



Austin/Travis County Health & Human Services Department



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MEMORANDUM

TO: Mayor and City Council

FROM: Shannon Jones III, Director

A handwritten signature in blue ink, appearing to read "Shannon Jones III".

Health and Human Services Department

DATE: August 7, 2015

SUBJECT: Council Resolution #20150507-027: Health Inequities in Austin Travis County

On July 27, the Health and Human Services Department (HHSD) provided a progress report to the Mayor and City Council related to Council Resolution #20150507-027, focusing on health and economic equity. HHSD was assigned the lead role related to the first part of the resolution focusing on health equity.

Attached please find the ***Health Inequities in Austin Travis County*** report. This report was developed in collaboration with community stakeholder groups, including *allgo*, Alliance for African American Health in Central Texas, Austin Immigrant Rights Coalition, and Mama Sana/Vibrant Woman.

The report includes an assessment of racial and ethnic health disparities in the community. Additionally, it provides short term programmatic and funding recommendations to implement enhanced community-based, non-traditional, holistic, and culturally specific services to address health disparities in Austin. Specifically, it examines and identifies gaps in services related to maternal and infant health, African American health disparities, health disparities in LGBT people of color, mental health for immigrant families, and elderly services. The recommended best practices for potential remedies result from input by members of the affected populations and the community-based organizations that serve them.

HHSD acknowledges there is a great need for enhanced public health interventions and strategies to address inequities which disproportionately affects communities of color in Austin. A second part of this report, to be issued separately, will comprehensively examine intervention strategies related to disparities and the social determinants of health.

HHSD would like to thank its partners and community members for their participation in this project. If you have additional questions, please contact me at (512) 972-5010, or by email at shannon.jones@austintexas.gov.

cc: Marc A. Ott, City Manager
Bert Lumbreras, Assistant City Manger

Attachments:

1. Health Inequities in Austin Travis County – Report and Recommendations
2. Council Resolution #20150507-027
3. Asian American Health Data
4. Health and Human Services Programs Cost-Benefit Matrices



Health Inequities in Austin Travis County

Report and Recommendations

August 5, 2015

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We hope the information provided in this report is helpful in the development of strategies to promote health equity and significantly improve the quality of life for all residents.



**Austin Travis County
Health and Human
Services Department**



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EXECUTIVE SUMMARY

On May 7, 2015, Austin City Council passed Resolution 20150507-027 focusing on health and economic equity. This resolution directed the City Manager to establish a working group to:

- Gather information for improving health outcomes for infants, mothers, and other members of the community
- Evaluate the impact that existing City policies and practices have on health equity
- Evaluate best practices in other cities
- Develop recommendations for addressing race and socioeconomic-based inequities throughout the City
- Provide a report to the Health and Human Services and Economic Opportunity Committees respectively

The Austin Travis County Health and Human Services Department (ATCHHSD) was assigned the lead role related to the first part of the resolution focusing on health equity.

This report is the product of collaboration between ATCHHSD and the primary community stakeholder group made up of allgo, Alliance for African American Health in Central Texas, Austin Immigrant Rights Coalition, and Mama Sana/Vibrant Woman. The content of this report includes the process used to respond to the Council Resolution, assessment of racial and ethnic health disparities in the community, and funding and programmatic recommendations to implement enhanced community-based, non-traditional, holistic and culturally specific health services targeted to disproportionately affected populations. The recommendations come from members of the affected populations and the community-based organizations that serve them.

The report recommends short term goals to address health disparities affecting communities of color in Austin. It also examines racial and ethnic disparities related to the following issue areas/populations:

- Maternal, infant health, and birth outcomes
- Chronic disease within the African American community
- Health of Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ) people of color
- Mental health for immigrant families
- Health and wellbeing of the elderly population

The partnership held community meetings to obtain input from a wide cross-section of the public regarding key issues and suggestions for interventions to help improve conditions affecting communities of color.

For each of the issue areas identified in this report, the recommendation is to implement community based, non-traditional, holistic, culturally specific programming. Such programming will include the following:

- Health prevention and education services that acknowledge the implications of the social determinants of health
- Development and utilization of an explicit community engagement methodology with culturally specific strategies
- Observance of national standards for Culturally and Linguistically Appropriate Services (CLAS)¹; including strategies to address barriers to access such as cost, transportation and child care
- Provision of accessible, culturally specific health and wellness programming to address exercise, nutrition, stress reduction, community building, and goal setting, including strategies to address barriers to healthy food access
- Rigorous assessment and evaluation of strategies to ensure the intended outcomes are being achieved

Such interventions can mitigate barriers to care and help foster a sense of empowerment that can shift the paradigm from reliance on the medical model to a holistic concept of health and on creating the conditions for health improvements.

The estimated initial annual cost to provide the recommended interventions is \$1,050,000.

INTRODUCTION

The Center for Disease Control Prevention's (CDC) definition of health equity is "When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance."

Despite the fact that Austin is frequently cited as one of the fittest cities in the United States, disparities continue to persist for African Americans, Immigrants, Latinos, and LBTGQ people of color. These populations continue to experience higher rates of death and disease. For example, incidence rates for cancer, diabetes, cardiovascular disease, HIV infection, infant mortality, and premature and low birth weight babies for African American and Hispanic populations in Austin and Travis County continue to be higher than that of other ethnic groups.²

State and local health departments, as well as community-based organizations, have worked to address adverse conditions affecting the aforementioned populations, yielding promising results. Examples include:

- **ATCHSD's Maternal Child and Adolescent Health, Community Services, and Health Promotion and Disease Prevention Divisions' programming, which includes:**
 - Maternal and Infant Outreach Program (MIOP): MIOP works with Community Health Workers to provide support to low-income African American women. The goals of the program are to reduce disproportionate rates of preterm births, low birthweight babies, and infant mortality among African American women in Travis County.
 - African American Quality of Life (AAQL): AAQL works to reduce health disparities for African Americans by providing public health education and promotion activities in traditionally underserved areas. The goals of the program are to increase awareness of the risk factors associated with chronic disease, provide screening services and referrals to primary care, and increase access to community resources to help residents overcome barriers to health.
 - Chronic Disease Prevention and Control Program (CDPC Program): CDPC works with community partners, worksites, schools, and health care organizations to implement evidence-based interventions to prevent chronic disease and control related risk factors by making the healthy choices the easy choices where people live, work, learn and play. CDPC offers free diabetes education and exercise classes targeted toward low-income African Americans and Hispanics who have otherwise limited access to health care resources.

- Health Equity Working group members:
 - allgo: provides education, safe spaces, and experience in wellness practice. Components of wellness are interwoven in all activities. Specific wellness programs include wellness dialogues and workshops, breast care, and HIV/AIDS prevention and safer sex education and supplies.
 - Mama Sana Vibrant Woman: Mama Sana/Vibrant Woman is a women's health project that works to support the individual and collective empowerment of low-income mothers of color while also improving pregnancy and birth outcomes for communities of color in Austin. Mama Sana provides low-income women of color support for healthy pregnancies, births and the early parenting phase. Mama Sana programs provide free group prenatal care appointments with individual physical exams by midwives, as well as culturally based emotional group support. A woman at Mama Sana can also choose to have a free birth companion (doula) and regular prenatal exercise classes.
 - Alliance for African American Health in Central Texas: The mission of the Alliance for African American Health in Central Texas (AAAHCT) is to reduce the number of African Americans diagnosed with, and dying from, preventable illnesses and diseases that affect African Americans at higher rates than other racial/ethnic groups. To achieve this mission, AAAHCT works with communities to outreach, educate and advocate for personal lifestyle, environmental, and policy changes that will lead to better health outcomes and quality of life. Areas of work have included providing access to breast health services and education, increasing opportunities for physical activity and healthy food options, assessing walkability of neighborhoods, and highlighting health role models from the community.

