PROGRAM WORK STATEMENT

FY 2017 Social Service Contract funded by Travis County Date prepared: 06/25/2016

Instructions:
- Answer the following questions as they pertain to *only those programs and services in which Travis County invests*.
- Ensure that all language (e.g. agency and program names, performance measures, etc.) is consistent across all contract forms.
- Do not delete any instructions or question descriptions.
- The information contained in this document will be used to report on your program to the Travis County Commissioners Court and the public, so the information herein should accurately explain and reflect the program and services.

1. Program Information

Provide agency name and program name as they appear on all contract documents.

Agency name: Austin/Travis County Health and Human Services Department

Program name: Quality of Life (QOL) Programs

2. Program Goals

Briefly describe the goals of the services purchased by Travis County in this contract.

The goal of Quality of Life Programs is to reduce health disparities in vulnerable populations through implementation of strategies being employed both regionally and nationally to address health disparities. These best and promising practices are:

- Culturally and linguistically appropriate
- Community based in order to maximize family and social supports
- Holistic in nature, addressing basic needs and other barriers to care

Quality of Life Programs will provide community-based prevention, education, health promotion and referral services in community settings through the mobile health van program and participation in community events and health fairs. Activities will not only increase personal awareness of individual health status, but provide resources, tools, information and referral to primary care and other support services to support healthy living.

3. Target Population

Briefly describe the target population of this program.

The target population of Quality of Life Programs are Blacks, Hispanics, and Asians living in Austin and Travis County.

According to the American Public Health Association (APHA), health disparities are differences in health status between people related to social or demographic factors such as race, gender, income or geographic region. In Austin and Travis County, data demonstrates citizens of color – Asians, Hispanics, and Blacks experience disparate health outcomes. According to data presented in the Austin/Travis County 2015 Critical Health Indicators Report:

- Black Americans have disproportionately higher rates of HIV and other sexually transmitted diseases and are more likely to die from HIV than other groups.
- The infant mortality rate for Blacks was two to three times higher compared to Whites, and babies born to Black mothers are more likely to be premature and have low birth weight.

- Blacks have a higher prevalence of cardiovascular disease than Whites and Hispanics, but both Blacks and Hispanics have higher rates of diabetes than Whites

Results from a survey of Austin/Travis county's Asian residents, conducted by Dr. Jang from the School of Social Work at the University Of Texas, Austin revealed the following needs:

- Improved access to medical services
- Improved mental health services:
    - Educational intervention on mental health literacy
    - Stigma reduction
    - Mental health counseling services

National data and research also show Asian Americans are at significantly higher risk for type 2 diabetes at younger ages and lower weights.

4. Client Eligibility

List all eligibility requirements for clients to receive services in the program, and fully describe the criteria for each requirement (see Sample Table below for examples). If eligibility requirements vary by program component, please specify in the descriptions. If your contracted program includes multiple service components with varying eligibility criteria, you may copy/paste the table below, complete one table per component, and title each table accordingly.

Sample Table:

Eligibility Requirement	Description of Criteria	Verification Method
Income level	*At least one-half of clients must be at or below 100% FPIG. Remainder can be up to 200% FPIG.*	*Income level is self-declared based on HUD 24th Code of Federal Regulations, part 5.*
Residency	*Clients must be residents of the five county area: Travis, Williamson, Hayes, Bastrop, Caldwell.*	*Residency verified by utility bill, lease or rental agreement, or government-issued photo identification.*

Program Component (if applicable): N/A

Due to the nature of our services, there are no eligibility requirements nor are clients asked to verify any identifying information provided. All services are offered free of charge. While the target population is Blacks, Hispanics, and Asians living in Travis County, services will be available to all. Youth under 18 years of age need parental consent for screening services.

5. Service Delivery

Describe the services and how they are provided through the program. This should be a clear and concise summary of how clients move from initial contact through exit and follow-up. Include all relevant components of the core services, such as:

- *Outreach*
- *Intake*
- *Eligibility determination process*
- *Service provision*
- *Duration of services*
- *Termination or discharge*
- *Coordination with and referral to/from other agencies*
- *If applicable, brief description of research or promising practice on which program is based*
- *Any other relevant components of service delivery for this program*

Through community-based interventions, the Quality of Life program seeks to reduce specific health disparities in vulnerable populations:

- Rates of death and disease due to chronic illnesses (i.e. cancer, diabetes, heart disease)
- Rates of HIV/STI
- Access to Mental Health services
- Improved birth outcomes

The Quality of Life prevention team uses a three-pronged approach in service delivery: Preventive services, Public Health Education and Promotion; and community Engagement.

