Together We Thrive

Austin/Travis County Community Health Plan

Health begins where we live, learn, work and play. Opportunities for health start at home, in our neighborhoods and work places. And all people—regardless of background, education or money—should have the chance to make choices that lead to a long and healthy life.

– ROBERT WOOD JOHNSON FOUNDATION

Community Health Improvement Plan

Austin/Travis County Texas

December 2012

CENTRAL HEALTH

St David's FOUNDATION

Seton Healthcare Family

UTHealth The University of Texas Health Science Center at Houston School of Public Health Austin Regional Campus

Dear Community Partner,

This Community Health Improvement Plan illustrates four priority issues for which our community will work together over the next 3-5 years to address in order to improve health and wellness. This has been a remarkable journey and we look forward to working with the community to make healthy people the foundation of our thriving Austin/Travis County.

From August 2011 through December 2012, Austin/Travis County Health and Human Services Department (A/TCHHSD) partnered with Travis County Health and Human Services and Veterans Services, Central Health, St. David's Foundation, Seton Healthcare Family, and the University of Texas Health Science Center (UTHSC) at Houston School of Public Health Austin Regional Campus to lead a comprehensive community health planning initiative. The community health improvement planning process was completed in December 2012 with a Community Health Assessment (CHA) and a draft Community Health Improvement Plan (CHIP) for Austin/Travis County.

The Austin/Travis CHA represents a collaborative and community participatory process in order to illustrate our health status, strengths, and opportunities for the future. The Austin/Travis County CHIP illustrates the four priority issue areas that our community, including residents, businesses, partners, and stakeholders, will work together on addressing and improving.

The drive, diligence, and support from the core partners, CHIP workgroup facilitators, and CHIP workgroup members—our Austin/Travis County CHA team—made planning, conducting, and completing this improvement plan possible.

Through our community's health improvement planning process, we share our community's collective story. Thank you for your ongoing contributions to this remarkable community health improvement process.

Sincerely,

Carlos Rivera
Director, Austin/Travis County HHSD

Shannon Jones
Chair of Steering Committee
Deputy Director, Austin/Travis County HHSD

Dr. Philip Huang
Health Authority, Austin/Travis County HHSD

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EXECUTIVE SUMMARY

Where and how we live, work, play, and learn affects our health. Understanding how these factors influence health is critical for developing the best strategies to address them. To accomplish these goals, Austin/Travis County Health and Human Services (ATCHHS) – in collaboration with Travis County Health and Human Services and Veterans Services, Central Health, St. David's Foundation, Seton Healthcare Family, and the University of Texas Health Science Center at Houston School of Public Health Austin Regional Campus – led a comprehensive community health planning effort to measurably improve the health of Austin/Travis County, TX residents. This effort, funded by the National Association of County and City Officials with support from the Robert Wood Johnson Foundation, includes two major phases:

1. A community health assessment (CHA) to identify the health related needs and strengths of Austin/Travis County
2. A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across Austin/Travis County

In addition to guiding future services, programs, and policies for these agencies and the area overall, the CHA and CHIP are also required prerequisites for the health department to earn accreditation, which indicates that the agency is meeting national standards.

The December 2012 Austin/Travis County CHIP was developed over the period July 2012 – November 2012, using the key findings from the CHA , which included qualitative data from focus groups, key informant interviews and community forums that were conducted locally, as well as quantitative data from local, state and national indicators to inform discussions and determine health priority areas. The CHA is accessible at www.austintexas.gov/healthforum.

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the Austin/ Travis County assessment and planning process engaged community members and Local Public Health System (LPHS) Partners through different avenues:

a. the Steering Committee was responsible for overseeing the community health assessment, identifying the health priorities, and overseeing the development of the community health improvement plan
b. the Core Coordinating Committee was the overall management of the process, and
c. the CHIP Workgroups, which represented broad and diverse sectors of the community, were formed around each health priority area to develop the goals, objectives and strategies for the CHIP.

The Steering Committee and the Core Coordinating Committee recognized that it was important to outline a compelling and inspirational vision and mission, and to identify a set of shared values that would support the planning process and the CHIP itself. The Committees participated in several brainstorming, force field, and prioritization activities, and developed the following vision, mission and shared values for the CHA-CHIP:

Vision

Healthy People are the Foundation of our Thriving Community

Mission

Our community – individuals and organizations (public, private, non-profit) – works together to create a healthy and sustainable Austin/Travis County

Shared Values

Efficient, Results-Oriented, Data Driven, and Evidence Informed: Approach designed to improve overall health and disparities

Diverse, Inclusive, Collaborative, and Respectful: Meaningful and respectful engagement of diverse stakeholders, broadly defined; ensuring equality of voice and representation in all approaches and processes, including vetting of group work

Health Promoting: Building on current assets and developing new assets

Perseverance, Excellence, and Creativity

Shared Accountability and Ownership

The Steering and Core Coordinating Committees participated in a prioritization activity and identified the following priority health issues that would be addressed in the CHIP:

Priority Area 1: **Chronic Disease – Focus on Obesity**
Goal 1: Reduce burden of chronic diseases caused by obesity among Austin/Travis County residents.

Priority Area 2: **Built Environment – Focus on Access to Healthy Foods**
Goal 2: All in our community have reasonable access to affordable quality nutritious food.

Priority Area 3: **Built Environment – Transportation**
Goal 3: Local and regional stakeholders will collaboratively increase accessibility to community resources via safe, active transportation.

Priority Area 4: **Access to Primary Care and Mental/Behavioral Health Services - Focus on Navigating the Healthcare System**
Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.

Austin/Travis County Community Health Improvement Plan

BACKGROUND

Where and how we live, work, play, and learn affects our health. Understanding how these factors influence health is critical for developing the best strategies to address them. To accomplish these goals, Austin/Travis County Health and Human Services (A/TCHHS) – in collaboration with Travis County Health and Human Services and Veterans Services**,** Central Health, St. David's Foundation, Seton Healthcare Family, and the University of Texas Health Science Center at Houston School of Public Health Austin Regional Campus – led a comprehensive community health planning effort to measurably improve the health of Austin/Travis County, TX residents.

The community health improvement planning process includes two major components:

1. A community health assessment (CHA) to identify the health related needs and strengths of Austin/Travis County
2. A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across Austin/Travis County

The December 2012 Austin/Travis County CHIP was developed over the period July 2012 – November 2012, using the key findings from the CHA , which included qualitative data from focus groups, key informant interviews and community forums that were conducted locally, as well as quantitative data from local, state and national indicators to inform discussions and determine health priority areas. The CHA is accessible at www.austintexas.gov/healthforum.

Moving from Assessment to Planning

Similar to the process for the Community Health Assessment (CHA), the CHIP utilized a participatory, collaborative approach guided by the Mobilization for Action through Planning and Partnerships (MAPP) process.[1] MAPP, a comprehensive, community-driven planning process for improving health, is a strategic framework that local public health departments across the country have employed to help direct their strategic planning efforts. MAPP comprises distinct assessments that are the foundation of the planning process, and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action. Since health needs are constantly changing as a community and its context evolve, the cyclical nature of the MAPP planning/implementation/evaluation/correction process allows for the periodic identification of new priorities and the realignment of activities and resources to address them.

[1]Advanced by the National Association of County and City Health Officials (NACCHO), MAPP's vision is for communities to achieve improved health and quality of life by mobilizing partnerships and taking strategic action. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. More information on MAPP can be found at: http://www.naccho.org/topics/infrastructure/mapp/

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the Austin/ Travis County HHSD led the assessment and planning process by engaging community members and Local Public Health System (LPHS) Partners through different avenues:

a) the **Steering Committee** was responsible for overseeing the community health assessment, identifying the health priorities, and overseeing the development of the community health improvement plan
b) the **Core Coordinating Committee** was the overall management of the process, and
c) the **CHIP Workgroups**, which represented broad and diverse sectors of the community, were formed around each health priority area to develop the goals, objectives and strategies for the CHIP.

In January 2012, Austin/Travis County Health and Human Services hired Health Resources in Action (HRiA), a non-profit public health organization located in Boston, MA, as a consultant partner to provide strategic guidance and facilitation of the CHA-CHIP process, collect and analyze data, and develop the report deliverables.

The Steering and Core Coordinating Committees participated in brainstorming, force field analysis[2], and prioritization activities to develop the vision, mission and shared values for the CHA-CHIP.

In early July 2012, the CHA Report was distributed to the members of the Steering Committee for their review and feedback. On July 13, 2012, a summary of the CHA findings was presented to the Steering Committee, Core Coordinating Committee, executives from One Voice Central Texas (a network representing 54 health and human services community based organizations), and representatives from the City of Austin Planning and Development Review Department for review and refinement, and to serve as the official launching point for the CHIP.

During this meeting, the group identified issues and themes from which priority health issues were identified and subcategories developed. While many areas were significant, it was emphasized that identifying a few priority areas would enable more focus and collaboration for impacting the community. A multi-voting process using dots and agreed upon selection criteria was used to identify which of the subcategories within the four main priority health issues would be addressed in the CHIP. For a complete description of the selection process, please see Section II C.

[2] As defined in the *Public Healthy Memory Jogger II* by Goal/QPC, a "force field analysis is used to investigate the balance of power involved in resolving an issue. It presents the 'positives' and 'negatives' of a situation for easy comparison. Force fields allow teams to come to a collective decision about a permanent result, and encourage honest consideration of real underlying root causes and solutions".

I. OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PLAN

A. What is a Community Health Improvement Plan?

A Community Health Improvement Plan, or CHIP, is an action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed, including strategies and measures, to ultimately improve the health of the community. CHIPs are created through a community-wide, collaborative planning process that engages partners and organizations to develop, support, and implement the plan. A CHIP is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.[3]

B. How to use a CHIP

A CHIP is designed to be a broad, strategic framework for community health, and should be modified and adjusted as conditions, resources, and external environmental factors change. It is developed and written in a way that engages multiple perspectives so that all community groups and sectors – private and nonprofit organizations, government agencies, academic institutions, community- and faith-based organizations, and citizens – can unite to improve the health and quality of life for all people who live, work, learn, and play in Austin/Travis County. We encourage you to review the priorities and goals, reflect on the suggested strategies, and consider how you can participate in this effort.

C. Methods

Building upon the key findings and themes identified in the Community Health Assessment (CHA), the CHIP aims to:

- Identify priority issues for action to improve community health
- Develop and implement an improvement plan with performance measures for evaluation
- Guide future community decision-making related to community health improvement

In addition to guiding future services, programs, and policies for participating agencies and the area overall, the community health improvement plan fulfills the required prerequisites for the Austin/Travis County Health and Human Services Department to be eligible for accreditation, which indicates that the agency is meeting national standards.

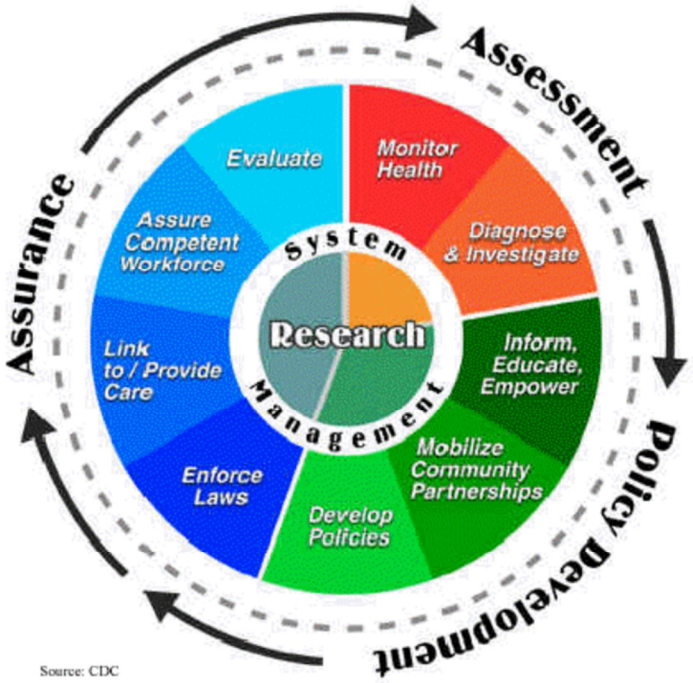
To develop the CHIP, the Austin/Travis County Health and Human Services Department was the convening organization that brought together community residents and the area's influential leaders in healthcare, community organizations, and other key sectors, such as transportation, mental health, local government, and social services. Following the guidelines of the National Association of County and City Health Officials (NACCHO), the community health improvement process was designed to integrate and enhance the activities of many organizations' contributions to community health improvement, building on current assets, enhancing existing programs and initiatives, and leveraging resources for greater efficiency and impact.

