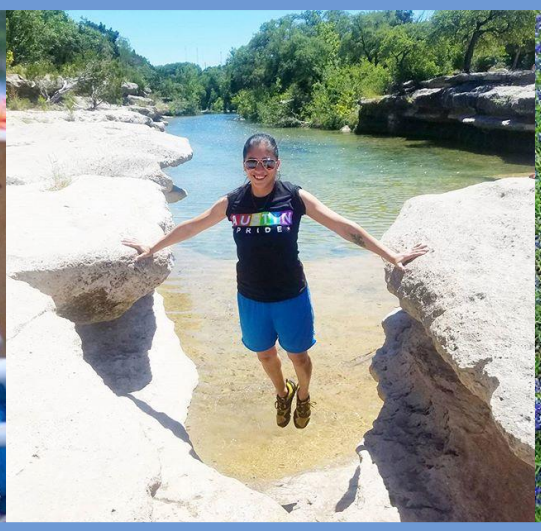
2018 Community Health Plan

Austin/Travis County, Texas

2022 Action Plan

Year 4


Together We Thrive

Austin/Travis County Community Health Plan

Austin/Travis County
2018 Community Health Plan
2022 Action Plan (Y4)

Introduction

Welcome to the Austin/Travis County Community Health Plan organized by Austin Public Health with support from our community partners. This initiative aims to develop a collaborative and community-focused effort in identifying and prioritizing health needs in our community by service providers. The Community Health Plan (CHP) is comprised of two component parts, the Community Health Assessment phase and the Community Health Improvement Plan (implementation) phase.

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

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

2022 Action Planning for Implementation

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

The Austin/Travis County Community Health Plan partners, including core agencies, workgroups members, stakeholders, and community residents, continued implementation of the 2018 Community Health Plan by prioritizing strategies for 2022 (Y4), developing specific action steps, assigning lead responsible parties, and identifying resources for each priority area during the Year 4 Action Planning Sessions held in February of 2022. These components form the Year 4 Action Plan further detailed in the following document. We encourage partners to continue to engage by joining one our four workgroups addressing Y4 strategies. As we know time is valuable, workgroup meetings are kept to a minimum, however community engagement is essential to assure fulfillment of the plan's strategies and the building of a truly collaborative process and shared effort for obtaining community health.

We thank you for your commitment.

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The Community Health Plan is managed by Austin Public Health

For additional information, please contact:
Maren A. Lujan, APH Planner
Austin/Travis County Community Health Plan
ATC.CommunityHealthPlan@austintexas.gov

Year 4 Community Health Plan - Leadership

Community Health Plan Steering Committee

Adrienne Sturrup (Chair)	*Director,* Austin Public Health
Monica Crowley	*VP, Chief Strategy & Planning Officer,* Central Health
Julie Mazur	*Regional Coordination Planner,* CapMetro
Lawrence Lyman	*Director of Research and Planning,* Travis County
Becky Pastner	*Vice President of Evaluation and Strategic Learning,* St. David's Foundation
Ann Marie Price	*Director of Community Affairs,* Baylor Scott & White
Anthony Segura	*Assistant Director,* Austin Transportation Dept.
Dr. Andrew Springer	*Associate Professor of Health Promotion and Behavioral Sciences,* UT School of Public Health
Ingrid Taylor	*Community Benefit Director,* Ascension Seton
Dr. Carmen Valdez	*Director, Community-Driven Initiatives,* UT Dell Medical School

Community Health Plan Core Committee

Kodjo Dodo (Chair)	*Planning and Evaluation Manager,* Austin Public Health
Ana Lidia Almaguel	*Planning Project Manager,* Travis County HHS
Megan Cermak	*Director of Public Health Strategy, Policy, and Disaster Response,* Central Health
Marianna Espinoza	*Learning & Evaluation Manager,* UT Dell Medical School
Muna Javaid	*Senior Planner,* Integral Care
Kelli Lovelace	*Texas Community Benefit Manager,* Ascension Seton
Katheryn Cromwell	*Regional Transit and Mobility Planner,* CapMetro
Jesse Simmons	*Senior Evaluation Officer,* St. David's Foundation
Tara Stafford	*System Director for Community Health,* Baylor Scott & White

Community Health Plan Priority Area Chairs

Priority Area 1: Access to and Affordability of Health Care

Vanessa Sweet	*Strategy Manager*, Central Health

Priority Area 2: Chronic Disease Prevention & Active Living Coalition

Sophia Benner	*Active Transportation Project Coordinator,* Austin Transportation Dept.
Jill Habegger-Cain	*Recreation Program Coordinator*, Austin Parks and Recreation Dept.
Dina Ortiz (Active Living Liaison)	*Chronic Disease & Injury Prevention Program Coordinator*, Austin Public Health

Priority Area 3: Sexual Health

Sandra Chavez	*Director of Outreach*, ASHwell

Priority Area 4: Stress, Mental Health, and Wellbeing (Behavioral Health)

Kacey Hanson	*Program Manager*, UT Dell Medical School

Year 4 Action Plan At-A-Glance

Priority Area 1: Access to and Affordability of Health Care **Goal 1:** Every Travis County resident has access to culturally sensitive, affordable, equitable, and comprehensive health care.	
Year 4 Objectives	**Year 4 Strategies**
Objective 1.1 By 2023, increase the employment of certified Community Health Workers (CHWs) and service coordinators by 10% to help residents navigate the health care system and promote health literacy.	1.1.1 Explore funding/reimbursement options for CHWs from insurance providers or local funders, so that community health workers are able to pursue a career in community health work that includes benefits, networks of social support, flexible time off and a living wage. Allowing community health workers to be a stable presence in the community and receive sufficient funding to keep them employed.
	1.1.2 Encourage partners/agencies to hire CHW/service coordinators (SCs) for local community-based outreach and/or education.
	1.1.3 Establish or tap into an existing professional development and networking opportunities for CHWs and Service Coordinators.
Objective 1.2 By 2023, increase enrollment in and use of eligible health care coverage and/or assistance programs by 10% for Travis County residents with household incomes at or below 200% Federal Poverty Level (FPL), ages 18-64	1.2.1 Utilize and enhance existing education and communication campaigns to inform Travis County residents in key communities of what health care coverage is available.
	1.2.8 By 2023, increase enrollment in and use of eligible health care coverage and/or assistance programs by 10% for Travis County residents with household incomes at or below 200% Federal Poverty Level (FPL), ages 18-64.
Objective 1.3 By 2021, decrease no-shows for health care appointments at safety-net health care providers by 10%.	1.3.1 Work with transportation partners to expand and enhance transportation options (e.g., number of accessible vehicles in the region, variety of transportation options to health care) for members of the community who have difficulty reliably traveling to healthcare appointments.
	1.3.2 Advocate to expand care delivery in under resourced areas via options such as co-locating, building new facilities, and use of telemedicine.
	1.3.6 Promote awareness of existing transportation resources, including Capital Metro's Mobility Management program, through a variety of communication avenues.
	1.3.8 Connect health navigators with Mobility Management services so they can refer people to the right transportation resources for their needs.