Preventive Services:

Preventive services are routine screenings and patient counseling to prevent illness, disease and other health-related problems. These screenings are the key components of the Mobile Van program.

Using the latest demographic data, zip codes with a high concentration of residents meeting target demographic are identified. Outreach staff then approach local businesses, resident associations, churches, etc., to establish sites for mobile outreach. Examples of current sites include HEB Springdale, J.C. Conoco on Airport Boulevard, and Texas Work Source. A monthly calendar of outreach locations is created and posted on the Health and Human Services website. Information about upcoming outreach activities is also given to Austin 311, and announced weekly during "Health Talk" radio show. Event flyers are distributed through local community centers, neighborhood centers, businesses and various schools within Austin Independent and Delvalle Independent school districts.

During outreach activities, clients can enter the mobile van and receive the following screening services:

- Blood pressure check
- Blood sugar check
- Cholesterol check
- HIV/STI testing
- Pregnancy
- Mental health screening (offered in partnership with Dell medical school).

All screenings are performed by or under supervision of a registered Nurse. Mental Health screenings are performed by Dell medical students using an online tool "MyM3." HIV/STI screenings are performed by a trained specialist.

Clients that present with out-of-range conditions or with a positive pregnancy test are referred to on-site nurse for further consultation and assessment. During the evaluation, the nurse will give important medical information about screening results, and instructions for follow up whether it be to a primary care physician or other community resources – diabetes management classes, fitness classes, health insurance providers, or other basic need services.

Clients that test positive for HIV or STI receive on-the-spot counseling and referral to care services. Similarly, clients at risk for mental illness are referred to community resources.

The registered nurse follows up with all clients receiving a referral to answer questions and to provide additional support to increase likelihood of client following through on referral.

Public Health Education and Promotion:

Health promotion is the development of individual, group, institutional, community and systemic strategies to improve health knowledge, attitudes, skills and behavior.

The purpose of health promotion is to positively influence the health behavior of individuals and communities as well as the living and working conditions that influence their health.

- Health promotion improves the health status of individuals, families, communities, states, and the nation.
- Health promotion enhances the quality of life for all people.
- Health promotion reduces premature deaths.
- By focusing on prevention, health promotion reduces the costs (both financial and human) of medical treatment.

Using the same demographic data to identify target locations, the Quality of Life Program offers community-based health education and health promotion activities. Some examples include, but are not limited to:

- Community needs assessments
- Exercise classes
- Prevention and education classes on relevant health issues:
    - Diabetes
    - High Blood pressure
    - Heart Disease
    - Cancer
    - HIV/AIDS
    - Sexually Transmitted Infections
    - Maternal Health
- Mass media campaigns
    - Partnership with 96.3 RNB
    - Weekly "Health Talk" radio show on KAZI
    - Community newspapers- El Mundo, Nokoa and the Villager
    - Guest appearances on "Radio Mujer"
- Community health fairs/events
    - Annual Take A Loved One For A Check UP
    - Annual Healthy Baby Health Mom
    - Annual Airport Transportation Drivers Health Fair

<u>Community Engagement:</u>

Community engagement can be defined as a planned process with the specific purpose of working with identified groups of people, whether they are connected by geographic location, special interest, or affiliation or identify to address issues affecting their well-being.

The Quality of Life Program works with community residents, faith-based organizations and community-based organizations in the creation and implementation of strategies to address health disparities in community. Current activities include:

- The Black Health and Wellness Coalition: QOL program provides technical assistance and information to facilitate formation and ongoing activities of a coalition of community residents and key stakeholders to focus on root causes of health disparities affecting the Black Community. The coalition meets monthly to discuss relevant health and social issues, and to develop strategies to further the work of the Health Department and other agencies at a grass-roots level.
- Faith-based Initiative: provides technical assistance and support to churches interested in starting an active health ministry, hosting a health fair, or implementing other health programs and activities at the church.
- Health and Wellness Consortium: Monthly resource sharing and networking for organizations providing health-related services and information to target population.

6. Service Accessibility

Describe any relevant strategies employed by the program to ensure service access related to the following issues:

- *Cultural competence*
- *Language and communication access*
- *Geographical access*
- *Anti-discrimination strategies*
- *Other accessibility issues relevant to the program*

The program strives to adhere to the principal standard of the National Standards for Culturally Linguistically Appropriate Services in Health and Health care – to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

In 2015, the Austin Travis County Health and Human Services Department implemented the Culturally and Linguistic Appropriate Materials (CLAMS) policy. The policy provides staff with information on guidelines and best practices in adherence with national and Public Health Accreditation standards to ensure that all health information provided to the public is current, accurate, culturally sensitive and linguistically appropriate to for the population served.