[3] As defined by the Health Resources in Action, Strategic Planning Department, 2012

The assessment/planning/implementation/evaluation/reassessment process is a continuous cycle of improvement that seeks to "move the needle" on key health priorities over the course of time. The cyclical nature of the Core Public Health Functions described above is illustrated below in Figure 1.

The next phase of the CHIP will involve broad implementation of the strategies and action plan identified in the CHIP, and monitoring/evaluation of the CHIP's short-term and long-term outcome indicators.

Figure 1: The Cyclical Nature of the Core Public Health Functions



Source: Centers for Disease Control and Prevention (CDC), Ten Essential Public Health Services

II. PRIORITIZATION OF HEALTH ISSUES

A. Community Engagement

The Austin/Travis County Department of Health and Human Services led the planning process for Austin/Travis County and oversaw all aspects of the CHIP development, including the establishment of CHIP Workgroups and to flesh out details for identified health priorities. The Core Coordinating Committee and the Steering Committee continued from the Assessment Phase to the Planning Phase, guiding all aspects of planning and offering expert input on plan components.

CHIP Workgroup members were comprised of individuals with expertise and interest in identified priority areas who volunteered to participate and who represented broad and diverse sectors of the community. **See Appendix A for workgroup participants and affiliations.**

B. Strategic Components of the CHIP

The Steering Committee and the Core Coordinating Committee recognized that it was important to outline a compelling and inspirational vision and mission, and to identify a set of shared values that would support the planning process and the CHIP itself. The Committees participated in several brainstorming, force field, and prioritization activities, and developed the following vision, mission and shared values for the CHA-CHIP:

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C. Development of Data-Based Community Identified Health Priorities

On July 13, 2012, a summary of the CHA findings was presented to the Steering Committee, Core Coordinating Committee and representatives from One Voice Central Texas and the City of Austin Planning and Development Review Department for further discussion. The following themes emerged most frequently from review of the available data and were considered in the selection of the CHIP health priorities:

Health Priority Areas

- Built Environment
- Transportation
- Affordable Housing
- Food Access
- Physical Activity Access

Chronic Disease and Related Conditions

- Obesity
- Diabetes
- Heart Disease
- Cancer

Mental Health

- Stress and Depression
- Co-occurring Disorders (e.g., substance abuse)
- Accessing Services
- Stigma/Discrimination

Access to Primary Care

- Health Facilities/Resources
- Emergency Room Overuse
- Health Insurance/Cost
- Navigating the Health Care System

Facilitators used a multi-voting process to identify the four most important public health issues for Austin/Travis County from the list of major themes identified from the CHA. Each participant received four dots to apply to their top four public health priorities, after reviewing, discussing, and agreeing upon the following common set of selection criteria:

Political will exists to support change

Community Values
- Community cares about it
- People, power and passion: Likely community mobilization
- Important to community

Key area of need (based on data)
- Size: Many people affected
- Trend: Getting worse
- Seriousness: Deaths, hospitalizations, disabilities
- Causes: Can identify root causes/social determinants
- Research/evidence-based

Achievable/doable
- Feasible and realistic

Resources available or likely
- Builds on or enhances current work

Measurable outcomes

Can move the needle
- Proven strategies to address multiple wins/catalytic actions
- Easy short-term wins

Population Based Strategies
- Some groups affected more
- Can focus on targeted population(s)

This process was followed by a show of hands vote, which resulted in the selection of the same issues and sub categories identified during the multi voting process. The dot voting process was one that was conducted in a short amount of time with a sizable group of people made up of both Steering Committee and Core Leadership members.

Based on the results of the multi-voting exercise, the Steering Committee and Core Leadership members agreed upon the following four health priority areas for the CHIP:

- Chronic Disease – focus on obesity
- Built Environment – focus on Access to Healthy Foods
- Built Environment- focus on Transportation
- Access to Primary Care and Mental Health /Behavioral Health Services – focus on improving access to primary care, improving access to mental health, and helping consumers navigate both systems

Steering Committee Members also suggested that health education/health literacy be included as cross-cutting strategies for each of the CHIP priorities, as appropriate. Access to Healthy Foods, Transportation, and Access to Primary Care and Mental/Behavioral Health Services were all identified as priorities aimed at addressing a social determinant of health inequity in Austin/Travis County. The social determinants of health are the circumstances in which people are born; grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances in turn are shaped by a wider set of forces: economics, social policies, and politics.[4] Addressing the role of social determinants of health is important because it is a primary approach to achieving health equity. Health equity exists when everyone has the opportunity to attain their full potential and no one is disadvantaged.[5]

D. Development of the CHIP Strategic Components

The Core Planning Group convened five, three hour planning sessions between August and October 2012. Community members and LPHS partners were invited to participate in working groups based on interest and expertise in each of the four identified priority areas. See Appendix A for a list of workgroup participants and affiliations.

A HRiA consultant facilitated the joint workgroup sessions, and 3-4 person teams comprised of Core Planning Group Members and local content experts facilitated the breakout sessions for all five planning meetings, resulting in draft goals, objectives, strategies, and performance indicators. The CHIP Workgroups utilized a template Implementation Plan that was adapted from the Wisconsin CHIP Infrastructure Project and was modified for the Austin / Travis County Community Health Improvement Process Action Plan.[6]

The Core Planning Group and HRiA provided sample evidence based strategies from a variety of resources including *the Community Guide to Preventive Services, County Health Rankings*, and the *National Prevention Strategy* for the strategy setting sessions. As policy is inherently tied to sustainability and effectiveness, workgroups indicated whether or not strategy implementation would necessitate policy changes. In addition, as noted by one of the local content experts Andrew Springer, "the strategies were meant to be broad enough to allow for creative thinking in terms of how to operationalize the strategy".

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[4] The World Health Organization http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html

[5] Brennan Ramirez LK, B.E., Metzler M., Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, Centers for Disease Control and Prevention, Editor. 2008, Department of Health and Human Services,: Atlanta, GA.)

[6] The Wisconsin CHIP Implementation Plan is accessible via the following link. http://www.walhdab.org/documents/TemplateImplementationPlanv1.0.doc

The Core Planning Group, the HRiA consultants and the Workgroup facilitators reviewed the draft output from the planning sessions and edited material for clarity, consistency, and evidence base. This feedback was incorporated into the final versions of the CHIP contained in this report.

III. CHIP IMPLEMENTATION PLAN

Goals, Objectives, Strategies, Key Partners, and Output/Outcomes Indicators

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing of the desired future, and a clear evaluation of whether efforts are making a difference. Output and Outcome indicators tell the story about where a community is in relation to its vision, as articulated by its related goals, objectives, and strategies.

The following pages outline the Goals, Objectives, Strategies, Potential Output and Outcomes Indicators, and Potential Partners/Resources for the four health priority areas outlined in the CHIP. Data from the Community Health Assessment is included in the beginning section of each priority area. **See Appendix B for a glossary of terms** used in the CHIP.

A. Priority One: Chronic Disease – Focus on Obesity

The quantitative results in the Austin/Travis County 2012 CHA show that in 2008-2010, the percentage of obese adults in Travis County (24.0%) was less than that of the state (29.6%), both of which are better than the HP2020 target (30.6%). It also showed however, that the obesity epidemic is much more severe in communities of color. Locally in Austin/Travis County, obesity among adult Blacks/African Americans is 41.7% and among Latinos/Hispanics it is 36.5% compared to less than 20% of Whites (19.4%).[7] This pattern is consistent for the youth population (grades 9-12), where the percentage of obese youth at the county level (10.1%) was below that of Texas overall (15.6%) and the national HP2020 target (14.6%), yet higher among Blacks/African Americans (12.0%) and Latinos/Hispanics (13.0%).[8] To address the issue of health equity, efforts must be targeted to address obesity prevention, along with related disease rates like type 2 diabetes, heart disease, stroke, hypertension and obesity related-cancer in communities with the highest burden of disease. Investments must also be made that result in policy and environmental changes that impact the entire population and make healthy eating and active living possible for all members of the community.

[7] Centers for Disease Control and Prevention (CDC), Texas Behavioral Risk Factor Surveillance Survey Data, 2008-2010

[8] Note: Obesity defined as at or above the 95th percentile body mass index (BMI) by age DATA SOURCE: Centers for Disease Control and Prevention (CDC). Travis County Youth Risk Behavioral Survey. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2010 and 2011

PRIORITY AREA 1: CHRONIC DISEASE – FOCUS ON OBESITY		
Goal 1: Reduce burden of chronic diseases caused by obesity among Austin/Travis County residents.		
Performance Measures - How We Will Know We are Making a Difference		
Short Term Indicators (by objective)	**Source**	**Frequency**
1.1 Increase the % of adults that engage in aerobic physical activity for 150 minutes per week in Austin/Travis County.	Behavioral Risk Factor Surveillance Survey (BRFSS)	Annual
1.1 Increase the % of youth engage in physical activity for at least 60 minutes per day on 5 or more days per week in Austin/Travis County.	School Physical Activity and Nutrition (SPAN) project9, Youth Risk Behavior Survey (YRBS)	Annual
1.1 Increase the % of Joint Use Agreements (with schools, parks, neighborhood centers and # of hours available)	Partners/ Stakeholders	Varies (contingent on resources)
1.1 Increase the % of environmental/policy changes that promote physical activity (breakdown by setting and population groups)	Transportation CHIP Workgroup	Annual
1.2 Increase the % of mothers who breastfeed for six months (12 months optimal)	Women Infants and children (WIC) population	Annual

[9] SPAN is the School Physical Activity and Nutrition Project conducted by researchers at the University of Texas School of Public Health in Houston and funded by the Texas Department of State Health Services. For more information, visit: https://sph.uth.edu/research/centers/dell/span-school-physical-activity-and-nutrition/
As of December 2012, the most recent published SPAN data may be accessed via: www.jacn.org/content/29/4/387.long

PRIORITY AREA 1: CHRONIC DISEASE – FOCUS ON OBESITY **Goal 1: Reduce burden of chronic diseases caused by obesity among Austin/Travis County residents.**		
1.2 Increase the # of sites with a mother friendly worksite breastfeeding policy[10]	Department of State Health Services (DSHS)	Annual
1.3 Increase % of child care settings that promote healthy eating	Child care settings	Annual
1.4 Decrease soda consumption among youth (for adults need to check on available data)	YRBS and worksites	Varies (contingent on resources)
1.4 Increase % of environmental/policy changes that promote drinking water and decrease access to sugar sweetened beverages	BRFSS, YRBS and childcare settings	Varies (contingent on resources)
Long Term Indicators (for Goal)	**Source**	**Frequency**
Decrease the percentage of adults who report a BMI > = 30 from 24% to 22.8%	BRFSS	Annual
Decrease the percentage of youth who report a BMI > = 30 from 10.1% to 9.6%.	YRBS/Fitness Gram	Varies (contingent on resources)

[10] According to the Texas Department of State Health Services, "Mother-Friendly Worksites are businesses that proactively support employees who choose to breastfeed their infants. Creating and implementing a Mother-Friendly policy is both simple and inexpensive. The most basic Mother-Friendly policies need only provide a private space, flexible scheduling for break time and other basic support so that mothers may express and store breast milk for their babies. Every employer can develop a policy that suits the unique needs of the business and its employees. By creating a customized policy and putting basic elements in place, mother-friendly businesses support employees to ease the transition back to work after parental leave while continuing to provide their babies with the very best nutrition." For more information, visit: http://www.texasmotherfriendly.org/what-is-mother-friendly.

