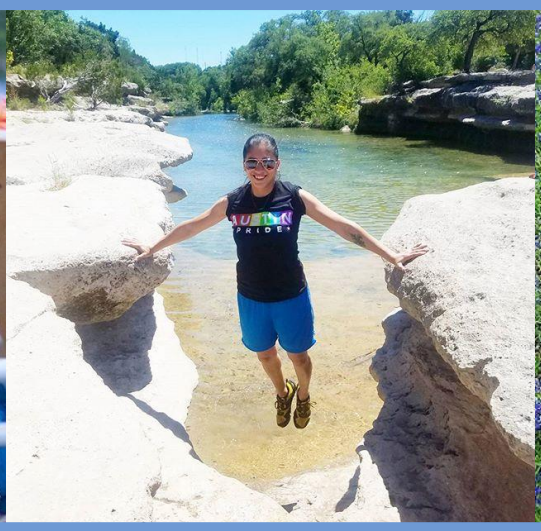
Community Health Improvement Plan

Austin/Travis County, Texas

August 2018

Year 2 Action Plan



Together We Thrive

Austin/Travis County Community Health Plan

Austin/Travis County
2018 Community Health Improvement Plan
Year 2 Action Plan

Introduction

Welcome to the Austin/Travis County Community Health Plan (aka CHA/CHIP) organized every five years by Austin Public Health with support from our community partners. This initiative aims to develop a collaborative and community-focused effort in identifying and prioritizing health needs in our community by service providers. CHA/CHIP refers to the two component parts of our Community Health Plan, the Community Health Assessment (CHA) phase and the Community Health Improvement Plan (CHIP) phase.

The Austin/Travis County CHA is a community participatory research process which illustrates our health status, strengths, and opportunities for the future. Through the CHA, community activities and events and the voices of our communities and public health partners contribute to an engaging and substantive process. We, as a community, work together to identify strengths, capacity, and opportunities to better address the many determinants of health.

Following the CHA, partners work together to implement a CHIP to determine major health priorities, overarching goals, specific objectives, and actionable strategies to implement in a coordinated way across Austin/Travis County. A CHIP is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement. This initiative is driven by our community health partners and cannot succeed without your involvement.

Year 2 Action Planning for Implementation

Adopted in 2018, The Austin/Travis County CHIP is beginning its second year of implementation. This is a pivotal time to become active in the CHIP, and we welcome and encourage participation by organizations and individuals in workgroups to help address the four priority areas of Access to Care, Mental Health, Sexual Health, and Chronic Disease identified during the CHA by community members.

The Austin/Travis County Community Health Plan partners, including core agencies, CHIP workgroups members, stakeholders, and community residents, continued implementation of the 2018 CHIP by prioritizing strategies for Year 2 (Y2), developing specific action steps, assigning lead responsible parties, and identifying resources for each priority area during the Year 2 Action Planning Summit on February 6, 2020. These components form the Year 2 Action Plan for the CHIP detailed in the following document. We encourage partners to continue to engage by joining one our four workgroups addressing Y2 strategies. As we know time is valuable, workgroup meetings are kept to a minimum, however community engagement is essential to assure fulfillment of the CHIP strategies and the building of a truly collaborative process and shared effort for obtaining community health.

We thank you for your commitment.

Table of Contents

Year 1 CHIP Annual Evaluation

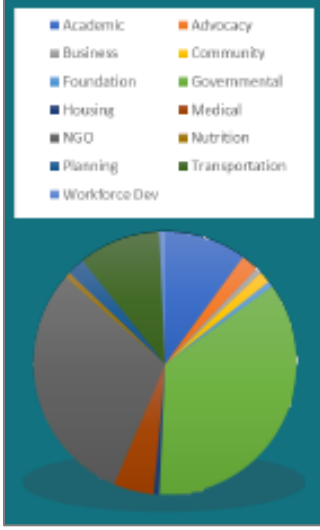
CHIP Annual Evaluation

As of February 2020, we have officially completed Year 1 of the Community Health Improvement Plan. To celebrate our achievement, we've chosen to highlight some of our major accomplishments of the year.

WORKGROUPS

MEETINGS
Health partners met a total of 38 times. This included regularly scheduled Core, Steering, and Workgroup meetings as well as several sub-groups: Transportation partners, Community Health Worker partners, and Mapping partners.

OUR PARTNERS
A total of 140 individual partners attended our meetings, representing 52 different organizations.



COMMUNITY

FORUMS
We attended 5 community fairs where 37 total community residents completed a survey with us. Also a total of 66 community members attended our two annual community forums.

FEEDBACK
Community members provided feedback on our health strategies in person and via surveys:

"In my experience, parks are pretty much available city-wide. I think it is more important to push the message of the parks rather than making more parks."

www.austintexas.gov/healthforum

CHIP ACTION PLAN

ACCESS TO CARE
~CHW Conference held in August 2019.
~Subsidized transport to doctor appts.
~New Hornsby Bend Route.

CHRONIC DISEASE
~Asset Mapping of recreational spaces.

SEXUAL HEALTH
~Letter to AISD Board in support of Sex Ed.
~Presentations on Fatherhood.
~Title X funding Discussions.

MENTAL HEALTH
~ACEs Presentations
~Resource Sheet Collab.

HEALTH INDICATORS

ACCESS TO CARE
Increased funding and focus on CHW training.

CHRONIC DISEASE
Drop in obesity rates for 2-4 yr old WIC and 10-17yr olds.

SEXUAL HEALTH
Downward trend in teenage pregnancies continues.

MENTAL HEALTH
Suicides down by 2% points.

Together We Thrive
Austin/Travis County Community Health Plan

Year 2 CHIP Implementation - Leadership

CHIP Steering Committee

Name	Organization
Chair: Stephanie Hayden	Austin Public Health
Vice Chair: Deborah Britton	Travis County Health and Human Services
Annick Beaudet	Austin Transportation Dept.
William Buster	St. David's Foundation
Monica Crowley	Central Health
David Evans	Integral Care
Sherri Fleming	Travis County Health and Human Services
Alexandra Garcia	UT Dell Medical School
Harold W. Kohl	UT School of Public Health
Lawrence Lyman	Travis County Health and Human Services
Ellen Richards	Integral Care
Rob Spillar	Austin Transportation Dept.
Andrew Springer	UT School of Public Health
Ingrid Taylor	Ascension Seton

CHIP Core Committee

Name	Organization
Chair: Hailey de Anda	Austin Public Health
Ana Almaguel	Travis County Health and Human Services
Amy Brandes	Ascension Seton
Megan Cermak	Central Health
Marianna Espinoza	UT Dell Medical School
Kacey Hanson	UT Dell Medical School
Muna Javaid	Integral Care
April Klein	Travis County Health and Human Services
Kelli Lovelace	Ascension Seton
Julie Mazur	Capital Metro
Liane Miller	Austin Transportation Dept.
Jesse Simmons	Ascension Seton

CHIP Priority Area Chairs

The CHIP workgroups, under the leadership of the chairs/co-chairs listed below, will work collaboratively with partners, stakeholders and community residents to implement the action steps outline in this Action Plan.

Priority Area	Chair/Co-Chairs
Priority Area 1: **Access to and Affordability of Health Care**	Liane Miller, Austin Transportation Department Vanessa Sweet, Central Health
Priority Area 2: **Chronic Disease**	Vanessa Castro, It's Time Texas Jill Habegger-Cain, COA Parks and Recreation Dept.
Priority Area 3: **Sexual Health**	Arlene Cornejo, Austin Public Health April Klein, Travis County Health and Human Services Joanna Saucedo, Community Member
Priority Area 4: **Stress, Mental Health, and Wellbeing**	Laura Enderle, Austin Public Health Kacey Hanson, UT Dell Medical School
To contact any of the Chair/Co-Chairs, please use the main CHA/CHIP mailbox: chachip@austintexas.gov	

Year 2 Action Plan At A Glance

Priority Area 1: Access to and Affordability of Health Care **Goal 1:** Every Travis County resident has access to culturally sensitive, affordable, equitable, and comprehensive health care.	
Year 2 Objectives	**Year 2 Strategies**
Objective 1.1 By 2023, increase the employment of certified Community Health Workers (CHWs) and service coordinators by 10% to help residents navigate the health care system and promote health literacy.	1.1.1 Explore funding/reimbursement options for CHWs from insurance providers or local funders, so that community health workers are able to pursue a career in community health work that includes benefits, networks of social support, flexible time off and a living wage. Allowing community health workers to be a stable presence in the community and receive sufficient funding to keep them employed.
	1.1.2 Encourage partners/agencies to hire CHW/service coordinators (SCs) for local community-based outreach and/or education.
	1.1.3 Establish or tap into an existing professional development and networking opportunities for CHWs and Service Coordinators.
	1.1.4: Establish criteria to incorporate CHW/SC into the care team (e.g., train employees to incorporate CHW into their staff).
Objective 1.2 By 2023, increase enrollment in and use of eligible health care coverage and/or assistance programs by 10% for Travis County residents with household incomes at or below 200% Federal Poverty Level (FPL), ages 18-64	1.2.1 Utilize and enhance existing education and communication campaigns to inform Travis County residents in key communities of what health care coverage is available.
	1.2.2 Expand training for Community Based Organizations (CBOs)s to educate clients and community residents about all healthcare coverage options/programs for which they are eligible and how to enroll in them.(Combined 1.2.2, 1.2.4, & 1.2.6)
	1.2.3 Provide agencies high level healthcare options training and referrals to organizations enrolling in coverage.
	1.2.5 Provide information and data to advocacy groups to support work regarding the impact of federal and state funding cuts to healthcare and outreach.
Objective 1.3 By 2021, decrease no-shows for health care appointments at safety-net health care providers by 10%.	1.3.1 Work with transportation partners to expand and enhance transportation options (e.g., number of accessible vehicles in the region, variety of transportation options to health care) for members of the community who have difficulty reliably traveling to healthcare appointments.
	1.3.2 Advocate to expand care delivery in under resourced areas via options such as co-locating, building new facilities, and use of telemedicine.
	1.3.4 Promote the Section 5310 grant program to assist local organizations with the purchase of wheelchair accessible vehicles.
	1.3.6 Promote awareness of existing transportation resources, including Capital Metro's Mobility Management program, through a variety of communication avenues.
	1.3.8 Connect health navigators with Mobility Management services so they can refer people to the right transportation resources for their needs.