In spite of these and other efforts, significant barriers to achieving equity in health outcomes persist. With limited resources, community organizations continue to find it challenging to provide relevant, effective programming. Realizing that achieving health equity would require systemic change, a group of community advocates comprised of representatives from the grassroots organizations Mama Sana/Vibrant Woman, allgo, and the Austin Immigrant Rights Coalition engaged members of City Council. The result of their efforts was Council Resolution 20150507-027, directing the City Manager to provide staff resources for a workgroup to gather information for improving health outcomes for infants, mothers and other vulnerable populations and, as a first step, provide recommendations and items for consideration to the Health and Human Services Committee during the 2015-2016 budget process.

Led by the ATCHHSD Director, a team of health department staff met with the primary stakeholders to discuss current efforts and research best practices that might be implemented to address health disparities for African Americans, Latinos, Immigrants and LGBTQ people of color. Once a draft plan was completed, open community meetings were conducted in order to gather input and feedback on the plan, as well as existing services, and to help identify other unmet needs.

This report:

- Examines the issues of maternal and infant health, African American Health disparities, disparities in LGBTQ people of color, and mental health for Immigrant families, and the elderly; and
- Summarizes identified best practices and provides recommendations for potential remedies informed by members of the affected populations and the community-based organizations that serve them.

PROFILE OF DISPARITIES

The United States Department of Health and Human Services defines a health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.” Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”³

Efforts to eliminate disparities and achieve health equity have focused primarily on diseases or illnesses and on health care services. However, the absence of disease does not automatically equate to good health.

Social determinants of health are factors that influence an individual’s or population’s health. These factors are the complex relationships that exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, language accessibility, and legislative policies.⁴

Other influences on health include the availability of and access to:⁵

- High-quality education
- Nutritious food
- Affordable and safe housing
- Affordable, reliable public transportation
- Culturally sensitive health care providers
- Health insurance

When examining the demographic characteristics of Austin in the context of health disparities, the following statistics are of note:

- Austin is the most economically segregated city in the country, nationally ranking fourth and fifth for occupational and educational segregation, respectively⁶
- 51.8% of African American children and 33% of Hispanic children under the age of 5 are living at or below federal poverty threshold, compared to 5.4% of Caucasian children in the same age group⁷
- 32.6% of Austin’s Hispanic residents do not have health insurance coverage⁸
- The Austin MSA has the fastest growing population of adults age 55-64, and the third fastest growing population of adults age 65 and older⁹, yet the number of physicians accepting new patients with Medicare in Texas has dropped from 78% in 2000 to only 58% in 2012.¹⁰
- Nearly 21% of the population age 50 and older lives at or below 200% of poverty.¹¹

Adverse health conditions do not occur randomly in the population. In the City of Austin, these determinants are having a profound impact in five key areas: maternal and infant health, African American health disparities, disparities affecting LGBTQ people of color, mental health of immigrant families, and needs of the elderly.

Maternal and Infant Health

Many women in Austin are unable to access holistic prenatal services. In 2011, an African American baby born in Travis County is three times more likely to die within the first year of life than a Caucasian baby, twice as likely to have a low birth weight, and nearly twice as likely to be born prematurely. Rates of infant mortality, prematurity and low birth weight for African American women in Travis County are higher than the state average for members of that same demographic. Comparatively, the rates for Caucasian women living in Travis County are significantly lower than the Texas state average. For Latina women living in Travis County, the rates of prematurity and infant mortality are also higher than the state average.¹²

Reflected in these disparate birth outcomes are strikingly unequal levels of access to prenatal healthcare. In Travis County, 41 percent of African American women and 53 percent of Latina women receive no prenatal care at all in the first trimester. Those rates are more than twice the 19 percent rate for Caucasian women.¹³ Babies born to mothers who have not had adequate prenatal care are at much higher risk for negative health outcomes, and their mothers are three to four times as likely to die of pregnancy-related complications than are women who have received care. Gaps in care do not end with the prenatal period; for most women, postpartum care is similarly inadequate. More than half of all maternal deaths occur within the first six weeks after delivery, but postpartum care typically consists of a single visit to a physician scheduled for six weeks after childbirth.¹⁴ These negative outcomes are due, in part, to barriers in access to publicly-funded programs. A 2010 Amnesty International report found that complicated bureaucratic requirements mean that eligible women often face significant delays in receiving prenatal care.¹⁵ Culturally and linguistically appropriate services are needed to bridge critical gaps in care and to assist women of color in navigating the healthcare system to access available resources.

Research shows that African American and Latina women who do access maternal care are more likely to experience discriminatory and inappropriate treatment.¹⁶ When women feel they are alienated, they may be less likely to attend appointments or classes. Similarly, when information related to healthy pregnancy is presented in ways that are not relevant or sensitive to their cultural norms, women are less likely to take in and act on that information. Inadequate maternity care has serious implications not only for the lives of women and their infants, but also for the economic cost of healthcare.

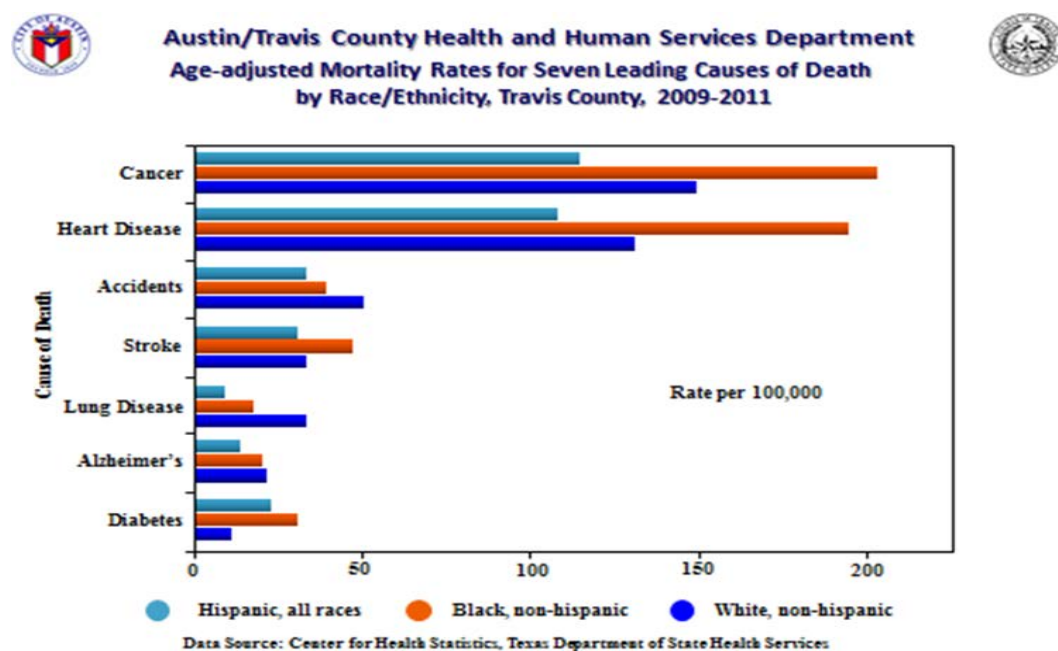
In addition to health care access issues, research has shown that:

- African American women who initiated prenatal care in the first trimester still had higher rates of infant mortality than Caucasian women with late or no prenatal care.¹⁷
- Babies born to high income African American women still have higher mortality rates than babies born to very low income Caucasian women.
- The infant mortality rate experienced by African American women who are college graduates is higher than that for Caucasian women who are high school dropouts.¹⁸

Therefore, even when accessibility factors are addressed, racial disparities in birth outcomes persist. Other risk factors for poor birth outcomes such as preterm birth, low birthweight, and infant mortality, are behavioral, including smoking, alcohol use, and inter-pregnancy intervals shorter than 18 months. Additional risk factors include social and environmental determinants of health, such as stress during pregnancy, chronic stress prior to pregnancy, stress due to experiences of racial bias and discrimination, and socioeconomics.¹⁹

African American Health Disparities

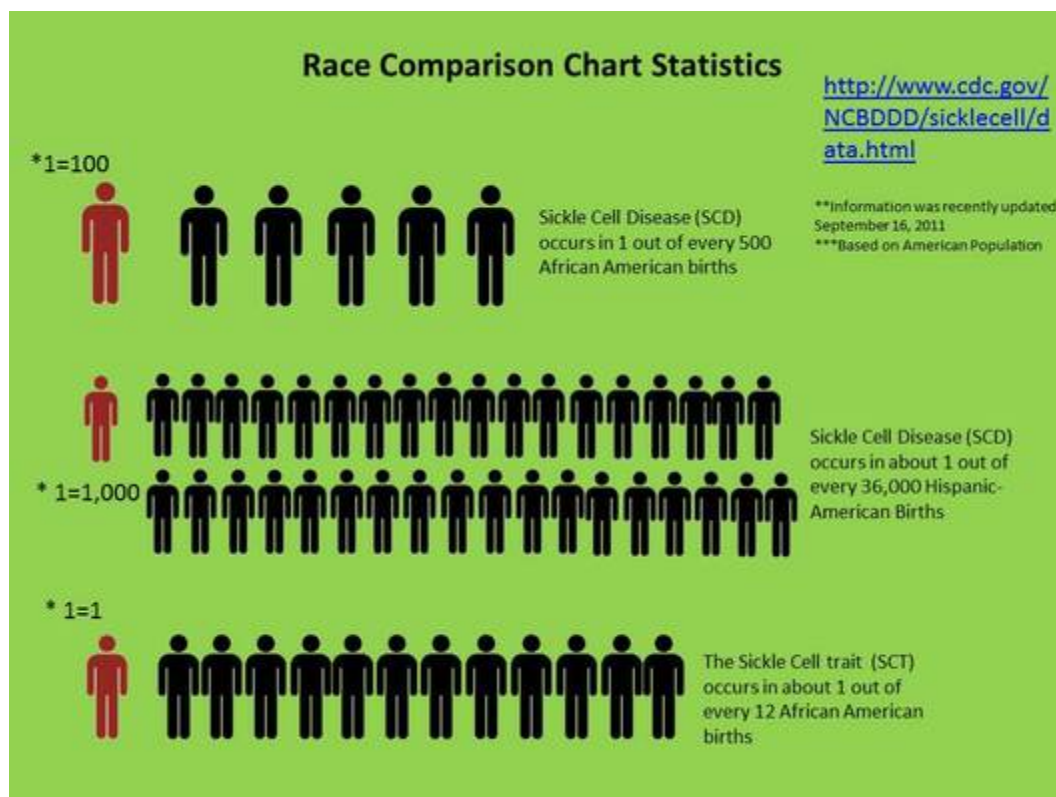
The table below from the ATCHHSD 2015 Critical Indicators Report indicates that from 2009 to 2011, African Americans had the highest mortality rate in four out of the seven leading causes of death reported.²⁰ The four causes were cancer, heart disease, stroke and diabetes. Although there have been improvements over the past ten years, higher morbidity and mortality rates for African Americans from leading illnesses and diseases is still pervasive.



According to the 2015 ATCHHSD Critical Health Indicators report, the prevalence of cardiovascular disease increased with age and decreased with increasing level of education. African Americans have a higher prevalence of cardiovascular disease than Caucasians and Hispanics. Adults who reported having diabetes also reported a higher prevalence of cardiovascular disease (23%) compared to adults without diabetes (3.5%). Obesity and being overweight are strongly associated with cardiovascular diseases as well. Over 9% of obese adults report having cardiovascular disease.²¹

HIV/AIDS also has a disproportionate impact on the African American community. The prevalence of HIV infections among African American males is twice the rate compared with Caucasian males. Even more significant, the prevalence of HIV among African American females is more than 12 times that of Caucasian females. African Americans are more likely to die from HIV/AIDS than others; the age-adjusted mortality rate for African Americans (14.6 deaths per 100,000 population) is over nine times higher compared with the age-adjusted mortality rate for Caucasians (1.6 deaths per 100,000).²²

While not as common as the aforementioned causes of death, Sickle Cell disease is a debilitating chronic condition that disproportionately impacts African Americans in Travis County. Sickle Cell is a genetic blood disorder that attacks the red blood cells. There is no cure and life expectancy is 40 years of age. According to the Texas Department of State Health Services, 9,258 babies were born with Sickle Cell Trait (SCT) in Central Texas (Region 7/8) in 2011-2012.²³ One in 12 African Americans and one in 36 Hispanics carry SCT.²⁴



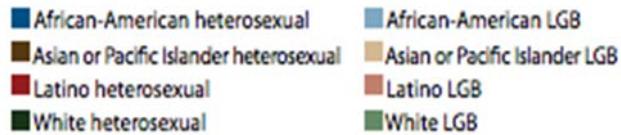
Asian American Health Disparities

In 2012, ATCHHSD contracted with the Asian Resource Center to conduct an Asian American Community Health Assessment. This report was intended to raise awareness about health concerns and disparities within the Asian American community. The report provided information and identified the top five health needs of the Asian American population in Austin.

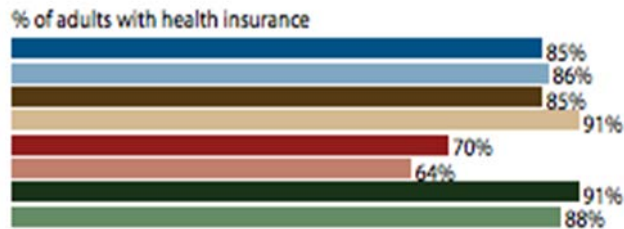
The report was released in July 2014 and demonstrated that Asian American subpopulations experience a disproportionate rate of chronic diseases such as diabetes and cardiovascular disease, similar to other minority populations. In addition, the report looked at obesity, cancer, behavioral health, tuberculosis and barriers to health care access. According to this report, Census data shows the Asian American population as having lower Body Mass Index (BMI) and a lower prevalence of obesity; however, the disaggregated data among ethnic subcategories reflected a disparity. “For example the Filipino American adults are 70% more likely to be obese as compared to the overall Asian American population.”²⁵ Cancer is the leading cause of death among Asian Americans, and the rate of heart disease among Indian Americans is the four times higher than Caucasians.²⁶

Health Disparities in LGBTQ People of Color

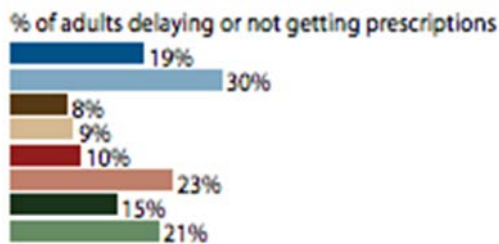
Communities of color disproportionately impacted in health disparities include LGBTQ (Lesbian, Gay, Bisexual, Transgender and Queer/Questioning) people, who are likely to struggle with co-morbidities including, but not limited to, HIV/AIDS and chronic diseases such as cardiovascular disease and diabetes.²⁷ People of color and LGBTQ people have come to be known as “hard-to-reach” because they frequently do not access health information and services in traditional ways through mainstream providers due to multiple socioeconomic barriers.²⁸ When people of color are also members of the LGBTQ community, their lack of access is compounded by multiple forms of discrimination, and therefore they experience additional barriers in access, quality and relevance of care.



