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Community Health Improvement Plan (CHIP) Development Meeting

December 9, 2025

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Health Department

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Welcome

9:00 – 9:10 AM

Adrienne Byrne
Health Director
Sedgwick County Health Department

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Health Department

Today's Participants

- Ascension Via Christi
- Child Start
- City of Wichita Transit
- COMCARE of Sedgwick County
- CRIBS
- DCF
- Derby Recreation Commission - Derby, KS
- ESSDACK - Haysville Learning Cafe
- Fairmount Neighborhood Association
- Gathered
- GraceMed Health Clinic
- Healthy Blue Kansas
- Health & Wellness Coalition of Wichita
- Health ICT
- HopeNet
- Hunter Health
- Kansas Children's Service League
- Kansas Department of Health and Environment
- Kansas Infant Death and SIDS Network
- K-State Extension
- KUSM-W CRIBS
- Metropolitan Area Planning
- Minds Matter LLC
- Mirror
- NICHE at WSU Tech
- Owner Gang Prevention Center
- Project Access
- Sedgwick County Emergency Management
- Sedgwick County Health Department
- Sedgwick Co. Food and Farm Council
- The Center
- The Neighboring Movement
- United Way of the Plains
- Urban League of Kansas
- Valley Hope Addiction Treatment and Recovery
- Wichita Area Sexual Assault Center
- Wichita Public Library
- Wichita State University, CEI

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Meeting Objectives

- Hear from experts about their work around CHIP Health Priorities
- Draft goals for the 2026 CHIP

Meeting Logistics

- Entry/exit doors
- Restrooms
- Breakfast available through morning break
- 30-minute lunch starts around 11:45 am
  - Eat at your Health Priority table

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Meeting Agenda

Morning:

- Community expert presentations
- CHIP design
- Health Education lens

After lunch:

- Facilitated group work at Health Priority tables
- Tables report out

Before you leave:

- Meeting effectiveness survey

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Resources

Participant Packets

- Agenda
- Two worksheets
  - Morning: Speaker Notes
  - After lunch: Goal Creation
- Reference documents
  - Guidelines for creating CHIP goals/outcome
  - 2023-25 CHIP goals and outcomes

At the Table

- Logic Model
- Outcome Measures
- Meeting Effectiveness Survey

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Where Are We Now?

9:10 – 9:20 AM

Ketki Kulkarni
Community Health Analyst
Sedgwick County Health Department

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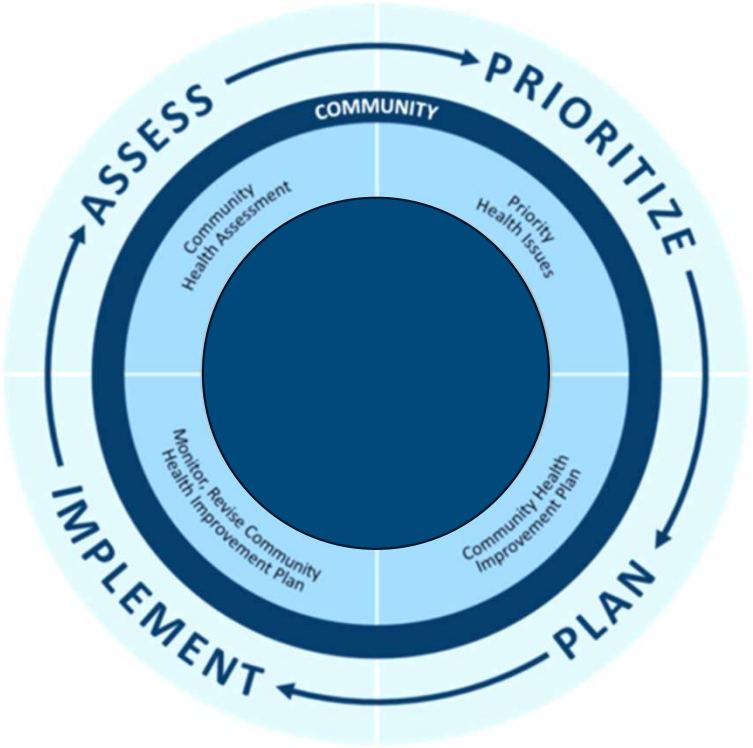
Accredited Health Department
PHAB
Advancing Public Health Performance
Public Health Accreditation Board

Community Health Improvement Cycle



Through data, strategic collaborations, and community power and engagement, we improve the community's health.

- Assess the community's health with the Community Health Assessment (CHA)
- Prioritize health issues
- Plan the goals for the Community Health Improvement Plan (CHIP)
- Implement the CHIP

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Adapted from the Minnesota Department of Public Health, "About the Local Public Health Assessment and Planning Cycle". Retrieved 9/5/2025, from About the Local Public Health Assessment and Planning Cycle - MN Dept. of Health

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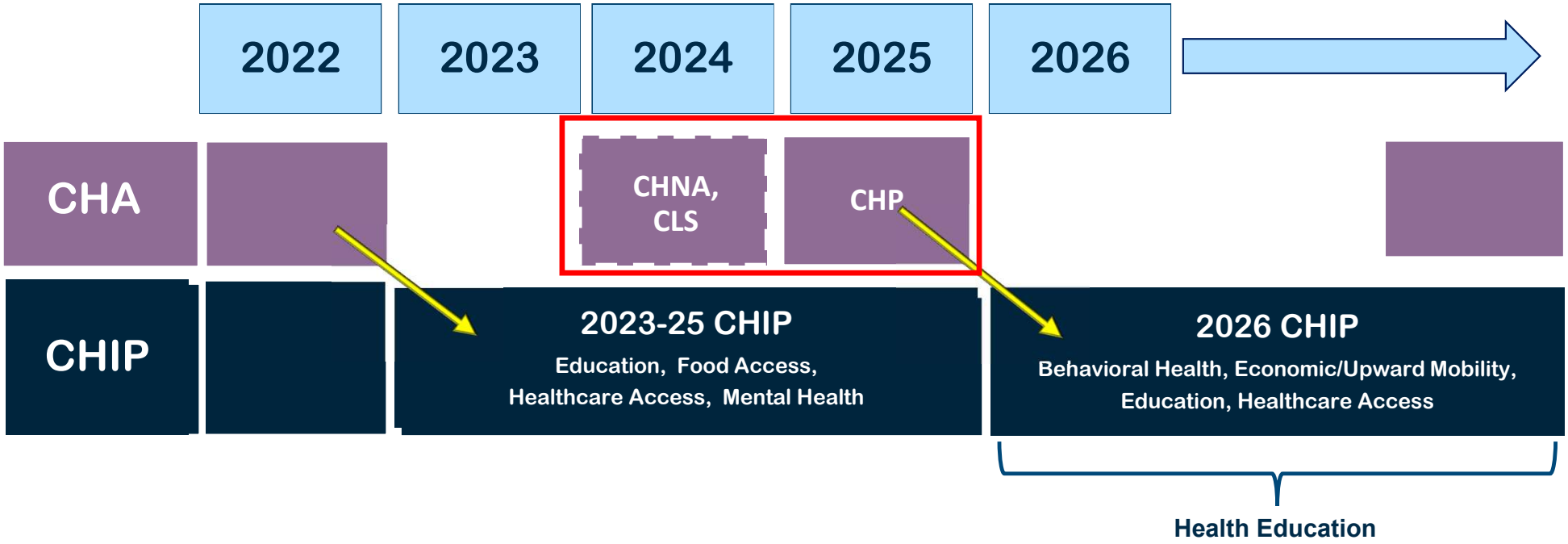
Community Health Improvement Cycle: Timeline



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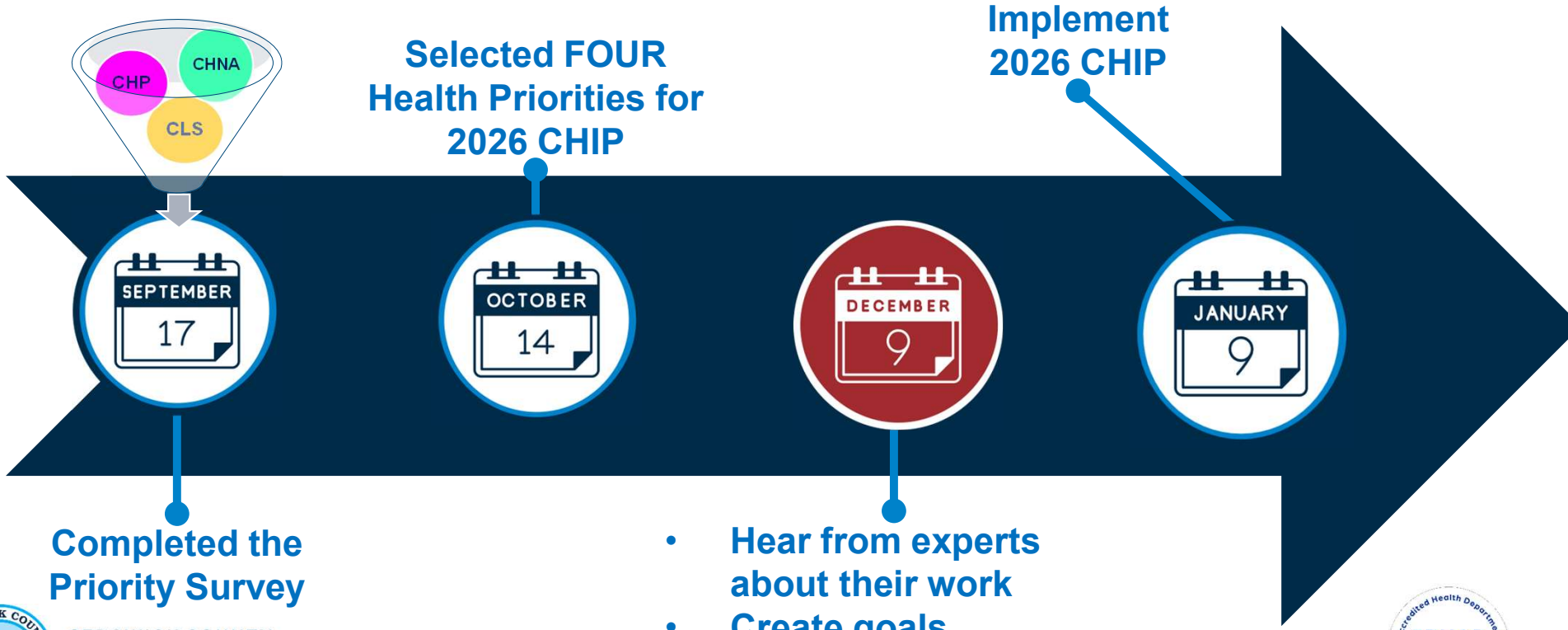
CHA to CHIP: A Data Driven Process



Completed the Priority Survey

Selected FOUR Health Priorities for 2026 CHIP

- **Hear from experts about their work**
- **Create goals**

Implement 2026 CHIP

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CHIP Development Meeting #1

- October 14, 2025
- Selected FOUR Health Priorities for the 2026 CHIP

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Participants:

- 50 attendees
- 25 community organizations
- Diverse group including community members and health partners

- Photos, data posters and presentation slides now available on the SCHD website

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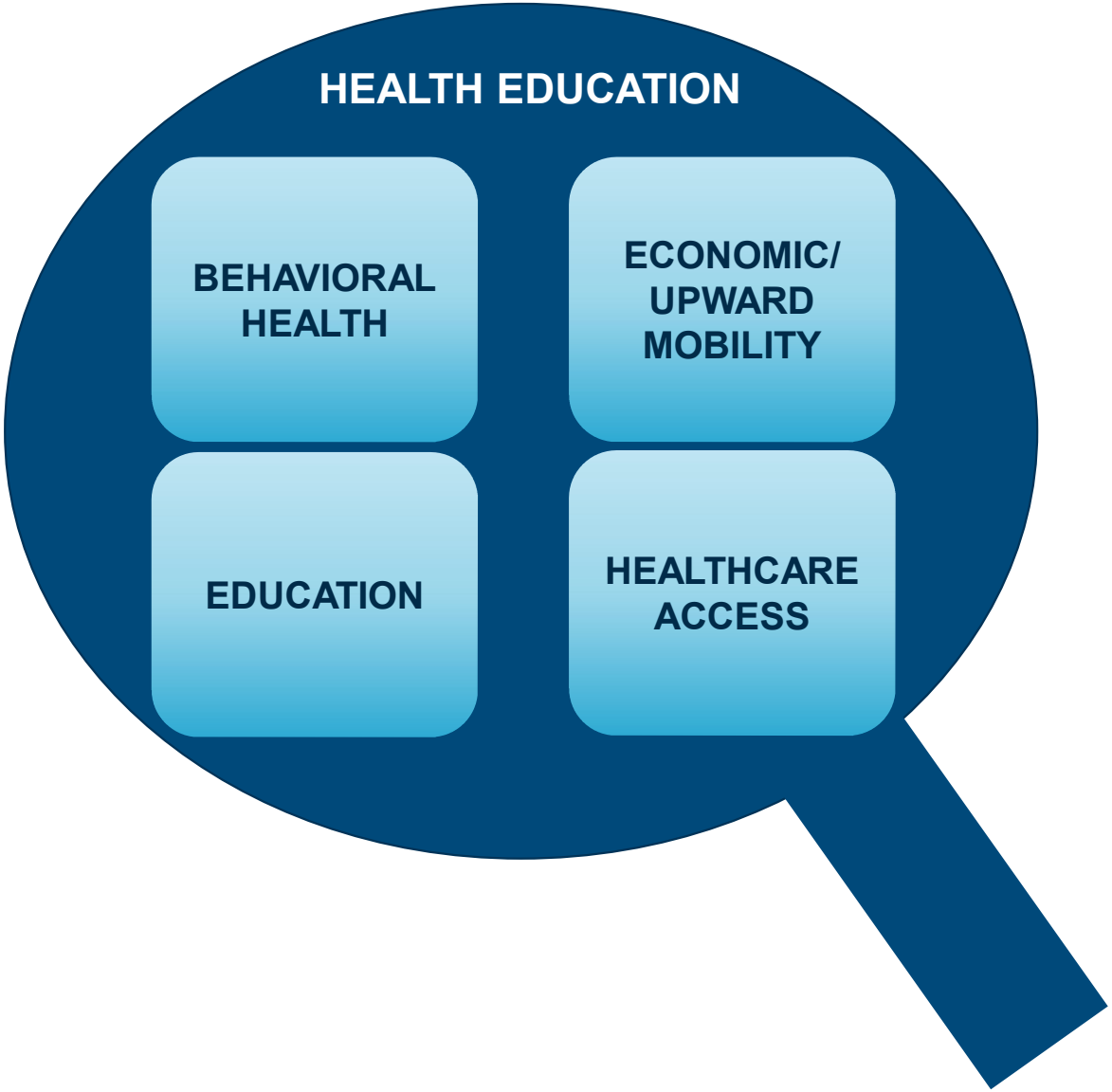
2026 CHIP Health Priorities



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2026 CHIP Development Outline

{Task for today!}

Completed by community partners on October 14, 2025

{ - - - To finish/ complete by June 2026- - - }

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Expert Panel

9:20 – 10:10 AM

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Health Education Lens

Joanna Sabally, MPH
Wichita State University

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Community Engagement Institute

Sedgwick County CHIP

A Health Education (education) Lens

December 2025

Wichita State University Community Engagement Institute

Center for Public Health Initiatives

Community Engagement Institute

Meet Taylor, (an imaginary) resident of Wichita

Knowing which resources to access

Community Engagement Institute

Have I observed someone else in my life doing this?

How ready do I feel to do this?

How much do I think this will make a difference?

What's considered normal in my friend circle?

How confident am I that I can do this?

What challenges will I have in seeking care?

How easy do I think this will be to do?

Will there be any negative impacts in my life if I do this?

What are the benefits of seeking care?

Does this make sense based on my culture?

Knowing which resources to access

Do I believe anything can change?

What advice do my family members give?

How much stress will this create in my life?

Community Engagement Institute

When I go to my first appointment, do I feel welcome/comfortable?

I don't want people to think I'm "crazy."

Do I have childcare?

How will I get there? (transportation)

Shouldn't I be able to just get through this on my own?

I'm struggling to get out of bed today, much less take something else on.

Knowing which resources to access

My grandpa said not to go to a therapist.

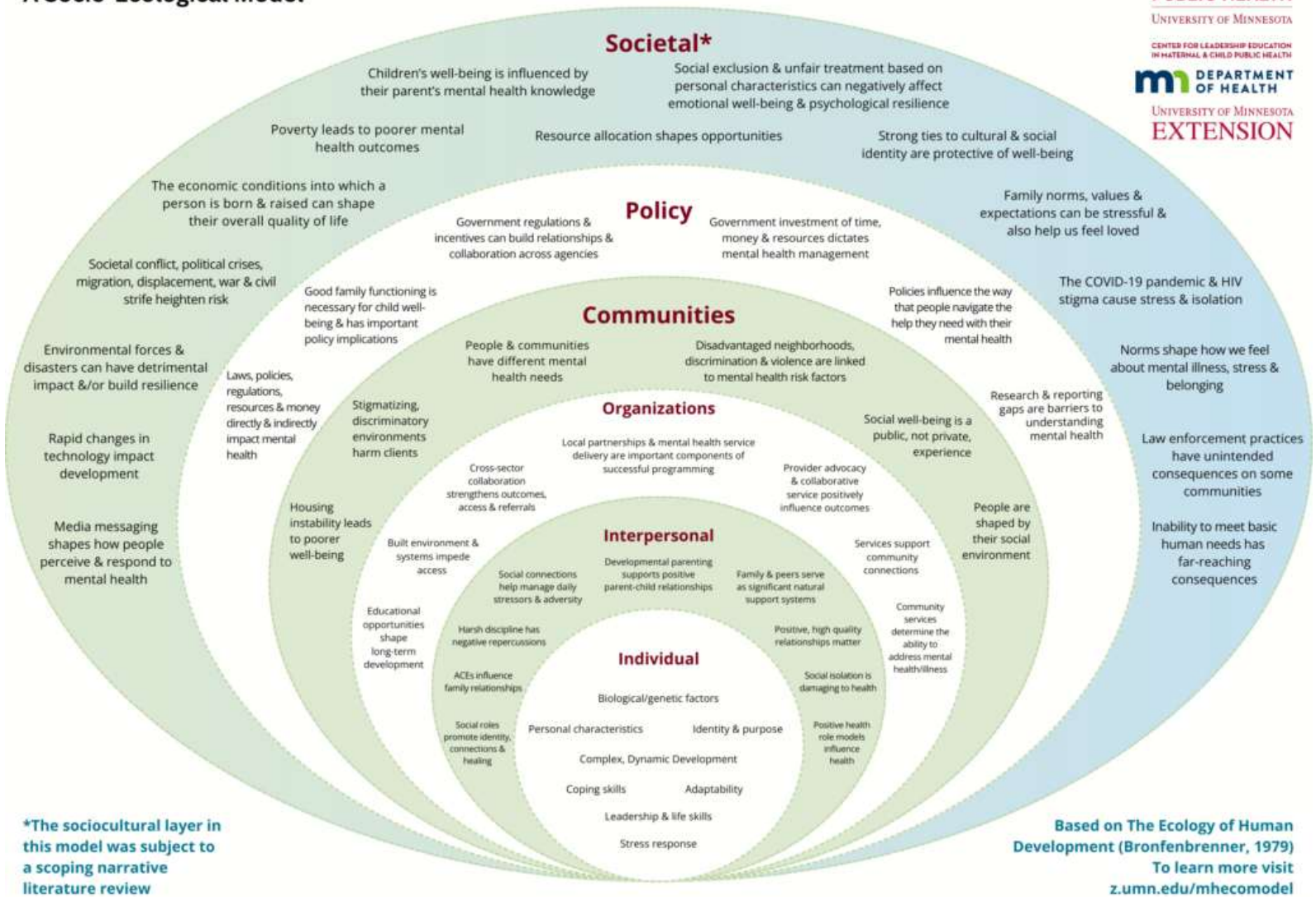
Could someone use it against me if I seek help?

Can I get off work or are hours outside of my work time?

Will this make a difference?

Can I pay for this?

