Perinatal Outcome Report	≤5%	5.4%	0.0%	0.0%	0.0%	0.0%	↓
Administration								
1 Operating Margin	CYMA	≥1.04	1.16	1.08	1.14	1.00	2.24	↓
2 % of agency performance measures meeting or exceeding target goal	Access	≥90%	55%	58%	68%	65%	69%	↔
3 % of press releases resulting in media coverage	Log	≥75%	74%	87%	100%	100%	89%	↑
4 # of visits to the website	Google Analytics	10% qrtly growth	23,585	15,349	3,892	4,135	5319	↓

WIC Statistics

November 21, 2011

	2011											
	January	February	March	April	May	June	July	August	September	October	November	December
LBW Babies	3	2	7	0	0	3	2	7	4	1		
All WIC Babies	42	27	38	30	51	30	42	58	37	27		
% LBW	7.1%	7.4%	18.4%	0.0%	0.0%	10.0%	4.8%	12.1%	10.8%	3.7%		
% LBW by Quarter	11.2%			2.7%			9.5%					
Low hemoglobin	56	61	65	70	65	62	71	79	79	84		
Children in WIC	789	767	771	772	777	762	790	808	805	815		
% Low hemoglobin	7.1%	8.0%	8.4%	9.1%	8.4%	8.1%	9.0%	9.8%	9.8%	10.3%		
% L hemoglobin by Quarter	7.8%			8.5%			9.5%					

WIC Trends 2010-2011



Emergency Preparedness Stats

Month

# of staff completing 1st 6 mo of employment:	<input type="text"/>	TAR score	<input type="text"/>
# of new staff completing trainings	<input type="text"/>	% of command staff contacted within 60 minutes of initiation of call down:	<input type="text" value="53.85%"/>
# of command staff contacted within 60 minutes	<input type="text" value="7"/>	% of all staff contacted within 90 minutes of initiation of call down:	<input type="text" value="70.45%"/>
# of command staff	<input type="text" value="13"/>	% of new staff having completed basic ICS training with the first 6 mo employment:	<input type="text"/>
# of staff reached within 90 minutes	<input type="text" value="31"/>	% of all staff who have completed all required ICS training:	<input type="text" value="90.91%"/>
# of staff who have completed all required ICS trainings	<input type="text" value="40"/>	Comments:	
# of staff	<input type="text" value="44"/>	<input type="text" value="1st use of automated call down system for all employees & volunteers. 30 employees (70 %) and 40 volunteers (47 %) were reached w/in 60 min. of initiation of call down.New ICS chart increased ICS training requirements for Rebecca H, Jenn P, Jeremy, Ashley"/>	

Performance and Outcome Measures Data Description Form

Program	Clinic - Communicable Disease
Measure	Infectious Disease investigations will be initiated \leq 24 hours
Health Department Goal	100%
Significance of Measure	Timely investigation of infectious disease cases will decrease spread of infection/disease to the public.
Comparable National or State Standard (if applicable)	N/A
Current Baseline (year)	99.4% (2010), 99.4% (2011)
Essential Service(s) (include PHAB Domain and Standard)	Diagnose and investigate health problems – PHAB Domain 2, Standard 2.1
Description of Data Collection Methods	
What is the data source?	CD log
Who will collect the data?	CD team leader
How frequently?	monthly
Calculation of Measure	
Numerator	Number of CD cases investigated within 24 hours
Denominator	Number of CD cases
Formula in word form	$\frac{\# \text{ of CD cases investigated } < 24 \text{ hours}}{\# \text{ of CD cases investigated}} \times 100 = \text{Rate}$
Network Link to Stored Data	\\wvs-xena\xena\NURSING\Programs\CD\CD_Log_2011.xlsx

Measure Name Review Cycle – 12 months

Origin Date 1/11

Revision Date(s)

Review Date(s) 1/11

Reviewed By :

