Community Health Improvement Plan

Austin/Travis County, Texas

August 2018



Together We Thrive

Austin/Travis County Community Health Plan

Photos on the front and back cover of this report were submitted by community members on Facebook, Twitter, and Instagram with the hashtag #ShowUsYourAustin in response to the question, "What does health mean to you?"

This social media campaign was used as a creative method to gather public input for the Austin/Travis County Community Health Assessment (CHA) in partnership with the City of Austin Mayor's Office and Office of Innovation.

To Our Partners

Austin Transportation Department

Capital Metropolitan Transportation Authority (CapMetro)

Central Health

Integral Care

Seton Healthcare Family

St. David's Foundation

Travis County Health and Human Services

The University of Texas at Austin Dell Medical School

The University of Texas Health Science Center at Houston School of Public Health in Austin

Thank you!

Austin Public Health

PREVENT. PROMOTE. PROTECT.

Dear Community Stakeholder,

Beginning in the fall of 2016, Austin Public Health partnered with many agencies to lead a comprehensive community health planning initiative, which included development of a Community Health Assessment (CHA). The process entailed community meetings, key informant interviews, and focus groups to gather a picture of our community's health and what we should do to address identified issues. The results of that effort are provided in the second CHA report, which was published in December 2017.

While the CHA illustrates the power of data driven evidence and the community's voice, the Community Health Improvement Plan (CHIP) identifies key priorities and provides direction on how Austin/Travis County will implement strategies to improve our health and well-being by establishing common goals and objectives for our community.

This CHIP provides direction and a roadmap for the next three years to collectively address pressing health issues in our community. We have the opportunity to advance and positively impact our community. Through policies, education, and programs/initiatives, we can affect the many determinants of health for a better, stronger, and sustainable Austin and Travis County.

We encourage all residents to read the report and work with the entire community to implement its recommendations. The goal is to effectively implement action steps that will move us closer to the targets set in the CHIP. We will assess and update each year as we go through this process.

On behalf of the entire CHA/CHIP Steering Committee and partner agencies, we look forward to each of you becoming involved in helping to make Austin and Travis County the Healthiest Community in America for all of its residents.

Healthy people are the foundation of our thriving community!

Sincerely,

Stephanie Y. Hayden, LMSW
Chair, Austin/Travis County CHA/CHIP Steering Committee

City of Austin Founded 1839

Accredited Health Department · Public Health Accreditation Board · PHAB Advancing public health performance

Table of Contents

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, our community is undergoing a comprehensive community health planning effort to measurably improve the health of Austin/Travis County residents. This effort is led by Austin Pubic Health (APH) (formerly Austin/Travis County Health and Human Services) – in collaboration with:

- Austin Transportation Department
- Capital Metropolitan Transportation Authority (CapMetro)
- Central Health
- Integral Care
- Seton Healthcare Family
- St. David's Foundation
- Travis County Health and Human Services
- The University of Texas at Austin Dell Medical School
- The University of Texas Health Science Center at Houston School of Public Health in Austin

This effort 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

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.[1] 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 maintain national accreditation, which indicates that the agency meets or exceeds rigorous public health standards. Guided by the findings from a robust evaluation of the previous CHA/CHIP planning cycle, the 2018 plan continues to build on learnings and collaborative partnerships.

The 2018 Austin/Travis County CHIP was developed over the period January 2018 through August 2018 using the key findings from the 2017 Community Health Assessment, which included qualitative data from focus groups, key informant interviews, community forums that were conducted locally, a door-to-door survey, and a social media campaign, 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.

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

The vision, mission, and the shared values from the 2012 CHA/CHIP continue to be relevant for the support and implementation of the 2018 CHIP.

Together We Thrive
Austin/Travis County Community Health Plan

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
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*

Efficient, Results-Oriented, Data Driven, and Evidence Informed:
Approach designed to improve overall health and disparities
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: **Access to and Affordability of Health Care**
Goal 1: Every Travis County resident has access to culturally sensitive, affordable, equitable, and comprehensive health care.
Cross Cutting Strategies: Transportation and Socioeconomic Inequalities

Priority Area 2: **Chronic Disease**, *with a focus on Primary and Secondary Prevention and the Built Environment*
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.
Cross Cutting Strategies: Cultural Competency and Education

Priority Area 3: **Sexual Health** *(Teen Pregnancy)*
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.
Cross Cutting Strategies: Cultural Competency and Education

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 systems.
Cross Cutting Strategies: Workforce Development and Stigma and Societal Norms

Background

The 2018 Austin/Travis County CHIP was developed over the period October 2017 through August 2018 using the key findings from the 2017 Community Health Assessment (CHA), conducted by Morningside Research and Consulting, Inc. and community partners. The CHA included qualitative data from focus groups, key informant interviews, community forums, a door-to-door survey, and a social media campaign, as well as quantitative data from local, state and national indicators. Both the quantitative and qualitative data informed discussion and selection of health priority areas. The CHA is accessible at www.austintexas.gov/healthforum.

Moving from Assessment to Planning

Like the CHA, the CHIP utilized a participatory, collaborative approach guided by the Mobilization for Action through Planning and Partnerships (MAPP) process.[2] 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.

