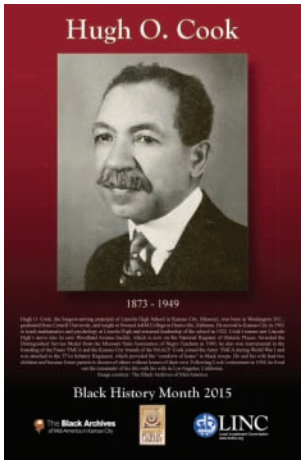
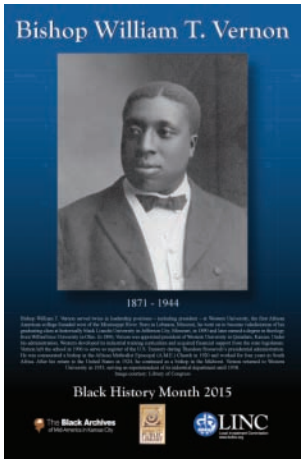
LINC Commission Meeting

January 26, 2015





Black History Month 2015

Recognizing African American Educators

The Local Investment Commission (LINC) produced these educational posters in partnership with the Kansas City Public Library and the Black Archives of Mid-America. The effort celebrates and supports Black History Month from a local perspective. More information about the project and books from prior years, can be downloaded at kclinc.org/blackhistory

LINC
Local Investment Commission
www.kclinc.org

Local Investment Commission (LINC) Vision

Our Shared Vision

A caring community that builds on its strengths to provide meaningful opportunities for children, families and individuals to achieve self-sufficiency, attain their highest potential, and contribute to the public good.

Our Mission

To provide leadership and influence to engage the Kansas City Community in creating the best service delivery system to support and strengthen children, families and individuals, holding that system accountable, and changing public attitudes towards the system.

Our Guiding Principles

1. COMPREHENSIVENESS: Provide ready access to a full array of effective services.
2. PREVENTION: Emphasize "front-end" services that enhance development and prevent problems, rather than "back-end" crisis intervention.
3. OUTCOMES: Measure system performance by improved outcomes for children and families, not simply by the number and kind of services delivered.
4. INTENSITY: Offering services to the needed degree and in the appropriate time.
5. PARTICIPANT INVOLVEMENT: Use the needs, concerns, and opinions of individuals who use the service delivery system to drive improvements in the operation of the system.
6. NEIGHBORHOODS: Decentralize services to the places where people live, wherever appropriate, and utilize services to strengthen neighborhood capacity.
7. FLEXIBILITY AND RESPONSIVENESS: Create a delivery system, including programs and reimbursement mechanisms, that are sufficiently flexible and adaptable to respond to the full spectrum of child, family and individual needs.
8. COLLABORATION: Connect public, private and community resources to create an integrated service delivery system.
9. STRONG FAMILIES: Work to strengthen families, especially the capacity of parents to support and nurture the development of their children.
10. RESPECT AND DIGNITY: Treat families, and the staff who work with them, in a respectful and dignified manner.
11. INTERDEPENDENCE/MUTUAL RESPONSIBILITY: Balance the need for individuals to be accountable and responsible with the obligation of community to enhance the welfare of all citizens.
12. CULTURAL COMPETENCY: Demonstrate the belief that diversity in the historical, cultural, religious and spiritual values of different groups is a source of great strength.
13. CREATIVITY: Encourage and allow participants and staff to think and act innovatively, to take risks, and to learn from their experiences and mistakes.
14. COMPASSION: Display an unconditional regard and a caring, non-judgmental attitude toward, participants that recognizes their strengths and empowers them to meet their own needs.
15. HONESTY: Encourage and allow honesty among all people in the system.

Monday, Jan. 25, 2015 | 4 – 6 pm
Kauffman Foundation
4801 Rockhill Rd.
Kansas City, Mo. 64110

Agenda

I. Welcome and Announcements

II. Approvals
   a. November minutes (motion)

III. Superintendent's Report

IV. LINCWorks

V. LINC Commission
   a. Selection of new chair
   b. Expanding the LINC Commission

VI. Kansas City Health Care Issues
   a. Bridget McCandless – Health Care Foundation of Greater Kansas City

VII. Video Reports
   a. Family and Schools Together
   b. LINC and the arts

VIII. Other

IX. Adjournment

THE LOCAL INVESTMENT COMMISSION – NOV. 24, 2014

The Local Investment Commission met at the Kauffman Foundation, 4801 Rockhill Rd., Kansas City, Mo. Commissioner **Bert Berkley** presided. Commissioners attending were:

Bert Berkley
Sharon Cheers
Jack Craft
Aaron Deacon
Steve Dunn
SuEllen Fried
Tom Lewin
Rosemary Lowe
Sandy Mayer
Mary Kay McPhee
Richard Morris
David Rock
David Ross
Bailus Tate

A motion to approve the Sept. 15, 2014, LINC Commission meeting minutes was passed unanimously.

David Ross, LINC Treasurer, introduced Angela Miratsky-Figas of BKD, LLP. She presented the findings of BKD's financial audit of LINC. BKD issued an unqualified opinion of LINC's finances, and made recommendations on changes to LINC's internal controls in order to remain compliant with federal A133 requirements. She reported that LINC filed its IRS Form 990 by the Nov. 15 deadline.

A video was shown of a press conference by **Gov. Jay Nixon** announcing a $4.5 million summer jobs program for young people in the Kansas City urban core.

A video was shown of the 2014 Digital Inclusion Summit held at the Kansas City Public Library. **Aaron Deacon** reported on efforts to build a regional approach and recruit partners to bridge the digital divide.

Betsy Van der Velde, a member of the LINC Professional Cabinet since 1992, announced she will be retiring from the Family Conservancy on Dec. 31. Dean Olsen will succeed her.

Sandy Mayer announced she will be retiring after 18 years' service to Jackson County.

Superintendents' Report

- **David Leone** (Superintendent, Center School District) reported the district was accredited with distinction. This year the district has a special focus on making students college- and career-ready.
- **John Ruddy** (Assistant Superintendent, Fort Osage School District) reported Fire Prairie Upper Elementary School will host the LINC Chess winter tournament on Dec. 6. The district is partnering with University of Missouri to prepare students for post-high-school education opportunities
- **Kevin Foster** (Executive Director, Genesis Promise Academy) reported the school board and community members are revising the mission statement as part of the charter renewal process. The school will continue to be committed to serving alternative students and being a community school. Over 150 people participated in a recent Luminaries anti-violence event. A video on the school's partnership with U.S. Tennis Association was shown.
- **Kenny Rodrequez** (Assistant Superintendent, Grandview School District) reported the district is expanding dual-credit offerings for students. In 2014, 34% of graduates received at least one college credit. The district is expanding biomedical and engineering courses

through partnerships with PREP-KC and Honeywell. The district recently hosted 650 students participating in a Math Relay.

- **Casey Klapmeyer** (Associate Superintendent, Hickman Mills School District) reported the Ervin Early Learning Center will soon open, continuing the district's effort to make education available for all four-year-olds at no cost to families. Symington Elementary School has been selected to receive an Apple Connected grant providing computing devices for students, technology in every classroom, and professional development on effective use of technology in the classroom.
- **John Tramel** (Director of Family Services, Independence School District) reported the district 500 staff have undergone training on student mental health trauma. The training will continue in spring and the next school year.
- **Jerry Kitzi** (Director of Early Learning, Kansas City Public Schools) reported the district received a clean audit for the third year in a row. The district is collaborating with LINC on a fathering program at Richardson Early Learning Community School. The district is engaging the community around its master planning effort to set appropriate school boundaries.

Robin Gierer, LINC Deputy Director-Operations, reported on LINC finances and personnel 2008-2014. During the period LINC responded to changes in the environment including moving resources from the Kansas City Public Schools to the Hickman Mills and Grandview school districts, returning to Kansas City with reduced district funding, taking on the Missouri Work Assistance (LINCWorks) contract, and moving from a pay-as-you-go model to a reimbursement model. Through this period LINC increased program staff but did not increase administrative staff. Discussion followed.

A motion to adopt the "Proposal for Selection of a New LINC Chair," included in the meeting packet, was approved.

The LINC in Photos 2014 slideshow was shown.

The meeting was adjourned.

Proposal for Selection of a New LINC Chair (approved by LINC Commission, Nov. 24, 2014)

The general process would involve a number of tasks carried out by a select committee of LINC Commissioners with support from LINC executive staff.

Here's the proposed process:

Step 1: LINC Commissioners will form and select a LINC Nominating Committee with overall responsibility for the selection process.

Step 2: LINC executive staff will collect information on important people to reach out to regarding needs of LINC's board leadership.

Step 3: The LINC Nominating Committee will review information gathered by the LINC Executive Staff.

Step 4: The LINC Committee will recommend an individual for the LINC Chair in January or February 2015.

Proposal for Selection of a New LINC Chair (amended by Nominating Committee, Dec. 2, 2014)

The general process would involve a number of tasks carried out by a select committee of LINC Commissioners with support from LINC executive staff.

Step 1: LINC Commissioners will form and select a LINC Nominating Committee with overall responsibility for the selection process.

Step 2: The LINC Committee will recommend an individual or individuals to serve as interim LINC Chair or co-Chairs, subject to approval by the full board at the January 2015 LINC Commission meeting.

Step 3: LINC executive staff will collect information on important people to reach out to regarding needs of LINC's board leadership.

Step 4: The LINC Nominating Committee will review information gathered by the LINC Executive Staff and make recommendations to the LINC Commission regarding new board members.

Step 5: The LINC Nominating Committee will recommend a board member for the LINC Chair.

Community Conversation on Health

SUMMARY REPORT

OCTOBER 11, 2014

Theme Team

"Good individual health depends on the health of all of those around us. We have to work together so that everyone has the opportunity to live fully. It takes a collection of voices and perspectives to get us there. This is an opportunity for us to learn about what we can do to make a healthy community for everyone."

Bridget McCandless, M.D.
HCF President/CEO

On October 11, 2014, the Health Care Foundation of Greater Kansas City (HCF) and the United Way of Greater Kansas City partnered to sponsor the "Community Conversation on Health".

Asked to attend were people in the community most challenged by the current economic and health care system – the uninsured and underserved. The focus of the symposium was generating responses to questions on what health means to them and what would help them live healthier lives.

Get the Conversation Rolling

Held in the Exhibit Hall of the Sheraton Crown Center in Kansas City, Missouri, 270 participants spent the day working in small groups with a trained facilitator responding to questions about health and community.

A volunteer at each table sent discussion notes via an iPad to an extended team of volunteers who used the notes to identify and categorize 10 common themes from the group discussions. Participants were asked to vote on themes from their answers using individual keypads. The results were compiled as a resource to be used in advocating for policy change in the coming future.

Groundwork for Change

Entering its second decade of grant-making, HCF will take the information learned from this symposium as a basis for advocating for policy issues that will help improve communities, give nonprofits resources to provide services as well as provide community leadership. The results from this event will also serve as a resource for other funders and community partners advocating the consumer's voice on health.

Included in this report are the details of the symposium including participant profiles, their opinions and priorities.

What is a healthy individual and healthy community?

Years ago, if you didn't have a disease, people considered you healthy. Oftentimes, disease was followed closely by death. Thankfully, that has changed and advances in public health have brought changes in how we define personal health.

As the definition of health has grown, so has the role of the community. Doctors are still important, but now everyone has a responsibility to make towns and cities places that support health. Anyone can speak up for things like bike paths, sidewalks, and access to fresh fruits and vegetables. Getting people involved can help us find and use practical, creative ways to build physical and mental health where we live. More often, people in towns and cities are organizing for change.

During table introductions, participants shared their name, where they live, and the one thing that first comes to mind when describing a healthy individual and a healthy community.

A Healthy Individual...

- is balanced in mind, body and spirit.
- is peaceful, purposeful with a positive attitude.
- takes good care of themselves (eats well, exercises).
- is disease free and has an absence of illness.
- has basic needs met.
- has access to medical, mental, dental resources and insurance.
- is active, engaged and continues to learn and grow.

A Healthy Community...

- has free access to health services and medical homes.
- has amenities: walking trails, bike lanes, parks and rec centers.
- is one where community members cooperate and help each other out.
- has community conversations/meetings to talk about health.
- is a safe community (ex. neighborhood watches, good policing).
- has access to healthy foods (ex. urban groceries and gardens).
- has clean water, streets and environment; trash picked up.
- has an awareness of available resources and coordination of services.
- reduces in poverty/homelessness and has high employment and pays a living wage.

"A healthy community is a place that promotes joy, safety, interdependence, and connectedness. It is where people in the community are being well taken care of with jobs, healthcare and places to exercise."

Local Successes

There are many existing programs where neighbors and co-workers are improving their own health and that of their community. Participants identified successful local programs and suggested lessons we could learn from them.

Local Successes

- Community centers & neighborhood associations like Ivanhoe, Legacy Park, Lee's Summit, Johnson County & others that provide a variety of resources and events for all ages.
- Programs for youth like LINC, free/reduced-cost lunch, Boys and Girls Clubs and after-school & summer programs.
- Community clinics providing health, mental health and dental services for underserved people at Swope, Kansas City CARE Clinic, Samuel Rodgers, UMKC Dental School & Metro Care.
- Programs for pregnant women like WIC.
- Tobacco education programs like TAR WARS.
- Community kitchens & food pantries such as Harvesters and Cass County.
- Transportations services such as OATs, CAR at Lexington County, Jewish Community Center.
- Free interpretation services.
- Homeless shelters like Hope House and Community Connect.
- Partnerships with police, mental health providers and courts.

Lessons We Can Learn from Them

- Significant amount of care is needed, especially for the homeless.
- Communicating and working together we can accomplish much.
- Being pro-active is better than being reactive.
- Greater access is needed to free clinics.
- More medical providers are needed.
- Providers and community need to be humble, respectful & cooperative.
- Culturally relevant practice and cultural competency are important.
- Immigration issues should not be a barrier to access.
- Family-focused services work.
- Mental illness should be decriminalized.
- Best practices are captured and duplicated.
- Sustainable funding is critical.
- Faith communities should be engaged on health issues.
- Education, awareness and prevention are essential.
- Services are coordinated among providers.

