Austin Public Health

Detailed Activity Pages



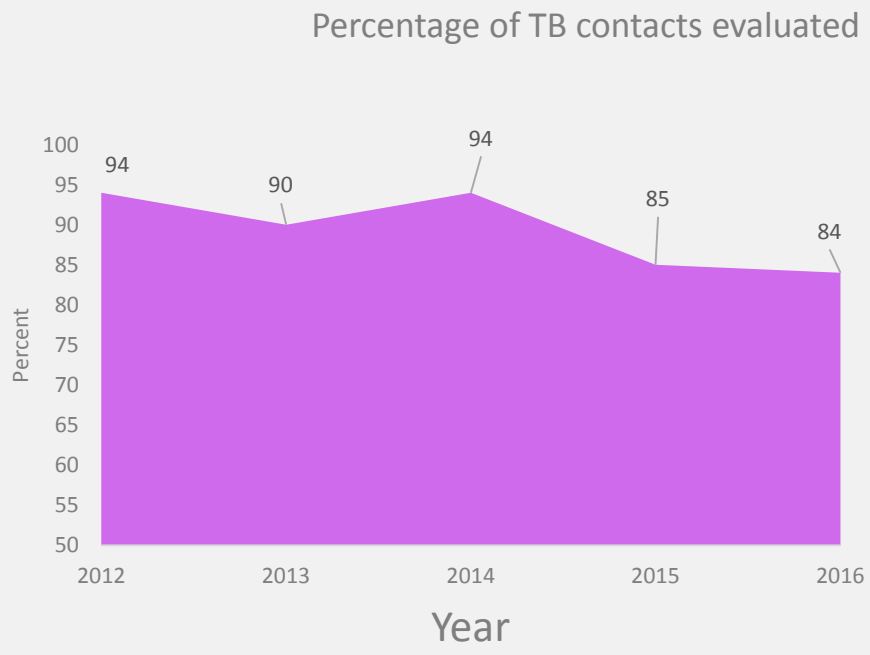


APPENDIX

Communicable Diseases Prevention

Austin Public Health Communicable Diseases Unit operates prevention teams including TB (tuberculosis) Investigation, TB Outreach/Directly Observed Therapy (DOT), HIV/STD Investigation, HIV/STD Targeted Testing, and Social Worker services (linkage to care). The investigation teams provide required and CDC-recommended Public Health contact investigations for every TB, HIV, and syphilis case in the city of Austin. The TB Outreach provides field DOT for every active TB case. The HIV/STD Targeted Testing provides HIV/STD education and screening for high-risk populations in various locations of the City.

Key Outcome



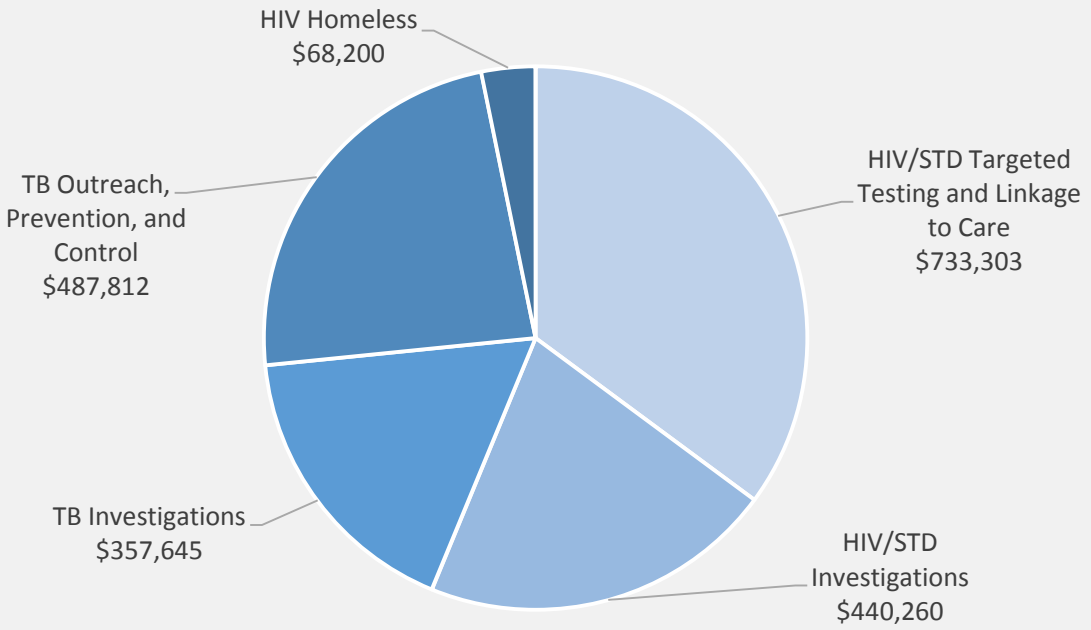
Number of Contacts Evaluated

1,157

11.6% From 2012

Activity Statistics	
Number of Targeted HIV/STD Screenings in Outreach Settings	2,558
Number of Contacts to HIV and Syphilis Cases Interviewed	3,860
Number of Units of Social Work Services Provided to HIV Patients	27,500

Breakdown of Communicable Disease Prevention Budget



Customers

- Active TB patients and contacts to each case
- HIV and syphilis patients and contacts to each case
- Persons with higher risk for contracting HIV/STDs

Equipment

- One HIV/STD Mobile Outreach/Testing Van
- Six City vehicles for HIV/ STD, TB investigations and outreach
- One City vehicle for Social Workers

Strategic Outcome Alignment

The Communicable Disease Prevention activity aligns with the Health strategic outcome. This program advances Health by preventing, treating and minimizing exposure to communicable diseases.

Services

- TB Investigations
- TB Directly Observed Therapy
- HIV/STD Investigations
- HIV/STD Targeted Testing
- Social Work and Linkage to Care

Budget

$2,087,220

Future Budget Drivers

- Caseload
- Federal Grant funds
- Personnel costs/Grant support

Employees

11 General Fund FTEs

30 Grant FTEs

Policy Issues

Federal and State grants may be affected by the changes of priorities at those governments, resulting in possible loss of programs and services in core public health follow-up service areas such as HIV, STD, TB investigations and outreach

Benefits of Service

- Provide TB investigations and screen contacts to TB cases; prevent spread of TB in the community
- Provide HIV and syphilis investigations and screen contact to HIV and syphilis cases; prevent spread of HIV and STD including syphilis in the community
- Provide DOT (Directly Observed Therapy) to TB patients in the field during the entire treatment period; prevent spread of TB by ensuring completion of therapy
- Provide targeted HIV/STD testing to high-risk individuals in underserved areas; prevent spread of HIV/STD in the community
- Provide linkage to care and social services (e.g. mental health, homeless, teens); prevent spread of diseases by linking to and retaining patients in care

Top 3 Challenges

1. Increasing population and morbidity rates, resulting in the higher demand for core public health follow-up (investigation, outreach, etc.) in TB, STD, HIV
2. Increasing use of apps and anonymous interactions, resulting in additional challenges in finding many contacts to HIV cases
3. Funding availability for CDC recommended interventions (e.g. PREP) to control infectious diseases (e.g. HIV)

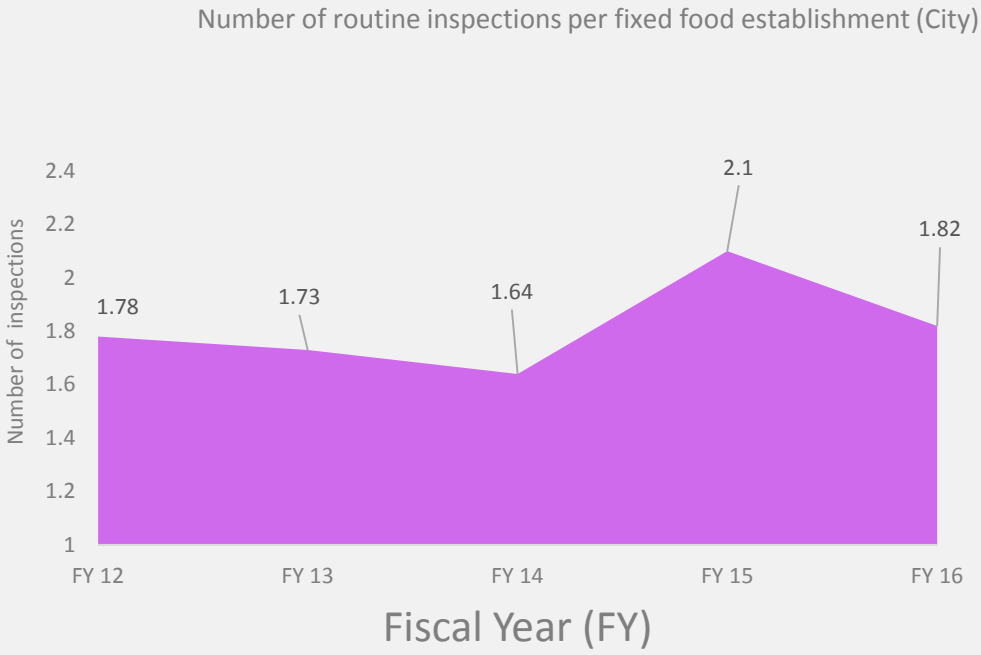
Areas for Improvement

Outreach to African-American MSM (Men having sex with Men) is particularly challenging in Austin area. This group is among the adversely affected groups by HIV; internal and external collaboration efforts are under way to better reach this group and provide necessary education and screening.

Environmental Health Services

The purpose of the Environmental Health Services program is to provide protection and enforcement services to the public in order to minimize environmental and consumer health hazards.

Key Outcome



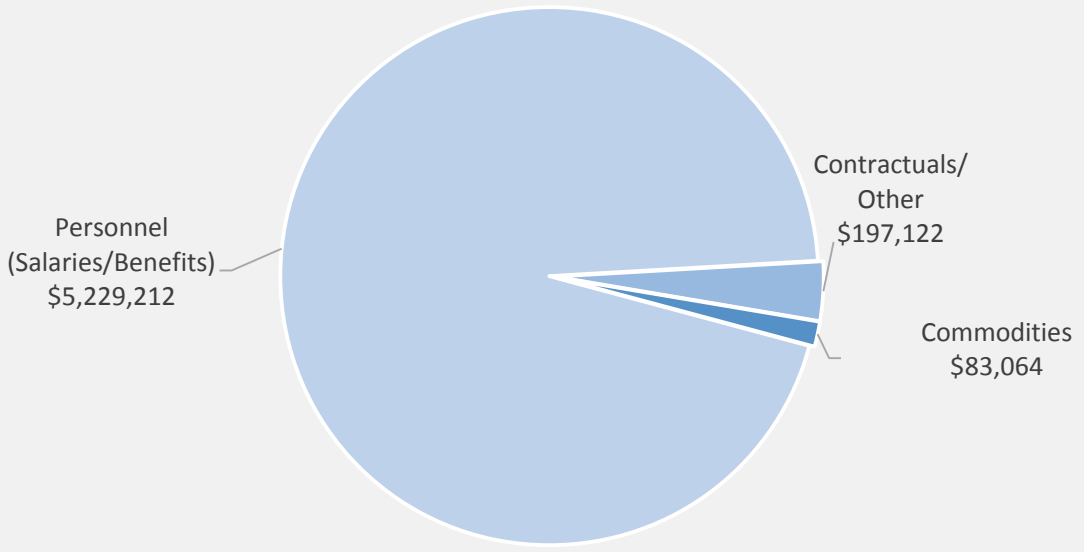
Number of routine inspections for fixed food establishments

9,296

2% From 2012

Activity Statistics	
Number of Mobile Vending permit inspections and routine inspections conducted.	2,223
Number of pool and spas permits issued	1,922
Number of Food Managers Certified	3,407
Percent of Retail and Food Service Fixed Establishment routine inspections that are substantially compliant	91.9%
Number of general environmental complaint investigations	667
Percentage of temporary food booths inspected	56.5%

Breakdown of Consumer Health Food Safety Compliance Budget



Customers

- Retail Food Service Industry
- Food Manufacturing Industry
- Consumer Citizens of Austin and Travis County

Employees

63 General Fund FTEs

Strategic Outcome Alignment

The Health and Food Safety Compliance activity aligns with the Health strategic outcome. This program advances Health by protecting the community from environmental health hazards such as foodborne disease as well as waterborne, rodent and vector-spread disease.