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the Austin/Travis County 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 responsible for the overall management of the process.
c. The **CHIP Workgroups**, were formed around each health priority area to develop the goals, objectives, indicators and strategies for the CHIP.
d. **Data and Research Subcommittee**: informed methods for measuring CHIP indicators and recommended data sources.

For specific membership for each committee, workgroup, and subcommittee see Acknowledgements and Appendix A.

[2]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/

In October of 2017, Austin Public Health contracted with Health Resources in Action, Inc. (HRiA), a non-profit public health organization based in Boston, Massachusetts, as a consultant partner to provide strategic guidance and facilitation of the CHIP process.

HRiA began work on the 2018 Austin/Travis County CHIP by conducting a review of the draft CHA and developing the 2018 CHIP Guiding Document. This document represents a synthesis and summary of the key themes and secondary data that are more fully detailed in the 2017 Community Health Assessment. The goal of this document is to assist in the identification of CHIP priorities and objectives. For the complete 2018 CHIP Guiding Document, please see Appendix E.

HRIA utilized the CHIP Guiding Document and other criteria to facilitate the Steering Committee's prioritization of thirteen CHA key themes to narrow the CHIP focus to a few priorities and cross cutting issues. The Steering committee also reflected on the previous CHIP evaluation recommendations related to need for greater focus in the next plan to increase the potential for greater impact to health issues in the community. A multi-voting process using agreed-upon selection criteria was used to identify which priority health issues would be addressed in the CHIP

For a complete description of the selection process, please see Section II C.

I. Overview of the Community Health Improvement Plan

A. What is a Community Health Improvement Plan?

A Community Health Improvement Plan, or CHIP, offers 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] A 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.

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 Austin Public Health to be eligible for accreditation, which indicates that the agency is meeting national standards

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. The CHIP is broad enough to allow for inclusivity of many community efforts that have similar purpose and intent, and is also specific enough to guide action. The CHIP 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

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

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 set forth in this CHIP, reflect on the suggested strategies, and consider how you can participate in this effort aimed at advancing the health of Austin/Travis County

The CHIP provides recommendations of how our community can align with National health goals identified in Healthy People 2020 (see Appendix D).

C. Methods

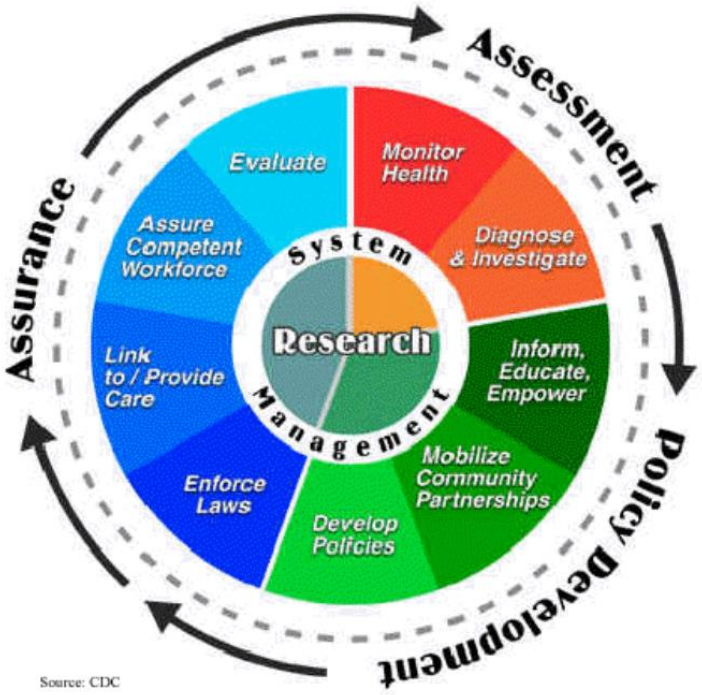
Building upon the key findings and themes identified in the Community Health Assessment (CHA), the CHIP aims to:

- 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

To develop the CHIP, Austin Public Health 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.

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 in Figure 1.

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



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

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.