- A staff person has been assigned Single Point of Contact (SPOC) for ensuring that all outreach materials meet guidelines outlined in the policy.
- QOL staff now have access to Voiance interpreter services when providing mobile screening services

In accordance to CLAMS standards, the program seeks to recruit and retain program staff that are culturally and linguistically diverse, and demonstrate experience working with target populations. Staff will receive ongoing training and support in culturally and linguistically appropriate policies and practices.

The Quality of Life Programs Mobile Van program helps to eliminate barriers to care due to lack of transportation and geographical access. Outreach sites are determined by demographic data, but are also determined by assessing available resources. Neighborhoods without access to clinics, hospitals or other health and wellness resources are targeted for outreach efforts.

All services are provided free of charge, regardless of race, ethnicity, social position or socioeconomic status.

7. Program Staffing

List the staff positions (titles only, no individual names) that are essential to this program, and provide a brief description of duties as they relate to this program. If there are multiple staff positions with the same title and duties, you can note the number of positions with the position title, e.g. "Case Manager (5)."

Position Title	Description of Duties
Registered Nurse Senior	Performs preventive screenings, supervises non licensed personnel performing screenings, makes referrals to community resources, follow up with high-risk clients
Community Worker	Outreach, point person for mobile van operations, assists with screening and education activities
Public Health Educator	Provides health education activities in community settings, assists with providing preventive screenings
Neighborhood Liaison	Coordinates supportive activities and resources, i.e. job fairs, assists with providing screening services, language translations
Public Health Program Specialist	Provides HIV/STI testing, education, counseling and referral services in community settings
Program Coordinator (2)	Responsible coordination of community resources, community organizing and educations, program development, provide screening services
Program Manager	General management and oversight of program, staff supervision, reporting, fiscal management, and other administrative tasks.

(If program has additional staff positions, insert additional rows in table. Please delete empty rows.)

8. Program Evaluation

a) Information Management and Data Collection

- *Describe the **tools and processes** used to collect program data, and the **systems** used to manage program data (i.e. client data, service information, or other data relevant to the program's overall service delivery and performance).*
- *If any surveys are used to collect information used in performance reporting, please provide a description of survey procedures (such as when, how, and by/to whom the survey is distributed, received, completed, and returned) and a copy of the most recent survey as an addendum.*

Data collection process for Preventive Screenings:

Type of data collected includes:

- Gender
- Ethnicity
- Unit of service (count)
- Referrals (count)
- Survey (count)
- Protected health information/screening results – (i.e. blood pressure reading)

1. Screening sheets are used to record date, screening location, client demographics and screening results.

2. Referral forms capture detailed contact data, screening results, and type of referral made to client with an out-of-range condition
3. Information from screening sheets – gender, ethnicity, unit of service count are entered into excel data base which tabulates, daily, monthly, quarterly, and annual totals of clients served, units of service, referrals, and completed surveys.
4. Separate excel spreadsheet counts number of referrals made, number of completed referrals, and any reported outcomes (i.e. patient is now on medication)
5. Staff person providing screening services ask clients to complete a short survey at the completion of screening. Survey assesses level of customer service and client's awareness of personal health status as a result of receiving screening. All of the surveys completed are entered into excel spreadsheet. The number of clients reporting improved awareness of personal health status is tabulated by hand.

b) Performance Evaluation

Describe how the agency uses the data it collects to evaluate both programmatic effectiveness (as described in questions 2 and 5 of this work statement) and progress towards performance goals (as described in 9 and 10 of this work statement).

Data collected is used to track program outputs and outcomes. From data collected the following is continually assessed:

1. Number of clients served - is the program increasing awareness of importance of screenings?
2. Communities in which services are being offered – is the program effectively targeting City/County areas with high morbidity and mortality?
3. Impact of services on client behavior – i.e., are clients becoming medication compliant, completing referrals to primary care or other community resources as a result of receiving QOL services?

c) Quality Improvement

Describe how the agency uses its evaluation results to: identify problems or areas for improvement in service delivery; design strategies to address these problems; implement those strategies; and follow up to ensure corrective actions have been effective.

HHSD has three levels of quality assurance:

1. Unit level: The services and programs delivered by the unit are reviewed by staff and program manager quarterly. The review includes staff performance, performance measures, and recommendations for addressing any problems uncovered.
2. Division level: Mobile health van statistics are reviewed by the Health Equity Unit manager. In addition, the program results are reviewed every six months by division management.
3. Department level: The department has an ongoing quality improvement committee that meets monthly to discuss and offer recommendations to resolve operational and service delivery issues. In addition, HHSD's internal auditor regularly reviews program operations and results to identify risks and make recommendations to reduce or eliminate them.