Priority Area 2: Chronic Disease **Goal 2:** Prevent and reduce the occurrence and severity of chronic disease through collaborative approaches to health that create environments that support, protect, and improve the well-being of all communities.	
Year 2 Objectives	**Year 2 Strategies**
Objective 2.1 Decrease the % of people who have risk factors leading to chronic disease by 10% by 2023.	2.1.1 Offer regular, free Community Fitness and "Healthy Living" classes (i.e. fitness, nutrition, etc.) at convenient times and diverse locations to reach target communities. Ensure that programming is culturally and linguistically appropriate.
	2.1.4 Engage worksites, schools, early childhood education centers, and after school programs in developing comprehensive policies and programs that promote healthy nutrition, physical activity, tobacco free campus, and Mother Friendly worksites.
Objective 2.2 Increase the rates of early detection of chronic disease among adults by 2% by 2023 (diabetes, hypertension) with special focus on disproportionately affected populations.	2.2.2 Partner with existing resources to personalize and implement community-based education and screenings. Focus on educating community members on the importance of routine screenings even without symptoms and knowing risk factors. Provide education and screenings at venues that serve at-risk populations in order to reach communities not seeking healthcare, such settings may include public housing, homeless shelters, schools, libraries, education kiosks in community laundromats.
Objective 2.5 By 2023, increase by 5% the number of safe, accessible, equitable, and culturally competent assets and opportunities for healthy food and physical activity.	2.5.1 Establish baseline data by convening ongoing community conversations and compiling existing data where community members identify existing assets (e.g., urban gardens, community gardens, green space, trails, parks, etc.) and opportunities for healthy food and physical activity. Use City data of community assets to confirm and supplement.
	2.5.3 Utilize community member input to improve existing data of assets and opportunities available for physical activity (e.g., urban gardens, community gardens, green space, trails, parks, etc.) and increase access and awareness of these sites.
	2.5.7 Advocate for and support ongoing efforts (e.g. Vision Zero Action Plan) to develop and enhance safe, multimodal transportation options across the community, paying particular attention to efforts that increase healthy food access and opportunities for physical activity. Ensure that plans and development take into consideration issues of equity.

Priority Area 3: Sexual Health **Goal 3:** Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.	
Year 2 Objectives	**Year 2 Strategies**
Objective 3.1 By 2023, decrease youth pregnancy rates by 10% among populations most affected by health disparities in Travis County.	3.1.3 Support and promote equitable pathways to higher education, to a range of diverse career paths, to workforce development and to life skill competency in all ISD, charter, and publicly funded schools.
	3.1.4 Promote information sharing between organizations and programs already engaged in sex education work.
	3.1.7 Advocate for 'Teen Friendly' or 'Youth Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer equitable affordable access to a full range of FDA-approved birth control methods and are trained to provide culturally appropriate contraceptive services
	3.1.8 Identify and reduce barriers to youth seeking same-day appointments for contraception. Promote LARC principles developed by National Women's Health Network and Sister Song for clinics and providers providing a full range of FDA-approved birth control methods.
	3.1.10 Promote technologies and best practices available to increase youth access to programs, services and information.
Objective 3.2 By 2023, decrease the rates of sexually transmitted infections (STIs) by 10% among youth populations aged 24 and younger most affected by health disparities in Travis County.	3.2.4 Advocate for 'Teen Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer affordable access to STI testing and treatment and HIV tests and are trained to provide culturally appropriate STI services.
	3.2.5 Identify and reduce barriers to youth seeking same-day appointments for STI tests and treatment.
Objective 3.4 By 2023, increase by 10% access to resources and referrals that are culturally sensitive and affordable, for youth who are pregnant and parenting, and their families.	3.4.1 Promote mental health and counseling services that are available for youth who are pregnant or parenting and their families.
	3.4.2 Support pregnant women in obtaining prenatal care in the first trimester (e.g., transportation services, patient navigators, etc.).

Priority Area 4: Stress, Mental Health, and Wellbeing **Goal 4:** Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.	
Year 2 Objectives	**Year 2 Strategies**
Objective 4.1 By 2023, decrease by 10% the incidence of excessive drinking and other substance use disorders among Travis County residents.	4.1.1 Identify, screen and provide intervention for at-risk populations.
Objective 4.2 By 2023, increase by 10% the number of system providers (schools, health care, etc.) who assess for adverse childhood experiences (ACEs) and other trauma informed care screening tools and refer to appropriate community supports.	4.2.1 Train providers on best use of trauma screening tools and trauma informed care; linking to appropriate referrals.
	4.2.3 Develop and maintain Connect ATX as an online resource list tool for providers to facilitate mental and behavioral health referrals as well as enable people to find and access linguistically appropriate mental health providers. (Combined with 4.3.5)
Objective 4.3 By 2023, Increase by 10% the proportion of adults aged 18 and up in Austin Travis County who receive mental health treatment or specialty treatment for substance use disorder or dependency with a focus on geographic equity.	4.3.2 Advocate for enhanced behavioral health benefits covered by the Medical Access Program (MAP).
	4.3.6 Pair mental health/SUD workers with all established mobile health outreach teams to geographically underserved populations.

Priority Area 1: Access to and Affordability of Health Care

Access to Care Partner Organizations

Alzheimer's Association
Ascension Seton
Austin Asian Community Health Initiative
Austin Public Health
Austin Transportation Dept.
CAPCOG
Capital Metro
Central Health
City of Austin
El Buen Samaritano
Foundation Communities
Goodwill Central Texas
Light and Salt Services
St. David's Foundation
Texas Department of State Health Services (DSHS)
The Arc of Capital Area
Travis County Health and Human Services
UT Dell Medical School
UT Health

Year 2 Action Plan Priority Area 1: Access to and Affordability of Health Care	
Goal 1:	**Every Travis County resident has access to culturally sensitive, affordable, equitable, and comprehensive health care.**
Objective 1.1:	**By 2023, increase the employment of certified Community Health Workers (CHWs) and service coordinators by 10% to help residents navigate the health care system and promote health literacy.**
Strategy 1.1.1:	**Explore funding/reimbursement options for CHWs from insurance providers or local funders, so that community health workers are able to pursue a career in community health work that includes benefits, networks of social support, flexible time off and a living wage. Allowing community health workers to be a stable presence in the community and receive sufficient funding to keep them employed. (Y1 & Y2)**
Action Steps	
a.	Disseminate CHW employer survey/send to list of employers.
b.	Identify sources of funding for CHW's who work in specific neighborhoods that have high needs.
c.	Conduct cost analysis of CHW employment.
Strategy 1.1.2:	**Encourage partners/agencies to hire CHW/service coordinators (SCs) for local community-based outreach and/or education (example: consider recommending the utilization of funds from unfilled positions to hire CHWs or service coordinators). (Y2)**
Action Steps	
a.	Develop database of CHW's in Central Texas in coordination with State guidelines/certifications/standards.
b.	Develop toolkit for employers re: hiring, supervision, retention, and advancement of CHW's.
c.	Gather and disseminate list of potential employers to CHWs
d.	Direct interested CHW's to state website re: opportunities, professional development, certification, etc.
e.	Work with state advisory board to develop tiered career pathways for advancement of CHW's.
f.	Gather CHW stories for a toolkit.
Strategy 1.1.3:	**Establish or tap into an existing professional development and networking opportunities for CHW's and Service Coordinators. (Y1 & Y2-revised)**
Action Steps	
a.	Promote CHW state conference (location and date TBD).
b.	Start Lunch and Learns for CHW's (networking).
c.	Continue free CHW credits/trainings.
d.	Offer additional training for CHW instructor credits/trainings.
e.	Update Leadership Committees/Organizational Leaders re: benefits of CHW's.

