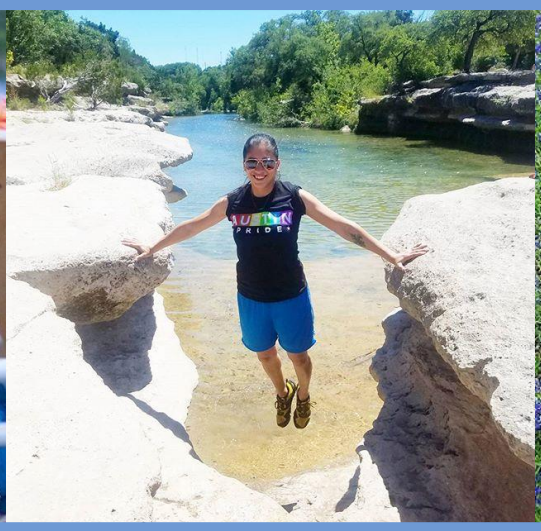
2018 Community Health Plan

Austin/Travis County, Texas

Year 3 Action Plan

March 2021


Together We Thrive

Austin/Travis County Community Health Plan

Austin/Travis County
2018 Community Health Plan
Year 3 Action Plan

Introduction

Welcome to the Austin/Travis County Community Health Plan (aka CHA/CHIP) organized 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/CHP 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 assessment phase, partners work together to implement an Improvement Plan to determine major health priorities, overarching goals, specific objectives, and actionable strategies to implement in a coordinated way across Austin/Travis County. This plan 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 3 Action Planning for Implementation

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

The Austin/Travis County Community Health Plan partners, including core agencies, workgroups members, stakeholders, and community residents, continued implementation of the 2018 Community Health Plan by prioritizing strategies for Year 3 (Y3), developing specific action steps, assigning lead responsible parties, and identifying resources for each priority area during the Year 3 Action Planning Sessions held in February and March of 2021. These components form the Year 3 Action Plan for the detailed in the following document. We encourage partners to continue to engage by joining one our four workgroups addressing Y3 strategies. As we know time is valuable, workgroup meetings are kept to a minimum, however community engagement is essential to assure fulfillment of the plan's 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

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Year 3 Community Health Plan Implementation - Leadership

Community Health Plan Steering Committee

Deborah Britton	*Chief Deputy,* Travis County HHS
Monica Crowley	*VP, Chief Strategy & Planning Officer,* Central Health
Sherri Fleming	*County Executive,* Travis County HHS
Stephanie Hayden (Chair)	*Director,* Austin Public Health
Julie Mazur - Interim	*Regional Coordination Planner,* CapMetro
Lawrence Lyman	*Director of Research and Planning,* Travis County
Becky Pastner	*Vice President of Evaluation and Strategic Learning,* St. David's Foundation
Ann Marie Price	*Director of Community Affairs,* Baylor Scott & White
Ellen V. Richards	*Chief Strategy Officer,* Integral Care
Rob Spillar	*Director,* Austin Transportation Dept.
Dr. Andrew Springer	*Associate Professor of Health Promotion and Behavioral Sciences,* UT School of Public Health
Ingrid Taylor	*Community Benefit Director,* Ascension Seton
Dr. Carmen Valdez	*Director, Community-Driven Initiatives,* UT Dell Medical School

Community Health Plan Core Committee

Ana Lidia Almaguel	*Planning Project Manager,* Travis County HHS
Amy Brandes	*Manager of Community Benefit,* Ascension Seton
Megan Cermak	*Interim Director of Public Health Strategy, Policy, and Disaster Response,* Central Health
Liane Conte	*Planning & Policy Program Manager,* Austin Transportation Dept.
Hailey de Anda (Chair)	*Interim Planning and Evaluation Manager,* Austin Public Health
Marianna Espinoza	*Learning & Evaluation Manager,* UT Dell Medical School
Kacey Hanson	*Program Manager,* UT Dell Medical School
Muna Javaid	*Senior Planner,* Integral Care
Kelli Lovelace	*Community Benefit Coordinator,* Ascension Seton
April Klein	*Research & Planning Division Planner,* Travis County HHS
Julie Mazur	*Regional Coordination Planner,* CapMetro
Jesse Simmons	*Senior Evaluation Officer,* St. David's Foundation
Tara Stafford	*System Director for Community Health,* Baylor Scott & White

Community Health Plan Priority Area Chairs

The 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 1: Access to and Affordability of Health Care

Liane Conte	*Planning & Policy Program Manager*, Austin Dept. of Transportation
Hilario Covarrubias - Interim	*Health Management Liaison*, Central Health
Vanessa Sweet	*Strategy Manager*, Central Health

Priority Area 2: Chronic Disease

Maggie Amaku	*Community Programs Manager*, It's Time Texas
Ashely Bischoff	*Chronic Disease & Injury Prevention Program Coordinator*, Austin Public Health
Jill Habegger-Cain	*Recreation Program Coordinator*, Austin Parks and Recreation Dept.