Priority Area 2: Chronic Disease **Goal 2:** Prevent and reduce the occurrence and severity of chronic disease through collaborative approaches to health that create environments that support, protect, and improve the well-being of all communities.	
Year 4 Objectives	**Year 4 Strategies**
Objective 2.1 Decrease the % of people who have risk factors leading to chronic disease by 10% by 2023.	2.1.4 Engage worksites, schools, early childhood education centers, and after school programs in developing comprehensive policies and programs that promote healthy nutrition, physical activity, tobacco free campus, and Mother Friendly worksites.
	2.1.2 Engage community leaders to design and conduct a media and marketing campaign that promotes and supports existing organizations and health resources (e.g., fitness class, nutrition, gardening classes, podcast programs, tobacco cessation resources, mobile health tools education and tracking).
Objective 2.2 Increase the rates of early detection of chronic disease among adults by 2% by 2023 (diabetes, hypertension) with special focus on disproportionately affected populations.	2.2.2 Partner with existing resources (APH and others) to personalize and implement community-based education and screenings. Focus on educating community members on the importance of routine screenings even without symptoms and knowing risk factors. Provide education and screenings at venues that serve at-risk populations in order to reach communities not seeking healthcare, such settings may include public housing, homeless shelters, barbershops, schools, libraries, transitional houses, education kiosks in community laundromats.
Objective 2.4 Increase adherence to Chronic Disease Care Plans by 10% by 2023.	2.4.1 Promote existing community resources and organizations that provide self-management education considering multiple location (e.g., physician's offices, chronic disease management nursing, mobile screening clinics, community and social caseworkers).
	2.4.4 Refer patients to social service providers and community-based supports who can help them overcome SDOH barriers that might keep them from adhering to their care plan.
Objective 2.5 By 2023, increase by 5% the number of safe, accessible, equitable, and culturally competent assets and opportunities for healthy food and physical activity.	2.5.3 Utilize community member input to improve existing data of assets and opportunities available for physical activity (e.g., urban gardens, community gardens, green space, trails, parks, etc.) and increase access and awareness of these sites.
	2.5.4 Utilize community member input to create new assets and opportunities for healthy food and physical activity.

Priority Area 3: Sexual Health **Goal 3:** Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.	
Year 4 Objectives	**Year 4 Strategies**
Objective 3.1 By 2023, decrease youth pregnancy rates by 10% among populations most affected by health disparities in Travis County.	3.1.4 Promote information sharing between organizations and programs already engaged in sex education work.
	3.1.7 Advocate for 'Youth Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer equitable affordable access to a full range of FDA-approved birth control methods, reduce barriers to youth seeking same-day appointments, and are trained to provide culturally appropriate contraceptive services. (See also Strategy 3.2.4).
Objective 3.2 By 2023, decrease the rates of sexually transmitted infections (STIs) by 10% among youth populations aged 24 and younger most affected by health disparities in Travis County.	3.2.4 Advocate for 'Teen Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer affordable access to STI testing and treatment and HIV tests and are trained to provide culturally appropriate STI services.
Objective 3.3 By 2023, increase by 10% the number of schools that provide evidence-informed sex education in Travis County.	3.3.1 Advocate for policy and/or policy change at the district, county and state level that could support inclusive, evidence-informed comprehensive sex education and create awareness and develop local community protections against harmful legislation against LGBTQI+ youth in Travis County schools.

Priority Area 4: Stress, Mental Health, and Wellbeing **Goal 4: Advance mental wellness, recovery, and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.**	
Year 4 Objectives	**Year 4 Strategies**
Objective 4.2 By 2023, increase by 10% the number of system providers (schools, health care, etc.) who assess for adverse childhood experiences (ACEs) and other trauma informed care screening tools and refer to appropriate community supports.	4.2.1 Expand the providers who are trained on Trauma Informed Care, linking to appropriate resources.
	4.2.2. Promote resilience in all community settings using trauma-informed approaches.
	4.2.3 Develop and maintain Connect ATX as an online resource list tool for providers to facilitate mental and behavioral health referrals as well as enable people to find and access linguistically appropriate mental health providers.
Objective 4.3 By 2023, increase by 10% the proportion of adults aged 18 and up in Austin Travis County who receive mental health/substance use disorder services, with a focus on geographic equity.	4.3.1 Promote the adoption of a collaborative care model in Austin and Travis County to provide treatment and to coordinate medical and behavioral health providers
	[Tentative] 4.3.2 Advocate for enhanced behavioral health benefits covered by the Medical Access Program (MAP).
	[Tentative] 4.3.6 Pair mental health/SUD workers with all established mobile health outreach teams to geographically underserved populations.

Priority Area 1: Access to and Affordability of Health Care

Participating Access to Care Partner Organizations

Alzheimer's Association
American Cancer Society
American Heart Association
Austin Area Urban League
Austin Asian Community Health Initiative
Austin Public Health
Austin Transportation Dept.
Austin Voices
Austin Youth River Watch
CapMetro
CARDEA
Caritas of Austin
Central Health
Children's Optimal Health
CommUnity Care
CommUnity Coalition for Health
El Buen Samaritano
Foundation Communities
GALS
HACA
Integral Care
KAZI FM
Project Access Austin
Travis County HHS
UT Dell Medical School

Year 4 Action Plan

Goal 1: Every Travis County resident has access to culturally sensitive, affordable, equitable, and comprehensive health care.

Objective 1.1:	**By 2023, increase the employment of certified Community Health Workers (CHWs) and service coordinators by 10% to help residents navigate the health care system and promote health literacy.**

Strategy 1.1.1:	**Explore funding/reimbursement options for CHWs from insurance providers or local funders, so that community health workers are able to pursue a career in community health work that includes benefits, networks of social support, flexible time off and a living wage. Allowing community health workers to be a stable presence in the community and receive sufficient funding to keep them employed. (Y1, Y2, Y3, Y4)**
	Action Steps
a.	Build a local coalition to create recommendations for funding strategies
b.	Research and education on current legislation as it pertains to CHW funding
c.	Develop a platform for CHW partners to explore projects around CHW programming and collaborations
d.	Design and adopt a community wide CHW assessment tool to understand the local landscape and capture data.