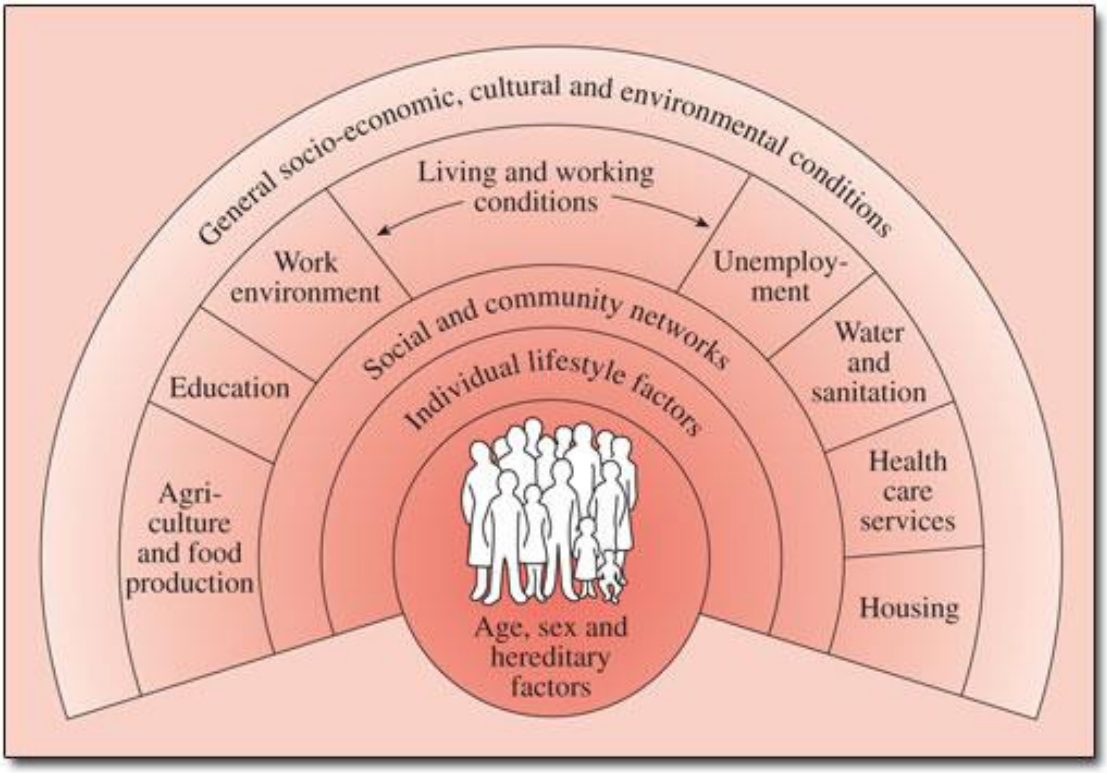
D. Social Determinants of Health Framework

It is important to recognize that multiple factors affect health and that there is a dynamic relationship between people and their environments. Where and how we live, work, play, and learn are interconnected factors that are critical to consider. That is, not only do people's genes and lifestyle behaviors affect their health, but health is also influenced by more upstream factors such as employment status and access to transportation. The social determinants of health framework addresses the distribution of wellness and illness among a population—its patterns, origins, and implications. While the data to which we have access is often a snapshot of a population in time, the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies. Building on this framework, this assessment utilizes data to discuss who is healthiest and least healthy in the community as well as to examine the larger social and economic factors associated with good and ill health.

The following diagram provides a visual representation of this relationship, demonstrating how individual lifestyle factors, which are closest to health outcomes, are influenced by more upstream factors such as employment status and educational opportunities (Figure 2). This CHIP provides information on many of these factors, as well as reviews key health outcomes among the people of Austin/Travis County.

See sections IIIB, IIIC, IIID and IIIE for more information about the social determinates of health impacting the priority areas identified in the CHIP.

Figure 2: Social Determinants of Health Framework



DATA SOURCE: World Health Organization, Commission on Social Determinants of Health. (2005)

II. Prioritization of Health Issues

A. Community Engagement

Austin Public Health helped convene and facilitate the planning process for all aspects of the CHIP development for Austin/Travis County, including the establishment of CHIP Workgroups and a Data & Research Subcommittee 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 Data & Research Subcommittee participants and their affiliations.**

B. Strategic Components of the CHIP

In the fall of 2016, an evaluation of the past 2012- 2016 CHA/CHIP cycle was conducted. The evaluation highlights success and lessons learned from the past CHIP. Some of the lessons learned identified through the evaluation process were:

- Strengthen the prioritization process of the CHIP
- Fine tune the organizational structure and delivery of the CHIP
- Enhancing community engagement throughout the CHIP development process

To address these lessons learned from the evaluation, changes were made to improve and strengthen the process of prioritizing themes from the Community Health Assessment (CHA) into key health issues to be addressed by the Community Health Improvement Plan (CHIP). The entire evaluation report is available at http://austintexas.gov/healthforum.

On January 26, 2018, a synthesized summary of the CHA findings, called the CHIP Guiding Document, was presented to the Steering Committee. The following themes emerged most frequently from review of the available data:

- Socioeconomic Inequities
- Education and Workforce Development
- Access and Affordability of Health Care
- Cultural Competency
- Health Literacy and Knowledge
- Health Outcomes and Health Disparities
- Stress, Mental Health, and Well-Being
- Transportation
- Access to Safe Recreational Spaces
- Access to Healthy Food
- Environmental Health
- Homelessness
- Societal Norms and Stigma

A rating tool was applied to the themes from the Guiding Document to identify key health priorities and cross cutting strategies. Following a brief presentation by HRiA and group discussion by the Steering Committee on each health theme, participants established consensus on CHIP priorities. (see Section D. Cross-Cutting Strategies).

Participants used the rating tool to rate each key health issue based on how well they met customized criteria, where 1=low, 2=medium, 3=high, 4=very high.