PRIORITY AREA 1: CHRONIC DISEASE – FOCUS ON OBESITY

Goal 1: Reduce burden of chronic diseases caused by obesity among Austin/Travis County residents.

Objective 1.1: By April 2016, increase by 5% the percent of adults and children in Travis County who meet or exceed physical activity guidelines for health.

BACKGROUND ON STRATEGY/OBJECTIVE: Increase Physical Activity among Adults and Children

Source: The Community Guide, NPLAN: Joint-Use Agreements
http://changelabsolutions.org/sites/phlpnet.org/files/Playing_Smart-National_Joint_Use_Toolkit_FINAL_20120309.pdf
Centers for Disease Control and Prevention Guide to Strategies for Increasing Physical Activity in the Community
https://www.myctb.org/wst/npaoeval/Shared%20Documents/Guidance%20Document%201.%20Physical%20Activity.pdf

Evidence Base: Studies demonstrate a broad range of effective physical activity promotion strategies appropriate for public health agencies and their partners that include: Community Wide Campaigns, Increased Access with Informational Approaches, and Increased Opportunities for Physical Activity in Schools. Enhanced playgrounds and playground amenities (basketball courts, playground markings, etc.) are positively related to increased physical activity in children and adolescents (Sallis et al., Ridgers et al., 2007; Stratton & Mullan, 2005). Active Living Research: Promoting physical activity through shared use of school and community recreational resources. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf72558

Policy Change (Y/N): Yes, policy changes in settings implementing joint use agreements[11] and policies to support physical activity.

Strategies:

Strategy 1.1.1: Conduct a community-wide physical activity media campaign that promotes physical activity and provides concrete steps on how to do so (e.g. walk or bike with your kids to take them to school instead of driving).

Strategy 1.1.2: Increase access and enhance quality of existing programs that promote physical activity among youth.

Strategy 1.1.3: Enhance the built environment in multiple settings (including worksites, places of worship, schools, parks, neighborhoods) to create opportunities for physical activity.

Strategy 1.1.4: Increase access to local school facilities, fields, basketball courts, community recreational facilities, parks, play grounds, etc. by establishing new joint- use agreements and improving adherence to existing joint-use agreements.

Strategy 1.1.5: Increase the number of settings with policies that promote/support physical activity (including worksites, schools, etc.).

Potential Partners

- City of Austin Mayor's Office, Children's Optimal Health, Youth Sports Leagues, WIC, United Way, Success by 6

[11] Change Lab Solutions defines a joint use agreement as "a formal agreement between two separate government entities–often a school and a city or county–setting forth the terms and conditions for shared use of public property or facilities". For more information, visit: http://changelabsolutions.org/publications/model-JUAs-national.

PRIORITY AREA 1: CHRONIC DISEASE – FOCUS ON OBESITY

Goal 1: Reduce burden of chronic diseases caused by obesity among Austin/Travis County residents.

Objective 1.2: By April 2016, increase the number of Travis County workplaces that have family supportive breastfeeding by 5%.

BACKGROUND ON STRATEGY/OBJECTIVE: Breastfeeding

Source: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm

Evidence Base: Breastfeeding has been linked to decreased risk of pediatric overweight in multiple epidemiologic studies.

Policy Change (Y/N): Yes, Local government has a policy requiring local government facilities to provide breastfeeding accommodations for employees that include both time and private space for breastfeeding during working hours.

Strategies:

Strategy 1.2.1: Develop mother friendly worksite breastfeeding policy template.

Strategy 1.2.2: Promote mother friendly worksite policies among small business, hospitality industries, and employers of hourly wage earners.

Strategy 1.2.3: Promote mother-friendly spaces in commercial business property potentially through certification program.

Strategy 1.2.4: Increased sensitivity for breastfeeding in the workplace through employee/employer training, flexibility in work schedules, etc.

Strategy 1.2.5: Increase awareness of breastfeeding benefits across the entire community through media and community wide campaigns.

Potential Partners

- Workforce Solutions, HR Professional Networks, Local chambers of commerce, including Hispanic, African-American, Asian, and general, Consulates – Ventanilla de Salud, Unions, Employment Resources – organizations who help job seekers, Mayor's Fitness Council, La Leche League, Any Baby Can, WIC, Mother's Milk Bank, Medical Societies, Hospitals, Clinics

PRIORITY AREA 1: CHRONIC DISEASE – FOCUS ON OBESITY

Goal 1: Reduce burden of chronic diseases caused by obesity among Austin/Travis County residents.

Objective 1.3: By April 2016, increase by 5% the number of Travis County child care settings that promote healthy eating. (Child care day operations are defined on the following page)

BACKGROUND ON STRATEGY: Obesity prevention strategies in child care settings
Source: Institute of Medicine, http://www.iom.edu/Reports/2011/Early-Childhood-Obesity-Prevention-Policies/Recommendations.aspx
Evidence Base: A wide range of environmental factors can influence a child's risk for obesity in the first years of life. There is a growing evidence base that emphasizes the importance of assessing the beginnings of obesity and instituting preventive measures in the early years.
Policy Change (Y/N): Yes, policy change would occur at the local childcare settings

Strategies:

Strategy 1.3.1 Build capacity of child care settings to promote healthy eating.

Strategy 1.3.2 Implement policies that increase access to drinking water and healthy food procurement.

Strategy 1.3.3 Publicize child care settings that meet requirements.

Strategy 1.3.4 Build capacity among caregivers of children in childcare settings to advocate for healthy food options.

Potential Partners

- Texas Department of State Health Services, Texas Department of Family & Protective Services, (See) Community Transformation Grant strategy on child care settings, Michael and Susan Dell Center for Healthy Living Coordinated Approach to Child Health (CATCH) in preschool, Deanna Hoelscher – University of Texas School of Public Health (UTSPH), Children's Optimal Health, Success by 6, Workforce Development Board, Early Childhood Council, Centex After School Network, Look at best practices from San Antonio

Objective 1.4: By April 2016, reduce the percent of children and adults who consume sugar sweetened beverages by 5%.

BACKGROUND ON STRATEGY Access to Sugar Sweetened Beverages
Source: http://www.cdph.ca.gov/SiteCollectionDocuments/StratstoReduce_Sugar_Sweetened_Bevs.pdf
Evidence Base: Several social and environmental factors are linked to the purchase and consumption of SSBs. These factors include advertising and promotion; increased portion sizes; fast food consumption; television watching; permissive parenting practices; parental SSB consumption; and increased access to SSBs in the home and school. Evidence that increasing water can reduce calories consumed from SSB: Giles et al., 2012. Am J Prev Med 2012;43(3S2):S136 –S142
Policy Change (Y/N): Yes, in settings that offer beverages or provide access to beverages

Strategies:

Strategy 1.4.1 Increase the number settings with food procurement policies that reduce access to sugar sweetened beverages.

Strategy 1.4.2: Increase the number of settings that promote the availability of drinking water.

Potential Partners

- Independent School Districts in city of Austin and Travis County
- Austin Water Utility, Youth Sports Leagues, Michael and Susan Dell Center for Healthy Living

Definition of Child Care Day Operations from Texas Department of Family and Protective Services

Listed Family Home**:** A caregiver provides care in the caregiver's own home for three or fewer children unrelated to the caregiver, birth through 13 years old, for at least four hours a day, three or more days a week, and more than nine consecutive weeks. The total number of children in care, including children related to the caregiver, may not exceed 12.

Registered Child-Care Home: A caregiver provides regular care in the caregiver's own home for not more than six children from birth through 13 years old, and may provide care after school hours for not more than six additional elementary school children. The total number of children in care at any given time, including the children related to the caregiver, must not exceed 12.

Licensed Child-Care Home: The caregiver provides care in the caregiver's own home for children from birth through 13 years old. The total number of children in care varies with the ages of the children, but the total number of children in care at any given time, including the children related to the caregiver, must not exceed 12.

Licensed Center**:** An operation providing care for seven or more children under 14 years old for less than 24 hours per day at a location other than the permit holder's home

- Child Care Program: is a licensed center that provides care for children under 14 years of age for less than 24 hours a day, but at least two hours a day, three or more days a week.
- Before or After-School Program: is a licensed center that provides care before or after, or before and after, the customary school day and during school holidays, for at least two hours a day, three days a week, to children who attend prekindergarten through grade six.
- School-Age Program: is a licensed center that provides supervision, along with recreation or skills instruction or training, and may provide transportation, before or after the customary school day, for at least two hours a day, three days a week, to children attending prekindergarten through grade six. A school-age program may also operate during school holidays, the summer period, or any other time when school is not in session.

B. Priority Two: Built Environment – Focus on Access to Healthy Foods

The built environment is broadly defined as manmade surroundings that include buildings, public resources, land use patterns, the transportation system, and design features.[12] Research continues to show that there is a link between the built environment, specific to this priority area, and access to affordable high-quality produce and other healthy foods, which in turn influences the choices people make in their daily lives. Improving the built environment is an important part of a strategic approach to reducing health disparities. Healthy foods are not equally available across all communities. Low income individuals and people of color are more likely to live in communities where residents have limited access to fresh fruits and vegetables and have a higher concentration of fast food outlets.

In 2006, 8.7% of Travis County's low-income population did not live close to a grocery store (i.e., less than 1 mile).[13] Less than 30% of Travis County and Texas adult residents reported eating five or more fruit and vegetable servings per day (the recommended guideline)[14]. Consumption was even lower for Black/African American and Latino/Hispanic adults in Travis County (both at 24.1%). When this data was stratified by income in Travis County, it was noted that the percentage of adults who consume the recommended amount of fruits and vegetables increased with income.[15]

The following action plan to promote access to affordable, healthy food is focused on three areas:

1. There are a number of programs that provide or subsidize nutritious food for residents
2. with low-incomes or other disadvantages. Ensuring that more eligible residents benefit from such programs can improve their ability to secure healthy food.
3. Geography can frequently be a barrier to access to healthy food in low-income neighborhoods. Steps can be taken to make healthy food more accessible physically by promoting production and distribution of healthy food within these neighborhoods.
4. Frequently, easy access to unhealthy food keeps people from accessing healthy food. Policy changes can make it harder to locate sources of unhealthy food in and around targeted areas.

[12] Transportation Research Board of the National Academies, "Special Report 282: Does the Built Environment Influence Physical Activity? Examining the Evidence," retrieved from http://www.trb.org/news/blurb_detail.asp?id=4536.