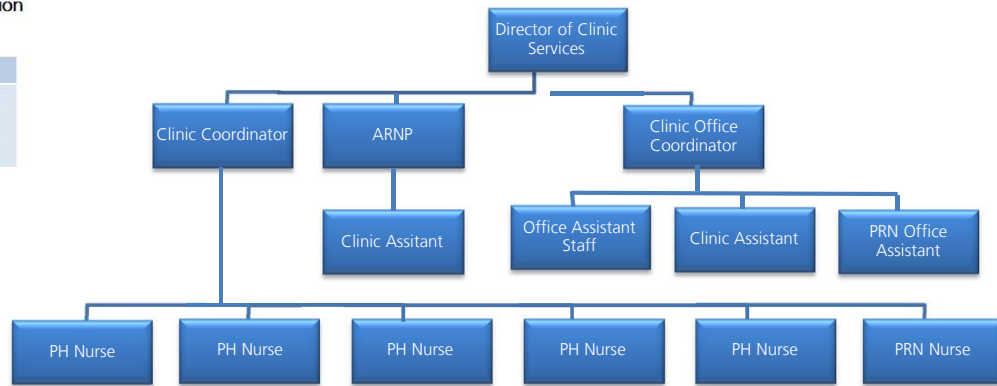
Page 1

Print Date

11/17/2011

Program Organization

FTE History	
2010	8.6
2011	8.6
2012	9.2



Program Description

Clinic services emphasize prevention and education by providing immunizations for all ages; offering women’s health, STD, and well child exams; and safeguarding the community by monitoring and investigating communicable diseases. Health Department services are provided to Douglas County residents regardless of inability to pay.

Program Impact Story

Dafne Vargas-Hernandez wanted to ensure that she found good health care for her son, Andres, who was only 3 months old when her family moved to Lawrence from Costa Rica.

Dafne called multiple health clinics and found out how the Health Department could help. She brought Andres to the Health Department for immunizations, well child screenings, WIC and was assisted with finding a family doctor.

Even though Andres was at a healthy weight based on Costa Rican standards, the American weight charts showed him at the low end of the scale.

"I always asked lots of questions and they had very appropriate and wise answers regarding his nutrition and development," she said.

Dafne’s experiences with health care in Costa Rica influenced her expectations of health care workers in the United States.

"Back home, the pediatrician does everything," she said.

When she came to the Health Department, however, Dafne found that the clinic nurses and WIC nutritionists treated her son with the same care and attention that she had experienced in her homeland.

"You feel that it is not only a service that they are providing," she said, "but that they are interested in the development of the child."

Performance Indicators

	2009	2010	2011	2012 Target
% of 2 year olds being seen at the Health Department who are up to date on their primary immunization series	79.0%	83.8%	80.7%	≥84%
% of communicable disease investigations initiated within 24 hours	99.0%	99.4%	100.0%	100%
% of female family planning/STD clients testing positive for chlamydia		6.1%		≤5%
% of first time contraception seekers who continue method for more than 3 months				85%
% of families participating in family-based sexuality education program who live in 66044 zip code		10.0%		15%

Revenue History

	2009 Actual	2010 Actual	2011 Actual	2012 Budget
Operating	25.5%	26.0%	32.9%	28.0%
Grants	30.5%	30.6%	28.8%	34.3%
Local tax	43.9%	43.4%	38.3%	37.7%
Other	0.1%	0.0%	0.0%	0.0%

Expenditure History

	2009 Actual	2010 Actual	2011 Actual	2012 Budget
	\$836,920	\$790,753	\$852,642	\$880,320

2012 Priority Areas for Improvement

We will:

1. Increase the number of 2 year olds being seen at the Health Department who are up to date on their primary immunization series.
2. Conduct communicable disease follow up appropriately.
3. Reduce the risk of unintended pregnancies by improving compliance among first time contraceptive users.
4. Assure that a diverse group of families receive education about appropriate sexual behavior.

Administration

Operating margin

Average number of online page views per media story

2009	2010	2011	2012 Target
1.05	1.06	1.95	1.04
NA			

Environmental Health

% of real estate inspections where violations are cited

% of recreational water facilities closed

2009	2010	2011	2012 Target
3.6%	5.4%		≤3%

Clinic Office

Cash drawer balance accuracy

Data entry accuracy

2009	2010	2011	2012 Target
		94.2%	97%
		NA	97%

Clinic Services

% of 2 year olds being seen at the Health Department who are up to date on their primary immunization series

% of communicable disease investigations initiated within 24 hours

% of first time contraception seekers who continue method for more than 3 months

2009	2010	2011	2012 Target
79.0%	83.8%	80.7%	≥84%
99.0%	99.4%	100.0%	100%
			85%

Healthy Families Douglas County

% of pregnant and post-natal women who smoke receiving counseling/education to quit smoking

% of caseload meeting goals on time

2009	2010	2011	2012 Target
		NA	≥50%

Child Care Licensing

% of complaint investigations initiated within 5 business days

% of facilities cited for 1 or more unsafe sleep practices

Rate of reportable accidents (# per 10,000 child care days)

2009	2010	2011	2012 Target
100.0%	100.0%	100.0%	100%
		16%	<5%
0.06	0.06	0.06	≤0.03

WIC

% of WIC fruit and vegetable checks redeemed

% of women who delivered a low birth weight baby at last delivery

% of WIC children age 2 to 5 years who are overweight (BMI ≥ 95th%ile)

2009	2010	2011	2012 Target
	72.0%	78.5%	>85%
6.4%	8.6%	6.7%	<7.8%
10.2%	10.2%	10.2%	<9.6%