Year 2 Action Plan Priority Area 1: Access to and Affordability of Health Care	
Goal 1:	**Every Travis County resident has access to culturally sensitive, affordable, equitable, and comprehensive health care.**
Strategy 1.1.4:	**Establish criteria to incorporate CHW/SC into the care team (e.g., train employees to incorporate CHW into their staff). (Y2)**
Action Steps	
a. Develop a patient-centered care presentation for CHW integration.	
Objective 1.2:	**By 2023, increase enrollment in and use of eligible health care coverage and/or assistance programs by 10% for Travis County residents with household incomes at or below 200% Federal Poverty Level (FPL), ages 18-64.**
Strategy 1.2.1:	**Utilize and enhance existing education and communication campaigns to inform Travis County residents in key communities of what health care coverage is available. (Y1 & Y2-revised)**
Action Steps	
a. Compile roster of healthcare options and their respective campaigns, funding, and client eligibility.	
b. Disaggregate data to identify and prioritize subpopulations living without healthcare coverage (new mothers, immigrants, refugees, etc.).	
NEW STRATEGY 1.2.2:	**Expand training for Community Based Organizations (CBOs) to educate clients and community residents about all healthcare coverage options/programs for which they are eligible and how to enroll in them. (Y2-combined 1.2.2, 1.2.4, and 1.2.6; Consider LEP Barriers)**
Action Steps	
a. Identify knowledge assets and gaps. Which organizations are working on enrollment, what are their resources, and what communities are they targeting?	
b. Develop and distribute resources for Latinx and Asian immigrant communities concerning eligibility of programs.	
c. Identify partners to bring enrollment education to refugees.	
d. Develop a presentation for One Voice to set up educational conference on all healthcare coverage options.	
Strategy 1.2.3:	**Provide agencies with high level healthcare options training and referrals to organizations enrolling in coverage. (Y1, Y2-revised; consider LEP barriers)**
Action Steps	
a. Identify and recommend enhancements to referral systems for coverage and programs; explore transportation options.	
b. Identify promotional materials and partners.	
Strategy 1.2.5:	**Provide information and data to advocacy groups to support work regarding the impact of federal and state funding cuts to healthcare and outreach. (Y2-revised)**
Action Steps	
a. Identify financial benefits to state and local coverage providers (e.g., value-based care).	
b. Connect with CPPP to identify current needs for information.	
Objective 1.3	**By 2021, decrease no-shows for health care appointments at safety-net health care providers by 10%.** (See also Objective 2.3)**.**
Strategy 1.3.1:	**Work with transportation partners to expand and enhance affordable transportation options (e.g., number of accessible vehicles in the region, variety of transportation options to health care) for members of the community who have difficulty reliably traveling to healthcare appointments. (Y1 & Y2)**
Action Steps	
a. Continue to convene partners to share information about what each is doing in this area, to share successes and challenges, and to work together to explore options, opportunities and funding through the Healthcare Transportation Working Group.	

Year 2 Action Plan Priority Area 1: Access to and Affordability of Health Care	
Goal 1:	**Every Travis County resident has access to culturally sensitive, affordable, equitable, and comprehensive health care.**
b. Begin working with RTCC (recently transitioned to CAPCOG) to coordinate transportation options throughout the metro region (including updating the regional plan, utilizing consistent technology platforms across services).	
c. Expand Capital Metro Pickup services and continue evaluating Pickup services to see if these services are filling gaps and expand as needed/feasible.	
d. Connect providers and nonprofits to the Transit Empowerment Fund.	
e. Gather more information about gaps in transportation access for key groups (e.g. new moms).	
Strategy 1.3.2:	**Advocate to expand care delivery in under resourced areas via options such as co-locating, building new facilities, and use of telemedicine. (Y1 & Y2)**
Action Steps	
a. Open Hornsby Bend Clinic	
b. Continue Central Health mobile clinics serving Creedmoor, Colony Park, and other areas of Eastern Travis County .	
c. Continue Community Care Street Team, with increasing focus on homeless population this year.	
d. Begin WIC mobile services.	
Strategy 1.3.4:	**Promote the Section 5310 grant program to assist local organizations with the purchase of wheelchair accessible vehicles. (Y2)**
Action Steps	
a. Focus promotion efforts by tracking grant program changes and communicating them to eligible agencies.	
Strategy 1.3.6:	**Promote awareness of existing transportation resources, including Capital Metro's Mobility Management program*, through a variety of communication avenues. (Y1 & Y2)** (*refers to expanded description of the Mobility Management Program included in the full CHIP report)
Action Steps	
a. Expand and enhance "accessibility" healthcare transportation information on GetThereATX; promote this website and work with ATD to expand messaging options for GetThereATX to different audiences beyond commuters. (Note: the promotion of GetThereATX and expanding messaging could be separate actions).	
b. Promote existing travel training program.	
c. Increase education and awareness of the wheelchair accessibility of all Capital Metro vehicles and the Safety Tether Program.	
d. Continue to distribute Senior Ride Guide and digitize it so it can be updated more frequently.	
e. Complete Smart Trips Northeast program.	
f. Increase availability of transportation services information in multiple languages.	
Strategy 1.3.8:	**Connect health navigators with Mobility Management services so they can refer people to the right transportation resources for their needs. (Y1 & Y2)**
Action Steps	
a. Connect with Enrollment Strategy 1.2.2./1.2.4/1.2.6 to identify navigators that transportation information could be provided to.	
a. Connect CHW's and HACA Smart City Ambassadors with Capital Metro Travel Trainers	
b. Explore and establish "Travel Trainer Ambassador Program": Training of Trainers	
c. Distribute language access card templates that were developed by Capital Metro Travel Training Program to organizations and CHWs.	

Priority Area 2: Chronic Disease

With a focus on Primary and Secondary Prevention and the Built Environment

Priority Area 2: Chronic Disease Partner Organizations

4H Capital
AIDS Services of Austin
Alzheimer's Association
Ascension Texas
Austin Public Health
Central Texas Food Bank
Children's Optimal Health
COA Parks and Recreation Department
It's Time Texas
People's Community Clinic
Prairie View A&M
Project Access Austin
Texas A&M AgriLife Extension
Texas Department of State Health Services
UT Dell Medical School

Year 2 Action Plan Priority Area 2: Chronic Disease	
Goal 2:	**Prevent and reduce the occurrence and severity of chronic disease through collaborative approaches to health that create environments that support, protect, and improve the well-being of all communities.**
Objective 2.1:	**Decrease the % of people who have risk factors leading to chronic disease by 10% by 2023. [Primary Prevention]**
Strategy 2.1.1	**Offer regular, free Community Fitness and "Healthy Living" classes (i.e. fitness, nutrition, etc.) at convenient times and diverse locations to reach target communities. Ensure that programming is culturally and linguistically appropriate. (Y1-revised & Y2)**
Action Steps	
a.	Define inventory criteria including target population/geographic area, cultural and linguistic characteristics. Conduct an inventory of existing classes and programs available. Map resources available. - Physical activity was worked on - Haven't done same cataloguing for nutrition category; doesn't need to be mapped. Use list
b.	Identify gaps in our OWN data collection methods
c.	Identify gaps in programming, locations and times including cultural and linguistic characteristics. (e.g. providers and frequency of classes)
d.	Identify organizations to fill gaps in programming and assess feasibility of expansion - Working with organizations to ensure they are culturally and linguistically appropriate (both PA and nutrition)
e.	Create pitch or strategy for 211 and Choose Healthier to add information - Finding HOME for the information that was gathered
Objective 2.1:	**Decrease the % of people who have risk factors leading to chronic disease by 10% by 2023. [Primary Prevention]**
Strategy 2.1.4:	**Engage worksites, schools, early childhood education centers, and after school programs in developing comprehensive policies and programs that promote healthy nutrition, physical activity, tobacco free campus, and Mother Friendly worksites. [Year 1 focus on worksites; Year 2 inclusion of schools (Consider all Travis County ISDs) and early childhood education centers] (Y1-revised, Y2-revised)**
Action Steps	
a.	Explore collaborations to offer support to Mayor's Health and Fitness Council (additional engagement: follow on Twitter; engage w/webpage)
b.	Engage with ongoing worksite wellness initiatives currently occurring in Austin/Travis County: Invites for Mother Friendly Certification sent to CD Workgroups; opportunities for Healthy Vending?