[13] United States Department of Agriculture, Food Environment Atlas (2006) as cited in County Health Rankings, 2012

[14] Centers for Disease Control and Prevention (CDC). Texas Behavioral Risk Factor Surveillance Survey Data. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2007 and 2009

[15] Centers for Disease Control and Prevention (CDC). Texas Behavioral Risk Factor Surveillance Survey Data. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2007 and 2009

PRIORITY AREA 2: BUILT ENVIRONMENT – FOCUS ON ACCESS TO HEALTHY FOODS		
Goal 2: All in our community have reasonable access to affordable quality nutritious food.		
Performance Measures - How We Will Know We are Making a Difference		
Short Term Indicators (by objective)	**Source**	**Frequency**
Increase % of farms, community gardens, private gardens (count of farms and community gardens regulated by City of Austin)	Austin/Travis County Health and Human Services Department (A/TCHHSD)	Annual
Increase % of Travis County low-income residents who are not living within 1 mile of grocery store (non-traditional distribution sites)	County Health Rankings (CHR)	Annual
Increase in the number of non-traditional distribution sites (i.e. farm-to-site programs, farmers markets)	A/TCHHSD	Annual
Increase in the # of traditional distribution sites	A/TCHHSD	Annual
Increase % of the municipalities that adopt healthy food zone policy	A/TCHHSD	Annual
Increase % of land area covered by healthy food zone policy (calculated and mapped, ATC HHSD)	A/TCHHSD	TBD
Long Term Indicators (for Goal)	**Source**	**Frequency**
% of adults reporting eating 5+ servings of fruits and vegetables/day	BRFSS	Annual
% of youth reporting eating 4+ servings of fruits and vegetables/day	YRBS	Varies (contingent on resources)
% of (individuals or families, depending on what unit Feeding America reports) that are food insecure	Feeding America	Annual

PRIORITY AREA 2: BUILT ENVIRONMENT – FOCUS ON ACCESS TO HEALTHY FOODS

Goal 2: All in our community have reasonable access to affordable quality nutritious food.

Objective 2.1: By April 2016, increase by 50% access to and participation of eligible people in food assistance programs (ex. SNAP, WIC, school breakfast and lunch program, summer food service, Elderly Nutrition Program) that increase access to healthy food.[16]

BACKGROUND ON STRATEGY/OBJECTIVE:

Source: From Food Research and Action Center Issue Briefs for Child Nutrition Reauthorization | Number 1, February 2010; http://www.frac.org/pdf/CNR01_qualityandaccess.pdf

Evidence Base: "There is considerable evidence about the effective role that participation in the federal nutrition programs plays in providing the nutrients children need for growth, development, and overall health. There also is a growing body of research on how the programs impact obesity. For these reasons, increasing participation in the federal nutrition programs is one of the healthy eating and physical activity strategies recommended in the Institute of Medicine's report Local Government Actions to Prevent Childhood Obesity.

Policy Change (Y/N): No

[16] Objective 2.1 focuses on increasing participation and access to food assistance programs but does not impact eligibility.

PRIORITY AREA 2: BUILT ENVIRONMENT – FOCUS ON ACCESS TO HEALTHY FOODS

Goal 2: All in our community have reasonable access to affordable quality nutritious food.

Objective 2.1: By April 2016, increase by 50% access to and participation of eligible people in food assistance programs (ex. SNAP, WIC, school breakfast and lunch program, summer food service, Elderly Nutrition Program) that increase access to healthy food.[17]

Strategies:

Strategy 2.1.1: Conduct assessment to establish baseline of the following:

a) current programs and services to determine which do support access to healthy foods
b) current capacity of relevant programs
c) participation (#/%) in relevant programs to determine which could absorb additional participants versus those that would require additional capacity before further enrollment could take place
d) gap analysis – population, geographic areas that are underserved –to understand what barriers seem to prevent participation and what means exist to overcome these barriers.

Strategy 2.1.2: Work with government and local community organizations to increase ease of access to food assistance program applications, local offices, and eligibility requirements so as to connect as many eligible people to benefits as possible (application assistance, use electronic applications or call centers, roving case workers, Benefits Bank, extending office hours, additional accommodations to applicants with language barriers or disabilities). Programs to be targeted will be identified through the assessment process described in strategy 2.1.1.

Strategy 2.1.3: Develop and implement an education/outreach strategy to increase the reach of Food Assistance Programs (as identified in 2.1.1) by enhancing awareness of the program's existence, eligibility requirements, and benefits may include: radio ads, brochures, community education, cooking demonstrations, community partnerships and retailers.

a) increase demand for nutritious food
b) reduce stigma of participation

Strategy 2.1.4: By April 2016, increase capacity of quality programs (programs identified in Strategies 2.1.1a and 2.1.11d)

Potential Partners

- Grocery Chains, Capital Area Food Bank, Sustainable Food Policy Board, 2-1-1 (and any other orgs providing referral to food sources) , Any social service agency performing means testing

[17] Objective 2.1 focuses on increasing participation and access to food assistance programs but does not impact eligibility.

PRIORITY AREA 2: BUILT ENVIRONMENT – FOCUS ON ACCESS TO HEALTHY FOODS

Goal 2: All in our community have reasonable access to affordable quality nutritious food.

Objective 2.2: **By April 2016, ensure that two new distribution and production points for healthy food are available and accessible in each of the five high need areas (The 5 areas currently without a full service grocery store are: 78723,78724,78725,78744, and 78754]). "Distribution Point" in this context refers to a physical location where affordable quality nutritious food can be accessed, including, but not limited to, grocery stores, farmers markets, and farm-to-site programs. "Production points" include, but are not limited to, farms and community gardens.**

BACKGROUND ON STRATEGY/OBJECTIVE
Source: CDC
Evidence Base: http://www.policylink.org
Policy Change (Y/N): No

Strategies:

Strategy 2.2.1: Implement assessment to inform strategies and targeting
a) where people travel/gather
b) where and what food is available

Strategy 2.2.2: Build partnership (with schools, parks, faith based community, businesses, community centers, etc.) to establish distribution and productions sites (i.e. community gardens, farmers markets, farm to site programs) in public or private spaces and organizations.

Strategy 2.2.3: Incentivize private enterprise to provide healthy, nutritious, and affordable food by establishing full service grocery stores in low-income communities

Strategy 2.2.4: Develop/implement education/messaging strategy to a) increase demand, b) ensure cultural relevance

Potential Partners

- Full Service Grocery Stores, Sustainable Food Center , Urban Roots, City of Austin Economic Growth and Redevelopment Services Office, Farmer's Markets, Faith Based organizations, Austin Water Utility

PRIORITY AREA 2: BUILT ENVIRONMENT – FOCUS ON ACCESS TO HEALTHY FOODS

Goal 2: All in our community have reasonable access to affordable quality nutritious food.

Objective 2.3: By April 2016, all local municipalities will establish a healthy food zone ordinance around schools, municipal parks, child care centers, libraries and recreation centers.

BACKGROUND ON STRATEGY/OBJECTIVE

Source: The National Policy & Legal Analysis Network to Prevent Childhood Obesity [18]

Evidence Base:

http://changelabsolutions.org/sites/phlpnet.org/files/nplan/HealthyFoodZone_Ordinance_FINAL_091008.pdf

Policy Change (Y/N): Yes

Strategies:

Strategy 2.3.1: Develop model policy(s) for city/county government promoting healthy food zones

Strategy 2.3.2: Engage the following to develop and support the health food zone ordinance

- advocacy groups
- grass roots/residents
- policy/thought leaders
- community residents

Potential Partners

- Travis County municipalities, Travis County, child care centers, independent school districts, colleges and universities

Model Healthy Food Zone Ordinance Developed by the National Policy & Legal Analysis Network to Prevent Childhood Obesity (NPLAN): The model Healthy Food Zone Ordinance prohibits the location of fast food restaurants within a certain distance (as determined by the community) of schools, and (again, as determined by the community) parks, child care centers, libraries, and other locations children frequent. Before enacting the ordinance, we recommend that the community conduct a mapping study or assessment to identify where fast food restaurants, mobile vendors, and neighborhood corner and convenience stores are located in proximity to schools. This study would help to identify (1) the current landscape of fast food; (2) whether a restrictive ordinance would be beneficial to the community; and (3) what buffer distance would be most appropriate for the community. If the community is contemplating a ban on mobile food vendors, a study would also help it determine an appropriate distance for that ban. Geographic information systems (GIS) mapping tools can be useful for completing these studies.

[18] The ordinance could be modeled on the work of the National Policy and Legal Analysis Network to Prevent Childhood Obesity; their model restricts fast food restaurants near schools or other areas children are likely to frequent.

C. Priority Three: Built Environment – Focus on Transportation

Researchers and community members alike have identified creating built environments that support healthy eating and active living as essential for good health. [19] Important characteristics of the built environment that are critical to supporting an active lifestyle include a good public transit system, the ability to walk or bike for transportation, parks, recreational facilities, and open spaces, and a community that is safe. Public transit is essential as it extends the distance people can travel via foot or bicycle. An environment that supports access to alternative modes of transportation instead of primarily cars can help people maintain an active lifestyle. Built environment features that place bus or train stops within walking distance of housing, offices, retail, and open spaces make it more convenient for people who live or work in these communities to travel by foot or by public transportation instead of by car.[20]

According to the Austin/Travis County 2012 CHA, census tract data in Austin reveal that at least one in eight households in some areas has no access to a car and must rely on public transportation to get to and from work, the grocery store, and the doctor's office.[21] Challenges around public transportation included long wait times for the bus, having to walk over a mile to the nearest bus stop, and rising fares. In 2010, the cost of transportation as a percent of income for Travis County was 24.4%.[22] According to focus group participants, transportation challenges disproportionately affected the elderly, disabled, and poor. For example, participants cited the limited availability of Capital Metro vehicles to transport the elderly and disabled. Residents living outside of Austin shared that they had to rely on a car because their community had no access to public transportation, highlighting the lack of a robust public transportation system that extends to outlying areas.

[19] H. Frumkin, "Healthy Places: Exploring the Evidence," American Journal of Public Health 93 (2003): 1451-1456.

[20] Strategies for Enhancing the Built Environment to Support Healthy Eating and Active Living, Prevention Institute Convergence Partnership (2008). Retrieved from http://www.calendow.org/uploadedFiles/Publications/Publications_Stories/builtenvironment.pdf

[21] U.S. Department of Commerce, Bureau of the Census, 1-year estimate American Community Survey (2009)

[22] The Housing and Transportation Affordability Index, Housing Costs as a Percent of Income: Travis County. Center for Neighborhood Technology (2010). Retrieved from http://htaindex.cnt.org/

PRIORITY AREA 3: BUILT ENVIRONMENT – TRANSPORTATION		
Goal 3: Local and regional stakeholders will collaboratively increase accessibility to community resources via safe, active transportation.		
Performance Measures - How We Will Know We are Making a Difference		
Short Term Indicators (by objective)	**Source**	**Frequency**
By April 2014, there will be a 2% increase in the number of adults that engaged in aerobic physical activity for 150 minutes per week in Austin/Travis County	BRFSS	Annual
By April 2014, there will be a 2% increase in the number of students that have engaged in physical activity for at least 60 minutes per day on 5 or more days per week in Austin/Travis County.	YRBS	Annual
Long Term Indicators (for Goal)	**Source**	**Frequency**
By April 2016, increase daily walking and cycling duration (minutes per capita per day) by at least 15% from the 2009 data, across all the population subgroups in Austin/Travis County.	National Household Travel Survey	Every 5 years (next survey year – 2015)
By April 2016, increase daily walking and cycling distance (miles per capita per day) by at least 15% from the 2009 data, across all population subgroups in Austin/Travis County.	National Household Travel Survey	Every 5 years
By April 2016, increase prevalence of 30 minutes of walking per day and 30 minutes of cycling per day by at least 15% from the 2009 data, across all population subgroups in Austin/Travis County.	National Household Travel Survey	Every 5 years
Active transportation commute mode share increase by 15% by April 2016.	American Community Survey	Every 5 years

PRIORITY AREA 3: BUILT ENVIRONMENT – TRANSPORTATION

Goal 3: Local and regional stakeholders will collaboratively increase accessibility to community resources via safe, active transportation.

Objective 3.1: April 2016, increase Travis County active transportation commute mode share from 6.7% to 7.7%.