Strategy 1.1.2:	**Encourage partners/agencies to hire CHW/service coordinators (SCs) for local community-based outreach and/or education (example: consider recommending the utilization of funds from unfilled positions to hire CHWs or service coordinators). (Y2, Y3, Y4)**
	Action Steps
a.	Create common standards for hiring with salary metrics, performance metrics and professional development pathways
b.	Identify professions that are similar in scope to CHW and educate partner organizations

Strategy 1.1.3:	**Establish or tap into an existing professional development and networking opportunities for CHW's and Service Coordinators. (Y1, Y2-revised, Y3, Y4)**
	Action Steps
a.	Continue to build upon existing networking opportunities and determine strategies to solidify the opportunities within the community

b.	Create and establish communication strategies to keep the CHWs aware and engaged with the networking opportunities
c.	Advocate for and provide training and professional development opportunities in the languages that people are receiving services in (e.g., Mandarin Chinese, ASL)

Objective 1.2:	**By 2023, increase enrollment in and use of eligible health care coverage and/or assistance programs by 10% for Travis County residents with household incomes at or below 200% Federal Poverty Level (FPL), ages 18-64.**

Strategy 1.2.1:	**Utilize and enhance existing education and communication campaigns to inform Travis County residents in key communities of what health care coverage is available. (Y1, Y2-revised, Y3, Y4)**
	Action Steps
a.	List of programs with ACA counselors and MAP application partners.
b.	Educate community partner staff to support education and enrollment campaigns.
c.	Focus on commuity-based in-person enrollment events throughout Travis County.
d.	Explore the funding reimbursement for CBOs and community navigators supporting ACA and MAP applications.

Strategy 1.2.8:	**By 2023, increase enrollment in and use of eligible health care coverage and/or assistance programs by 10% for Travis County residents with household incomes at or below 200% Federal Poverty Level (FPL), ages 18-64.**
	Action Steps
	[To follow action steps developed in 1.2.1]

Objective 1.3	**By 2021, decrease no-shows for health care appointments at safety-net health care providers by 10%. (See also Objective 2.3).**

Strategy 1.3.1:	**Work with transportation partners to expand and enhance affordable transportation options (e.g., number of accessible vehicles in the region, variety of transportation options to health care) for members of the community who have difficulty reliably traveling to healthcare appointments. (Y1, Y2, Y3, Y4)**
	Action Steps
a.	Continue to convene partners to share information about what each is doing in this area, to share successes and challenges, and to work together to explore options, opportunities and funding through the Healthcare Transportation Working Group.
b.	Continue to participate in the Regional Transportation Coordination Committee (RTCC) Planning efforts to help coordinate transportation options throughout the metro region, especially in rural areas (MPO is funding the consultant for this planning).
c.	Continue to expand Capital Metro Pickup services and continue evaluating Pickup services to see if these services are filling gaps inside and outside of Capital Metro's Service Area and expand as needed/feasible.
d.	Learn more about MetroBike expansion work Also/Cross-Reference with Chronic Disease Action Plan.

Strategy 1.3.2:	**Advocate to expand care delivery in under resourced areas via options such as co-locating, building new facilities, and use of telemedicine. (Y1, Y2, Y3, Y4)**
	Action Steps
a.	Continue mobile delivery of health care services serving Eastern Travis County and special populations (e.g. persons experiencing homelessness).
b.	Disseminate and educate community partners on barriers to telemedicine and digital devices used in care.
c.	Track and identify barriers to telemedicine participation; develop possible solutions to addressing barriers.
d.	Continue to coordinate with Capital Metro and other transit providers in planning for expanded and/or new facilities (Del Valle, Hornsby Bend).

e.	Gather lessons learned related to digital access and equity especially as related to telehealth/telemed access; and experiences of providers related to reimbursement models during the COVID-19 pandemic. Use the learning to develop action steps for moving forward.

Strategy 1.3.6:	**Promote awareness of existing transportation resources, including Capital Metro's Mobility Management program*, through a variety of communication avenues. (Y1,Y2, Y3, Y4) (*refers to expanded description of the Mobility Management Program included in the full CHIP report)**
	Action Steps
a.	Identify how best to educate community partners (e.g. Ride Guide) on transportation options are available for their needs. Promote existing travel training program, including virtual and individual training options.
b.	Raise community awareness of free transportation options for health services.
c.	Update Senior Ride Guide; print and distribute. Digitize guide and publish as a website so information can be updated on an ongoing basis. Update information on related sites (GetThereATX).
d.	Connect providers and nonprofits to the Transit Empowerment Fund and MetroAccess Van Grant program.
e.	Translate transportation resources (websites, flyers, guides, etc.) in multiple languages.

Strategy 1.3.8:	**Connect health navigators with Mobility Management services so they can refer people to the right transportation resources for their needs. (Y1,Y2,Y3, Y4)**
	Action Steps
a.	Invite CHWs to RTCC, Transportation workgroup and other forums for collaboration.
b.	Connect CHW's and HACA Smart City Ambassadors with Capital Metro Travel Trainers.
c.	Explore and establish "Travel Trainer Ambassador Program": Training of Trainers.
d.	Distribute language access card templates that were developed by Capital Metro Travel Training Program to organizations and CHWs.
e.	Learn more about digital navigation and how to support patients needing transportation services for healthcare needs.

Priority Area 2: Chronic Disease

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

Participating Chronic Disease Partner Organizations

American Heart Association
Ascension Seton
Austin Public Health
Austin Transportation Dept.
CCCN
City of Austin
Foundation Communities
GAVA
It's Time Texas
Mayor's Commission for People with Disabilities
PARD
Prairie View A&M
Project Access Austin
Travis County HHS
UT Dell Medical School

Year 4 Action Plan

Goal 2: Prevent and reduce the occurrence and severity of chronic disease through collaborative approaches to health that create environments that support, protect, and improve the well-being of all communities.

Objective 2.1:	**Decrease the % of people who have risk factors leading to chronic disease by 10% by 2023. [Primary Prevention]**

Strategy 2.1.4:	**Engage worksites, schools, early childhood education centers, and after school programs in developing comprehensive policies and programs that promote healthy nutrition, physical activity, tobacco free campus, and Mother Friendly worksites. [Year 1 focus on worksites; Year 2 inclusion of schools (Consider all Travis County ISDs) and early childhood education centers] (Y1-revised, Y2-revised, Y3, Y4)**
Action Steps	
a.	Support AISD & PARD in providing walkable maps or route to fieldtrips. Utilize Nature Rocks virtual platform and the CCCN Austin map.
b.	Create a template of existing resources: where resources have been applied, and where there are gaps.
c.	Gather contacts from school-based organizations, districts, SHACs, afterschool programming, Austin voices and admins.
d.	Engage school-based organizations, districts, SHACs, afterschool programming, Austin voices and admins, by asking about their needs.