Services

- ✓ Food Safety Inspection Services
- ✓ Food Establishment Permitting
- ✓ Inform and Educate Operators
- ✓ Regulatory Compliance
- ✓ Complaint Investigations
- ✓ Food Borne Illness Response

Budget

$5,509,038

Future Budget Drivers

- Number of inspections conducted per establishment
- Cost recovery fees

Top Challenges

1. Resources – Environmental Health Officer staff to conduct increased inspections.
2. Technology – mobile inspection capability, on-line payment functionality.

Benefits of Service

- Provides for accreditation and compliance with the FDA Voluntary National Retail Regulatory Program Standards.
- The FDA Standard uses a process that groups food establishments into categories based on potential and inherent food safety risks.
- Inspection frequency is assigned based on the risk categories to focus program resources on food operations with the greatest food safety risk.

Alignment with Strategic Plans

APH 2016-18 Strategic Plan

Priority – To serve as a model of innovative and sustainable best/promising practices.

Goal – To minimize the public's exposure to environmental and health hazards.

Maternal, Child and Adolescent Health

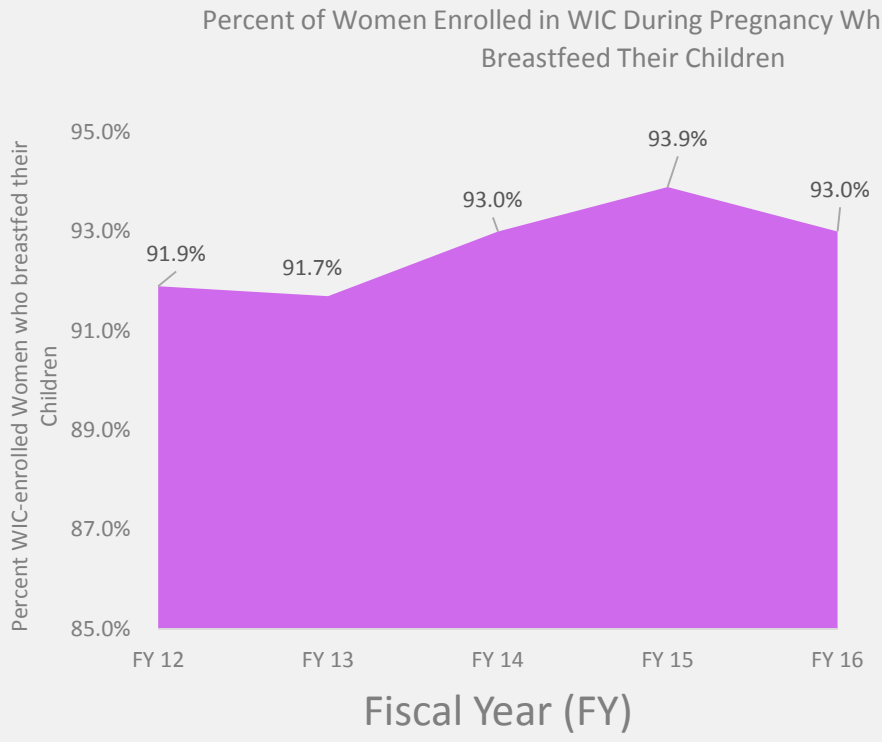
Supplemental Nutrition Program for Women, Infants and Children (WIC) is a preventive public health nutrition program that provides nutrition and breastfeeding education, nutritious foods, and improved access to regular health care and social services to low and moderate-income women and young children with, or at risk of developing, nutrition related health problems.

Healthy Texas Babies (HTB) is designed to improve preconception and inter-conception health of African Americans, Latinas and Latinos, and teens, and to reduce the number of babies in Travis County who are born too early or die before their first birthday.

Early Childhood Education staff assist with the community's School Readiness Action Plan, a strategic, community plan focused on improving services for young children.

The Austin Healthy Adolescent (AHA) Program seeks to promote and enhance positive health outcomes for adolescents ages 13-24. Health education activities and curriculum are provided strategically so as to help reduce health disparities in teen pregnancy and the incidences of sexually transmitted diseases.

Key Outcome



Number of WIC clients who breastfeed children

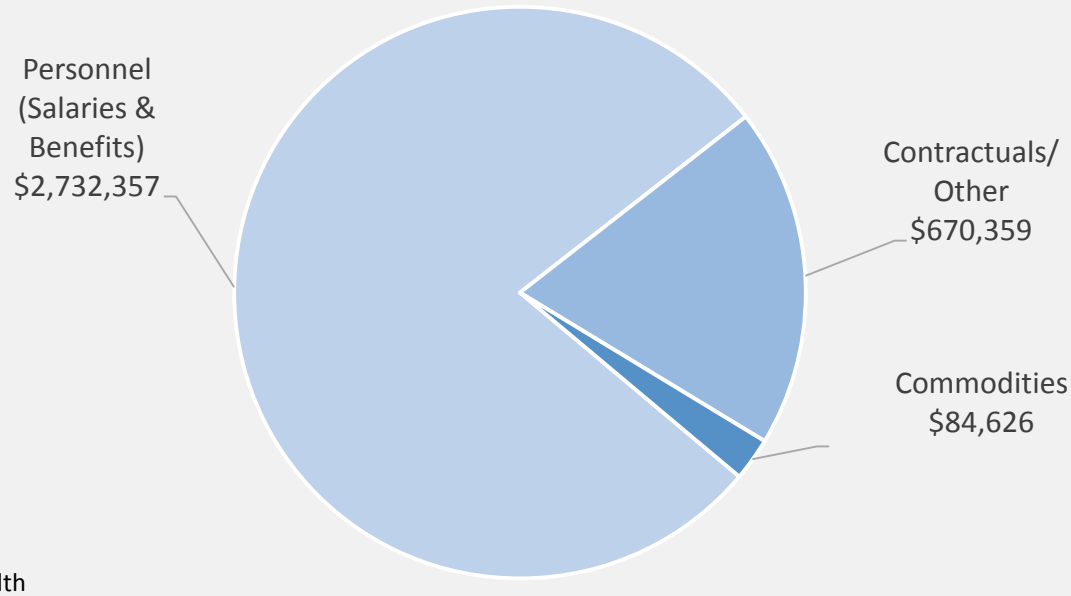
4,809

5% From FY12

Activity Statistics	
Infant mortality rate among Blacks is 7.58 (per 1,000 live births) vs. 2.56 among Whites	
Women ≤20 years old (and ≥40 older) have highest infant mortality rate	
Black infants have the lowest rates of breastfeeding initiation and duration	
Travis County ranked 7th highest in Texas in number of births to Hispanic teens	
Percent of Black babies born preterm (<37 completed weeks of gestation) (compared to 9.6% of White babies, 9.8% of Hispanic babies, and 9.4% of babies of other races/ethnicities.)	14.6%
% of women who report having a positive change in how they feed their families.	60%
Number of WIC nutritious food packages provided to women, infants & children.	365,230
Percent of WIC potential eligible served	43.8%
Percent of women who breastfed as long as they wanted to	49%
Number of lactation consultations provided at Mom's Place	2,142
Percent of full day early care and education centers with 10 or more subsidized children aged 0-5 that are rated 4 star or higher	55%
Percent of all eligible 4 year old children enrolled in full day public Pre-K	80%
Number of Sexuality Education and Skills Development Encounters Provided to Youth Ages 13 to 24	3,235

Significant Contracts	
Amala Foundation: Training for youth on diversity and healthy equity (AHA)	$16,500
Baylor University: Graduate research assistant services (HTB)	$7,320
Dr. Tyan Parker Dominguez: Evaluation Services (HTB)	$3,000

Breakdown of Maternal, Child and Adolescent Health Budget



Strategic Outcome Alignment

The Maternal, Child and Adolescent Health activity aligns with Health. This program advances Health by providing public health nutrition and breastfeeding services to low income women, infants and children to ensure healthy outcomes.

Top 3 Challenges

1. Policies banning condom demonstration as a part of sexual health education curriculum in public schools
2. Reliance on grant funding based on participation and participation is decreasing
3. Lack of consistent and accurate breastfeeding information and support from health care providers

Services

- ✓ Nutritional health assessment and counseling
- ✓ Healthy foods
- ✓ Referrals to other health and social service agencies
- ✓ Farmers Market Nutrition Program
- ✓ Summer Feeding Program
- ✓ Breastfeeding education and support
- ✓ Breastfeeding Peer Counselor Program
- ✓ Lactation services
- ✓ Clinical Lactation Practicum and Lactation training for health care professionals
- ✓ Sexual health education and positive youth development
- ✓ Peer to Peer health education
- ✓ Forum for young artists to develop public health messages for their community through creative expression
- ✓ Education on preconception and inter-conception health

Employees

7 General Fund FTEs

97.75 Grant FTEs

Budget

$3,487,342

Future Budget Drivers

Dependence on Grant Funds

Increasing Personnel Costs

Increasing Facility Costs

Clients

WIC serves pregnant, postpartum and breastfeeding women, infants and children under 5 years who are at or below the 185% poverty level.
AHA serves youth ages 13-24 years at Eastside, Del Valle, Lanier, Reagan, Austin and Travis High Schools and Dobie Middle School.
HTB priority populations are African Americans, Latinas and Latinos, and Teens.

Benefits of Service

- Reduction in infant mortality and preterm birth
- Reduction in household food insecurity and childhood hunger
- Improve dietary intake healthful behaviors that are linked to reducing childhood obesity
- Increased knowledge and access to support for breastfeeding to increase breastfeeding rates
  (If 90% of U.S. mothers exclusively breastfed their infants to 6 months, the U.S. would save $13 billion in medical expenses and prevent over 900 deaths annually.)
- Increased access to information regarding other social and health services available locally
- Teaches families how to use farmers' markets and purchase/prepare local, fresh fruits and vegetables
- Improved health of African Americans, Latinas and Latinos, and teens
- Public education about pre- and inter-conception health and racial disparities in birth outcomes
- Elimination of racial disparities in birth outcomes
- Peer Health Educators and youth participants in workshops have increased in knowledge and skills based an analysis of post intervention tests
- Increase in knowledge and skills for most program participants in the Youth Adult Council's Gender Matters curriculum offerings
- Attendees of the Stigma HIV Awareness play reported that they have more ways to engage in difficult conversations around sexual health

Success Stories

A Del Valle Peer Health Educator first went though the Peer to Peer (P2P) Curriculum and soon applied and was accepted as a Peer Health Educator in her own school. Next, she graduated, enrolled in ACC, continued to teach with AHA at Austin High school as she is interested in becoming a physician. AHA wanted to help her pursue her goals and she has now been trained to teach 3 sexual health curriculums. Recently, she was hired to work at CYD while still continuing school and P2P work. She serves as a model for youth leadership.

“I am a mom of two children. I am very happy and proud that the Moms Place program exists.
I acquired moms Place because I was unable to breastfeed my first child. Now I had such a desire to breastfeed this child, but I did not know how. My breast hurt so much, but thanks to Moms Place today I am the happiest mom in the world giving my baby breast milk without a problem.

Moms Place thank you for your help and encouragement.” –Moms Place Client

“I really value and appreciate these services. I have adopted the good practices for my family as a lifestyle. Very helpful and useful information!” St John WIC Client

Stability and Self-Sufficiency Programs

The Neighborhood Services Unit provides a wide range of services which include help with basic needs, employment, social work case management, crisis intervention and preventive health for low and moderate income families.