BACKGROUND ON STRATEGY/OBJECTIVE

Source: CDC, APHA

Evidence Base: http://www.cdc.gov/transportation/references.htm; http://www.apha.org/advocacy/priorities/issues/transportation

Policy Change (Y/N) Yes

Strategies:

Strategy 3.1.1: Work with school districts, community colleges, universities, businesses, city and county government to implement programs that educate, incentivize, and encourage the use of active transportation (use of public transportation, walking biking and carpooling) among commuters with a specific target on the disadvantaged.

Strategy 3.1.2: Enhance enforcement of existing policies/laws that ensure the safety of active transportation users. (The planning group identified that safety has to be addressed in order to increase the number of active transport commuters, especially bike & walk, through enforcement of existing laws)

Strategy 3.1.3: Develop and implement policies that level the playing field between active transportation and other modes of transportation (e.g. Changes to parking policies to reflect the true cost of providing the real estate to allow this function; Dedicating travel lanes on public right-of-ways (where appropriate) to allow transit travel times to be competitive with the private cars, etc.).

Potential Partners

- School districts, universities and community colleges, Safe Routes to Schools, City of Austin and Imagine Austin

Objective 3.2: By April 2016, our community through its local authorities will approve a comprehensive funding plan for implementation of the active transportation master plans (i.e. sidewalks, bike, trails, transit, etc.).

BACKGROUND ON STRATEGY/OBJECTIVE

Source: Plans housed in City of Austin and CAMPO. The majority of the active transportation master plans already exist. However, our community needs to find ways to fund them

Evidence Base: Promote Active Transportation, http://www.cdc.gov/transportation/references.htm; http://policy.rutgers.edu/faculty/pucher/pucher_dill_handy10.pdf

Policy Change (Y/N): No

Strategies:

Strategy 3.2.1: inventory and align existing active transportation plans, and identify gaps, prioritizing the needs of the disadvantaged.

Strategy 3.2.2: inventory and identify resources needed to implement active transportation plans.

Strategy 3.2.3: develop comprehensive active transportation funding master plan using 3.2.1 and 3.2.2.

Potential Partners

- City of Austin, Safe Routes to School

PRIORITY AREA 3: BUILT ENVIRONMENT – TRANSPORTATION

Goal 3: Local and regional stakeholders will collaboratively increase accessibility to community resources via safe, active transportation.

Objective 3.3: By April 2016, the City of Austin and Travis County will require and incentivize active transportation connections for all new development outside of the activity centers identified in the Capital Area Metropolitan Planning Organization's (CAMPO) 2035 Plan.

BACKGROUND ON STRATEGY/OBJECTIVE
Source: CDC; Complete Streets; Active Transportation Policy
Evidence Base: Encourage Healthy Community Design; www.completestreets.org; http://www.atpolicy.org/reforming-land-use-and-zoning-regulations-promote-active-transportation
Policy Change (Y/N): Yes

Strategies:

Strategy 3.3.1:	Convene local government and the development community to identify policies to incentivize development with active transportation and disincentives development without it.
Strategy 3.3.2:	Modify development policies to encourage active transportation.
Strategy 3.3.3:	Adopt a policy to require active transportation in new public facility location decisions.
Strategy 3.3.4:	Work with government and non-government organizations to implement a Complete Streets policy in the City of Austin and Travis County.

Potential Partners

- Municipalities in Travis County, Homebuilder Association, Real Estate Council, Chambers of Commerce, Urban Land Institute

Transportation Definitions

Active transportation: Active Transportation includes any method of travel that is human-powered, but most commonly refers to walking, bicycling and using public transit. People are more physically active when they ride a bike, walk or take public transportation.

Active transportation commute mode share: Proportion of total commute (school or work) trips that are taken via active transportation.

CAMPO activity center: Multiple areas defined by our Metropolitan Planning Organization to accommodate the majority of future regional growth. Activity centers are:

a. More intensely developed than their surroundings ƒ
b. Pedestrian-oriented (many destinations within walking distance, safe and convenient pedestrian facilities)
c. Connected to surrounding neighborhoods and the region by a range of transportation options
d. Possess a mix of employment, housing, and retail and
e. Tailored to the local area;

More information on CAMPO here: http://www.campotexas.org/pdfs/CAMPO%202035%20Growth%20Concept_07_516Revised.pdf

D. Priority Four: Access to Primary Care and Mental/Behavioral Health Services – Focus on Navigating the Healthcare System

Access to affordable primary health care has posed one of the most persistent challenges to our health care system. Even people who have health insurance can be medically disenfranchised, but it is low-income, uninsured, and minority populations who are disproportionately affected. These individuals, and many others who confront additional barriers to care including language and culture, transportation, provider shortages and poor physician distribution, require a source of regular, continuous primary and preventive care.[23]

BRFSS data from 2008-2010 showed that adults in Travis County report having private or public health care coverage at a rate (80.9%) slightly higher than the state (75.9%). However, only 73.4% of the Black/African American population and 58.6% of the Latino/Hispanic population reported having health care coverage. Additionally, according to BRFSS data, approximately three-fourths of Travis County adults reported that they had a personal doctor or health care provider in 2008-2010, which was slightly higher than that of the state. As seen with health care coverage rates however, the Latino/Hispanic population of Travis County had a notably lower percentage of adults reporting having a doctor (60.9%) compared to 73.5% of Black/African Americans and 82.5% of Whites.[24]

In addition to improving the primary care health system, evidence exists that demonstrates that integration of primary care and behavioral health care can improve access to individuals suffering from behavioral health issues. Integrating mental health services into a primary care setting offers a promising, viable, and efficient way to ensuring that people have access to needed mental health services. Successful integration however, requires the support of a strong primary care delivery system.

Mental health was one of the foremost health concerns raised by Travis County residents in the 2012 CHA. Focus group participants and interviewees reported rising rates of mental health conditions among residents in the region, its relationship with substance abuse, and the challenges of inadequate mental health services. Consistent with the state percentage, approximately 20% of Travis County adults experienced five or more days of poor mental health in the past month. A greater proportion of Blacks/African Americans (24.3%) and Latinos/Hispanics (26.6%) reported poor mental health than did Whites in the County (17.9%).[25]

[23] Primary Care Access: An Essential Building Block of Health Care Reform. NACHC, 2009, see http://www.nachc.com/client/documents/pressreleases/PrimaryCareAccessRPT.pdf

[24] Centers for Disease Control and Prevention (CDC). Texas Behavioral Risk Factor Surveillance Survey Data. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010.

[25] Centers for Disease Control and Prevention (CDC). Texas Behavioral Risk Factor Surveillance Survey Data. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

PRIORITY AREA 4:
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES - FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM

Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.

Performance Measures - How We Will Know We are Making a Difference

Short Term Indicators (by objective)	Source	Frequency
4.1, 4.4 Increase % of utilized patient centered best practices	local safety net provider survey	Annual
4.1 - 4.4 Increase % of patients connected to a Joint Commission or National Committee for Quality Insurance (NCQA) certified medical home	Joint Commission, NCQA (to establish baseline)	Annual
4.1, 4.4 Increase % of providers trained on health literacy	Literacy Coalition of Central Texas/other known providers of health literacy training (organizational records, e.g. provider sign in sheet); and/or local provider survey	Annual
4.1, 4.4 Increase %of patients trained on health literacy	Literacy Coalition of Central Texas/other known providers of health literacy training (organizational records, e.g. provider sign in sheet); and/or local provider survey	Annual
4.2 Increase % of providers serving safety net population using Health IT system	local safety net provider survey	Annual
4.2 Increase % of HHS providers using HIE	Centex Systems Support Services (CSSS)	Annual
4.2 Increase % of primary care and behavioral health providers using EHRs	local safety net provider survey, CSSS	Annual
4.3 Expand residency and training programs	Council on Graduate Medical Education (CGME); or DSHS, Health Professions Resource Center, Center for Health Statistics	Annual (If using CGME, may require a special query request)
4.3 Implementation of telemedicine within UMCB (University Medical Center Brackenridge), CHCs (Community Health Centers) and in support of MCOT (Mobile Crisis Outreach Team)	local safety net provider survey	Annual
4.5 Increase use of evidence based models	local provider survey	Annual

PRIORITY AREA 4:
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES - FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM

Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.

Performance Measures - How We Will Know We are Making a Difference

Short Term Indicators (by objective)	Source	Frequency
4.1-4.5 The HEDIS measures below are the precursors to long term system indicators. HEDIS measures were selected based on their impact on reducing "downstream" hospital admissions for ambulatory care sensitive conditions. Several measures were also selected to proxy for integration of primary medical and behavioral health. – Frequency of ongoing prenatal care – Comprehensive adult diabetes care – Use of appropriate medications for people with asthma – Medication management for people with asthma – Asthma medication ratio – Follow-up after hospitalization for mental illness – Antidepressant medication management – Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications – Diabetes monitoring for people with diabetes and schizophrenia – Cardiovascular monitoring for people with cardiovascular disease and schizophrenia – Adherence to antipsychotic medications for individuals with schizophrenia – Follow-up care for children prescribed ADHD medication	Healthcare Effectiveness Data and Information Set (HEDIS) 2013 and Centex Systems Support Services(CSSS) (Electronic health record chart audit)	Annual

PRIORITY AREA 4:
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES - FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM

Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.

Performance Measures - How We Will Know We are Making a Difference

Long Term Indicators (for Goal)	Source	Frequency
Increase the proportion of persons with a usual primary care provider	local provider survey AHRQ (national	Annual
Increase the proportion of persons who have a specific source of ongoing care	local provider survey AHRQ (national)	Annual
Decrease in ambulatory care sensitive conditions	Texas Department of State Health Services (Texas Hospital Discharge Dataset: recommended measures: low birth weight, hypertension, adult asthma, pediatric asthma, diabetes short-term, complications, diabetes – long-term, complications, uncontrolled diabetes, lower-extremity amputation, among patients with diabetes)	Annual
Reduce utilization of hospital, emergency room and psychiatric emergency services	Texas Department of State Health Services – Texas Hospital Discharge Dataset recommended measures: TBD	Annual
Reduce % of adults reporting one or more days of poor mental health over a one month period	BRFSS	Annual
Reduce % of hospital admissions that are potentially preventable	Texas Department of State Health Services – Texas Hospital Discharge Dataset recommended measures: TBD	Annual
Reduce % of emergency room visits that are potentially preventable	Texas Department of State Health Services – Texas Hospital Discharge Dataset recommended measures: TBD	Annual

PRIORITY AREA 4:
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES - FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM

Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.

Objective 4.1: April 2016, increase the adoption of patient-centered strategies within the safety net.

BACKGROUND ON STRATEGY/OBJECTIVE: The deployment of patient-centered strategies by safety net providers is central to the implementation of a patient-centered medical home (PCMH). Patient-centered strategies strive to account for the unique needs, culture, values, and preferences of an individual. Accordingly, the cultural and linguistic competence of providers of care becomes an important factor to formally assess and, where necessary, improve. "Linguistic competence" is perhaps the most readily understandable of these two concepts and can be defined as providing easy access to oral and written language services to limited English proficiency (LEP) patients through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators. "Cultural competence" may be defined as: "A set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework" (Cross et al, 1998). A combined definition of "cultural and linguistic competence" is offered as follows: "… the ability of healthcare providers/organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter" (OMH, 2000).

Source: Office of Minority Health (OMH); Agency for Healthcare Research and Quality (AHRQ); Institute of Medicine

Evidence Base:

Cultural and Linguistic Competence:

- Cross et al. 1998. Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. Washington DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.
- U.S. Department of Health and Human Services, Office of Minority Health. 2000. Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda. http://www.omhrc.gov/clas/finalpo.htm Accessed January 17, 2003.