Year 2 Action Plan Priority Area 2: Chronic Disease	
Goal 2:	**Prevent and reduce the occurrence and severity of chronic disease through collaborative approaches to health that create environments that support, protect, and improve the well-being of all communities.**
c. Year 2: Explore opportunities for sharing best practices to participating worksites, childcare centers, or schools. - Delve deeper into sector-level opportunities	
d. Year 2: Provide technical assistance to develop policies as needed.	
Objective 2.2:	**Increase the rates of early detection of chronic disease among adults by 2% by 2023 (diabetes, hypertension) with special focus on disproportionately affected populations. [Secondary Prevention]**
Strategy 2.2.2:	**Partner with existing resources (APH and others) to personalize and implement community-based education and screenings. Focus on educating community members on the importance of routine screenings even without symptoms and knowing risk factors. Provide education and screenings at venues that serve at-risk populations in order to reach communities not seeking healthcare, such settings may include public housing, homeless shelters, schools, libraries, education kiosks in community laundromats.**
Action Steps	
a. Community groups reach out to APH Health Equity as part of SSPR (required to fund 3 sites)	
b. Partner with different community leaders (e.g. Central Health, Community Care, Food Bank, North YMCA, South, North, NE, diabetic classes, library downtown) to provide services	
c. Identify language Access plan for Interpreters in English, Spanish, and other languages	
d. Identify curriculum for chronic disease classes; standard delegation orders to allow APH to do A1C, HIV/STI pregnancy testing, etc.	
e. Nurse and Community health workers conduct screenings across the city, but NO diagnosis	
f. After screening- refer out to appropriate CBO organization (e.g. nutrition, chronic disease management)	
g. Follow up after referral and report it to county	
h. Continue to support Equity Unit within APH	
Objective 2.5:	**By 2023, increase by 5% the number of safe, accessible, equitable, and culturally competent assets and opportunities for healthy food and physical activity. [Built Environment]**
Strategy 2.5.1:	**Establish baseline data by convening ongoing community conversations and compiling existing data where community members identify existing assets (e.g., urban gardens, community gardens, green space, trails, parks, etc.) and opportunities for healthy food and physical activity. Use City data of community assets to confirm and supplement. (Y2)**
Action Steps	
a. Identify where healthy food resources are housed and how often they're updated (e.g. Our Parks Our Future, Trail Foundation, Parks and Rec, Keep Austin Beautiful); - Review initiatives that have happened recently/recently published reports - Synthesize recommendations from other community engagement efforts	
b. Agree on question/data point to include for existing efforts; identify why or why not people are using them	
c. Identify partners who can ask Community question/data point that was agreed upon	
d. Identify and synthesize assess community understanding of what resources exist and what's missing (e.g. culturally competent food choices, - Define and differentiate urban garden vs. Community garden; equitable services like at churches) etc.	

Year 2 Action Plan Priority Area 2: Chronic Disease	
Goal 2:	**Prevent and reduce the occurrence and severity of chronic disease through collaborative approaches to health that create environments that support, protect, and improve the well-being of all communities.**
Strategy 2.5.3:	**Utilize community member input and existing databases to improve existing data of assets and opportunities available for physical activity (e.g., urban gardens, community gardens, green space, trails, parks, etc.) and increase access and awareness of these sites. (Y1-revised & Y2)**
Action Steps	
a.	Collaborate with PARD to create map overlay to identify access points and barriers (See 2.1.1). [Consider community input to supplement existing data for a better understanding of lived experiences]: nutrition classes; fitness classes; parks, community gardens, trails, transportation access points in shape files
b.	Identify specific target populations/geographic focus for implementation.
c.	Identify access barriers to physical activity opportunities, especially transportation barriers [Consider community input in identifying barriers]: 8/9 organizational barriers to mapping and detailing available resources: funding, housed where, managed by whom, how accessed? - Include question from 2.5.1 baseline data in this action step
d.	Encourage improvements to the built environment to promote physical activity and seek to reduce barriers (ex: active transit opportunities, sidewalk and bike lane infrastructure, infrastructure in parks, urban trails) [Consider community input regarding solutions to addressing barriers]
e.	Promote physical activity and support programs use of assets (Smart Trips, Walk Texas, etc.) and sharing of data. (refer back to 2.1.2)
Strategy 2.5.7:	**Advocate for and support ongoing efforts (e.g. Vision Zero Action Plan) to develop and enhance safe, multimodal transportation options across the community, paying particular attention to efforts that increase healthy food access and opportunities for physical activity. Ensure that plans and development take into consideration issues of equity. (Y1 & Y2)**
Action Steps	
a.	Include public health stakeholders (CHA/CHIP) in ATD outreach efforts.
b.	Participate in equity assessment tool development and usage.
c.	Increase the number of entrances to existing parks in order to expand the number of residents within walking distance of a park
d.	Support the efforts of the Austin Strategic Mobility Plan, city departments, and partners in advancing the mobility network beyond the PARD parks system.
e.	Improve web-based information describing the parks system to help people quickly find amenities and experiences they are seeking

Priority Area 3: Sexual Health

Priority Area 3: Sexual Health Partner Organizations

Alzheimer's Association
Ascension Seton
ASHWell
Austin Harm Reduction Coalition (AHRC)
Austin Public Health
Commission on Seniors
Community Advancement Network
Community Coalition for Health (C2H)
Front Steps
Integral Care
Texas A&M University
The Arc of the Capital Area
Travis County Health and Human Services
United Way for Greater Austin
UT Dell Medical School

Year 2 Action Plan Priority Area 3: Sexual Health	
Goal 3:	**Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.**
Objective 3.1:	**By 2023, decrease youth pregnancy rates by 10% among populations most affected by health disparities in Travis County.**
Strategy 3.1.3:	**Support and promote equitable pathways to higher education, to a range of diverse career paths, to workforce development and to life skill competency in all ISD, charter, and publicly funded schools. (Workforce Development)**
Action Steps	
a. Make it movement – continued discussion for feasibility of implementation in Austin with a particular focus on CHWs	
a. Promoting workforce development opportunities among public health partners and online platforms - Connect ATX, Online lists	
b. Discussion of momentum for workforce workgroup – Discussion with workforce solutions – See room for connection with 2 Gen Meetings	
Strategy 3.1.4:	**Promote information sharing between organizations and programs already engaged in sex education work. (See also Strategy 3.3.2).**
Action Steps	
a. Identify the work already happening in this area by non-profit organizations	
b. Work with the TCAHC sexual education and healthy relationships workgroup to enhance awareness on existing sex education policy	
c. Identify what sex education is happening in each school district in TC including student populations being reached	
d. Outreach to include youth-serving organizations that are doing this work	
e. Monitor policy changes at the State Board of Education and legislature impacting sex education	
Strategy 3.1.7:	**Advocate for 'Teen Friendly' or 'Youth Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer equitable affordable access to a full range of FDA-approved birth control methods and are trained to provide culturally appropriate contraceptive services. (See also Strategy 3.2.4).**
Action Steps	
a. Work with the Youth Friendly workgroup of the TCAHC to expand awareness and participation of clinics providing these services	
b. Identify potential partnerships with clinics already participating in this work	

Year 2 Action Plan Priority Area 3: Sexual Health	
Goal 3:	**Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.**
c. Partner with organizations that provide culturally and linguistically appropriate services and materials to incorporate an equity lens in the services provided through cross-training and collaborative efforts and sharing resources	
Strategy 3.1.8:	**Identify and reduce barriers to youth seeking same-day appointments for contraception. Promote LARC principles developed by National Women's Health Network and Sister Song for clinics and providers providing a full range of FDA-approved birth control methods.**
Action Steps	
a. Identify providers that currently offer family planning services	
b. Identifying barriers to offering and accessing same-day services by both providers and youth, including information on how and where youth learn about STI's and family planning resources (e.g. surveys or interviews). (convenient & affordable services)($25 clinic)	
c. Provide technical support to address barriers so that clinics can provide same day services. Consider advocacy opportunities to influence policy. (financial screening, eligibility fast-track, contraceptive issue via telephone)	
d. Provide technical support to clinics ensuring compliance to LARC principles and national best practices.	
Strategy 3.1.10:	**Promote technologies and best practices available to increase youth access to programs, services and information. (See also Strategy 3.4.5).**
Action Steps	
a. Ensure that current navigation systems are up to date and accurate regarding	
b. Promote Aunt Bertha and 211 among youth through youth-friendly applications	
c. Identify what youth populations do not have access to technology and why	
d. Identify potential existing applications	
e. Engage Aunt Bertha and 211 to see how they could adapt to increase their access to youth via and AP or text number	

Year 2 Action Plan Priority Area 3: Sexual Health	
Goal 3:	**Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.**
Objective 3.2:	**By 2023, decrease the rates of sexually transmitted infections (STIs) by 10% among youth populations aged 24 and younger most affected by health disparities in Travis County.**
Strategy 3.2.4:	**Advocate for 'Teen Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer affordable access to STI testing and treatment and HIV tests and are trained to provide culturally appropriate STI services. (See also Strategy 3.1.7)**
Action Steps	
a.	Work with the Youth Friendly workgroup of the TCAHC to expand awareness and participation of clinics providing these services
b.	Identify potential partnerships with clinics already participating in this work (home visiting, teen pregnancy, and teen reproductive health)
c.	Partner with organizations that provide culturally and linguistically appropriate services and materials to incorporate an equity lens in the services provided through cross-training and collaborative efforts and sharing resources
d.	Explore the implications of teen access to PrEP and PEP and educate youth serving clinics
Strategy 3.2.5:	**Identify and reduce barriers to youth seeking same-day appointments for STI tests and treatment.**
Action Steps	
a.	Identify, document and share providers that currently offer STI services and same-day appointments.
b.	Identifying barriers to offering and accessing same-day services by both providers and youth, including information on how and where youth learn about STI's and family planning resources (e.g. surveys or interviews). [See 3.1.8] *Note barriers to providing access to youth and adolescents specifically. Continue the conversation about the gaps in care and the racial disparities in services and some of the causes-history, trust, transportation
c.	Identify technical support available to address barriers and coordinate sharing information so that clinics can provide same day services. Consider advocacy opportunities to influence policy.
d.	Explore options to create a referral system between STI-specific service providers and family planning providers.
e.	Promote STI testing services to youth (based on findings).
f.	Explore the implications of teen access to PrEP and PEP and educate youth serving clinics
Objective 3.4:	**By 2023, increase by 10% access to resources and referrals that are culturally sensitive and affordable, for youth who are pregnant and parenting, and their families.**
Strategy 3.4.1:	**Promote mental health and counseling services that are available for youth who are pregnant or parenting and their families.**
Action Steps	
a.	Gather information (Kids Living Well/Children's mental) health plan (18 and under) on services performed to meet this strategy.
b.	Promote services identified and distribute to organizations that serve youth who are pregnant or parenting and their families.
Strategy 3.4.2:	**Support pregnant women in obtaining prenatal care in the first trimester (e.g., transportation services, patient navigators, etc.). Example of possible program is home pregnancy testing designed to get women into prenatal care sooner.**
Action Steps	
a.	Gather information from the Central TX Perinatal Coalition on services they're performing to meet this strategy.
b.	Promote services identified and distribute to organizations that serve youth who are pregnant.