Project LIVELY

% of clients connected to services

% of new referrals visited within 3 business days

% of community partners satisfied with services each year

2009	2010	2011	2012 Target
			≥90%
			≥90%
97.0%	91.0%	100.0%	≥95%

Preparedness

% of workforce contacted within 60 minutes of initiation of notification drill

% of workforce completing all required ICS training

2009	2010	2011	2012 Target
			≥95%
			≥90%

2012 Health Board Appointments

	City			County		Joint	KU
2007	Dr. Gerald Pees (1)	Alan Cowles		Carl McElwee	Karen Shumate		
2008				Paul Liechti (1)		Donna Bell	
2009	Dr. Gerald Pees (2)					Shirley Martin-Smith (1)	
2010*		Maley Wilkins (1)	David Ambler (1)		Ray Davis (1)		Carol Seager (1)
2011				Paul Liechti (2)			
2012	Appointment				Appointment	Appointment	

Action Needed: New member to replace Dr. Pees and reappointment of Ray Davis and Shirley Martin-Smith should they desire to serve a second term.

* Board reorganized in 2010 to expand from 5 to 8 members adding KU as an appointing body

Elevator Speech

The Lawrence-Douglas County Health Department is working to build and preserve a strong and healthy community. Our focus is to improve the health of our community by sharing community health information, developing and providing expertise on evidence-based public health strategies, and providing leadership for community collaboration that promotes health in all programs and policies.

LAWRENCE COMPLETE STREETS POLICY

SECTION ONE: TITLE.

This policy shall be known as the “Complete Streets Policy.”

SECTION TWO: PURPOSE.

The purpose of the Complete Streets Policy is to use an interdisciplinary approach to incorporate the needs of all Users into the design and construction of Street Projects within Lawrence where feasible and fiscally appropriate. This Complete Streets Policy establishes guiding principles and practices to create an equitable, balanced, and effective transportation system that encourages walking, bicycling, and transit use, to improve health and reduce environmental impacts, while simultaneously promoting safety for all Users of Streets.

SECTION THREE: DEFINITIONS.

- (a) Complete Streets means a comprehensive and integrated transportation network that permits safe and convenient travel along and across all Streets for all Users.
- (b) Complete Streets Elements mean design features that contribute to a safe, convenient, and comfortable travel experience for all Users, including but not limited to such features as: sidewalks; shared use paths; bicycle lanes; automobile lanes; paved shoulders; street trees and landscaping; planting strips; curbs; accessible curb ramps; bulb-outs; crosswalks; refuge islands; pedestrian and traffic signals, including countdown and accessible signals; signage; street furniture; bicycle parking facilities; public transportation stops and facilities; transit priority signalization; traffic calming devices; narrow vehicle lanes; raised medians; roadway diets; and dedicated transit lanes.
- (c) Streets mean any rights of ways, public or private, including arterials, collectors, local streets, and roadways by any other designation, as well as bridges, tunnels, and any other portions of the transportation network.
- (d) Street Project means the construction, reconstruction, retrofit, or major alteration of any Street and includes the planning, design, approval, and implementation processes, except that Street Project does not include minor routine upkeep and maintenance such as mill & overlay, micro abrasion, microsurfacing, crack seal, concrete rehab, curb repair, sweeping, mowing, spot repair, and interim measures on detour routes.
- (e) Users means all persons that use Streets, including pedestrians, bicyclists, motor vehicle drivers, public transportation drivers and riders, of all ages and abilities, including children, youths, families, older adults, and persons with disabilities.

SECTION FOUR: PRINCIPLES.

Guiding principles and practices of the Complete Streets Policy are as follows:

- (a) Complete Streets are designed to serve everyone: pedestrians, bicyclists, transit riders, and motorists, regardless of age or ability.
- (b) It is the intent of this Complete Streets Policy that the design and construction of all Street Projects should include Complete Streets Elements as feasibility and funding allows, including, but not limited to:
 - (1) Public Plans adopted by the City of Lawrence, which may be independent or part of the Lawrence-Douglas County Comprehensive Plan;
 - (2) Development-related ordinances and resolutions, including Land Development Codes and Subdivision Regulations, among others, that are adopted or passed by the City of Lawrence;
 - (3) Corridor Plans approved by the City of Lawrence (or in the case of State Routes, those corridor plans approved jointly by the City of Lawrence and the Kansas Department of Transportation).
 - (4) The Metropolitan Transportation Plan approved by the Lawrence-Douglas County Metropolitan Planning Organization.
- (c) Complete Streets Elements should be considered within the balance of mode and context of the community, including but not limited to: environmental sensitivity; costs; budgets; demand; probable use; space and area requirements and limitations; and legal requirements and limitations. Not all Complete Streets elements are required to make a street complete and/or be feasible at all locations or times.
- (d) It is the intent of the City of Lawrence to recognize that street projects are limited in scope by available funding resources. Fiscal responsibility should be used when considering Complete Streets elements.
- (e) It is the intent of the City of Lawrence to incorporate the Complete Streets principles into appropriate public strategic plans, standards, relevant ordinances, practices and policies, and appropriate subsequent updates. The Complete Streets principles, where applicable and appropriate, may also be incorporated into plans, manuals, rules, practices, policies, training, procedures, regulations, and programs.
- (f) It is the goal of the City of Lawrence to foster a partnership with the State of Kansas, Douglas County, area school districts, citizens, businesses, neighboring communities, and neighborhoods in consideration of functional facilities and accommodations in furtherance of this Complete Streets Policy and the continuation of such facilities and accommodations beyond the jurisdiction of the City of Lawrence.
- (g) The City of Lawrence recognizes that Complete Streets may be achieved through elements incorporated into a single project, or incrementally through a series of improvements or maintenance activities, in order to create a network of facilities that promotes connectivity to destinations.
- (h) The City of Lawrence will consider all appropriate possible funding sources to plan and implement the Complete Streets Policy and shall direct staff to investigate grants that may be available to make the realization of Complete Streets economically feasible.

SECTION FIVE: APPLICABILITY.

- (a) It is the intent of the City of Lawrence that its departments make Complete Streets practices a routine part of everyday operations, that its departments approach every appropriate transportation project and program as an opportunity to improve public and private streets and the transportation network for all Users, and that its departments work in coordination with other departments, agencies, and jurisdictions to achieve Complete Streets, where feasibility and funding allows, throughout Lawrence.
- (b) The City of Lawrence departments, where feasibility and funding allows, shall incorporate Complete Streets Elements into existing public and private streets to improve the safety and convenience of all Users and to construct and enhance the transportation network for every User. If the safety and convenience of Users can be improved within the scope of pavement resurfacing, restriping, or signalization operation on streets, then it is the intent of the City of Lawrence that such projects shall also include Complete Streets Elements.
- (c) The City of Lawrence departments shall include key Complete Streets Elements in the normal review and/or development of plans, zoning and subdivision codes, laws, procedures, rules, regulations, guidelines, programs, templates, and design manuals, including pertinent portions of the Lawrence Land Development Code, the Lawrence-Douglas County Comprehensive Plan, subarea/sector plans, and corridor plans, to integrate, accommodate, and balance the needs of all Users in all Street Projects.
- (d) The City of Lawrence departments shall coordinate Complete Streets design templates with street classifications and revise them to include Complete Streets infrastructure, such as bicycle lanes, sidewalks, street crossings, and planting strips. All facilities will be designed and constructed in accordance with applicable laws and regulations using best practices and guidance from the following, among others: American Association of State Highway and Transportation Officials (AASHTO) publications, the Manual on Uniform Traffic Control Devices (MUTCD), the Americans with Disabilities Act Accessibility Guidelines (ADAAG), and the Public Rights-of-Way Accessibility Guidelines (PROWAG).

SECTION SIX: EXCEPTIONS.

Every Street Project should incorporate Complete Streets elements sufficient to enable reasonably safe travel along and across the Street for all Users, provided, however, that such infrastructure may be excluded from a Street Project where:

- (a) Use by non-motorized Users is prohibited by law, there is insufficient space to safely accommodate the facility, or there are relatively high safety risks to include facilities for all Users.
- (b) The cost would be excessive or disproportionate to the need or probable future use over the long term.
- (c) There is an absence of current or future need.
- (d) There are topographic or natural resource constraints.
- (e) A reasonable and equivalent alternative already exists for certain Users or is programmed to exist.

SECTION EIGHT: EFFECTIVE DATE.

This Complete Streets Policy shall be in full force and effect from the date of its passage, adoption, and approval.

Sent: Wednesday, November 09, 2011 4:42 PM
To: KALHD
Cc: Robert Siedlecki (Robert.Siedlecki@srs.ks.gov)
Subject: State Agency Reorganization

To the Kansas Association of Local Health Departments,

Secretary Siedlecki and I would like to update you with some information about the proposed reorganization of our agencies.

As you have heard, under the Governor's reorganization plan, SRS will become the Department for Children and Families. Under the plan, programs that involve activities that strengthen and focus services for children and families from other agencies will be moved to SRS at the beginning of the next state fiscal year, July 1, 2012. Programs from KDHE include:

Child Care Licensing

- Foster Care Licensing
- Infant and Toddler Services
- Children and Youth with Special Health Care Needs
- Maternal, Infant and Early Childhood Home Visitor Program
- Healthy Start Home Visitor Program
- Pregnancy Maintenance Initiative
- Abstinence Education
- Teen Pregnancy Prevention

The programs' management will move to the Department for Children and Families, which looks forward to continued relationship with local partners such as health departments in the provision of these important services.