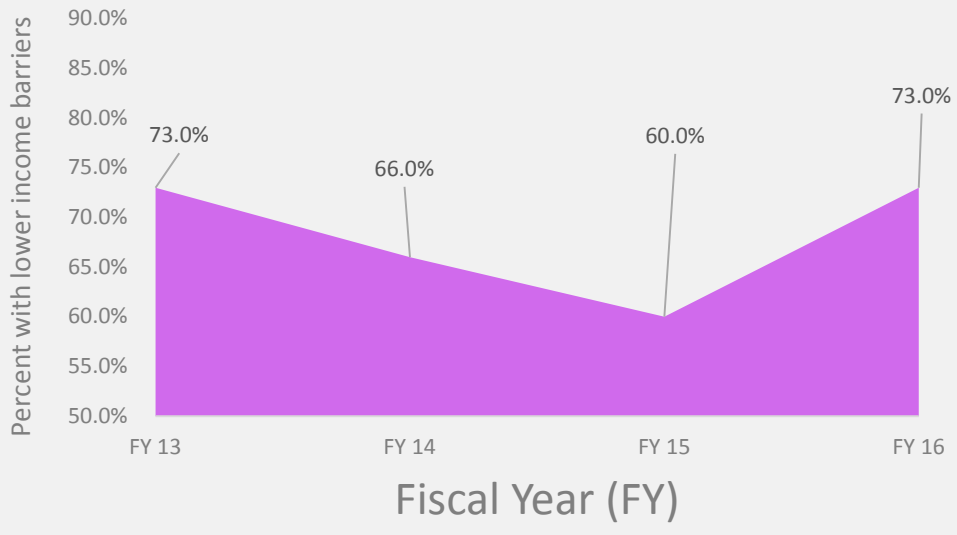
The Austin Youth Development (AYD) Program provides services around educational development and employability skills for youth/young adults who may have had limited opportunities and/or who are at-risk such as not completing high school. AYD work is focused on graffiti abatement and lawn services.

The First Workers' Day Labor Center is a resource for citizens, contractors, and business owners who need workers for a few hours, a day or longer.

The Community Youth Development (CYD) Program aims to prevent juvenile delinquency and promote positive youth development by helping reduce referrals to juvenile probation and encourage alternative methods to deal with opposing views.

Key Outcome

Percent of Clients Enrolled in Self-Sufficiency Case Management Who Reported a Reduction or Elimination of Income Barriers



Number of clients who reduced or eliminated income barriers

387

No Change from FY13

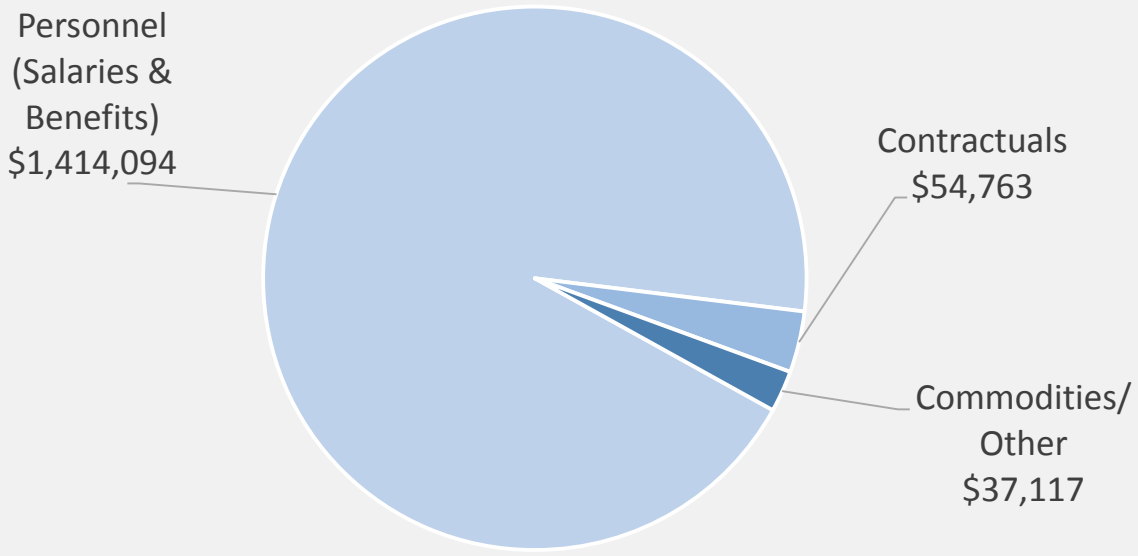
Activity Statistics	
Increase in poverty in Travis County from 2000 to 2013	9.9% to 15.9%
Percent of Austin's poor population who live in neighborhoods with poverty rates of 20% or higher	54%
Number of children under age 18 living in poverty	1 in 5
Number of unduplicated persons served with basic needs	55,866
Number of unduplicated households receiving case management	373
Number of persons transitioned out of poverty	76
Number of youth in AYD direct services completing educational goals	24
Number of youth in AYD completing individual development plans	40
Average number of business days graffiti is removed	23.54
Number of graffiti clean-ups completed	2,771
Number of Day Labor placements (duplicated)	19,141
Percent of Day Labor clients placed weekly	68%
Average number of targeted youth served annually	600
Percent of youth in CYD not engaged in delinquent behavior	100%

Significant Contracts	
Creative Action: interactive cultural theater addressing current youth issues	$78,346
Austin Public Library (APL) for lawn services	$63,840
Austin Resource Recovery (ARR) for lawn services	$25,080

Strategic Outcome Alignment

The Stability and Self Sufficiency activity aligns with the Health and Economic Opportunity and Affordability strategic outcomes. This program advances Health through outreach, health planning assistance, and educational and vocational development to improve health outcomes of youth and families. This program advances Economic Opportunity and Affordability through the job and skill development programs for youth and young adults.

Breakdown of Stability and Self-Sufficiency Budget



Clients Served

- 88% of households served are below 125% of the Federal Poverty Income Level
- 37% of those served are children under 18
- 28% of those served are over age 55
- 41 % are Black or African American
- 43 % are Hispanic or Latino
- AYD youth are ages 17-22 years
- CYD youth are ages 10-17 years

Facilities

- There are 6 Neighborhood Centers and 3 outreach sites.
- Most of the centers were built in the late 1970s or early 1980s
- They are primarily concentrated in Central East Austin
- Outreach sites developed in areas with increasing populations of low income residents to meet these needs

Services

- Help with finding and keeping a job
- Help with food, clothes, transportation (basic needs)
- Limited financial assistance
- Health screenings and education
- Links to community resources
- Crisis Intervention
- Mentoring
- Youth Based Curriculum
- Youth leadership development and job readiness preparation
- Graffiti abatement - public and private properties
- Lawn maintenance for City Departments
- Provide meeting space for employers and day laborers to negotiate potential employment opportunities
- Provide laborers with medical screenings and referrals to neighborhood centers for social service needs

Employees

26.75 General Fund FTEs

19 Grant FTEs

Budget

$1,505,974

Future Budget Drivers

- Dependence on Grant Funds
- Increasing Personnel Costs
- Increasing Facility Costs to Provide Services in Areas Where Low Income Populations are moving

Benefits of Service

- Increased access to healthy food for low and moderate income families
- Employment support for individuals who may have barriers to finding and keeping a job (e.g., limited work history, criminal background, health issues)
- Increased knowledge of prevention of chronic disease, injury prevention and linkages to health care
- Crisis intervention for individuals and families to help them regain stability
- Youth develop an understanding of job readiness and workplace expectations in a real work environment
- During the last 3 months of the program, the youth are assisted in developing their resumes and job searches
- The youth participate in required educational programs, including General Educational Development test preparation, diploma/certificate programs, and life skills training
- Graffiti abatement on public and private properties
- Provide employment opportunity for laborers
- Medical screenings and social service referrals to those laborers in need
- Reduce or eliminate juvenile referrals to Juvenile Probation
- Positive youth social and leadership development

Success Stories

A client who was screened by a Neighborhood Center Public Health Nurse had a blood sugar of 390 and declined to go to the emergency room, but understood that he needed immediate medical attention. He was referred to a local health provider, and received diabetes education. The client came back recently for a blood sugar check and his fasting blood sugar result was 81. He had been prescribed diabetes medication by the primary care provider and is taking his medication as prescribed. Client stated he is also exercising, playing basketball, and is feeling healthier.

A single African American male in his early 30's came to the St. John Community Center seeking assistance. He had been sleeping on his brother's sofa since he had recently been released from jail. He asked for help with employment and housing. He was able to get into Commercial Driver's License (CDL) training through Workforce Solutions. He entered case management with the St. John social worker who provided assistance with food, short-term counseling (to work through background barriers to employment and housing), budgeting and rental assistance. He graduated with CDL in April and found employment above 125% of FPIL. Within 30 days he reported income above the living wage. He received rental assistance in July that helped him obtain safe and stable housing. By August, he provided proof of income which documented a stable income for the last 90 days and is now transitioned out of poverty.

Top 3 Challenges

1. Reliance on grant funding to support key services and programs
2. Lack of facilities and staffing in areas where low income populations are moving
3. Graffiti abatement requests are increasing

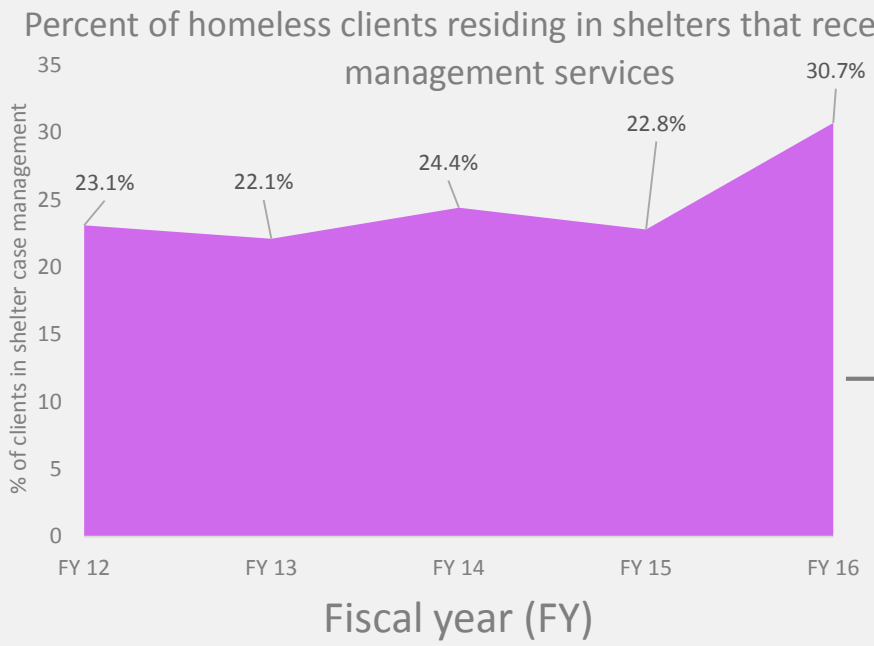
CIP

- Parking lot expansion at Montopolis Neighborhood Center is completed
- Montopolis Recreation and Community Center is joint project with Parks and Recreation Department that will provide Neighborhood and Austin Healthy Adolescent (AHA) services. Projected completion in 2019

Social Services Contracts

The Social Services Contracts program provides an array of social services that promote self-sufficiency for eligible individuals and households and improves their quality of life.