Figure 3 Criteria for Prioritization

Criteria for Prioritization	
Feasibility My organization has the social and financial capital needed to make an impact in this issue area.	- Alignment with my organization's plan(s). - My organization has allocated resources to address this issue. - My organization will assist with identifying and bringing stakeholders /groups to participate in CHIP. - My organization will help in promoting the issue area forward. - My organization will be able to provide input on how CHIP workgroups can help address gaps within this issue area.
Appropriateness To the best of my knowledge, this issue area will benefit from CHIP action planning.	- Community stakeholders can champion issue area. - Metrics /data exists to track progress. - Clear target areas/populations - Issue area would benefit from increased awareness. - Stakeholders would benefit from increased communication and regular engagement. - Appropriate partners are already Steering Committee members.
Impact Community identified issue area as important.	- Focus group participants identified issue area as a high priority. - Feedback and comments from public forum indicates interest in addressing issue area. - Comments from public feedback support the selection of this issue area.

Participants calculated an overall rating for each health issue by adding their three ratings. Each participant received three sticker dots and were asked to place their dots on the three key health issues that received the three highest overall total ratings on their rating worksheet. Participants used their personal judgment to break any ties.

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

- Stress, Mental Health, and Wellbeing
- Access to and Affordability of Health Care
- Health Outcomes and Disparities
- Access to Healthy Food

Discussions were held with the Steering Committee following the prioritization meeting regarding the broad scope of the Health Outcomes and Disparities priority area. The decision was made to divide this priority area into two distinct priorities, which were identified utilizing the data and areas of need identified in the CHA, to enable a greater focus for planning and implementation efforts. The following priorities for the 2018 CHIP resulted:

- Stress, Mental Health, and Wellbeing
- Access to and Affordability of Health Care
- Health Outcomes and Disparities *with a focus on Sexual Health*
- Health Outcomes and Disparities *with a focus on Chronic Disease Risk Factors and Community Based Disease Management*
- Access to Healthy Food

Additionally, discussion with community partners around the key health priority of Access to Healthy Food revealed pre-existing and ongoing community efforts to strategically and collaboratively address access to healthy food. The Austin/Travis County Food Policy Board guides the efforts that are carried out by multiple workgroups. One of which specifically focuses on healthy food access and food security. Stakeholders involved with the food access initiatives of the Food Policy Board agreed to ensure connection and regular communication with the CHA/CHIP Steering Committee to avoid duplication of efforts and overburdening the organizations engaged in this work.

C. Development of Data-Based Community Identified Health Priorities

To ensure the most appropriate election of key health priority areas, Steering Committee members considered data specific to the three criteria and applied this information for all ratings. Below is a description of how ratings were informed (See Section IIB for more information on the criteria and rating system).

- **Feasibility:** Steering Committee organizations were asked to review their own organization's plans (such as business plans or improvement plans or strategic plans) to identify overlap. The greater the overlap the higher the rating.
- **Appropriateness**: Criterion was developed based on the results of the evaluation of the 2012-2016 CHA/CHIP cycle. The criterion reflected what the CHIP did well. Each Steering Committee member considered how much a theme would benefit from being part of the CHIP. The greater the benefit the higher the rating.
- **Impact:** Steering Committee members considered public input and prioritizations for the 2017 Community Health Assessment (CHA). Themes which community members prioritized the highest or identified the most frequently were given the highest ratings. To learn more about how this feedback was collected please reference the CHA available online at www.austintexas.gov/healthforum.

The Steering Committee decided further focus within each area was needed for better guidance during CHIP development. Building on the initial selection of key health priorities in January, a follow-up meeting was held in March. During this meeting, Steering Committee members reviewed the CHIP Guiding Document's findings specific to the key health priorities and voted on two specific issue areas within each key health priority. Additionally, during this meeting the cross-cutting strategies were assigned to the most appropriate key health priority. This guidance was provided to the CHIP workgroups to assist in the development of CHIP objectives and strategies during an April summit.

D. Cross-Cutting Strategies

Steering Committee Members agreed that there were several health priorities called out in the CHIP Guiding Document that should be included as cross-cutting strategies, as opposed to being identified as key health priority areas. Cross-cutting strategies are issues that have been identified as a key focal point for integration across more than one priority area in the plan. Proposed Cross-Cutting Strategies for the 2018 CHIP include:

- Socioeconomic Inequity
- Education
- Workforce Development
- Cultural Competency
- Societal Norms and Stigma
- Transportation

The planning process for the CHIP was designed to provide additional focus within each priority based upon the social determinants of health. 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]

Prior to the CHIP Planning Summit, members of the Steering Committee provided further direction on areas of focus for each of the priority areas and guidance on which cross-cutting strategies were most important to address under each priority area.