Strategies for Achieving the Results

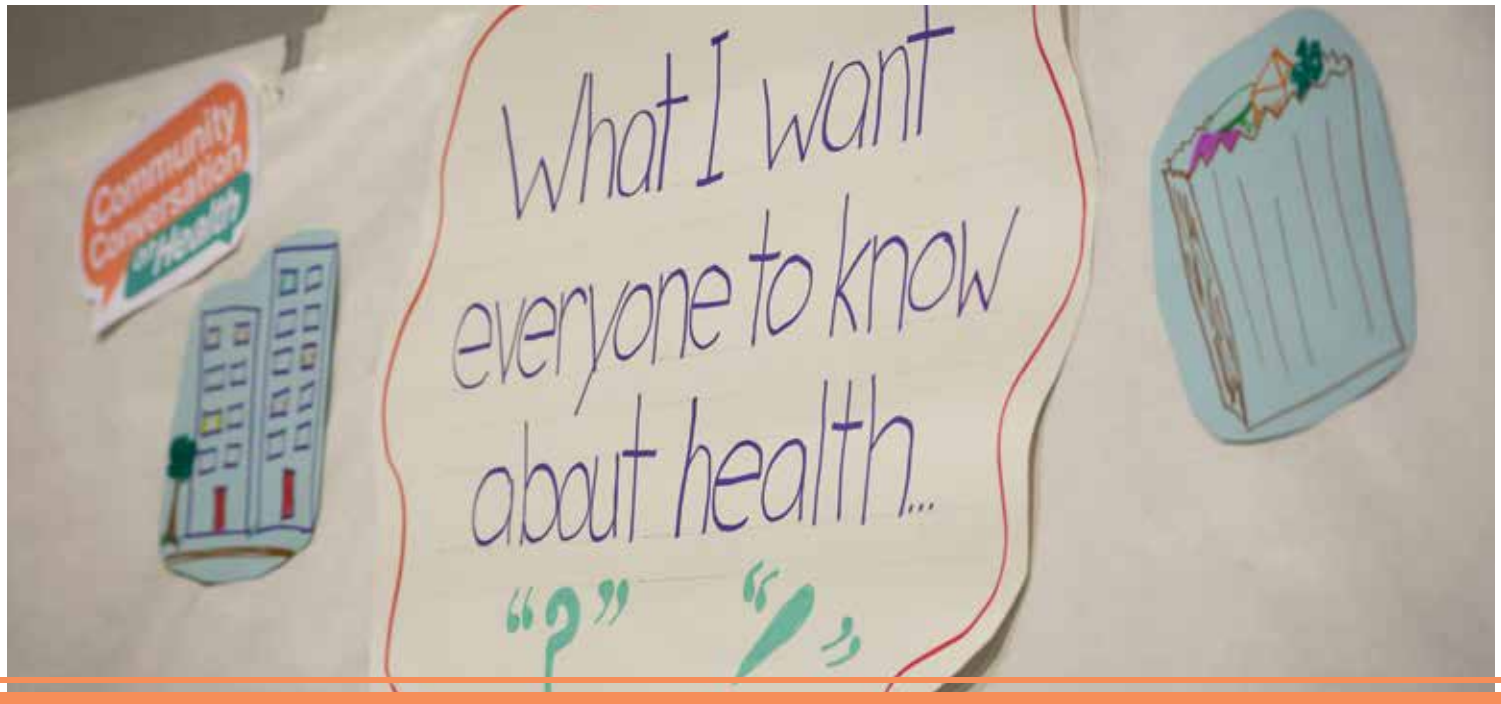
During the next discussion, tables were assigned one of the results and were asked to identify strategies for achieving them. The table below shows examples rather than themes.

THE RESULT	EXAMPLES OF STRATEGIES
Affordable healthcare for all (including immigrants).	• Advocate expansion of Medicaid outside the metro KC area, including all state representatives in KS and MO. • Foster collaboration among healthcare interest groups & other stakeholders working toward affordable health care for all. • Push for health care policies that will regulate the health care system and standardize fees for equitable health care. Voting will be promoted to pass these policies.
Policy makers and community members are working together to address health issues.	• Hold politicians accountable and publicize votes. • Require participation at town hall meetings. • Institute campaign finance reform by eliminating special interest influence.
Reduction in prevalence of chronic diseases – cancer, obesity, autism, HIV, dementia, lupus, heart disease.	• Teach healthy food choices and portions to children. • Increase physical education activities in schools and centers. • Promote development of home and community gardens. • Use marketing, media to educate about chronic disease.
Communities are safer and violence is reduced	• Build positive relationships between communities and police. • Involve communities in neighborhood watch programs. • Create alternatives for youth activities. • Use public-private partnerships to improve safety.
Reduction in tobacco, drugs and alcohol use.	• Increase tobacco and alcohol taxes to fund prevention and treatment. • Institute prescription drug monitoring system in Missouri. • Include substance abuse and smoking cessation treatment in all insurance coverage.
Stigma of mental illness is erased.	• We need to find ways to change the language in such a way that mental health challenges can be easily recognized and treated with compassion. • More public stories of what a person with mental illness "looks" like. Educating parents about what mental illness looks like. • Treatment programs should incorporate job corps. and/or volunteer opportunities so that users can feel a sense of self-worth.
Improvements in youth health (reduction in obesity, mental health, teen pregnancy).	• Train parents on how to talk to their kids about sex, pregnancy and mental health. • Teach kids early in school how to eat healthy and exercise. • Educate youth on making the good food choices instead of restricting foods. Substituting not restricting. For example: one oatmeal cookie instead of two chocolate chip cookies. • Provide more safe things for kids to do outside of school.

Strategies for Achieving the Results, cont.

During the next discussion, tables were assigned one of the results and were asked to identify strategies for achieving them. The table below shows examples rather than themes.

THE RESULT	EXAMPLES OF STRATEGIES
Increased access to quality in-home health care, more seniors staying in their homes.	• Make sure that in-home healthcare provider for seniors, are educated, honest, accountable and affordable. • Provide financial support so seniors can remain in home, such as tax breaks and modifications to Medicare.
Increased access to healthy foods.	• Provide a tax structure that incentivizes for urban grocery stores and farms; re-appropriate National Farm Bill funds. • Offer a property tax break to individuals growing their own food. • Offer classes in communities on how to cook and prepare healthier meals.
Electronic medical records are accessible and portable.	• All patient records will be kept by the "medical care home" (or primary care physician's office) with proper security measures implemented. The patient then, has one account to view all medical records and one password electronically. • Develop a 'micro-dot' to be placed on individual's ID cards including driver's license. Something small enough that it is handy when people go to the doctor's office and hospitals.



"I got Medicare but do not have prescription coverage. I waited two years for this coverage and have mounting medical bills and meds I cannot afford."

"I was working in food service as a production worker and had to deny my raise because it would have taken my children off Medicaid."

"I am a mother to a disabled child. It is a constant struggle to get her basic medical needs covered. I am always praying for a better solution."

"It takes a village. We need to communicate. Plan out ideas. Apply yourself. We don't work together. Nobody knows their neighbor. Care for each other."

"Health care is a right not a privilege. We need comprehensive health care from cradle to grave, with less emphasis on the business side."

"The violence in our communities are unacceptable. People are in survival mode on a grander scale than we ever realized."

"There is such great disparity. How can one county have a number one ranking and the next be at the bottom?"

Medicaid Makes (Dollars &) Sense

Savings Improve Missouri's Fiscal Picture

MBP
MISSOURI BUDGET PROJECT

Opponents of Medicaid expansion in Missouri claim that Missouri cannot afford to extend Medicaid benefits to healthy adults up to 138 percent of the federal poverty level. But because the federal government would pick up many costs the state is currently paying, expanding Medicaid would actually ***save*** the state money – more than $81 million initially, and more than $100 million annually in later years.[1] ***The truth is, Missouri can't afford not to expand and transform our Medicaid program.***

Medicaid - The History

Medicaid and Medicare were passed by Congress in 1965. Medicare, a program funded and managed by the federal government, would serve seniors and people with disabilities. Medicaid would be a voluntary state-federal partnership to serve lower-income people. In 1967, Missouri joined that state-federal partnership by creating its own Medicaid program, now known as MO HealthNet.

MO HealthNet is the most expansive and diverse health care program in the state. It covers the cost of nearly half the births every year in Missouri.

Missouri's MO HealthNet:

- covers 1 out of every 7 Missourians[2]
- covers 34% of Missouri's children[2]
- pays for 42% of all births in the state[3]
- covers 1 out of every 10 seniors over age 65
- pays for 61% of all nursing home care in the state[4]
- covers Medicare premiums, deductibles, and coinsurance for eligible seniors and people with disabilities

Nearly 34 percent of Missouri's children and one out of every ten senior citizens are insured through MO HealthNet, which is the largest payer of long-term care in the state.[5]

Currently, MO HealthNet has the lowest eligibility allowed under federal law, covering custodial parents with incomes up to just 19 percent of the federal poverty level. It does not cover adults without children at all.

While 28 percent of MO HealthNet participants are aged, blind or disabled, they account for 64 percent of the program's cost; the 72 percent of participants that are parents and children account for only 36 percent of the cost.[6]

While the general proportion of federal to state dollars can vary slightly, in Missouri the federal government currently pays 63 percent of the costs of the program, and the state pays 37 percent.[7]

The ACA and 138% FPL

The Affordable Care Act (ACA) passed by Congress in 2009 took a two-prong approach to expanding health insurance coverage: subsidies to purchase health insurance through an "exchange" or "marketplace" would be available to individuals between 100 and 400 percent of the federal poverty level, and states would expand the benefits of their Medicaid programs to parents and to adults without children at home to those with incomes up to 138 percent of the federal poverty level (FPL).[8]

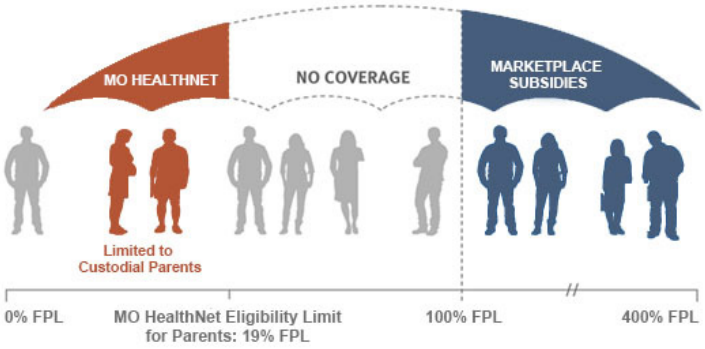
[1] Missouri Office of Administration, Division of Budget and Planning
[2] StateHealthFacts.org "Health Coverage and the Uninsured, 2011," Kaiser Family Foundation, 2014, http://kff.org/state-category/health-coverage-uninsured/
[3] Missouri Information for Community Assessment (MICA), "Prenatal Service Utilization" Missouri Department of Health and Senior Services, 2011, http://health.mo.gov/data/mica/mica/birth.php.
[4] IBID 2
[5] StateHealthFacts.org, "Distribution of Certified Nursing Facility Residents by Primary Payer Source, 2011," Kaiser Family Foundation, 2014, http://statehealthfacts.org/comparebar.jsp?ind=410&cat=8.
[6] "Where do the MO HealthNet dollars go?", Missouri Department of Social Services, Division of MO HealthNet
[7] StateHealthFacts.org "Federal Medicaid Assistance Percentage (FMAP) for Medicaid and Multiplier," Kaiser Family Foundation, http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/
[8] Modified Adjusted Gross Income (MAGI) after 5% income disregard

UPDATED January 2015

Under this Medicaid expansion, the federal government would cover 100 percent of the cost for three years (2013-2016) and then slowly ratchet down to 90 percent over several years. **The 90 percent match rate is a permanent rate. Over the 48 year life of Medicaid, the federal government has never reduced a permanent match rate.**[9]

Because the ACA assumed states would extend Medicaid benefits, and Missouri's eligibility thresholds are so low, parents between 19 and 100 percent FPL and all childless adults below the poverty level are ineligible for premium assistance to purchase insurance through the healthcare marketplace – creating a "coverage gap" for more than 260,000 Missourians.

Failing to Expand MO HealthNet Leaves Gap in Coverage



The Federal Reimbursement Allowance (FRA)

When calculating the general revenue contribution to Medicaid expansion, it is critical to remember the valuable role of the federal reimbursement allowance (FRA). Often called the Provider Tax, the FRA is a tax paid by hospitals to help cover the state cost for MO HealthNet. There are now reimbursement allowances in Missouri that also cover nursing facilities, as well as pharmacy and ambulance services.

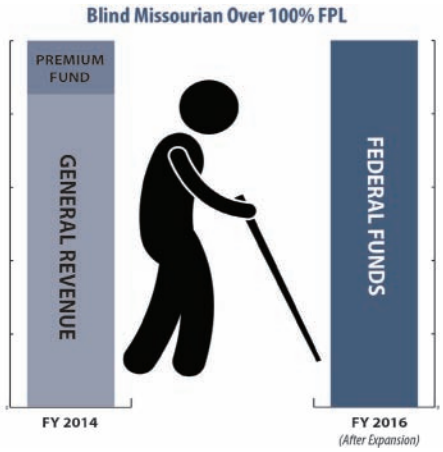
This funding mechanism, passed in Missouri in 1992, allows the entity paying the tax to immediately turn around and receive an even greater payback from the federal match. Essentially, before the tax has even been paid, the taxpayer has already received a benefit outweighing the cost of the tax.

Here's how it works: A hospital pays the state a tax of one dollar - that tax can be through non-reimbursed services provided or direct cash payment. MO HealthNet then takes that dollar and uses it to leverage the matching funds that the federal government provides for Medicaid. In Missouri, the state receives two federal dollars paid for every one state dollar. Those two dollars are then paid back to that same hospital to provide services to people who are covered under MO HealthNet. As a result, the FRA reduces the general revenue portion of the state's Medicaid costs, which will further reduce the cost of Medicaid expansion, as explained later.

Saving State Dollars through Expansion

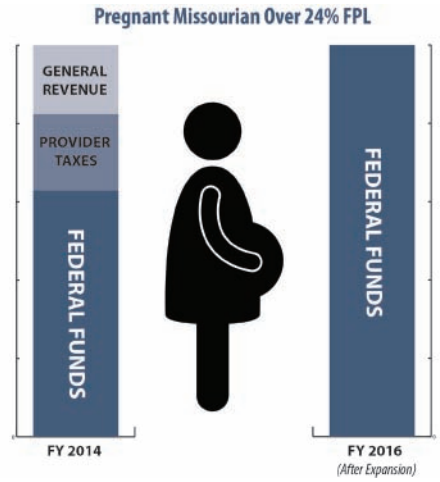
Although it seems counterintuitive, the State of Missouri can actually save money by expanding MO HealthNet to healthy adults living below 138 percent of the federal poverty level and by taking advantage of the ACA's higher match rate for populations already covered for health services in Missouri.