Key Outcome



Homeless clients in shelters receiving case management

1,355

33% From FY12

Activity Statistics

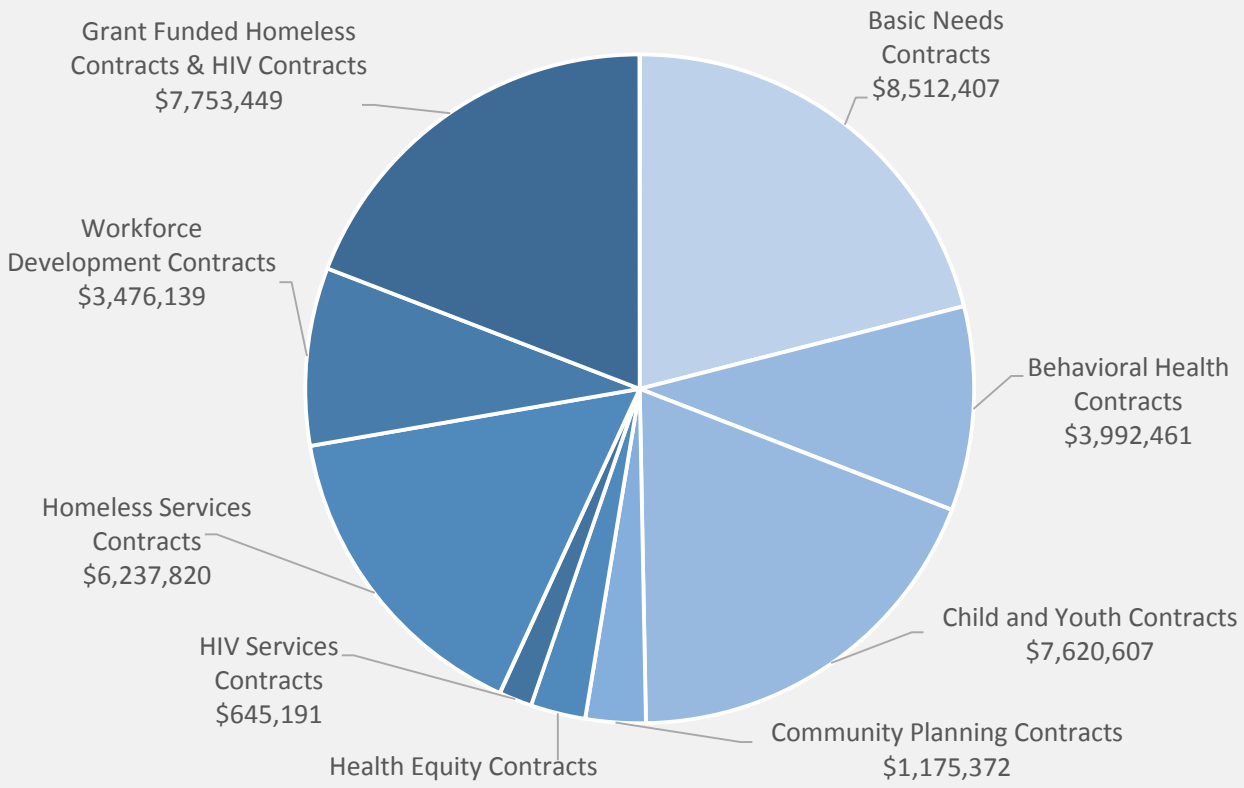
Individuals served through Social Services contracts	69,834
Percent of households at risk of homelessness that maintain housing	80%
Percent of individuals who meet their treatment plan goals	83%
Percent of children or youth progressing to the next developmental or academic level	92%
Percent of deliverables achieved in community planning contracts	100%
Percentage of HIV positive patients having a viral load less than 200 copies/mL at the last test taken	81%
Percent of those receiving homeless services who move into housing	75%
Percent of individuals demonstrating improved life skills and/or knowledge	86%

Significant Contracts	
Basic Needs contracts (18)	$ 8,512,407
Behavioral Health contracts (11)	$ 3,992,461
Child and Youth contract (27)	$ 7,620,607
Community Planning contracts (10)	$ 1,175,372
Health Equity contracts (7)	$ 1,074,150
HIV Services contracts (4)	$ 645,191
Homeless Services contracts (13)	$ 6,237,820
Workforce Development contracts (2)	$ 3,476,139
Grant funded HIV Services contracts (13)*	$ 6,655,247
Grant funded Homeless Services contracts (7)	$ 1,098,202
One Time Funding contracts (5)	$ 547,775
Total	$ 41,035,371

**Anticipated remainder of full grant award for HIV contracts included and currently pending*

***$1,396,675 in social service contracts from 1115 Waiver, not reflected in this activity*

Breakdown of Social Services Contracts Budget



****Budget total includes Council directed one-time FY17 funding in the amount of $547,775, not reflected in pie chart*

Customers

Our customers are the clients receiving services and the agencies providing services.

Clients

- Live in Austin/Travis County
- Household income at or below 200% of federal poverty guidelines (FPG)

HIV Services Clients

- Live in one of 10 counties (including Travis)
- Household income levels vary up to 500% FPG

Agencies

- 68 lead agencies with social services contracts in FY17
- Non-profits, HIV Service Organizations, AISD, ATCIC, UT, ACC

Strategic Outcome Alignment

Due to the fact that Social Service contracts provide a variety of services, there are multiple strategic outcomes.

- Basic Needs Contracts promote Economic Opportunity & Affordability by providing access to resources that address clients' barriers in obtaining the basic needs of life.
- Behavioral Health Contracts promote Health by providing critical mental health and substance abuse services for eligible individuals, and support services for individuals with intellectual or developmental disabilities and their families.
- Child and Youth Contracts promote Economic Opportunity & Affordability through outreach, health planning assistance, and educational and vocational development to improve health and economic outcomes of youth and families.
- Community Planning Contracts promote government that works by developing coordinated strategies with community organizations and stakeholders.
- Health Equity Contracts promote Health by addressing the social determinants of health to ensure that all residents can lead healthy lives.
- HIV Contracts advance Health by preventing, treating and minimizing exposure to HIV.
- Homeless Contracts promote Economic Opportunity & Affordability by providing tools for homeless persons to achieve self-sufficiency.
- Workforce Development promote Economic Opportunity & Affordability by providing educational and vocational development.

Services

Services include but are not limited to:

- Quality Early Child Care
- Individual Case Management
- Adult Education / Job Training
- Rental / Utility Assistance
- Tutoring & Afterschool Enrichment
- HIV Services including Medical Case Management & Support
- Emergency Shelter
- Permanent Supportive Housing
- Individual & Group Behavioral Health Services
- Healthcare Navigation
- Legal & Tenant Rights Services
- Health Equity Services for Targeted Populations
- Food Delivery & Money Management for Seniors & Individuals w/ Disabilities

Budget

$41,035,371

Future Budget Drivers

- Increasing cost of doing business
- Federal & State priorities impacting grant funding
- Growth of Austin population and economic divide

Employees

7 General Fund FTEs

1 Grant FTE

Top 3 Challenges

1. Funding directed to agencies that can't meet threshold Purchasing requirements for entering into a legal agreement with the City
2. Health and economic disparities among different populations
3. Adding contract funding without increasing staff capacity for negotiation and management in order to meet City accountability standards

Impact of Services

- The Best Single Source Plus Collaborative responded to the flood of October 30, 2015, with eight partner agencies serving a total of 107 clients in 22 households, providing housing re-location services, direct financial assistance, and addressing basic needs of individuals and families in crisis.

- The WERC (Workforce & Education Readiness Continuum) collaborative was able to provide paid internships to workforce development clients completing occupational training or those who experienced significant difficulty finding employment due to lack of job experience. This new service improved the likelihood of a client obtaining a job with a self-sufficient hourly wage.

- Family Eldercare obtained status as a Fiduciary from the U.S. Department of Veterans Affairs. With this designation, FEC is able to enhance program services provided to veterans.

- Austin Tenants' Council's Housing Stability pilot program assisted 23 clients with housing debt negotiation services, reducing clients' debt by more than $25,000 and negotiating a stop to eviction filing for four clients. On average, ATC debt negotiations reduced debt by 29%.

Areas for Improvement

1. Staff recommends that Council direct funding to an issue area or service rather than to specific organizations, allowing APH to solicit competitive proposals that seek the best services at the lowest cost.
2. Funding should be aligned with desired outcomes identified by City/Department.

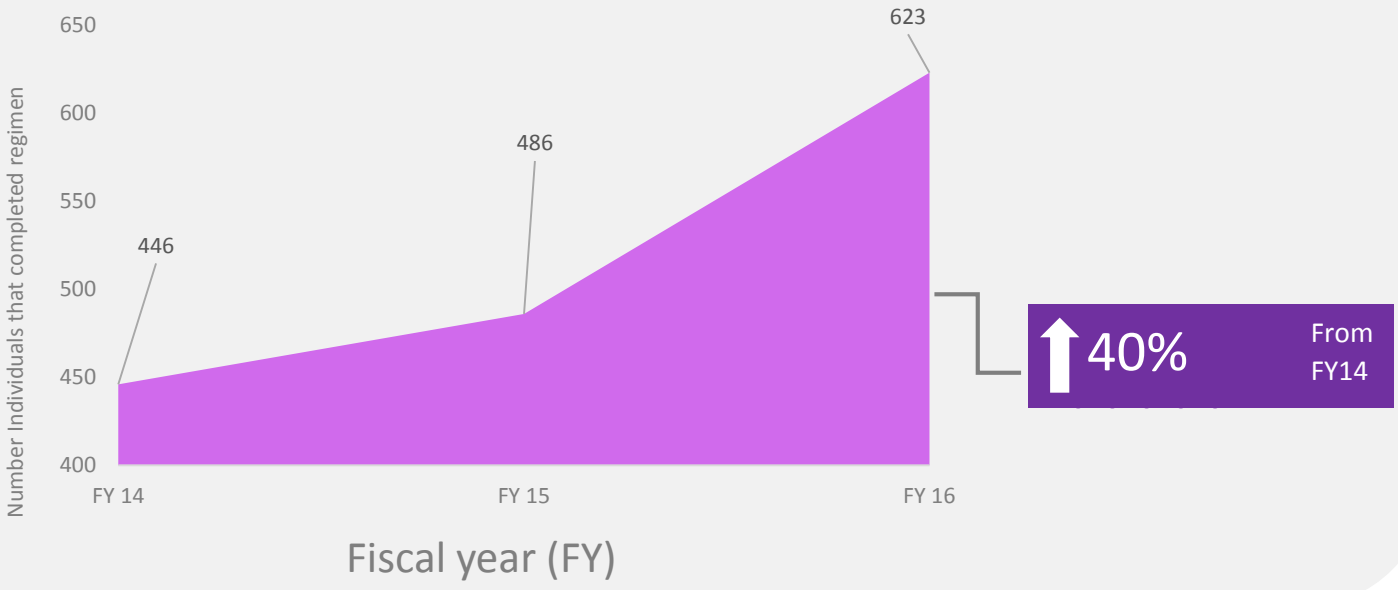
1115 Waiver (DSRIP)

Delivery System Reform Incentive Payment (DSRIP) are payments available for programs under the 1115 Waiver of the Center for Medicaid Services (CMS) to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided, and the health of the patients and families served. As of January 2017, APH has received more than $28.7 million through DSRIP.

APH implements nine programs through the 1115 Waiver: Permanent-Supportive Housing (PSH), Diabetes Education, Tobacco Cessation, the Maternal/Infant Outreach Project (MIOP), Healthy Families, Immunizations, Workforce Development, Peer to Peer Sex Education, and Latent Tuberculosis Infection (LTBI) treatment.

Key Outcome

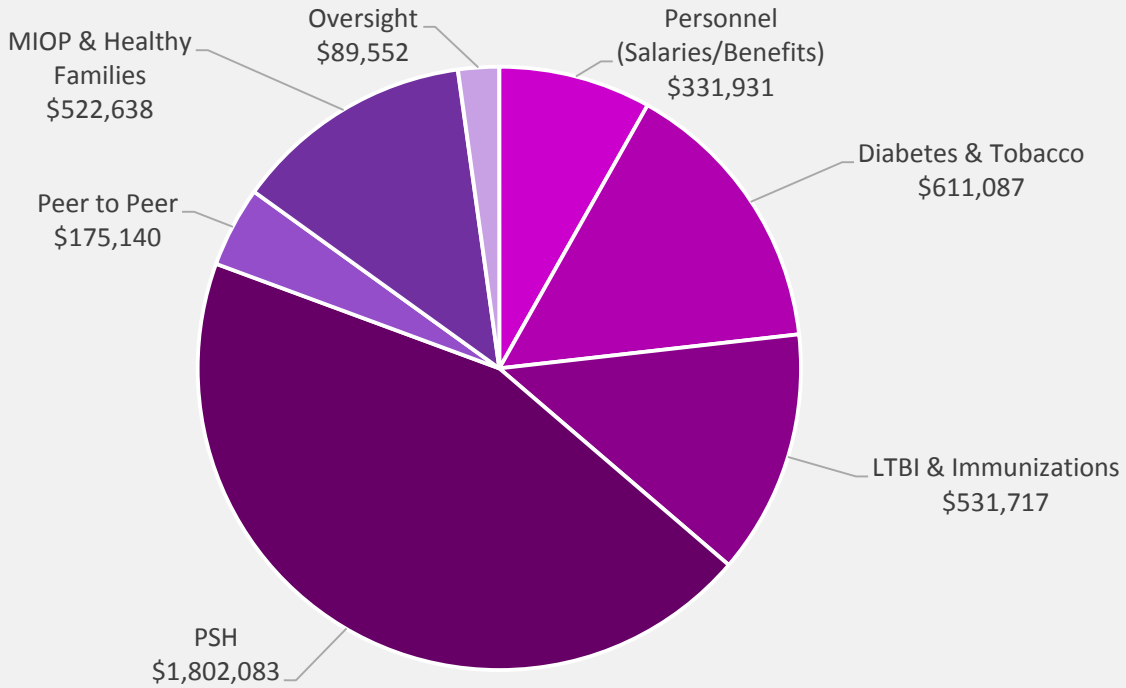
Individuals with Latent Tuberculosis Infection (LTBI) that completed the treatment regimen.