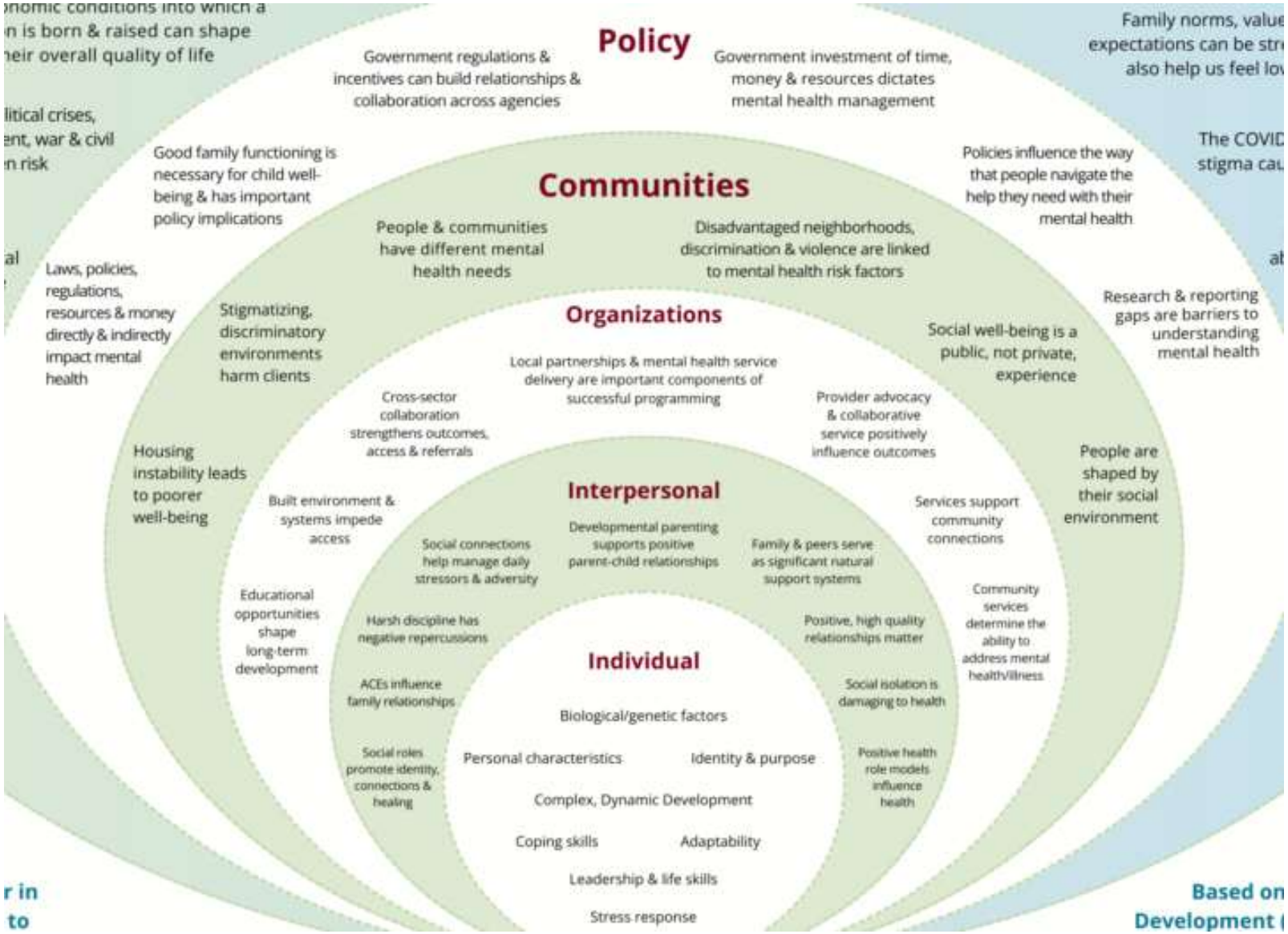
Mental Health & Well-being: A Socio-Ecological Model



SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF MINNESOTA
CENTER FOR LEADERSHIP EDUCATION IN MATERNAL & CHILD PUBLIC HEALTH
DEPARTMENT OF HEALTH
UNIVERSITY OF MINNESOTA EXTENSION

***The sociocultural layer in this model was subject to a scoping narrative literature review**

Based on The Ecology of Human Development (Bronfenbrenner, 1979)
To learn more visit z.umn.edu/mhecomodel


Policy
Government regulations & incentives can build relationships & collaboration across agencies
Government investment of time, money & resources dictates mental health management
Communities
Good family functioning is necessary for child well-being & has important policy implications
People & communities have different mental health needs
Disadvantaged neighborhoods, discrimination & violence are linked to mental health risk factors
Policies influence the way that people navigate the help they need with their mental health
Laws, policies, regulations, resources & money directly & indirectly impact mental health
Organizations
Stigmatizing, discriminatory environments harm clients
Local partnerships & mental health service delivery are important components of successful programming
Social well-being is a public, not private, experience
Research & reporting gaps are barriers to understanding mental health
Cross-sector collaboration strengthens outcomes, access & referrals
Provider advocacy & collaborative service positively influence outcomes
Housing instability leads to poorer well-being
Interpersonal
Built environment & systems impede access
Developmental parenting supports positive parent-child relationships
Services support community connections
People are shaped by their social environment
Social connections help manage daily stressors & adversity
Family & peers serve as significant natural support systems
Educational opportunities shape long-term development
Community services determine the ability to address mental health/illness
Harsh discipline has negative repercussions
Positive, high quality relationships matter
Individual
ACEs influence family relationships
Social isolation is damaging to health
Biological/genetic factors
Social roles promote identity, connections & healing
Personal characteristics
Identity & purpose
Positive health role models influence health
Complex, Dynamic Development
Coping skills
Adaptability
Leadership & life skills
Stress response

Community Engagement Institute

Examples of Mental/ Behavioral Health Support at a Systems Level

- Mental Health First Aid
- Resource navigation and support (CHW, Peer Support)
- Mental health literacy education at schools
- Programs to reduce loneliness and social isolation (newer field)
- Zero Suicide Toolkit implementation
- HOPE (Healthy Outcomes from Positive Experiences) training
- Medical and Behavioral Health Integration
- Routine Screening, Brief Intervention and Referral to Treatment (SBIRT)

Community Engagement Institute

What Has Been Shown to Work?

- Healthy People 2030- Evidence-Based Resources
- The Guide to Community Preventive Services
- County Health Rankings- What Works for Health
- AMCPH Innovation Hub
- SAMHSA Evidence-Based Practices Resource Center
- RAND Focus Areas

The Health Education (education) Lens

Questions?

Contact: Joanna Sabally at
joanna.sabally@wsu.edu

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Health Education Lens

Michelle Vann, ThD, DCC, MS
The Center

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Behavioral Health

Elizabeth Ablah, PhD, MPH, CPH
The University of Kansas School of Medicine - Wichita

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Mental Health, Mental Illness, Substance Use Disorder

Elizabeth Ablah, PhD, MPH, CPH

Professor of Population Health

University of Kansas School of Medicine-Wichita

Accomplished

- Conducted interviews about mental health and illness (n=81)
- Conducted community trainings about mental health and illness
  - Skills based training for interested individuals (n=25)
  - Skills based training for trainers (n=42)
  - Knowledge based training for community at large (n=926)
- Worked with partners to conduct training for 60 community health workers to improve knowledge and comfort with working with those who have mental illness

Accomplished

- Assessment of mental health organizations – what kind of workforce they need
- Directory of mental health professionals with experience, expertise
- Videos, resources

Mental Health Campaign

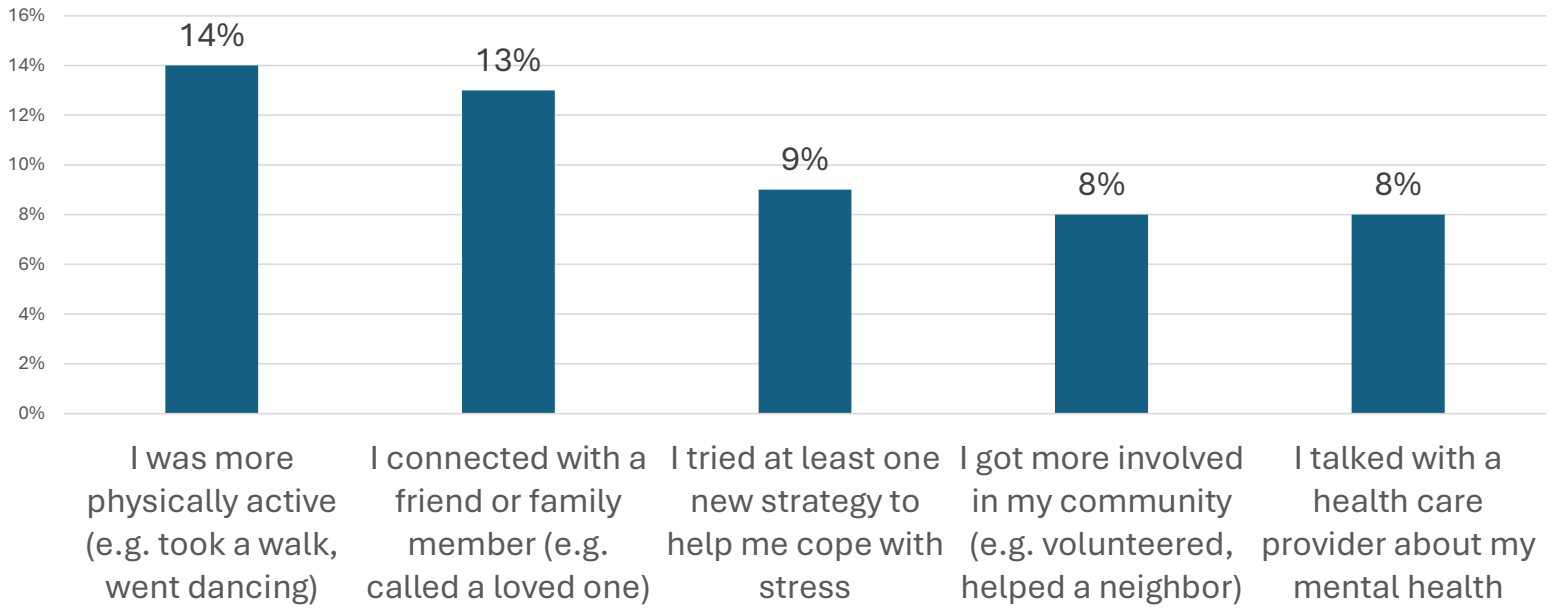
With quant and qual eval data

Community Mental Health Campaign

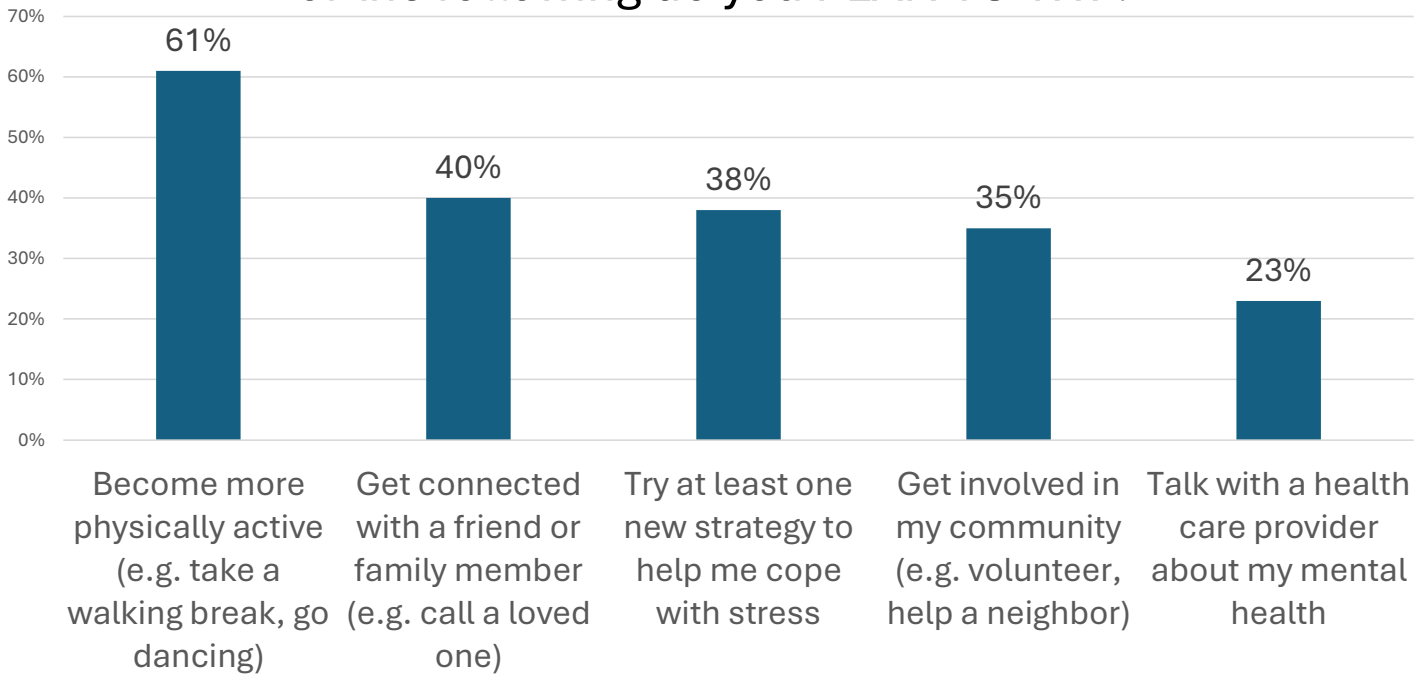
Community Mental Health Campaign (Spanish)

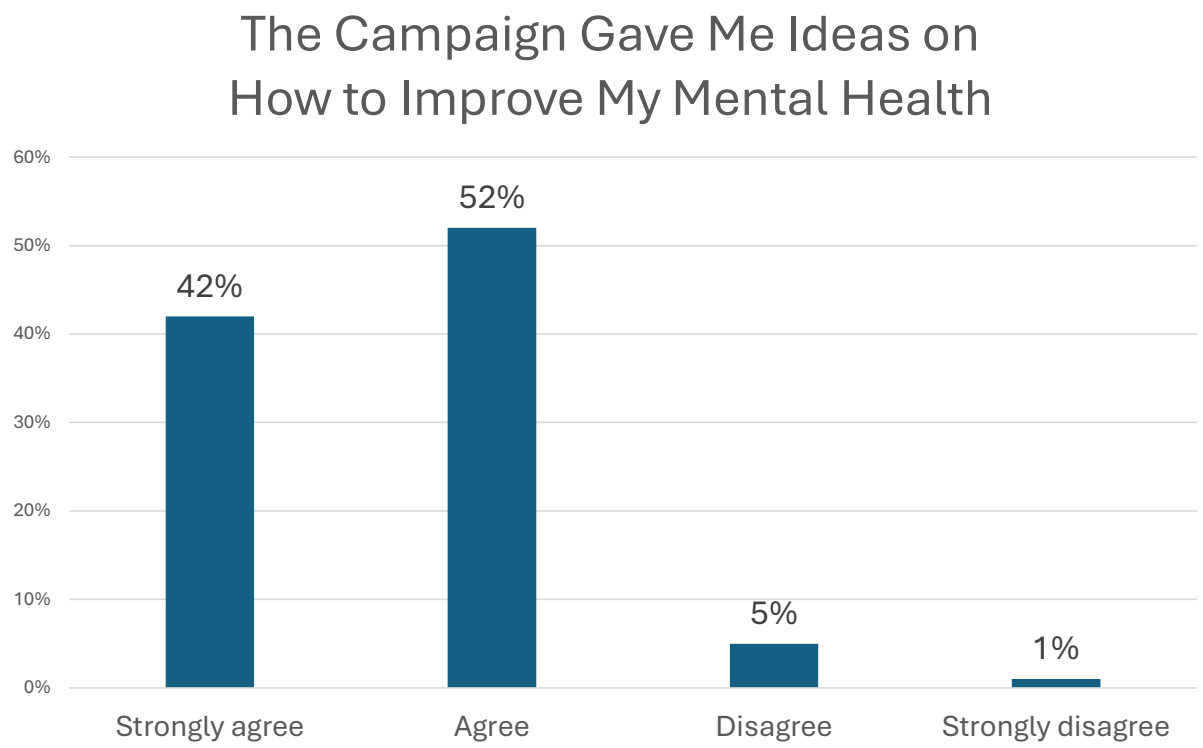
Community Mental Health Campaign (Vietnamese)

Between the first time you saw the campaign image and today, have you engaged in any of the following activities BECAUSE of the campaign?



Now that you have seen this campaign image, which of the following do you PLAN TO TRY?





Nearly all (94%, n=405) reported that the campaign had given them ideas on how to improve their mental health

Substance Use Disorder

Accomplished

- Conducted interviews about SUD (n=82)
- Conducted community trainings about SUD
  - Knowledge based training for community at large (n=429)
- Worked with partners to conduct training for 75 community health workers to improve knowledge and comfort with working with those who have mental illness and/or SUD

Accomplished

- Assessment of organizations serving those with mental illness and/or SUD – what workforce they need
- Directory of SUD resources
- Cost savings analysis of COMCARE and SACK services

Accomplished with SCHD

- Training of healthcare professionals
  - SBIRT (n= 141)
  - Clinical guideline regarding opioid prescription (n= 131)
- Training of public safety professionals
  - SBIRT (n= 592)

Accomplished with SCHD

Smaller studies/projects

- Distribution and use of naloxone
- Peer support
- Relationship between substance overdose and wastewater

In Process with SCHD

- Organizing work group teams
    1. Community health workers as wrap-around services in systems where needed (ED, criminal and legal, recovery housing, unhoused, pharmacies)

    2. Work for sustained integrated care
        - Address reimbursement rates
        - Address policy changes needed
        - Sales tax initiative

    3. Support re-entry

    4. Expand opportunities for diversion and treatment

    5. Advocate for increase in MAT prescriptions

    6. Improve service delivery post non-fatal overdose

    7. Community stigma reduction

SUD Health Literacy Campaign

91% (n=236) indicated that the campaign gave them ideas on how to reduce stigma about SUD

Stigma among Healthcare Professionals

Objectives

- Assess stigma
- Identify health professionals' barriers to caring for individuals with SUD
- Develop strategies to improve access to care

Partners

- Sedgwick County Medical Society
- DCCCA
- Kansas Board of Pharmacy
- Kansas Hospital Association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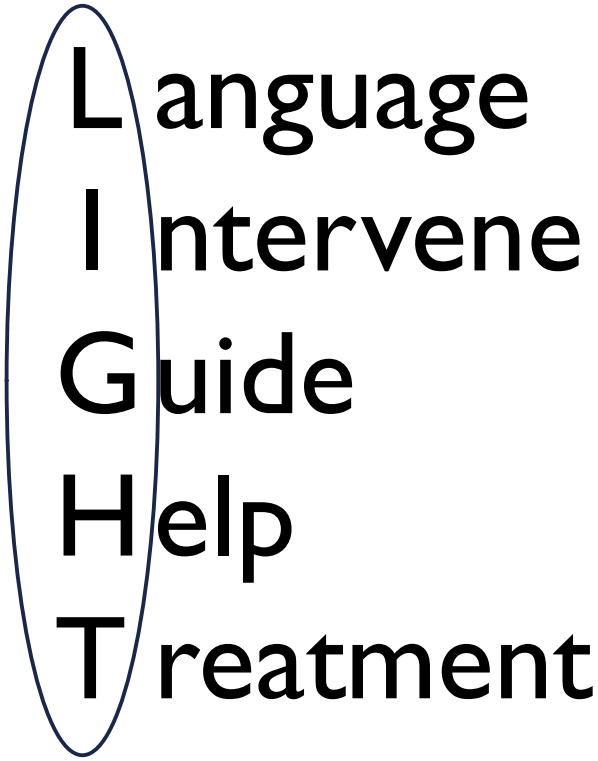
Watch later
Share
MORE VIDEOS
0:57 / 1:57
YouTube

Be the LIGHT



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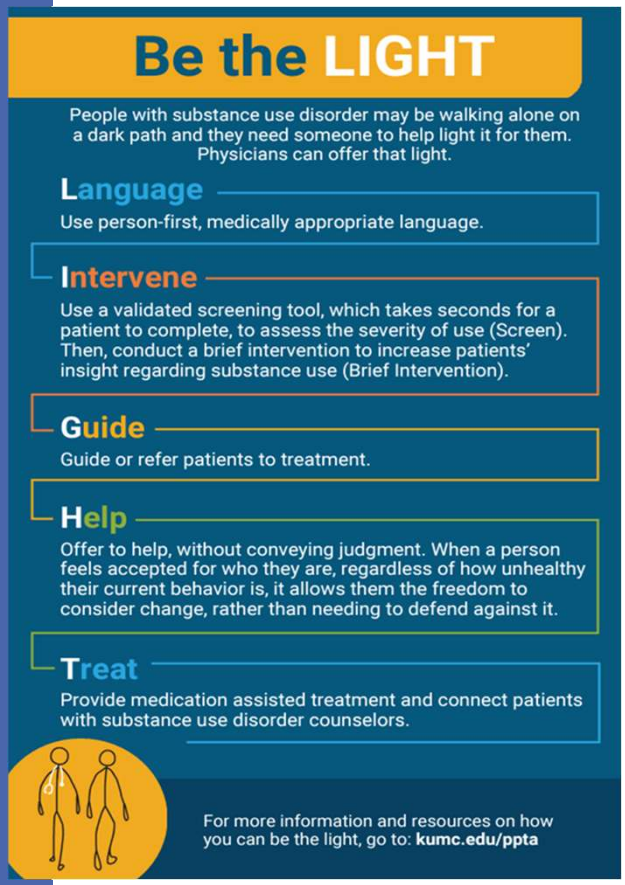

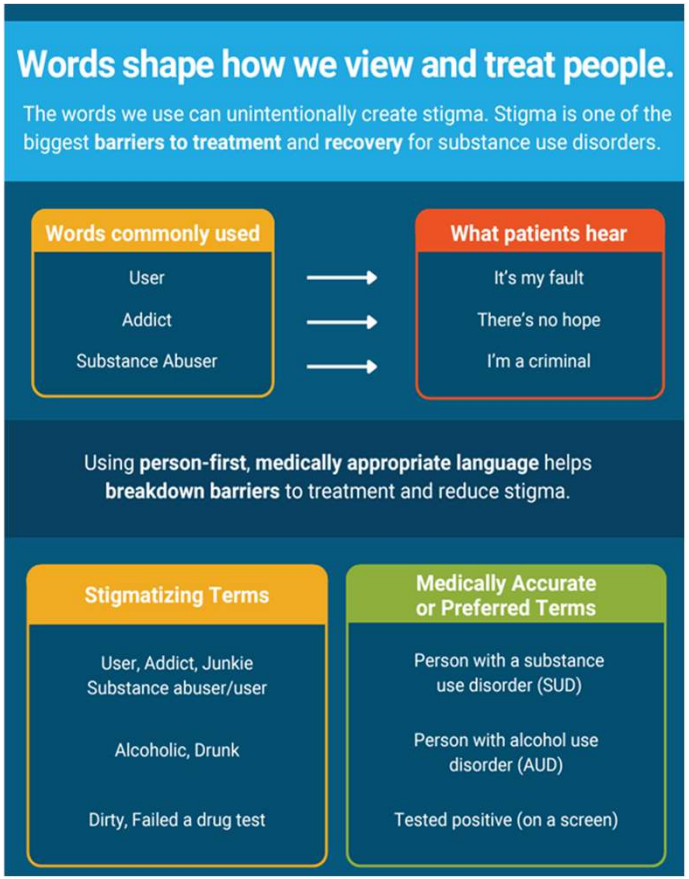

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Validated Screening Tools

Brief health screen

We ask all our adult patients about substance use because it can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

How many times in the past year have you had **4** or more drinks in a day? _____

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? _____

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Validated Screening Tools

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for alcohol use? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W, GM, ≥65:	0-3	4-12	13-19	20+

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Validated Screening Tools

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

_____

_____

☐ methamphetamines (speed, crystal)
☐ cannabis (marijuana, pot)
☐ inhalants (paint thinner, aerosol, glue)
☐ tranquilizers (valium)
☐ cocaine
☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ hallucinogens (LSD, mushrooms)
☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you always able to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+