Missouri currently covers some populations that do not receive any federal matching dollars at all. For instance, MOHealthNet covers some blind Missourians using state-only dollars. Likewise, prisoners in the custody of the Department of Corrections[10] (childless adults) must receive medical care, but because MO HealthNet doesn't cover them, the state pays 100 percent of the cost.



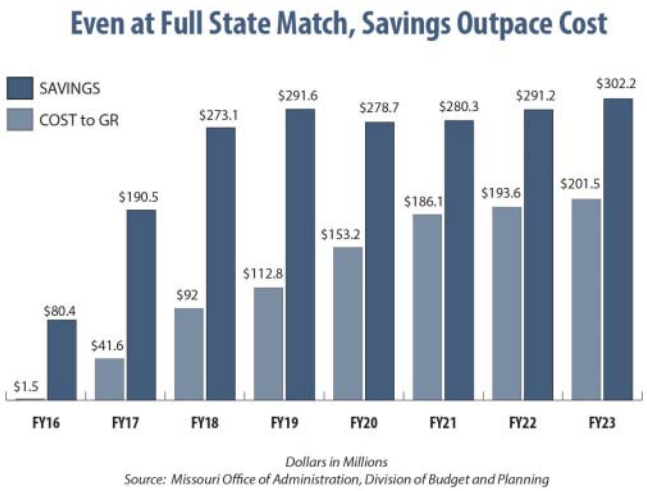
[9] National Health Law Program, "Why the Medicaid Expansion is a Safe Choice for Your State", February 2013
[10] Medicaid coverage for prisoners only allowable for inpatient hospital care

UPDATED January 2015

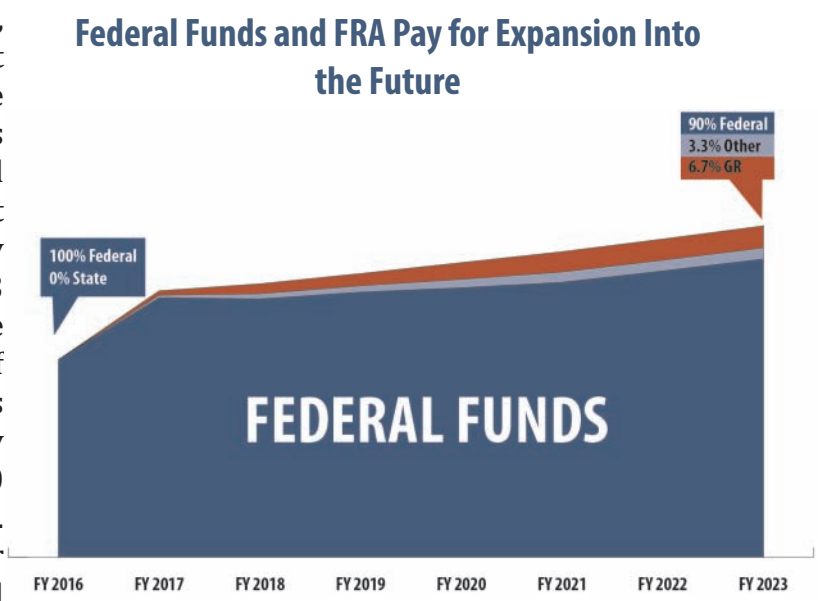


In addition, MO HealthNet covers some populations that the federal government currently provides 63 percent of the cost for, but if MO HealthNet is expanded, they will pay 100 percent of the cost, slowly lowering to 90 percent. These consumers will receive the same care under the same program – only the entity paying the bill changes.

In all, Missouri stands to gain more in savings from the current program than the state will spend on covering new populations. These savings result from the enhanced permanent 90 percent match rate for populations the state currently covers at lower (or nonexistent) match rates.



In addition, because Missouri's FRA will cover a portion of the state match for the expanded coverage, even when Missouri's full commitment of state dollars is phased in, the state general revenue portion of the cost will be just 6.7 percent of the total cost. As a result, the savings far outpace the state's general revenue cost.



These savings DO NOT account for the economic activity that will no doubt come from an influx of $2 billion into the state economy; it's just the simple math of moving one population from one funding source to another.

Conclusion

The math is simple and clear. Missouri must act quickly if we are to take full advantage of the resources being offered to make our system more efficient and effective for consumers. The eventual $100+ million annual savings could be used to fund the K-12 education formula or restore some services cut during the Great Recession. As the 2015 legislative session begins, Medicaid expansion should be a top budgeting and policy priority.

Appendix

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Number of Newly Eligible Medicaid Participants								
	301,473	308,082	314,690	321,298	321,298	321,298	321,298	321,298
Cost-For Newly Eligible Participants								
Total	($1,792,218,527)	($2,415,736,782)	($2,479,314,405)	($2,572,590,561)	($2,671,583,231)	($2,770,774,102)	($2,885,501,805)	($3,005,553,177)
State Share-GR	$0	($40,723,088)	($91,193,804)	($112,010,439)	($152,329,800)	($185,269,455)	($192,794,801)	($200,639,355)
State Share-Other	$0	($20,323,134)	($45,355,815)	($55,487,000)	($75,402,506)	($91,807,955)	($95,755,379)	($99,915,962)
Federal Share	($1,792,218,527)	($2,354,690,561)	($2,342,764,785)	($2,405,093,123)	($2,443,850,926)	($2,493,696,692)	($2,596,951,625)	($2,704,997,860)
Savings-State Share Change in Existing Programs								
Pregnant Women	$12,507,538	$33,004,979	$43,175,611	$43,547,481	$42,341,483	$41,820,410	$43,576,868	$45,407,096
Breast/Cervical Cancer	$1,344,043	$3,813,675	$6,122,376	$6,928,467	$6,742,641	$6,664,576	$6,944,488	$7,236,157
Blind Pension	$715,970	$949,806	$959,647	$989,370	$1,008,642	$1,034,124	$1,077,558	$1,122,815
Corrections	$1,174,053	$1,526,268	$1,479,306	$1,463,652	$1,432,344	$1,408,863	$1,408,863	$1,408,863
Mental Health	$22,690,557	$30,181,154	$30,035,310	$29,889,467	$29,816,545	$29,816,545	$29,816,545	$29,816,545
Other	$41,983,886	$121,065,936	$191,357,908	$208,845,016	$197,343,151	$199,601,627	$208,396,741	$217,197,932
Total	**$80,416,047**	**$190,541,818**	**$273,130,159**	**$291,663,454**	**$278,684,807**	**$280,346,146**	**$291,221,063**	**$302,189,408**
Medicaid Reform Savings-Expansion Population								
Cost Sharing	$0	$499,715	$1,113,343	$1,362,017	$1,859,662	$2,266,689	$2,368,583	$2,487,023
Reduced Recidivism	$2,119,961	$3,741,703	$5,191,921	$6,084,363	$6,825,445	$7,378,544	$7,736,289	$8,118,020
Subtotal	$2,119,961	$4,241,417	$6,305,264	$7,446,380	$8,685,107	$9,645,233	$10,104,872	$10,605,042
GR Summary								
GR Cost - New Eligibles	$0	($40,723,088)	($91,193,804)	($112,010,439)	($152,329,800)	($185,269,455)	($192,794,801)	($200,639,355)
GR Cost - Administration	($1,527,500)	($842,500)	($842,500)	($842,500)	($842,500)	($842,500)	($842,500)	($842,500)
GR Savings - Existing Programs	$80,416,047	$190,541,818	$273,130,159	$291,663,454	$278,684,807	$280,346,146	$291,221,063	$302,189,408
GR Savings - Expansion	$2,119,961	$4,241,417	$6,305,264	$7,446,380	$8,685,107	$9,645,233	$10,104,872	$10,605,042
TOTAL SAVINGS	**$81,008,508**	**$153,217,648**	**$187,399,119**	**$186,256,894**	**$134,197,614**	**$103,879,424**	**$107,688,634**	**$111,312,596**

Source: Office of Administration, Division of Budget and Planning

Missouri lawmakers continue opposition to Obamacare and Medicaid expansion

BY JASON HANCOCK - THE STAR'S JEFFERSON CITY CORRESPONDENT

01/04/2015 7:59 PM

JEFFERSON CITY - Bob Onder hasn't been sworn in as a state senator yet, but his first priority is already clear.

"Fighting the effects of Obamacare in Missouri is at the top of my legislative agenda," Onder said.

The only bill the Republican from St. Charles has filed so far would strip an insurance company of its license to sell policies in Missouri if it were to accept federal subsidies for plans sold through Missouri's federally run health exchange.

But he doesn't intend to stop there. Onder also made another campaign promise regarding the federal health law that he intends to keep.

"I will do everything I can," he said, "to prevent Medicaid expansion."

As it turns out, keeping that promise probably will be pretty easy.

Legislative leaders in the Missouri House and Senate have said any discussion of Medicaid expansion is off the table in 2015. A group of Republican senators has promised to filibuster expansion if it somehow did get traction.

Even expansion's loudest boosters don't see much cause for hope in the short term.

"If (legislative) leadership doesn't want to talk about it, then there's not a whole lot that can be done," said state Sen. Ryan Silvey, a Kansas City Republican who sponsored an expansion bill during the 2014 session.

The Republican-dominated General Assembly has repeatedly balked at the idea of accepting billions of federal dollars to offer Medicaid coverage to around 300,000 uninsured Missourians — a key provision in the federal health care law.

Opponents of the idea have expressed concerns about the long-term costs, both to the federal and state governments. They also object to expanding the number of people in the Medicaid program without dramatic changes to how it functions.

"To expand Medicaid would only put further stress on a system that's already strained," Onder said.

Those arguments have won the day. And with expanded GOP majorities in both legislative chambers, that's not likely to change anytime soon.

"Take a look at the elections," incoming House Speaker John Diehl, a Republican from the St. Louis suburbs, said shortly after his party won its historic veto-proof majority. "Clearly, on the

federal level, Obamacare has been rejected by the voters of this country and … it's also been rejected by the voters of this state."

While odds are long for success, proponents of expansion continue to lean on two factors they hope will sway skeptical lawmakers.

The first is a coverage gap.

Currently, to be eligible for Medicaid in Missouri, a non-elderly adult must have a dependent child and can earn no more than 19 percent of the poverty level, or roughly $3,700 for a single mother with two children. Federal tax credits help offset costs of insurance for those earning between 138 percent and 400 percent of the poverty level.

Medicaid expansion was supposed to cover the 200,000 Missourians earning between 19 percent of the poverty level and 138 percent. As things stand, though, they qualify neither for Medicaid nor federal subsidies to help them purchase private insurance.

That means a family of four earning up to $95,000 a year qualifies for assistance. A similar family earning $32,000 doesn't.

The second concern of proponents is the phasing out of federal funding for hospitals to offset the costs of providing care to the uninsured.

When the federal health law was written, it was assumed hospitals would no longer need that money because the previously uninsured would have either subsidized private coverage or Medicaid.

The Missouri Hospital Association has warned rural hospitals will face huge cutbacks, or even closure, without Medicaid expansion.

"It won't be the president that closes rural hospitals," said state Rep. John Rizzo, a Kansas City Democrat. "It will be the rural legislators themselves who opposed Medicaid expansion."

Silvey says simply expanding Medicaid would be a mistake. But he said the state shouldn't stand by while rural hospitals close and the working poor remain stuck in the coverage gap.

"We have to govern in the world we live in," Silvey said, "not the world we wish we lived in."

Besides, Silvey said, Republicans can achieve a litany of long-sought changes to the state's welfare system if they are tied to expansion.

Last session he helped put together a plan that would use federal money to help finance private health insurance for low-income adults. It would also implement changes to Medicaid and other entitlement programs such as food stamps.

"These reforms individually would face a filibuster or they would get vetoed," Silvey said. "But as part of a comprehensive reform package of the state's welfare system that includes some sort of expansion, I think they could become law."

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http://www.examiner.net/article/20150117/News/150119058#ixzz3P5I62pGa

Hospital challenged by insurance gap

By Jeff Fox - jeff.fox@examiner.net
Jan. 17, 2015

Independence, Mo. With one-third of its patients lacking medical insurance, the cost of uncompensated care continues to hammer the finances of Truman Medical Center.

“These are folks that tend to be very sick, without means and are without health insurance,” President and CEO Charlie Shields told Jackson County legislators this week. “That’s what it means to be a safety-net hospital.”

Shields outlined TMC’s challenges during county budget hearings. The county’s $292.02 million budget, likely to be approved Tuesday, includes nearly $10 million for TMC – $3.4 million for operations and $6.3 million for debt service, mainly for renovations several years ago at the Lakewood facility.

TMC has two hospitals. The Hospital Hill facility is at 23rd Street and Holmes Road in Kansas City. The Lakewood facility at Lee’s Summit Road and 79th Street provides care for a large number of Eastern Jackson County residents.

About three-fourths of TMC patients have incomes below the poverty line. Of the two hospitals’ 112,000 patients last year, 41,000 had no insurance, Shields said. They generally have low-paying jobs with no health coverage.

“The folks that get care from Truman face a number of challenges every day that you or I don’t face,” Shields told legislators.

As a public hospital, TMC takes all patients, regardless of the ability to pay. Its two campuses provided $134 million in uncompensated care last year – 12 percent of all uncompensated care in the state. That figure is expected to hit $140 million this year.

“So the gap continues to grow,” he said.

Hospital officials across the state also say not expanding the Medicaid program is hurting their finances. Nationwide, 29 states have expanded Medicaid – health insurance for the poor – in accordance with the Affordable Care Act. Missouri is not among them, and advocates say that leaves roughly 300,000 Missourians

without health coverage. The General Assembly is considered unlikely to act on the issue this year.

“I think it’s still a challenging issue for the Legislature,” said Shields, a former state senator.

Without that expansion, there is a gap: Those with incomes above the federal poverty level can buy insurance – and often get subsidies – through the health-care exchanges set up under Obamacare. Those at or below 18 percent of the federal poverty level – $4,200 a year for a family of four – can get Medicaid in Missouri. Those in between do not qualify for any assistance – and that’s what drives the high level of uncompensated care.