Activity Statistics	
Satisfaction Rate of Individuals Receiving Immunizations Services (Immunizations)	94%
Percent Improvement in the Number of Well-Child Visits Completed by 15 months old (Healthy Families)	17.4%
Percent Improvement in the Number of Healthy Term Newborns Among Children Born to African-American Mothers (MIOP)	33.2%
Percent Decrease in the Emotional Distress in Individuals Related to the Management of their Diabetes (Diabetes)	18.3%
Percent of Individuals who Demonstrated Improved Overall Functioning while in Permanent-Supportive Housing (PSH)	62%

Significant Contracts	
Austin/Travis County Integral Care (PSH)	$1,074,675
Capital IDEA (Workforce Development)	$385,704
Foundation Communities (PSH)	$322,000
Travis County (Healthy Families)	$250,000
Incite (Tobacco)	$249,000

Breakdown of 1115 Waiver Budget



Customers

1115 Waiver programs primarily focus on Medicaid or Low-Income or Uninsured (MLIU) populations. These populations include some of the most vulnerable, high-risk customers in each project category.

Our Immunizations project focuses on vulnerable adult and late-adolescent populations at increased risk for vaccine preventable disease(s) and/or lacking access to vaccination services. Vulnerable populations include (but in no way are limited to) homeless, men who have sex with men (MSM), women at risk (including pregnant women), substance abusers, LGBTQ individuals, HIV positive individuals and their partners, and people who use tobacco products.

Our Diabetes, MIOP, and Healthy Families projects focus on African-American and Hispanic communities who are disproportionately affected by Diabetes and infant mortality.

Strategic Outcome Alignment

The APH 1115 Waiver program aligns with the Health strategic outcome. This program advances Health by increasing access to health care, improving the quality of care, and enhancing the health of clients and families served.

Services

- Immunizations screenings & vaccinations
- LTBI diagnosis & treatment
- Service navigation for new and expecting families
- Promotion of tobacco cessation services
- Support & education on the healthy management of diabetes
- Peer health training & education
- Permanent supportive housing

Budget

$4,064,148

Future Budget Drivers

- Cost of Medications
- Increasing Personnel Costs
- Growing Population

Employees

20 Grant FTEs

Benefits of Service

- 1115 Waiver has received $28,681,294 in DSRIP payments since 2013
- At least 13,136 service encounters between Workforce & Immunizations each year
- At least 7,364 clients receive service through PSH, Diabetes, Tobacco, MIOP, Healthy Families, Peer to Peer, and LTBI each year
- Utilizing federal and state funding resources (i.e. DSRIP grant funding, and the Texas Adult Safety Net Program) the Immunizations project has been able to make a significant present and future impact on the health of this community and particularly its diverse at-risk populations
- DSRIP has increased the number of community partners APH works with in the delivery and coordination of public health services
- The Percentage of MIOP clients who had Healthy Term Births (babies born between 37 - 42 weeks who do not have significant complications during birth or nursery care) is 91.4%.

Top 3 Challenges

1. 1115 Waiver ending December 31, 2017. APH only has enough funding from DSRIP payments to sustain projects, in some capacity, through approximately FY 2021
2. Limited Number of PSH Housing Units
3. Increased focus from HHSC and CMS on linkage with Medicaid Managed Care Organizations (MCOs) which often do not cover the public health services APH provides

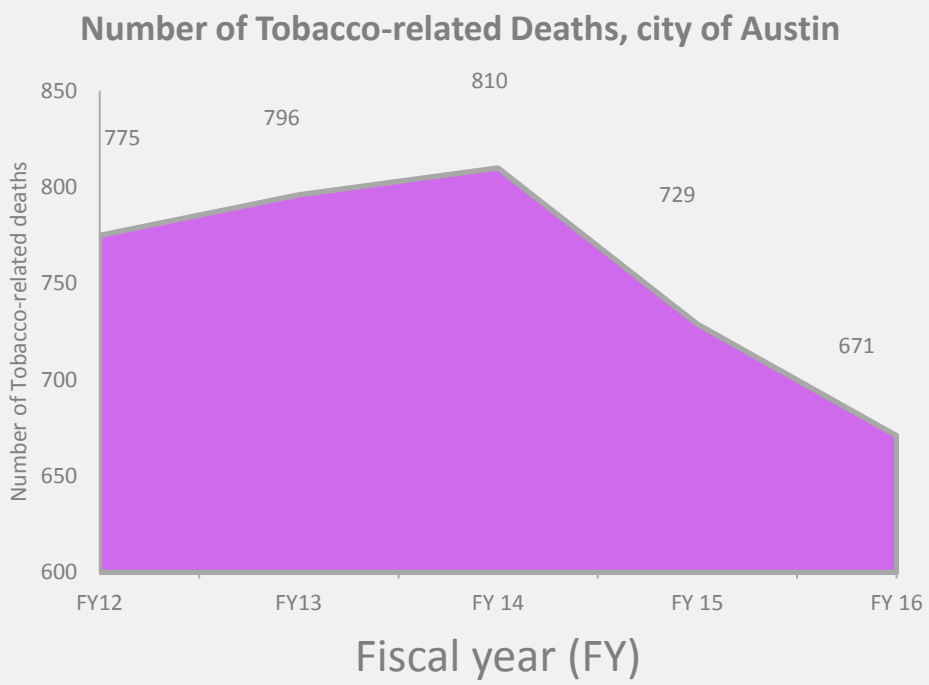
Alignment with Strategic Plans

APH FY16-FY18 Strategic Business Plan Goal 2: “Improve Maternal, Child and Adolescent Health Outcomes” (MIOP, Healthy Families, Peer to Peer)
APH FY16-FY18 Strategic Business Plan Goal 3: “Reduce Preventable Chronic and Communicable/Infectious Diseases” (Diabetes, Tobacco, Immunizations, Peer to Peer, LTBI)
APH FY16-FY18 Strategic Business Plan Goal 5: “Assist People in Achieving Stability and Self-Sufficiency” (PSH, Workforce)

Chronic Disease & Injury Prevention

The Chronic Disease and Injury Prevention Program (CDIP) utilizes best practices and community partnerships to address some of the leading causes of death in Austin/Travis County: cancer, heart disease, accidents, chronic lung disease, stroke, and diabetes. Data collection & analysis & health education are key strategies to address major chronic disease risk factors. Tobacco prevention and control goals include decreasing youth initiation of tobacco, increasing cessation among youth and adults, eliminating second hand smoke exposure, and ensuring compliance with all tobacco laws. Food access projects provide affordable, high quality fruits and vegetables in food desert areas and other areas lacking access. Activities also include education on diabetes, physical activity promotion programs, car seat safety checks, bicycle safety classes, and safe sleep education.

Key Outcome



Individuals reached through tobacco cessation programs

800

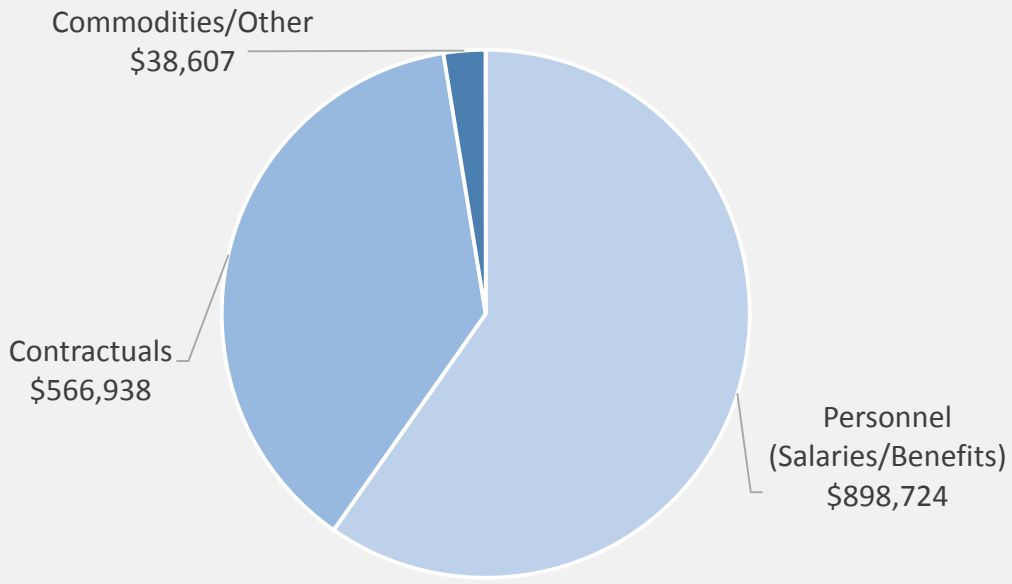
▼ 13.4% from FY12

Activity Statistics

Chronic Disease & Injury Prevention Activities	164
Chronic Disease & Injury Prevention Encounters	2808
Community Changes in the area of chronic disease prevention	19

Significant Contracts	
Emmis/Incite (83% grant funded) – Healthy Food Access	$300,000
Marathon Kids – Healthy Food Access	$75,000
University of Texas Health Science Center – Healthy Food Access	$58,000
Farmshare Austin – Healthy Food Access	$58,000
Sustainable Food Center – Healthy Food Access	$58,000

Breakdown of Chronic Disease and Injury Prevention Budget



Customers

- City and County population as a whole
- Individuals with chronic disease risk factors
- Faith based organizations
- Employers and multi-unit housing communities
- Schools and childcare facilities
- Health disparate populations
- Medically underserved individuals with the highest rates of chronic disease
- African American, Hispanic, and Asian residents

Strategic Outcome Alignment

The Community Health activity aligns with the Health strategic outcome. This program advances Health by providing preventive health services for the public in order to optimize health and well being.

Services

- ✓ Tobacco Prevention and Control
- ✓ Healthy Food Access (mobile produce markets, farm stands, healthy food retail)
- ✓ Injury Prevention
- ✓ Diabetes Education
- ✓ Physical Activity Promotion
- ✓ Promotion of Healthy Eating
- ✓ Breastfeeding Support

Budget

$1,504,269

Future Budget Drivers

- Population growth
- Rising obesity rates

Alignment with Strategic Plans

CDIP Program activities align with Imagine Austin. Priority Program 7: Create a Healthy Austin. In addition, these efforts are in alignment with implementing the Vision Zero Action Plan and directly support the Austin Public Health Community Health Improvement Plan.

Benefits of Services

Chronic diseases and conditions such as cancer, heart disease, chronic lung disease, stroke, diabetes and obesity are among the most common, costly and preventable of all health problems in Travis County. Of these chronic diseases, tobacco is the number one preventable cause of death and disability (671 tobacco related deaths in 2015). Unintentional injuries – falls, motor vehicle crashes, poisonings, drownings, and other events sometimes called "accidents" – are the third leading cause of death in Travis County. Unintentional injuries are the leading cause of death among children and are responsible for the deaths of nearly 500 residents per year.

CDIP programs and services:

Improve Diabetes Prevention and Management

656 persons reached through diabetes education classes in FY2016. Of the 138 persons with diabetes, 82% report making a lifestyle change as a result of these classes. There was also a measurable improvement in quality of life among participants with diabetes (a drop of 58% in diabetes management-related distress), which correlates with improved Hemoglobin A1c.