Priority Area 4: Stress, Mental Health, and Wellbeing

Priority Area 4: Mental Health Partner Organizations

AIDS Services of Austin (ASA)
American YouthWorks
Any Baby Can
Austin Public Health
Capital IDEA
CARDEA
Central Health
El Buen Samaritano
Excel Center
Goodwill Excel Center
LifeWorks
Mama Sana Vibrant Woman
Planned Parenthood
Texas Campaign to Prevent Teen Pregnancy
Travis County Health and Human Services
United Way for Greater Austin

Year 2 Action Plan Priority 4: Stress, Mental Health, and Wellbeing	
Goal 4:	**Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.**
Objective 4.1	**By 2023, decrease by 10% the incidence of excessive drinking and other substance use disorders among Travis County residents.**
Strategy 4.1.1	**Identify, screen and provide intervention for at-risk populations.(Y1 & Y2)**
Action Steps	
a.	Coordinate planning for SUD and excessive drinking. Develop planning body for SUD owned by all three taxing authorities: to provide recommendations to planning bodies on usage of resources
b.	Form recommendations for SUD planning body for use of data and data-driven strategies; promote the development of a community-wide database for SUD resources.
c.	Compile existing substance use data: What's already happening? Identify at-risk populations. Identify providers. Identify current screening tools in place and by whom.
d.	Update the data (on excessive drinking and SUD) and share with the community.
e.	Identify trainings for service providers, with a focus on linguistics, cultural competence, provider bias and empathy.
Objective 4.2:	**By 2023, increase by 10% the number of system providers (schools, health care, etc.) who assess for trauma through the use of trauma screening tools and refer to appropriate community supports.**
Strategy 4.2.1:	**Train providers on best use of trauma screening tools and trauma informed care, linking to appropriate referrals. (Y1 & Y2)**
Action Steps	
a.	Provider assessment: providers' knowledge of ACEs and other tools' conceptual framework and screening practice; which providers are using trauma informed care or screenings. Existing data of number of providers trained in trauma informed care/ACEs; number of organizations screening for trauma.
b.	Identify components to either increase awareness, expand utilization and provide access to tools. Identify best-practices - training on how to.
c.	Identify and develop a list of key stakeholders of early champions of trauma screening and referrals; tailor approaches to engage with different sector providers; decide level of screening and targeting. Include school providers.
d.	Establish evaluation cycle (assess, plan, evaluate, revise).
e.	Identify and create a list of early trauma screening adopters and referral agencies.
f.	Invite/encourage early adopters to provide education opportunities on screening and referrals at conferences, meetings and on website.
g.	Explore collecting Community-wide data system for data amongst champions.
h.	Identify components of trauma informed care to share with champions from TICC Resources.

Year 2 Action Plan Priority 4: Stress, Mental Health, and Wellbeing	
Goal 4:	**Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.**
Strategy 4.2.3	**(Combined with 4.3.5): Develop and maintain Connect ATX as an online resources list tool for providers to facilitate mental and behavioral health referrals as well as enable people to find and access linguistically appropriate mental health providers. (Y1 & Y2)**
Action Steps	
a.	(4.2.3) Promote the use of the tool to the community and to people who could make behavioral health referrals (i.e., teachers, physicians (such as primary care physicians, DOs, PCP, Pas, Travis County Medical Society, Travis County Pediatric Society, faith based organizations, community health workers, social workers, nurses, LPCs, case managers, social services offices etc.).
b.	(4.2.3) Invite lead on Connect ATX to provide overview
c.	(4.3.5) Connect with organizations/resources that identify culturally/linguistically appropriate Mental Health providers/ resources
d.	(4.3.5) Identify organizations that have completed an equity tool.
Objective 4.3:	**By 2023, Increase by 10% the proportion of adults aged 18 and up in Austin Travis County who receive mental health treatment or specialty treatment for substance use disorder or dependency, with a focus on geographic equity.**
Strategy 4.3.2:	**Advocate for enhanced behavioral health benefits covered by the Medical Access Program (MAP). (Y2)**
Action Steps	
a.	Identify the level of coverage for Community Health Plans and eligibility criteria to include TX health for adults -asset mapping.
b.	Identify gaps through comparison chart/asset mapping.
c.	Identify Bridges for continuum of care based on age; where one coverage ends but can be picked up by another.
d.	Advocate: Identify a champion in community health care agencies to present to workgroup finding (i.e., APH, Central Health) (Go to Board Meeting, give feedback, identify objective that we are working on, identify person within PH to help, Present to the Joint Inclusion committee, Present at City Council, Present to Travis County Commissioner's Office)
Strategy 4.3.6:	**Pair mental health/SUD workers with all established mobile health outreach teams to geographically underserved populations. (Y2)**
Action Steps	
a.	Identify who has mobile health outreach teams/services
b.	Survey MHO teams
c.	Connect MHO teams to 4.3.2/4.3.5.
d.	Identify behavioral health providers who can pair mental health professionals or Community Health Workers with MHO teams.
e.	Enhance capacity of CHW to do this work with training in behavioral health and navigation as needed.

Appendices

Appendix 1: CHIP Planning Participants (by Organization)

Organization	First Name	Last Name	Access to Care	Chronic Disease	Sexual Health	Mental Health
4H Capital	Katelyn	Scheetz		X		
AIDS Services of Austin (ASA)	Tarie	Beldin		X		
AIDS Services of Austin (ASA)	Martha	Breck			X	
Alzheimer's Association	Haydee	Becerril	X			X
Alzheimer's Association	Alejandra	Scott		X		
Alzheimer's Association	Maxine	Vieyra	X			
Alzheimer's Association	Maxine	Vieyra				X
American YouthWorks	Allison	Brandt			X	
Any Baby Can	Faviela	Parrilla			X	
Ascension Seton	Kelli	Lovelace				X
Ascension Seton/Commission on Seniors/UT Dell Medical School	Erica	Garcia-Pittman				X
Ascension Seton/UT Health Austin	Rachel	Linton	X			
Ascension Texas	Amy	Brandes		X		
ASHWell	Jettie	Young				X
ASHWell/Austin Harm Reduction Coalition (AHRC)	Sandra	Chavez				X
Austin Asian Community Health Initiative (AACHI)	Lucy	Nguyen	X			
Austin Public Health	Dominique	Alexander			X	
Austin Public Health	Crescencia	Alvarado	X			
Austin Public Health	Vicky	Bailey	X	X		
Austin Public Health	Angelica	Benton-Molina			X	
Austin Public Health	Ashley	Bischoff		X		
Austin Public Health	Arlene	Cornejo			X	
Austin Public Health	Laura	Enderle				X
Austin Public Health	Michelle	Friedman	X			
Austin Public Health	Stephanie	Helfman		X		
Austin Public Health	Flor	Hernandez Ayala			X	
Austin Public Health	Jaseudia	Killion			X	
Austin Public Health	Binh	Ly	X			
Austin Public Health	Scott	Lyles			X	
Austin Public Health	Lauren	Marsh			X	
Austin Public Health	Ana	Montiel		X		
Austin Public Health	Estephanie	Olivares				X
Austin Public Health	Sara	Richman Davidow			X	
Austin Public Health	Fernanda	Santos			X	
Austin Public Health	Donna	Sundstrom	X			
Austin Public Health	Tabitha	Taylor				X
Austin Public Health	Fabiola	Thomas	X			
Austin Public Health	Zoe	Thompson		X		
Austin Public Health	Stephanie	Trevino	X			
Austin Public Health	Tammy	Walker		X		