“So they’re in that gap, and that’s the challenge,” Shields said.

TMC gets about $100 million in government subsidies a year – $9.8 million from the county, $26 million from Kansas City and the rest in federal payments to offset uncompensated care, but Washington plans to cut those funds dramatically in a few years on the theory that expanding Medicaid means many of those dollars flow to hospitals for their services.

TMC is looking at about a $14 million deficit this year, Shields said, and it’s making up the difference by deferring depreciation.

The hospital has cut 170 to 180 positions through employee buyouts and leaving open positions unfilled, and it now has fewer than 4,000 employees.

“We’re not trying to be the next St. Luke’s, the next Centerpoint,” he said. “We want to be a very good safety-net hospital.”

Readmore: http://www.examiner.net/article/20150117/News/150119058#ixzz3P5IEzLpr

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A+E
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OUR HEALTH IS GOING DOWNHILL

Experts say a lack of public commitment to better well-being has caused rankings to slide for Kansas and Missouri.

By ALAN BAVLEY
The Kansas City Star

So what's the matter with Kansas *and* Missouri?

We used to be among the nation's healthiest states. But we've been plummeting toward the bottom half of the pack.

The United Health Foundation, which has been ranking the overall health of states since 1990, recently named Kansas and Missouri among the seven states that have sunk the furthest on its list over the past 25 years. The rankings are based on a broad range of health, environmental and socioeconomic data.

A robust Kansas was in 12th place in 1990; now it's a middling 27th, according to the latest edition of the foundation's America's Health Rankings. Missouri used to be among the better half of states at 24th place; now it's a dismal 36th.

Sure, plenty of us still smoke. Few of us exercise. We're not bothering to keep our kids up to date on their vaccinations. And we aren't eating our fruits and vegetables.

But there's a lot more going on here, health experts say. In much of the Midwest, we just haven't been making a major public commitment to improving the health of our citizens, they say, and the results are catching up with us.

Along with Kansas and Missouri, the five other states that have fallen the most in the health rankings are all in the nation's heartland, from Ohio to Oklahoma. It's not that these states haven't made any improvements; some trends are positive.

SEE RANKINGS | A10

HEALTH RANKINGS

In the latest edition of America's Health Rankings, Kansas stands at 27th among the states, down from 12th in 1990. Missouri used to be in 24th place; now it's No. 36.

Source: United Health Foundation
THE KANSAS CITY STAR

"What explains this dramatic difference between the coasts and the Midwest is broad investments on the coasts in things that make communities healthy."

PATRICK REMINGTON, UNIVERSITY OF WISCONSIN

ILLUSTRATION BY NEIL NAKAHODO | THE KANSAS CITY STAR

Another Bol reaches for the heights

SAM MELLINGER

COMMENTARY

The boy walked into his high school basketball coach's office staring at the ground. He didn't want to be here, at this new school with all of these strangers. He no longer cared who knew. He needed some help.

"Look at me," the boy told his coach. "How am I supposed to be happy like this?"

The boy is 14 years old and already 6 feet 10 — taller than 99 percent of American adults and most of the NBA. He is already talented enough that the coaches at Kansas have called. Same with Missouri, Kansas State and many others. All for a freshman who hasn't even played a varsity basketball game yet.

A transfer rule will keep him off varsity for another month, so the boy's high school career consists of two junior varsity games. Out of the first came a video that spread across the country, this smooth creation of arms and legs and bones blocking shots and even hitting a step-back three-pointer. His coach says the video is misleading, which the people who

SEE BOL | A12

RICH SUGG | THE KANSAS CITY STAR

Looking at Bol Bol, a 6-foot-10-inch freshman at Bishop Miege, people often see reflections of his father, former NBA star Manute Bol.

Gift card economy is so simple and yet so mysterious

We like the cards but don't always grasp that retailers want them used in a hurry.

By RICK MONTGOMERY
The Kansas City Star

The U.S. economy has functioned just fine on gift card currency since Christmas.

These last several days, wise consumers wasted no time redeeming that IOU from Best Buy or Home Depot, courtesy of cousin Carl.

Lest they forget and let all that value languish in a junk drawer. In fact, a survey by Consumer Reports found that one in four of us doesn't spend gift cards within a year of getting them.

But most shoppers are learning in this everywhere-you-turn economy of the modern gift card, now observing its 20th anniversary.

"My advice would be to use up your gift cards as soon as you get them," said Shelley Hunter of GiftCards.com, a trader in gift cards of all varieties. "Do it now."

Retailers, for one, would love that.

Contrary to common notions about unused gift cards, "retailers really do want you to use these cards up," Hunter said. "It's cleaner on their books."

Cleaner on their books? So what else don't we know about these cards?

Experts say consumers take gift cards for granted and don't know how they function. Same as money, right, only encoded on

SEE GIFT CARDS | A20

LOCAL

A video of a mid-Missouri drug task force detective kicking a restrained, prone suspect in the head is raising allegations of police brutality. The suspect's family has hired a lawyer to look into the matter. **| A4**

A+E **D1** | CAREER BUILDER **F1** | CLASSIFIED **F2** | DEATHS **A14-17** | H+H **C1** | LOCAL **A4** | LOTTERIES **A8** | MOVIES **D7** | OPINION **A18-19** | SPORTS DAILY **B1** | SUNDAY HOMES **E1**

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RANKINGS: Unhealthy slide in Kansas, Missouri

FROM A1

And there are visible signs of progress, like bicycle lanes cropping up in Kansas City, Kan.; community gardens in Jackson County; and new smoking restrictions in many places.

But other states, notably on the East and West coasts, have been doing a lot more.

"What explains this dramatic difference between the coasts and the Midwest is broad investments on the coasts in things that make communities healthy, from education to public health," said Patrick Remington, associate dean for public health at the University of Wisconsin. Wisconsin dropped from seventh to 23rd.

"It generally reflects an attitude in these Midwestern states that there should be a limited role for public health, as compared to a place like New York," Remington said.

New York saw the most dramatic improvement in the rankings over the past 25 years, rising from 40th place to 14th. New York expanded its Medicaid program to provide health insurance coverage for more people with low incomes long before the Affordable Care Act made that a national policy — although it's a policy that Kansas, Missouri and many other states have not followed.

New York also has strict laws limiting public smoking. New York City even tried to prohibit megaservings of sugary drinks before a court struck down the ban.

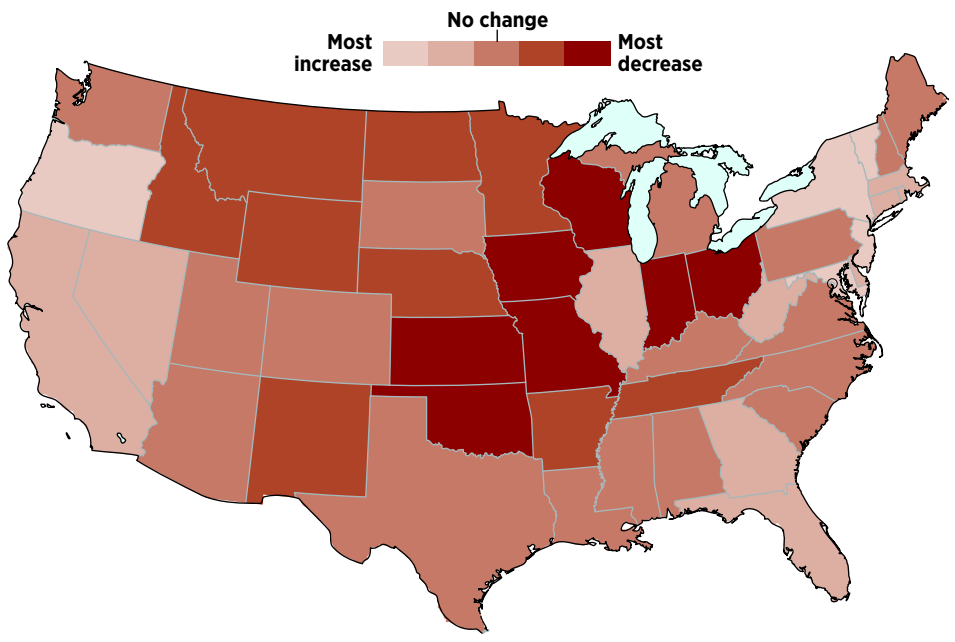
"Obviously, Missouri is a different place from New York, and that's fine," said Sarah Patrick, an associate professor at the St. Louis University College for Public Health and Social Justice. "But we are getting behind the curve on these health behaviors."

Patrick used to be Missouri's state epidemiologist, tracking its disease trends from 2008 through 2011. She saw the state's approach to health promotion firsthand.

"Missouri has just been (reluctant) to take policy actions to improve health," she said. "There's a lack of engagement or belief that policies can work."

HOW'S OUR HEALTH TRENDING?

Data collected over 25 years by the United Health Foundation to rank states' health status show that, with some exceptions, states on the East and West coasts have seen their standings rise the most, while Midwestern states, including Missouri and Kansas, have fallen the furthest.



LARGEST CHANGES IN RANK SINCE 1990

Rank improved	1990 rank	2014 rank	Change
New York	40	14	26
Vermont	20	2	18
Oregon	28	12	16
Maryland	31	16	15
Alaska	37	26	11
New Jersey	21	11	10

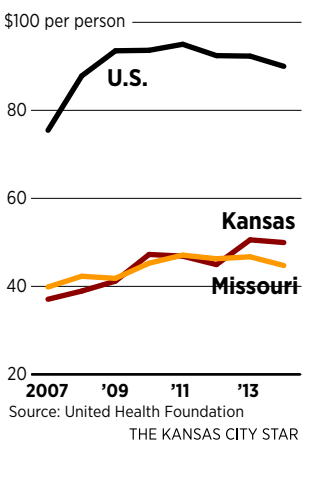
Rank declined	1990 rank	2014 rank	Change
Iowa	6	24	18
Wisconsin	7	23	16
Kansas	12	27	15
Oklahoma	32	46	14
Ohio	27	40	13
Missouri	24	36	12
Indiana	30	41	11

Source: United Health Foundation THE KANSAS CITY STAR

> "I could make a huge difference in life expectancies in Kansas City if I had just the median of what other health departments are paid."
>
> REX ARCHER, KANSAS CITY HEALTH DEPARTMENT DIRECTOR

PUBLIC HEALTH FUNDING

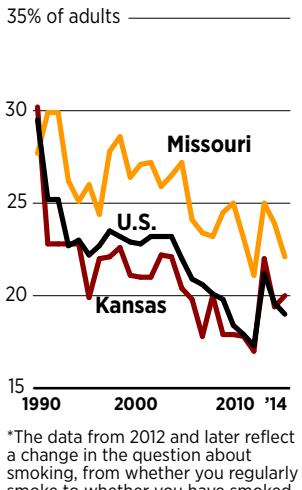
Missouri budgets less money per capita for public health than any other state. Kansas comes in at No. 44. This chart includes both state and federal dollars.



Source: United Health Foundation THE KANSAS CITY STAR

ADULT SMOKERS

Kansas used to have a lower percentage of smokers than the U.S. as a whole, but not in the latest survey.



*The data from 2012 and later reflect a change in the question about smoking, from whether you regularly smoke to whether you have smoked at least 100 cigarettes in your lifetime and if you currently smoke.

Source: United Health Foundation THE KANSAS CITY STAR

Missouri slumps

Consider the data cited by America's Health Rankings:

- Over the past 25 years, the nation's cancer death rate has been slowly going down. Missouri's has been creeping up.
- In 1990, the rate of heart disease deaths was lower in Missouri than for the nation as a whole. Now the rate is higher.
- Diabetes used to be slightly less prevalent in Missouri than in the rest of the nation. Now it's just as common.

Out of the 27 measures used in the rankings, Missouri is among the bottom 20 states in 18 categories. In four categories —including smoking and immunizing adolescents — it's among the 10 worst.

Patrick said some relatively simple policy changes, starting with raising the state's tobacco tax, could benefit the health of Missourians.

At 17 cents per pack of cigarettes, Missouri has the lowest tobacco tax in the nation. The average state tax is $1.54 per pack. New York's tax is the highest at $4.35 per pack.

"We're just ignoring some of the evidence out there that higher taxes discourage smoking," Patrick said.

Missouri also can do more to prevent drug deaths, she said. It's the only state in the nation that doesn't have a system for monitoring sales of prescription painkillers and other potentially dangerous drugs, she said.

"The illegal drug distribution industry knows, 'Go to Missouri,'" Patrick said. "Nobody is monitoring there."

The drug death rate has been increasing in Missouri during the past few years while it has remained fairly flat nationwide.

A factor that stands out for Patrick is funding for public health.

"Since the beginning of the rankings, Missouri has been near the bottom," she said. "Many times, county health departments feel that public health functions are being pushed over to them by the state."

According to the Trust for America's Health, Missouri budgets less money per capita for public health than any other state. The national median for state spending is $27.49 per person. In Missouri, it's $5.86.

For the Kansas City Health Department, that means the state covers only about a fifth of what it costs to manage outbreaks of infectious diseases such as measles and whooping cough, department director Rex Archer said.

Archer estimates that his department's budget would grow by more than $10 million if Missouri spent as much on public health as other states do.

"I could make a huge difference in life expectancies in Kansas City if I had just the median of what other health departments are paid," he said.

With more money, Archer said, he could more aggressively tackle childhood exposure to lead, broaden outreach efforts to get more people immunized against the flu and provide more new parents with advice on good nutrition and language learning to better the brain development of their young children.

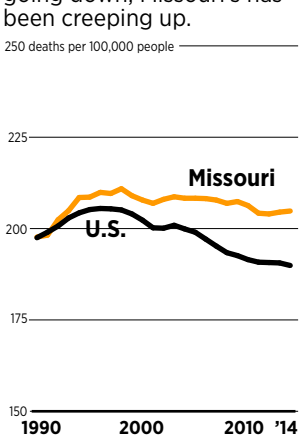
Archer suggested that it may have been easier politically to scrimp on public health than on other government programs. Budget cuts for roads or schools quickly lead to potholes and crowded classrooms. Health programs are less visible and can take years to yield a payoff.

Missouri's tight budget for public health "didn't happen on any one person's watch," Archer said. "But collectively, we just let it go downhill."

> "These are the consequences of more than two decades of underinvestment in public health."
>
> JEFF WILLETT, KANSAS HEALTH FOUNDATION VICE PRESIDENT

CANCER DEATHS

While the nation's cancer death rate has been slowly going down, Missouri's has been creeping up.