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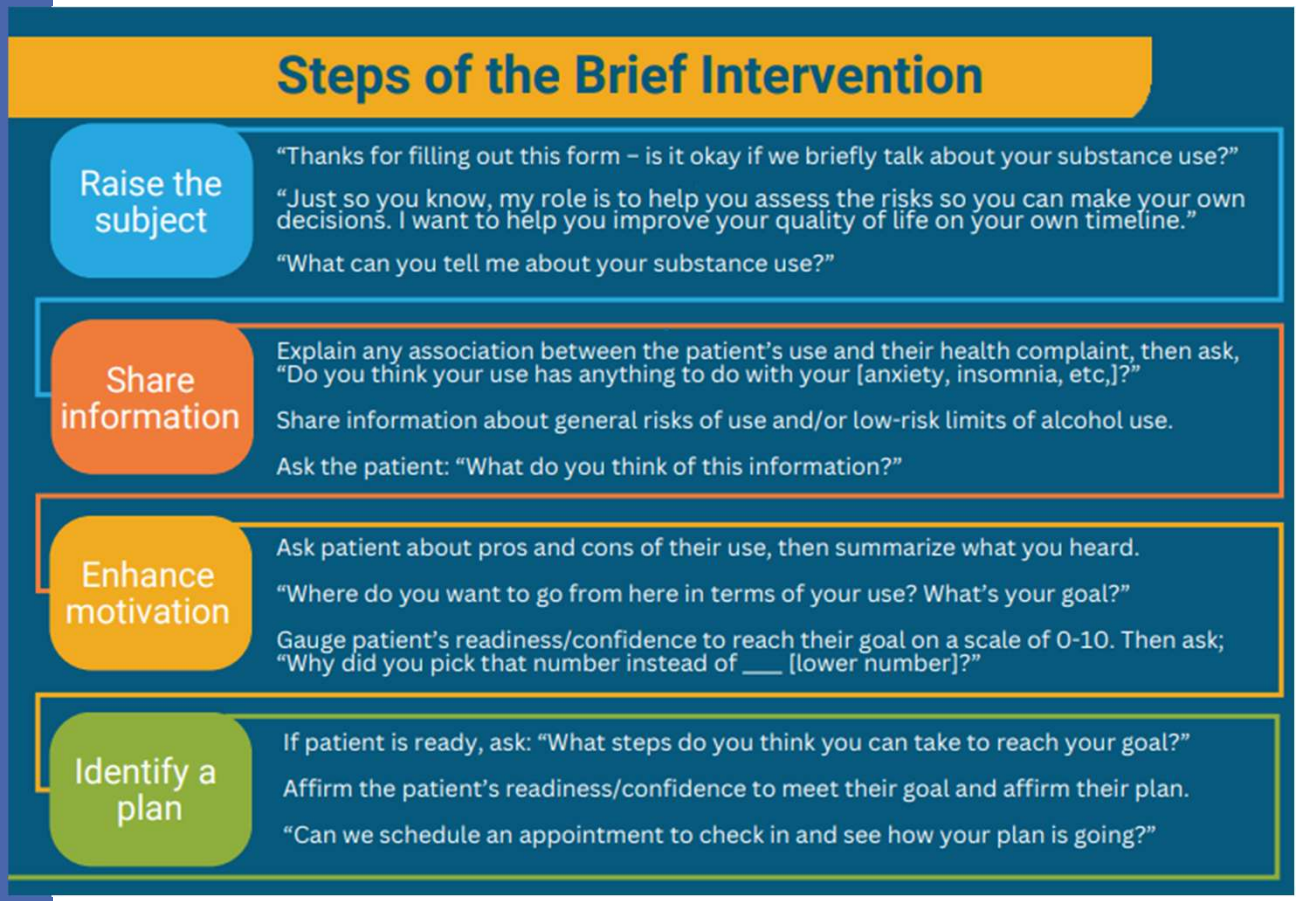

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Video – Early Interventions

Chad Harmon (CEO, Substance Abuse Center of Kansas) discusses screening and early inventions for substance use disorder. Someone with lived experience describes the importance of such an intervention.

Language Intervene Guide Help Treatment

State of Kansas Directory coming soon!

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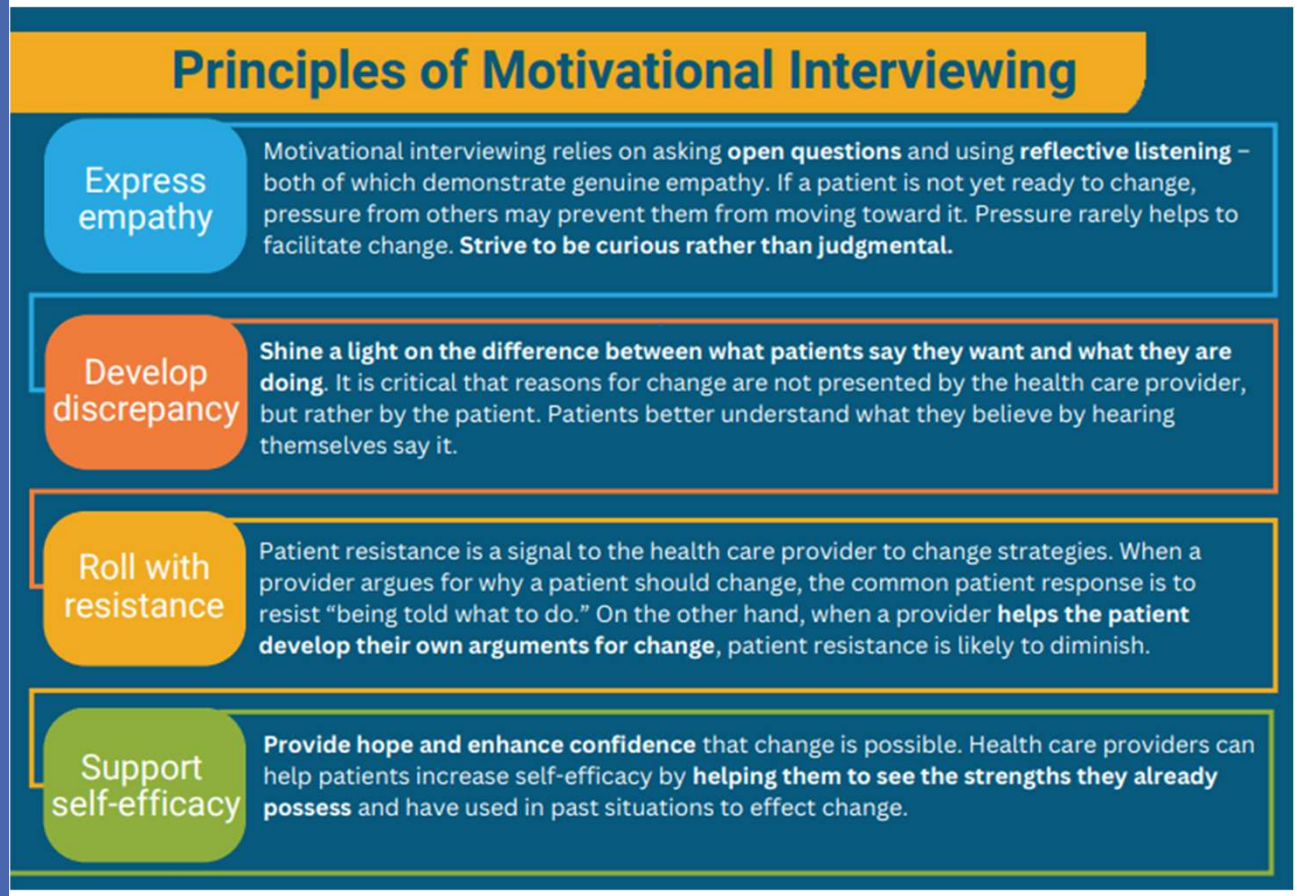
Motivational Interviewing Quick Reference Guide



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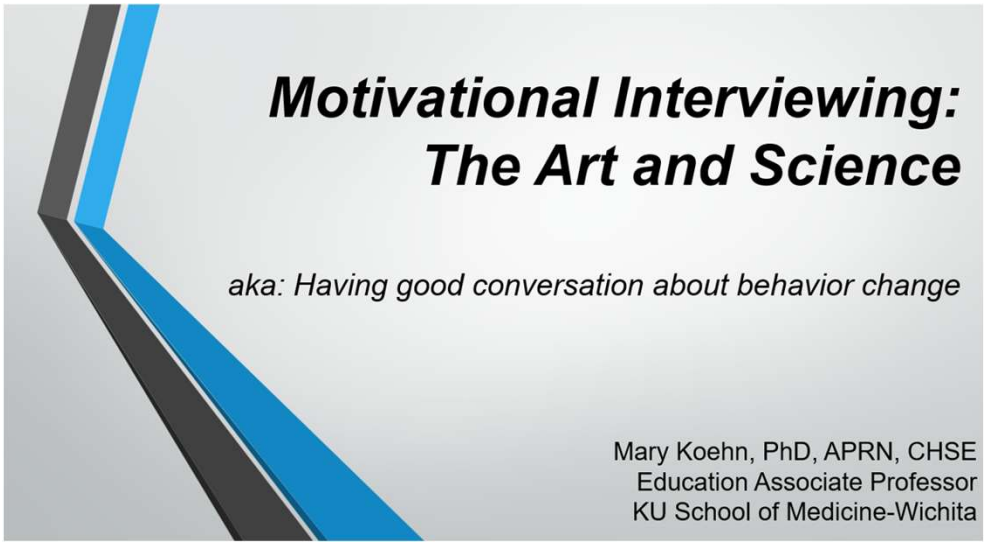
Video – Motivational Interviewing



Dr. Mary Koehn describes theory and evidence associated with motivational interviewing and explains communication strategies to promote behavioral change.

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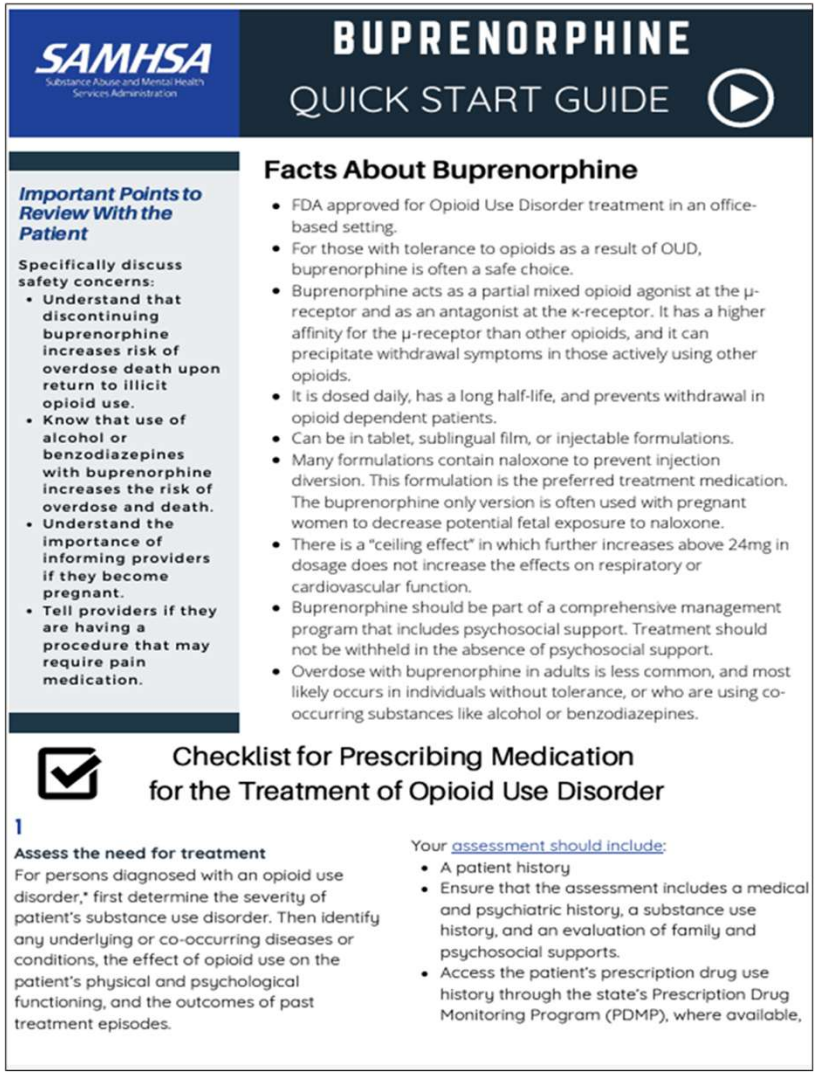

SAMHSA
Substance Abuse and Mental Health Services Administration

BUPRENORPHINE
QUICK START GUIDE

Important Points to Review With the Patient

Specifically discuss safety concerns:

- **Understand that discontinuing buprenorphine increases risk of overdose death upon return to illicit opioid use.**
- **Know that use of alcohol or benzodiazepines with buprenorphine increases the risk of overdose and death.**
- **Understand the importance of informing providers if they become pregnant.**
- **Tell providers if they are having a procedure that may require pain medication.**

Facts About Buprenorphine

- FDA approved for Opioid Use Disorder treatment in an office-based setting.
- For those with tolerance to opioids as a result of OUD, buprenorphine is often a safe choice.
- Buprenorphine acts as a partial mixed opioid agonist at the μ-receptor and as an antagonist at the κ-receptor. It has a higher affinity for the μ-receptor than other opioids, and it can precipitate withdrawal symptoms in those actively using other opioids.
- It is dosed daily, has a long half-life, and prevents withdrawal in opioid dependent patients.
- Can be in tablet, sublingual film, or injectable formulations.
- Many formulations contain naloxone to prevent injection diversion. This formulation is the preferred treatment medication. The buprenorphine only version is often used with pregnant women to decrease potential fetal exposure to naloxone.
- There is a "ceiling effect" in which further increases above 24mg in dosage does not increase the effects on respiratory or cardiovascular function.
- Buprenorphine should be part of a comprehensive management program that includes psychosocial support. Treatment should not be withheld in the absence of psychosocial support.
- Overdose with buprenorphine in adults is less common, and most likely occurs in individuals without tolerance, or who are using co-occurring substances like alcohol or benzodiazepines.

Checklist for Prescribing Medication for the Treatment of Opioid Use Disorder

1

Assess the need for treatment

For persons diagnosed with an opioid use disorder,* first determine the severity of patient's substance use disorder. Then identify any underlying or co-occurring diseases or conditions, the effect of opioid use on the patient's physical and psychological functioning, and the outcomes of past treatment episodes.

Your assessment should include:

- A patient history
- Ensure that the assessment includes a medical and psychiatric history, a substance use history, and an evaluation of family and psychosocial supports.
- Access the patient's prescription drug use history through the state's Prescription Drug Monitoring Program (PDMP), where available,

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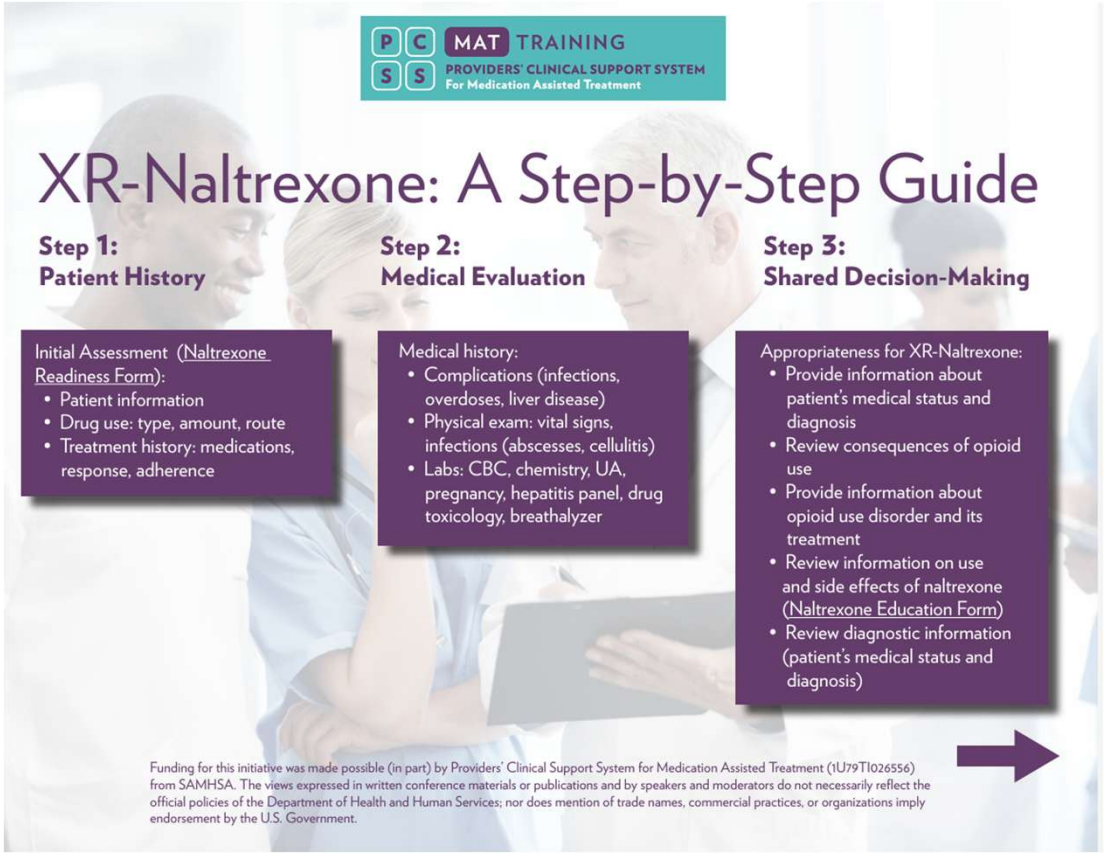

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Medication Assisted Treatment (MAT) Videos

We partnered with Dr. Tim Scanlan to develop two videos.

Video #1 – Dr. Scanlan discuss what **you can expect as a physician** when you provide medication assisted treatment (MAT).

Video #2 – Dr. Scanlan explains **what patients can expect** when they begin medication assisted treatment (MAT).

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Behavioral Health

Jennifer Wilson, LMSW, COMCARE of Sedgwick County

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Behavioral Health

COMCARE of Sedgwick County

Jennifer Wilson, LMSW

Director of Crisis Services

COMCARE
A Certified Community Behavioral Health Clinic

Core Services:

- Required to be provided through Evidence Based Practices

24-Hour Mobile Crisis	**Outpatient Clinic Primary Care Screening and Monitoring**
Emergency Crisis Intervention/ Stabilization	Treatment Planning
Outpatient Mental Health	Substance Use Services
Screening, Diagnosis & Risk Assessment	Targeted Case Management Services
Psychiatric Rehabilitation	Peer/Family Support
Peer Counseling	**Mental Health for Armed Forces/Veterans**

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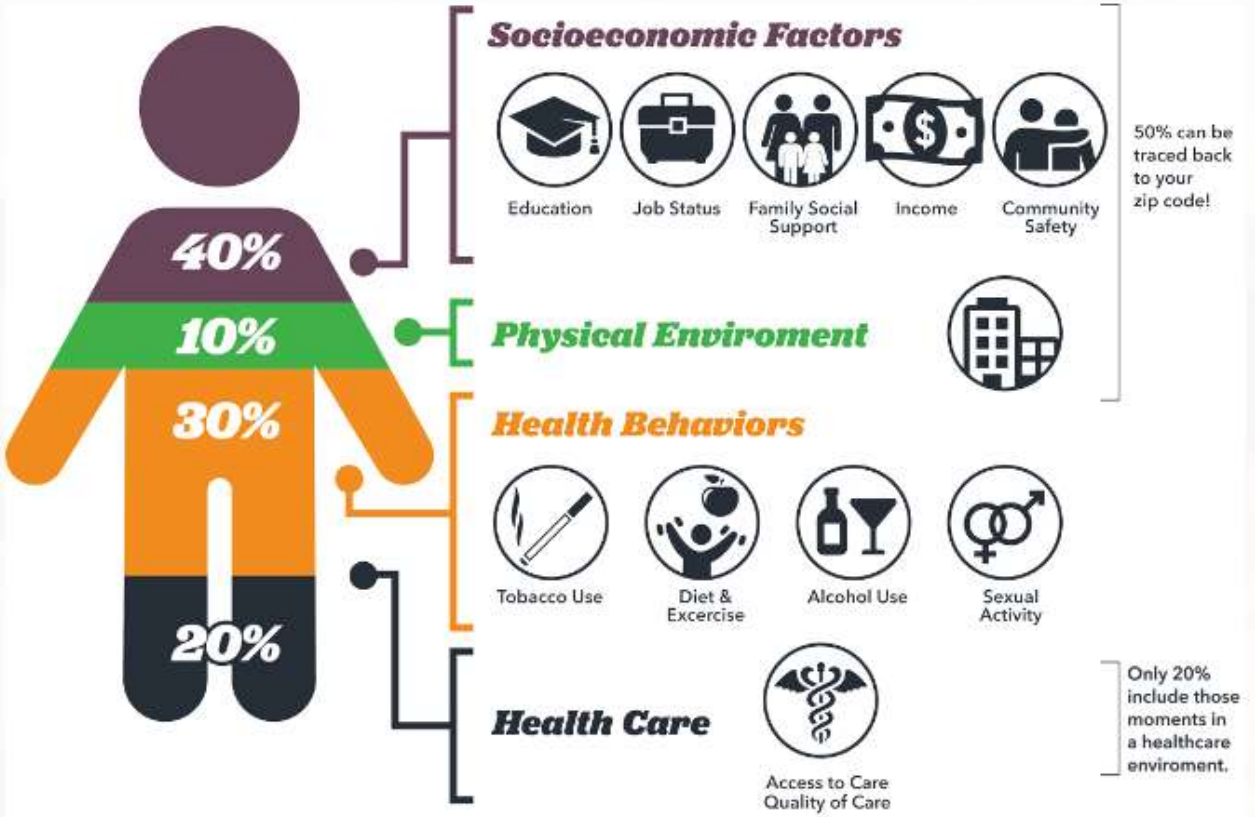
Did you know?

By removing barriers, we increase our patients' overall health. Our patients deserve Health Equity

80% Did you know...that 80% of what makes up someone's health is determined by what happens outside of the hospital and health clinic? Of the 80%, the largest segment is made up of the "Social Determinants of Health" or "Socioeconomic Factors".