We will be working through reorganization planning from now up to the new state fiscal year. We will keep this a transparent process and will work with our community partners to make these programs a continued success.

Sincerely,

Robert Moser, MD
Secretary, Kansas Department of Health and Environment

Robert Siedlecki
Secretary, Kansas Department of Social and Rehabilitation Services

HOUSE BILL No. 2094

By Committee on Health and Human Services

1-26

1 AN ACT concerning public health; relating to exemptions from the
2 administration of vaccinations; amending K.S.A. 72-5209 and K.S.A.
3 2010 Supp. 65-508 and repealing the existing sections.
4

5 *Be it enacted by the Legislature of the State of Kansas:*

6 Section 1. K.S.A. 2010 Supp. 65-508 is hereby amended to read as
7 follows: 65-508. (a) Any maternity center or child care facility subject to
8 the provisions of this act shall: (1) Be properly heated, plumbed, lighted
9 and ventilated; (2) have ~~plumbing, water~~ and sewerage systems which
10 conform to all applicable state and local laws; and (3) be operated with
11 strict regard to the health, comfort, safety and social welfare of the
12 residents.

13 (b) Every maternity center or child care facility shall furnish or
14 cause to be furnished for the use of each resident and employee
15 individual towel, wash cloth, comb and individual drinking cup or
16 sanitary bubbling fountain, and toothbrushes for all other than infants,
17 and shall keep or require such articles to be kept at all times in a clean
18 and sanitary condition. Every maternity center or child care facility shall
19 comply with all applicable fire codes and rules and regulations of the
20 state fire marshal.

21 (c) (1) The secretary of health and environment with the cooperation
22 of the secretary of social and rehabilitation services shall develop and
23 adopt rules and regulations for the operation and maintenance of
24 maternity centers and child care facilities. The rules and regulations for
25 operating and maintaining maternity centers and child care facilities shall
26 be designed to promote the health, safety and welfare of the residents
27 who are to be served in such facilities by ensuring safe and adequate
28 physical surroundings, healthful food, adequate handwashing, safe
29 storage of toxic substances and hazardous chemicals, sanitary diapering
30 and toileting, home sanitation, supervision and care of the residents by
31 capable, qualified persons of sufficient number, after hour care; an
32 adequate program of activities and services, sudden infant death
33 syndrome and safe sleep practices training, prohibition on corporal
34 punishment, crib safety, protection from electrical hazards, protection
35 from swimming pools and other water sources, fire drills, emergency
36 plans, safety of outdoor playground surfaces, door locks, safety gates and

1 transportation and such appropriate parental participation as may be
2 feasible under the circumstances. Boarding schools are excluded from
3 requirements regarding the number of qualified persons who must
4 supervise and provide care to residents. The notice of hearing on initial
5 rules and regulations proposed to be adopted to carry out the amendments
6 to this subsection (c)(1) by this act shall be published in the Kansas
7 register after February 14, 2011, but prior to March 11, 2011.

8 (2) Rules and regulations developed under this subsection shall
9 include provisions for the competent supervision and care of children in
10 child care facilities. For purposes of such rules and regulations,
11 competent supervision as this term relates to children less than five years
12 of age includes, but is not limited to, direction of activities, adequate
13 oversight including sight or sound monitoring, or both, physical
14 proximity to children, diapering and toileting practices; and for all
15 children, competent supervision includes, but is not limited to, planning
16 and supervision of daily activities, safe sleep practices, including, but not
17 limited to, visual or sound monitoring, periodic checking, emergency
18 response procedures and drills, illness and injury response procedures,
19 food service preparation and sanitation, playground supervision, pool and
20 water safety practices. The notice of hearing on initial rules and
21 regulations proposed to be adopted under this subsection (c)(2) shall be
22 published in the Kansas register after February 14, 2011, but prior to
23 March 11, 2011.

24 (d) Each child cared for in a child care facility, including children of
25 the person maintaining the facility, shall be required to have current such
26 immunizations as the secretary of health and environment considers
27 necessary. The person maintaining a child care facility shall maintain a
28 record of each child's immunizations and shall provide to the secretary of
29 health and environment such information relating thereto, in accordance
30 with rules and regulations of the secretary, but the person maintaining a
31 child care facility shall not have such person's license revoked solely for
32 the failure to have or to maintain the immunization records required by
33 this subsection.