Objective 2.2:	**Increase the rates of early detection of chronic disease among adults by 2% by 2023 (diabetes, hypertension) with special focus on disproportionately affected populations. [Secondary Prevention]**

Strategy 2.2.2:	**Partner with existing resources (APH and others) to personalize and implement community-based education and screenings. Focus on educating community members on the importance of routine screenings even without symptoms and knowing risk factors. Provide education and screenings at venues that serve at-risk populations in order to reach communities not seeking healthcare, such settings may include public housing, homeless shelters, barbershops, schools, libraries, transitional houses, education kiosks in community laundromats.**
Action Steps	
a.	Identify locations & partners for screenings
b.	Provide health literacy that meets CLAS standards.
c.	Identifying effective channels to refer people to primary care so that they can follow up after screenings

Objective 2.4	**By 2023, increase by 5% the number of safe, accessible, equitable, and culturally competent assets and opportunities for healthy food and physical activity. [Built Environment]**

Strategy 2.4.1:	**Promote existing community resources and organizations that provide self-management education considering multiple location (e.g., physician's offices, chronic disease management nursing, mobile screening clinics, community and social caseworkers).**
	Action Steps
a.	Develop a telehealth subgroup to review COH data. Recruit from Access to Care & CDPALC.
b.	Survey patients to understand barriers.
c.	Address anxiety and barriers to use telehealth. Provide education on how to use telehealth
d.	Compile list of what partners are providing resources, including telehealth options. When identifying existing resources, paying special attention to who is offering language access in languages beyond Spanish
e.	Provide education and resources for telehealth
f.	Provide dissemination of existing resources

Strategy 2.4.4:	**Refer patients to social service providers and community-based supports who can help them overcome SDOH barriers that might keep them from adhering to their care plan.**
	Action Steps
a.	Identify resources to refer patients to social service providers and community-based supports already existing in the community.
b.	Identify SPOCs within organizations who manage entries in those sites.
c.	Create a cheat sheet on how the resources are best used (e.g. considering timeliness, etc).
d.	Identify ways to share with individuals providing the referrals.

Objective 2.5:	**By 2023, increase by 5% the number of safe, accessible, equitable, and culturally competent assets and opportunities for healthy food and physical activity. [Built Environment]**

Strategy 2.5.3:	**Utilize community member input and existing databases to improve existing data of assets and opportunities available for physical activity (e.g., urban gardens, community gardens, green space, trails, parks, etc.) and increase access and awareness of these sites. (Y1-revised, Y2, Y3, Y4)**
Action Steps	
a.	a. Identify organizations, reports or projects engaging with the community
b.	Engage organizations completing community outreach and local assessments.
c.	Develop media campaign based on community feedback.
d.	Engage ATX Walk Bike Roll outreach contacts, including the ambassadors. Ask about barriers to physical activity (e.g. heat, lack of shade, lighting, etc.)

Strategy 2.5.4:	**Utilize community member input to create new assets and opportunities for healthy food and physical activity.**
Action Steps	
a.	Review feedback from Strategy 2.5.3.
b.	Develop Action Steps based on community input.

Priority Area 3: Sexual Health

Participating Sexual Health Partner Organizations

ASHWell
Austin Public Health
CommUnity Care
Fast-Track Cities
Foundation Communities
HIV Planning Council
LifeWorks
Planned Parenthood
Texas Campaign
UT at Austin
Vivent Health

Year 4 Action Plan

Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.

Objective 3.1:	**By 2023, decrease youth pregnancy rates by 10% among populations most affected by health disparities in Travis County.**

Strategy 3.1.4:	**Promote information sharing between organizations and programs already engaged in sex education work. (See also Strategy 3.3.2). (Y1,Y2-revised,Y3, Y4)**
	Action Steps
a.	Monitor legislature impacting sex education.
b.	Brainstorm strategies for information sharing on existing sex education work, to include partner identification and topic selection (e.g. polling, gap analysis, etc)
c.	Provide presentations for workgroup members touching on different updates/topics to encourage information sharing.
d.	Standing meeting between representatives from partners involved; sharing updates from organizations.
e.	Pursue the use of a virtual platform for partners to keep informed on current activities
f.	Engage in post-Covid outreach/resource fair events.

Strategy 3.1.7:	**Advocate for 'Teen Friendly' or 'Youth Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer equitable affordable access to a full range of FDA-approved birth control methods and are trained to provide culturally appropriate contraceptive services. (See also Strategy 3.2.4). (Y2,Y3, Y4)**
	Action Steps
a.	Identify potential partnerships with clinics already participating in this work (e.g. People's Community Clinic, Northwest Austin Universal Health Clinic (NAUHC), Vivent Health)
b.	Work to expand awareness and participation of clinics providing these services.
c.	Promotion of resources for youth including information about Title X provider expansion.
d.	Presentation on results of pre-assessment on Youth Friendly Assessment.
e.	Promoting education/awareness of the recognition status training.

Objective 3.2:	**By 2023, decrease the rates of sexually transmitted infections (STIs) by 10% among youth populations aged 24 and younger most affected by health disparities in Travis County.**

Strategy 3.2.4:	**Advocate for 'Teen Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer affordable access to STI testing and treatment and HIV tests and are trained to provide culturally appropriate STI services. (See also Strategy 3.1.7) (Y2,Y3, Y4)**
	Action Steps
a.	Identify partners to provide a training of culturally appropriate STI services

b.	Disseminate information on Texas Campaign's Texas Youth Friendly Initiative and their certification process to interested clinical partners; engage clinical partners.
c.	Identify clinic partners/contacts that might complete TYFI certification process
d.	Review what support the Sexual Health Workgroup can provide in facilitating the certification process for Austin/Travis County area (e.g. Administrative Support, Application Support, Contacts, etc.)