Health Literacy:

- Health Literacy: A Prescription to End Confusion. Lynn Nielsen-Bohlman, Allison M. Panzer, David A. Kindig, Editors, Institute of Medicine, Committee on Health Literacy

Patient-Centered:

- Scholle SH, Torda P, Peikes D, Han E, Genevro J. Engaging Patients and Families in the Medical Home. (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2.) AHRQ Publication No. 10-0083-EF. Rockville, MD: Agency for Healthcare Research and Quality. June 2010.
- Suggested Citation: Peikes D, Genevro J, Scholle SH, primary care settings and patients. Publication No. 11-0029. Rockville, MD: Agency for Healthcare Research and Quality. February 2011.

Policy Change (Y/N): Yes

PRIORITY AREA 4:
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES - FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM

Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.

Strategies:

Strategy 4.1.1: Expand the # of safety-net health care providers that are Joint Commission or NCQA certified medical homes.

Strategy 4.1.2 Expand health literacy training to # of unduplicated patients served by Travis County safety net providers.

Strategy 4.1.3: Train # of providers at each participating agency on health literacy principles and effective patient-provider communication strategies.

Strategy 4.1.4: Expand the number of providers serving the safety net that are linguistically competent.

Strategy 4.1.5: Expand the number of providers serving the safety net that are culturally appropriate.

Strategy 4.1.6: Expand the number of providers serving the safety net who have locations, contact points, hours and appointment availability that meet the needs of that population.

Potential Partners

- LiveStrong, Central Health, United Way, Latino Healthcare Forum, Literacy Coalition of Central Texas, CSSS, Lone Star Circle of Care, CommUnity Care, El Buen Samaritano, Catholic Charities, People's Community Clinic, Seton Healthcare Family, Austin/Travis County Integral Care, Community Action Network, Travis County HHS & VS, InsuraKid, Any social service provider with case management/referral activities

Objective 4.2: By April 2016, expand by 10% the number of entities serving safety net populations that are utilizing health IT systems

BACKGROUND ON STRATEGY/OBJECTIVE: The deployment of patient-centered strategies by safety net providers is central to the implementation of a patient-centered medical home (PCMH). Patient-centered strategies strive to account for the unique needs, culture, values, and preferences of an individual. Accordingly, the cultural and linguistic competence of providers of care becomes an important factor to formally assess and, where necessary, improve. "Linguistic competence" is perhaps the most readily understandable of these two concepts and can be defined as providing easy access to oral and written language services to limited English proficiency (LEP) patients through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators. "Cultural competence" may be defined as: "A set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework" (Cross et al, 1998). A combined definition of "cultural and linguistic competence" is offered as follows: "… the ability of healthcare providers/organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter" (OMH, 2000).

Health literacy is a further concept that pertains to the deployment of patient-centered strategies and is related to cultural and linguistic competence. Many patients have difficulty comprehending and acting upon health information; and many types of health information contains complex text. Health literacy" can be defined as "…the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions" (Institute of Medicine, 2004). However, it is important to note

Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.

that health literacy goes beyond the individual. It also depends upon the skills, preferences, and expectations of health information providers. In sum, health literacy arises from a convergence of education, health services, and social and cultural factors.

In addition to cultural and linguistic competence and health literacy, patient-centered strategies seek to involve the patient in his/her care plan, support any ongoing self-care efforts that the patient is engaged in, and provide superior access to care (including convenient locations, a network of community contact points, hours of operation, after hours coverage, and appointments on demand).

Source: Office of Minority Health (OMH); Agency for Healthcare Research and Quality (AHRQ); Institute of Medicine

Evidence Base: *Cultural and Linguistic Competence:* Cross et al. 1998. Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. Washington DC: CASSP Technical Assistance Center, Georgetown University Child Development Center. U.S. Department of Health and Human Services, Office of Minority Health. 2000. Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda. http://www.omhrc.gov/clas/finalpo.htm Accessed January 17, 2003. *Health Literacy*: A Prescription to End Confusion. Lynn Nielsen-Bohlman, Allison M. Panzer, David A. Kindig, Editors, Institute of Medicine, Committee on Health Literacy
Patient-Centered: Scholle SH, Torda P, Peikes D, Han E, Genevro J. Engaging Patients and Families in the Medical Home. (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2.) AHRQ Publication No. 10-0083-EF. Rockville, MD: Agency for Healthcare Research and Quality. June 2010.Suggested Citation: Peikes D, Genevro J, Scholle SH, primary care settings and patients. Publication No. 11-0029. Rockville, MD: Agency for Healthcare Research and Quality. February 2011.

Policy Change (Y/N): Yes

Strategies:

Strategy 4.2.1: Encourage and incentivize health and human services providers to participate in a Health Information Exchange (HIE) for optimal client-provider interactions.

Strategy 4.2.2: Encourage and incentivize primary care and behavioral health providers to adopt and implement certified electronic health records (EHRs).

Potential Partners

- Lone Star Circle of Care, Community Care, People's Community Clinic, and Seton Healthcare Family, St. David's, El Buen Samaritano, Integrated Care Collaboration, CSSS, and Planned Parenthood, Austin/Travis County Integral Care, School Districts, VA Health System

PRIORITY AREA 4:
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES - FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM

Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.

Objective 4.3: By April 2016, expand by 5% primary care and behavioral/mental health workforce capacity who will care for safety-net population.

BACKGROUND ON STRATEGY/OBJECTIVE: A primary goal of care coordination is to transfer information (e.g. medical history, medication list, diagnostic results, patient preferences, etc.) from one individual/organization involved in a patient's care to another, including the transfer of information to the patient. Information and data sharing also occurs between/amongst: (1) health care professionals and patients and their families; (2) within teams of health care professionals; (3) across health care teams or settings. Important information sharing activities must also surround transitions of care (e.g. discharge from a hospital to home); (5) connecting the patient to community resources; and at the system level, where aggregate health information/data (e.g. the kind produced by an HIE) can assess the needs of populations, identify gaps, and realign systems to close them.

The effectiveness and efficiency of such care coordination activities is heavily dependent on the types of health information technology (HIT) systems available to providers of care, and the ability of those systems to interface with one another. Electronic health records (EHRs), and certified EHRs in particular, provide a foundation/baseline for the potential of information sharing via electronic connectivity. Health information exchanges (HIEs) further the ability of participants in a patient's care to communicate with one another via electronic means and serve the additional function of aggregating atomized patient information into a dataset that can be analyzed to assess population needs.

Source: Council on Graduate Medical Education (CGME); Health Resources and Services Administration (HRSA), Seton (primary care access study)

Evidence Base: HRSA Health Professional Shortage Areas

Policy Change (Y/N): Yes

Strategies:

Strategy 4.3.1: Increase the size of residency and training programs for primary and mental/behavioral health care providers (including physicians, nurses, social workers, and others) (This is an 1115 Waiver Strategy).

Strategy 4.3.2: Develop and implement telemedicine to increase access to MH/BH services (This is an 1115 Waiver Strategy).

Strategy 4.3.3: Develop and implement improved local reimbursement strategies.

Potential Partners

- Seton Healthcare Family, Central Health, UT, ATCIC, Community Care, Lone Star Circle of Care, Workforce Solutions, Austin Community College

PRIORITY AREA 4:
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES - FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM

Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.

Objective 4.4: By April 2016, increase the adoption of coordination strategies within the safety net.

BACKGROUND ON STRATEGY/OBJECTIVE: Coordination of care is one of the major functions of primary medical care, and a hallmark characteristic of PCMHs. Primary care creates cohesive care by integrating the range of services a patient needs. This integrative function–interpreting with patients the meaning of many streams of information and working together with the patient to make decisions based on the fullest understanding of this information in the context of a patient's values and preference–is one of the main reasons that primary care contributes substantially to the value of health care in many different health systems. Navigation models are one of the primary components that help clinical teams coordinate care and manage contact with the patient between office visits.

Source: Agency for Healthcare Research and Quality

Evidence Base: Meyers D, Peikes D, Genevro J, Peterson Greg, Taylor EF, Tim Lake T, Smith K, Grumbach K. The Roles of Patient-Centered Medical Homes and Accountable Care Organizations in Coordinating Patient Care. AHRQ Publication No. 11-M005-EF. Rockville, MD: Agency for Healthcare Research and Quality. December 2010.

Policy Change (Y/N): Yes

Strategies:

Strategy 4.4.1: Expand the # of safety-net health care providers who are Joint Commission or NCQA certified medical homes.

Strategy 4.4.2: Expand community navigation staff with access to HIE data across entire healthcare delivery system defined as contributors to ICARE.

Strategy 4.4.3: Increase the knowledge of existing health and social service resources among providers and the community.

Potential Partners

- LiveStrong, Central Health, United Way, Latino Healthcare Forum, Literacy Coalition of Central Texas, CSSS, Lone Star Circle of Care, CommUnity Care, El Buen Samaritano, Catholic Charities, People's Community Clinic, Seton Healthcare Family, Austin/Travis County Integral Care, Community Action Network, Travis County HHS & VS, InsuraKid, Any social service provider with case management/referral activities, Austin Community College, Workforce Solutions

PRIORITY AREA 4:
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES - FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM

Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.

Objective 4.5: By April 2016, expand comprehensive care strategies within the safety net.

BACKGROUND ON STRATEGY/OBJECTIVE: Comprehensive care strives to meet the majority of each patient's physical and behavioral health care needs, including prevention and wellness, acute, and chronic care. There are some groups of patients, especially amongst the safety net population, whose health care needs are complex, and who therefore require more intensive medical services coordinated across multiple providers. Patient characteristics that increase the complexity of care include multiple chronic or acute physical health problems, the social vulnerability of the patient, and a large number of providers and settings involved in a patient's care. Patients' preferences and their abilities to organize their own care can also affect the need for care coordination. Patients with high acuity levels require a range and intensity of services that can be met by PCMHs designed to provide coordinated and comprehensive care to patients with complex needs. Often, patients with complex needs have co-morbidities that require addressing both by primary medical care providers and by behavioral health providers. Traditionally, however, the delivery systems for primary medical care and behavioral health have been separate. This separation has resulted not only in decreased efficiency for patients and providers, but also decreased effectiveness. For PCMHs who serve patients with complex needs then, the integration of primary medical care and behavioral health is an important and necessary step to achieving optimal clinical outcomes. Integrated care brings together health-care teams who can treat the whole person. Instead of working separately, primary care and behavioral health providers work together to diagnose patients' problems, plan and provide treatment and evaluate whether that treatment is effective. Evidence suggests that integrating psychological care with primary care and other services can enhance patients' access to services, improve the quality of their care and lower overall health-care costs.

Source: American Psychological Association, SAMHSA-HRSA Center for Integrated Health Solutions

Evidence Base: Integrated Behavioral Health in Primary Care: Step-by-Step Guidance for Assessment and Intervention. Christopher L. Hunter, PhD, ABPP; Jeffrey L. Goodie, PhD, ABPP; Mark S. Oordt, PhD, ABPP; and Anne C. Dobmeyer, PhD, ABPP; Comparative Effectiveness of Collaborative Chronic Care Models for Mental Health Conditions Across Primary, Specialty , and Behavioral health Care Settings: Systematic Review and Meta-Analysis. E Woltmann et al

Policy Change (Y/N): Yes

Strategies:

Strategy 4.5.1: Increase the use of evidence based models to integrate primary and mental/behavioral care, including substance use disorders.

Strategy 4.5.2: Expand the # of safety-net health care providers that are Joint Commission or NCQA certified medical homes.

Strategy 4.5.3: Increase the ability of safety-net providers to treat and manage complex co-occurring medical conditions

Potential Partners

- Seton Health Care Family, Central Health, UT, ATCIC, Community Care, Lone Star Circle of Care, ICC, and CSSS

DEFINITIONS

Patient Centered Medical Home (PCMH): A PCMH is an evidence-based model/platform for organizing and delivering personalized, coordinated, and comprehensive primary care services to patients. In the literature, PCMHs are the preferred primary care delivery system component for accountable care organizations (ACOs).