Source: United Health Foundation THE KANSAS CITY STAR

In an emailed response, the Missouri Department of Health and Senior Services said that in recent years it has supported efforts to expand Medicaid and implement a prescription drug monitoring program. The department is "continuously looking for potential initiatives and resources that could help improve health and wellness in our state ... (and) is always working to ensure both state and federal resources are used as effectively as possible."

But Missouri lawmakers have balked at expanding Medicaid or starting a prescription drug monitoring program.

Kansas too

Public health funding in Kansas also has come up short, and that's helped send the state skidding in the health rankings, said Jeff Willett, vice president of the Wichita-based Kansas Health Foundation, which funds health improvement initiatives.

The state budget's $14.07 per capita for public health puts it in 44th place, according to the Trust for America's Health.

And while it's not in the rankings cellar like Missouri, Kansas has slipped badly:

- Kansas has seen its cancer death rate rise since 1990. Nationally it has fallen.
- Kansas has one of the highest rates of occupational fatalities, more than 50 percent higher than the national rate.
- Kansas has among the lowest rates for immunizing children and adolescents. Just 53.8 percent of Kansas teens had all their recommended shots. In neighboring Nebraska, 68.4 percent of teens were fully immunized.

"These are the consequences of more than two decades of underinvestment in public health," Willett said.

And even where Kansas has made strides, such as reducing smoking, "the rest of the nation is outpacing us," he said. Kansas is among the 20 states with the highest smoking rates, according to the health rankings.

"We believe the state could turn this around," Willett said.

Increasing the state's tobacco tax — at 79 cents per pack, among the lowest — would raise revenues and reduce smoking, he said.

The Kansas Department of Health and Environment said in an emailed statement to The Star that since 2011 the department "has taken a closer look at our core public health mission and (has) implemented a strategic approach to budgeting for programs across the agency to better align our spending with our core public health mission ... to protect and improve the health and environment of all Kansans."

But casting a giant shadow over spending on public health is the state's looming revenue shortfall. Gov. Sam Brownback's recently proposed budget includes cuts to the state health department.

Turning it around

America's Health Rankings is the longest-running effort to compare the health status of states by using the voluminous data collected by government agencies, medical associations, academics and private organizations.

The rankings are determined by the United Health Foundation in partnership with the American Public Health Association and the Partnership for Prevention, a nonprofit organization that promotes preventive health care services.

The measures that go into the rankings include a range of health behaviors like smoking and binge drinking; personal health indicators such as diabetes and obesity; and indicators, such as preventable hospitalizations, that are used to rank health care quality. Also in the mix are environmental and social factors such as air pollution levels and number of violent crimes.

Over the past quarter century, the rankings have tracked numerous improvements in measures of the nation's health: Fewer people smoke. More are graduating from high school. Deaths from cancer and heart disease are down. There's less air pollution and fewer violent crimes.

But at the same time, rates of obesity and diabetes have soared. And levels of physical inactivity have remained persistently high.

States that have made the most progress "looked at their numbers and made deliberate efforts to focus on their weaknesses," said Georges Benjamin, executive director of the American Public Health Association.

Benjamin was Maryland's secretary of health from 1999 to 2002. His state was among the six to rise the most in the rankings, from 31st in 1990 to 16th in 2014.

Maryland "focused like a laser" on reducing its high infant mortality rate, Benjamin said, developing initiatives to make sure that pregnant women received health care and substance abuse treatment when needed.

Although still slightly above the national rate, infant mortality in Maryland dropped 43 percent over the past 25 years.

When many other states were plugging holes in their budget with the windfall they received from the multibillion-dollar 1998 national settlement of lawsuits against tobacco companies, Maryland was devoting much of it to cancer care and smoking prevention, Benjamin said. The state now has one of the lowest smoking rates in the nation.

"Public policy has always been a part of public health," Benjamin said. "In Maryland, we strongly believe that public policy, when done right, does work."

KC area efforts

Those kinds of initiatives have started taking root locally.

Since 2008, Truman Medical Centers has run a weekly produce market at its Hospital Hill and Lakewood campuses. A few years ago, the hospital ripped the seats out of an old city bus and replaced them with bins to create a rolling produce stand that brings fresh fruit and vegetables to underserved neighborhoods.

The hospital's next step is to build a grocery store on land it has acquired at 27th Street and Troost Avenue.

"The idea is to bring better choices of food to the people in those areas," hospital spokesman Shane Kovac said.

Kansas City, Kan., was galvanized into action in 2009 after a county-by-county health ranking placed Wyandotte County dead last in the state.

The mayor at the time, Joe Reardon, summoned community leaders to come up with priorities for improving the city's health and assembled teams of volunteers to develop plans. Their goals included making health care more affordable, fresh food more accessible, and streets and sidewalks friendlier to pedestrians and cyclists.

"We have an incredibly supportive commission and mayor, but we needed people like these in the community advocating," said Wesley McKain, program coordinator of the Healthy Communities Wyandotte initiative, which came out of these early discussions.

The results are beginning to appear. About a year ago, Wyandotte County built its first bike lane. The 3 ½-mile stretch along Southwest Boulevard is being extended along Merriam Lane to connect with Johnson County. Another bike lane is being developed along 10th Street.

During the enrollment periods for health insurance plans through the Affordable Care Act, Wyandotte County government and community groups mobilized to sign up the uninsured. Banks of volunteers were stationed at the health department and other locations to help people enroll. By last spring, the uninsured rate in Wyandotte County had fallen from 26 percent to 18 percent.

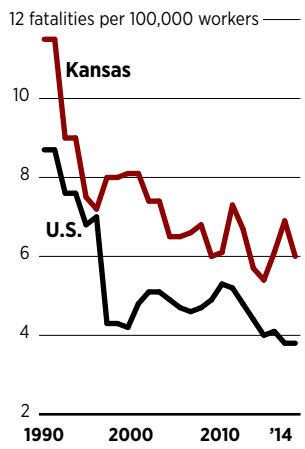
The Unified Government Commission last month approved a master plan, spearheaded by Mayor Mark Holland, to redevelop downtown Kansas City, Kan., as a "healthy campus" with a community and recreation center, grocery store, farmers market, green space, recreation fields, trails and sidewalks. Fundraising for the community center is underway.

"I do have faith that change is possible," Patrick said. "The idea is, how do we roll up our sleeves and deal with these issues?"

To reach Alan Bavley, call 816-234-4858 or send email to abavley@kcstar.com.

OCCUPATIONAL FATALITIES

Although Kansas' rate has dropped, it remains more than 50 percent higher than the national rate.



Source: United Health Foundation THE KANSAS CITY STAR

Center Superintendent David Leone announces retirement

01/07/2015

Center School District Superintendent David Leone announced Wednesday that he will be retiring at the end of the school year.

He spent 27 years in the south Kansas City district and 40 years in education, but will serve just one year as superintendent because of concerns with his health and his wish to spend more time with his family.

“This was not my plan when I signed on (to be superintendent),” the 61-year-old educator said. “I intended to stay a few years in the district I dearly love.”

Leone had taken over the helm after former Superintendent Bob Bartman retired last June. Leone had served as the special assistant to the superintendent. In past years he had been a principal, central office administrator and assistant superintendent in a district that has established itself as one of the area’s highest-performing urban school systems.

Center school board President Joe Nastasi praised Leone for his service, saying in a written statement, “Although some unforeseen health challenges have shortened his time as superintendent, it will not diminish the love he has shown the Center family.”

The board will begin discussions on a search process in an open board meeting at 6 p.m. Monday at Boone Elementary School, 8817 Wornall Road.

Joe Robertson, jrobertson@kcstar.com

Snodgrass to be district's next leader

By Brandon Dumsky brandon.dumsky@examiner.net
Posted Dec. 23, 2014 @ 6:11 am

Independence, Mo. - Fort Osage High School Principal Jason Snodgrass will become the new Fort Osage superintendent when Mark Enderle retires on June 30.

“The board is extremely excited to have Dr. Snodgrass as the next superintendent for Fort Osage,” said Fort Osage Board of Education President Diana Rice in announcing the decision on Sunday. “He is a genuine and warm person who possesses the knowledge and skills to keep Fort Osage moving into the future.”

Snodgrass has been the principal at Fort Osage High School since 2009.

The district said that under his leadership the high school has:

• Increased the graduation rate from 85.9 to 98.4 percent

• Reduced drop outs from 45 to 6 students

• Reduced the percentage of courses failed by 16 percent

• Increased the number of students taking the ACT exam by 10 percent

• Increased ACT composite scores from 20.9 to 21.3

• Increased the percentage of students scoring above the national average on the ACT exam from 29 to 35 percent

• Increased the MSIP student attendance standard by 7 percent

• Implemented 21 additional weighted courses

• Increased the number of advanced placement courses by 10 percent

• Increased number of students receiving post-secondary education

• Developed the Opportunity Plus Program

• Expanded the Credit Recovery Program

“I am honored to have been selected as the next superintendent of the Fort Osage School District,” said Snodgrass in a district release. “I look forward to working

cooperatively with the board of education, administrative team, faculty, staff, students, parents and patrons to provide the best school district possible."

Before becoming principal at Fort Osage, Snodgrass served as principal at Polo High School in Polo, Missouri, from 2003 to 2009. He also has worked in the Marceline and Brookfield school districts in north-central Missouri.

Snodgrass also has a number of distinctions and accomplishments. He was most recently recognized as the Missouri High School Principal of the Year in 2014 and named the Missouri Association of Student Councils Administrator of the Year for the Kansas City area and the Greater Kansas City Principal of the Year in 2013.

"We want what is best for the children of this district, and it all starts with great leadership at the top level," Rice said.

Snodgrass earned a bachelor of science in education degree from the University of Central Missouri in Warrensburg. He holds master of science in education and education specialist degrees from Northwest Missouri State University in Maryville. Snodgrass obtained a doctorate in educational leadership from St. Louis University in May 2010.

He and his wife, Jodie, live in Independence with their five children. Outside of school, Snodgrass serves as a youth league basketball coach. His family attends the Fort Osage Church of the Nazarene.

"My family and I are excited about being members of the Fort family for years to come. Fort Osage is a special community filled with wonderful people and I am thrilled about this opportunity," said Snodgrass.

Read more:
http://www.examiner.net/article/20141223/News/141229750#ixzz3OF5rT2SS

GOVERNING
THE STATES AND LOCALITIES

A Major Flaw in the Welfare Law

A new GAO report says the nation's largest cash assistance program fails to incentivize states to help people find work.

by J.B. Wogan | January 13, 2015

The 1996 federal welfare reform law is discouraging states and localities from experimenting with some of the most promising ideas for getting people back to work, according to a recent report by the U.S. Government Accountability Office (GAO). The independent auditing arm of Congress found that incentives baked into the nation's largest cash assistance program -- Temporary Assistance for Needy Families (TANF)-- actually undermine efforts to employ the poor.

The problem, according to the report, is that the current system encourages states to focus on activities that help them meet a flawed federal performance measure: the work participation rate. The measure, said Elizabeth Lower-Basch, a welfare policy analyst at the Center on Law and Social Policy, doesn't reflect how many people on TANF are working, or even doing the things most likely to lead to work. "It's a process measure," she says. "It doesn't look at whether people get jobs."

Instead, the participation rate requires states to make sure that at least half of eligible TANF families participate in one or more prescribed activities -- such as searching for work or job training -- for a certain number of hours per month. The report also notes that the measure adversely encourages TANF agencies to concentrate on job-ready participants or participants that might not need as much help as "hard-to-employ" participants who have health problems, disabilities, criminal records, dependence on drugs, limited education or a responsibility to care for a disabled relative. In either case, states appear to be meeting the letter of the law, but not its intent.

To better promote innovative, research-driven employment approaches, the GAO report points to four evidence-based strategies, detailed below, being implemented in 10 places around the country: subsidized employment, treatment coupled with employment services, career pathways and modified work first.

With **subsidized employment**, public funds create or support temporary work for someone who would otherwise be unemployed. One example is the San Francisco Jobs Now! program, which gradually reduces its contribution to a participant's wage over five months. Public funds cover 100 percent of wages in the first month, 75 percent in the second month and $1,000 per month for the next three months. Employers have to agree to try to retain the participant once the subsidy runs out. San Francisco

administrators told the GAO that the employee retention rate is between 75 percent and 80 percent. Subsidized employment strategies are also being tried in Los Angeles, Erie County, N.Y., and Kentucky.

Under **treatment and employment services**, officials try to address barriers to employment, such as mental health needs, substance abuse or a physical disability, while helping people look for work. Utah's Licensed Clinical Therapist Program still assists people with job searches and resume building, but also offers a clinical assessment of mental health problems and clinical therapy sessions. These services are also offered in New York City and Ramsey County, Minn.

Under the **career pathways** model, TANF participants receive basic education while also learning skills needed for a specific job and industry, usually with guidance from local employers. In Washington state, 34 community and technical colleges train people in classrooms for careers with a demonstrated market demand in the region, such as health care, early childhood education and advanced manufacturing. Kentucky and Minnesota are also experimenting with career pathways models.

"Work first" refers to mandatory work-related activities, such as job searching, rather than education and training that might lead to a job later on. The district's **modified work-first** program differentiates people who are ready for a job and those who need to upgrade their skills, experience or education before looking for work.