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

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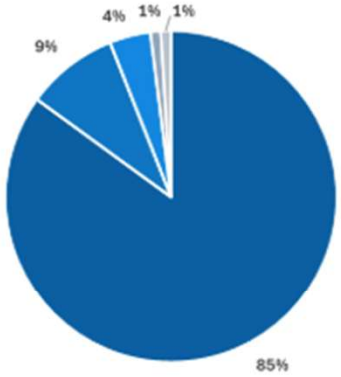
REVENUE STREAMS
2025

Payor Mix

How do COMCARE patients pay for their care?



85%	Medicaid
9%	Self Pay
4%	Commercial
1%	State Funded
1%	Medicare
<1%	Contractual

Funding Streams

How is COMCARE funded?

65%	Encounter/Service Rate	3%	State Grants
16%	State Funds	3%	Federal Funds
7%	County Support	1%	Housing Grants
5%	Misc. Contracts	>1%	Special Alcohol Funds

SEDGWICKCOUNTY.ORG

Increased capacity allowed COMCARE to serve more patients, and to serve them faster

Children

861 served in 2022.
1,710 served in 2024.

Average number of days from call to initial evaluation decreased from 14 days to less than two days.

Adult

1,651 served in 2022.
1,776 served in 2024.

Average number of days from call to initial evaluation decreased from one day to less than half a day.

Addiction Treatment Services

372 served in 2022.
509 served in 2024.

Average number of days from call to initial evaluation decreased from 36.5 days to less than an hour.

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COMMUNITY PARTNERSHIPS
2023-2025

Care Coordination

Agency-wide Care Coordination Activities

1st Quarter 2024- 1,830 activities

1st Quarter 2025- 5,958 activities

This means more people are being connected to food, housing, primary health care, and more!

Original Partners

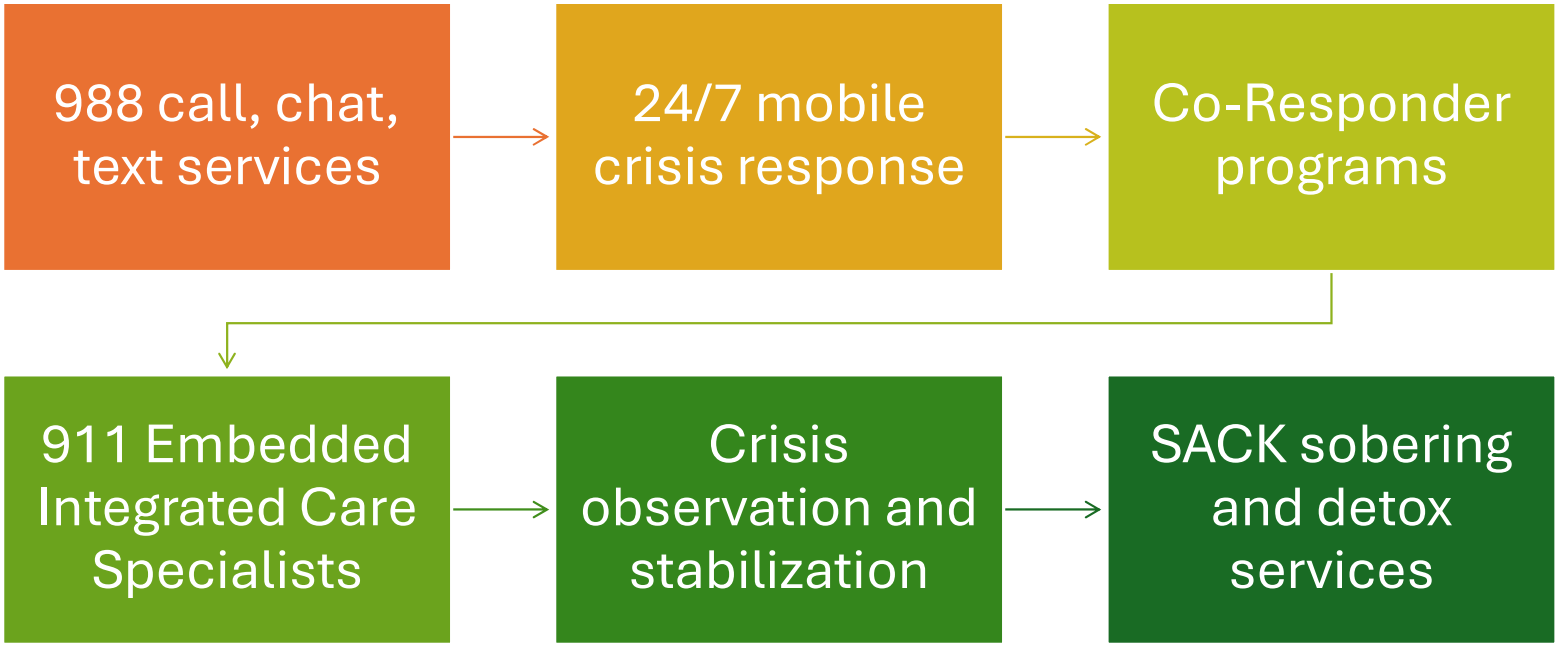
Schools: USD 259 (36), Maize (7), Derby, Mulvane (2), and Valley Center (2)
Foster Care Facilities: St. Francis, KVC, TFI, and Cornerstones
Law Enforcement Agencies: Sheriff, Corrections, and City PD
Hospitals: Via Christi, Wesley, and St. Joe
State Hospitals: KVC, OSH
Physical Health Providers: Hunter Health and Grace Med
Providers: SACK, MHA, and Behavioral Link
Housing: City of Wichita and Human Kind
Veterans: KS National Guard, KS Army National Guard, KS Air National Guard, and Dole VA
Other Partners: NAMI, CMHCs (25), KDADS, and Association of CMHC

New Partnerships Since Jan 2023

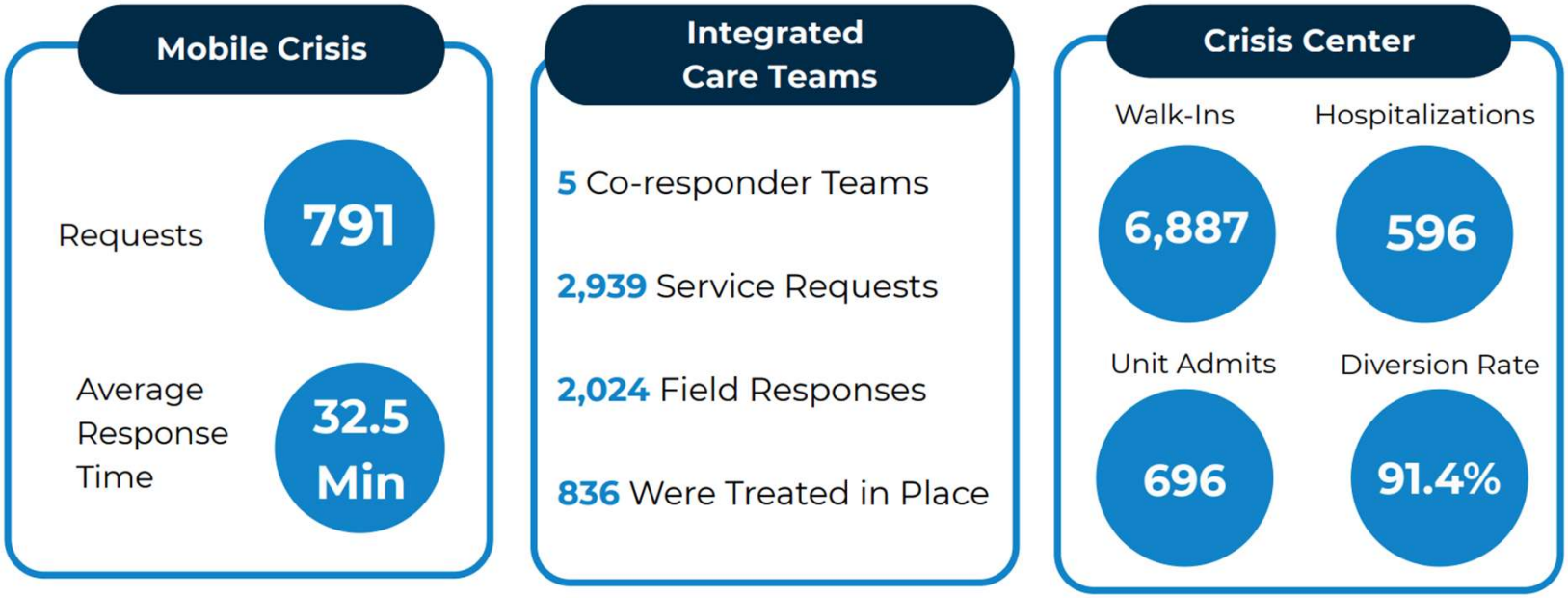
From 99 to 114 partnerships

Schools: Valley Center (4), Maize (1)
Foster Care Facility: Ember Hope
Physical Health Providers: Sedgwick County Health Department
Providers: DCCCA and JayDoc Community Clinic
Housing: Union Rescue Mission, Wichita Children's Home, and 2nd Light
Other Partners: Hart Pharmacy
Care Coordination Provider: Unite Us
Universities: Newman University and Wichita State University

Crisis Services



Crisis and Mobile Response 2024



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Crisis Expansion Goals

- Design a facility that consolidates all staff and services within a single, cohesive location.
- Develop an environment that is welcoming and comfortable for patients, ensuring they have the space necessary for a positive experience.
- Transition services from a residential facility to a Crisis Intervention Center, a new level of care for Sedgwick County.
- Establish a workplace that equips staff with the resources needed to effectively perform their roles, along with designated spaces for rest and rejuvenation.

Future Focus

CARE COORDINATION/COMMUNITY PARTNERSHIPS

CARE FOR UNINSURED AND UNDERINSURED

GROWING SENIOR POPULATION

Future Focus-Care Coordination

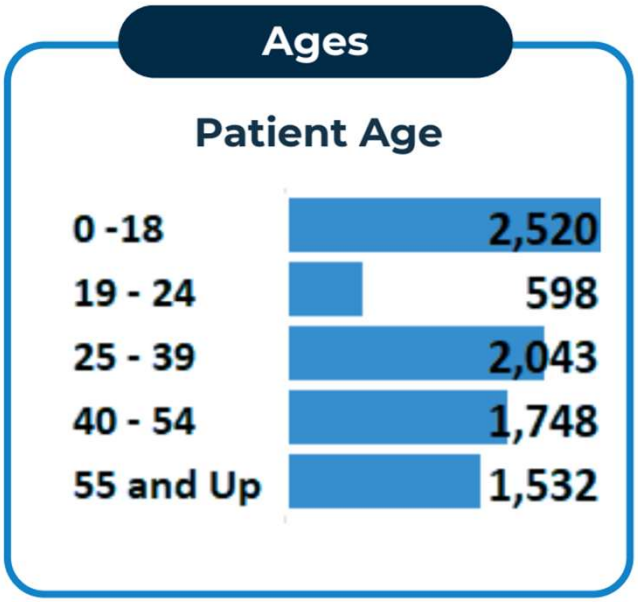
- 7 added Care Coordinators
  - 2- Second Light
  - 1- Mobile Care Coordination
  - 1- 988 Follow Up
  - 1- Coordination of Follow up after ER/Hospitalization
  - 1- Drug Court
  - 1- Housing Support
- How can we track and document success?

Future Focus-Uninsured/Underinsured

- No current medical detox options for patients without private insurance.
- No current reimbursement options for MAT, testing, and behavioral health medications
- Benefits applications-initial and renewal applications

Future Focus-Aging Population

COMCARE demographics by age



Sedgwick County Data

- 16.3% of the population is 65 or older
- While there are services, **access can still be a barrier**: older adults may face mobility issues, limited ability to pay, or lack of awareness of community mental health services.
- **Comorbidity**: Older adults often have multiple health conditions (chronic illnesses, mobility issues) — mental health problems like depression or anxiety can worsen physical health outcomes, reduce adherence to treatment, and increase hospitalization risk.
- Increased demand on the healthcare system
- Financial challenges (reimbursement rates, workforce challenges, complex care)

SEDGWICKCOUNTY.ORG

Questions?

COMCARE

A Certified Community Behavioral Health Clinic

SEDGWICKCOUNTY.ORG

Education

Brad Richards, Wichita State University

SEDGWICK COUNTY
Health Department

Wichita Collective Impact

Mission & Vision

Our Mission

Wichita Collective Impact connects people, organizations, and resources to improve Kindergarten Readiness and 3rd grade reading proficiency to increase economic prosperity in the 67214 ZIP code.

Our Vision

To build a future where every child in our communities has the foundation to thrive academically and economically, driven by collaborative efforts, innovative programs, and evidence-based solutions.

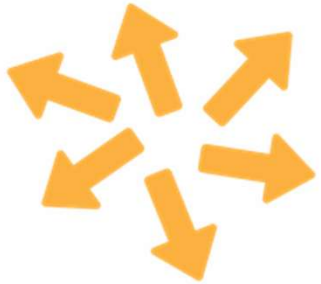
Guiding Principles

- **Built by Trust:** We develop trust through collaboration and partnerships to align resources for sustainable success
- **Focused on Community:** We commit to empowering community voices and prioritizing community needs
- **Informed by Data:** We will use data-driven decision making as well as storytelling to inform and strengthen WCI efforts and initiatives
- **Committed to Dignity:** WCI will focus on opportunities and growth, with all efforts and storytelling focused on dignity and hope through asset-based language
- **Promoters of Positivity:** We will celebrate wins, efforts, advances, and other work by the collective and community
- **Aligned for Impact:** We will align our strategies, resources, and outcomes for greater impact

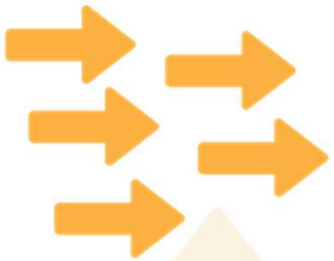
Collective Impact vs. Other Efforts

A Collective Impact approach brings together organizations and people who are already doing the good work to collectively use their resources to achieve better outcomes.

Disorder & Confusion
Limited Impact



Individual Impact
In Isolation



Coordinated Impact
With Alignment

Collective Impact
With Collaborative Action

Five Conditions of Collective Impact

Mutual Activities

Common Agenda

Shared Measurement

Backbone Support

Continuous Communication

Local Organizations Working Together

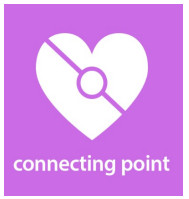
Cargill
Lead private sector funder

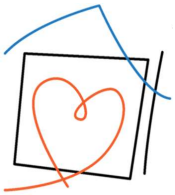
Greater Wichita YMCA
Programming & community coordinator at school site

Wichita Public Schools
Academic & strategic direction

Public Policy & Management Center
Research, evaluation, & engagement assistance

Wichita Collective Impact Partners





Working Together as a Community

Organizations across the community are working together to align with USD 259 goals.
(USD 259 goal updates are incorporated into WCI goals as available)

-3.5%

Decrease the percentage of students below benchmark on 3rd grade aReading.
(from 56.5% to 53%)

Partnership Types and Structure

- **Data Partners** – provide access to relevant datasets, information sources, and data infrastructure
- **Program Partners** – Community organizations that are willing to align programming efforts with USD 259 and WCI goals
- **Community Partners** – Community organizations that align with the overarching work and provide critical resources
- **Philanthropy Partners** – Provide funding or assist with resource needs
- **Statement of Support** – Individuals, businesses, or others who commit to support WCI efforts

Benefits of Partnership

- Collaborative Success
- Community Impact
- Access to Resources
- Data-Driven Decision Making
- Positive Community Engagement

Why Are We Intervening?

The importance of early milestones

Critical Pathways within Literacy

Kindergarten Readiness

3rd Grade Reading

Why Kindergarten Readiness

- **The Risk Gap Starts Early**
  - 50% of risk gaps already exist at kindergarten entry (Annie E. Casey Foundation, 2021)
  - Risk factors include:
    - Lower resource access
    - Non-English primary language
    - Parental education level (American Academy of Pediatrics, 2019)
  - **Risk gaps widen during first 4 years of school** (American Academy of Pediatrics, 2019)

Why 3rd Grade Literacy

- Kindergarten readiness scores *directly predict* 3rd grade success (Applied Survey Research, 2017)
- Students who meet grade level standards in 3rd grade are less likely to struggle in 4th grade and beyond (Stanovich, 2009)
  - 4th grade marks the transition between learning to read and reading to learn
  - Students who achieve grade-level literacy standards by 3rd grade are better equipped to succeed in future learning in reading, math, social studies, science, and beyond

Impact of Missing Key Milestones

Children who are not reading at grade level by the end of third grade are **four times less likely** to graduate from high school.

Children who are **both under-resourced AND not reading** at grade level by the end of third grade are **13 times less likely** to graduate from high school.

Future Implications of Low Literacy

- **Economic and Workforce Development**
  - Lower likelihood of being full-time employed by age 30
  - More likely to be in low-skilled or semi-skilled roles
- **Health and Well-Being**
  - Worse health outcomes for adults with low literacy
    - Affects both physical and mental health
    - Higher incidence of chronic illness
  - Children of low-literacy adults also have worse health outcomes

Where Are We Investing?

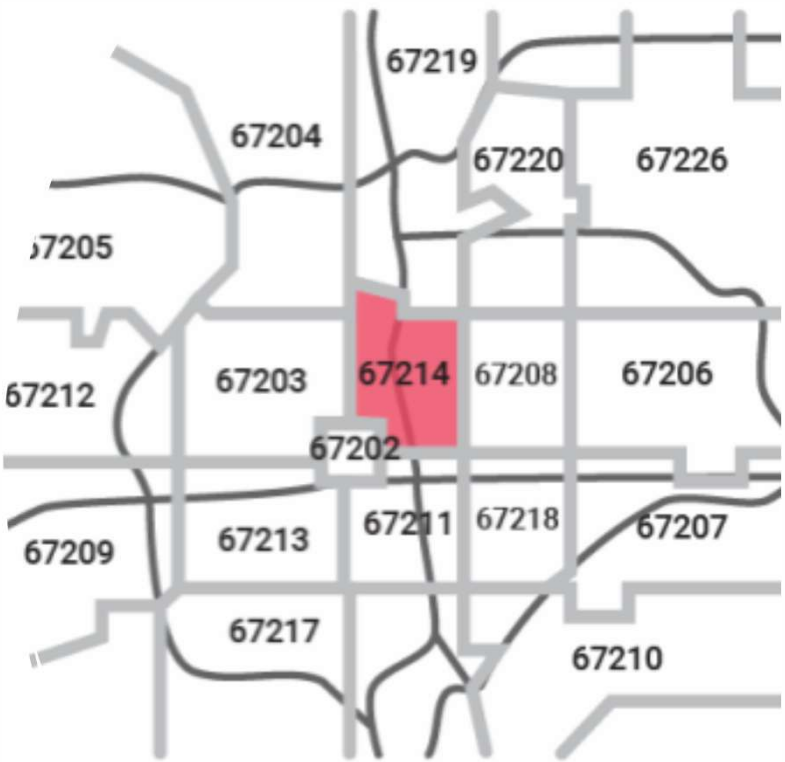
67214 Zip Code

SG1

Why 67214?

Under-resourced, disinvested communities result in disparities in income, employment, high school attainment, and access to healthcare and health coverage in the 67214 Zip Code

- **38%** of households below the poverty level
- **55%** employment (ages 16+)
- **24%** did not complete high school (ages 25+)
- **33%** of people 5+ speak a language other than English at home



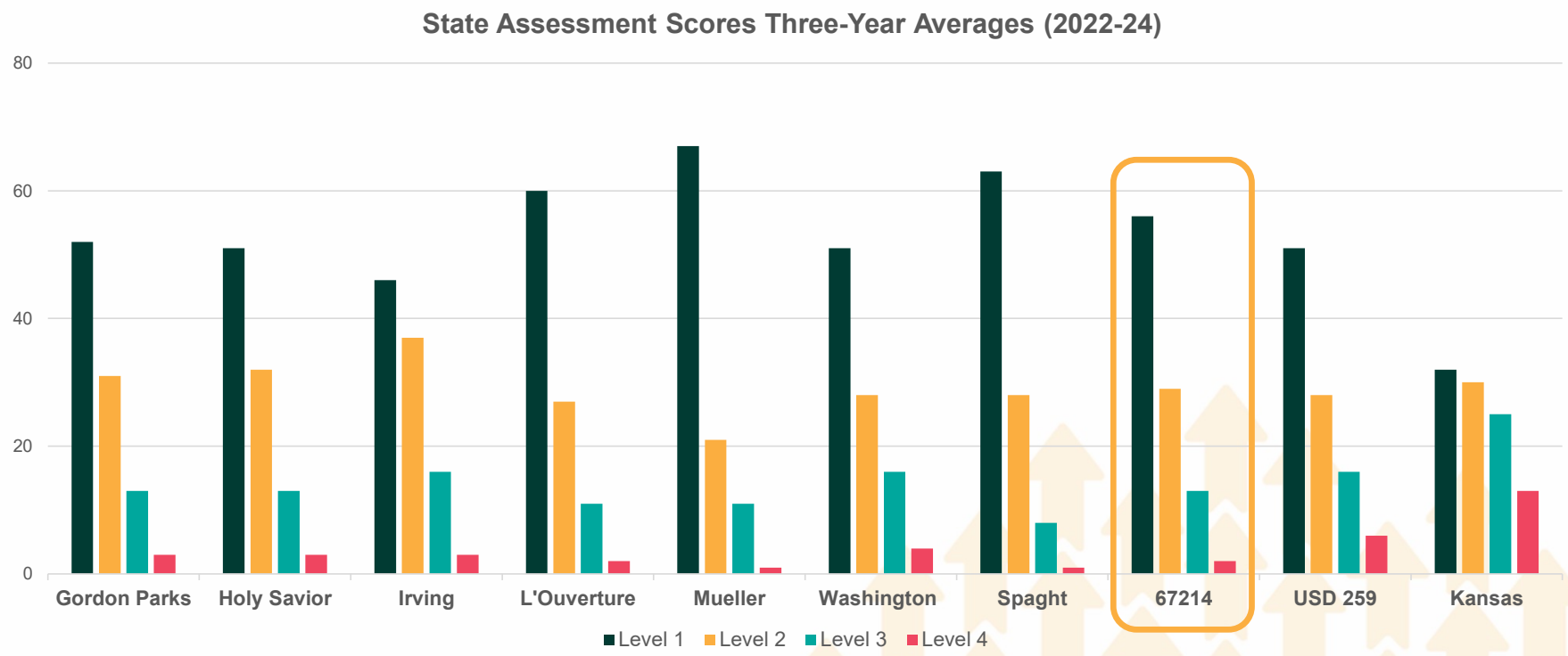
Slide 98

SG1 Source
Gooding, Sarah, 2025-02-12T21:11:42.687

SG1 0 Is this updated?
Gooding, Sarah, 2025-05-22T19:50:01.534

SG1 1 Let’s add sources to the notes on this slide so we can check and ensure updates periodically
Gooding, Sarah, 2025-06-09T15:43:47.073

3rd Grade Reading in 67214



Spaght Elementary: 3rd Grade Reading

On average, from 2022-2024, **63%** of Spaght students in 3rd grade tested with limited mastery of grade level standards.