Priority Area 3: Sexual Health

Arlene Cornejo	*Austin Healthy Adolescent Program Coordinator*, Austin Public Health
Joanna Saucedo	*Case Investigator*, Austin Public Health

Priority Area 4: Stress, Mental Health, and Wellbeing

Laura Enderle	*Social Services Unit Planner*, Austin Public Health
Kacey Hanson	*Program Manager*, UT Dell Medical School

Year 3 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 3 Objectives	**Year 3 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 3 Objectives	**Year 3 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.
	2.1.2 Engage community leaders to design and conduct a media and marketing campaign that promotes and supports existing organizations and health resources (e.g., fitness class, nutrition, gardening classes, podcast programs, tobacco cessation resources, mobile health tools education and tracking). (See also Strategy 2.4.3)
	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.
	2.1.5 Identify barriers to health by screening in clinics for non-healthcare related social determinants of health, and partner with community-based organizations and elected officials to utilize this aggregated data to affect neighborhood-level changes.
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.	2.2.3 Implement web-based home education and home testing to overcome barriers to access (e.g., home test kits, diagnostic surveys, online monitoring).
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.	2.5.3 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 3 Objectives	**Year 3 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.
	3.1.5 Promote support programs that provide culturally and linguistically appropriate resources for families.
	3.1.6 Advocate for a bill(s)/ bill that would allow adolescents to consent to their own reproductive healthcare if they have a child already.
	3.1.7 Advocate for '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, reduce barriers to youth seeking same-day appointments, and are trained to provide culturally appropriate contraceptive services. (See also Strategy 3.2.4).
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. (See also Objectives 2.2 and 2.3)
	3.2.4 Advocate for 'Youth 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 sexual healthcare services not provided through ISD campuses. (See also Strategy 3.1.4)
	3.3.3 Implement mentoring or skill-based activities that help educate youth regarding healthy relationships, and address social norms and healthy choices.
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.).
	3.4.5 Promote technologies and best practices available to increase youth access to programs, services and information. (See also Strategy 3.1.10)

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 3 Objectives	**Year 3 Strategies**
Objective 4.1 By 2023, decrease by 10% the incidence of excessive drinking and other substance use disorders among Travis County residents.	4.1.2: Identify or develop and implement a community awareness initiative to decrease binge drinking and substance use disorder for pre-identified at-risk populations (include age appropriate messaging for multimedia campaign, Outreach in community-based settings with Community Health worker (see also Objectives 1.1 and 2.1) and Substance Use Disorder (SUD) specialists).
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.
Objective 4.3 By 2023, increase by 10% the proportion of adults aged 18 and up in Austin Travis County who receive mental health/substance use disorder services, 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.
	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.

Priority Area 1: Access to and Affordability of Health Care

Access to Care Partner Organizations

Alzheimer's Association
American Heart Association
Ascension Seton
Austin Asian Community Health Initiative (AACHI)
Austin Public Health
Austin Transportation Dept.
Capital Area Council of Governments (CAPCOG)
Capital Metro
Cardea
Central Health
Children's Optimal Health
CommUnity Care
El Buen Samaritano
Light and Salt Services
Meals on Wheels Central Texas
Project Access Austin
St. David's Foundation
Travis County HHS
UT Dell Medical School

Year 3 Action Plan

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, Y3)**
Action Steps	
a.	Conduct cost analysis of CHW employment; *see 1.1.4*
b.	Track progress of CHW legislation in 2021. Individual organizations will submit recommendations as appropriate. https://legiscan.com/TX/text/SB136/2021
c.	Create a platform for information sharing, education, and awareness of CHW employment (can be used to inform legislation).

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, Y3)**
Action Steps	
a.	Continue to advocate CHW recruitment in CBOs and health institutions for community-based initiatives (pilot by Dell Medical School), including COVID support.
b.	Keep informed on the research project with the National Association of Community Health Workers on CHW Leadership, and how findings might impact our work.