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

Strategy 3.3.1:	**Advocate for policy and/or policy change at the district, county and state level that could support inclusive, evidence-informed comprehensive sex education and create awareness and develop local community protections against harmful legislation against LGBTQI+ youth in Travis County schools (Y1, Y3, Y4-Revised)**
	Action Steps
a.	Coordinate a presentation with Texas Campaign to present on legislative update on Sexual Health and education to build awareness of recent sex-ed policy changes.
b.	Contact and connect with school-based organizations for advocacy work (SHACs, after-school based orgs, ISDs, School Nurses, School counselors, PSS, etc.)
c.	Engage with clinicians and school-based organizations and districts (SHACs, after-school based orgs, ISDs, School Nurses, School counselors, PSS, etc.)
d.	Develop next steps based on interactive discussion to address local policy gaps and needs.
e.	Engage religious leaders in discussion about policies affecting LGBTQ+ youth

Priority Area 4: Stress, Mental Health, and Wellbeing

Participating Behavioral Health Partner Organizations

Austin Asian Community Health Initiative
Austin Public Health
City of Austin
CommUnity Care
Contigo Wellness
DVISD
Foundation Communities
Integral Care
LifeWorks
Travis County HHS
UT Dell Medical School

Year 4 Action Plan

Goal 4: Advance mental wellness, recovery, and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.

Objective 4.2:	**By 2023, increase by 10% the number of system providers (schools, health care, etc.) who assess for trauma through the use of trauma screening tools and refer to appropriate community supports.**

Strategy 4.2.1:	**Expand the providers who are trained on Trauma Informed Care, linking to appropriate resources. (Y1,Y2,Y3, Y4)**
Action Steps	
a. Identify and educate the community about Trauma Informed Care trainings that are available.	
b. Encourage organizations to make it a priority to allow their staff the time to participate in the training and implement processes.	
b. Provide Road map for becoming TIC, identify the components of TIC and provide general awareness, especially for smaller organizations.	
c. Investigate creating quarterly learning community.	

Strategy 4.2.2:	**Promote resilience in all community settings using trauma-informed approaches.**
Action Steps	
a. Identify what types of training community settings might want/need to accomplish this strategy.	
b. Share training lessons learned with community agencies.	

Strategy 4.2.3:	**Develop and maintain Connect ATX as an online resource list tool for providers to facilitate mental and behavioral health referrals as well as enable people to find and access linguistically appropriate mental health providers.**
Action Steps	
a. Coordinate meeting with ConnectATX, organizations who are expanding services and building resource lists.	
b. Sharing list of linguistic appropriate mental health providers that have been vetted by community-based organizations.	

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

Strategy 4.3.1:	**Promote the adoption of a collaborative care model in Austin and Travis County to provide treatment and to coordinate medical and behavioral health providers**
Action Steps	
a. Identify available programming by geographic coverage area.	

Objective 4.3:	**By 2023, Increase by 10% the proportion of adults aged 18 and up in Austin Travis County who receive mental health/substance use disorder services, with a focus on geographic equity. (revised Y3)**
b.	Identify and promote organizations that can provide crisis support while patients wait to access long-term services.
c.	Identify and promote organizations with available waitlists and/or capacity for long-term counseling (e.g. Capital Area Counseling, YWCA, Gramercy, etc.)
d.	Create a space for greater collaboration among organizations to enroll more individuals for benefits and provide services which are not being provided by integrated teams (e.g. regarding SUD services).

Appendices

Appendix 1: Summit and Action Planning Participants (by Organization)

Unique Organizations (n = 50)	Summit	Access to Care	Chronic Disease /Active Living	Behavioral Health	Sexual Health
African American Youth Harvest Foundation	X				
African-American Men's Health Clinic	X				
Alzheimer's Association	X	X			
American Cancer Society		X			
American Heart Association	X	X	X		
Ascension Seton			X		
ASHWell	X				X
Austin Area Urban League		X			
Austin Asian Community Health Initiative	X	X		X	
Austin Parks and Recreation Dept.	X		X		
Austin Public Health	X	X	X	X	X
Austin Public Library	X				
Austin Resource Recovery	X				
Austin Transportation Dept.	X	X	X		
Austin Voices		X			
Austin Youth River Watch	X	X			
BJ Events	X				
CapMetro	X	X			
CARDEA		X			
Caritas of Austin		X			
Central Health	X	X			
Children's Optimal Health		X			
City of Austin			X	X	
Community Advancement Network (CAN)	X				
CommUnity Care	X	X		X	X
Community Coalition for Health (C2H)	X	X			
Community Medical Services	X				
Contigo Wellness				X	
Del Valle ISD	X			X	
El Buen Samaritano	X	X			
Foundation Communities	X	X	X	X	X
GALS		X			
GAVA			X		
HACA		X			
Integral Care	X	X		X	
It's Time Texas			X		
KAZI FM		X			
LifeWorks	X			X	X
Mayor's Commission for People with Disabilities			X		
NAMI Central TX	X				
Planned Parenthood	X				X

Unique Organizations (n = 50)	Summit	Access to Care	Chronic Disease /Active Living	Behavioral Health	Sexual Health
Prairie View A&M	X		X		
Project Access Austin	X	X	X		
St. David's Foundation	X				
Texas A&M	X				
Texas Campaign					X
Travis County HHS	X	X	X	X	
UT at Austin					X
UT Dell Medical School	X	X	X	X	
Vivent Health					X

Appendix 2: Changes to Strategies from Year 3 to Year 4

Note:

- Strategies in blue cells are new to Year 4 Action Plan.
- Strategies in ~~strikethrough~~ text were included in the Y3 Action Plan but are not included in the Y4 Action Plan.
- Tracked changes also show revisions to wording for Objectives or Strategies.