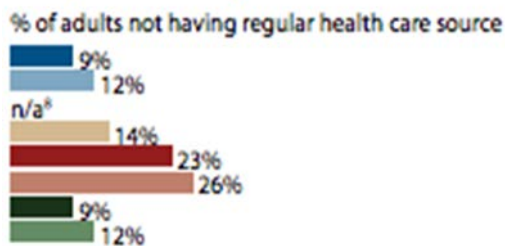
Health Disparity #1: LGB Latino adults are least likely to have health insurance.⁴



Health Disparity #3: LGB African-American adults are most likely to delay or not get needed prescription medicine.⁶



Health Disparity #4: LGB Latino adults are least likely to have a regular source for basic healthcare.⁷



Data source: The Center for American Progress analysis of 2007 California Health Interview Survey data

Mental Health of Immigrant Families

Resettling in a new country brings a unique set of challenges, leaving immigrants and their families vulnerable to mental health problems. Compared with nonimmigrant families, immigrant families may experience high levels of stress, depression, grief, and traumatic events.²⁹ Most immigrant parents are faced with immediate challenges to their survival – securing a job, finding a place to live, buying food, and enrolling their children in school.

Children tend to learn English much more quickly than adults, causing parents to develop a reliance on their children for language interpretation and assistance with understanding how to navigate community systems. This change in power dynamics may bring communication and relationship challenges for parents and children. Children face enormous pressure from their parents to stay true to their culture while feeling pressure at school to fit in and act “more American.” Seniors are less likely to feel comfortable speaking English and are especially at risk for social isolation. Such stressors may have painful effects and may lead to depression, substance abuse, family violence, or dropping out of school.³⁰

Many children in immigrant communities face multiple barriers to accessing health care services that are comprehensive, affordable, and culturally and linguistically appropriate. These barriers include language, poverty, fear and stigma, high mobility, lack of understanding of how the health care system works, social isolation, and lack of insurance and/or access to health care. Many children of immigrant families belong to racial and ethnic minority groups with disparities that are worsened by their living circumstances. For some, the fear of violence or harassment because of their immigrant status compounds their already fragile living conditions.³¹

Services for the Elderly

Older adults are at high risk for developing chronic illness including diabetes, congestive heart failure, and dementia. While preventive health services may be valuable in maintaining quality of life and wellness for older adults, these services continue to go underutilized, particularly by elderly persons of color.³²

Availability of affordable healthcare is a key concern. When a senior develops a significant health concern, it often leads to additional medical expenses and other health issues. Nearly 15% of seniors released from a hospital in Austin will be re-admitted within 30 days. Only 17% of seniors surveyed felt confident that they could afford a significant medical expense.³³ Out of pocket medical expenses are on the rise, particularly for those over 65, and although Medicare and Medicaid may help with these rising costs, the Texas Medical Association has seen a recent decline in physicians accepting Medicare patients despite the growing number of enrollees.

Transportation is another barrier to care for many of Austin’s seniors, with 50% of seniors surveyed by the Mayor’s Task Force on Aging responding that they would be likely to take advantage of a mobile health unit if one visited their community. The census tracts where 30% or more of seniors are in poverty correlate with the zip codes where residents expressed an interest in mobile healthcare units.³⁴

BEST/PROMISING PRACTICES

Effective strategies do exist and are being employed regionally and nationally to address health disparities. Best and promising practices for improving health status of different populations share the following characteristics:

- Culturally and linguistically appropriate
- Community-based in order to maximize family and social supports
- Holistic in approach, taking into account basic needs and other barriers to care

Community Health Workers

Community Health Workers (CHWs) living in affected communities are a logical resource that is willing and able to be mobilized to address the needs and problems of their communities. CHWs are known by many names including community outreach workers, promotores de salud, community health advisors, peer educators, peer counselors, and/or lay health workers.³⁵

CHW programs are a community-based response to improve the health care system and health-social conditions of uninsured and underserved populations in all of the issue areas highlighted in this report. CHWs are hired for a wide variety of reasons such as being seen as cost effective, having an enhanced ability to reach and organize their own communities, and excellence in providing one-to-one education and outreach. They are often better at reaching communities that others have been unwilling or have failed to reach.³⁶

Midwifery

Extensive evidence documents excellent outcomes of midwifery for the poor in urban and rural settings over the past 75 years.³⁷ For example, a study conducted in 2007 by the Winter Park Health Foundation and the Health Council of East Central Florida on 100 women receiving care revealed that there were no low birth weight or premature infants born to African American or Latina women who participated in the Easy Access program developed by Licensed Midwife Jennie Joseph.³⁸ The American College of Nurse-Midwives identifies specific areas of health disparities that are of particular concern to midwives, including infant mortality, premature birth, low birth weight, sudden infant death syndrome (SIDS), deaths due to complications from pregnancy or childbirth, breast and cervical cancer, HIV/AIDS infection, and heart disease. Additionally, numerous clinical studies have found that the presence of a doula (birth companion) at a birth results in shorter labor with fewer complications, reduces negative feelings about the birth, reduces the need for medical interventions, increases success with breastfeeding, and reduces the incidence of postpartum depression.³⁹

Lifecourse Perspective

CDC published 10 recommendations in 2006 to improve health and health care for women in the United States before and after pregnancy.⁴⁰ The recommendations address both preconception and interconception care. “Preconception care” is defined as a set of interventions to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management. “Interconception care” refers to the time between pregnancies, including, but not restricted to, the postpartum period.⁴¹ Both CHW programs and the Midwifery model take a lifecourse perspective when working with women.

Community and Faith Based Interventions

The “Check, Change, Control” program from the American Heart Association (AHA) is a chronic disease prevention initiative that shows promise. This program is based on positive results of “Check It, Change It,” which was launched in Durham County, North Carolina to help people in a targeted majority African American community maintain healthy blood pressure. The program uses a web-based tracking tool, [Heart360](#), in collaboration with remote monitoring, health mentoring, and guidance from physician assistants as needed.⁴²

A research study examining various interventions for their effectiveness in reducing cardiovascular disease in African Americans revealed that utilizing community-based clinics and community volunteers are two of the most promising strategies. “Approximately half of the interventions were in high-risk populations (low income, low education, urban) and hypertension and nutrition and physical activity were the most common focuses. The interventions that received the most enthusiasm from the reviewers used community-based clinics with lay health volunteers.”⁴³

The growth in faith-based health ministries in African American churches is another positive trend. Approximately 40 African American churches in Austin are known to have some form of a health ministry. Faith-based organizations have impacted the political and social perspectives of African Americans for many years. Integrating health care into faith-based entities can foster an environment that promotes stewardship of resources, social supports, creation of trust in the health care system, and dialogues on the intersection of religion and health. Evidence based interventions such as *Body & Soul*, which utilizes the church community to increase the consumption of fruits and vegetables, have proven to be effective means reaching the African American population. A total of 15 churches, with 1,022 participants from California, Georgia, North Carolina, South Carolina, Delaware, and Virginia, were randomly assigned to the Body & Soul intervention or to a control group.⁴⁴ At six month follow-up, Body & Soul participants consumed more fruits and vegetables per day than control participants, decreased their percentage of calories from fat, were more motivated to eat fruits and vegetables, and had greater self-efficacy and social supports to eat fruits and vegetables compared to control participants.⁴⁵