9. Output Performance Measures

Enter the output performance measures to be reported for the program in quarterly performance reports. You must report the number of unduplicated clients served and at least one other output. Total annual goals should be 12-month goals. Outputs should be reported quarterly unless a specific programmatic or data-driven limitation exists. Please use the comments section to specify and provide explanation for any reporting exceptions.

Output Measure	Total Annual Goal	Quarters Reported

1. Number of clients served	4500	1,2,3,4
2. Number of units of preventative health service	6000	1,2,3,4

(If approved for additional Output measures, insert additional rows in table. Please delete empty rows.)

Comments (for reporting exceptions, if applicable): The Mobile Van program does not report the number of unduplicated clients served, due to the anonymous nature of the program. Clients are seen in community settings and not asked to provide any other personal identification information beyond their name and zip code of residence. Asking clients to provide such information in an outreach setting may be an unintentional barrier to care.

10. Outcome Performance Measures

Enter the outcome performance measures (numerators, denominators, and outcome rates) to be reported for the program in quarterly performance reports. Total annual goals should be 12-month goals. Outcomes should be reported quarterly unless a specific programmatic or data-driven limitation exists. Please use the comments section to specify and provide explanation for any reporting exceptions.

	Outcome Measure		Total Annual Goal	Quarters Reported
1.	a. Number of clients who report improved awareness of health status resulting from QOL Prevention Team initiative	(numerator)	1710	1,2,3,4
	b. Total number of Mobile van clients who complete a survey	(denominator)	1800	
	c. Percentage of clients that report improved awareness of health status resulting from QOL prevention team initiative	(rate)	95%	
2.	a. Number of clients who followed through with referrals to healthcare provider or community resource	(numerator)	43	1,2,3,4
	b. Total number of referred clients successfully contacted by nurse	(denominator)	50	
	c. Percentage of clients who followed through with referrals to healthcare provider or community resource	(rate)	85%	

(If approved for additional outcome measures, insert additional rows in table. Please delete empty rows.)

Comments (for reporting exceptions, if applicable):

11. Community Planning

a) Community Planning Group Participation

If the agency participates in any community planning groups relevant to the issue area and services under this contract, please list them here, along with the name and title of agency representatives who participate and a brief description of their role and participation in that planning group.

Community Planning Group	Agency Participant Name/Title	Participation Role/Description
Healthy Texas Baby Steering Committee	Adrienne Sturrup/Program Manager	Planning
Black Health and Wellness	Sam Price/Program Coordinator	Technical Assistance

Coalition		
National Forum Cholesterol Awareness Initiative	Darrell Barnett/Public Health Educator	Planning
Restore Rundberg	Adrienne Sturrup/Program Manager & Herman Gentry/Community Worker	Health subcommittee
Central Texas African American Family Support Conference	Adrienne Sturrup/Program Manager	Conference planning/sustainability committee

(If agency is involved in additional planning groups, insert additional rows in table. Please delete empty rows.)

b) Community Plan

If the agency aligns itself with a Community Plan, provide the name of the plan and its authoring body, and a brief description of how you align your agency with and respond to the plan's shared community goals. If there is not an established community plan in this issue area, describe what the agency uses to orient itself to community needs and goals.

The Community Health Improvement Plan (CHIP) is based on a wide-ranging Community Health Assessment (CHA) of which Travis County HHSVS and many other community partners helped craft.

The following health priorities identified in the CHA reflect Quality of Life Program goals:

1. Chronic disease and related conditions
2. Access to primary care
3. Mental health – particularly access to care, and addressing to stigma.

c) Response to Community Change

Have there been, or do you anticipate, any changes to the community plan or community goals, that will impact how you provide services over the remainder of your contract period?

The Quality of Life Programs have responded to community needs and relevant health data by expanding scope of services to include HIV/STI, mental illness, and birth outcomes; as well as to expand target population to include other vulnerable groups.

Increased funding from the County will support this expansion of services by allowing for an additional outreach team comprised of a Community Worker, Registered Nurse, Social Worker, and Public Health Educator. The team will provide targeted education and screening services in Del Valle, Manor, Pflugerville, and Jonestown. In the first year, we estimate that an additional 2000 county residents will be served through this expanded effort. It is estimated that it may take 4 -6 months to see increased productivity. This will be dictated by when additional positions are approved by Council and entered into budget. From that point, the hiring process usually takes an additional 3 months from posting to start date.

Proposed services include:
HIV/STI testing and counseling
Blood Pressure Screening
Glucose Screening
Cholesterol screening

Pregnancy Testing
Health and Wellness activities
Prevention education (i.e., High Blood Pressure, Diabetes, HIV)

In addition to staffing support, additional funds for medical and educational supplies and other program support is being requested.