Spaght Level 1

2022:	68%
2023:	63%
2024:	58%
3 year average:	63%

What Are We Doing Differently?

Partnering for data-driven results

Summer Programs

Summer 2023

- Average scores increased on every literacy measure across all grades
- 94% of students showed improvement

Summer 2024

- 90% of students improved or maintained their literacy measures
- 80% of enrolled students were retained through the entire summer program

Students. Together. Afterschool. Reading Program (S.T.A.R)

STAR- Students Together Afterschool Reading

WHO: Spaght 3rd Graders

DATE: Starts September 9th, Tuesdays Wednesdays & Thursdays

TIME: 4:10PM -5:15PM

LOCATION: Spaght Magnet Elementary

The STAR Program is designed for 3rd graders to help them shine on their literacy journey! Each day, students enjoy:

- ENGAGING READING EXERCISES
- FUN LITERACY ACTIVITIES
- A QUICK GAME TO KEEP THINGS LIVELY
- A HEALTHY SNACK TO REFUEL

Our mission is to support students in reaching 3rd grade State Reading Standards, as well as building strong foundations for future success in school—and in life!

Let your child's reading skills shine with STAR!

Contact Sandy Kimball at sandy.kimball@ymcawichita.org with questions.

GREATER WICHITA YMCA | ymcawichita.org | #FORALL /ymcawichita /greater_wichita_ymca

Kindergarten Readiness

KINDERGARTEN READY

WICHITA COLLECTIVE IMPACT

Preparing children aged 2-5 for kindergarten through the lens of the Kansas Early Learning Standards involves fostering a range of skills across several developmental domains. Here are the top 10 skills:

1. **SOCIAL SKILLS:** Interact positively with peers and adults including sharing, taking turns, and cooperating in group settings.
2. **EMOTIONAL REGULATION:** Recognizing and managing their emotions and expressing feelings appropriately.
3. **LANGUAGE DEVELOPMENT:** Expanding vocabulary and effectively communicating needs and ideas.
4. **EARLY LITERACY SKILLS:** Recognizing letters and sounds and engaging with books through storytelling and discussions.
5. **MATHEMATICAL THINKING:** Identifying numbers, shapes, and patterns.
6. **CRITICAL THINKING AND PROBLEM-SOLVING:** Asking questions, exploring, and finding solutions through hands-on activities and play.
7. **FINE MOTOR SKILLS:** Developing hand-eye coordination through activities like drawing, cutting, and manipulating small objects.
8. **GROSS MOTOR SKILLS:** Participating in physical activities that enhance balance, coordination, and overall physical fitness, such as running, jumping, and climbing.
9. **CREATIVE EXPRESSION:** Engaging in art, music, and imaginative play, which allows children to express themselves and think creatively.
10. **UNDERSTANDING OF HEALTH AND SAFETY:** Learning basic hygiene practices (like handwashing) and safety rules, promoting awareness of personal health and well-being.

These skills align with the Kansas Early Learning Standards and help create a strong foundation for children as they transition into the kindergarten environment.

Cargill · the YMCA · Wichita State University Public Policy and Management Center · Wichita Public Schools

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WICHITA COLLECTIVE IMPACT

Cargill · WICHITA PUBLIC SCHOOLS · Wichita State University Public Policy and Management Center · the YMCA

BEE K-READY

JUNE 3-26, 2025

Tuesdays and Thursdays, 5:30-7:00PM

Downtown YMCA - Community Room

For Parents and Children Ages 3-5

Let's get our kids BEE K-Ready for school with EIGHT FREE sessions for parents and kids focused on becoming kindergarten ready! K-ready professionals from USD 259 will help us know what kids should be doing now to be ready for their first day of class and beyond. Sign up with this QR Code so your child can BEE – Kindergarten ready!

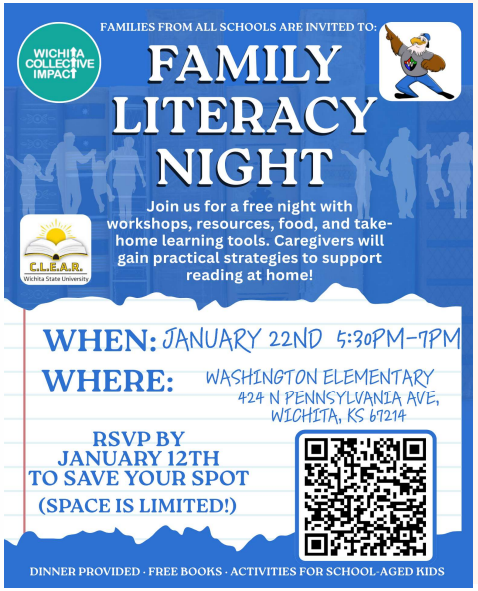
Please come dressed ready to move. (jeans, sweatpants, athletic wear)

Attend all eight sessions and receive a $50 Dillon's gift card!

REGISTER BY MAY 19

/WichitaCollectiveImpact /Wichita.Collective.Impact

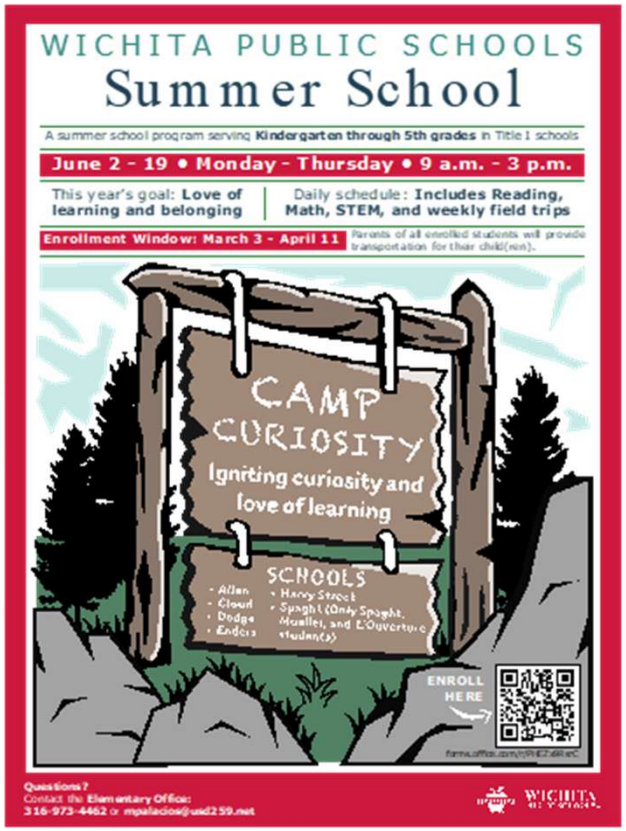
WCI Family & Community Engagement



WCI Goals for S.T.A.R Program

15% fewer students at Spaght in "Level 1: Limited mastery of third grade level standards."

Summer Programs 2025



Collective Impact with Wichita Public Library


Questions?

Contact Us

Are you interested in joining Wichita Collective Impact or do you want more information? **Contact Brad**.

brad.richards@wichita.edu

Want more information about WCI programming at Spaght? **Contact Tyrone.**

tyrone.baker@ymcawichita.org

Stay Connected

Facebook

@WichitaCollectiveImpact

Twitter

@Wichita_Impact

Instagram

@Wichita.Collective.Impact

Discussion Question

Which parts of the programs we talked about seem most helpful for improving literacy based on the data you saw?

Are there any parts that don't seem to match the needs as well?

Discussion Question

How do you think our community activities affect people's trust in our organization, especially when it comes to helping with literacy?

What could make that trust stronger or weaker?

Discussion Question #1

What are your thoughts on how well these statements align with or address the problem as you understand it?

5-8 minute break

What we heard last session:
Family Centered Approach

Supporting parents and caregivers as children's first teachers, rather than focusing only on direct child instruction.

- Build parent confidence in helping with reading at home
- Provide practical tools that fit into daily routines
- Recognize time and resource constraints of working families
- Empower families with realistic strategies they can actually use

FJ1

What we heard last session:
Cultural Responsiveness and Accessibility

Ensuring literacy programming reflects our community's diversity and fits real family life.

- Include books and materials that represent diverse backgrounds and languages
- Offer activities during car rides, meal prep, bedtime - not separate time slots
- Recognize different learning styles and family structures
- Make programs accessible regardless of work schedules or transportation

Slide 117

FJ1 Formatting...
Fuller, Jamie-Lee, 2025-07-18T20:45:46.095

Discussion Question

What can we do to help parents feel more prepared and supported in helping their kids with reading, especially when life is busy or stressful?

What we heard last session:
Community Partnership Model

Schools and community organizations working together strategically, not separately.

- Leverage school expertise and community connections
- Create seamless support systems for families
- Extend school-based learning into neighborhood settings
- Avoid duplication by coordinating efforts across organizations

Discussion Questions

What would effective community-school partnerships actually look like?

Are you aware of existing programs already doing this?

What we heard last session:
Building on Community Assets

Identifying and strengthening existing community strengths rather than starting from scratch.

- Connect families to share strategies and provide mutual support
- Recognize parents already care deeply about children's education
- Build on informal networks and respected community leaders
- Pair grassroots knowledge with adequate institutional resources

Discussion Questions

What are the best ways to connect parents so they can support each other with their children's literacy?

How can we make sure families know about and can access available resources?

Discussion Questions

Looking at these four areas, which ones resonate most with your own experience?

Are there perspectives or solutions do you think we might have missed in our earlier conversations?

“If you want different results, do not do the same things.”

Albert Einstein

Opportunities to Engage

- Become a WCI partner
- Join WCI
- Invite us to speak to your organization
- Participate in quarterly luncheons and community events

Past Summer Program Outcomes

Summer 2023

- Average scores increased on every literacy measure across all grades
- 94% of students showed improvement

Summer 2024

- 90% of students improved or maintained their literacy measures
- 80% of enrolled students were retained through the entire summer program

Parent Engagement

Approximately 90% of parents surveyed felt the summer program was extremely effective at helping their child retain the knowledge gained during the school year and keeping their child engaged in learning during the summer

Discussion Question

What's the most important thing WCI should do to help with literacy here?

How Can You Help?

Join our mission and next steps

Benefits of Partnership

- Collaborative Success
- Community Impact
- Access to Resources
- Data-Driven Decision Making
- Positive Community Engagement

Icebreaker

What motivated you to come to this event?

SEDGWICKCOUNTY.ORG

Break

10:10 – 10:20 AM

SEDGWICK COUNTY
Health Department

SEDGWICKCOUNTY.ORG

Expert Panel

10:20 – 11:10 AM

SEDGWICK COUNTY
Health Department

SEDGWICKCOUNTY.ORG

Economic/Upward Mobility

Sarah Crick Milligan, MPA
United Way of the Plains

SEDGWICK COUNTY
Health Department

A JOB ISN'T ENOUGH

Why Working Families are Struggling in Kansas

UNITED WAY of the Plains

ASSET LIMITED

No safety net in times of crisis

Income Constrained

Income falls short of covering essentials

Employed

Working, yet not earning enough

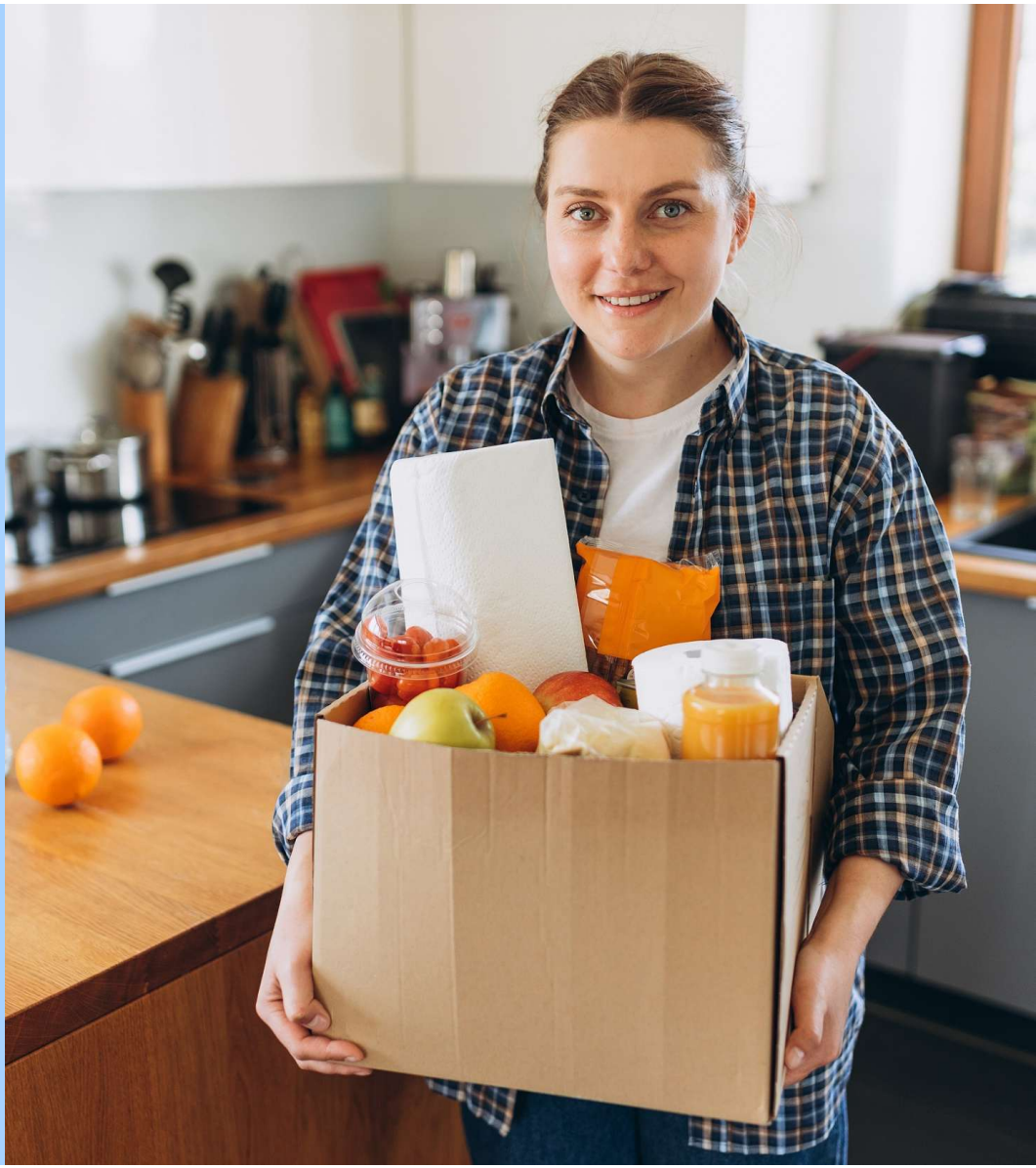
UNITED WAY of the Plains

ALICE THRESHOLD

The average income needed to cover the **Household Survival Budget**, which is based on the minimum costs of essentials:

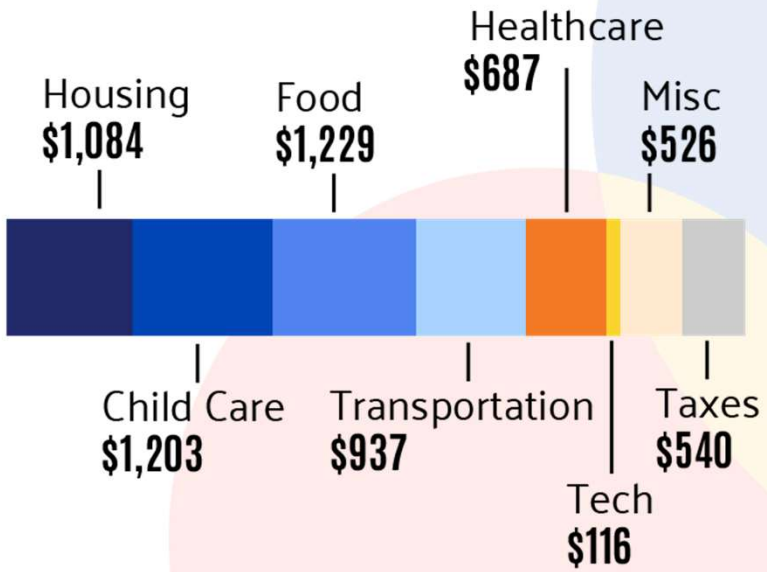
- Housing
- Childcare
- Food
- Transportation
- Health care
- Basic smartphone plan
- Miscellaneous
- Taxes

UNITED WAY of the Plains



HOW MUCH DOES IT COST TO SURVIVE?

Family of 4: 2 Adults and 2 Children in Childcare in Sedgwick County



Combined Hourly Wage

$37.93

Monthly Household Total

$6,322

Annual Household Total

$75,864

UNITED WAY of the Plains

40%

of Sedgwick County households are ALICE

UNITED WAY
of the Plains

Health Care and Social Assistance

Retail Trade

Manufacturing

Accommodation and Food Services

Administrative and Support; Waste Management and Remediation Services

UNITED WAY of the Plains

ALICE HOUSEHOLDS

A snapshot:

- 79% of single-female headed households
- 50% of single-male-headed households
- 64% are under 25 years old
- 46% are 65 years and over
- 61% of Black/African American households
- 46% of Hispanic households
- 48% of households with 2 or more races

- 48% work full-time
- 38% are renters
- 62% are rent burdened
- 47% are homeowners
- 44% are owner burdened
- 25% are uninsured
- 65% are not enrolled in preschool

UNITED WAY of the Plains

Stable households
Stronger communities

“We all have a role to play.”

–THE STATE OF ALICE IN KANSAS 2025 REPORT

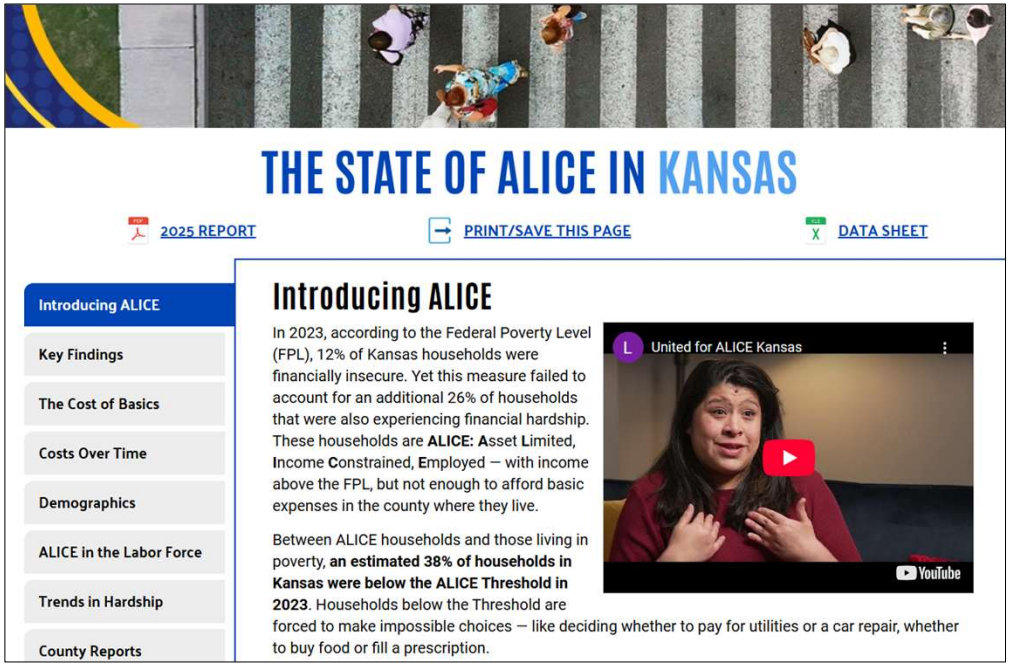
UNITED WAY of the Plains

QUESTIONS?

UNITED WAY
of the Plains

ALICE IN KANSAS REPORT

Scan the QR code



UNITED WAY of the Plains

UnitedForAlice.org/introducing-ALICE/Kansas

Economic/Upward Mobility

Lindsay Wilke, M.Ed.
Kansas Health Foundation
and
Ricki Ellison, M.A. Doctoral Candidate – Ed.D (ABD)
Greater Wichita Partnership

SEDGWICK COUNTY
Health Department

SEDGWICKCOUNTY.ORG

Upward Mobility

Kansas Health Foundation

Overall Rank

28

Measures

		State Rank	State Value	U.S. Value
Social & Economic Factors		**21**	**0.248**	
Community and Family Safety	Homicide (Deaths per 100,000 population)	22	5.8	7.6
	Occupational Fatalities (Deaths per 100,000 workers)	31	4.8	4.2
	Public Health Funding (Dollars per person)	38	$95	$124
Economic Resources	Economic Hardship Index (Index from 1-100)	26	51	–
	Food Insecurity (% of households)	17	10.6%	12.2%
	Income Inequality (80-20 Ratio)	11	4.30	4.87
Education	Fourth Grade Reading Proficiency (% of public school students)	34	30.5%	32.1%
	High School Completion (% of adults age 25+)	24	91.7%	89.8%
Social Support and Engagement	Adverse Childhood Experiences (% of children ages 0-17)	30	17.0%	14.5%
	High-Speed Internet (% of households)	28	93.5%	93.8%
	Residential Segregation - Black/White (Index from 0-100)	16	60	–
	Volunteerism (% of population age 16+)	7	31.5%	23.2%
	Voter Participation (% of U.S. citizens age 18+)	15	62.6%	59.5%
Physical Environment		**40**	**-0.043**	
Air and Water Quality	Air Pollution (Micrograms of fine particles per cubic meter)	40	8.8	8.6
	Drinking Water Violations (Average violations per community water system)	31	2.2	2.8
	Water Fluoridation (% of population served)	32	65.4%	72.3%
Climate and Health	Climate Policies (Number out of four policies)	36	0	–
	Heat and Worker Health (Cases per 10,000 full-time workers)*	13	0.2	–

Economic status is an important

predictor of your health outcomes.