Improve Health Through Tobacco Cessation

800 individuals reached through tobacco cessation outreach. Of these individuals, 72% enrolled in cessation services through SmokefreeTXT.

Protect the Community from Second Hand Smoke

128 organizations in Austin/Travis County as of 2016 are now tobacco- or smoke-free, with a total of 815 locations/campuses around the county.

Increase Healthy Food Access

64 Farm Stand and Mobile Market Operational Days across 7 sites, reaching 805 customers during the first quarter of implementation (Oct-Dec 2016). 8 corner stores have added healthy foods.

Prevent Unintentional injury Among Vulnerable Populations

64 Injury Prevention health activities, reaching 1597 individuals through car seat safety checks, bicycle safety classes, and other activities. Austin Public Health is a key partner in the City's Vision Zero efforts.

Increase healthy nutrition and physical activity

21 place-based chronic disease prevention mini-grants to community-based organizations to reduce chronic disease among health disparate populations and make lasting changes to improve physical activity, tobacco-free living, and healthy eating. Over 1 million radio impressions to encourage reduction in sugar sweetened beverage consumption, a key contributor to obesity.

Success Stories

With the help of Austin Public Health CDIP staff, Austin Resource Center for the Homeless (ARCH) adopted a tobacco-free policy, which includes all forms of tobacco including electronic cigarettes in FY2016. ARCH clients are more likely to use tobacco and have other substance abuse issues, and the policy change can help in reducing the rates of chronic disease in this health disparate population Below are quotes from participants in Diabetes Education and Prevention Classes:

"I have put into practice eating more fruits and vegetables. I've switched from soda to water and from red bull to a banana and fruits and I have felt better"

"Eat healthier, daily exercise, manage glucose levels and control daily stressors. I plan to now sign up for healthy cooking classes thanks to the instructor…"

Top 3 Challenges

1. Increasing rates of obesity
2. Uncertain future of grant funds
3. Social determinants of health impact chronic disease and food access (such as education, income, transportation)

Employees

8 General Fund FTEs

1 Grant Funded FTEs

Areas for Improvement

CDIP is constantly utilizing data and evidence-based practices to drive initiatives. Areas for expanded focus include engagement of more worksites to implement health policies that promote healthy lifestyles, development of a pilot project to increase purchasing power of SNAP recipients in “bricks and mortar” grocery stores, cross-departmental collaboration to expand access to grocery stores in underserved and food desert areas, and expanded focus on safe sleep for infants and prevention of drownings and falls.

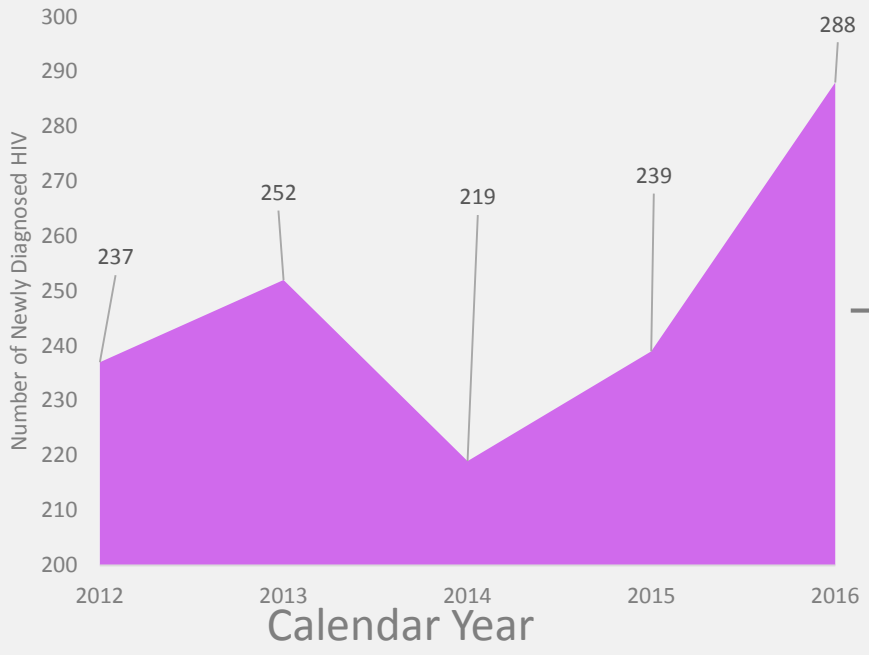
Communicable Disease and Immunization Clinics

Austin Public Health operates TB (tuberculosis), STD (Sexually Transmitted Disease), and Refugee Health Screening clinics. These clinics provide screening, diagnosis, treatment, follow-up care, and referrals for the patients. The clinics provide medical services for intervention and management of TB, HIV, syphilis, gonorrhea, and chlamydia. Refugee clinic also provides the necessary immunizations, laboratory testing, and screening for all refugees settling in Austin. STD's, TB and other infectious diseases are important public health problems. Some of the diseases are treatable using antibiotics, and some such as HIV infection are not curable and can be fatal.

APH also provides direct provision of immunizations as well as provision of immunizations through work with 73+ community Vaccine for Children (VFC) providers.

Key Outcome

Number of Newly Diagnosed HIV Cases in Austin/Travis County



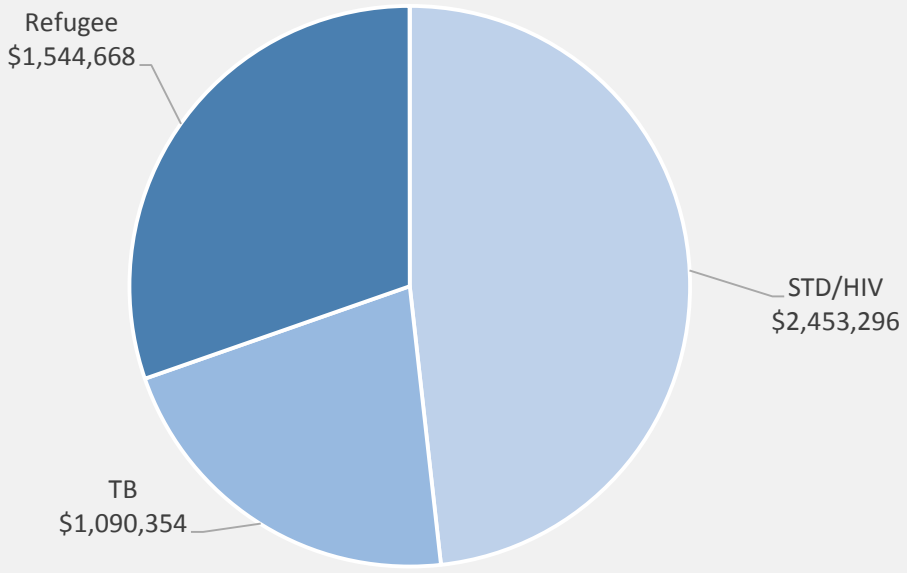
Number of Newly Diagnosed HIV Cases from Outreach Testing

20

21.5% From 2012

Activity Statistics	
Number of STD Clinic Visits	13,860
Number of TB Clinic Visits	8,590
Percentage of Active TB Cases Completing Therapy	100%
Number of Vaccines Provided to Refugees, uninsured children and adults and children on Medicaid	51,392
Number of vaccinations provided to Travis County children and adults from VFC providers and APH immunization staff in FY 2016.	257,095

Breakdown of Health Clinics Budget



Customers

- Active/Latent TB patients
- STD and HIV patients (infected or at risk)
- All refugees
- Uninsured children and adults, and children on Medicaid
- All City of Austin residents

Strategic Outcome Alignment

The Communicable Disease and Immunization Clinic activity aligns with the Health strategic outcome. This program advances Health by preventing, treating and minimizing exposure to communicable diseases.

Benefits of Service

- Provide treatment for TB patients; provide preventive TB medication; control spread of TB in the community
- Provide HIV and STD screening; provide STD treatment (e.g. syphilis, gonorrhea, chlamydia); control spread of HIV and STDs in the community
- Provide diagnostic laboratory testing and immunizations for refugees; control spread of communicable and preventable diseases in the community
- Provide referrals and linkage to care in addition to social services; improve linkage to and retain patients in care (e.g. HIV, mental health, primary care, etc.)
- Immunizations are noted by CDC as one of the 10 greatest public health achievements of the 20th century
- CDC estimates that for every $1 spent on vaccinations, the healthcare system avoids $16 in future costs

Employees

35 General Fund FTEs

28 Grant FTEs

Budget

$5,088,318

Future Budget Drivers

Caseload

Federal Grants

Personnel Costs/ Grant Support

Services

- ✓ Medical case management and treatment for all active TB cases
- ✓ Preventive TB medication
- ✓ HIV testing, STD testing/treatment
- ✓ Linkage/referral to care and social work services
- ✓ Screening and translation of foreign and domestic Immunizations records
- ✓ Provision of recommended and required immunizations

Top 3 Challenges

1. Increasing population and demand for core public health services in TB, STD, HIV, immunizations, etc.
2. Limited central clinic accessibility to many due to geographic expansion of the City
3. Lack of funding availability for CDC recommended interventions (e.g. Pre-exposure Prophylaxis - PREP) to control infectious diseases (e.g. HIV)

Policy Issues

- Federal and State grants may be affected by the changes of priorities at those governments, resulting in possible loss of programs and services in core public health areas such as HIV, STD, TB, Refugee Health.
- Possible repeal of the Affordable Care Act may impact access to chronic disease prevention and treatment services.

Areas for Improvement

Plan for additional clinic locations for HIV/STD, TB and immunization services to provide better accessible locations to more affected areas and residents.
Plan on securing funding to establish additional STD/HIV clinic with PREP services to seriously affect the spread of HIV in the community.

Alignment with Strategic Plans

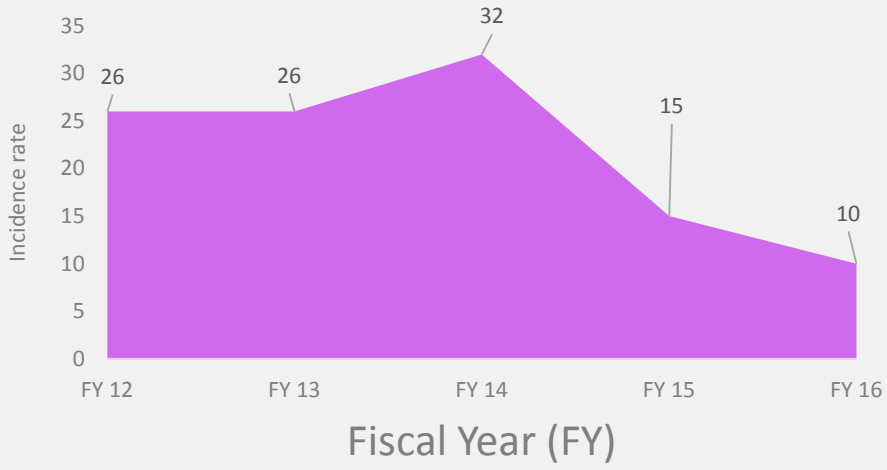
Imagine Austin. Priority Program 7: Create a Healthy Austin

Epidemiology, Disease Surveillance, and Office of Vital Records

Epidemiology is the core science of public health and comprises the collection, recording, analysis, and interpretation of data that identify the burden of acute and chronic diseases within the community and risk factors for developing disease. Epidemiology and disease surveillance use data analyses to monitor disease occurrence and outbreaks, implement prevention and control measures, and evaluate the effectiveness of interventions and prevention strategies that limit the spread of disease within the community. The Office of Vital Records provides local registration and issuance of birth and death events. Birth and death records are managed in a secure process that prevents identify theft and other fraudulent acts, as well as provide data used to monitor the prevalence of disease, develop programs to improve public health, and evaluate the effectiveness of interventions.