Risk Screening and Risk Reduction Interventions: HIV

A risk screening is a brief evaluation that identifies behavioral factors such as unprotected sex or sharing of drug-injection equipment that may affect the chance of others being exposed to HIV. Biomedical or biologic factors that influence HIV viral load, viral shedding and infectiousness may also be determined through risk screening. Based on the results of risk screenings, Community Health Outreach Workers and Peer Educators working outside of health care settings can provide risk reduction information, materials, and interventions onsite, or link clients to other providers or organizations. Over a lifetime, these interventions can promote safer sexual and drug injection behaviors and minimize the risk of other factors such as STDs that may facilitate HIV transmission.⁴⁶

Risk Screening and Risk Reduction Interventions: Sickle Cell Disease

Newborn screening for Sickle Cell Trait (SCT) is a very effective practice for identifying carriers at an early stage. Building on this effectiveness, the Texas Department of State Health Services' newborn notification for newborns born with SCT provides additional opportunity to educate families about the possible associated health outcomes and the potential for having another child with SCT or Sickle Cell Disease. A previous study showed that such families welcomed genetic counseling and health education.⁴⁷

For programs that reported the positive SCT results, 37% had no mechanism to determine whether or not that information was received by the intended recipient.⁴⁸ This suggests that opportunities to educate families about the potential health effects of SCT and the implications for future family planning decisions were missed. In addition, there might be consequences for the infant's own family planning, and education might also have an impact on other children of those parents or their extended family members.⁴⁹ Free or low cost testing for adults can help mitigate this risk.

Education is a very important mechanism for sickle cell disease management. Hemoglobinopathy education is a very detailed process of educating families about Sickle Cell disease management. Ongoing education is important because needs change as the person ages. Lifetime education is a best practice to help reduce emergency room visits and to enable the patient and to family better manage the disease. Physician education has also proven to be important. It has been shown that even among physicians there is limited knowledge about Sickle Cell disease.⁵⁰ The ability to continuously educate the medical community is important.

Community Based Health: Sexual Health and Wellness

Significant social, cultural and economic factors creating disparities in rates of HIV infection and incidents of chronic disease for LGBTQ people of color can be effectively mitigated through culturally specific and research based interventions. Research further demonstrates that community-based programs conducted by and for people of color are the most effective with hard-to-reach minority underserved populations.

The World Health Organization defines sexual health as a component of reproductive health. Reproductive health is “a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Reproductive health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.”⁵¹

Community Based Health: Immigrant Mental Health

Based upon its own research, the Child and Family Research Institute in the School of Social Work at the University of Texas at Austin recommend that “advocates and providers should help to increase access to mental health services that can work to repair the trauma of migration and family separation. Services offered should include supportive services for parents struggling to manage changes in family dynamics, counseling for children to help increase their strategies for coping with the ambiguity of their parents’ legal status, and empowerment of parents in planning for the future.”

The community-based health model allows for clients to receive affirmational support to help reduce isolation. This model addresses basic needs first, creates a safe environment to help clients feel welcome and to be productive, taps into cultural traditions to create a spiritually nurturing environment where families can reconstruct their positive self and group identities, and establishes a sense of community to enhance emotional health. This facilitates a sense of openness among participants to express their feelings and collectively cope with life difficulties.⁵²

Other strategies include increased coordination and communication between voluntary organizations, social services and mental health services; training of staff on cross-cultural issues; increase access to mental health services and reduce fear of stigma through provision of mental health care services within the primary healthcare setting; educational initiatives focused on families and broader social groups to help empower individuals to deal with their condition; integration of mental healthcare with primary care; psychoeducational initiatives focused on families and broader social groups; and technology-based interventions.⁵³

Community Based Health: Elderly

The Community Preventive Services Task Force is an independent, nonpartisan, nonfederal, unpaid 15-member panel of public health and prevention experts appointed by the Director of the Centers for Disease Control and Prevention (CDC), recommends social support interventions for older adults in community settings that focus on building, strengthening, and maintaining social networks that provide supportive relationships to support for physical activity. Activities include setting up a buddy system, walking groups or other groups to provide friendship and support.

A number of communities throughout the United States have implemented Mobile Health Care programs. Mobile units are outfitted with basic medical equipment and supplies. Practitioners from a wide variety of fields including nursing, physical therapy, occupational therapy, pharmacy, and dietetics staff the units. Some of the focus areas include health and risk assessment, medication management, foot care, health education, memory loss assessment, nutrition counseling and injury prevention.

WORKING GROUP RECOMMENDATIONS

Based on the analysis of current data trends, research of best practices, and input from community members, the working group recommends that \$1,050,000 be allocated for the 2015-2016 fiscal year to support the delivery of non-traditional, culturally specific, community-based interventions to address issues of mental health, chronic disease, maternal and infant health, elder support, and sexual health and wellness for African Americans, Latinos, Immigrants and LGBTQ people of color.

Successful Programming

Programming Objective: Programs will improve access, cultural relevance, quality, and outcomes of care.

Successful programs will:

- Provide accessible culturally specific health and wellness programming to address exercise, nutrition, stress reduction, community building, and goal setting
- Include strategies to address barriers to access, including transportation support, child care, and on-site classes
- Include strategies to address barriers to healthy food access
- Increase and diversify the production of health education materials that are culturally and linguistically appropriate
- Include health prevention and education services that acknowledge the implications of the social determinants of health
- Develop and utilize an explicit community engagement methodology with culturally specific strategies
- Prioritize communities most directly impacted by health disparities
- Include a culturally congruent staff that builds deep relationships with clients
- Include a community-wide effort
- Recognize mental health as a key component to wellness, as a person's mental health has a direct bearing on his/her physical health and vice versa
- Offer services in a variety of locations that individuals feel are welcoming and safe environments

Organizations selected to provide services must meet the following criteria:

- Have a history of ongoing community programs focused on communities facing health disparities for at least two years
- Be culturally and linguistically appropriate with a board or leadership team representative of the clients served

- Provide programs and services primarily to historically underserved communities, as reflected in the organization's mission statement
- Use innovative models where program design and implementation is led by community members directly impacted by the health disparities being addressed
- Successfully use a community organizing methodology as a tool for meaningful community engagement

Maternal and Infant Health

Action: Develop and implement culturally specific, holistic, programs that prioritize communities most directly impacted by maternal health inequities, including women of color, LGBTQ and gender non-conforming women, immigrant women, and young women. Programs will reduce common barriers to care such as language, transportation and family support in order to positively impact maternal and infant outcomes for women of color.

Meaningful performance measures might include:

- Reduced number of premature births
- Reduced number of low birth weight babies
- Reduced rates of infant mortality
- Reduced rates of deaths due complications from pregnancy or childbirth

Estimated initial annual cost: \$390,000

African American Health Disparities

Action: Develop and implement faith and community-based, culturally specific risk screening and risk reduction intervention models that support behavior change through education and social supports with the goal of reducing rates of HIV infection and chronic disease for African Americans. Include community-based risk screening and risk reduction interventions to provide emotional and social supports for persons with Sickle Cell Trait or Disease.

Meaningful performance measures might include:

- Weight loss
- Reduced rates of mortality
- Reduced rates of HIV infection
- Increase in the number of adults who are aware of their risks of Sickle Cell Trait/Disease

Estimated initial annual cost: \$410,000

Services for the Elderly

Action: Develop and implement culturally specific, community-based services that focus on physical, emotional, mental and social well-being of elderly people. These services will provide health education, resources and social support to promote healthy outcomes.