Strategy 1.1.3:	**Establish or tap into an existing professional development and networking opportunities for CHW's and Service Coordinators. (Y1, Y2-revised, Y3)**
Action Steps	
a.	Facilitate the conversation for CHW's in all areas of health, wellness, and emotional health (e.g., Leadership Committees, Organizational Leaders, and CHP working groups for other CHP priority areas).
b.	Provide expanded and free training opportunities for CHW's (e.g., Mental Health, COVID, Breast Cancer).
c.	Advocate for and provide professional development in the languages that people are receiving services in (e.g., Mandarin Chinese, ASL).

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, Y3)**
Action Steps	
a.	Learn about, support, and build from Dell Medical School's pilot: completing evaluation to further develop modeling work for CHW programs; piloted with Ascension Seton, Lonestar Circle of Care, and outreach mobility teams.

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, Y3)**
Action Steps	
a.	Use partner agency social media platforms to promote the Medical Access Program and the Health Insurance Marketplace; two key health care coverage options for this population.
b.	Promote Health care coverage through paid media.

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, Y3)**
Action Steps	
a.	Provide a high-level overview of health care coverage options, eligibility requirements and how to enroll in coverage to CBO's thru quarterly webinars.
b.	Develop and distribute resources for Latinx and Asian immigrant communities concerning eligibility of programs.

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, Y3)**
Action Steps	
a.	Central Health will implement a Community Partner Program that will provide agencies and community-based organizations wanting to assist their clients with enrolling in the Medical Access Program (MAP) with outreach and education materials. Community Partners that sign an MOU with Central Health will receive in-depth training on eligibility and learn how to submit electronic applications directly to Central Health Eligibility
b.	Central Health will hold quarterly webinars for all Community Partners to provide them eligibility and application updates
c.	Convene partners (APH, FC, Central Health) to coordinate outreach activities.

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, Y3)**
Action Steps	
a.	Central Health will share with advocacy groups population and utilization trends and general challenges faced by the patient population (e.g. Services and Enrollment Dashboard for Travis County).
b.	Identify advocacy organizations.
c.	Join/Reestablish/Extend Invites to legislative update meetings (Central Health Equity Policy Council Conference Call for Legislative updates).

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, Y3)**
	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.
b.	Participate in the Regional Transportation Coordination Committee (RTCC) Planning efforts to help coordinate transportation options throughout the metro region, especially in rural areas (MPO is funding the consultant for this planning).
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.	Research expanding MetroBike; see Also/Cross-Reference with Chronic Disease Action Plan.
e.	Connect providers and nonprofits to the Transit Empowerment Fund.

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, Y3)**
	Action Steps
a.	Continue Central Health mobile clinics serving Creedmoor, Colony Park, and other areas of Eastern Travis County.
b.	Continue Community Care Street Team, with increasing focus on homeless population this year.
c.	Track the impact of recently implemented mobile healthcare and COVID relief delivery services (e.g., WIC, testing sites, vaccination sites).
d.	Track legislation around expanding broadband internet Access.
e.	Gather lessons learned related to digital access and equity especially as related to telehealth/telemed access; and experiences of providers related to reimbursement models during the COVID-19 pandemic. Use the learning to develop action steps for moving forward.
f.	Coordinate with Capital Metro and other transit providers in planning for expanded and/or new facilities (Del Valle, Hornsby Bend).

Strategy 1.3.4:	**Promote the Section 5310 grant program to assist local organizations with the purchase of wheelchair accessible vehicles. (Y2,Y3)**
	Action Steps
a.	Focus promotion efforts by tracking grant program changes and communicating them via email to eligible agencies (launch in early 2021).

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, Y3)** (*refers to expanded description of the Mobility Management Program included in the full CHP report)
	Action Steps
a.	Promote existing travel training program, including virtual and individual training options.
b.	Promote awareness of free transportation options for COVID testing and vaccinations.
c.	Update Senior Ride Guide; print and distribute. Digitize guide and publish as a website so information can be updated on an ongoing basis. Update information on related sites (GetThereATX).
d.	Convene Healthcare Transportation Work Group to focus activities in Y3.