Behaviorally Enhanced/Behaviorally Integrated: In a "behaviorally enhanced" PCMH, mental/behavioral health services are integrated at the practice level. Behaviorally enhanced PCMHs are a natural extension of their mandate to provide comprehensive care. When a practice's patients are complex and exhibit numerous co-morbidities that are both physical and mental/behavioral, it makes sense to "enhance" the PCMH to optimally care for both the mind and body of the patient.

FOUNDATIONS OF PCMH OBJECTIVES: RATIONALE. Health IT is critical to successfully implementing the hallmark features of PCMHs. Further, building primary healthcare systems that communities can rely on for accessible, affordable, and high-quality care will also require workforce development.

HEALTH IT. Health IT is a critical foundation of the PCMH model because it can help collect, store, and manage personal health information in addition to aggregating data that can be utilized by practices to improve care processes and health outcomes for patients. Health IT can also be used to support communication, clinical decision making, and patient self-management.

WORKFORCE. The PCMH model also rests on a strong, multi-disciplinary primary care workforce. Amid a primary care workforce shortage, it is imperative to develop a workforce trained to provide care based on the elements of the PCMH.

ELEMENTS OF PCMH OBJECTIVES:

COMPREHENSIVE. PCMHs strive to meet the majority of each patient's physical and behavioral health care needs, including prevention and wellness, acute, and chronic care. Comprehensive care necessitates a team of multi-disciplinary care providers. Such teams can be built within the PCMH, or built virtually, by linking practices and their patients to providers and services in their communities.

CONTINUITY. PCMHs strive to ensure that each patient has a primary relationship with one care provider, thereby ensuring a longitudinal relationship that can be leveraged for its mutual trust and respect to improve joint decision-making regarding the patient's care plan and treatment.

PATIENT-CENTERED. Patient-centered care is oriented towards the whole person and is relationship-based. Building a partnership with each patient and his/her family is foundational to that person learning to manage and organize his/her own care at the level he/she chooses. Such a partnership necessitates understanding and respect for each patient's needs (including health literacy), culture, language, values, and preferences.

COORDINATED. PCMHs coordinate care for each patient across the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is paramount during transitions between sites of care (e.g. hospital discharge). Additionally, PCMHs also excel at building clear and open communication among patients and families, the practice, and members of the broader care team.

ACCESSIBLE. PCMHs strive to provide care on demand, delivering accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. PCMHs are responsive to patients' preferences regarding access.

QUALITY AND SAFETY. PCMHs are committed to continuous quality improvement as demonstrated by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support

tools to guide shared decision making with patients and families; engaging in performance measurement and improvement; measuring and responding to patient experiences and patient satisfaction; and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

E. Relationship between the CHIP and other Guiding Documents and Initiatives

The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the public health of Austin/Travis County. Rather than conflicting with or duplicating the recommendations and actions of existing frameworks and coalitions, the participants of the CHIP development process identified potential partners and resources wherever possible. Austin/Travis County will expand the list of potential collaborators and resources when finalizing the CHIP and completing 1-year implementation plans.

The Austin/Travis County CHIP alignment with national and state priorities is illustrated in Appendix C through comparison with Healthy People 2020 objectives and the State of Texas Legislative Interim Charges.

IV. NEXT STEPS

The components included in this report represent the strategic framework for a data-driven, community-enhanced Community Health Improvement Plan. The Austin/Travis County Community Health Improvement team, including the core agencies, CHIP workgroups, partners, stakeholders, and community residents, will continue finalizing the CHIP by prioritizing strategies, developing specific 1-year action steps, assign lead responsible parties, and identify resources for each priority area. Community-wide engagement opportunities will occur through interactive public meetings. These steps will occur during the next phase between January 2013 and April 2013 resulting in a final CHIP and 1-year implementation plan. An annual CHIP progress report will illustrate performance and will guide subsequent 1-year implementation planning.

V. SUSTAINABILITY PLAN

As part of the action planning process, partners and resources will be solidified to ensure successful CHIP implementation and coordination of activities and resources among key partners in Austin/Travis County. The CHIP Steering Committee will continue to serve as the executive oversight for the improvement plan, progress, and process. The Steering Committee and Core Coordinating Committee will expand agency membership to match the scope of the CHIP's four priority issue areas. The Steering Committee will meet quarterly while the Core Coordinating Committee will meet monthly. Additional workgroup meetings and participants will be identified once the 1-year action plan is developed. Community dialogue sessions and forums will occur in order to engage residents in the implementation where appropriate, share progress, solicit feedback, and strengthen the CHIP. Regular communication including via website to community members and stakeholders will occur throughout the implementation. New and creative ways to feasibly engage all parties will be explored at the aforementioned engagement opportunities.

VI. ACKNOWLEDGEMENTS

The dedication, expertise, and leadership of the following agencies and people made the 2012 Austin / Travis County Community Health Improvement Plan a collaborative, engaging, and substantive plan that will guide our community in improving the health and wellness for the residents of Austin/Travis County. Special thanks to all of you.

Austin/Travis County appreciates the National Association of County and City Health Officials (NACCHO) and the Robert Wood Johnson Foundation (RWJF) for their selection of Austin/Travis County HHSD as a Demonstration Site for Community Health Improvement Planning and Accreditation Preparation. Thank you NACCHO and RWJF for your guidance and training.

To the Steering and Core Coordinating Committee members: Your perseverance, guidance, and management continuously exceed expectations. Thank you for taking the lead and motivating others to do the same.

CHIP community member and agency workgroup facilitators and members: Your insight, dedication, and expertise are unparalleled. We look forward to our continued partnership.

To Health Resources in Action, for their strategic community health improvement planning expertise, insight, and passion from facilitation to report writing.

To Suma Orchard Social Marketing, for working with us to design the *Together We Thrive* logo and one-page talking points tool.

Steering Committee

Bobbie Barker	VP of Grants and Community Affairs , St. David's Foundation
Ashton Cumberbatch	VP of Advocacy and Community Relations, Seton Healthcare Family
Vince Delisi	Assistant Division Manager Austin/Travis County Health and Human Services Department
Sherri Fleming	County Executive, Travis County Health and Human Services & Veterans Services
Christie Garbe	Chief Communications and Planning Officer, Central Health
Stephanie Hayden	Assistant Director of Community Services Austin/Travis County Health and Human Services Department
Philip Huang	Health Authority, Austin/Travis County Health and Human Services Department
Shannon Jones	Chair of Steering Committee and Deputy Director Austin/Travis County Health and Human Services Department
Harold (Bill) Kohl	Professor, University of Texas Health Science Center at Houston School of Public Health Austin Regional Campus
Blanca Leahy	Research and Planning Division Director Travis County Health and Human Services & Veterans Services
Cheryl Perry	Professor and Regional Dean, University of Texas Health Science Center at Houston School of Public Health Austin Regional Campus
Carlos Rivera	Director, Austin/Travis County Health and Human Services Department

Core Coordinating Committee

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Victoria Bailey	Public Health Nursing Coordinator Austin/Travis County Health and Human Services Department
Katie Coburn	Healthcare Planner, Central Health
Filip Gecic	Business Consultant Manager Austin/Travis County Health and Human Services Department
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Becky Pastner	Program Officer for Health Policy and Grants, St. David's Foundation
Ellen Richards	Director of Planning, Central Health
Elizabeth Vela	Planner, Travis County Health and Human Services & Veterans Services
Veena Viswanathan	Chair of Core Coordinating Committee and Project Manager, Austin/Travis County Health and Human Services Department

Appendices

APPENDIX A: CHIP PLANNING SESSION WORKGROUP MEMBERS

Priority Area One: Chronic Disease – Focus on Obesity

Content and Process Facilitators

Victoria Bailey	Public Health Nursing Coordinator, Austin/Travis County Health and Human Services Department (Austin/Travis County HHSD)
Kate Coburn	Healthcare Planner, Central Health
Cassandra DeLeon	Program Manager, Austin/Travis County HHSD
Philip Huang	Health Authority, Austin/Travis County HHSD
Andrew Springer	Professor, University of Texas Health Science Center (UTHSC) at Houston School of Public Health Austin Regional Campus

Workgroup Members

Matt Balthazar	Community Benefit Manager, Seton Healthcare Family
Daniel Crowe	Chief Medical Officer, CommUnityCare
Darcie DeShazo	Associate Executive Director, The Settlement Home for Children
Tracy Diggs Lunoff	Comprehensive Health Services Supervisor, Austin ISD
Tamarah Duperval-Brownlee	Chief Executive and Chief Medical Officer for Medical Services, Lone Star Circle of Care
Bianca Flores	Director of Health Promotion, People's Community Clinic
Kristy Hansen	Program Coordinator, Austin/Travis County HHSD
Pamela Larson	Planner, City of Austin Planning & Development Review Department
Nancy Neavel	Member Advocate, League of Women Voters
Janet Pichette	Chief Epidemiologist, Austin/Travis County HHSD
Stephen Pont	Assistant Professor of Pediatrics and Medical Director of Austin ISD Student Health Services, Dell Children's Medical Center
Lindsey Ripley	Project Manager, Children's Optimal Health

Priority Area Two: Built Environment – Focus on Access to Healthy Foods

Content and Process Facilitators

Ashton Cumberbatch	VP Advocacy and Community Relations, Seton Healthcare Family
Lawrence Lyman	Planning Manager, Travis County Health and Human Services & Veterans Services (Travis County HHS & VS)
Becky Pastner	Program Officer for Health Policy and Grants, St. David's Foundation

Workgroup Members

Laura Belew	Treasurer, Sickle Cell Association of Austin
Maureen Britton	President/Executive Director, Children's Optimal Health
Megan Crigger	Cultural Arts Program Manager City of Austin Economic Growth & Redevelopment Services Office
Vincent Delisi	Assistant Division Manager, Austin/Travis County HHSD
Alexandra Evans	Professor , UTHSC at Houston School of Public Health Austin Regional Campus
Robert Kingham	Program Supervisor, Austin/Travis County HHSD
Clifford May	Advisory Board Member of Partnership and Affordable Cohousing
Dusty McCormick	City of Austin, Economic Growth & Redevelopment Service Office
Vanessa Sarria	Executive Director, Community Action Network
Linda Terry	Policy Aide, Austin/Travis County HHSD

Priority Area Three: Built Environment – Focus on Transportation

Content and Process Facilitators

John-Michael Cortez	Manager of Community Involvement, Capital Metro
Filip Gecic	Business Consultant Manager, Austin/Travis County HHSD

Workgroup Members

Robert Anderson	CTG Planner, City of Austin Planning and Development Review Department
Jean Barrett Teel	Executive Director, Faith in Action Caregivers
Jennifer Golech	Transportation Planner, Capital Metro
Kris Hafezizadeh	Director of Transportation, Austin ISD Transportation
Deborah Lowndes	Practice Administrator, CommUnityCare
Sly Majid	Executive Assistant, City of Austin Office of Mayor Lee Leffingwell
John McNabb	Executive Director, Vaughn House, Inc.
Abiodun Oluyomi	Professor, UTHSC at Houston School of Public Health Austin Regional Campus
Jessica Tunon	Project Consultant Specializing in Creative and Effective Solutions

Priority Area Four: Access to Primary Care and Mental/Behavioral Health Services – Focus on Navigating the Healthcare System

Content and Process Facilitators

Ana Almaguel	Planning Project Manager, Travis County HHS & VS
Dawn Handley	Chief Program Operations Officer, Austin/Travis County Integral Care
Stephanie Hayden	Assistant Director of Community Services, Austin/Travis County HHSD
Vella Karman	Grants Coordinator, Austin/Travis County HHSD
Rhonda Mundhenk	Chief Operating Officer of Clinical Services, Lone Star Circle of Care
Ellen Richards	Director of Planning, Central Health
Elizabeth Vela	Planner, Travis County HHS & VS

Workgroup Members

Mary Caputo	Executive Director, Austin Clubhouse
Seanna Crosbie	Director of Program Services, Austin Child Guidance Center
Kris Downing	Clinical Coordinator, Communities In Schools of Central Texas
Denise Esper	Chief Revenue Officer, Lone Star Circle of Care
Kathleen Fox	Senior Planner, City of Austin Planning & Development Review Department
Erin Gilmer	Health Policy Attorney, Gilmer Law
Teresa Griffin	Director of Planning, Seton Healthcare Family,
Andres Guariguata	Austin Travis County Integral Care
Adrienne Kennedy	Board of Directors President, National Alliance on Mental Illness (NAMI) Austin
Kim McPherson	Program Officer, St. David's Foundation
Susan Millea	Community GIS Facilitator, Children's Optimal Health
Peter Morrison	Health Literacy Program Manager, Literacy Coalition of Central Texas
Athan Schindler	Navigation Manager, LIVESTRONG Cancer Navigation Center
Pamela Schott	Clinical Director, YWCA Greater Austin
Julie Thorpe	Interim Chief Operating Officer, CommUnity Care
Catherine Weaver	Board of Directors Advocacy Chair, National Alliance on Mental Illness (NAMI) Austin

APPENDIX B: GLOSSARY OF TERMS

Active Transportation: any method of travel that is human-powered, but most commonly refers to walking, bicycling and using public transit. OR - non-motorized transportation modes, such as bicycling and walking, which are well integrated with public transportation.