Meaningful and appropriate performance measures might include:

- Improved self-management of chronic disease
- Increased use of preventive health services

Estimated initial annual cost: \$50,000

LGBTQ People of Color Sexual Health and Wellness

Develop and implement nontraditional, culturally specific interventions that focus on the physical, emotional, mental and social well-being of LGBTQ people of color to help remove stigma and other barriers to care and reduce rates of HIV infection and chronic disease.

Meaningful and appropriate performance measures might include:

- Reduced rates of HIV infection
- Reduced rates of STI/STD infection

Estimated initial annual cost: \$100,000

Immigrant Mental Health

Develop and implement nontraditional, interdisciplinary, culturally specific, and community-based health programs that address basic needs and provide concrete tools to help immigrants develop social support strategies to positively affect physical and mental health over the life span.

Meaningful performance measures might include:

- Increased awareness of mental health services
- Increased ability to access mental health services
- Increased feeling of social support

Estimated initial annual cost: \$100,000

COMMUNITY MEETINGS

On July 9 and 18, 2015 respectively, community meetings were held at the Southeast Health and Wellness Center and YMCA Joint City facility. Meetings were facilitated by the stakeholder members. Three methods were used to collect information:

1. Community response
2. Facilitated Small Group Discussion
3. Feedback Form

Community Response:

This process provided all attendees a time to address the group. Attendees used this time to express their feelings about the process, their experiences with preventative and clinical health programs, and any other information they wanted to share.

Facilitated Small Group Discussion:

This method is a facilitated process of small groups using a “Conversation Café” process, which includes a group agreement of respect for each member’s comments and allows the opportunity for all members to speak. This process asked the following three questions:

1. What do you think about the four issue areas discussed (maternal/child health, African American health, LGBTQ community health; and immigrant families’ mental Health?
2. In your opinion, what other issue areas should be included?
3. Are there health programs that you have participated in that you felt were effective? Why or Why not?

Feedback Form:

The community feedback form asked the same questions as listed above for the Facilitated Small Group discussions.

Attendees provided positive feedback regarding the process and provided personal stories about unique programming and experiences that had changed their lives. Some mentioned examples of exceptional customer service by healthcare professionals, as well as some suggested improvements.

The following provides more information about the responses collected from the feedback form, public comment or small group discussions:

1. What do you think about the four issue areas discussed (maternal/child health, African American health, LGBTQ community health, and immigrant families' mental health)?
 - Agree with areas
 - Focus on Hispanic/Latino Health
 - Collaborations and partnerships
 - Sharing resources and working with others
 - Diversity and cultural awareness
 - Conduct more analysis over time
2. In your opinion, what other issue areas should be included?

Attendees suggested the following additional issue areas:

- Establish a Community Council
 - Establish a customer service line (bilingual/multilingual where people can call for information.
 - Elderly Services
 - Mental health for all populations
 - Safety and Violence reduction outside of the Criminal Justice system.
 - Youth Services
3. Are there health programs that you have participated in that you felt were effective? Why or why not?

Attendees suggested several programs they participated in over the years. Some of the common themes of why these programs were effective include the following:

- "Successful programs involve communities that are affected (design, implementation and feedback)"
- "Programs held on the weekend"
- "Relationships established with the leader and partners participating"
- "Strong attachments such as community connection system where is it everyone's issue"
- "Structure of the program including accountability and follow up"

CONCLUSION

Efforts to eliminate ethnic and racial health disparities must consider the social determinants of health that influence population's health and understand health and wellbeing within the complexed relationships that exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, language accessibility, and legislative policies.⁵⁴

State and local health departments, as well as community-based organizations, have worked to address adverse conditions affecting the aforementioned populations, yielding promising results. Effective strategies exist and are being employed regionally and nationally to address health disparities. Strategies for improving health status of different populations share the following characteristics:

- Culturally and linguistically appropriate
- Community-based in order to maximize family and social supports
- Holistic in approach, taking into account basic needs and other barriers to care

We are appreciative of the tremendous community response to this Council Resolution and those who contributed and attended the three community meetings. A comprehensive and detailed report will be forthcoming to address the second part of the resolution focusing on economic equity and equity assessment.

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RESOLUTION NO. 20150507-027

WHEREAS, a recent study from the Martin Prosperity Institute determined that Austin is the most economically segregated city in the country, and also that Austin ranked 4th nationally for occupational segregation and 5th nationally for educational segregation; and

WHEREAS, the first Regional Affordability Committee included a presentation from the City Demographer (Presentation) stated that the reduction in the local poverty rate from 20.3 percent in 2012 to 17.8 percent in 2013 was at least partially attributable to the displacement of low-income residents, shown by increases in poverty rates in surrounding counties such as Bastrop, which saw an increase from 10 percent to 22 percent over the same period of time; and

WHEREAS, the Presentation included 2013 data from the American Community Survey produced by the United States Census Bureau that shows that 5.4 % of non-Hispanic white children under the age of 5 in the City of Austin were living at or below the federal poverty threshold, where 51.8% of African-American children and 33.0% of Hispanic children in the same age group are living at or below the federal poverty threshold; and

WHEREAS, the infant mortality rate is an estimate of the number of infant deaths for every 1,000 births, and the Centers for Disease Control and Prevention states that this metric is often used as an indicator to measure the health and well-being of a community, because factors affecting the health of entire populations can also impact the mortality rate of infants; and

WHEREAS, according to data from 2010 provided in a presentation from the Austin/Travis County Health and Human Services Department, white infants have significantly better infant mortality rates in Travis County than in Texas or

across the country, but both Hispanic and African-American have worse outcomes when compared to the average in Texas and in the United States; and

WHEREAS, community advocates including the Austin Immigrant Rights Coalition, Mama Sana/Vibrant Woman, and allgo have urged the City Council to reevaluate existing practices and develop solutions to address inequities within the City of Austin; and

WHEREAS, maternal and infant health outcomes are impacted by all of the social determinants of health, and comprehensive equity tools can help to address all areas where inequities affect our community; and

WHEREAS, equity assessment tools are being developed and implemented in cities, counties, and states across the country including Seattle, Portland, Minneapolis, Iowa, Connecticut, Oregon, Minnesota, and King County, Washington to proactively address equity issues; and

WHEREAS, Seattle has implemented a Race and Social Justice Budget and Policy Filter Supplemental Tool Kit that includes best practices criteria, definitions, and instructions for completing a Racial Equity Impact Analysis during the budget process; and

WHEREAS, Seattle has created work plans and strategies to reduce racial disparity and foster multiculturalism, and addresses five broad areas across all departments including workforce equity, economic equity, public engagement, immigrant and refugee inclusion and access to services, and capacity building; and

WHEREAS, developing a similar equity tool to use across City departments and during the budget process has the potential to address equity challenges in the City of Austin; and

WHEREAS, on March 30, 2015, the Austin Independent School Board of Trustees voted to recommend that the District undertake a self-assessment regarding equity, diversity, and inclusion; and

WHEREAS, Austin would benefit from taking steps to implement an equity assessment tool and other policies to address significant inequities in health outcomes and other disparities that impact quality of life for many low-income communities which are disproportionately communities of color in Austin; and

WHEREAS, the City of Austin Health and Human Services Department (HHSD) has a Women, Infant and Children activity within the Maternal, Child, and Adolescent Health program that focuses on providing nutritional and preventative health services to targeted women and children to ensure healthy outcomes; and