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,Y3)	
Action Steps	
a.	Connect with Enrollment Strategy 1.2.2./1.2.4/1.2.6 to identify navigators to whom we could provide transportation information.
b.	Connect CHW's and HACA Smart City Ambassadors with Capital Metro Travel Trainers.
c.	Explore and establish "Travel Trainer Ambassador Program": Training of Trainers.
d.	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

American Heart Association
Area Agency on Aging of the Capital Area (AAACAP)
Ascension Seton
Austin Parks and Recreation Dept. (PARD)
Austin Public Health
Austin Transportation Dept.
Capital Metro
Children's Optimal Health
It's Time Texas
Prairie View A&M
Project Access Austin
Texas A&M AgriLife Extension
Texas Children in Nature
UT Dell Medical School
UT School of Public Health

Year 3 Action Plan

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, Y3)**
Action Steps	
a.	Support the work of the "Active Living Plan" by combining the role of the working group to form an Active Living Coalition.
b.	Identify and compile a list of partners who are available to increase capacity of fitness and healthy living classes and individual training.
c.	Connect partners who offer training with partners who are available to train trainers and refer participants.
d.	Expand offerings in under resourced areas (e.g., Manor/Del Valle)
e.	Encourage partners to offer resources that are available virtually or COVID safe and expand the number of classes in different languages.
f.	Incorporate existing dashboards or platforms into resource promotion and awareness.

Strategy 2.1.2	**Engage community leaders to design and conduct a media and marketing campaign that promotes and supports existing organizations and health resources (e.g., fitness class, nutrition, gardening classes, podcast programs, tobacco cessation resources, mobile health tools education and tracking). (See also Strategy 2.4.3) (Y3)**
Action Steps	
a.	Engage partners to gather input on campaign messaging.
b.	Identify partners to help broadcast the media and marketing campaign (e.g., UT Center for Health Communications).
c.	Create and refine the messaging for various methods and populations.
d.	Run the campaign (must be run by the end of August).
e.	Evaluate the results (report received from the media vendors, consider reaching out to Community directly).
f.	Engage with partners to discuss evaluation results and explore opportunities for continuing campaign.

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, Y3)**
	Action Steps
a.	Engage childcare sites as they implement the OLE! Texas strategy. Based on DSHS goals.
b.	Support AISD & PARD in providing walkable maps or route to fieldtrips. Utilize Nature Rocks virtual platform and this CCCN Austin map.
c.	Explore expansion of walkable maps for outlying areas in Travis County.

Strategy 2.1.5:	**Identify barriers to health by screening in clinics for non-healthcare related social determinants of health, and partner with community-based organizations and elected officials to utilize this aggregated data to affect neighborhood-level changes. (Y3)**
	Action Steps
a.	Information gathering about what is being done and what is being learned regarding SDOH screening and linkage to services through clinics.
b.	Reach out to relevant partners to identify SPOCs and gauge interest in engagement regarding SDOH screening and linkage to services for information gathering and sharing.
c.	Develop next steps once more information is gathered and partners have convened.

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 2.2.3:	**Implement web-based home education and home testing to overcome barriers to access (e.g., home test kits, diagnostic surveys, online monitoring). (Y3)**
	Action Steps
a.	Build off Access to Care action step (Strategy 1.3.2 action step e.).
b.	Information gathering about what is being done and what is being learned around telehealth.
c.	The Community Engagement Subcommittee will be crafting questions for community members for the upcoming assessment phase. Incorporate digital access questions or conversations.

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 2.5.3:	**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, Y3)**
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,Y3)**
Action Steps	
a.	Health & Transportation Subgroup will start reconvening. Ensure this strategy gets folded into their work.
b.	Pursue relationship between heat mapping and Active Transportation infrastructure, to include discussion about trail locations, shaded areas, and other equity concerns.

Priority Area 3: Sexual Health

Priority Area 3: Sexual Health Partner Organizations

allgo
Austin Public Health
Cardea
Communities of Color United for Racial Justice
CommUnity Care
LifeWorks
N. Lamar Neighborhood Plan
Planned Parenthood
Texas Campaign to Prevent Teen Pregnancy
Texas Harm Reduction Alliance

Year 3 Action Plan

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 3.1.2:	**Promote support programs on healthy relationships and teen dating violence. (Y3)**
	Action Steps
a.	Continue to support the collaboration between APH, Safe Place, and Del Valle High School as part of Del Valle Healthy Adolescent grant; up to age 20.

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) (Y1, Y2, Y3)**
	Action Steps
a.	Identify strategies for reducing teenage/youth (18-24) pregnancy with consideration for choice and religion to embed into Family Pathways work.
b.	Connect young parents to Sexual Health, including family planning, services/resources
c.	Identify organizations working with young parents in order to build ongoing connection between Family Pathways and Sexual Health Workgroup

Strategy 3.1.4:	**Promote information sharing between organizations and programs already engaged in sex education work. (See also Strategy 3.3.2). (Y1,Y2-revised,Y3)**
	Action Steps
a.	Monitor implementation of curriculum standard changes at the State Board of Education.
b.	Monitor legislature impacting sex education.
c.	Brainstorm strategies for information sharing on existing sex education work, to include partner identification and topic selection (e.g. polling, gap analysis, etc.)
d.	Provide presentations for workgroup members touching on different updates/topics to encourage information sharing.