Organization	First Name	Last Name	Access to Care	Chronic Disease	Sexual Health	Mental Health
Austin Public Health	Alan	Washington				
Austin Transportation Department	Cari	Buetow	X			
Austin Transportation Department	Liane	Miller	X			
Austin Transportation Department	Anne	Milne	X			
CAPCOG	Cecilia	Bliss	X			
Capital IDEA	Daniel	Lopez			X	
Capital Metro	Julie	Mazur	X			
CARDEA	Vanessa	Sarria			X	
Central Health	Kit	Abney Spelce	X			
Central Health	Megan	Cermak	X			
Central Health	Hilario	Covarrubias	X			
Central Health	Ivan	Davila	X			
Central Health	JP	Eichmiller	X			
Central Health	Isela	Guerra	X			
Central Health	Elizabeth	Marrero	X			
Central Health	Stephanie	McDonald			X	
Central Health	Vanessa	Sweet	X			
Central Health	Nelida	Terrazas	X			
Central Health	Michelle	Tijerina	X			
Children's Optimal Health	Susan	Millea		X		
COA Parks and Recreation Department	Jill	Habegger-Cain		X		
Community Advancement Network (CAN)	Jelina	Tunstill				X
Community Coalition for Health (C2H)	Mia	Greer				X
Community Coalition for Health (C2H)	Charles	Moody				X
Community Member	Marcia	Beckford				
Community Member	Lisa	Hinely				X
Community Member	Joanna	Saucedo			X	
Community Member	Katie	Wolfe			X	
El Buen Samaritano	Monique	Arriaga			X	
El Buen Samaritano	David	Bustamante	X			
El Buen Samaritano	Amanda	Doenges			X	
El Buen Samaritano	Martha	Lujan	X			
El Buen Samaritano	Juan	Rosa			X	
El Buen Samaritano	Anita	Swayze			X	
Foundation Communities	Arianna	Anaya	X			
Front Steps	Alexandra	Gomez				X
Goodwill Central Texas	Jeremy	Thomas	X			
Goodwill Excel Center	Florence	Folgar			X	
Goodwill Excel Center	Antonio	Ramirez			X	
Integral Care	Marlene	Buchanan				X
Integral Care	Mary	Dodd				X
Integral Care	Muna	Javaid				X
It's Time Texas	Ayesha	Badar		X		
It's Time Texas	Vanessa	Castro		X		
It's Time Texas	Joel	Gross		X		
It's Time Texas	Kara	Prior		X		
LifeWorks	Jackie	Platt			X	
LifeWorks	Sara	Reeves			X	

Organization	First Name	Last Name	Access to Care	Chronic Disease	Sexual Health	Mental Health
Light and Salt Services	Barbara	Chang	X			
Mama Sana Vibrant Woman	Hailey	Williams			X	
People's Community Clinic	Elizabeth	Washington		X		
Prairie View A&M	Nathan	Tucker		X		
Project Access Austin	Kathy	Gichangah		X		
St. David's Foundation	Jesse	Simmons	X			
Texas A&M AgriLife Extension	Sonia	Coyle		X		
Texas A&M University	Luz	Waters				X
Texas A&M University	Oscar	Zamora				X
Texas Campaign to Prevent Teen Pregnancy	Jen	Biundo			X	
Texas Campaign to Prevent Teen Pregnancy	Melanie	Chasteen			X	
Texas Department of State Health Services (DSHS)	Beatrice	Smith	X			
Texas Department of State Health Services (DSHS)	LaQuisha	Umemba		X		
The Arc of the Capital Area	Diana	Trevino	X	X		
Travis County Health and Human Services	Ana	Almaguel	X			
Travis County Health and Human Services	April	Klein			X	
Travis County Health and Human Services	Laura	Peveto				X
Travis County Health and Human Services	Scheleen	Walker		X		
United Way for Greater Austin	Carlisia	McCord			X	
United Way for Greater Austin	Thomas	Trinh				X
UT Dell Medical School	Virginia	Brown				X
UT Dell Medical School	Marianna	Espinoza		X		
UT Dell Medical School	Ricardo	Garay	X			
UT Dell Medical School	Kacey	Hanson				X

Appendix 2: Changes to Strategies from Year 1 to Year 2

Note: Strategies in blue text are new to Year 2

Priority Area 1: Access to and Affordability of Health Care **Goal 1:** Every Travis County resident has access to culturally sensitive, affordable, equitable, and comprehensive health care.	
Year 2 Objectives	**Year 2 Strategies**
Objective 1.1 By 2023, increase the employment of certified Community Health Workers (CHWs) and service coordinators by 10% to help residents navigate the health care system and promote health literacy.	1.1.1 Explore funding/reimbursement options for CHWs from insurance providers or local funders, so that community health workers are able to pursue a career in community health work that includes benefits, networks of social support, flexible time off and a living wage. Allowing community health workers to be a stable presence in the community and receive sufficient funding to keep them employed.
	1.1.2 Encourage partners/agencies to hire CHW/service coordinators (SCs) for local community-based outreach and/or education (example: consider recommending the utilization of funds from unfilled positions to hire CHWs or service coordinators).
	1.1.3 Establish or tap into an existing professional development and networking opportunities for CHWs and Service Coordinators. ~~/SCs to share learnings and experiences.~~
	1.1.4: Establish criteria to incorporate CHW/SC into the care team (e.g., train employees to incorporate CHW into their staff).
Objective 1.2 By 2023, increase enrollment in and use of eligible health care coverage and/or assistance programs by 10% for Travis County residents with household incomes at or below 200% Federal Poverty Level (FPL), ages 18-64	1.2.1 Utilize and enhance existing education and communication campaigns to inform Travis County residents in ~~targeted~~ key communities of what health care coverage is available.
	1.2.2 Expand training for Community Based Organizations (CBOs)s to educate clients and community residents about all healthcare coverage options/programs for which they are eligible and how to enroll in them. ~~Train enrollment personnel to educate residents about all health coverage options/programs for which they are eligible.~~ (Combined 1.2.2, 1.2.4, & 1.2.6)
	1.2.3 Provide agencies high level healthcare options training and referrals to organizations enrolling in coverage. ~~(for-profit & non-profit) who work with people at <200% FPL with referral information across health care and social service options/programs so that they can cross-refer (housing, at birth of a child, WIC, SNAP, etc.). Consider providing cross training at preplanned or ongoing conferences, forums or trainings.~~
	~~1.2.4 Expand training for social service providers on how their clients can qualify for the Affordable Care Act (ACA) or other health insurance programs (MAP, CHIP, and Medicaid). Ensure clients are aware of special year around enrollment opportunities for life events.~~
	1.2.5 Provide information and data to advocacy groups to support work regarding the impact of federal and state funding cuts to healthcare and outreach.
Objective 1.3 By 2021, decrease no-shows for health care appointments at safety-net health care providers by 10%.	1.3.1 Work with transportation partners to expand and enhance transportation options (e.g., number of accessible vehicles in the region, variety of transportation options to health care) for members of the community who have difficulty reliably traveling to healthcare appointments.
	1.3.2 Advocate to expand care delivery in under resourced areas via options such as co-locating, building new facilities, and use of telemedicine.
	1.3.4 Promote the Section 5310 grant program to assist local organizations with the purchase of wheelchair accessible vehicles.
	1.3.6 Promote awareness of existing transportation resources, including Capital Metro's Mobility Management program, through a variety of communication avenues.
	~~1.3.7 Explore options for making Capital Metro's Mobility Management program more robust (e.g., centralizing, tech/software solutions).~~
	1.3.8 Connect health navigators with Mobility Management services so they can refer people to the right transportation resources for their needs.

Priority Area 2: Chronic Disease **Goal 2:** Prevent and reduce the occurrence and severity of chronic disease through collaborative approaches to health that create environments that support, protect, and improve the well-being of all communities.	
Year 2 Objectives	**Year 2 Strategies**
Objective 2.1 Decrease the % of people who have risk factors leading to chronic disease by 10% by 2023.	2.1.1 Offer regular, free Community Fitness and "Healthy Living" classes (i.e. fitness, nutrition, etc.) at convenient times and diverse locations to reach target communities. Ensure that programming is culturally and linguistically appropriate.
	2.1.4 Engage worksites, schools, ~~and~~ early childhood education centers, and after school programs in developing comprehensive policies and programs that promote healthy nutrition, physical activity, tobacco free campus, and Mother Friendly worksites.
Objective 2.2 Increase the rates of early detection of chronic disease among adults by 2% by 2023 (diabetes, hypertension) with special focus on disproportionately affected populations.	2.2.2 Partner with existing resources to personalize and implement community-based education and screenings. Focus on educating community members on the importance of routine screenings even without symptoms and knowing risk factors. Provide education and screenings at venues that serve at-risk populations in order to reach communities not seeking healthcare, such settings may include public housing, homeless shelters, schools, libraries, education kiosks in community laundromats.
Objective 2.5 By 2023, increase by 5% the number of safe, accessible, equitable, and culturally competent assets and opportunities for healthy food and physical activity.	2.5.1 Establish baseline data by convening ongoing community conversations and compiling existing data where community members identify existing assets (e.g., urban gardens, community gardens, green space, trails, parks, etc.) and opportunities for healthy food and physical activity. Use City data of community assets to confirm and supplement.
	2.5.3 Utilize community member input to improve existing data of assets and opportunities available for physical activity (e.g., urban gardens, community gardens, green space, trails, parks, etc.) and increase access and awareness of these sites.
	2.5.7 Advocate for and support ongoing efforts (e.g. Vision Zero Action Plan) to develop and enhance safe, multimodal transportation options across the community, paying particular attention to efforts that increase healthy food access and opportunities for physical activity. Ensure that plans and development take into consideration issues of equity.