UPWARD MOBILITY

The ability to **stabilize, thrive** and make choices over time, without losing connection to culture, community, or self.

We want every Kansan to have the **opportunity to succeed**, regardless of their starting point in life.

“I WISH FOR...

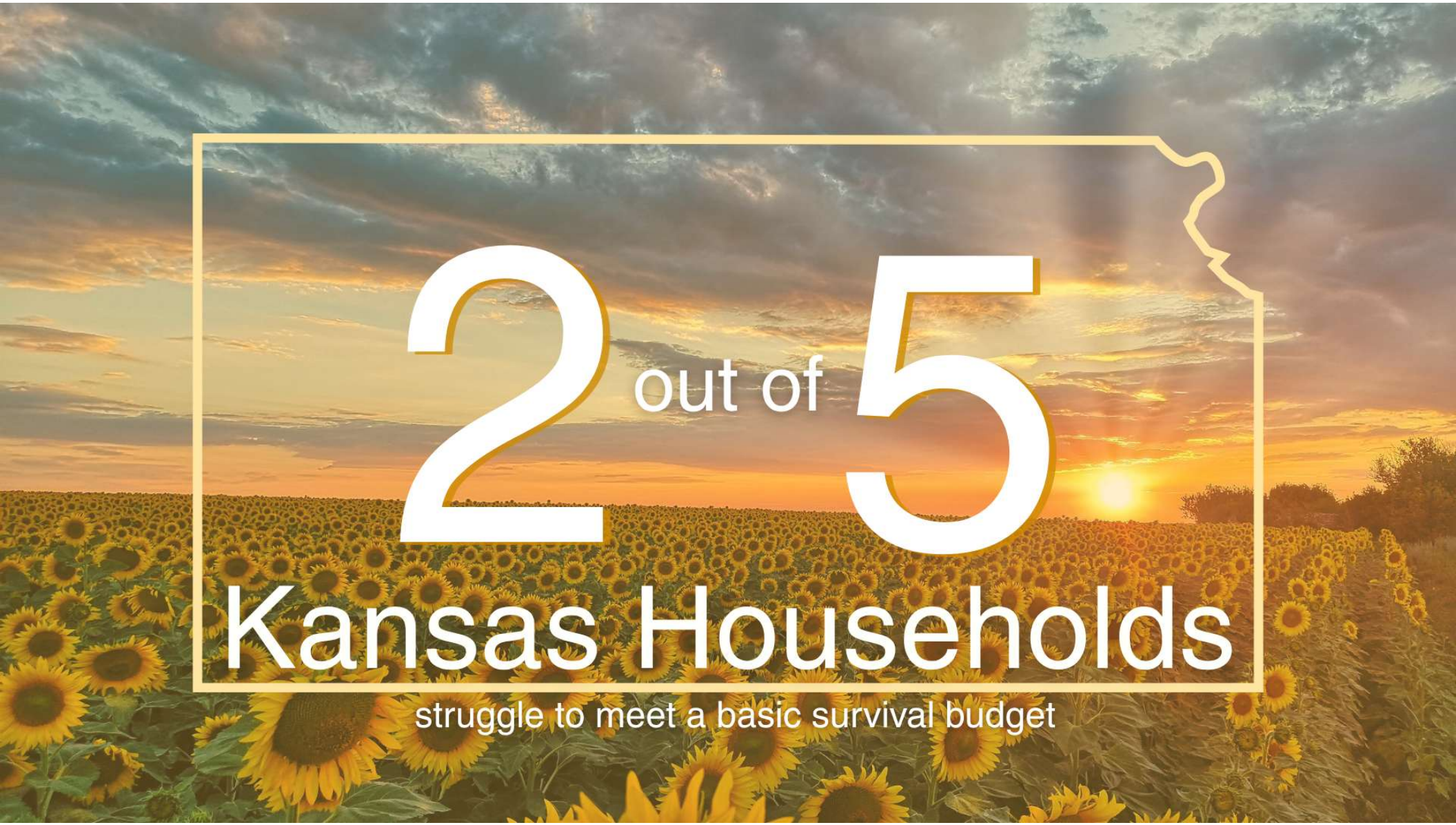
“Anyone struggling to have access to a good job and food.”

“Everyone to have access to affordable education.”

“My friend to have affordable housing!”

“Less struggles for single moms.”

“Barriers to jobs to be removed. Not every job needs a degree.”


2 out of 5
Kansas Households
struggle to meet a basic survival budget

Key Finding: $71,892: The estimated survival budget for a Kansas household of two adults and two children in child care.

Figure 7. **Survival and Stability Budgets with Two Examples of Annual Income for a Kansas Family of Two Adults and Two Children in Child Care, 2022**

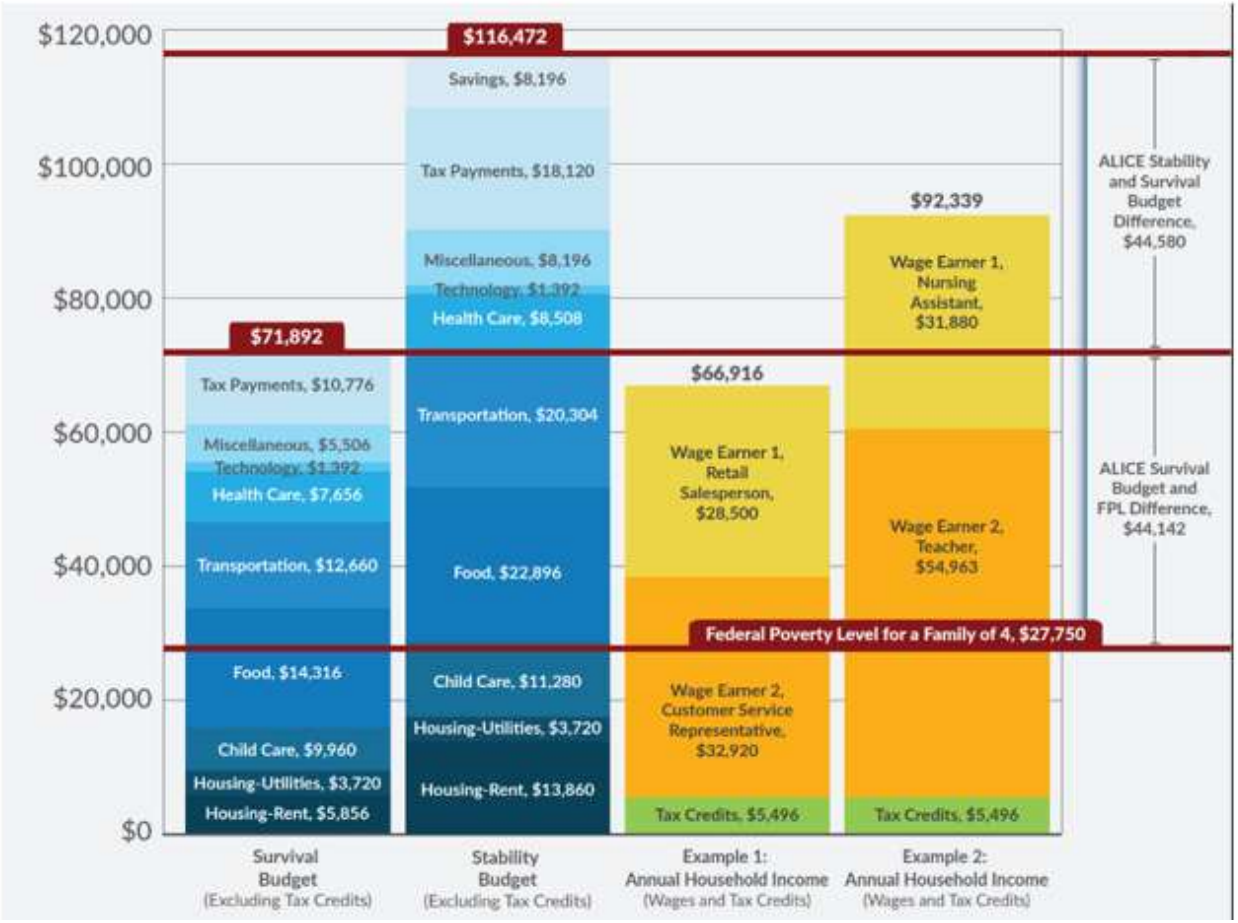
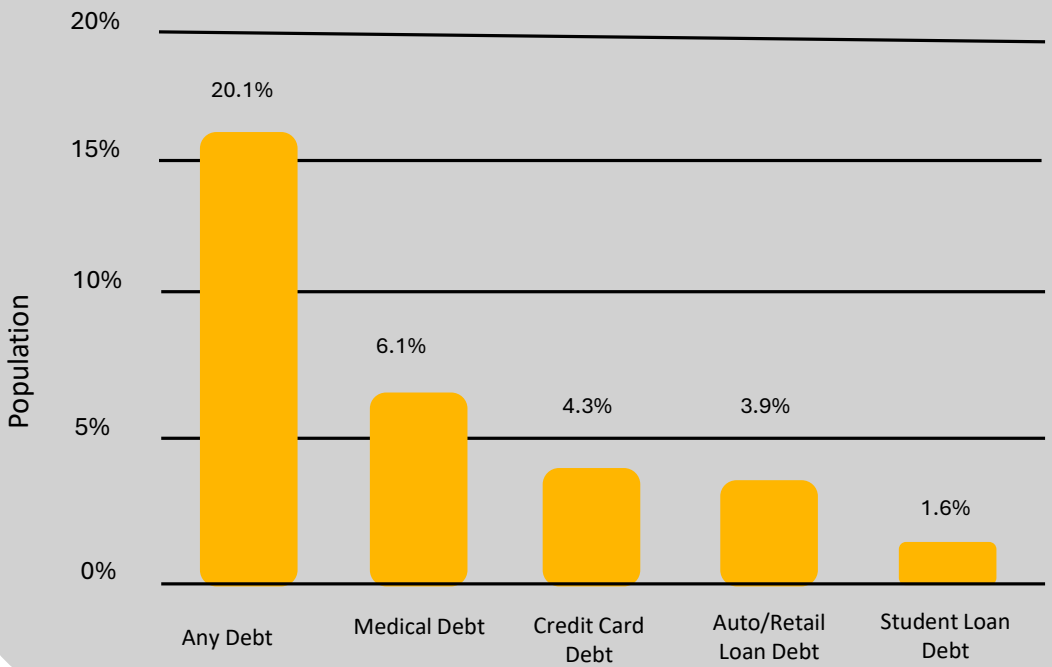


Figure 6 PERCENT OF KANSANS WITH DEBT IN COLLECTIONS, SIXTY DAYS DELINQUENT OR IN DEFAULT, 2023



Kansans age

16 to 29

experience unemployment rates

3x higher

than those age 45-64

The Average Job in

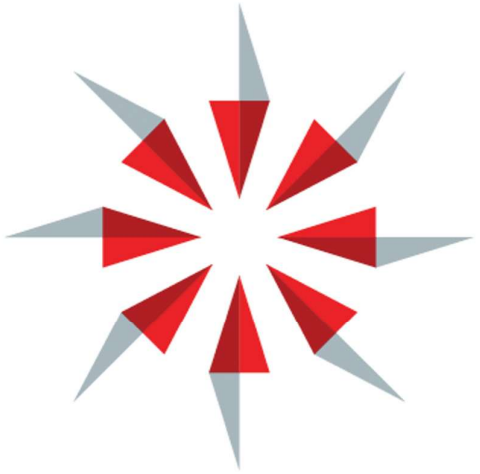
84

Out of

105

counties pays less than 60 cents for every dollar needed to meet basic living costs.


Rewarding Work
Employment opportunities
Jobs paying living wages
Opportunities for income
Financial security
Wealth-building opportunities
High-Quality Education
Access to preschool
Effective public education
School economic diversity
Preparation for college
Digital access
Opportunity-Rich & Inclusive Neighborhoods
Housing affordability
Housing stability
Economic inclusion
Racial diversity
Social capital
Transportation access
Healthy Environment & Access to Good Health Care
Access to health services
Neonatal health
Environmental quality
Safety from trauma
Responsive & Just Governance
Political participation
Descriptive representation
Safety from crime
Just policing



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Economic Mobility in Sedgwick County:
Reframing Possibility

Defining Economic Mobility:

"Movement toward stability, opportunity, and choice with dignity"

- Nearly **1 in 3** Sedgwick County households fall below the ALICE threshold
- Middle-skill workforce roles offer the strongest mobility lift
- Zip code remains a strong predictor of life outcomes
- Urban Institute Upward Mobility Framework + Opportunity Insights

CHIP Integration: Embed mobility questions into every health priority

Our Regional Work: From Vision to Activation

- 10-county regional Economic Mobility Plan
- Led by The Partnership | Funded by Kansas Health Foundation
- 40+ partners, stakeholder sessions, lived-experience input

Three Priority Areas

Workforce Pathways

Policy & Systems

Data & Measurement

CHIP Integration:

- **Strengthen system navigation**
- **Elevate transportation & childcare as cross-cutting health supports**

Aligning Regional Efforts: Partners, Data & CHIP's Role

- Shared Data Model: Opportunity Insights + ALICE Data
- Common Themes: shared priorities, shared data, stigma-free framing, neighborhood-based access

Partners

Greater Wichita Partnership
Kansas Health Foundation
Wichita Foundation
Goodwill Industries of Kansas
BridgesICT HopeNet
Workforce Alliance of South Central Kansas
United Way of the Plains
Health & Wellness Coalition of Wichita
City of Wichita
Sedgwick County, Kansas
Wichita State University
WSU Tech

CHIP Integration:

- **Align mobility indicators with CHIP metrics**
- **Center dignity and lived experience in goal design**

Mobility is a *health strategy.*

Greater Wichita
Partnership

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Healthcare Access

Brittany Ruiz, MPH, MBA
Ascension Via Christi

SEDGWICK COUNTY
Health Department

2025 CHNA Implementation Strategy

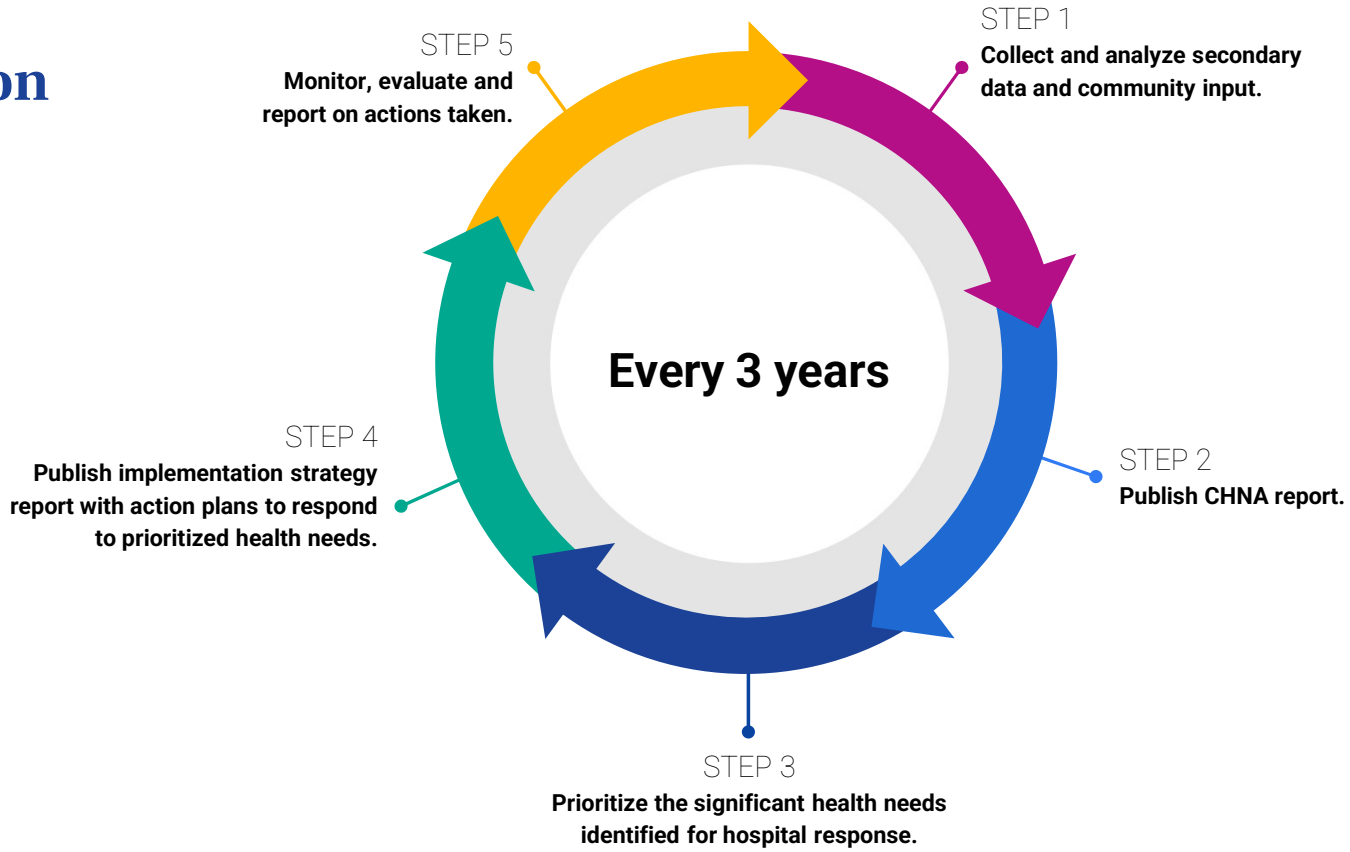
Sedgwick County

Ascension

Listening to you, caring for you.®

Brittany Ruiz, MPH, MBA
Manager, Community Benefit
Ascension Kansas

CHNA and implementation strategy cycle



Strategy focus areas

Access to care	Access to health insurance* Access to affordable medications* Access to primary care*
Chronic conditions	Heart disease Cancer
Social determinants of health	Transportation Food security Community resources*

Access to care

*"[To me, health means] everyone has **access** to the health and mental healthcare they need, with no waiting around on a list because they live in poverty, can't afford it, or because they have an insurance the providers aren't accepting." — Participant, Community Listening Session*

Focus area	Strategy	Description
Access to health insurance	Assist patients with eligibility and applications for public health insurance programs.	Financial counselors assist referred patients with eligibility determination and applications.
Access to affordable medications	Provide free or reduced-cost medications for qualifying uninsured and underinsured individuals.	Through innovative stewardship of the pharmaceutical supply chain, Dispensary of Hope collects and distributes millions of dollars of pharmaceuticals annually to pharmacies and safety-net clinics to dispense to low income, chronically ill patients.
Access to primary care	Increase primary care connections for individuals who are uninsured or receive Medicaid.	Connecting uninsured and Medicaid patients to primary care and ensuring they have a medical home.

Chronic conditions

*"Health disparities are preventable. Unequal access to health resources can lead to higher rates of **disease**, disability, even death."*
— Participant, Key Informant Interview

Focus area	Strategy	Description
Heart disease	Coordinate care for high-risk heart disease patients through Transitional Care Clinic programs.	Provides short-term healthcare to connect patients to primary care doctors. Also provides programs for patients with chronic illness to reduce ER readmission.
Cancer (Lung)	Provide lung screenings for first responders through the Firefighter Screening Initiative.	Increase preventative lung screenings and support services for high-risk groups.
Cancer (Breast)	Provide breast screenings across the community via HOPE Mobile Mammography.	Increase access to preventative breast cancer screenings among rural and high-SVI areas, and areas that may lack transportation.

Social determinants of health

*"To make progress on **social determinants of health**, we have to get out of silos — past politics and competition — to create collaboration."*
— Participant, Key Informant Interview

Focus area	Strategy	Description
Transportation	Provide non-emergency rides to medical appointments for individuals experiencing barriers to reliable transportation.	Patients are referred to transportation team if they are needing to be transferred to another facility and without a ride.
Food security	Support food security efforts of community partners through cash and in-kind donations.	Cash donation, associate volunteer, and food drives
Community resources	Connect patients and community members with identified social needs to local community resources.	Through FindHelp's Neighborhood Resource, connect patients to community-based resources such as food pantries, housing and transit, financial assistance (e.g., rent, utilities) and safety-net programs.

Full CHNA and IS reports available at:
https://healthcare.ascension.org/chna

Ascension

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Healthcare Access

Lety Dominguez, LPN
Guadalupe Clinic

SEDGWICK COUNTY
Health Department

Welcome to Guadalupe Clinic

Providing health care to the uninsured and those affected by poverty in Wichita and surrounding areas since 1985.

OUR MISSION

As missionary disciples of Christ, and with other people of good will, Guadalupe Clinic works to provide access to quality health care for people in need.

OUR HISTORY

Guadalupe Health Station was created in 1985 by a group of nurses providing health education and referrals as needed.

Founding Nurses

Guadalupe Clinic

Mission:
Provide compassionate, comprehensive medical care to uninsured and underinsured individuals, regardless of ability to pay.

Who We Serve:
Primarily low-income adults in Wichita and surrounding communities who fall through the gaps of traditional healthcare systems.

Care Model:
Fully volunteer-driven medical staff, enabling free health care, high-impact delivery of services.

Scope of Services:
- Primary care
- Chronic disease management
- Preventive screenings
- Immunizations
- Specialty referrals
- Wellness education

TIERED HEALTHCARE ACCESS

Academic/Tertiary Hospitals

- Complex/Specialty Insured, Medicare/Medicaid
  - Highest-level acute care, research, teaching.

Community/General Hospitals & Private Practices

- Specialty Care Coordinators

- Insured, Medicare/Medicaid
  - Acute care, routine surgery, general population primary/specialty care.

Federally Qualified Health Centers (FQHCs)

- County Public Health

- Uninsured (Sliding Fee), Medicaid/KanCare
  - Comprehensive primary care, dental, behavioral health (e.g., **GraceMed, HealthCore Clinic**).

Charitable Clinics

- Uninsured in Extreme Poverty
  - Essential primary care, chronic disease management (e.g., **Guadalupe Clinic, Mayflower Clinic**).