Strategy 3.1.5:	**Promote & support programs that provide culturally and linguistically appropriate resources for families. (Y3)**
	Action Steps
a.	Continue to follow up with ongoing programs with HACA Bringing Health Home program (English/Spanish) resources for families and El Buen Samaritano.
b.	Compile a list of culturally and linguistically appropriate resources to be shared.
c.	Identify methods to share the information gathered under “b”. Also see 3.1.4 c

Strategy 3.1.6:	**Advocate for a bill(s) that would allow adolescents to consent to their own reproductive healthcare if they have a child already. (Y3)**
Action Steps	
a.	Identify partners and conduct outreach to identify teen parents who might be experiencing difficulties with access to healthcare following the birth of their child.
b.	Connect and identify ways to support Texas Campaign

Strategy 3.1.7:	**Advocate for '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, reduce barriers to youth seeking same-day appointments, and are trained to provide culturally appropriate contraceptive services. (See also Strategy 3.2.4). (Y1,Y2,Y3-revised (combined with 3.1.8))**
Action Steps	
a.	Identify potential partnerships with clinics already participating in this work (e.g., Northwest Austin Universal Health Clinic (NAUHC), ASA (AIDS Services Austin))
b.	Work to expand awareness and participation of clinics providing these services.
c.	Promotion of resources for youth including information about Title X provider expansion.
d.	Presentation on results of pre-assessment on Youth Friendly Assessment

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 3.2.1:	**Promote and offer STI testing, education, and enhanced linkage to reproductive and sexual health services. (See also Objectives 2.2 and 2.3) (Y3)**
Strategy 3.2.4:	**Advocate for 'Youth 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) (Y2,Y3)**
Strategy 3.2.5:	**Identify and reduce barriers to youth seeking same-day appointments for STI tests and treatment. (Y1,Y2,Y3)**
Action Steps	
Implementation activities for strategies under Objective 3.2 will be achieved through a partnership with Fast-Track Cities.	

Objective 3.3:	**By 2023, increase by 10% the number of schools that provide evidence-informed sex education in Travis County.**

Strategy 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. (Y1,Y3)**
Strategy 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 sexual healthcare services not provided through ISD campuses. (See also Strategy 3.1.4). (Y1-revised, Y3)**
Strategy 3.3.5:	**Promote technologies and best practices available to increase youth access to programs, services and information. (See also Strategy 3.1.10) (Y3)**
Action Steps	
Action Steps for strategies under Objective 3.3 will be developed throughout the implementation year.	

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. (Y1,Y2,Y3)**
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. (Y1,Y3)**
Strategy 3.4.5:	**Promote technologies and best practices available to increase youth access to programs, services and information. (See also Strategy 3.1.10) (Y3)**
Action Steps	
Action Steps for strategies under Objective 3.4 will be developed throughout the implementation year.	

Priority Area 4: Stress, Mental Health, and Wellbeing

Priority Area 4: Mental Health Partner Organizations

Ascension Seton
ASHWell
Austin Public Health
Austin Recovery Network
Building Promise USA
Central Health
Changing How I Live Life
Children's Optimal Health
Communities for Recovery
Community Advancement Network
Community Medical Services
Cross Creek Hospital
Downtown Austin Community Court
Grassroots Leadership
Integral Care
LifeWorks
NAMI Central Texas
Texas Harm Reduction Alliance
Travis County Underage Drinking Prevention
UT Dell Medical School

Year 3 Action Plan

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 4.1.2	
Action Steps	
a.	Form ad hoc committees comprised of populations whose voices are not always heard (particularly POC and people with lived experience) to gather input and implement this strategy (perhaps two different groups - youth and adults). - Reach out to partner organizations (e.g., TC Youth Substance Abuse Prevention Coalition, NAMI) to identify potential participants (e.g., people with lived experience)
b.	Partner with COVID community groups to take advantage of their communications work and get them to focus on additional high priority needs such as binge drinking.
c.	Explore ways to keep media engaged in public servicing messaging on binge drinking and SUD.
d.	Incorporate the use of environmental strategies.
e.	Enhance work with youth to engage them in this issue.
f.	Identify test for alcoholism and help the community learn how to identify if their family has the disease of alcoholism and how youth can move forward with that information.
g.	Address stigma reduction in the messaging that is developed (including with primary care providers, hospital staff - especially those covering the ER (for example during a power outage, lack of awareness of the providers of the need for medications)).