Active transportation commute mode share: Proportion of total commute (school or work) trips that are taken via active transportation.

Behaviorally Integrated Medical Home: a service delivery system that coordinates behavioral care with medical care

Built Environment: man made surroundings that include buildings, public resources, land use patterns, the transportation system, and design features

Complete Streets: are streets that are designed and operated to enable safe access for all users, including pedestrians, bicyclists, motorists and transit riders of all ages and abilities.

Community Health Improvement Plan (CHIP): an action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed

Comprehensive Care Strategies: The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment.

Cultural competence: A set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework

Distribution Point: physical location where affordable quality nutritious food can be accessed, including, but not limited to, grocery stores, farmers markets, and farm-to-site programs.

Evidence-based Method: a strategy for explicitly linking public health or clinical practice recommendations to scientific evidence of the effectiveness and/or other characteristics of such practices

Goals: identify in broad terms how the efforts will change things to solve identified problems

Health Equity: When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstances

Health Disparity: A type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability

Health Literacy: the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.

Linguistic Competence: providing easy access to oral and written language services to limited English proficiency (LEP) patients through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators.

Objectives: measurable statements of change that specify an expected result and timeline, objectives build toward achieving the goals

Patient Centered Care: Patient-centered care is oriented towards the whole person and is relationship-based. Building a partnership with each patient and his/her family is foundational to that person learning to manage and organize his/her own care at the level he/she chooses. Such a partnership necessitates understanding and respect for each patient's needs (including health literacy), culture, language, values, and preferences.

Performance Measures: the changes that occur at the community level as a result of completion of the strategies and actions taken

Priority Areas: broad issues that pose problems for the community

Strategies: action-oriented phrases to describe how the objectives will be approached

Social Determinants of Health: The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

APPENDIX C: AUSTIN/TRAVIS COUNTY CHIP ALIGNMENT WITH STATE AND NATIONAL PRIORITIES

I. Chronic Disease with focus on Obesity

Austin/Travis County Health Priority Issue Areas, Goals, and Objectives	Healthy People 2020* Alignment	State of Texas Priorities** and Local Alignment
Goal: Reduce burden of chronic diseases caused by obesity among Travis County residents.	Physical Activity (PA) Goal: Improve health, fitness, and quality of life through daily physical activity. Maternal, Infant, and Child Health (MICH) Goal: Improve the health and well-being of women, infants, children, and families. Nutrition and Weight Status (NWS) Goal: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.	82nd Legislature Interim Charges Texas Senate: Agriculture and Rural Affairs Committee
Objectives:		
1.1: By April 2016, increase percent of adults and children that meet physical activity recommendations by 5%.	PA-1: Reduce the proportion of adults who engage in no leisure-time physical activity. PA-2: Increase the proportion of adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity. PA-3: Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity. PA-5: Increase the proportion of adolescents who participate in daily school physical education.	

I. Chronic Disease with focus on Obesity, continued		
Austin/Travis County Health Priority Issue Areas, Goals, and Objectives	**Healthy People 2020* Alignment**	**State of Texas Priorities** and Local Alignment**
1.2: By April 2016, increase the number of Travis County workplaces that have family supportive breastfeeding by 5%.	MICH-21: Increase the proportion of infants who are breastfed. MICH-22: Increase the proportion of employers that have worksite lactation support programs Increase the proportion of employers that have worksite lactation support programs.	
1.3: By April 2016, increase by 5% the number of Travis County child care settings that promote healthy eating	NWS-2: Increase the proportion of schools that offer nutritious foods and beverages outside of school meals	Examine ways to increase the use of Texas agricultural products in healthy foods readily available to Texas consumers. Evaluate the role of community initiatives in reducing obesity and diet-related diseases.
1.4: By April 2016, reduce the percent of children and adults who consume sugar sweetened beverages by 5%.	NWS-17: Reduce consumption of calories from solid fats and added sugars in the population aged 2 years and older	

II. Built Environment focusing on Access to Healthy Foods

Austin/Travis County Health Priority Issue Areas, Goals, and Objectives	Healthy People 2020* Alignment	State of Texas Priorities** and Local Alignment
Goal: All in our community have reasonable access to affordable quality nutritious food	Nutrition and Weight Status (NWS) Goal: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.	82nd Legislature Interim Charges Texas House of Representatives: Committee on Agriculture and Livestock; Committee on Public Health; Committee on Urban Affairs; Texas Senate: Agriculture and Rural Affairs Committee
Objectives:		
2.1: By April 2016, increase by 50% access to and participation of eligible people in food assistance programs (ex. SNAP, WIC, school breakfast and lunch program, summer food service, Elderly Nutrition Program) that increase access to healthy food.	NWS-4 (Developmental) Increase the proportion of Americans who have access to a food retail outlet that sells a variety of foods that are encouraged by the Dietary Guidelines for Americans.	Identify policies to alleviate food insecurity, increase access to healthy foods, and incent good nutrition within existing food assistance programs. Consider initiatives in Texas and other states to eliminate food deserts and grocery gaps, encourage urban agriculture and farmers' markets, and increase participation in the Summer Food Program. Evaluate the desirability and feasibility of incorporating nutritional standards in the Supplemental Nutrition Assistance Program (SNAP).
2.2: By April 2016, ensure that two new distribution and production points for healthy food are available and accessible in each of the five high need areas (The 5 areas currently without a full service grocery store are: 78723, 78724, 78725, 78744, and 78754).		Evaluate role of community gardens and urban farming efforts increasing access to healthy foods and examine possible impact that state and local policies have on the success of programs of this type, especially in high population areas.
2.3: By April 2016, all local municipalities will establish a healthy food zone ordinance around schools, municipal parks, child care centers, libraries and recreation centers.		Examine ways to increase the use of Texas agricultural products in healthy foods readily available to Texas consumers. Evaluate the role of community initiatives in reducing obesity and diet-related diseases.

III. Built Environment focusing on Transportation

Austin/Travis County Health Priority Issue Areas, Goals, and Objectives	Healthy People 2020* Alignment	State of Texas Priorities** and Local Alignment
Goal: Local and regional stakeholders will collaboratively increase accessibility to community resources via safe, active transportation.	Physical Activity (PA) Goal: Improve health, fitness, and quality of life through daily physical activity. Environmental Health (EH) Goal: Promote health for all through a healthy environment.	82nd Legislature Interim Charges Texas House of Representatives: Committee on Appropriations; Committee on Transportation Texas Senate: Transportation and Homeland Security Committee
Objectives:		
3.1: By April 2016, increase Travis County active transportation commute mode share by 5%.	PA-13: (Developmental) Increase the proportion of trips made by walking; PA-14: (Developmental) Increase the proportion of trips made by bicycling PA-15: (Developmental) Increase legislative policies for the built environment that enhance access to and availability of physical activity opportunities EH-2: Increase use of alternative modes of transportation for work	Review and make recommendations regarding best practices for traffic-flow management to meet future statewide transportation needs. This study should consider a full range of options, including implementing employee flex time at all state agencies, park & ride, telecommuting, and rail. Study transportation funding reforms and develop long-term state funding recommendations, with an eye on any federal reforms that become law.
3.2: By April 2016, our community through its local authorities will approve a comprehensive funding plan for implementation of the active transportation master plans (i.e. sidewalks, bike, trails, transit, etc.)		
3.3: By April 2016, the City of Austin and Travis County will require and incentivize active transportation connections for all new development outside of the activity centers identified in the Capital Area Metropolitan Planning Organization's 2035 Plan.		

IV. Access to Primary Care and Mental/Behavioral Health focusing on Navigating the Healthcare System

Austin/Travis County Health Priority Issue Areas, Goals, and Objectives	Healthy People 2020* Alignment	State of Texas Priorities** and Local Alignment
Goal: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.	Mental Health and Mental Disorders (MHMD) Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services. Access to Health Services (AHS) Goal: Improve access to comprehensive, quality health care services.	Texas House of Representatives: Committee on Human Services; Committee on Public Health Texas Senate: Committee on Health and Human Services
Objectives:		
4.1: By April 2016, expand by 10% the number of entities serving safety net populations that are utilizing health IT systems.	MHMD-5: Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral MHMD-9: Increase the proportion of adults with mental health disorders who receive treatment MHMD-10: Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders MHMD-11: Increase depression screening by primary care providers AWS-3: Increase the proportion of persons with a usual primary care provider AHS-5: Increase the proportion of persons who have a specific source of ongoing care	Examine adequacy of primary care workforce in Texas in context of aging population, the Patient Protection and Affordable Care Act, state and federal funding reductions for graduate medical education and loan repayment programs. Study impact of alternative reimbursement strategies, telemedicine and physician extenders. Study the impact of HB specifically on physician loan repayment programs. Assess the current infrastructure and funding mechanisms for mental health services in both rural and urban areas throughout the state. Study innovative local programs that could be expanded, as well as successful delivery and financial models in other states. Make recommendations to expand access and improve services through increased efficiency, competition, and transparency.
4.2: By April 2016, expand by 5% primary care and behavioral/mental health workforce capacity who will care for safety-net population.		
4.3: By April 2016, increase the adoption of coordination strategies within the safety net.		
4.4: By April 2016, expand comprehensive care strategies within the safety net.		

Austin/Travis County Health Priority Issue Areas, Goals, and Objectives	Healthy People 2020* Alignment	State of Texas Priorities** and Local Alignment
4.5 April 2016, increase the adoption of patient-centered strategies within the safety net.	See Above.	Review the state's public mental health system and make recommendations to improve access, service utilization, patient outcomes and system efficiencies. Study current service delivery models for outpatient and inpatient care, funding levels, financing methodologies, services provided, and available community-based alternatives to hospitalization. The review should look to other states for best practices or models that may be successful in Texas. The study shall also review and recommend "best value" practices that the state's public mental health system may implement to maximize the use of federal, state, and local funds. Monitor the implementation of legislation addressed by the Senate Committee HHS and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to: Health Care Quality and Efficiency, Federal Flexibility, Foster Care Redesign, and Implementation of DOJ.

* Healthy People 2020, www.healthypeople.gov

** As noted in the Interim Charges for the Texas House and Senate 82nd Legislative Session.

House: http://www.house.state.tx.us/_media/pdf/interim-charges-82nd.pdf

Senate: http://www.senate.state.tx.us/assets/pdf/SenateInterimCharges82_Final.pdf