GUADALUPE CLINIC & CHIP HEALTH

- Expanding Access to Primary Care
- Serve as a medical home for uninsured adults.
- Provide ongoing, relationship-based care to reduce ER dependence.
- Walk-in appointments prevent unnecessary emergency visits.

Chronic Disease Management

- Focus on high-prevalence conditions: diabetes, hypertension, heart disease.
- Support long-term management and medication assistance.
- Specialized help from Jackie (diabetes educator).
- Provide patients with needed medications and tools.

Preventive Health & Wellness

- Offer immunizations* (flu), screenings, and health education.
- Empower patients with tools, knowledge, and supportive partnerships:
  - JayDoc Clinic
  - Jackie (diabetes education)
  - Joan (nutrition guidance)
- Provide glucose monitors to patients.

*Currently, flu vaccines are provided.

Addressing Social Determinants of Health

- Identify barriers like transportation, language, and food insecurity.
- Nelly leads efforts in patient resource navigation and culturally competent care.
- Offer bilingual communication (English/Spanish).
- Provide Lyft rides for access to care.

Reducing Health Disparities

- Prioritize underserved and minority populations affected by poor health outcomes.
- Deliver equitable, culturally sensitive care via bilingual, diverse staff.
- Shape programs to meet unique community needs.

PARTNERSHIPS & OPPORTUNITIES

Collaborations Supporting CHIP Priorities

- Local hospitals and health systems: coordinate referrals, reduce preventable ER visits.
- Community organizations: address food and transportation needs.
- Public health agencies: align efforts with county health initiatives.
- Educational institutions & volunteer networks: engage medical students, volunteers, and JayDoc Clinic.
- Specialty care partners: Project Access and others offer donated/low-cost specialty services.

Possible Opportunities

- Dental care expansion
- Community extension partnerships

Designing the 2026 CHIP

11:10 – 11:25 AM

Chris Steward, MPH
Sedgwick County Health Department

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Change to the CHIP Structure

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Guiding the Work: MAPP 2.0 **Foundational Principles** (Adapted)

MAPP =
Mobilizing for
Action through
Planning and
Partnerships

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Adapted from National Association of County & City Health Officials (NACCHO) MAPP 2.0 User's Handbook Retrieved 10/12/25, from https://www.naccho.org

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MAPP Framework: Individual Social Needs and Community-wide Conditions

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Sedgwick County MAPP Work

Definition of Community

- Collective groups of people with diverse perspectives who **currently and in the future** live, work, play, worship, lead, and connect with/utilize/need resources within Sedgwick County.*

Mission Statement

- To promote a healthier Sedgwick County **by engaging and collaborating with our community**, fostering partnerships that drive equitable health outcomes for everyone.**

Values

- Connectedness, Awareness, Inclusiveness, Community-driven**

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*Developed at the Sedgwick County Health Alliance Meeting, 9/6/24
**Developed at the Sedgwick County Health Alliance Meeting, 10/9/24

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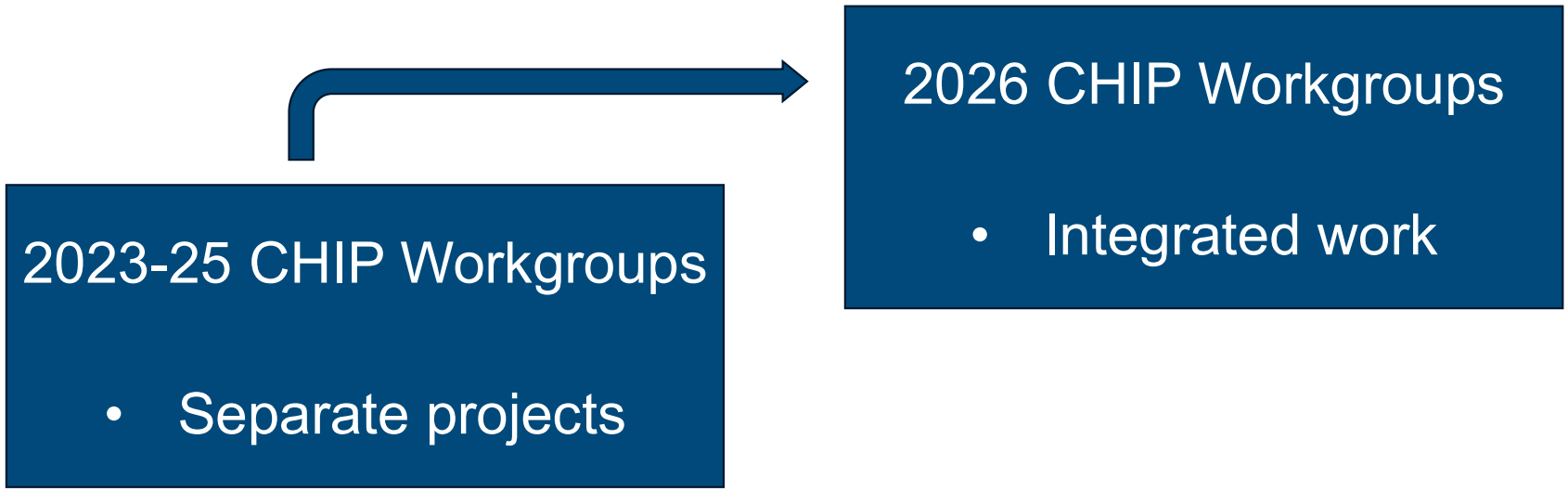
October 14 CHIP Meeting Summary

1. Make measurable community change within the four Health Priorities:
   - Behavioral Health
   - Economic/Upward Mobility
   - Education
   - Healthcare Access

2. Promote behavior and systems change across Health Priorities
   - Health education lens: Evidence-based classes and access to resources

What is a CHIP Workgroup?

- Community partners working together to make community change.



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Opportunities for the 2026 CHIP Workgroups

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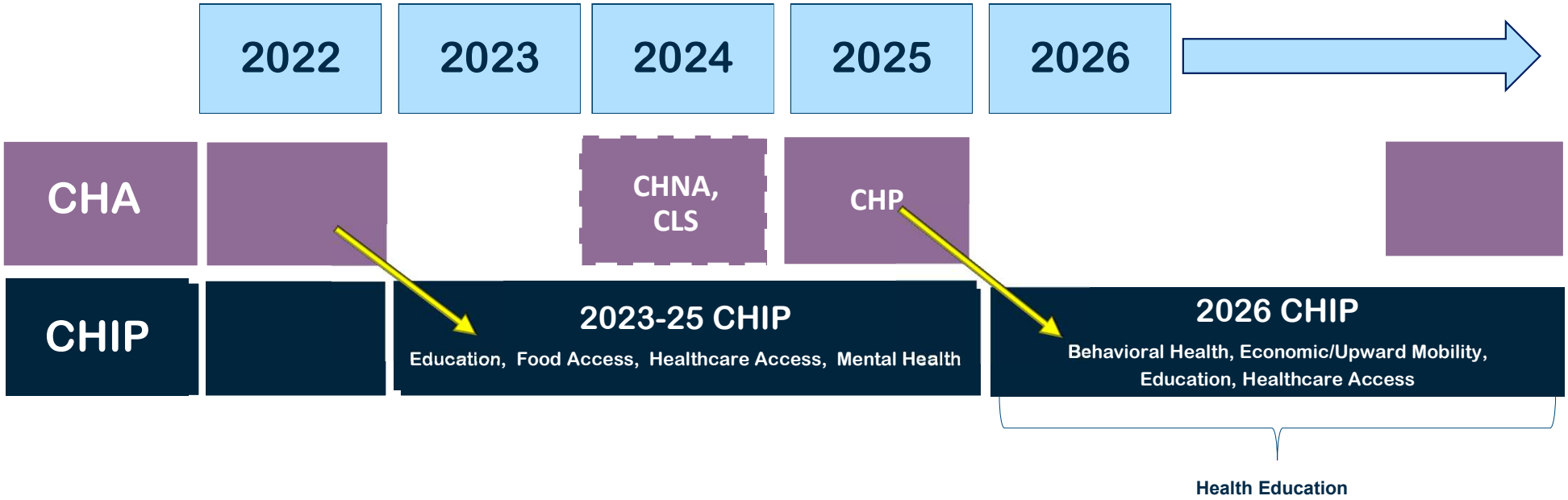
Community Health Improvement Cycle: Timeline



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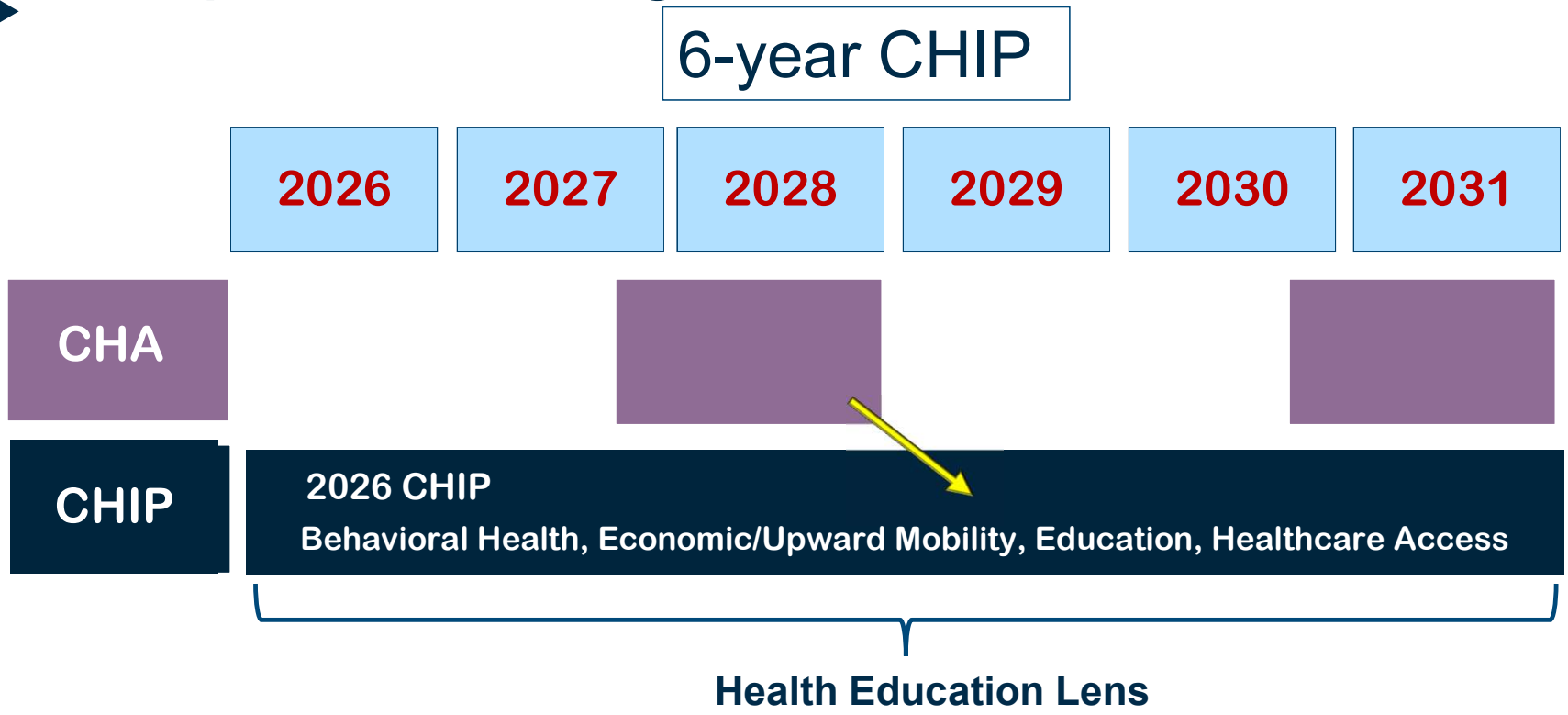
Proposed Change in CHIP Structure



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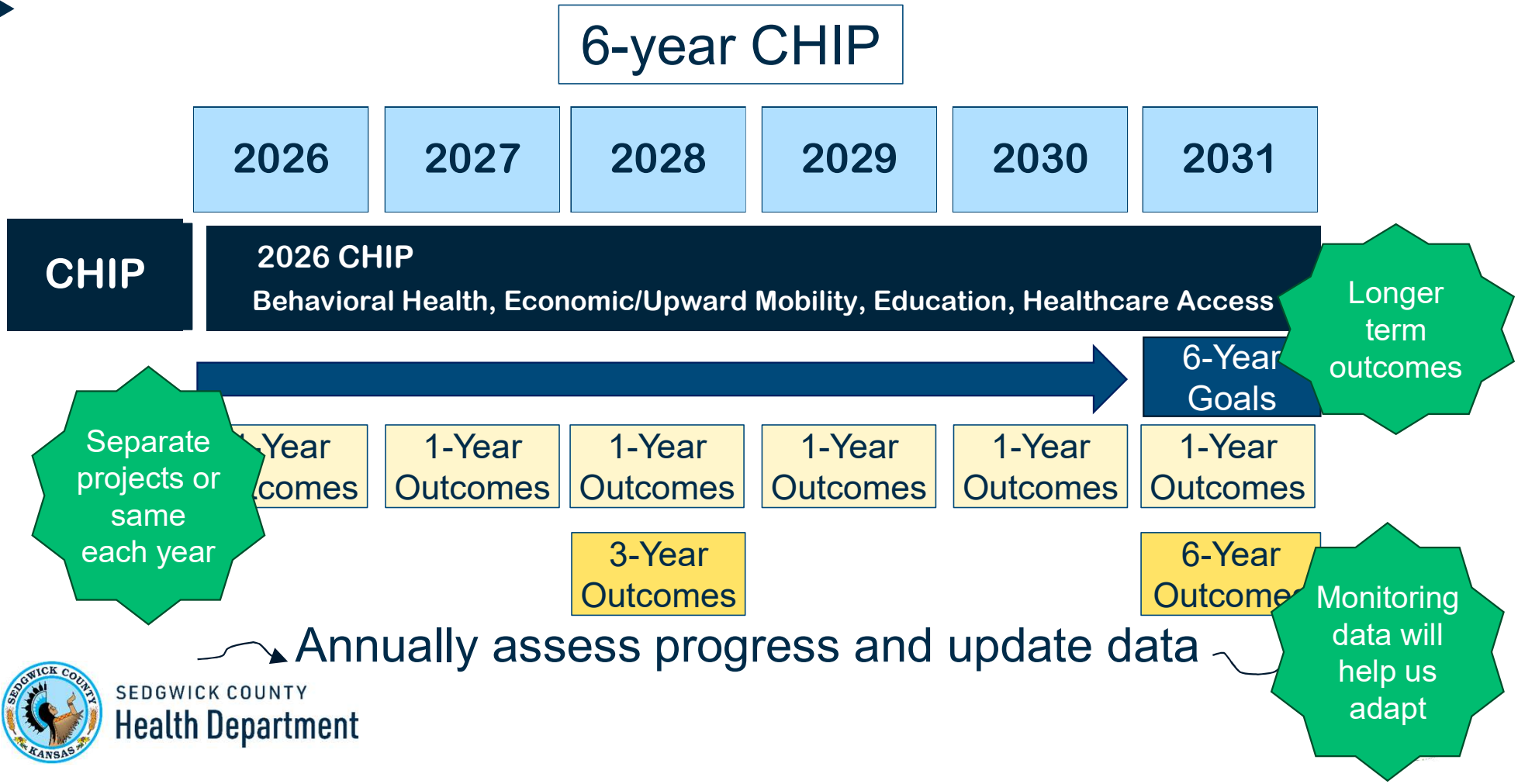
Proposed Change in CHIP Structure



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Drafting Goals

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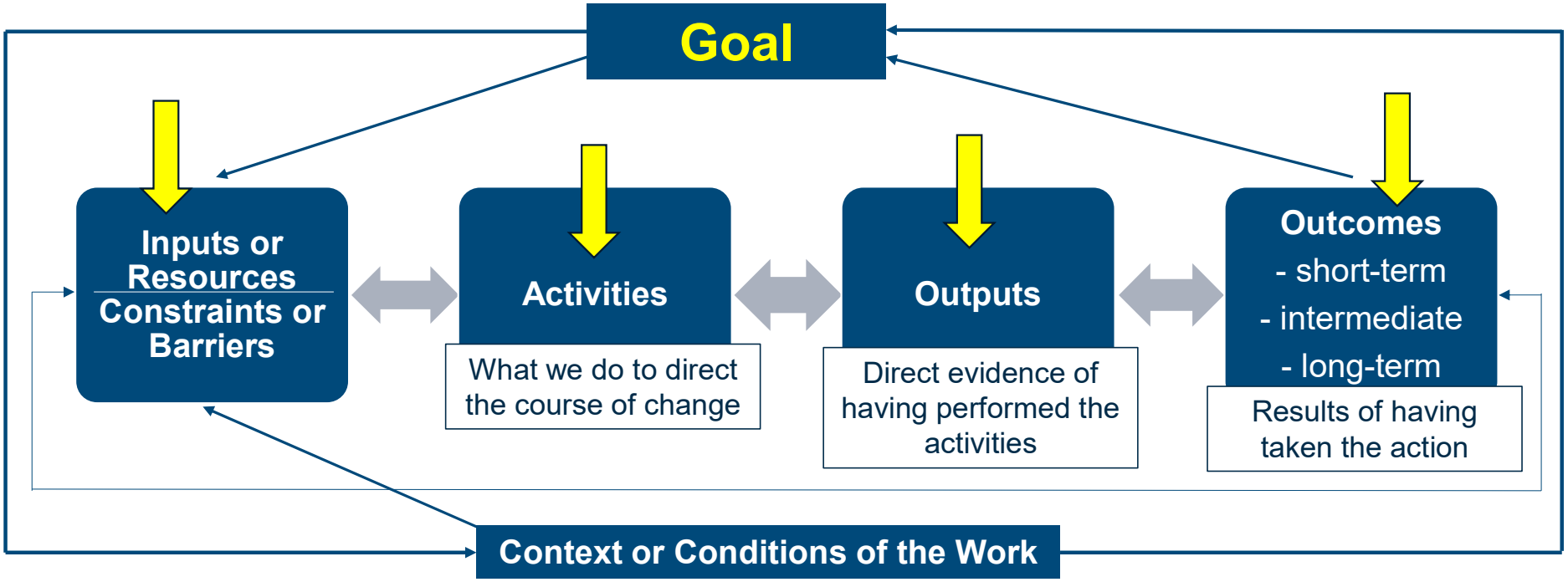
Describing a CHIP Initiative



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Adapted from KU Community Toolbox
https://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/logic-model-development/main

Characteristics of a Goal

- Provides overall focus, vision, and direction
- Is broad and overarching with no detailed action
- **Example:** Increase community knowledge of health-related services and resources through education

Goal Creation Worksheet Questions

In setting goals, consider the following:

Draft Goal #1:		
Current and Desired State		
What is the current state? Answer the following: 1. What is currently happening in the community around this goal? 2. Who is doing the work? 3. What programs are using evidence-based or promising practices?	**What is the desired state (possible)?** Answer the following: 1. How can the CHIP support and enhance current work to create an impact in the next three years? 2. What organizations need to be at the table that are not currently involved? 3. What are the priority populations? 4. If funding becomes available, what is possible?	**How do we get to the desired state?** Answer the following: 1. What are the barriers that prevent us from achieving the desired state? 2. What needs to happen to bridge the gap between the current and desired state? For example, is the current state due to lack of resources, personnel, coordination, knowledge, skill, attitude, or practices?

Next Steps

1. Next, we will discuss the Health Education Lens
2. During lunch, move to your assigned Health Priority table.
3. After lunch, use **Goal Creation Worksheet** at your table
    a. Introductions: “What does your organization value that is associated with this Health Priority?”
    b. Identify spokesperson
    c. Identify people for health education lens
    d. Draft 2-3 goals per Health Priority

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Additional Notes

- **Facilitators** will move the discussion along & ensure time is monitored
- **Notetakers** will document discussion
- **Online coordinators** will monitor and speak for the online participants
- **Ground rules**: Ideas welcome, respect, silence phones
- Tables should start summarizing at 1:20.
- Report out at 1:30.