Priority Area 3: Sexual Health **Goal 3:** Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.	
Year 2 Objectives	**Year 2 Strategies**
Objective 3.1 By 2023, decrease youth pregnancy rates by 10% among populations most affected by health disparities in Travis County.	~~3.1.2 Promote support programs on healthy relationships and teen dating violence.~~
	3.1.3 Support and promote equitable pathways to higher education, to a range of diverse career paths, to workforce development and to life skill competency in all ISD, charter, and publicly funded schools.
	3.1.4 Promote information sharing between organizations and programs already engaged in sex education work.
	3.1.7 Advocate for 'Teen Friendly' or 'Youth Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer equitable affordable access to a full range of FDA-approved birth control methods and are trained to provide culturally appropriate contraceptive services
	3.1.8 Identify and reduce barriers to youth seeking same-day appointments for contraception. Promote LARC principles developed by National Women's Health Network and Sister Song for clinics and providers providing a full range of FDA-approved birth control methods.
	3.1.10 Promote technologies and best practices available to increase youth access to programs, services and information.
Objective 3.2 By 2023, decrease the rates of sexually transmitted infections (STIs) by 10% among youth populations aged 24 and younger most affected by health disparities in Travis County.	~~3.2.1 Promote and offer HIV and other STI testing, education and enhanced linkage with reproductive and sexual health services.~~
	3.2.4 Advocate for 'Teen Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer affordable access to STI testing and treatment and HIV tests and are trained to provide culturally appropriate STI services.
	3.2.5 Identify and reduce barriers to youth seeking same-day appointments for STI tests and treatment.
~~**Objective 3.3**~~ ~~By 2023, increase by 10% the number of schools that provide evidence-informed sex education in Travis County.~~	~~3.3.1 Advocate for policy and/or policy change at the district, county and state level that could support inclusive, evidence-informed comprehensive sex education and reproductive health manipulative demonstrations in Travis County schools.~~
	~~3.3.2 Promote collaborations between organizations and programs engaged in sex education work, including creating linkages between ISDs and local healthcare providers for referrals for students for sexual healthcare services not provided through ISD campuses.~~

Priority Area 3: Sexual Health **Goal 3:** Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.	
Year 2 Objectives	**Year 2 Strategies**
Objective 3.4 By 2023, increase by 10% access to resources and referrals that are culturally sensitive and affordable, for youth who are pregnant and parenting, and their families.	3.4.1 Promote mental health and counseling services that are available for youth who are pregnant or parenting and their families.
	3.4.2 Support pregnant women in obtaining prenatal care in the first trimester (e.g., transportation services, patient navigators, etc.).
	~~3.4.3 Promote home visiting programs for pregnant women, new mothers, their partners, and families focused on education on infant care (e.g. nutrition, stress reduction, postpartum and newborn care).~~
	~~3.4.6 Promote programs that support the involvement of young fathers and fathers-to-be in the raising and caring of their children, including but not limited to: prenatal care, birthing classes and parenting classes, mentoring, job training, managing finances, etc.~~

Priority Area 4: Stress, Mental Health, and Wellbeing **Goal 4:** Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.	
Year 2 Objectives	**Year 2 Strategies**
Objective 4.1 By 2023, decrease by 10% the incidence of excessive drinking and other substance use disorders among Travis County residents.	4.1.1 Identify, screen and provide intervention for ~~pre-identified~~ at-risk populations.
Objective 4.2 By 2023, increase by 10% the number of system providers (schools, health care, etc.) who assess for adverse childhood experiences (ACEs) and other trauma informed care screening tools and refer to appropriate community supports.	4.2.1 Train providers on best use of ~~ACEs~~ trauma screening tools and trauma informed care; linking to appropriate referrals.
	4.2.3 Develop and maintain Connect ATX as an online resource~~s~~ list tool for providers to facilitate mental and behavioral health referrals as well as enable people to find and access linguistically appropriate mental health providers.(Combined with 4.3.5)
Objective 4.3 By 2023, Increase by 10% the proportion of adults aged 18 and up in Austin Travis County who receive mental health treatment or specialty treatment for substance use disorder or dependency with a focus on geographic equity.	~~4.3.1 Promote the adoption of a collaborative care model in Austin and Travis County to provide treatment and to coordinate medical and behavioral health providers.~~
	4.3.2 Advocate for enhanced behavioral health benefits covered by the Medical Access Program (MAP).
	4.3.6 Pair mental health/SUD workers with all established mobile health outreach teams to geographically underserved populations.
	~~4.3.7 Develop additional teams of mobile mental health/SUD outreach workers who engage with the community at community events and maintain a visual presence in underserved areas.~~

Appendix 3: Priority Area One-Pagers

Priority Area 1: Access to and Affordability of Health Care

The Austin/Travis County Community Health Improvement Plan (CHIP) works towards every Travis County resident having access to culturally sensitive, affordable, equitable, and comprehensive health care.

objective **1.1**

BY 2023, INCREASE EMPLOYMENT OF COMMUNITY HEALTH WORKERS AND SERVICE COORDINATORS BY 10%

to help residents navigate the health care system and promote health literacy

objective **1.2**

BY 2023, INCREASE ENROLLMENT AND USE OF ELIGIBLE HEALTH COVERAGE AND ASSISTANCE PROGRAMS BY 10%

for Travis County residents with household incomes at or below 200% of the Federal Poverty Level

objective **1.3**

BY 2021, DECREASE NO-SHOWS FOR HEALTH CARE APPOINTMENTS AT SAFETY-NET HEALTH CARE PROVIDERS BY 10%

Integral Care · The University of Texas at Austin Dell Medical School · METRO · UTHealth School of Public Health · St. David's Foundation · Central Health · Ascension · Seton

Together We Thrive
Austin/Travis County Community Health Plan

Chronic disease was identified among Austin and Travis County's largest health priorities.

Learn about the Austin/Travis County Community Health Improvement Plan to address health disparities and more at austintexas.gov/healthforum

---

PREVENTATIVE SERVICES

Use of preventative services such as wellness exams and regular health screenings varies significantly by income.

HEALTHY BEHAVIORS

Healthy behaviors such as a balanced, nutritious diet, regular exercise, and more can impact a person's likelihood of developing chronic diseases.

60%

of Travis County **women over the age of 40 making less than $25,000 received a mammogram in the past two years**, compared to 80% of women making over $75,000 △

21%

of Travis County **adults making less than $25,000 are current smokers**, compared to 7% of residents making over $75,000 △

55%

of Travis County **residents over the age of 50 making less than $25,000 have ever received a colonoscopy or a sigmoidscopy**, compared to 76% of residents over 50 making more than $75,000 △

37%

of Travis County **adults making less than $25,000 report no participation in any physical activities or exercise**, compared to 19% of residents making over $75,000 △

The Austin/Travis County Community Health Improvement Plan (CHIP) works towards preventing and reducing the occurrence and severity of chronic disease through collaborative approaches to health that create environments that support, protect, and improve the well-being of all communities.

objective **2.1** BY 2023, DECREASE THE AMOUNT OF TRAVIS COUNTY RESIDENTS WITH RISK FACTORS FOR CHRONIC DISEASE BY 10%

objective **2.2** BY 2023, INCREASE RATES OF EARLY DETECTION OF CHRONIC DISEASE AMONG ADULTS BY 2%

with a special focus on disproportionately affected populations

objective **2.3** BY 2023, REDUCE RATES OF PERSONS UNABLE TO OBTAIN OR DELAY IN OBTAINING NECESSARY MEDICAL CARE BY 10%

through services and education provided in client's home or at a community setting