34 (e) The immunization requirement of subsection (d) shall not apply
35 if one of the following is obtained:

36 (1) Certification from a licensed physician stating that the physical
37 condition of the child is such that immunization would endanger the
38 child's life or health; or

39 (2) a written statement signed by a parent or guardian that the parent
40 or guardian is an adherent of a religious denomination whose teachings
41 are opposed to immunizations; or

42 (3) a written statement signed by a parent or guardian of the child
43 that the parent or guardian of the child declines immunization for

1 *reasons of conscience or personal beliefs.*

2 Sec. 2. K.S.A. 72-5209 is hereby amended to read as follows: 72-
3 5209. (a) In each school year, every pupil enrolling or enrolled in any
4 school for the first time in this state, and each child enrolling or enrolled
5 for the first time in a preschool or day care program operated by a school,
6 and such other pupils as may be designated by the secretary, prior to
7 admission to and attendance at school, shall present to the appropriate
8 school board certification from a physician or local health department that
9 the pupil has received such tests and inoculations as are deemed
10 necessary by the secretary by such means as are approved by the
11 secretary. Pupils who have not completed the required inoculations may
12 enroll or remain enrolled while completing the required inoculations if a
13 physician or local health department certifies that the pupil has received
14 the most recent appropriate inoculations in all required series. Failure to
15 timely complete all required series shall be deemed non-compliance.

16 (b) As an alternative to the certification required under subsection
17 (a), a pupil shall present:

18 (1) An annual written statement signed by a licensed physician
19 stating the physical condition of the child to be such that the tests or
20 inoculations would seriously endanger the life or health of the child; or

21 (2) a written statement signed by one parent or guardian that the
22 child is an adherent of a religious denomination whose religious
23 teachings are opposed to such tests or inoculations; or

24 (3) *a written statement signed by a parent or guardian of the child*
25 *that the parent or guardian of the child declines such inoculations for*
26 *reasons of conscience or personal beliefs.*

27 (c) On or before May 15 of each school year, the school board of
28 every school affected by this act shall notify the parents or guardians of
29 all known pupils who are enrolled or who will be enrolling in the school
30 of the provisions of this act and any policy regarding the implementation of
31 the provisions of this act adopted by the school board.

32 (d) If a pupil transfers from one school to another, the school from
33 which the pupil transfers shall forward with the pupil's transcript the
34 certification or statement showing evidence of compliance with the
35 requirements of this act to the school to which the pupil transfers.

36 Sec. 3. K.S.A. 72-5209 and K.S.A. 2010 Supp. 65-508 are hereby
37 repealed.

38 Sec. 4. This act shall take effect and be in force from and after its
39 publication in the statute book.



Steven J. Anderson, CPA, MBA, Director

Division of the Budget

Sam Brownback, Governor

February 3, 2011

The Honorable Brenda Landwehr, Chairperson
House Committee on Health and Human Services
Statehouse, Room 151-S
Topeka, Kansas 66612

Dear Representative Landwehr:

SUBJECT: Fiscal Note for HB 2094 by House Committee on Health and Human Services

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2094 is respectfully submitted to your committee.

HB 2094 would allow a child to be exempt from required immunizations or inoculations for reasons of conscience or personal beliefs. The parent or guardian must provide a written statement declaring the exemption. Religious and medical exemptions are currently allowed by statute.

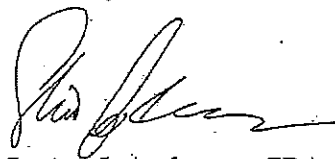
The Department of Education indicates that passage of the bill would have no fiscal effect on its operations. The Department of Health and Environment estimates that the bill would increase State General Fund expenditures by \$63,149 in FY 2012 for an additional FTE position and related operating expenses, and by \$10,000 in FY 2014 to update the immunization database. The expenditures are described in the table below:

Salaries and wages for 1.00 FTE position	\$57,576
Office equipment one-time expense	2,100
Telephone and network charges	1,200
In-State travel	1,000
Out-of-State Travel	<u>1,273</u>
Total agency estimate for FY 2012	\$63,149
Modify the KSWebIZ database in FY 2014	\$60,000

The Division of the Budget agrees that the programming updates would be required; however, it is not clear why the vendor would charge \$60,000 to add three new fields to the database, and why it would take two years to perform that task. In addition, it is not clear why the agency would need a new position and operating expenditures to handle the record-keeping

and follow-up for the children of parents who want to opt out for conscientious reasons. There are staff currently in place to keep track of the other cases; it would seem reasonable that existing staff could handle the additional types of cases.

Sincerely,

A handwritten signature in black ink, appearing to read "Steven J. Anderson". The signature is fluid and cursive, with a long horizontal stroke at the end.