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Health Education Lens

11:25 – 11:45 AM

Chris Steward, MPH
Sedgwick County Health Department

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Accredited Health Department
PHAB
Advancing Public Health Performance
Public Health Accreditation Board

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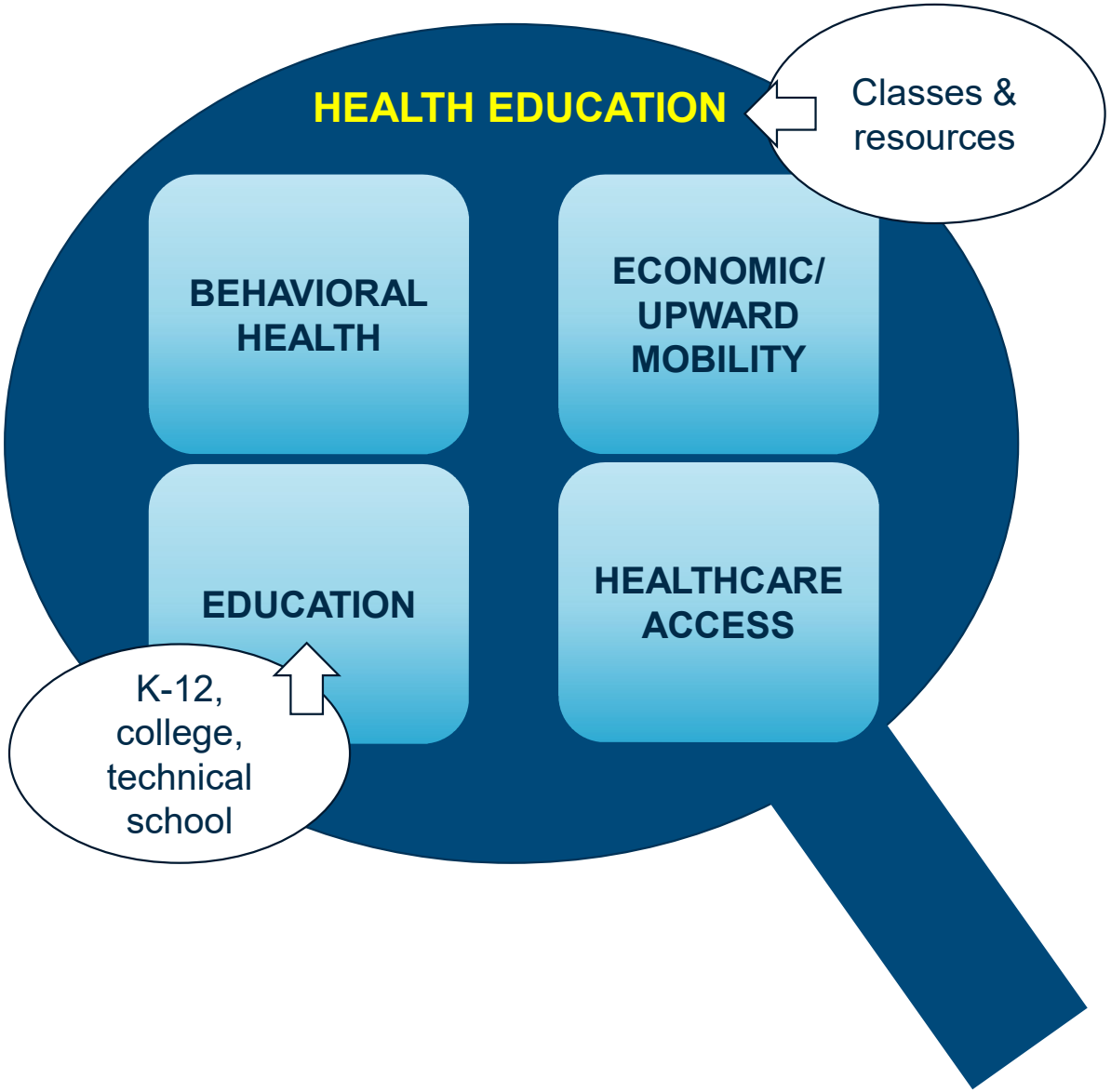
2026 CHIP Health Priorities



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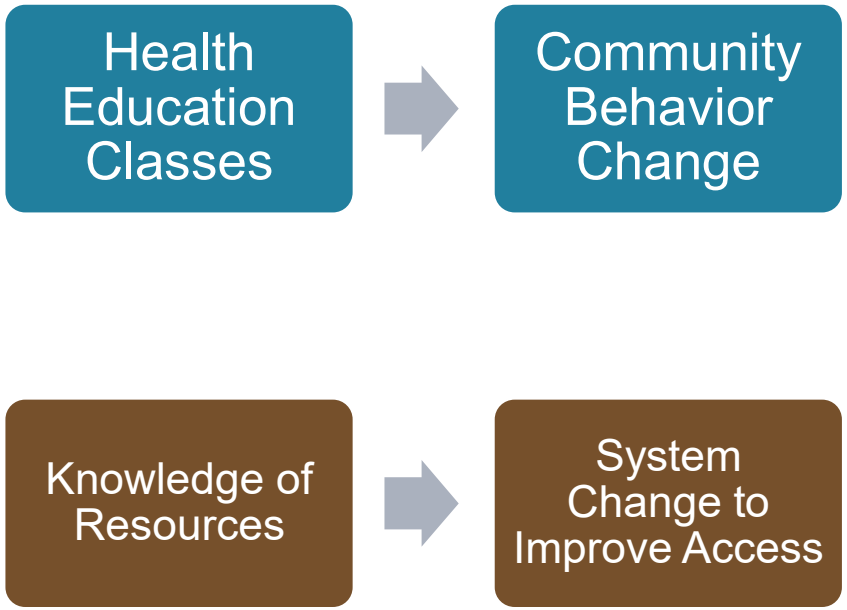
Health Education Poll

Stand up if in a former or current job you:

- Held the title of Health Educator
- Taught health education classes
- Provided health education to a client/patient
- Provided resources to a client/patient

Little “e” and the October 14 CHIP Meeting

Health Education



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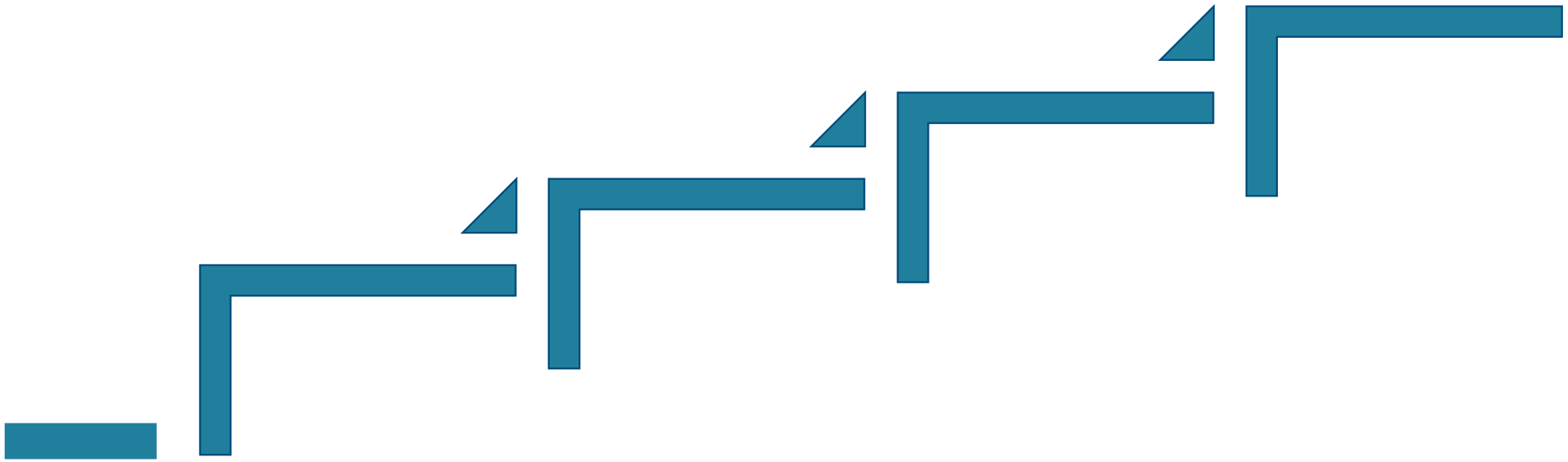
Health Education: Classes



Community Classes

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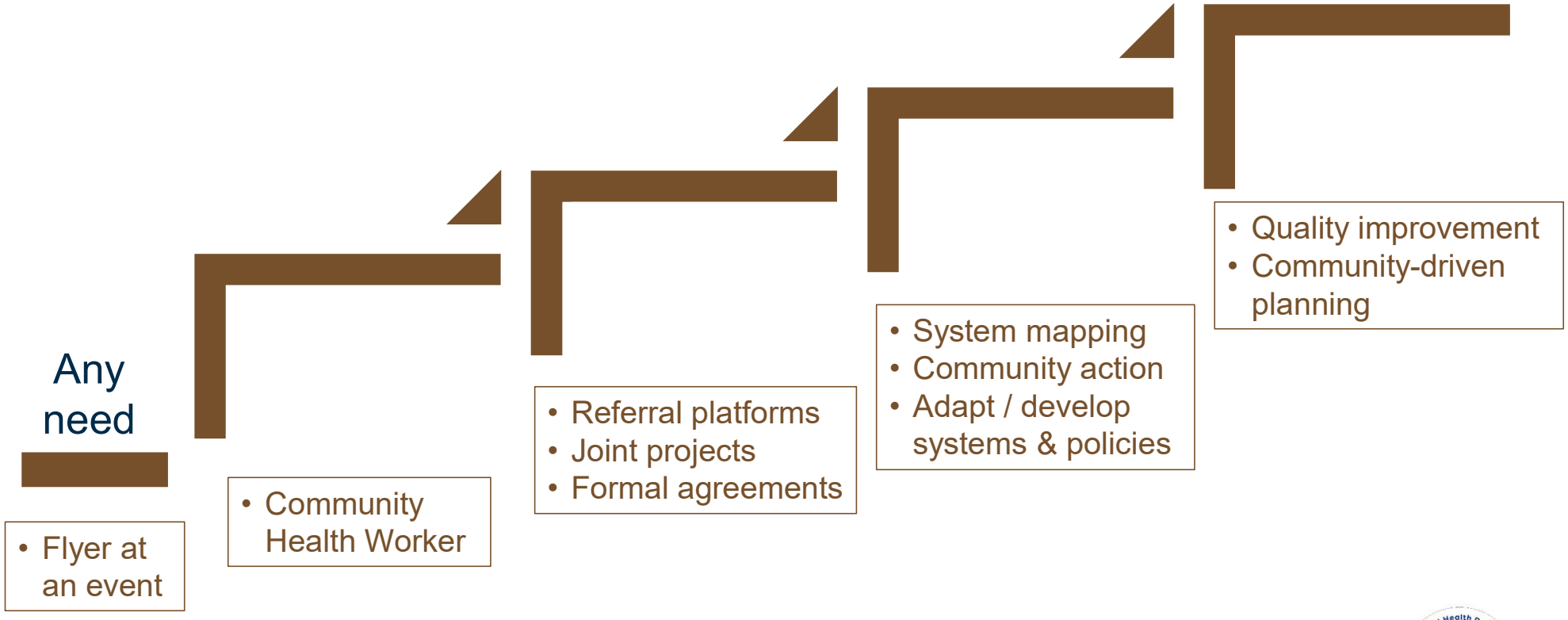
Health Education: Knowledge of Resources



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Historical CHIP Health Education Work

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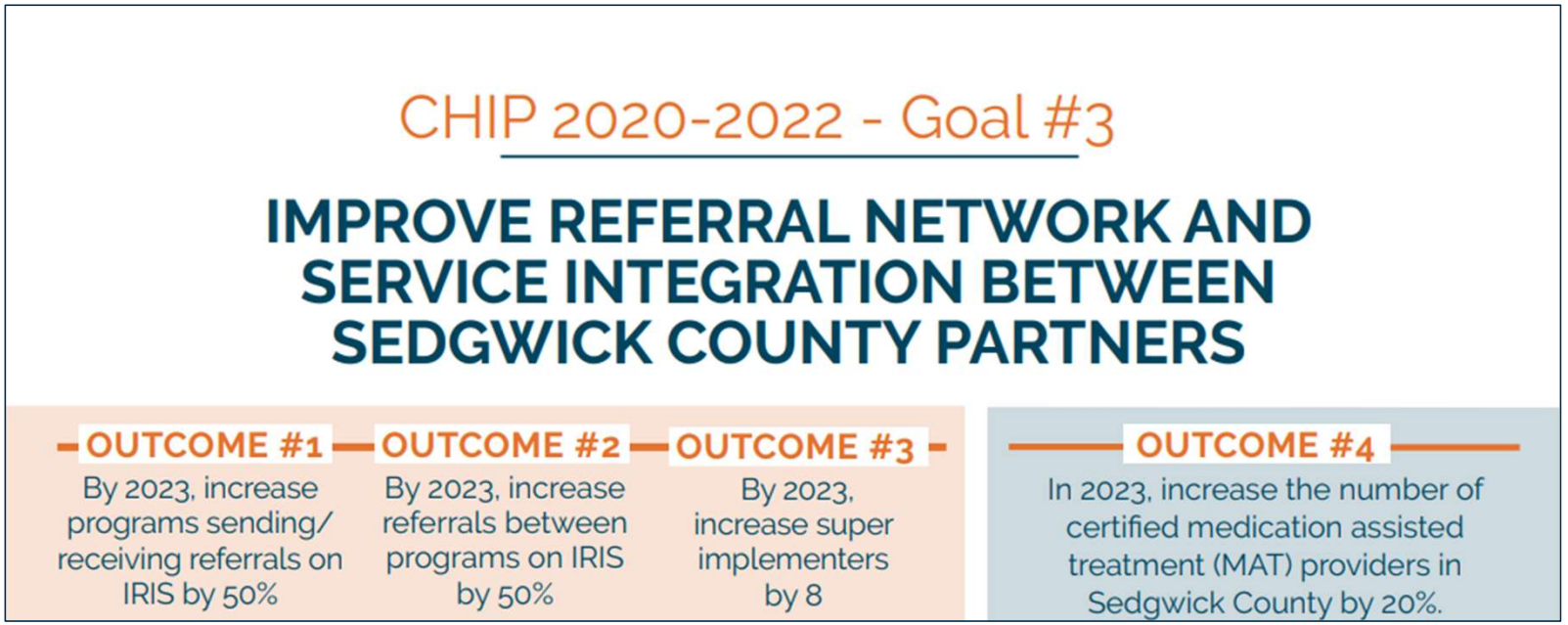
2020-2022 CHIP Goal #1

2020-2022 CHIP Goal #3



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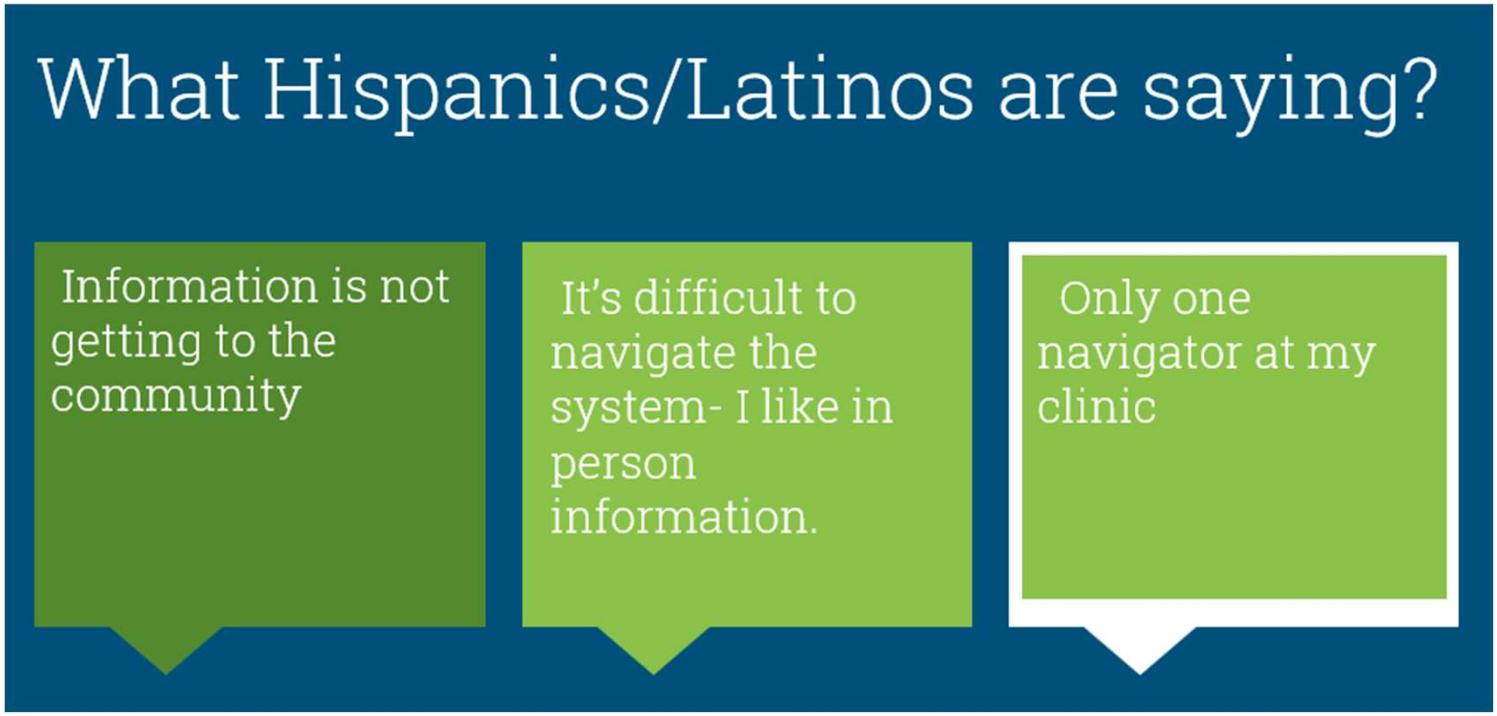
November 2022 CHIP Development Meeting: Salud + Bienestar Presentation



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2023-2025 CHIP
Healthcare Access Workgroup

GOAL

INCREASE COMMUNITY KNOWLEDGE OF SERVICES AND RESOURCES THROUGH EDUCATION AND CARE COORDINATION

OUTCOMES

By 2025

Community Health Workers

Increase the number of certified Community Health Workers (CHWs) by 20 to enhance community access to information about available resources.

By 2025

Limited English Proficiency

Increase the number of agencies who have a process to serve residents in 67207, 67210, and 67211 who have Limited English Proficiency by enhancing the knowledge of language and interpretation services available

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2023-2025 CHIP: Education Workgroup

GOAL

IMPROVE COMMUNITY AWARENESS OF EDUCATIONAL OPPORTUNITIES

Activities

Collaborated with Wichita Transit to address transportation barriers for parents/guardians who want to continue their education

Distributed flyers for literacy initiatives, including 1,000 Books Before Kindergarten and summer reading programs, to increase participation

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2023-2025 CHIP Food Access Workgroup

OUTCOMES

By 2025

1

- Sustain and connect more households to identifiable food sources and food assistance resources in high priority ZIP Codes that receive food assistance by increasing the percentage of households on SNAP in ZIP Codes 67210, 67213, 67214, and 67218 by 2%
- Improve coordination among community resources/partners within the food ecosystem by 20 %.

By 2025

2

- Increase the number of individuals who report increased knowledge, comfort with advocacy, and empowerment regarding access to services and eligibility among people accessing food opportunities

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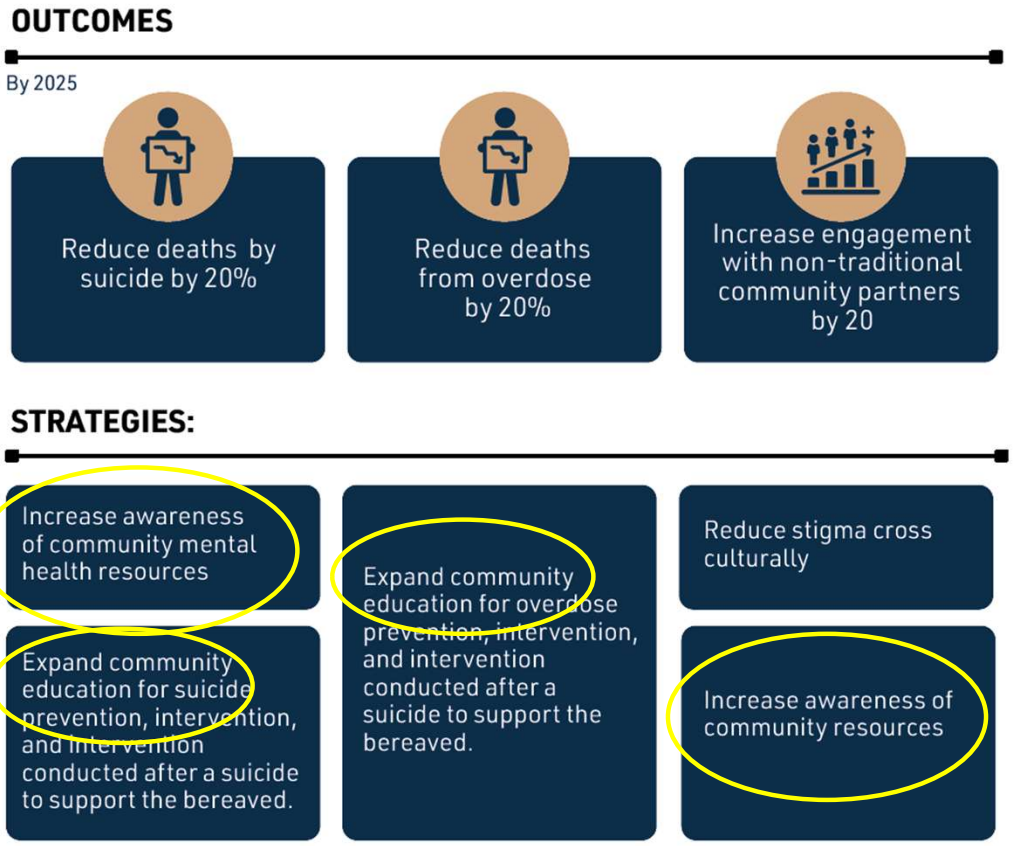
2023-2025 CHIP Mental Health Workgroup



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Proposal for Health Education Lens

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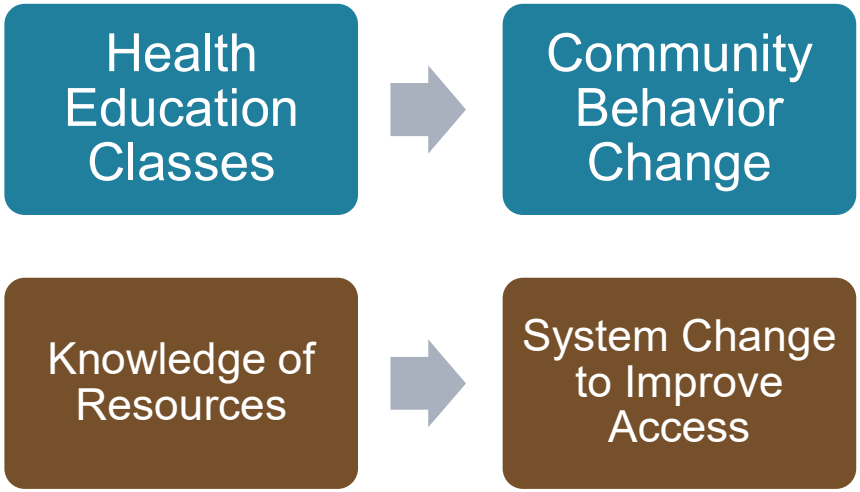
Proposal to Incorporate a Health Education Lens into the 2026 CHIP

- Purpose of the lens: Coordinated approach over all Health Priorities
- 1-2 members from each workgroup are identified to focus on health education
  - Health education classes
  - Knowledge about resources
- Quarterly meetings with CHIP co-chairs for coordination

Lens Discussion

1. The name “Health Education”
2. How to approach:



3. Additional comments?

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Lunch!

11:45 AM – 12:15 PM

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Creating Goals for Selected Health Priorities: Table Work

12:15 – 1:30 PM

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Report Out

1:30 – 1:50 PM

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Closing & Next Steps

1:50 – 2:00 PM

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