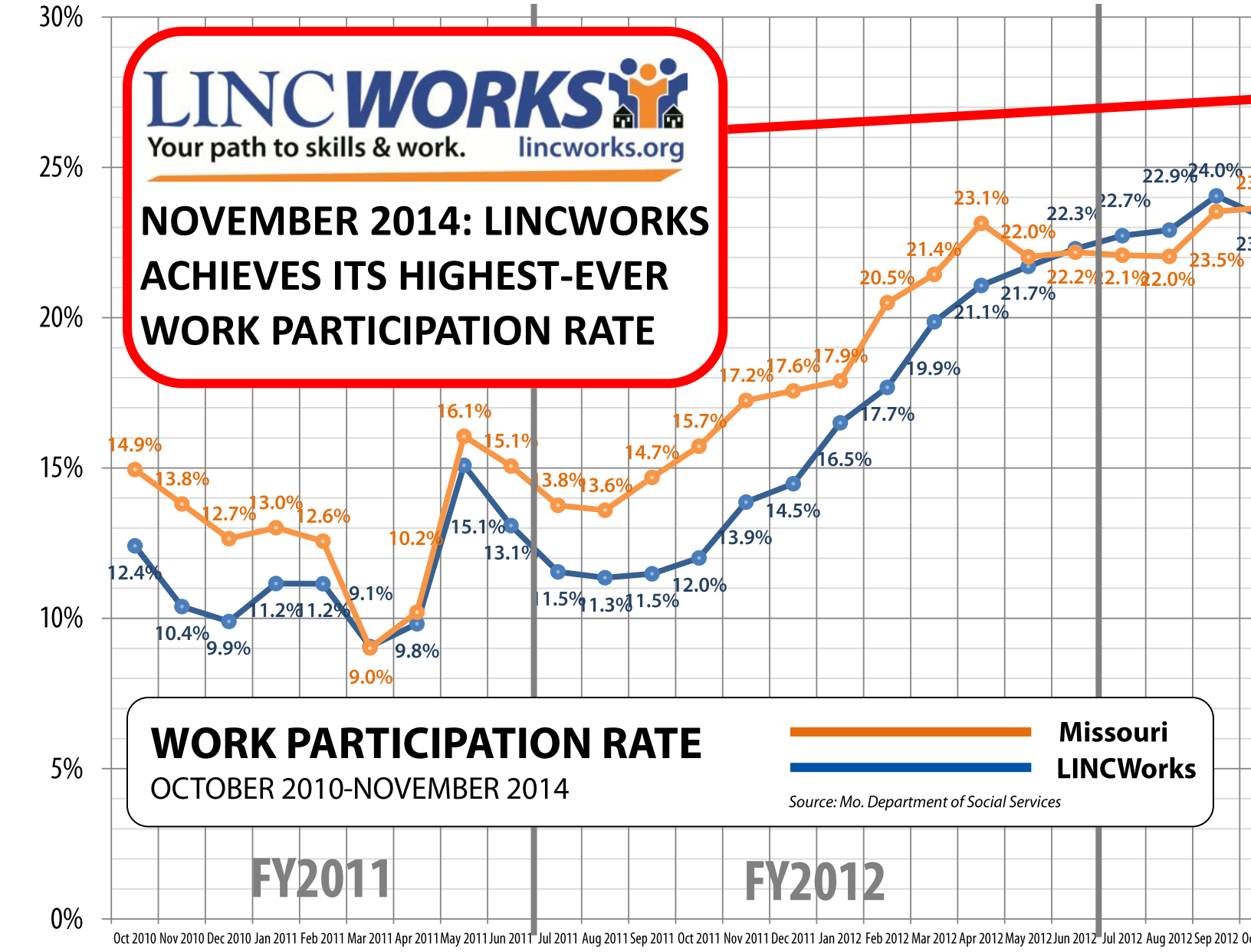
The GAO review of 10 jurisdictions experimenting with employment-focused approaches underscores a paradox: All these programs aim to place people in work, but administrators from half the programs said they didn't prioritize meeting the federal work requirement. They could afford to do that, in part, because these jurisdictions are part of larger TANF programs with other components that focus on the participation rate.

Despite the fact that research suggests the highlighted approaches might be some of the best ideas today for helping the poor get jobs, administrators in three of the jurisdictions said it would be difficult to secure state funding for their programs -- in light of other demands for the same money - if they started today. The GAO authors concluded that it is unlikely the lessons learned from these programs will be widely adopted until Congress changes the law that created TANF.

The federal government also ought to offer incentives to states for evaluating experimental TANF programs, the GAO authors wrote. Since the work participation rate fails to track employment outcomes, the report also suggested that TANF agencies need to conduct additional research on which approaches work best. Currently, the federal government isn't funding state research centered on employment-focused programs in TANF, and states are unlikely to take it upon themselves to do it.

There are other good reasons why TANF agency heads would be reluctant to conduct a scientific assessment of their programs -- besides the money, obviously. Rigorous evaluation comes with the political risk that it will reveal a current program isn't working. Plus, the randomized design in evaluations means that some needy residents

will end up in control groups and won't benefit from a potentially effective service. But the biggest hurdle? The funding for a study is "coming out of money you could have been spending on actual services," Lower-Basch said, "which is always a hard case to make."



REGION 18 AT A GLANCE (FY2015 TO DATE)

CASELOAD (AVG.)

3,284

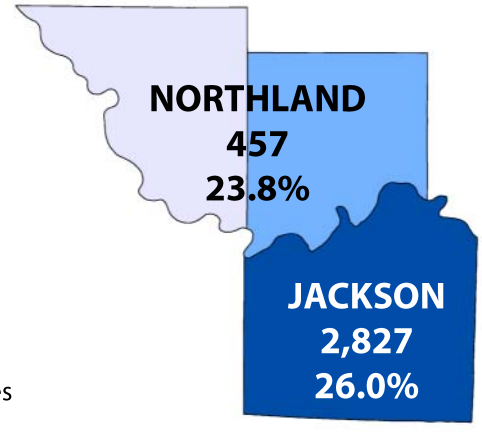
Adult single-parent household TANF cases subject to work requirement

PARTICIPATION (AVG.)

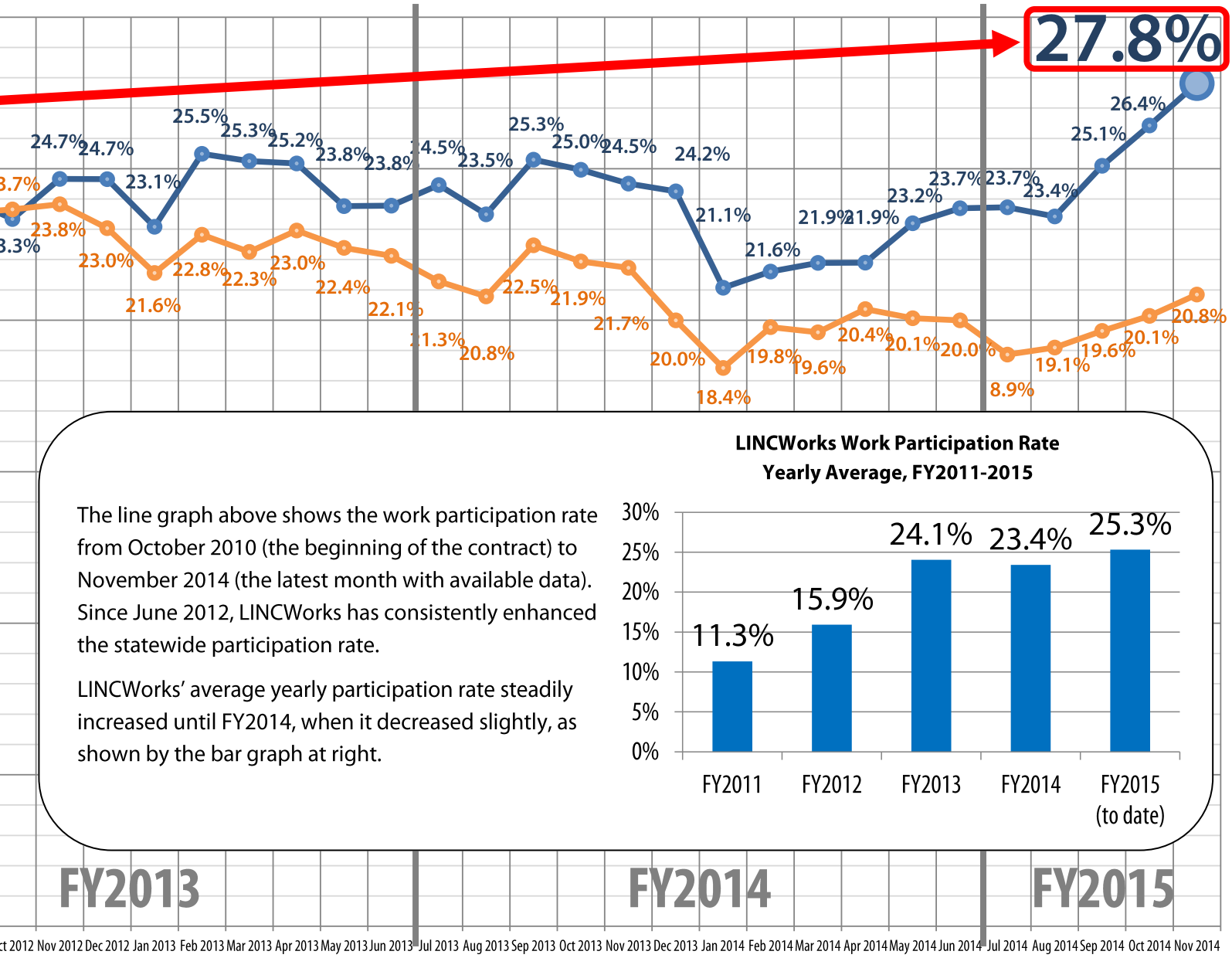
25.7%

Clients engaged in countable work activities

Average FY2015 caseload and participation within Region 18



While the Region 18 MWA population resides predominantly in urban Jackson County, LINCWorks also serves participants in the Northland (Clay and Platte counties), where the population is more rural.



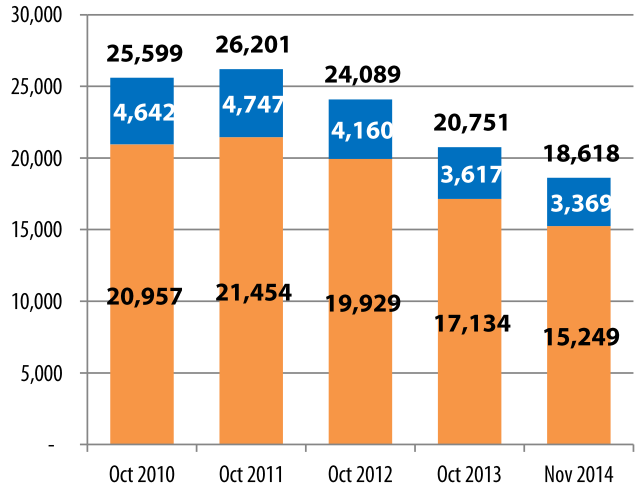
The line graph above shows the work participation rate from October 2010 (the beginning of the contract) to November 2014 (the latest month with available data). Since June 2012, LINCWorks has consistently enhanced the statewide participation rate.

LINCWorks' average yearly participation rate steadily increased until FY2014, when it decreased slightly, as shown by the bar graph at right.

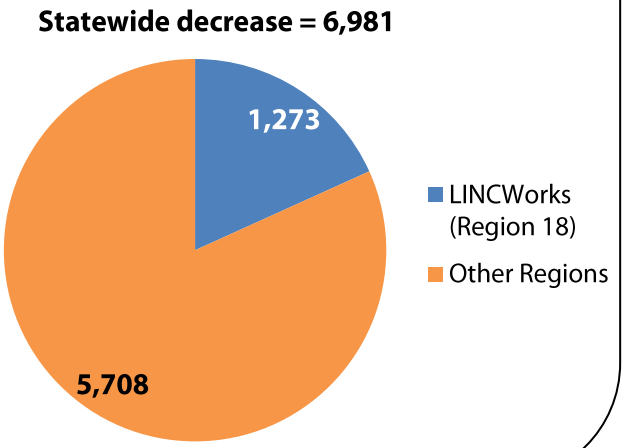
LINCWorks Work Participation Rate
Yearly Average, FY2011-2015

MWA CASELOAD REDUCTION, OCTOBER 2010-NOVEMBER 2014

Decrease in MWA caseload, Oct. 2010-Nov. 2014



Decrease of Region 18 MWA caseload, Oct. 2010-Nov. 2014, as a share of statewide total



November 2014

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

Action Is Needed to Better Promote Employment-Focused Approaches

GAO Highlights

Highlights of GAO-15-31, a report to congressional requesters

Why GAO Did This Study

The TANF block grant requires states to engage a certain percentage of work-eligible cash assistance recipients in specified work-related activities, such as job search assistance and training. Yet, data suggest that more TANF recipients could receive assistance that would help them gain employment and reduce their dependence. GAO was asked to provide examples of what some states are doing to achieve these goals and how to expand these efforts.

This report (1) reviews some approaches that have been identified as holding promise for engaging TANF recipients in employment and increasing their earnings and examines ways in which selected states and localities have used them, and (2) identifies factors that influence their use. To first identify promising approaches, GAO reviewed summaries and syntheses of rigorous research on approaches that increase employment and earnings, and profiled 10 state and local programs that were nominated by experts familiar with welfare research and state and local efforts, and that were selected to represent a range of approaches. GAO also reviewed relevant federal laws, regulations, and agency guidance, and interviewed agency officials and experts with a range of views.

What GAO Recommends

GAO recommends that HHS should issue guidance to clarify how the career pathways approach can be used by TANF agencies and identify potential changes to address the lack of incentives in the TANF program. HHS agreed with GAO's recommendations.

View GAO-15-31. For more information, contact Kay E. Brown at (202) 512-7215 or brownke@gao.gov.

What GAO Found

The 10 state and local programs GAO examined used various promising approaches to help Temporary Assistance for Needy Families (TANF) cash assistance recipients gain employment by meeting a range of participant needs. These approaches included the use of subsidized employment, employment alongside treatment for a health condition, and training for high-demand jobs. For example, for individuals in need of additional work experience, San Francisco's TANF program has provided subsidies to employers to place participants in temporary, wage-paying jobs. To help individuals with mental and physical disabilities and substance abuse problems, nonprofit contractors for New York City's TANF program have provided individualized assessment and treatment, often combined with employment. To prepare individuals with various skill levels for high-demand jobs, Minnesota and Washington have used a career pathways approach of combining occupation-specific training with basic skills education and support services. However, experts told us that some states have a misperception that this approach is not allowable under TANF rules, even though the Departments of Labor, Education, and Health and Human Services (HHS) support its use. HHS told us that states could still meet program requirements while using this approach, but the agency has not issued formal guidance clarifying this. Internal control standards for the federal government state that information should be communicated to managers in a form that enables them to carry out their responsibilities. As a result of these misperceptions, the career pathways approach may be underused by TANF agencies and TANF recipients could miss out on the potential benefits of this approach.