Priority Area 1: Access to and Affordability of Health Care **Goal 1:** Every Travis County resident has access to culturally sensitive, affordable, equitable, and comprehensive health care.	
Year 4 Objectives	**Year 4 Strategies**
Objective 1.1 By 2023, increase the employment of certified Community Health Workers (CHWs) and service coordinators by 10% to help residents navigate the health care system and promote health literacy.	1.1.1 Explore funding/reimbursement options for CHWs from insurance providers or local funders, so that community health workers are able to pursue a career in community health work that includes benefits, networks of social support, flexible time off and a living wage. Allowing community health workers to be a stable presence in the community and receive sufficient funding to keep them employed.
	1.1.2 Encourage partners/agencies to hire CHW/service coordinators (SCs) for local community-based outreach and/or education.
	1.1.3 Establish or tap into an existing professional development and networking opportunities for CHWs and Service Coordinators.
	~~1.1.4: Establish criteria to incorporate CHW/SC into the care team (e.g., train employees to incorporate CHW into their staff).~~
Objective 1.2 By 2023, increase enrollment in and use of eligible health care coverage and/or assistance programs by 10% for Travis County residents with household incomes at or below 200% Federal Poverty Level (FPL), ages 18-64	1.2.1 Utilize and enhance existing education and communication campaigns to inform Travis County residents in key communities of what health care coverage is available.
	~~1.2.2 Expand training for Community Based Organizations (CBOs)s to educate clients and community residents about all healthcare coverage options/programs for which they are eligible and how to enroll in them. (Combined 1.2.2, 1.2.4, & 1.2.6)~~
	~~1.2.3 Provide agencies high level healthcare options training and referrals to organizations enrolling in coverage.~~
	~~1.2.5 Provide information and data to advocacy groups to support work regarding the impact of federal and state funding cuts to healthcare and outreach.~~
	1.2.8 By 2023, increase enrollment in and use of eligible health care coverage and/or assistance programs by 10% for Travis County residents with household incomes at or below 200% Federal Poverty Level (FPL), ages 18-64.
Objective 1.3 By 2021, decrease no-shows for health care appointments at safety-net health care providers by 10%.	1.3.1 Work with transportation partners to expand and enhance transportation options (e.g., number of accessible vehicles in the region, variety of transportation options to health care) for members of the community who have difficulty reliably traveling to healthcare appointments.
	1.3.2 Advocate to expand care delivery in under resourced areas via options such as co-locating, building new facilities, and use of telemedicine.
	~~1.3.4 Promote the Section 5310 grant program to assist local organizations with the purchase of wheelchair accessible vehicles.~~
	1.3.6 Promote awareness of existing transportation resources, including Capital Metro's Mobility Management program, through a variety of communication avenues.
	1.3.8 Connect health navigators with Mobility Management services so they can refer people to the right transportation resources for their needs.

Priority Area 2: Chronic Disease **Goal 2:** Prevent and reduce the occurrence and severity of chronic disease through collaborative approaches to health that create environments that support, protect, and improve the well-being of all communities.	
Year 3 Objectives	**Year 3 Strategies**
Objective 2.1 Decrease the % of people who have risk factors leading to chronic disease by 10% by 2023.	~~2.1.1 Offer regular, free Community Fitness and "Healthy Living" classes (i.e. fitness, nutrition, etc.) at convenient times and diverse locations to reach target communities. Ensure that programming is culturally and linguistically appropriate.~~
	2.1.2 Engage community leaders to design and conduct a media and marketing campaign that promotes and supports existing organizations and health resources (e.g., fitness class, nutrition, gardening classes, podcast programs, tobacco cessation resources, mobile health tools education and tracking). ~~(See also Strategy 2.4.3)~~
	2.1.4 Engage worksites, schools, early childhood education centers, and after school programs in developing comprehensive policies and programs that promote healthy nutrition, physical activity, tobacco free campus, and Mother Friendly worksites.
	~~2.1.5 Identify barriers to health by screening in clinics for non-healthcare related social determinants of health, and partner with community-based organizations and elected officials to utilize this aggregated data to affect neighborhood-level changes.~~
Objective 2.2 Increase the rates of early detection of chronic disease among adults by 2% by 2023 (diabetes, hypertension) with special focus on disproportionately affected populations.	2.2.2 Partner with existing resources (APH and others) to personalize and implement community-based education and screenings. Focus on educating community members on the importance of routine screenings even without symptoms and knowing risk factors. Provide education and screenings at venues that serve at-risk populations in order to reach communities not seeking healthcare, such settings may include public housing, homeless shelters, barbershops, schools, libraries, transitional houses, education kiosks in community laundromats.
	2.2.3 ~~Implement web-based home education and home testing to overcome barriers to access (e.g., home test kits, diagnostic surveys, online monitoring).~~
Objective 2.4 Increase adherence to Chronic Disease Care Plans by 10% by 2023. [Secondary Prevention]	2.4.1 Promote existing community resources and organizations that provide self-management education considering multiple location (e.g., physician's offices, chronic disease management nursing, mobile screening clinics, community and social caseworkers).
	2.4.4 Refer patients to social service providers and community-based supports who can help them overcome SDOH barriers that might keep them from adhering to their care plan.
Objective 2.5 By 2023, increase by 5% the number of safe, accessible, equitable, and culturally competent assets and opportunities for healthy food and physical activity.	2.5.3 Utilize community member input to improve existing data of assets and opportunities available for physical activity (e.g., urban gardens, community gardens, green space, trails, parks, etc.) and increase access and awareness of these sites.
	2.5.4 Utilize community member input to create new assets and opportunities for healthy food and physical activity.
	~~2.5.7 Advocate for and support ongoing efforts (e.g. Vision Zero Action Plan) to develop and enhance safe, multimodal transportation options across the community, paying particular attention to efforts that increase healthy food access and opportunities for physical activity. Ensure that plans and development take into consideration issues of equity.~~

Priority Area 3: Sexual Health **Goal 3:** Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.	
Year 4 Objectives	**Year 4 Strategies**
Objective 3.1 By 2023, decrease youth pregnancy rates by 10% among populations most affected by health disparities in Travis County.	~~3.1.2 Promote support programs on healthy relationships and teen dating violence.~~
	~~3.1.3 Support and promote equitable pathways to higher education, to a range of diverse career paths, to workforce development and to life skill competency in all ISD, charter, and publicly funded schools.~~
	3.1.4 Promote information sharing between organizations and programs already engaged in sex education work.
	~~3.1.5 Promote support programs that provide culturally and linguistically appropriate resources for families.~~
	~~3.1.6 Advocate for a bill(s)/ bill that would allow adolescents to consent to their own reproductive healthcare if they have a child already.~~
	3.1.7 Advocate for 'Youth Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer equitable affordable access to a full range of FDA-approved birth control methods, reduce barriers to youth seeking same-day appointments, and are trained to provide culturally appropriate contraceptive services. (See also Strategy 3.2.4).
Objective 3.2 By 2023, decrease the rates of sexually transmitted infections (STIs) by 10% among youth populations aged 24 and younger most affected by health disparities in Travis County.	~~3.2.1 Promote and offer HIV and other STI testing, education and enhanced linkage with reproductive and sexual health services. (See also Objectives 2.2 and 2.3)~~
	3.2.4 Advocate for 'Teen Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer affordable access to STI testing and treatment and HIV tests and are trained to provide culturally appropriate STI services.
	~~3.2.5 Identify and reduce barriers to youth seeking same-day appointments for STI tests and treatment.~~
Objective 3.3 By 2023, increase by 10% the number of schools that provide evidence-informed sex education in Travis County.	3.3.1 Advocate for policy and/or policy change at the district, county and state level that could support inclusive, evidence-informed comprehensive sex education and create awareness and develop local community protections against harmful legislation against LGBTQI+ youth ~~reproductive health manipulative demonstrations~~ in Travis County schools.
	~~3.3.2 Promote collaborations between organizations and programs engaged in sex education work, including creating linkages between ISDs and local healthcare providers for referrals for sexual healthcare services not provided through ISD campuses. (See also Strategy 3.1.4)~~
	~~3.3.3 Implement mentoring or skill-based activities that help educate youth regarding healthy relationships, and address social norms and healthy choices.~~
~~**Objective 3.4**~~ ~~By 2023, increase by 10% access to resources and referrals that are culturally sensitive and affordable, for youth who are pregnant and parenting, and their families.~~	~~3.4.1 Promote mental health and counseling services that are available for youth who are pregnant or parenting and their families.~~
	~~3.4.2 Support pregnant women in obtaining prenatal care in the first trimester (e.g., transportation services, patient navigators, etc.).~~
	~~3.4.5 Promote technologies and best practices available to increase youth access to programs, services and information. (See also Strategy 3.1.10)~~