Figure 4 CHIP Priority Areas

Priority Area	Recommended Objective Topics	Cross-Cutting Strategies to be Addressed
Priority 1: **Access to and Affordability of Healthcare**	• Preventative Services • Physical Access	• Transportation • Socioeconomic Inequalities
Priority 2: **Health Outcomes and Disparities** with a focus on Chronic Disease Risk Factors and Community Based Disease Management	• Primary and Secondary prevention	• Cultural competency • Education
Priority 3: **Health Outcomes and Disparities** with a focus on Sexual Health	• Teen Pregnancy and specific related health risks for younger teens and their babies.	• Cultural competency • Education
Priority 4: **Stress, Mental Health, and Wellbeing**	• Lack of Mental Health providers and resources • Substance abuse with focus on binge drinking	• Workforce development • Stigma and Societal Norms

E. Development of the CHIP Strategic Components

APH conducted a Preplanning Webinar on March 28, 2018 to familiarize the planning summit invitees with an overview of the community health improvement process, introduce them to the priorities that were selected for the 2018 CHIP and the process by which they were selected, review the cross-cutting strategies, and outline the documents they would be asked to review prior to the planning summit. The webinar was recorded and made available to invitees who were not able to participate in the live webinar.

[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.)

On April 13, 2018, over 60 community members and CHA/CHIP partners participated in an all-day planning summit at CommUnityCare Southeast Health and Wellness Center to develop the core elements of the CHIP. HRiA facilitators led participants through the FAST™ Planning Process (Facilitating Alignment and Strategic Thinking). FAST™ is an efficient and effective rapid strategic planning process designed by Health Resources in Action (HRiA) to provide a shorter, more cost-effective approach to planning that produces high-quality results and delivers high value and satisfaction for stakeholders.

CHIP workgroup participants were provided sample evidence-based strategies from a variety of resources including *The Community Guide to Preventive Services*, *County Health Rankings*, *Healthy People 2020*, and the *National Prevention Strategy*.

Following the planning summit, HRiA consultants reviewed the draft output from the planning sessions and edited material for clarity and consistency. The Data and Research Committee reviewed the goals, objectives, and strategies so that they could identify, clarify, and expand upon success indicators drafted at the planning summit. The draft CHIP components were disseminated to working group members for three successive cycles of electronic review and feedback. For each cycle, feedback was reviewed by HRiA consultants and APH staff, revisions were incorporated into successive revisions, resulting ultimately in the final draft of the CHIP, which will be used to guide annual implementation plans.

See Appendix A for workgroup participants, Data & Research Subcommittee members, and their affiliations.

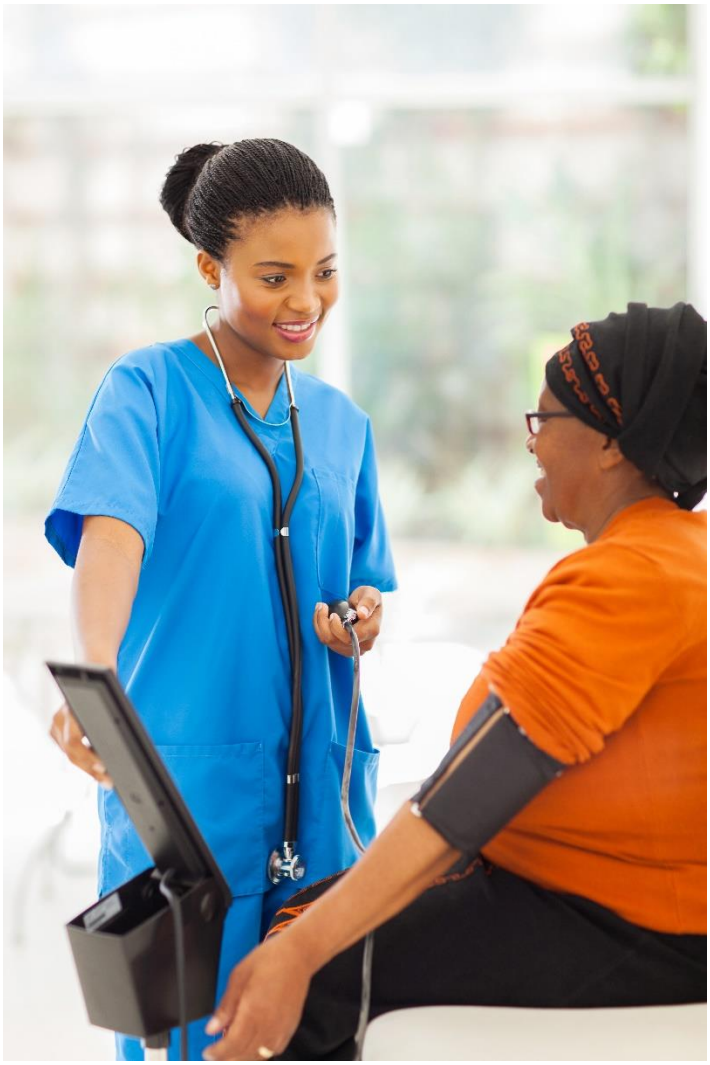
III. CHIP Implementation Plan

A. 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 CHIP Guiding Document is included in the beginning section of each priority area. See Appendix B for a glossary of terms used and Appendix C for a listing of acronyms used throughout the CHIP.