WHEREAS, HHSD has a Health Equity Working Group that has been meeting for over a year to develop policies to increase inclusiveness and ensure that services provided are both culturally and linguistically appropriate; and

WHEREAS, Council Resolution 20140626-078 (Resolution) initiated a process to evaluate funding levels for the HHSD and social service contracts and to develop a metric to be used as a minimum for funding increases for Health and Human Services and social service contracts in the annual budget; and

WHEREAS, staff from HHSD developed a collaborative working group that coordinated regularly with community stakeholders to develop recommendations, which led to adoption of a policy through Council Resolution 20141211-114 to close the gap in funding for the HHSD including social service contracts, and the development of an index to be used for annual increases in social service contracts; and

WHEREAS, a similar collaborative process that includes staff from HHSD's Health Equity Working Group, HHSD's Maternal, Child, and Adolescent Health Program, Central Health and community stakeholders would be invaluable in gathering information about how to address disparities in infant and overall health outcomes for the community and how to develop an assessment tool for addressing racial disparity throughout the city; and

WHEREAS, the primary stakeholder groups to be involved in this process should include Austin Immigrant Rights Coalition, allgo, and Mama Sana/Vibrant Woman in addition to other community organizations and members directly impacted by inequities; and

WHEREAS, the stakeholder group could also collaborate with the City Manager and staff from the City of Austin Budget office to give input on developing citywide policies to address equity issues and develop an equity tool to be used during the budget process; **NOW, THEREFORE,**

BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF AUSTIN:

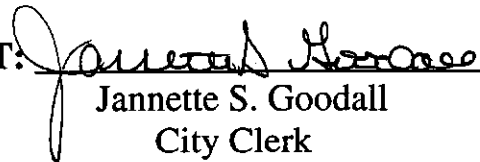
The City Manager is directed to provide staff resources for a working group to gather information for improving health outcomes for infants, mothers, and other members of the community. The working group shall meet a minimum of three times and include coordination between staff from the City of Austin Health and Human Services Department, primary stakeholder groups, and other interested individuals and organizations. The working group shall present a progress report including initial recommendations and potential items for budget consideration shall be provided at the Health and Human Services Committee no later than August 3rd, 2015, and shall present a final report to the Health and Human Services Committee no later than December 7, 2015.

BE IT FURTHER RESOLVED:

The City Manager is further directed to coordinate with the working group and City of Austin Budget Office staff and other departments to evaluate the impact that existing City policies and practices have on equity, evaluate best practices in other cities, and develop recommendations for addressing current race and socioeconomic-based inequities throughout the City in terms of economics, working conditions, local health outcomes, and participation in public affairs. The recommendations should include, but not be limited to the development of an equity assessment tool to be used by every City department during the budget process. The working group shall present a progress report with initial findings to the Economic Opportunity Council Committee no later than September 14, 2015 and shall present final recommendations to the Economic Opportunity Council Committee no later than December 14, 2015.

ADOPTED: May 7, 2015

ATTEST:


Jannette S. Goodall
City Clerk

Asian American Health Data

[Source: Asian American Health Assessment]

Obesity

- Studies suggest that being foreign-born is associated with a greater resiliency to obesity. At the same time, acculturation to the United States was associated with a greater BMI.

Diabetes

- South Asian American immigrants are 7 times more likely to have type 2 diabetes than the general population.
- It is likely that current BMI standards are not a valid predictor of diabetes in Asian Americans. A better diagnostic tool is needed.

Cancer

- Cancer is the leading cause of death among Asian Americans.
- Asian American females are the first American population to experience cancer as the leading cause of death.
- Vietnamese American women's cervical cancer incidence rates are 5 times higher than white females'.
- Vietnamese American men have the highest rate of liver cancer among all other ethnic groups.
- Korean American men have the highest rate of stomach cancer among other ethnic groups, and fivefold increased stomach cancer rate over white men.

Hepatitis B

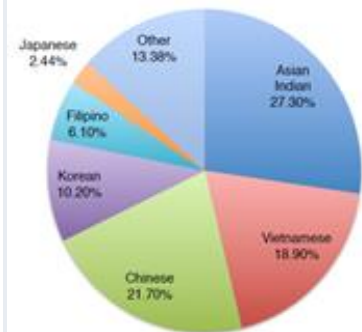
- 1 million of Asian Americans are living with chronic Hep-B – more than half of all the cases in the United States. It continues to be the biggest health disparity between Asian Americans collectively and the U.S. population.
- Asian Americans are 7 times more likely to die from Hep-B than whites.

Asian Americans

• • •

- Asian alone make-up about 6% of total population in Travis County

Percent Shares of total Travis County Asian alone Population by Country of Origin



Asian American Health Issues at a Glance

• • •

- Obesity
- Diabetes
- Heart Disease
- Cancer
- Hepatitis B
- Tuberculosis
- Behavioral Health
- Healthcare access barriers

Heart Disease

- Heart disease is the second leading cause of death for Asian Americans.
- The rate of heart disease among Indian Americans is 4 times higher than the rate among whites.
- The risk factors for high blood pressure include low levels of awareness and control; very little awareness among Laotian, Cambodian, and Vietnamese immigrants and low screening rates among Asian Americans in general.

Tuberculosis

- Asian Americans have the highest rates of tuberculosis of any ethnic group in the U.S.
- The tuberculosis rates are increasing for Asian Americans and Pacific Islanders, while decreasing for the rest of the population.

Behavioral Health

- Asian American college students report higher levels of depressive symptoms than white students.
- National data suggests that Asian Americans have historically been at higher risk for behavioral health problems and also have the highest rates of reported suicides compared to other races when disaggregated by age, gender, and subgroup.
- Older Asian American women have the highest suicide rate of all women aged 65 and older, with elderly Chinese American women exhibiting rates 10 times higher than those of white elderly women.
- Certain mental health conditions like depression, anxiety, and posttraumatic stress disorder are common among Asian refugee population.

Health Care Barriers

- Asian Americans are less likely than non-Hispanic whites to receive health insurance through their employers. For Texas, Asian Americans are the second largest population who are uninsured.
- Lack of access to care, language barriers, and lack of culturally and linguistically responsive providers are major challenges.

Health and Human Services Department

Maternal Child and Adolescent Division – Initiatives Addressing Maternal, Infant, and Youth Health Disparities

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Department of State Health Services Grant Funded		
Total Budget: 6.269 million		Staffing 78 PFTEs 6 .5PFTEs 21 Temps
Purpose of Program	Provide nutrition and breastfeeding education, nutritious foods and improved access to regular health care and social services to low and moderate income women and young children with or at risk of developing nutrition related health problems.	
Program Goals	To decrease the risk of poor birth outcomes and to improve the health of participants during critical times of growth and development.	
Program Accomplishments	94% of infants whose mothers were on WIC during pregnancy initiate breastfeeding. 39% of pregnant women who enrolled in WIC were in their 1st trimester. 99.5% of participants who indicated during enrollment that they have no health care source were referred to at least one source of health care.	

MCAH – WIC “Women Place” Services Department of State Health Services Grant Funded Initiative		
Total Budget Allocated: \$331,160 with additional \$217,500 in new funding through “Women’s Place” Expansion.		Staffing 6PFTEs 1 .5PFTEs 4Temps
Purpose of Program	Lactation center for WIC mothers with breastfeeding problems, training center for WIC staff and other health providers to receive clinical experience working with breastfeeding mothers, and a statewide Lactation Resource Center for health providers to utilize the information and assistance when working with pregnant and breastfeeding women.	
Program Goals	Assist breastfeeding mothers to reach her breastfeeding goals and to act as resource center to other organizations and health care providers.	
Program Accomplishments	2,143 counseling services provided to breastfeeding mothers in FY14. 8,617 assistance provided through phone calls in FY14. 56 students (WIC, healthcare professionals) completed the Clinical Lactation Practicum in FY14.	