Steven J. Anderson, CPA, MBA
Director of the Budget

cc: Pat Kuester, KDHE
Dale Dennis, Education



SEDGWICK COUNTY HEALTH DEPARTMENT

Claudia Blackburn, MPH, RNC, CPM

Health Director

1900 E. 9th St. N. • WICHITA, KS 67214-3115 • PHONE (316) 660-7300 • FAX (316) 262-1980
www.sedgwickcounty.org

Written Testimony on House Bill 2094

Presented to: Health and Human Services Committee

February 7, 2011

Madame Chair and members of the committee, I am Claudia Blackburn, representing the Sedgwick County Health Department. Thank you for the opportunity to testify in opposition to the proposed changes to K.S.A. 72-5209 and K.S.A. 2010 Supp. 65-508.

Stopping vaccine-preventable diseases – and saving lives in the process – must be a community-wide effort to vaccinate infants, children, adolescents, and adults. Without strong regulations requiring vaccination for schools and childcare settings, the Centers for Disease Control and Prevention report that we would see epidemics of diseases that are nearly under control today. More children would get sick and more would die.

We don't vaccinate just to protect our children. We also vaccinate to protect our grandchildren and their grandchildren. Strong vaccination programs have proven that they can be effective in eradicating disease. Our children don't have to get smallpox shots any more because the disease no longer exists. If we keep vaccinating now, parents in the future may be able to trust that diseases like polio and meningitis won't infect, cripple, or kill children. Vaccinations are one of the best ways to put an end to the serious effects of certain diseases.

The proposed broad vaccination exemption, increases the chance for more and more children to go unvaccinated, which increases the chance for disease to be spread and outbreaks to occur. Other states have adopted similar exemptions proposed in this bill. California allows parents to opt out from providing proof that their children have received mandatory vaccinations by stating that they are philosophically opposed to their child being vaccinated. In 2009, about two percent of their kindergarteners opted out due to personal beliefs. According to the California Department of Health, California is in the midst of a whooping cough epidemic that has made roughly 5,300 people sick in 2010 – *the most cases reported in 60 years*. Nine people have died, all of them babies. Eight of them were under two months of age, too young to be vaccinated against the disease.

A review of studies in the Journal of the American Medical Association regarding vaccination personal exemptions found that exemptors were 22 to 35 times more likely to get measles.

In Sedgwick County, we have over 85,000 children enrolled in schools, thousands more in daycares, and over 8,000 births each year. Please help protect the health of these children and generations to come by maintaining the current immunizations regulations.

Sedgwick County... working for you

F.Y.I.

By and for the staff and volunteers of the
Lawrence-Douglas County Health Department

Vol. 2, No. 43
November 2011

Nurses, paramedics team up to vaccinate city staff

Clinics were a first for both the Health Department and Fire/Medical Department

The term — vaccination station — took on a whole new meaning during a special series of flu shot clinics Oct. 26-29 at fire station 5. Billed as both an exercise and the annual city employee flu immunization clinics, paramedics from Lawrence Douglas County Fire Medical gave 511 vaccinations, with oversight from Health Department nurses.

Nurses **Kim Ens, Kathy Col-**

son, Catherine Bird, Shirley Grubbs, Kelli Raney and Peggy Gabler reviewed vaccine consent forms and assisted the paramedics when needed.

Having the paramedics serve as vaccinators would be integral in immunizing the county if another pandemic like H1N1 were to strike said **Charlie Bryan**, Community Health Planner.

“By working with Lawrence Douglas County Fire Medical, we have improved the local surge

See ‘Exercise’ on page 2



Z. Holland, a Lawrence Parks and recreation employee, receives a flu shot from Paramedic Vincent Davis.

F.Y.I. focus group renews newsletter

By *Lisa Horn,*
Communications Coordinator

As you may have noticed, the *F.Y.I.* is sporting a new look these days and still exists as a source of information (and a little fun) for Health Department staff.

At the focus group meeting held Oct. 5 to hear staff input on refreshing the publication, the decision to keep the newsletter with a few changes was the overwhelming voice.

Thanks to **Sue McDaneld, Jennifer Thompson, Andrew Stull, Kathy Colson, Jennifer Hayward** and **Brenda Hawkins** for sharing their thoughts at the meeting.

While several features were asked to be kept in the newsletter, such as Director **Dan**



Out with the old, in with the new.

Partridge's column, new elements to be implemented are: adding photos of all new employees and interns who start at the agency, alternating the light-hearted “People and their Pets” with a “Guess the Baby?” feature using staff baby photos and adding a quality improvement (QI) corner to update staff on various QI projects.

See ‘Focus group’ on page 2

From the Director

My column this month will touch on several of the actions taken at the October Health Board meeting as I believe several significant steps were taken there that will help define our future.



Among the Board's actions were: the approval of a new strategic plan, the formation of an Advisory Council, approval of a contract with the University of Kansas to assist us with the completion of a community health assessment and community health plan by November 2012 and approval of the 2012 budget.