Priority Area 1:
Access to and Affordability of Health Care



B. Priority Area 1: Access to and Affordability of Health Care

Priority Area	Objective Topics	Cross-Cutting Strategies to be Addressed
Priority 1: **Access to and Affordability of Healthcare**	• Preventive Services • Physical Access	• Transportation • Socioeconomic Inequalities

The Austin/Travis County Region is characterized by an increasingly diverse population, both racially, ethnically and linguistically. The racial and ethnic distribution is shifting, with the majority of youth (<18 years of age) representing a minority racial or ethnic group. Poverty disproportionately affects Hispanic/Latino and Black/African American populations and economic growth, population growth, and the high cost of living continues to displace Hispanic/Latino, Black/African American and low-income populations to the suburbs and rural areas. Displacement to the suburbs and rural areas limits access to health centers that serve people with lower income which are usually located nearer to the city center. Even when access to a health center is not an issue, hours of operation (e.g., normal business hours) are not always convenient for residents who work full-time and/or work multiple jobs. Weekend and evening hours were perceived as being a key need among residents.

Public transportation was identified as a critical need for those without access to a vehicle. Public transportation may be difficult to use because of proximity to service, hours of operation, and frequency of service. This is especially true in rural communities including Del Valle, Jonestown, Austin's Colony, Manor, and other unincorporated areas within Travis County, some of which are not served by public transportation. While health clinics were cited as an overall strength within the city of Austin, some neighborhoods (e.g., east side of Austin and Travis County) have fewer health clinics available. Community members also described some types of clinic services being limited in certain areas as well, such as mental health services or vision and dental care. This is further compounded by the increase in population moving to areas outside of the urban core due to increased cost of living.

Many residents forego seeing doctors due to cost. Black/African American, Hispanic/Latino, and lower income residents are disproportionally affected by the cost of a doctor's visit. In addition, middle-class residents struggle to afford health insurance and health care costs and do not qualify for assistance. Health insurance enrollment outreach has improved access to health care, and the Medical Access Program (MAP) was identified as a strength, but there is room for further improvement in reducing the barriers associated with health care costs for both the uninsured and the insured. While uninsured residents have limited options for accessing health care, insured individuals discussed challenges with insurance networks and finding providers that are in-network or finding providers that accept Medicaid.

Based on these key issues identified in the CHA, the Austin/Travis County CHIP workgroup on Access to and Affordability of Health Care identified the following goals and objectives:

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.

Long-Term Indicators

- The number of credentialed Community Health Workers (CHW) in Travis County – Department of State Health Services Community Health Worker Training and Certification Program.

Short-Term Indicators will be identified and reviewed through the action planning and implementation phase.

Strategies

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 targeted community-based outreach and/or education (example: consider recommending the utilization of funds from unfilled positions to hire CHWs or service coordinators).

1.1.3: Establish or tap into an existing network for CHW/SCs to share learnings and experiences.

1.1.4: Establish criteria to incorporate CHW/SC into the care team (e.g., train employees to incorporate CHW into their staff).

1.1.5: Partner with higher education (e.g., Schools of Nursing) and influence their long-term strategies for support of CHW/SC.

(See also Strategies 2.1.1, 2.3.3, 2.4.5, and 4.1.2 which include the delivery of services in community settings and are opportunities for CHW to provide navigation.)

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.** *Next phase would look at increasing the programs available.*

Long-Term Indicators

- Average annual MAP enrollment from 2019- 2023.
- Percentage of Travis County residents under age 65 with no health insurance- American Community Survey.

Short-Term Indicators will be identified and reviewed through the action planning and implementation phase.

Strategies

1.2.1: Utilize existing education and communication campaigns to inform Travis County residents in targeted communities of what health care coverage is available.

1.2.2: Train enrollment personnel to counsel residents about all health coverage options/programs for which they are eligible.

1.2.3: Provide agencies (for-profit & non-profit) who work with people at <200% FPL with referral information across health care and social service options/programs so that they can cross-refer (housing, at birth of a child, WIC, SNAP, etc.). Consider providing cross training at preplanned or ongoing conferences, forums or trainings.

1.2.4: Expand training for social service providers on how their clients can qualify for the Affordable Care Act (ACA) or other health insurance programs (MAP, CHIP, Medicaid). Ensure clients are aware of special year around enrollment opportunities for life events.

1.2.5: Advocate with State agencies around impact of funding cuts to insurance enrollment efforts and insurance subsidies.

1.2.6: Reach out to immigrant networks to share information on coverage and/or assistance programs available.

1.2.7: Reach out to school districts, PTAs, special education departments, etc. to share information on coverage and/or assistance programs available.

1.2.8: Partner with people who do community surveys to distribute information on coverage and/or assistance programs available.

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)

Indicators:

- Decrease in no show rates.

Strategies

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.

1.3.3: Develop recommended operational procedures to help facilities increase % of walk-in appointments available, increase % of patients who get care even if late, decrease time to schedule appointment, and increase extended hours available.

1.3.4: Promote the Section 5310 grant program to assist local organizations with the purchase of wheel chair accessible vehicles.

1.3.5: Identify partners to support the insurance and maintenance of vehicles from the Capital Metro vehicle mobility grant program.

1.3.6: Promote awareness of existing transportation resources, including Capital Metro's Mobility Management program*, through a variety of communication avenues.

1.3.7: Explore options for making Capital Metro's Mobility Management program more robust (e.g., centralizing, tech/software solutions).