Key Outcome

Incidence Rate per 100,000 Population of Reported Cases of Measles, Pertussis, Mumps, and Rubella in the Community Served



Number of Reported Cases of Measles, Pertussis, Mumps, and Rubella

124

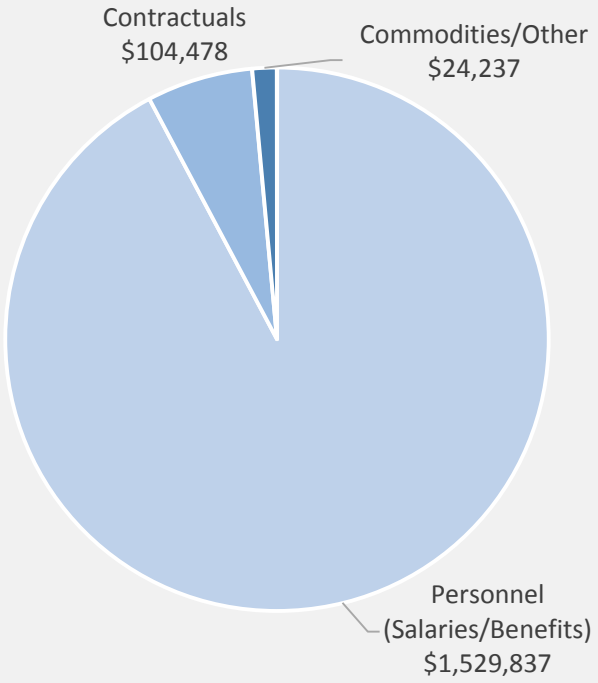
62% From FY12

Activity Statistics

Number of human exposures to rabid animals investigated	663
Number of initiated investigations of persons with a possible reportable disease	11,962
Number of laboratory reports reviewed for evidence	26,774
Number of death and birth records registered or amended	28,050
Number of certified copies of death and birth certificates issued	46,896

Significant Contracts	
Remote Certification of Vital Records, Texas Department of State Health Services	$25,000

Breakdown of Epidemiology Budget



Customers

- Residents of Austin and Travis County
- Visitors of Austin and Travis County
- Public Safety
- Healthcare
- Emergency Management

Strategic Outcome Alignment

The Epidemiology and Disease Surveillance activity aligns with the Health strategic outcome. This program advances Health by investigating disease occurrence and outbreaks, monitoring disease trends, and implementing control measures to prevent the spread of disease in the community.

Services

- ✓ Surveillance and investigation of 70 notifiable diseases and health conditions
- ✓ Epidemiologic investigation of disease outbreaks, disease prevention and control
- ✓ Toxicological reviews of monitoring data collected to determine the potential for adverse human effects from releases to air, water, and soil
- ✓ Birth, death, and fetal death certificate registrations for City of Austin
- ✓ Issuance of certified copies of vital records for all events occurring in Austin
- ✓ Issuance of certified copies of birth certificates occurring in Texas
- ✓ Issuance of burial-transit permits to Texas funeral homes of Austin events
- ✓ Analysis of birth and death data for City of Austin departments
- ✓ Death notifications to Texas Secretary of State and to Texas voter registrars
- ✓ Participation on Travis County Child Fatality Review Team

Top 3 Challenges

1. Reliance on state and federal funds to support activities (90% grant funded)
2. Public health not being viewed as a public safety entity
3. Population growth (more people, more disease, more public health threats) and globalization (threats are only a plane ride away)

Employees

17 General Fund FTEs

14 Grant FTEs

Budget

$1,658,552

Future Budget Drivers

- Population Growth
- Emerging Disease Threats
- Need for Public Health Personnel

Benefits of Service

Disease surveillance, preparedness and response to emerging infectious diseases, and bioterrorism.

- Preparing a coordinated response for the early detection of bioterrorism agents.
- High consequence infectious disease preparedness activities (Ebola)
- Zika virus disease and mosquito surveillance, preparedness and response
- OVR produces legal birth and death certificates. Many federal, state, and local agencies rely on birth certificates for proof of age, proof of citizenship, identification for employment purposes, to issue benefits or other documents (e.g. driver licenses, Social Security cards and passports) and to assist in determining eligibility for public programs or benefits.
- A death certificate is one of the most important documents a family needs to settle affairs of their loved one. The death certificate is the official, legal record of death and includes information about the person who died and the cause of death. Insurance companies, the Social Security Administration, and other federal and state agencies need the death certificate as proof of death.
- Social Service response and case management of displaced residents following a natural disaster (flooding, wildfire, extreme weather)

Other

The Office of Vital Records received the 2016 Five Star Award for Local Registration for the 15th from the Texas Department of State Health Services. The award recognizes partners who go above and beyond their duties in timeliness, document management, information systems, and training.

Policy Issues

As a statutorily mandated function, the Office of Vital Records is regulated by several state laws and state guidelines that we must remain knowledgeable of and ensure that the staff is properly trained and compliant with in daily operations. Governing regulations include the Texas Health and Safety Code, Texas Administrative Code, Texas Family Code, Texas Code of Criminal Procedure, Local Government Code, and Texas Election Code.

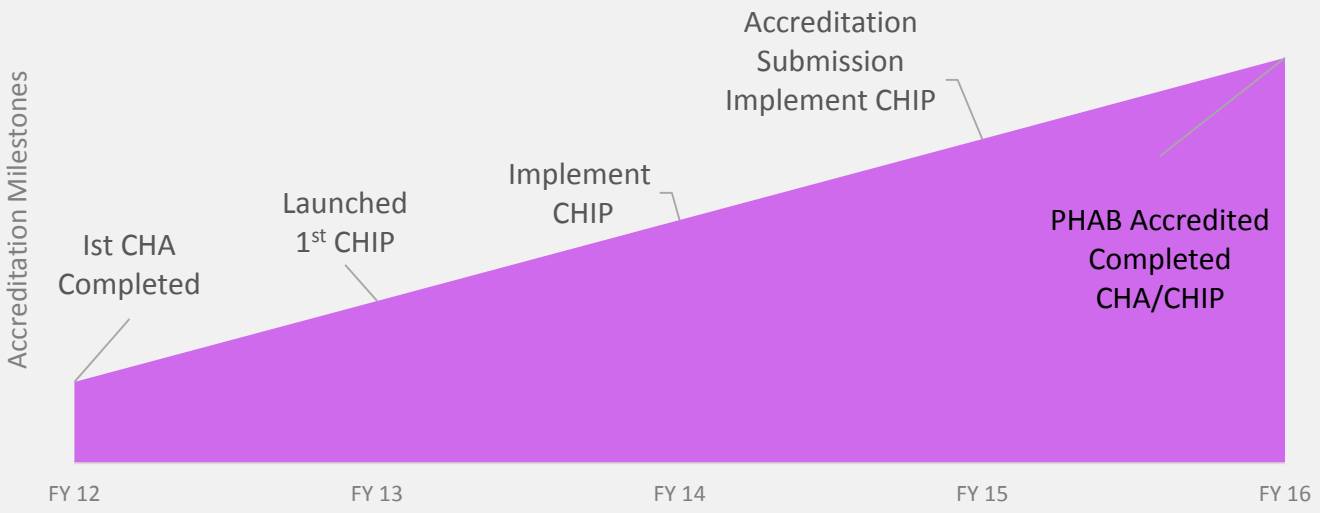
Community Engagement

Austin Public Health (APH) is a nationally accredited public health department. The five-year Community Health Assessment (CHA) and subsequent Community Health Improvement Plan (CHIP) are required for APH to maintain accreditation. This is a collaborative process that engages the community at every level to ensure all voices are involved in identifying and addressing the most pressing health concerns throughout Austin/Travis County.

Key Outcome

Achieve/Maintain Public Health Accreditation

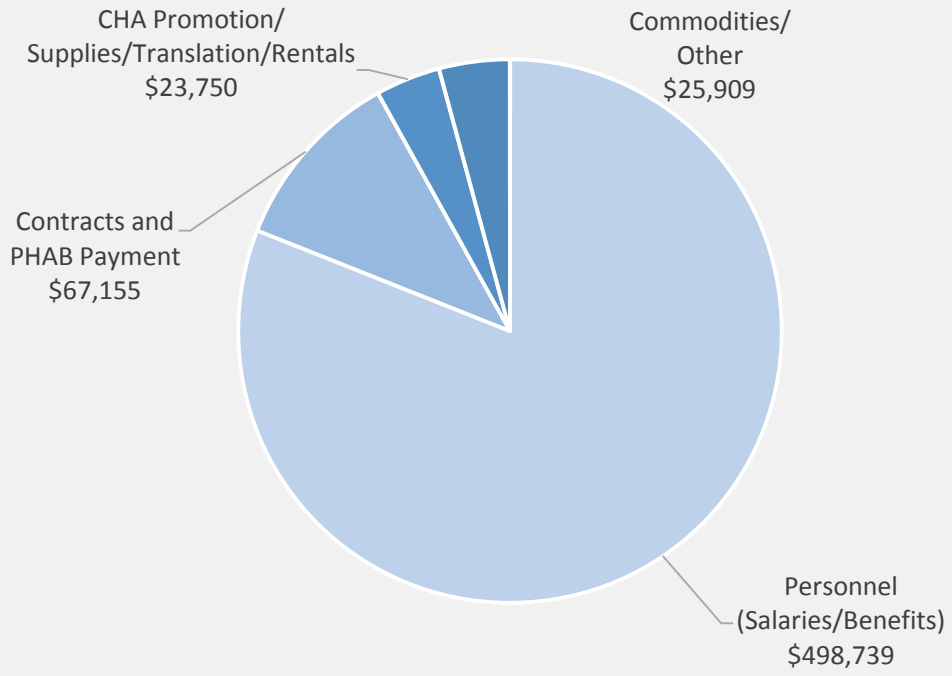
CHA/CHIP Engagement Requirements



CHA/CHIP Priorities Identified as Very Important by Community Stakeholders Survey Source: University of Texas School of Public Health	
Access to Healthy Food	83.1%
Access to Primary Health Care Services	83.1%
Access to Mental Health Services	85.9%
Access to Transportation	73.9%
Obesity	87.7%

Significant Contracts	
Professional Services Consultant for Community Health Assessment	$45,000

Breakdown of Community Engagement



Customers

The community engagement process through CHA/CHIP is a collaborative and inclusive process led by 10 organizations, including:

- Austin Public Health
- Travis County Health and Human Services and Veteran Services
- Capital Metro
- Central Health
- Seton Healthcare Family
- St. David's Foundation
- Integral Care
- Austin Transportation Department
- UT Dell Medical School
- UT School of Public Health

The process works to engage a wide network of partners and community stakeholders that support the health goals set forth in the CHIP. At the end of the first iteration **393** individuals were participating in implementation.

The community is continuously engaged in the process through:

✓Community Forums
✓Focus Groups
✓Key Informant Interviews
✓Community Surveys

Strategic Outcome Alignment

The Community Engagement activity aligns with the Health and Government that Works strategic outcomes. This program advances both strategic outcomes by developing coordinated and collaborative public health and social service strategies with community-based organizations and key stakeholders, including a community-wide Comprehensive Health Improvement Plan (CHIP).

Services

- ✓ Conduct 5-year community health assessment
- ✓ Implement community health improvement plan
- ✓ On-going partner engagement
- ✓ On-going community engagement

Budget

$615,553

Future Budget Drivers

- High reliance on long-term temporary personnel
- Community Based Contracts: Funding to support CHIP priorities

Employees

14 General Fund FTEs

10 Grant FTEs

Benefits of Service

- Sets forth a vision for a Healthy Austin
- Strategic alignment with key community partners
- Shared benefit of resources committed to agreed upon health outcomes
- Provides a community forum to discuss health
- Increased community buy-in for health initiatives
- Recognized as a national and state leader for public health practices

Other

Austin Public Health is the convener of the CHA/CHIP process. The CHA/CHIP has been accepted at the City and County level by City Council and Commissioners' Court, respectively. In addition to meeting PHAB Accreditation requirements, this process assists the hospital systems with meeting IRS mandates for community health needs assessments. Public Health Accreditation is a five year cycle with annual reviews on implemented practices that meet or exceed national standards. APH will apply in 2021 to achieve reaccreditation within that year.

Top Challenges

1. Ongoing need to assess health status and adjusting accordingly
2. Increase community awareness/interest in participating

Alignment with Strategic Plans

The CHIP is in alignment with Imagine Austin. Teams for both CHIP and Imagine Austin report measures to each other in order to satisfy performance management requirements.