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,Y3)**
	Action Steps
a.	Identify funding for Trauma Informed Care training.
b.	Identify cost effective and accessible ways to conduct/provide the training, especially for smaller organizations.
c.	Gather input from those who are doing the training around training limitations, ways they are doing the training, how we can expand the training they are doing, etc.
d.	Identify and create a list of early trauma screening adopters and referral agencies.

Objective 4.3:	**By 2023, Increase by 10% the proportion of adults aged 18 and up in Austin Travis County who receive mental health/substance use disorder services, with a focus on geographic equity. (revised Y3)**

Strategy 4.3.2:	**Advocate for enhanced behavioral health benefits covered by the Medical Access Program (MAP). (Y2,Y3)**
	Action Steps
a.	Advocate for provider recruitment so that there will be enough providers to see the patients who are waiting for services.
b.	Develop a comprehensive list of what these BH benefits are, covering the entire spectrum of addiction. Coordinate these efforts with other ongoing efforts.
c.	Explore what is being done around BH data collection, and what providers might want to report on that. (any requests to Data Core would need to come with the funding).
d.	Define what our advocacy efforts would look like once we have the data in hand.

Strategy 4.3.6:	**Pair mental health/SUD workers with all established mobile health outreach teams to geographically underserved populations. (Y2,Y3)**
	Action Steps
a.	Identify behavioral health providers who can pair mental health professionals or Community Health Workers with MHO teams.
b.	Learn about how 9-1-1 Mental/Behavioral Health outreach/crisis teams is being incorporated into call center; track data for equity concerns.
c.	Identify who has mobile health outreach teams/services

Strategy 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. (Y3)**
	Action Steps
a.	Connect with APD Crisis Teams for opportunities to encourage positive engagement with community (*see Strategy 4.3.6*)
b.	Seeking partners for mobile outreach teams
c.	Raise awareness for community engagement events and provide linkage for partners providing services/assistance
d.	Identifying long-term strategies for relationship-building and outreach; build off existing best practices

Appendices

Appendix 1: Community Health Planning Participants (by Organization)

Organization	Access to Care	Chronic Disease	Sexual Health	Behavioral Health
allgo			X	
Alzheimer's Association	X			
American Heart Association	X	X		
Area Agency on Aging of the Capital Area (AAACAP)		X		
Ascension Seton	X	X		X
ASHWell				X
Austin Asian Community Health Initiative (AACHI)	X			
Austin Parks and Recreation Dept. (PARD)		X		
Austin Public Health	X	X	X	X
Austin Recovery Network				X
Austin Transportation Dept.	X	X		
Building Promise USA				X
Capital Area Council of Governments (CAPCOG)	X			
Capital Metro	X	X		
Cardea	X		X	
Central Health	X			X
Changing How I Live Life				X
Children's Optimal Health	X	X		X
Communities for Recovery				X
Communities of Color United for Racial Justice			X	
Community Advancement Network				X
Community Medical Services				X
CommUnity Care	X		X	
Cross Creek Hospital				X
Downtown Austin Community Court				X
El Buen Samaritano	X			
Grassroots Leadership				X
Integral Care				X
It's Time Texas		X		
LifeWorks			X	X
Light and Salt Services	X			
Meals on Wheels Central Texas	X			
N. Lamar Neighborhood Plan			X	
NAMI Central Texas				X
Planned Parenthood			X	
Prairie View A&M		X		
Project Access Austin	X	X		
St. David's Foundation	X			
Texas A&M AgriLife Extension		X		
Texas Campaign to Prevent Teen Pregnancy			X	
Texas Children in Nature		X		
Texas Harm Reduction Alliance			X	X
Travis County HHS	X			
Travis County Underage Drinking Prevention				X
UT Dell Medical School	X	X		X
UT School of Public Health		X		

Appendix 2: Changes to Strategies from Year 2 to Year 3

Note:
Strategies in blue text are new to Year 3 Action Plan.
Strategies in ~~strikethrough~~ text were included in the Y2 Action Plan but are not included in the Y3 Action Plan.
Tracked changes show revisions to wording for Objectives or Strategies.