1.3.8: Connect health navigators with Mobility Management services so they can refer people to the right transportation resources for their needs.

NOTE: Transportation issues are common to all objectives addressing access issues. (See Objective 2.5 and Strategy 3.4.2)

* Mobility Management Program integrates the regional network of transit service to find ways that connect people to needed goods and services in our Central Texas area. The Office is a collaboration between two transit agencies, Capital Metro and Capital Area Rural Transportation System (CARTS), with access to twenty-six community partners serving senior adults, people with disabilities and veterans. To learn more visit mytxride.com

Potential Partners/Resources for Priority Area 1: Access to and Affordability of Health Care

- 211
- Austin Independent School District (AISD)
- Austin Public Health (APH)
- Asian American Resource Center
- Austin Dental Cares
- Austin Transportation Department
- Capital Metropolitan Transportation Authority (CapMetro)
- Capital Area Rural Transportation System (CARTS)
- Catholic Charities
- Community Care Collaborative (CCC) providers
- Central Health
- City of Austin Transportation Department
- Community Health Workers
- CommUnityCare Health Centers
- Dell Seton Medical Center
- Del Valle ISD
- Diocese of Austin
- El Buen Samaritano
- EnrollATX
- Faith-based organizations
- Foundation Communities
- Healthy Texas Women
- Integral Care
- Latino Healthcare Forum
- Lone Star Circle of Care
- Manor ISD
- Mama Sana/Vibrant Woman
- People's Community Clinic
- Pflugerville ISD
- Seton Healthcare Family
- St. David's Foundation grants
- Texas Department of State Health Services (certify the CHW certificates and set the standard)
- Transportation network companies (Uber, Lyft, RideAustin, etc.)
- Transportation providers (Waze, Google, Ridescout, etc.)
- Travis County (Transit Development Plan implementation)
- Travis County Transportation & Natural Resources
- TxDOT
- University of Texas (UT)

Priority Area 2: Chronic Disease

C. Priority Area 2: Chronic Disease

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

Priority Area	Objective Topics	Cross-Cutting Strategies to be Addressed
Priority 2: Health Outcomes and Disparities with a focus on Chronic Disease Risk Factors and Community Based Disease Management	• Primary and Secondary prevention	• Cultural competency • Education

Data indicates that chronic disease is a major contributor to death and illness. The leading causes of death -- cancer and heart disease, and diabetes and obesity -- were identified as priorities by community health assessment participants. While the incidence of cancer, heart disease, diabetes, and obesity has declined, these health issues disproportionally affect communities of color.

The Community Health Assessment indicates that the community lacks knowledge of the many services that exist in Austin/Travis County for the prevention, detection, and treatment of chronic disease. Additionally, assessment participants described challenges interacting with the healthcare system, including navigating health insurance, finding in-network doctors, legal aspects of medical paperwork, and terminology.

Data shows substantial disparities in preventive health screenings by income level. Far fewer women over age 40 who earn <$25,000 received a mammogram in the past two years as compared to women with incomes $75,000+. The number of residents age 50 and older who earn <$25,000 and reported having a sigmoidoscopy/colonoscopy was significantly lower than residents with incomes $75,000+. Data also shows disparities in preventive health immunizations, such as influenza and pneumococcal vaccination, by race.

While a smaller proportion of adults in Travis County reported being current smokers than for Texas overall, the county has not met the Healthy People 2020 target of ≤12% residents who currently smoke. Smoking is disproportionately concentrated among low-income residents, with adults with incomes <$25,000 reported being a current smoker at almost three times the proportion of adults with incomes of $75,000+.

Residents discussed challenges to adopting healthier eating habits, understanding health information, and understanding prescription medications. Additionally, some participants mentioned that it can be difficult to know what food is healthy because of conflicting messages in food marketing and package labels. There is a need to support existing culturally appropriate cooking and physical activity classes, and to increase the availability of such classes.

Based on these key issues identified in the CHA, the Austin/Travis County CHIP workgroup on Chronic Disease identified the following goals and objectives:

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]

Long-Term Indicators

- Source BRFSS:
  - Obesity or overweight rate.
  - Tobacco use prevalence.
  - % of people who meet nutrition and physical activity goals/recommendations

Short-Term Indicators will be identified and reviewed through the action planning and implementation phase

Strategies

2.1.1: Offer regular, free Community Fitness and Nutrition Classes at convenient times and diverse locations to reach target communities. Ensure that programming is culturally and linguistically appropriate. (See also Objective 1.1 and Strategy 4.1.2)

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)

2.1.3: Develop and execute an awareness campaign on risk factors and how to reduce risk of chronic disease involving all community partners, physicians, dental, mental health, Community Health Workers etc. (e.g., Market and conduct Community Health Events in different parts of Travis County each year).

2.1.4: Engage worksites, schools, and early childhood education centers in developing comprehensive policies and programs for nutrition and physical activity.

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. [Secondary Prevention]

Indicators

- Source BRFSS:
  - Screening rates for diabetes
  - Screening rates for hypertension

Strategies

2.2.1: Integrate routine, culturally appropriate chronic disease screenings for all clinic visits.