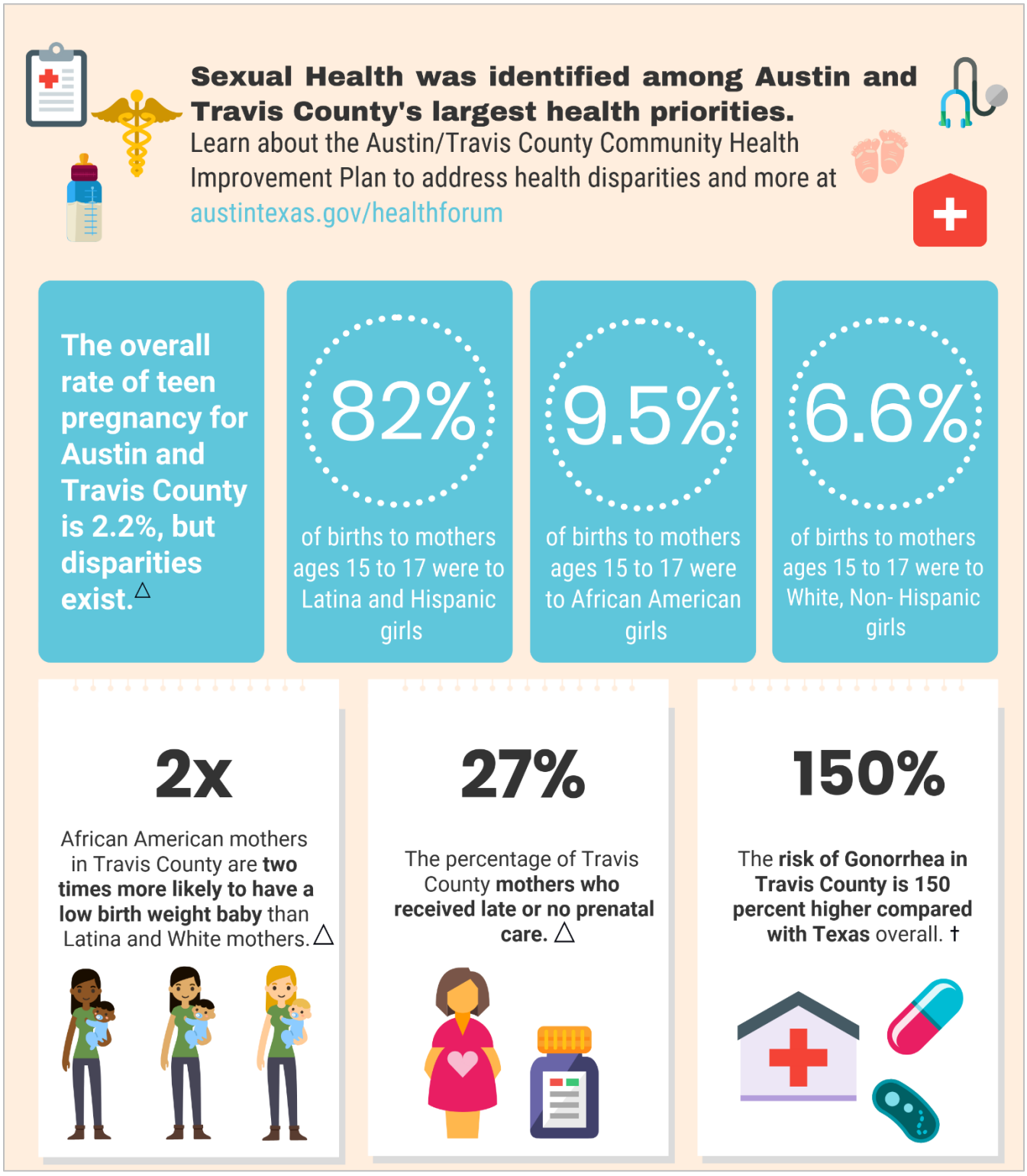
objective **2.4** BY 2023, INCREASE ADHERENCE TO CHRONIC DISEASE CARE PLANS BY 10%

objective **2.5** BY 2023, INCREASE SAFE, ACCESSIBLE, EQUITABLE, AND CULTURALLY COMPETENT ASSETS AND OPPORTUNITIES FOR HEALTHY FOOD AND PHYSICAL ACTIVITY BY 5%

Integral Care · The University of Texas at Austin Dell Medical School · METRO · UTHealth School of Public Health Austin Regional Campus · St David's Foundation · Central Health · Ascension · Seton

Together We Thrive
Austin/Travis County Community Health Plan

Priority Area 3: Sexual Health



The Austin/Travis County Community Health Improvement Plan (CHIP) works towards empowering youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.

objective **3.1** BY 2023, DECREASE YOUTH PREGNANCY RATES AMONG POPULATIONS MOST AFFECTED BY HEALTH DISPARITIES IN TRAVIS COUNTY BY 10%

objective **3.2** BY 2023, DECREASE RATES OF SEXUALLY TRANSMITTED INFECTIONS BY 10%

among youth populations aged 24 and younger most affected by health disparities in Travis County

objective **3.3** BY 2023, INCREASE THE NUMBER OF SCHOOLS THAT PROVIDE EVIDENCE INFORMED SEX EDUCATION IN TRAVIS COUNTY BY 10%

with a focus on geographic equity

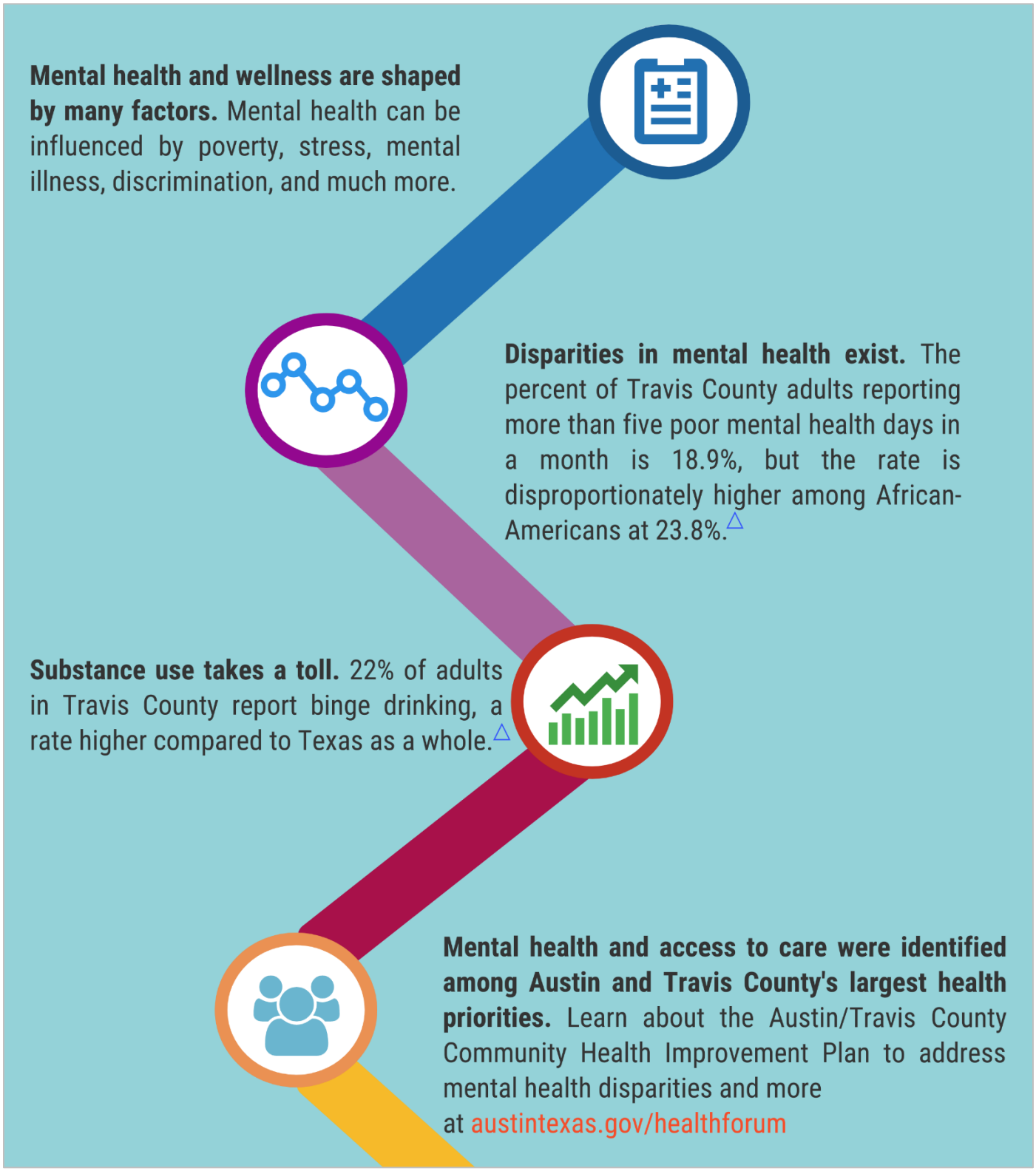
objective **3.4** BY 2023, INCREASE ACCESS TO RESOURCES AND REFERRALS THAT ARE CULTURALLY SENSITIVE AND AFFORDABLE BY 10%

for youth who are pregnant and parenting, and their families

Together We Thrive
Austin/Travis County Community Health Plan

△ Texas Department of State Health Services, Texas Health Data: Birth (2012-2014).
† TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services

Priority Area 4: Stress, Mental Health, and Wellbeing



The Austin/Travis County Community Health Improvement Plan (CHIP) works towards advancing mental wellness, recovery, and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.

objective **4.1** BY 2023, DECREASE THE INCIDENCE OF BINGE DRINKING AND OTHER SUBSTANCE USE DISORDERS AMONG TRAVIS COUNTY RESIDENTS BY 10%

objective **4.2** BY 2023, INCREASE THE NUMBER OF SYSTEM PROVIDERS WHO ASSESS FOR ADVERSE CHILDHOOD EXPERIENCES AND REFER TO APPROPRIATE COMMUNITY SUPPORTS BY 10%

objective **4.3** BY 2023, INCREASE PROPORTION OF TRAVIS COUNTY ADULTS RECEIVING TREATMENT FOR SUBSTANCE USE DISORDERS OR DEPENDENCY BY 10%

with a focus on geographic equity

Together We Thrive
Austin/Travis County Community Health Plan