Priority Area 4: Stress, Mental Health, and Wellbeing **Goal 4: Advance mental wellness, recovery, and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.**	
Year 4 Objectives	**Year 4 Strategies**
~~**Objective 4.1**~~ ~~By 2023, decrease by 10% the incidence of excessive drinking and other substance use disorders among Travis County residents.~~	~~4.1.2: Identify or develop and implement a community awareness initiative to decrease binge drinking and substance use disorder for pre-identified at-risk populations (include age-appropriate messaging for multimedia campaign, Outreach in community-based settings with Community Health worker (see also Objectives 1.1 and 2.1) and Substance Use Disorder (SUD) specialists).~~
Objective 4.2 By 2023, increase by 10% the number of system providers (schools, health care, etc.) who assess for adverse childhood experiences (ACEs) and other trauma informed care screening tools and refer to appropriate community supports.	4.2.1 Expand the providers who are trained on Trauma Informed Care, linking to appropriate resources.~~Train providers on best use of trauma screening tools and trauma informed care; linking to appropriate referrals.~~
	4.2.2. Promote resilience in all community settings using trauma-informed approaches.
	4.2.3 Develop and maintain Connect ATX as an online resource list tool for providers to facilitate mental and behavioral health referrals as well as enable people to find and access linguistically appropriate mental health providers.
Objective 4.3 By 2023, increase by 10% the proportion of adults aged 18 and up in Austin Travis County who receive mental health/substance use disorder services, with a focus on geographic equity.	4.3.1 Promote the adoption of a collaborative care model in Austin and Travis County to provide treatment and to coordinate medical and behavioral health providers
	[Tentative] 4.3.2 Advocate for enhanced behavioral health benefits covered by the Medical Access Program (MAP).
	[Tentative] 4.3.6 Pair mental health/SUD workers with all established mobile health outreach teams to geographically underserved populations.
	~~4.3.7 Develop additional teams of mobile mental health/SUD outreach workers who engage with the community at community events and maintain a visual presence in underserved areas.~~

Appendix 3: Y3 Implementation Progress by Priority Area

AUSTIN/TRAVIS COUNTY

Community Health Plan

2021 Progress Report

Access to and Affordability of Healthcare

Process:
- Quarterly Meetings
- Met four times in 2021
- 145 Contacts /64 Organizations
- 40 Active Members/Average Attendance: 25 partners

Plan Progress:

Obj. 1.1: CHWs

1.1.1 AACHI implemented reimbursement and sustainability models; CommUnity Care hired dedicated staff: patient navigators, HIV integration services, and program coordinators.
1.1.2 NCHW developed a national policy platform. AACHI hired 4 bilingual Community Health Navigator roles for vaccine outreach and assisted with certification. Travis County Contracted w/CBOs using $200k CARES Act dollars to outreach and provide PPE and COVID behavior change.
1.1.3 CARDEA/DMS/UTNursing/El Buen enhanced certification process; El Buen building online courses.
1.1.4. Partners, including Dell Medical School and CommUnity Care used integrated model. CommUnity Care doubled efforts in 2021; DMS completing a comparative analysis.

Objective 1.2: Healthcare Coverage

1.2.1 Enhanced funding resulted in extended ACA/MAP campaigns. APH LGBTQI+ Resource Fair on Dec. 4th had 117 attendees,26 partner organizations and COA depts. QWELL served 2,500 clients, identified 400+ LGBTQIA+ recommended healthcare providers, preparing for Inclusive Health Leaders Association.
1.2.2 Central Health's MAP call center & website available (English/Spanish, & Language Line). ECHO/Central Health's MAP webinar attended by 100+. Building Promise USA/Reentry Advocacy Project/C2H organized Reentry Vaccination Initiative, access for formerly incarcerated people. DMS' Central Texas Check-In assessed and addressed pandemic needs.
1.2.3 Project Access and Central Health continued collaboration on partner presentations.
1.2.5 Cover Texas Now Coalition advocacy campaign in support of Build Back Better bill

Objective 1.3: No-Shows

1.3.1 CapMetro Pflugerville 1yr pilot started in March, on demand & WC accessible. CapMetro Vehicle Grant Program donated 14 vehicles (WC accessible) to local orgs. CARTS Now serving Bastrop & Taylor.
1.3.2 CommUnityCare telehealth continued; developing long-term service strategies for alignment of service provision between Central Health and CapMetro (e.g. Hornsby Bend). APL awarded funds to hire navigators to address digital access to social & health services.
1.3.3 Multiple partners took vaccinations to locations where individuals already convened: DMS CHW Pilot; Manor Community Wellness Alliance vaccinated 2,000 at Manor Senior HS
1.3.4 CAMPO call for applications summer of 2021 for WC vehicles and other.
1.3.6 CapMetro Senior ride guides (English/Spanish): distributed to doctor's offices, Senior Comm. Centers, & senior apt. living complexes.
1.3.8 DMS CHW pilot provided bus passes to help "close the loop."