Expertise and dedicated funds facilitated use of these promising approaches, but the federal TANF program, itself, lacks incentives for their wider adoption. Of the 10 programs GAO examined, 9 drew on the expertise of partner organizations—including community college systems, workforce agencies, and nonprofits. The programs also benefitted from decisions by state and local policymakers to dedicate funds—including TANF funds—for the selected programs, according to officials. However, incentives for large numbers of state and local TANF agencies to adopt and test promising approaches are lacking under the structure of the TANF program for several reasons. First, many program design and funding choices are left to the states, and GAO's prior work has shown that state use of TANF funds for more costly welfare-to-work approaches can compete with other allowable uses of TANF funds. Second, TANF's main performance measure does not necessarily encourage agencies to use certain approaches that incorporate longer-term education and training or treatment services, although states are not prohibited from doing so. Third, little incentive exists for TANF agencies to evaluate their programs. HHS's authority over many aspects of TANF is limited and it has not proposed legislative changes to address these areas. Yet, because HHS oversees TANF, it is positioned to identify, suggest, and work in consultation with Congress on potential changes that would better address the lack of incentives for the use of promising approaches by states and to better meet the TANF goal of increasing employment. Without federal action, adoption and evaluation of promising approaches may continue to be limited to select states and localities, leaving TANF recipients in other locations without access to these promising approaches.

MISSOURI KIDS COUNT

Article from the new Missouri Kids Count website

Missouri's New Approach to Trauma

December 22, 2014

How Head Start Trauma Smart in Kansas City is Teaching Traumatized Children and Their Communities to Cope, Stay Calm, and Grow

Jayden knows what to do when he gets upset: use his breathing buddy, count to four, then talk to an adult about why he is angry or sad. It helps him to feel better and regain his calm.

These steps are just some of the techniques Jayden, and thousands of children like him, have learned through Head Start Trauma Smart, a program that teaches traumatized children in the Kansas and Missouri area how to manage their extreme emotional distress.

Like many of the children in the Head Start Trauma Smart program, Jayden has suffered enough personal tragedy to fill a lifetime. At the tender age of 4, he lost his father to an automobile accident, leaving Jayden and his three siblings in the care of their single mother.

Though he was always a happy, bright child, following the accident, Jayden's behavior changed dramatically: he began to throw tantrums, he threw toys; he was in a perpetual state of either extreme anger or distress; his constant nightmares kept him and the other children up at night, endangering the stability of his already fractured home environment. Without a playbook, guidance, or additional aid, Jayden's teachers and his mother feared the worst.

Enter the Crittenton Children's Center in Kansas City, where therapists and other professionals worked together to develop an early childhood response to complex trauma that would become known as Head Start Trauma Smart, and the driving force of positive change in Jayden's life.

The idea behind Trauma Smart was to go beyond individual treatment (i.e., technical fixes through one-on-one therapy) and instead engage the community directly surrounding the traumatized child: family members, teachers, caregivers, and fellow students. This approach would require each member of the community to alter their lifestyle, replacing practices that compounded, amplified, or ignored the affected child's behavior with elements that instead promoted resilience, well-being, and emotional health.

For children like Jayden, who have been traumatized, the routine of daily life can be challenging and often next to impossible. Their sleep schedule is erratic, fitful, and filled with nightmares. They often feel ill or at unease. They startle easily and live in a

perpetual state of hyper-vigilance and dread. This type of chronic adversity interferes with the healthy development of a child, both emotionally and cognitively.

Unfortunately, there is no catered national response for children who struggle with these types of challenges. The education system, as a whole, exercises the same disciplinary action across the board, regardless of a child's background. When a traumatized child acts out in class by externalizing his or her symptoms through bad behavior, there is nothing in the established playbook that accounts for the causes of this behavior—they are reprimanded the same as their unaffected peers. This is often to the detriment of the child.

With the Trauma Smart model, when Jayden is angry or feeling overwhelmed, there is a specialized protocol to help him regain his composure. If he is upset at school, he goes to the designated area in his classroom to use his breathing buddy—just one of the many available tools that encourage him to breathe deeply, regain awareness and, in turn, calm down. Outside of the classroom, Jayden continues to receive support from his family and the other caregivers in his community. His bus driver, the cafeteria personnel, and even the custodial workers have all received training on how to interact with traumatized children, ensuring Jayden's healthy development continues.

This type of training is a key component of the Head Start Trauma Smart model and was developed based on the highly recognized ARC (Attachment, Self Regulation and Competency) framework. It teaches those adults in Jayden's community how to react more appropriately, responding in a manner that is both conducive to Jayden's overall well-being and their own emotional health. One of the most important lessons adults learn through the Head Start Trauma Smart program is that the best way to care for a traumatized child is to first take care of, and to calm, themselves.

Though it has just cleared its inaugural phase, the Trauma Smart initiative has already yielded very promising results. Using the University of Virginia-Charlottesville Curry School of Education CLASS tool, Head Smart Trauma Smart classrooms have achieved significant and consistent gains in both classroom climate and teacher sensitivity. As a corollary to those gains, significant improvements in academic performance have been achieved as well.

Beyond an improved classroom culture and academic performance, Trauma Smart implementation also represents several potential cost saving measures that could play a substantial role in freeing up a district's financial resources. For example, children like Jayden, who externalize the symptoms of their trauma, are likely to receive an Individualized Education Program—a uniquely tailored curriculum meant to address the specific needs of an individual child. Though this measure is an attempt to go beyond the traditional response to children with emotional disabilities, it is an expensive one.

The average annual cost per student for an IEP is approximately $33,000. Conversely, and based on the initial development period of the program, the annual cost for a classroom of 20 children and their community of caregivers to participate in the Trauma

Smart model is approximately $9000, roughly 25% the cost, and a savings of about $24,000.

Since becoming involved in Trauma Smart, Jayden has continued to take strides in a positive direction. Through training, therapeutic support and with the help of his teachers and caregivers, that same happy child everyone remembers has returned, and with the help of the Trauma Smart program, he's going to stay.

Though it started in Kansas City, the intention at Crittenton Children's Center is to help traumatized children and their communities everywhere. Since its inception and the national recognition that followed, Trauma Smart has been replicated and introduced into Head Start classrooms in 26 counties in the Kansas City metro area and across Missouri and its model is being studied everywhere, all with the hope that children who suffer these traumas will be cared for and encouraged to develop in a healthy and positive manner.

For more information, please visit traumasmart.org.

Additional Information

"Three or 4 year old children who have been exposed to trauma are at much greater risk of lacking biological foundations or the behavior skills that will allow them to succeed in school and in life. The trauma keeps stealing their opportunities moment by moment and day by day."

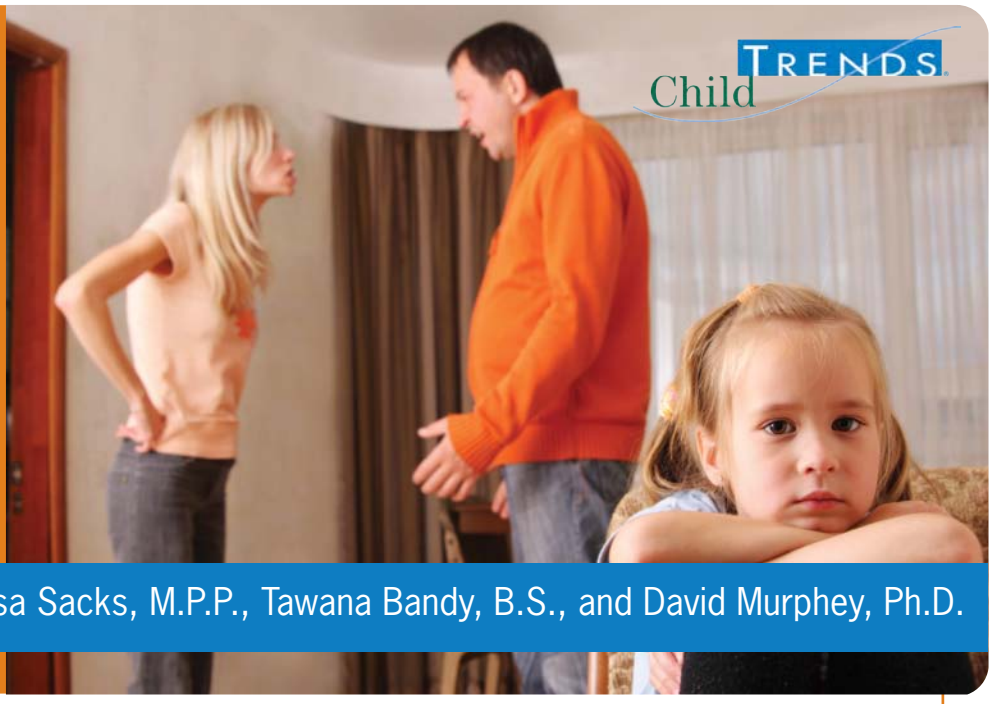
The Crittenton Children's Center in Kansas City has developed a training program, Trauma Smart, that has been in place in Head Start classrooms since 2010, to counter the all too common childhood exposure to chronic trauma. Trauma Smart trains not only the child, but the adults who care for them, teaching them resilience, self-care, problem-solving, deep breathing and calming themselves.

Trauma Smart combines the best trauma therapy science with early education in the most natural setting of the classroom. Crittenton is studying how to scale up so that Trauma Smart can be offered in classrooms across Missouri.

Missouri KIDS COUNT is pleased to highlight the work being done by Crittenton.

Fact Sheet:
Adverse Childhood Experiences and the Well-Being of Adolescents

July 2014



Kristin Moore, Ph.D, Vanessa Sacks, M.P.P., Tawana Bandy, B.S., and David Murphey, Ph.D.

Adverse childhood experiences (ACEs) are potentially traumatic events that can have negative, lasting effects on health and well-being.[1] These experiences range from physical, emotional, or sexual abuse, to parental divorce or the incarceration of a parent or guardian. Child Trends analyzed data from the 2011/12 National Survey of Children's Health (NSCH) to assess the prevalence of adverse childhood experiences among children and youth. These are the first nationally-representative data on these experiences; previous studies have been restricted by subgroup or location.

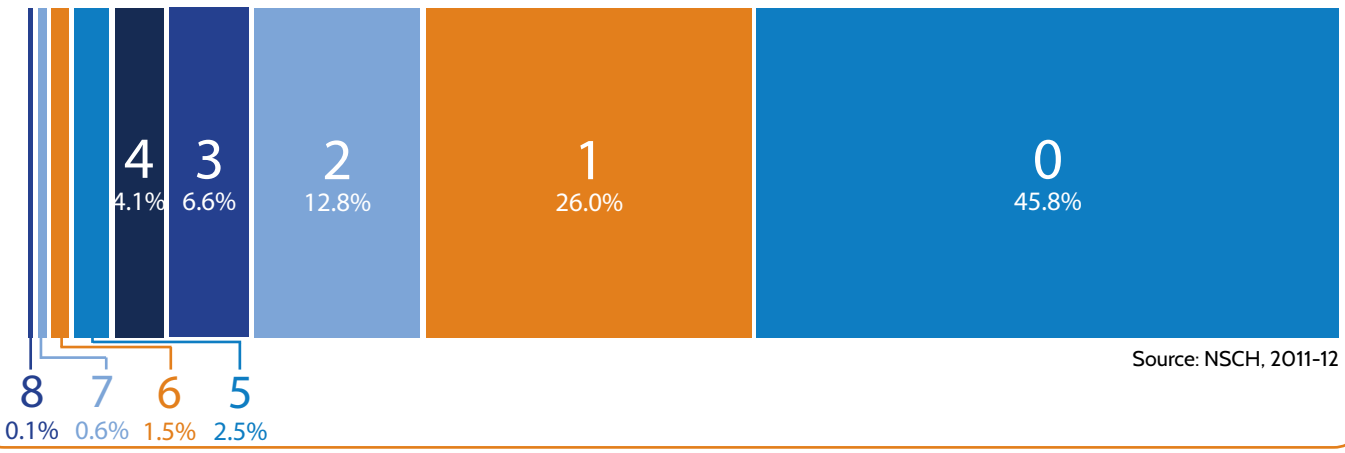
The prevalence of adverse childhood experiences

The eight adverse childhood experiences we looked at include whether, according to parental report, the child has ever:

1. Lived with a parent or guardian who was divorced or separated
2. Lived with a parent or guardian who died
3. Lived with a parent or guardian who served time in jail or prison
4. Lived with anyone who was mentally ill or suicidal, or severely depressed for more than a couple of weeks
5. Lived with anyone who had a problem with alcohol or drugs
6. Witnessed a parent, guardian, or other adult in the household behaving violently toward another (e.g., slapping, hitting, kicking, punching, or beating each other up)
7. Been the victim of violence or witnessed any violence in his or her neighborhood
8. Experienced economic hardship "somewhat often" or "very often" (i.e., the family found it hard to cover costs of food and housing)

We found that more than half of adolescents have had at least one of these adverse childhood experiences, and nearly one in ten have experienced four or more.

Number of Adverse Childhood Experiences Among Adolescents Ages 12-17, by Percent



Source: NSCH, 2011-12

The relationship between adverse experiences and child well-being

Studies of adults who experienced multiple adverse experiences in their youth have found increased risk for poor health outcomes such as obesity, alcoholism, and depression.[2] Less is known about the relationship between adverse experiences and well-being in childhood or adolescence. The large sample of the NSCH allows us to examine the association between high numbers of negative experiences and measures of child well-being.

The data reflect a consistent association, similar to that found for adults, indicating that a greater number of adverse childhood experiences are related to poorer well-being. In particular, our analysis finds that the percentage of adolescents with indicators of poor well-being is much higher among those who have had three or more adverse childhood experiences, compared with those who have experienced one or none, according to parental report. Nearly half of adolescents who have experienced three or more adverse childhood experiences have low levels of engagement in school, and do not finish tasks they start. Also, just over 40 percent demonstrate negative behaviors outwardly, such as arguing too much and bullying or being cruel to others, compared with 25 percent and 18 percent, respectively, of adolescents who have had no adverse childhood experiences.

Our findings suggest a need for research and intervention efforts to prevent adverse childhood experiences and to mitigate their consequences. They also suggest that the ACEs measure represents a potential screening tool to identify children and youth at risk for negative outcomes.