Each of these actions are related to each other and will help move us forward in our effort to fill our gaps in delivering the essential public health services with the goal of improving the health of the community. Our strategic plan calls for an emphasis on: policy development, becoming accredited and connecting the work of each of your programs with a community developed plan that prioritizes health issues in Douglas County and guides the work of community agencies. This work begins with an as-

See ‘Director’s note on page 2



Health Board to meet at a new time

At the October Health Board meeting, board members voted to move meetings from 5:30 p.m. to 5 p.m.

The new time will take effect at the November meeting on Monday, Nov. 21. The meeting will be held in the first floor meeting room.

Myrna Hartford accepts Healthy Families admin position

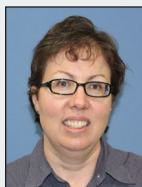
Myrna Hartford began working Oct. 24 in the part-time family information specialist position with Healthy Families Douglas County.

She will continue her duties as WIC clinic assistant, working Monday evenings at the front desk and some back up as the family planning clinic assistant. She will be located in the HFDC office with **Kim Duncan, Kemly Regidor** and **Rene Romig**.

New nurse joins clinic staff

Anne Smith, started Oct. 24 at the Health Department. She will serve primarily in nursing clinic with some family planning.

Anne previously worked at American Consultants, a temp agency in Overland Park, where she served as an agency nurse in a variety of settings in the Kansas City area, including the Kansas City Free Health Clinic, a health department, pediatrician's office and staffing flu shot clinics and health fairs. Anne has also worked as a nurse epidemiologist at Research Medical Center.



Smith

Accounting intern starts at agency

Jessica Holding, a student at Johnson County Community College, is currently completing an accounting internship at the Health Department.

She is working closely with **Jennie Henault** and **Jen Hayward** assisting with scanning documents, filing and entering deposits. She will finish her coursework in December.



Holding

Richard Ziesenis to receive Public Manager certification

Director of Environmental Health **Richard Ziesenis** will graduate from the University of Kansas Certified Public Manager course Nov. 18. Rich has been attending classes two days a month for the past year at KU's Public Management Center in Topeka. Class topics included: conflict management/mediation, communication, organizational behaviors, human resources law, budget and project management. Rich said the course has been very beneficial and highly recommends it to others looking to sharpen their management skills.

Project LIVELY Coordinator serving on retiree task force

Project LIVELY Coordinator **Rebecca Holmes** is currently serving on the Retirees Attraction Task Force, established to create recommendations on how Lawrence can better position itself to attract members from the 50-plus age set. Rebecca is one of 20 people serving on the steering committee made up of representatives from various organizations including Lawrence Memorial Hospital, the University of Kansas and local real estate agencies.

Director's note: Budget developments

Continued from page 1

assessment of the local public health system on Dec. 9 that will be facilitated by the Health Department and the University of Kansas.

To help us achieve our goals, we need additional personnel and skill sets. Given that our principal essential service gaps are: monitoring the health status of the community and mobilizing community partners to address important health issues affecting the community, we have included in our 2012 budget the option of hiring two new positions for the community health program, which will begin with a search for a Director of Health Promotion to lead the community health program.

As the Advisory Council matures and gets organized, our intent is to use their input to help us improve the quality and efficiency of the services we provide. Because of the work you have already done to improve efficiencies, we are able to provide funds for a 1 percent cost of living adjustment and merit increases of 2 percent or 4 percent in the 2012 budget — without receiving additional funding from the city and county.

At our monthly leadership meetings, we have spent a great deal of time working through all of these issues and we will devote most of our December general staff meeting to discussing these issues with you in more detail.

Focus group provides new ideas

Continued from page 1

Focus group participants said they enjoyed the articles that expand on Health Department events and issues. Profiles on staff were also well liked. Both of these elements will continue in future issues.

Another request that came out of the meeting was for employees to choose whether they would like to

receive the *FYI* electronically. If you would prefer for the newsletter to be emailed to you, please contact me. If you'd like to continue receiving the *FYI* in your mailbox, there is no need to take action.

The *FYI* is your newsletter and I am always open to suggestions to make it better. Please don't hesitate to let me know. Thanks!

Exercise provides unique opportunity for partnership

Continued from page 1

capacity necessary for an effective and timely response to a large-scale public health emergency," Bryan said.

The use of fire station 5, with its four drive-through bays, also showed that it would provide ample protection from high winds and other inclement weather.

A meeting was held Oct. 31 to review the event, which all participants deemed to be a success, Bryan said. The clinics will most likely be held again next year with a possible expansion to include a second fire station and opening the clinics to more groups of people.

With the Health Department required to conduct two exercises a year, Bryan said, the Fire Medical clinics could prove to be a simple and inexpensive way to practice necessary public health emergency (PHE) skills with limited PHE funds.