Areas for Improvement

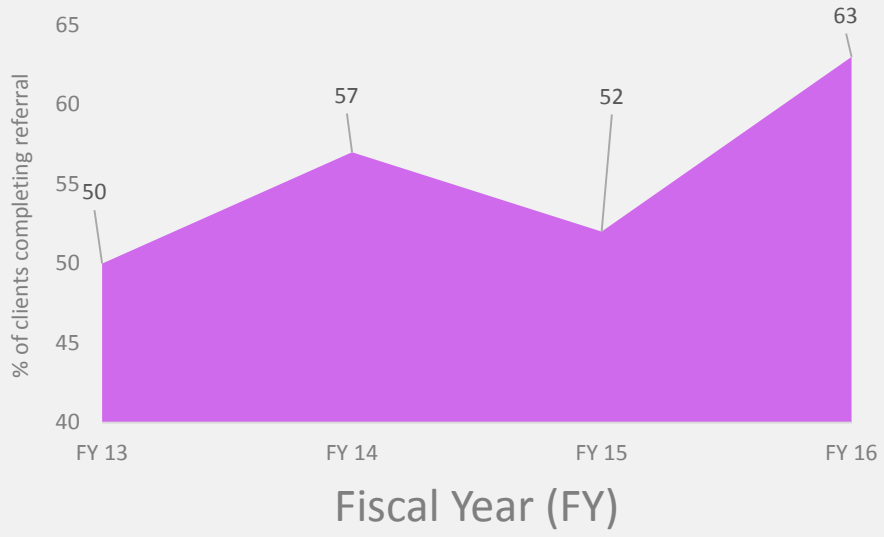
Austin Public Health is working toward evolving and improving community engagement processes. Public Health Accreditation provides national standards to ensure processes and capacity. Additionally, an evaluation of the 1st CHA/CHIP iteration has been conducted. The evaluation findings have been integrated into the 2nd CHA process which launched in January 2017. The evaluation findings will be considered during each phase of the CHA/CHIP process to ensure appropriate adjustments are made.

Quality of Life Program

The Quality of Life Program provides targeted, community based interventions including health screenings, health education and wellness activities to improve quality of life to reduce the years of potential life lost due to preventable chronic disease.

Key Outcome

Percent of Quality of Life clients who followed through with referral to health care or community resource



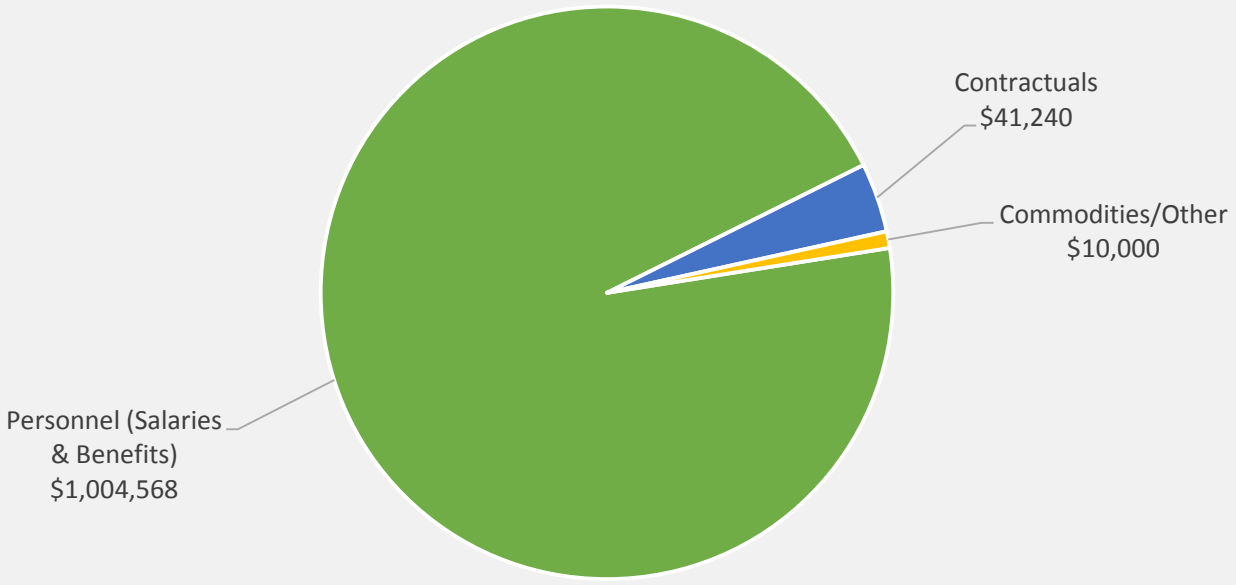
Clients with out of range conditions who sought follow up care/services

1,593

26% From FY13

Activity Statistics	
Number of Clients served by the Quality of Life Preventive Team	2,528
Number of units of preventative health services provided by QOL Team	3,677
Number of job fairs developed in underserved areas	6

Breakdown of Quality of Life Program Budget



Customers

- African American, Hispanic, and Asian residents
- Low income residents
- Underinsured residents
- Faith based organizations
- Community based organizations
- Schools/Colleges/Universities

Strategic Outcome Alignment

The Quality of Life Program aligns with the Health strategic outcome. This program advances Health by addressing social determinants of health to ensure that all residents have full and equal access to opportunities that allow them to lead healthy lives.

Benefits of Service

- Fewer trips to the E.R. in lieu of routine care
- Decreased cost of health care over life span
- Reduction of health disparities among vulnerable populations
- Improvement in overall health of Austin's residents

Budget

$1,055,808

Future Budget Drivers

- Diversification of population
- Effects of gentrification
- Limited options for Health insurance

Employees

9 General Fund FTEs

Top 3 Challenges

1. Growing diversity – meeting demands with translation services
2. The need to diversify the workforce
3. Trickle down effect of changes to or the repeal of the Affordable Care Act

Services

- ✓ Health Screenings
- ✓ Health Education
- ✓ Referrals to care/community resources
- ✓ Employment support
- ✓ HIV/STI Testing and education

Alignment with Strategic Plans

The Quality of Life Program aligns with Imagine Austin's Priority goal 7: Create a Healthy Austin by working to reduce chronic disease and risk factors for chronic disease. Quality of Life Programs also support the Department's stated mission to prevent disease, promote health and protect the well being of our community. It also supports the following Business Plan goals:

- Improve Quality of Life to Reduce the Years of Potential Life Lost due to Preventable Chronic Diseases.
- Assist People in Achieving Stability and Self-Sufficiency

Areas for Improvement

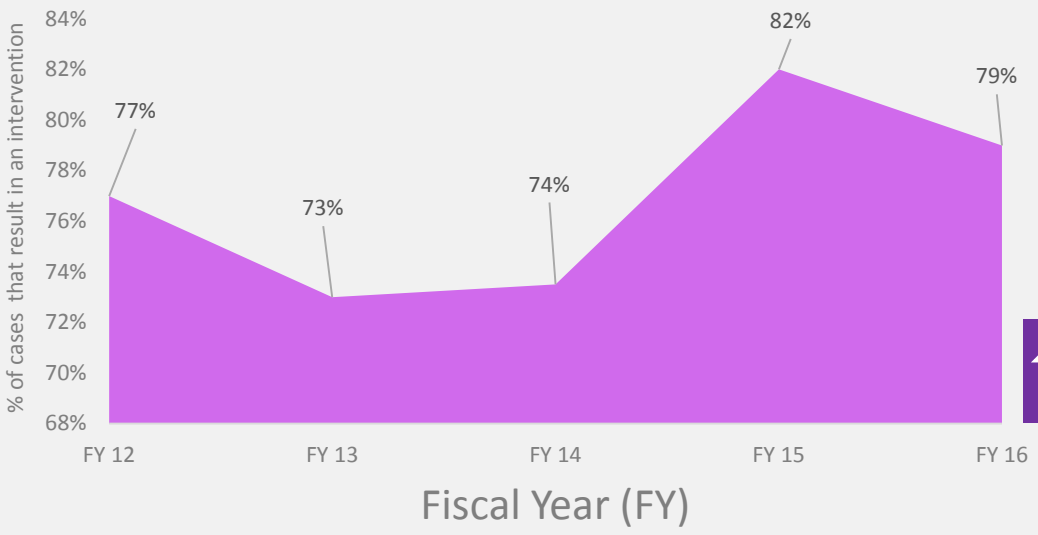
- Improve the quality of services by expanding prevention team to include an additional registered nurse position, as well as a social worker position to assist with follow up and linkages to care
- Employ Community Health Worker model to support behavior change in target communities

Public Health Emergency Preparedness

Public health emergency response capability allows Austin Public Health to plan, train and effectively respond to a range of public health threats, including infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological events. APH also supports public safety activities in the areas of biosurveillance, intelligence and ensuring first responder safety and health.

Key Outcome

Percent of cases investigated that result in a disease intervention



Number of Cases Investigated by Epidemiology and Disease Surveillance

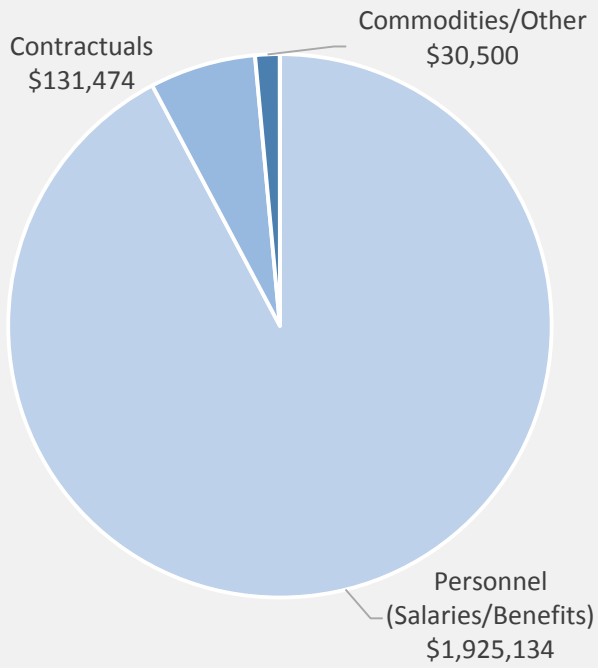
1,681

2.5% From FY12

Activity Statistics

Percentage of Emergency Response Plans reviewed and/or developed	100%
Number of air samples collected and tested for biologic agents	4,380
Number of infectious disease reported that result in an intervention strategy	1,681

Breakdown of Public Health Emergency Preparedness Budget



Customers

- Residents of Austin and Travis County
- Visitors of Austin and Travis County
- Public Safety
- Healthcare
- Emergency Management

Services

- ✓ Conduct All- Hazard Emergency Preparedness Response Planning and Response including the development of plans for pandemic and emerging infectious disease, natural disasters, and biological, chemical, and radiological incidents
- ✓ Develop a plan and exercise the distribution of life-saving medical countermeasure for the Austin Metropolitan area
- ✓ Early event detection of bioterrorism using air monitoring and biosurveillance
- ✓ Core Public Health and Social Service response following natural disasters and other incidents

Strategic Outcome Alignment

The Public Health Preparedness activity aligns with the Health strategic outcome. This program advances Health by providing an emergency response capability to prevent and protect the community from public health threats.

Benefits of Service

- Prepare, plan and respond to public health threats including natural and man-made disasters, disease pandemics and emerging infectious diseases, infectious disease outbreaks, and bioterrorism
- Preparing a coordinated response for the early detection of bioterrorism agents.
- High consequence infectious disease preparedness activities (Ebola)
- Zika virus disease and mosquito surveillance, preparedness and response
- Social Service response and case management of displaced residents following a natural disaster (flooding, wildfire, extreme weather)

Budget

$2,087,108

Future Budget Drivers

- Population Growth
- Emerging Disease Threats
- Need for Public Health Personnel

Employees

1 General Fund FTE

10 Grant FTEs

Top 3 Challenges

1. Reliance on state and federal funds to support activities (90% grant funded)
2. Public health not being viewed as a public safety entity
3. Population growth (more people, more disease, more public health threats) and globalization (threats are only a plane ride away)