Prevalence of indicators of negative well-being, by number of adverse childhood experiences (teens 12-17)

Measure of well-being	0 ACEs	1 ACE	2 ACEs	3+ ACEs
High externalizing behavior	18%	26%	33%	41%
Low engagement in school	25%	33%	44%	48%
Household contacted due to problems at school	13%	23%	31%	38%
Grade repetition	6%	12%	14%	21%
Does not stay calm and controlled	24%	34%	40%	44%
Does not finish tasks started	27%	36%	44%	49%
Diagnosed with a learning disability	9%	13%	16%	23%
Fair or poor physical health	2%	4%	4%	6%

Data used in this fact sheet

The National Survey of Children's Health (NSCH) was conducted in 2011/12 in all 50 states and the District of Columbia by the National Center for Health Statistics, with funding from the Maternal and Child Health Bureau, U.S. Department of Health and Human Services. Telephone numbers from a random sampling process were used to contact households, and one child in each household with children was randomly selected to be the focus of the study. An adult in the household knowledgeable about the child (most often the mother) answered questions about the child and themself. The survey is representative of children under 18 years old nationwide and within each state. A total of 95,677 interviews were completed in 2011/12.

Measures of adolescent negative well-being, as reported by parents, are as follows:

1. High externalizing behavior: The adolescent "usually" or "always" argues too much *and/or* the adolescent "sometimes," "usually," or "always" bullies or is cruel or mean to others.
2. Low school engagement: The adolescent only "sometimes," "rarely," or "never" cares about school *and/or* does all the required homework *and/or* is curious and interested in new things.
3. The household has been contacted at least once in the past 12 months about any problems the adolescent is having with school.
4. The adolescent has repeated a grade in school.
5. The adolescent "sometimes," "rarely," or "never" stays calm and in control when faced with a challenge.
6. The adolescent "sometimes," "rarely," or "never" finishes the tasks he/she starts and follows through with what he/she says he/she will do.
7. A doctor, health care provider, teacher, or school official has said the adolescent has a learning disability.
8. The adolescent's health is "fair" or "poor."

1. Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., & Koss, M. P. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine* 14(4), 245-258.
2. Ibid.

Publication #2014-32. For more information about ACEs, see the Child Trends DataBank at http://www.childtrends.org/?indicators=adverse-experiences.

DECEMBER 16, 2014

By the Numbers: The National Summer Learning Project

STUDY FEATURES

- **5 urban districts**, selected from **35 candidates**
- **5,637** students
- **Randomized Controlled Trial** (RCT)
- **$50 million** + **$5 million** 2-year extension
- **6 years**, beginning in 2011
- **5 public reports**

PARTICIPATING STUDENTS

- **Completed 3rd grade in 2013**
- **89%** low-income
- **47%** African American
- **40%** Hispanic

PROGRAM DESIGN

- **5-6 week** summer programs
- **3 hours** daily academics
- **Daily** enrichment activities
- **Certified teachers**

NEAR-TERM IMPACT OF ONE SUMMER

- Students in the program performed better on fall math tests than students who applied but were not selected for the program.
- The impact equals 17-21% of average increase in math learning for children this age in one year.
- The study did not show an advantage in reading for participating students, but did reveal factors related to reading achievement.

WHY THE MATH FINDINGS MATTER

The Need

Nationwide, 27% of low-income 4th grade students score below "basic proficiency" in mathematics, vs. only 7% of their higher income peers (National Assessment of Educational Progress, 2013)

The Impact

This study's near-term impact on math performance was larger than the average impact on test scores of 89 RCT evaluations in elementary education (Lipsey *et al.*, 2012)

PARTNERS

- Big Thought (Dallas, TX)
- Boston (MA) Public Schools
- Boston After School & Beyond
- Dallas (TX) Independent School District
- Duval County (FL) Public Schools
- Pittsburgh (PA) Public Schools
- Rochester (NY) City School District
- The RAND Corporation
- The Wallace Foundation

Read the full report: *Ready for Fall? Near-Term Effects of Voluntary Summer Learning Programs on Low-Income Students' Learning Opportunities and Outcomes* (2014). RAND.org | wallacefoundation.org/readyforfall

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www.wallacefoundation.org

The Wallace Foundation®

KNOWLEDGE IN BRIEF

Findings from New Wallace Commissioned Research

BUILDING OUR UNDERSTANDING OF SUMMER LEARNING: NEAR-TERM FINDINGS OF THE NATIONAL SUMMER LEARNING PROJECT

The National Summer Learning Project is a six-year effort seeking to answer an important question: Can two summers of voluntary, district-led summer programs, offering academic instruction and enrichment activities like arts and field trips, help boost low-income students' success in school?

Children from low-income families often do not have the same opportunities to learn and to experience enriching activities during the summer as children from wealthier families and consequently can lose ground academically.

Previous research has shown that some, though not all, summer learning programs can lead to achievement gains. However, we have not known whether urban school districts could develop and implement, at large-scale, voluntary summer learning programs combining academic instruction aligned with the school year curriculum and enrichment activities that expand children's horizons. Nor do we know what impact these programs can have on children's success in school, and how long these effects may last.

The achievement gap between low-income students and their more affluent peers continues to be a stubborn obstacle. The findings from this project could help inform one possible strategy for shrinking the achievement gap: voluntary, district-led summer learning programs.

STUDY DESIGN AND METHODOLOGY

This study, the largest of its kind, is a partnership of The Wallace Foundation, the RAND Corporation, Boston Public Schools, Dallas Independent School District, Duval County (FL) Public Schools, Pittsburgh Public Schools, and the Rochester City School District. It looks at whether and how large-scale, voluntary summer learning programs led by public school districts, offered for two consecutive summers, five to six weeks each summer, can help improve educational outcomes for children in low-income, urban communities. Specific areas of exploration include:

- Can large urban school districts successfully implement quality summer learning programs?
- Can they successfully attract large numbers of students who could potentially benefit from their programs?
- What impact can these programs have on student outcomes?
- What are the steps, from planning to professional development, needed to implement quality summer programs?

The evaluation, conducted by RAND, focuses on students who were in 3rd grade in spring 2013. More than 5,600 students are part of the study. Students who applied were randomly selected to participate or not participate in the program for two summers (2013 and 2014)—as a result of the funding from Wallace, more students were able to take part in their districts' summer programs than otherwise would have been possible. RAND is gathering a wide range of data from both groups of students through the

WHY USE A RANDOMIZED CONTROLLED TRIAL TO EVALUATE THE IMPACT ON STUDENTS?

A randomized controlled trial, or RCT, randomly places eligible children into one of two groups: children who take part in the program and children who do not. It ensures fairness, especially when, as is the case in the participating districts, more students are interested in the program than space allows. Random assignment makes sure that there are no systematic differences between the two groups when the study begins. This means that we can attribute any differences at the end to the program. An RCT is a rigorous method of evaluation, providing the evidence educators, policymakers, and funders need to make decisions about supporting and implementing summer learning programs.

7th grade, including school year grades and attendance, student performance on standardized tests of math and reading, and measures of social-emotional skills.

NEAR-TERM FINDINGS

The study is determining the effects of two consecutive summers of programming on students' academic outcomes. It's also exploring what impact these programs can have on behavior and social-emotional skills. These are big research topics, requiring the collection and analysis of a great deal of data over a substantial period of time, in five diverse cities. Over the coming several years, data collection and analysis will continue—the results will emerge in stages, building to a robust knowledge base about how to design and implement a summer learning program and what kinds of outcomes to expect.

> "As a result of the funding from Wallace, more students were able to take part in their districts' summer programs than otherwise would have been possible."

These near-term findings, published in December 2014 in the RAND report *Ready for Fall?: Near-Term Effects of Voluntary Summer Learning Programs on Low-Income Students' Learning Opportunities and Outcomes,* are only the first set of findings from the RCT. They tell us the near-term effect of one summer of programming as measured by reading and math tests and social-emotional skill assessments administered in the fall of 2013, shortly after the first summer of programming ended. They provide valuable insights into the impact of summer learning. It's important to keep in mind, however, that these near-term findings do not tell us the impact that one summer's programming has on school-year grades, state tests, and school-year attendance. RAND is still analyzing that data and will share the report in the summer of 2015.

DISTRICTS CAN DEVELOP AND IMPLEMENT LARGE-SCALE PROGRAMS

The project shows that school districts can successfully plan and implement, and attract large numbers of children to, a voluntary summer learning program. There is strong demand among low-income students and their families for free, voluntary programs that combine academics and enrichment.

HIGHER SCORES ON FALL MATH ASSESSMENTS

In the fall of 2013, children in the study took a math assessment. Children who were selected to take part in the summer learning programs in 2013 scored higher on the math assessment. They entered school in the fall with a meaningful advantage in math, compared to children who applied but were not selected. Indeed, the impact the study had on math skills equals 17-21 percent of the average increase in math performance that students of this age and grade level make in an average year. The impact on math performance was larger than the average impact on test scores among 89 RCT evaluations in elementary education reviewed by Lipsey, *et al.* (2012). The math findings are particularly important because students from low-income households score much lower on 4th-grade math tests than their more affluent counterparts—27 percent score below basic compared to 7 percent of wealthier students.

NO DIFFERENCE ON ASSESSMENTS OF READING AND SOCIAL-EMOTIONAL SKILLS

The assessment of reading comprehension and vocabulary skills conducted in fall 2013 did not detect differences in reading achievement between the two groups of students.

In fall 2013, teachers completed an assessment of each student's social-emotional skills. The assessment did not reveal differences between students who were selected to take part in the summer learning program and those who applied but were not selected to take part.

PROGRAM FACTORS THAT PROMOTE QUALITY

The near-term findings also reveal a number of factors related to positive outcomes. The RCT did not show that these factors caused these positive outcomes, but the relationship is clear enough to offer guidance to practitioners on program implementation:

- In math:
  - The more days students attended, the greater the advantage they exhibited in math compared to children who had applied but were not selected for the program.
  - More instructional time was associated with better math outcomes.
- In English Language Arts (ELA):
  - There was an association between classroom instructional quality and students' reading assessment scores.
  - Students in ELA sites that were orderly had better reading scores than children who were not selected to take part in the program.
  - Students whose summer reading teacher had just taught 3rd or 4th grade (the grade the children had either just completed or were about to enter) performed better on the reading assessment than other children who took part in the program.

WHAT CAN WE LEARN FROM THESE NEAR-TERM FINDINGS?

We can draw some conclusions from these near-term findings. It's important, however, to recognize that the story will build—and perhaps change—as RAND collects and analyzes data and we share more findings.

We now know that it's feasible for urban districts to mount voluntary summer learning programs, with research-based features, at large scale, and attract large numbers of students.

It's also clear that summer learning programs can have a positive impact on math outcomes, at least in the short-term. Assessments administered in the fall following one session of summer learning programs demonstrated that children who participated had stronger math skills than children who were not selected to take part.

And the initial findings point to a number of factors—including attendance, instructional time, quality of instruction, behavior, and teacher experience—that are related to positive outcomes. School districts offering summer learning programs may want to consider if and how to address these elements of the student experience.

Over the coming months, we will learn the effect of one summer of programming on academic achievement, behavior and social-emotional skills over the course of an entire school year. Subsequently, we will learn the impact of two sessions of summer learning. That story will continue to unfold as additional data is collected and analyzed, and reported over the next few years.

THEMES EMERGING FROM THE DIGITAL INCLUSION SUMMIT

In reviewing, categorizing, and analyzing participant responses, nine themes emerged from the Digital Inclusion Summit participant discussions.

The themes are summarized in this section with:

- A brief introduction
- A sampling of related participant comments (some edited for length, clarity, and redundancy)
- An overview of opportunities, implications, and/or potential next steps

The nine themes include:

1. CREATE A COLLABORATIVE MOVEMENT ACROSS DIGITAL INCLUSION INITIATIVES
2. REFRAME DIGITAL INCLUSION AROUND GEOGRAPHIC AND ORGANIZATIONAL LINES
3. BUILD STRONGER AWARENESS OF REAL OPPORTUNITIES AND ASPIRATIONS
4. INVOLVE FAITH-BASED AND COMMUNITY GROUPS TO REACH PEOPLE
5. MEANINGFULLY ENGAGE BUSINESSES IN DIGITAL INCLUSION
6. TAKE ADVANTAGE OF CROSS-GENERATIONAL OPPORTUNITIES
7. ADDRESSING CONCERNS, RISKS, AND FEARS
8. BARRIERS TO ACCESS EXTEND WELL BEYOND TECHNOLOGY ISSUES
9. AGGREGATE DIGITAL INCLUSION RESOURCES AND SERVICES, REVIEW BEST PRACTICES, AND ESTABLISH BENCHMARKS

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DESCRIPTION / DIMENSIONS OF THE ISSUE

VISION

Exclusion from access to computers and the Internet, including high-speed connectivity, can have profound repercussions for those on the wrong side of the digital divide. Those without access are very disadvantaged in today's digital society and face challenges in conducting business, accessing health information, gathering research, looking for a job, learning, completing school assignments, securing government services, or even communicating on a day-to-day basis. Digital inclusion must be seen as a priority for our community, and we must all come together to develop a joint vision and strategy to narrow the digital divide. Without a community-wide inclusion initiative, many people will be left behind.

KANSAS CITY DIGITAL DIVIDE SNAPSHOT

The State of Internet Connectivity in Kansas City study performed by Google in June 2012 shows that for those residents living in Kansas City:

17% of them do not use the Internet.

Of the 17% non-users:

41% THINK THE INTERNET IS IRRELEVANT

28% LACK ACCESS

44% ARE SENIORS

42% MAKE LESS THAN $25K A YEAR

46% ARE AFRICAN AMERICAN

64% HAVE ONLY A HIGH SCHOOL EDUCATION OR LESS

MISSOURI KIDS COUNT

mokidscount.org

Missouri KIDS COUNT has launched its new website, mokidscount.org, including stories, policy briefs and connections to new and improved data connections.

The website includes Missouri KIDS COUNT data book that highlights indicators and county rankings, a searchable archive of Missouri KIDS COUNT data available since 1993 and data reports and research paper.

Missouri KIDS COUNT is a diverse team of public sector, non-profit and private sector members; together we are the Annie E. Casey (AECF) KIDS COUNT partner in Missouri.

The Family and Community Trust, the AECF KIDS COUNT grantee, is a non-profit corporation with Board members drawn from the top leadership in state government and the private sector to promote and support collaboration and innovation in service delivery for Missouri's children and families through its 20 Community Partnerships around the state.

LINC is the the Kansas City area community partnership.

FACT is joined by its Missouri KIDS COUNT partners, the University of Missouri Office of Social and Economic Data Analysis (OSEDA) and the Children's Trust Fund (CTF).