Health and Human Services Department

Maternal Child and Adolescent Division – Initiatives Addressing Maternal, Infant, and Youth Health Disparities

Healthy Families* 1115 Waiver Funds (Contracted to Travis County)		
FY 15- \$250,000 sub-contracted to Travis County HHS/VS		Staffing 3 FTEs
Purpose of Program	Provide home visit and family support services based on the Healthy Families America model to improve access to preventive health services	
Program Goals	Improve families' access to preventive services including establishing a medical home, immunizations, well-child checks and developmental assessments	
Program Accomplishments	• 75 participants served to date • Outcomes below are in progress • Number of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life will increase by 5% in DY4 • Number of children who turned 15 months old during the measurement period and had six or more well-child visits with a PCP during their first 15 months of life will increase by 10% in DY4. • Number of children who receive required immunizations by their second birthday will increase by 10% in DY4	

Maternal, Infant Outreach Program (MIOP)* 1115 Waiver Funds		
FY 15 - \$386,772		Staffing 2.5FTEs 6 CHWs (Temps)
Program Goals	Use Community Health Workers (CHWs) to improve birth and twelve-month postnatal outcomes with an emphasis on African American women through increased access to pre- and post-natal care and health literacy	
Program Accomplishments	• 107 participants served to date. Between October 1, 2014 and March 31, 2015, MIOP enrolled 48 new clients and provided services to 59 clients. • Between October 1, 2014 and March 31, 2015, 18 of 20 or 90% Healthy term newborns. • Strengthened program capacity - 7 Certified CHWs, and 1 Certified CHW Instructor • Established the 1115 Maternal Health Referral System - a formal partnership with other DSRIP grantees and local service providers working in the area of maternal and child health to ensure that low-income women in our community get all the services and support they need by creating and constantly improving upon an inter-agency referral process and improving patient engagement. Participating entities/organizations in the Referral System are: - o WIC - o Travis County Healthy Families - o Central Health - o Seton - o Any Baby Can - o Planned Parenthood	

*Grant-funded programs in existence for 1- 2 years.

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Health and Human Services Department

Maternal Child and Adolescent Division – Initiatives Addressing Maternal, Infant, and Youth Health Disparities

Healthy Texas Babies* Department of State Health Services Grant Funded Initiative	
FY 15- \$90,000 with 2 additional renewal options.	
1 FTE	
Purpose of Program	This program funds the development of a Healthy Texas Babies coalition tasked with implementing community and clinical intervention to improve the health of women in Travis County during the preconception and inter-conception time periods with the goal of improving birth outcomes.
Program Goals	Improve maternal, child, and adolescent health outcomes from pre-conception through young adulthood.
Program Accomplishments	- Established formal collaborations with over 20 organizations in Austin Travis County to address birth outcomes disparities, as well as prenatal, postnatal, and inter-conception services for women. - Healthy Texas Babies is supporting HHSD's work related to MIOP and Healthy Families goal to reduce disparities in birth outcomes by bringing together key organizations to coordinate efforts.

AHA's Peer To Peer (P2P) Project* 1115 Waiver Funds	
\$173,877 (1115 Waiver Grant)	
1.0 FTE 3 staff @ 0.5 FTE each VISTA (split between multiple projects)	
Purpose of Program	Health education model to decrease the prevalence of teen pregnancy among Latina females ages 13-19. The P2P Framework will include outreach and education, youth development, partnerships with schools and community collaborations. A culturally relevant evidenced based program will be utilized.
Program Goals	Use evidence-based Peer-To-Peer models to decrease the prevalence of teen pregnancy among Latina females ages 13-19.
Program Accomplishments	- Reached 675 youth (13-19 yrs. Old) with evidenced base sexual health education ("Cuidate Curriculum") 24 Peer Health Educators trained to deliver the "Cuidate" curriculum. *Approximately 83% increase in attitudes and reported behavior related to sexual health, decision making, and relationship communications. *Approximately 90% increase in knowledge regarding methods to prevent HIV/STDs and pregnancies. *in process of developing a longitudinal evaluation. - Established partnerships with Lanier, Eastside Memorial, Del Valle and Dobie Middle School, and Parks and Recreations Department (PARD).

*Grant-funded programs in existence for 1- 2 years.

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Health and Human Services Department

Maternal Child and Adolescent Division – Initiatives Addressing Maternal, Infant, and Youth Health Disparities

AHA's Youth-Adult Council* Department of State Health Services Grant Funded Initiative	
\$162,500/year x 3 years	
Staffing 1.0 FTE 2 staff @ 0.5 FTE each VISTA (split between multiple projects)	
Purpose of Program	To build a comprehensive local youth system to improve the health and well-being of youth so that all young people can reach their full potential. It is a collective, local, action-oriented network of youth and adults working in partnership to align efforts to achieve positive outcomes for all youth.
Program Goals	Establish a local youth/adult council. Prevention of sexually transmitted infections Prevention to focus on men who have sex with men (MSM) 16-24
Program Accomplishments	• 20 youth adult council members recruited. • Identified curriculum and set training for African American and Latino youth. • Reached 50 African American and Latino MSM with education & information • Agreement established with Andersonville's "Pink House" to serve as the location for Council activities. • 75 youth have contributed towards the creation of innovative methods to address health disparities in East Austin and highlight the strengths and resiliency of youth.

*Grant-funded programs in existence for 1- 2 years.

Health and Human Services Department

Improving Quality of Life Through Peer-led Diabetes Self-Management Education 1115 Waiver Funds	
FY 15 - \$248,000* *includes subcontracts to El Buen Samaritano, Abundant Rain Christian Fellowship, Promotoras De Salud	Staffing - 1.5FTEs
Program Goal	Improve diabetes self-management and diabetes prevention among African American and Hispanic population by offering the Diabetes Empowerment Education Program through the use of trained Community Health Workers or Promotoras
Program Accomplishments	• Approximately 280 participants served per year, with 140 participants with Diabetes. • Increased community capacity by supporting 2 African American individuals to achieve Community Health Workers certification with a specific focus on diabetes self-management and training in the Diabetes Empowerment Education Program Curriculum. • Based on pre/post surveys, class participants reported: ○ Decreased stress related to diabetes ○ Decreased consumption of sugar sweetened beverages ○ Increased physical activity ○ Increased knowledge of diabetes

Health and Human Services Department

African American Quality of Life Program		
FY 15 - \$702,281		Staffing - 7 FTEs
Purpose of the Program	The purpose of the African American Quality of Life Unit is to prevent disease and promote health through education and health screenings in underserved communities	
Program Goals	To reduce the burden of chronic illness and disease for African Americans in Austin and Travis County	
Program Accomplishments	• Provided 7,815 units of services to 5,046 clients. ○ Health screenings and testing ○ Blood pressure check ○ Blood sugar ○ Pregnancy ○ HIV ○ Educational workshops for chronic disease prevention and care • 99% of clients surveyed report improved awareness of health status as a result of AAQL services • Provided 207 referrals for follow up care • Annual community events to provide services and information about community resources ○ ABIA Transportation Workers Health Fair – provided 264 health screenings ○ Take A Loved One For A Check Up – provided 709 health screenings, including immunizations • 6 Job fairs serving 729 residents • Community Engagement ○ Comprehensive approach involving partners ○ Community Based Organization outreach ○ Faith Based outreach	