Together We Thrive
Austin/Travis County Community Health Plan

AUSTIN/TRAVIS COUNTY

Community Health Plan

2021 Progress Report

Chronic Disease Prevention and Active Living Coalition

Process:
- Bimonthly Meetings
- Met six times in 2021
- 153 Contacts / 67 Partner Organizations
- 59 Active Members / Average Attendance: 18 partners

Plan Progress:

Objective 2.1: Reduce Risk

2.1.1 PARD hosted Community Garden Leadership Trainings,mushroom, and Spanish language gardening classes; surveyed community on how far they would be willing to travel to garden. UTHealth: asset mapping in Del Valle; DMS and comm. member developed an online yoga for WOC. Austin Parks Foundation provided a Fitness in the Park Series. Waterloo Greenway Conservancy provided yoga classes. "Capital of Texas Team Survivor" assisted women cancer survivors get to classes. Online exercise classes: PARD's Virtual Senior Programs held weekly strength & stretch and chair yoga class; PARD/Common Threads virtual Family Cooking Class; Coming of Age partnered with the University of St. Augustine and AGE of Central TX to offer A Matter of Balance Fall Prevention online program.
2.1.2 Active Living Plan Media Campaign completed by Workgroup: "Find Adventure near you"; digital ads shared by partners. UT Austin Center for Health Communication worked with UT System and other colleges to prevent tobacco use and support cessation.
2.1.3 NCFH provided CHW training for health coaching and hypertension management.
2.1.4. "Moving the Needle" highlighted community organizations, schools, and community member(s) that pivoted during pandemic to meet the health and well-being goals. AISD/PARD created walking fieldtrips. APH printed 8K maps for top 10 places in nature. ~20 OLE Childcare sites created by Texas Children in Nature Network to prevent obesity.
2.1.5 ConnectATX and FQHCs implemented social determinants of health screenings; DMS partnered with UT Health Austin reached over 350 with health related and SDOH survey.

Objective 2.2: Early Detection

2.2.3 Lonestar Circle of Care assisted blood-pressure monitoring at home; March of Dimes provided blood pressure monitoring cuffs through CommUnity Care for pregnant women. DMS worked with clinical partners to send CRC screening packets directly to CommUnityCare and Lone Star Circle of Care patients. Coming of Age and APH provided home-screening tools. PARD/APL providing tablets to seniors.

Objective 2.5: Increase Opportunities

2.5.2 PARD hosted food distributions at two sites and surveyed families about fruits and vegetables.
2.5.3 DMS Community Driven Initiatives Program received 9 food and 2 physical activity idea proposals. APH worked on Safe Routes in Del Valle. UT Health created asset map in Del Valle.
2.5.7. ATD's ATX Walk Bike Roll worked with ~12 Community Ambassadors to gather input to inform trails, sidewalks, and bike paths.

Together We Thrive
Austin/Travis County Community Health Plan

AUSTIN/TRAVIS COUNTY

Community Health Plan

2021 Progress Report

Process:
- Paused Meetings
- Met once in 2021
- 86 Contacts / 35 Organizations
- 20 Active Members

Plan Progress:

Sexual Health

Objective 3.1: Decrease Youth Pregnancies

3.1.2 CommUnity Care and Huston-Tillotson University collaborated to hold two dorm discussions on safe sex and healthy relationships. APH has used their partner grant with Safe Place, Del Valle High School to help address mental health/trauma and focused on a specific population. El Buen launched new training topics for Community Health Workers working with Texas Council of Family Violence. These training topics included, teen dating violence prevention, health and domestic violence for service providers. El buen also worked with DSHS to provide credits for upcoming semesters.
3.1.3 HIV Planning Council held space for community input for their Peer Navigation Program
3.1.4 Travis County Adolescent Health Collaborative continued meeting regularly; Fast-Track Cities (FTC) held 3 consortiums. State Representative Ana-Maria Ramos (HD 102) filed the My Body, My Future Bill, HB 3369, to allow young people under the age of 18 in Texas to be able to consent to birth control in Texas. A bill was filed to reverse SB22 but was unsuccessful. SB1109 to educate students about child, family, and domestic abuse passed, but was then vetoed.
3.1.7: Lonestar Circle of Care, CARDEA, and El Buen Samaritano launched youth friendly campaigns for health assessments.
3.1.8. Planned Parenthood offered same day LARCS for youth with parental permission.

Objective 3.2: Address STIs

3.2.1 CommUnity Care collaborated with Huston-Tillotson University and Delta Sigma Theta Sorority Inc. on World AIDS Day to raise awareness: filled 65 bags with safe sex materials and 25 home HIV test kits for students. Several HIV grants went through an RFA process: Ending the HIV Epidemic (EHE), Ryan White Part A, and HOPWA. The EHE contracts were executed Nov 2021. Ryan White part A/HOPWA will be executed in 2022; FTC informed EHE RFA. APH provided STI testing at first LGBTQ+ Resource Fair; 117 attended and 9 received testing.
3.2.4 CommUnity Care developed referrals process and workflows to enroll patients into sexual health access services at high-utilization sites.
3.2.5 HIV Planning Council held space for community input for their Peer Navigation Program

Together We Thrive
Austin/Travis County Community Health Plan

AUSTIN/TRAVIS COUNTY

Community Health Plan

2021 Progress Report

Process:
- Bimonthly Meetings
- Met five times in 2021
- 84 Contacts / 44 Partner Organizations
- 40 Active Members / Average Attendance: 19 Partners

Stress, Mental Health, and Wellbeing

Plan Progress:

Obj. 4.1: Reduce Substance Use

4.1.2 Integral Care offers enhanced recovery support services with additional peer support specialists in their clinics, the community, and across the substance use services continuum.

Obj. 4.2: Address ACES/Trauma

4.2.1. Workgroup hosted Seanna Crosbie for a Trauma-Informed Care training to implement trauma- informed practices and services.
4.2.2.Dr. Patrick Schnarrs and Rocky Lane presented on Childhood Adversity and Mental Health in LGBTQ+ Texans. Manor Community Wellness Alliance developing "Behavioral Activation for Teens" with UT in collaboration with Manor ISD and the City of Manor for evidence-based mental health support for adolescents.

Obj. 4.3: Increase Access

4.3.1 Since February 2021, City of Austin 9-1-1 now receives Mental Health Crisis calls for which Integral Care's Mobile Crisis Outreach provides support. Approximately 80% of calls had been diverted from police response. Integral Care implemented a new fully integrated telehealth solution to offer HIPAA-compliant virtual care, increased intake capacity by hiring additional helpline customer care staff as well as clinic and community-based intake staff and expanded outpatient and community-based services with additional clinical staff to increase level-of-care services, additional housing stability specialists to help clients maintain safe stable housing, and CHWs to focus on whole health and wellness. DMS Community Driven Initiatives Program received 15 ideas from members of the community for addressing mental health in Austin, Travis County, and Central Texas.
4.3.7 NAMI offered a free eight-session educational program for adults with mental health conditions who are looking to better understand themselves and their recovery.

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