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 3 Objectives	**Year 3 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 3 Objectives	**Year 3 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.
	2.1.2 Engage community leaders to design and conduct a media and marketing campaign that promotes and supports existing organizations and health resources (e.g., fitness class, nutrition, gardening classes, podcast programs, tobacco cessation resources, mobile health tools education and tracking). (See also Strategy 2.4.3)
	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.
	2.1.5 Identify barriers to health by screening in clinics for non-healthcare related social determinants of health, and partner with community-based organizations and elected officials to utilize this aggregated data to affect neighborhood-level changes.
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.~~
	2.2.3 Implement web-based home education and home testing to overcome barriers to access (e.g., home test kits, diagnostic surveys, online monitoring).
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 3 Objectives	**Year 3 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.
	3.1.5 Promote support programs that provide culturally and linguistically appropriate resources for families.
	3.1.6 Advocate for a bill(s)/ bill that would allow adolescents to consent to their own reproductive healthcare if they have a child already.
	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, reduce barriers to youth seeking same-day appointments, and are trained to provide culturally appropriate contraceptive services. (See also Strategy 3.2.4).
	~~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. (See also Objectives 2.2 and 2.3)
	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 sexual healthcare services not provided through ISD campuses. (See also Strategy 3.1.4)
	3.3.3 Implement mentoring or skill-based activities that help educate youth regarding healthy relationships, and address social norms and healthy choices.
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.).
	3.4.5 Promote technologies and best practices available to increase youth access to programs, services and information. (See also Strategy 3.1.10)

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 3 Objectives	**Year 3 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.~~
	4.1.2: Identify or develop and implement a community awareness initiative to decrease binge drinking and substance use disorder for pre-identified at-risk populations (include age appropriate messaging for multimedia campaign, Outreach in community-based settings with Community Health worker (see also Objectives 1.1 and 2.1) and Substance Use Disorder (SUD) specialists).
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~~services, 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.
	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: Y2 Implementation Progress by Priority Area

Affordability and Access to Healthcare

AUSTIN/TRAVIS COUNTY

Community Health Plan

2020 Progress Report

Process:

- Quarterly Meetings
- Met four times in 2020
- 26 Active Members
- Average Attendance: 12 partners

Plan Progress:

Objective 1.1

1.1.2 CHWs integrated into hiring practices and interventions, including HACA, Central Health, APH, and CBOs / AACHI expanded CHN services to Mandarin speaking community.
1.1.3 Austin Healthy Adolescent (AHA) offered CHW training to high school graduates in collaboration with El Buen Samaritano and the Health Equity Unit with online Texas A&M Health Science Center training option/ Cardea and UT School of Nursing convened quarterly CHW networking meetings related to sharing information on resources in response to COVID.
1.1.4 Central Health developed a curriculum for new hires with CHW credentials and integrated them into multiple roles across Central Health.

Objective 1.3

1.3.1 Commute Solutions transitioned to CAMPO/City of Pflugerville approved InterLocal Agreement (ILA) with Capital Metro to work on PickUp pilot; services expanded throughout Central Texas/ Project Connect approved by voters along with Prop B funding for active transportation programs.
1.3.4 CAMPO moved toward two-year grant approval, to be released in 2021.
1.3.6 Smart Trips transitioned to an online citywide program and Transportation Resource Guide/City of Austin maintained and added to GetThereATX.com which provides information about transportation options and resources.

Together We Thrive
Austin/Travis County Community Health Plan

CHRONIC DISEASE

AUSTIN/TRAVIS COUNTY

Community Health Plan

2020 Progress Report

Process:
- Bi-Monthly Meetings
- Met five times in 2020
- 29 Active Members
- Average Attendance: 14 partners

Plan Progress:

Objective 2.1

2.1.1 PrairieView offered physical Activity classes: Virtual Fitness for Kids/ AgriLife and AVANCE held 9 virtual health and wellness lessons in Spanish/ TOPS and Wesley United Methodist Church offered Step Up Scale Down, a virtual 12-week weight loss program/ COVID-101 classes were offered in Spanish to help Head Start families /It's Time Texas held their free, virtual Healthier Texas Summit Series.
2.1.4 The UT School of Public Health recruited schools for a randomized controlled trial of CATCH My Breath, a middle school e-cigarette prevention program.

Objective 2.2

2.1.5 & 2.2.1 Dr. Grey at Southeast Health and Wellness Center implemented a Food Access Screener / People's Community Clinic administered a Social Determinants of Health (SDoH) screener to their patients.
2.2.2, 3.1, & 3.2 APH, Nicole Treviño Consulting, SAFE Alliance, UTSPH, El Buen Samaritano, partnered with Del Valle ISD to secure a 3-year grant from HHS Office of Population Affairs to promote healthy adolescent development.

Objective 2.5

2.5.1 & 2.5.3 Children's Optimal Health and Chronic Disease Group assessed physical activity resources and assets for Austin/Travis County.
2.5.1 Central Texas Food Bank, Brighter Bites, YMCA, and PARD provided food distribution /Travis County Extension Service and Central Texas Seed Savers provided free seeds/ UT Public Health and Parks Foundation researched park use during the pandemic/Green School Yard project helped three nature deficient elementary schools with nature gardens.
2.5.2 The Active Living Plan for Austin/Travis County was posted for public feedback.
2.5.5 The Neighborhood Partnering Program completed the Grackle Green Pocket Park and Loewy Family Playground/Murchison Playscape.
2.5.6 The Austin Land Development Code dedicated land and fees to parkland.
2.5.7 Propositions approved in 2020 will require Cap Metro to have a financial board which could be an opportunity for community engagement in active transportation plans.

Together We Thrive
Austin/Travis County Community Health Plan

SEXUAL HEALTH

AUSTIN/TRAVIS COUNTY

Community Health Plan

2020 Progress Report

Process:
- Bi-Monthly Mtgs/Newsletters
- Met five times in 2020
- 16 Active Members
- Average Attendance: 10 partners

Plan Progress:

Objective 3.1

3.1.1 The Texas Campaign to Prevent Teen Pregnancy hosted a webinar series
3.1.3 Family Pathways-United Way for Greater Austin participated in the Austin Opportunity Youth Collaborative and collaborated closely with the Workforce Solutions Capital Area board to amplify employment training opportunities.
3.1.4 Variety of organizations and programs engaged and collaborated through the Travis County Adolescent Health Collaborative grant partnership through the City of Austin to work in Del Valle ISD.
3.1.8 Planned Parenthood offered same day LARCS for youth with parental permission.
3.1.10 Planned Parenthood provided a chat program for sexual health education.

Objective 3.2

3.2.1 Region 6 hosted a Virtual Forum to Address Racial and Ethnic Health Disparities in HIV, Hep C, & STIs.
3.2.4 Planned Parenthood Downtown Center was in Cohort 3 for Texas Health Youth Friendly Initiative and funding was available for El Buen Samaritano to receive youth friendly recognition.
3.2.5 Appointments for STI tests and treatment continued through Planned Parenthood, KIND, ASA, Out youth, and APH Health Equity Unit

Objective 3.4

3.4.1 APH's Maternal and Infant Outreach Program (MIOP) and Lifeworks Teen Parent Services Program provided counseling services for parents.
3.4.2 MIOP transported and accompanied mothers and infants to prenatal and postnatal appointments.

Together We Thrive
Austin/Travis County Community Health Plan

Stress, Mental Health, & Wellbeing

AUSTIN/TRAVIS COUNTY

Community Health Plan

2020 Progress Report

Process:
- Pre-Covid: Monthly Meetings
- Only one meeting in 2020
- 2020 Summit Attendance: 19
- Average Attendance: 9 Partners

Plan Progress:

Objective 4.1

4.1.1 & 4.3.2 Integral Care's IOP provided medication assisted programs and narcotic program. Challenge: Methadone and Norepinephrine not covered or limited in treatment and not covered by MAP.

4.1.2 Integral Care provided substance use treatment in AISD Alternative Ctr / UT SHIFT program launched to address substance use on college campuses.

Objective 4.2

4.2 Texas Senate Bill 11 passed and created The Texas Child Mental Health Care Consortium.

4.2 & 1.3.2 Texas Child Health Access Through Telemedicine (TCHATT) also approved as telehealth access to mental health in school districts.

4.2.1 & 4.2.3 Plan aligned with Travis County Children's Mental Health Plan/Kids Living Well Update: Goal 1& 2.

Objective 4.3

4.3.1 & 3.1.4 APH began developing a Teen pregnancy program with Safe, Integral Care, and other partners to serve Dell Valle high school students. Starting ACEs training.

4.3.1 & 1.3.2 Community Care in collaboration with Integral Care provided medication assisted treatment out of Dove Springs Clinic.

4.3.1/4.3.2/4.3.3/4.3.4 Plan aligned with 2021-2026 update to the Travis County Plan for Children's Mental Health; to be published in March

4.3.7 CommUnity Health Paramedics program expanded its Mental Health/Substance Use Disorder workforce /APH released a solicitation for Substance Misuse for $1,117,120 in ongoing funding and $350,000 in one-time funding/ Integral Care's EMCOT program expanded.

Together We Thrive
Austin/Travis County Community Health Plan