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, schools, libraries, education kiosks in community laundromats.

2.2.3: Implement web-based home education and home testing to overcome barriers to access (e.g., home test kits, diagnostic surveys, online monitoring).

(See also Objective 2.3 and Strategy 3.2.1)

Objective 2.3: Reduce the proportion of persons who are unable to obtain or delayed in obtaining necessary medical care by 10% by 2023 through services and education provided in client's home or at a community setting. [Secondary Prevention] (See also Objective 1.3)

Long-Term Indicators

- Percentage of Adults with a Personal Doctor or Health Care Provider in Texas and by Race/Ethnicity in Travis County BRFSS
- Percentage of Adults Who Needed to See a Doctor but Did Not Due to Cost in past 12 Months in Texas and by Race/Ethnicity in Travis County BRFSS

Short-Term Indicators will be identified and reviewed through the action planning and implementation phase.

Strategies

2.3.1: Explore home visiting, such as an automatic weekly nurse visit, for patients whose chronic disease is not currently being managed.

2.3.2: Provide linkage to care after hospital discharge by scheduling follow-up appointments and promoting pharmaceutical assistance programs. Ideally this service and support would be provided in home or a community setting.

2.3.3: Utilize and train additional community health workers to provide linkage to care after hospital discharge and in other community-based settings; and engage faith community for support. (See also Objective 1.1)

(See also Objectives 1.1, 1.2, and 1.3 which include additional resources to improve access to culturally appropriate care. (See also Strategy 3.2.1))

Objective 2.4: Increase adherence to Chronic Disease Care Plans by 10% by 2023. [Secondary Prevention]

Indicators

- Source BRFSS:
  - Have ever received diabetes education
  - Controlled A1C
  - Seen doctor for diabetes

Strategies

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).

2.4.2: Engage CHWs and faith community in the development of culturally appropriate and culturally sensitive care plans (evidence-based models or best practices) as part of their related and interdependent support roles.

2.4.3: Ensure proper marketing of resources and benefits available for self-management of chronic diseases to help clients adhere to their care plan. (See also Strategy 2.1.2)

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.

2.4.5: Engage CHWs and faith community to promote and support follow up visits. (See also Objective 1.1)

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]

Long-Term Indicators:

- Source BRFSS
    - Percent of adults that consume 5 or fruit or vegetables per day.

Short-Term Indicators will be identified and reviewed through the action planning and implementation phase.

Strategies

2.5.1: Establish baseline data by convening community conversations and compiling existing data where community members identify existing assets (e.g., urban gardens, community gardens, green space, trails, parks, etc.) and opportunities for healthy food and physical activity. Use City data of community assets to confirm and supplement.

2.5.2: Utilize community member input to inform education about currently available assets and opportunities for healthy food and physical activity.

2.5.3: Utilize community member input to improve access to existing assets and opportunities for healthy food and physical activity.

2.5.4: Utilize community member input to create new assets and opportunities for healthy food and physical activity.

2.5.5: Identify publicly owned property for use as parkland, trails or green space in areas of high need.

2.5.6: Advocate for the automatic incorporation of green space in private development plans.

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.

Potential Partners/Resources for Priority 2: Chronic Disease

- Austin Independent School District (AISD)
- Austin Public Health (APH)
- Austin Parks Foundation
- Austin Transportation Department
- B-Cycle
- Bike partners
- Capital Metropolitan Transportation Authority (CapMetro)
- Catholic Charities
- Cities Connecting Children to Nature (CCCN)
- Clinics
- Community Care Collaborative (CCC)
- CommUnityCare Health Centers
- Community organizers
- Del Valle ISD
- Dell Med
- Diocese of Austin
- Doctors' offices
- Employment Workforce Solutions, Urban League, etc.
- Emergency Medical Services (EMS)
- Faith-based organizations
- Foundation Communities (FCs) affordable housing providers
- Go! Austin / VAMOS! Austin (GAVA)
- Health Equity
- Homeless service providers
- Hospitals
- Housing Authority City of Austin (HACA)
- It's Time Texas
- Jails, prisons, detention centers
- Labs
- Libraries
- Mayors Health & Fitness Council
- Meals on Wheels
- Neighborhood Centers
- Neighborhood groups
- Parks and Recreation Department (PARD)
- Public Works Department (PWD)
- Restore Rundberg
- School districts
- School Health Advisory Council
- Seton Healthcare Family
- St. David's Hospital
- Sustainable Food Center (SFC)
- State Health Department
- Tech partners
- Transportation Network Companies (TNCs)
- Travis County Parks and Natural Resources Divisions
- University of Texas (UT) Austin
- University of Texas School of Public Health's Michael and Susan Dell Center for Healthy Living
- Urban Roots

Priority Area 3: Sexual Health

D. Priority Area 3: Sexual Health

Priority Area	Objective Topics	Cross-Cutting Strategies to be Addressed
Priority 3: **Health Outcomes and Disparities** with a focus on Sexual Health	• Teen Pregnancy and specific related health risks for younger teens and their babies.	• Cultural competency • Education

Discussions held as part of the Community Health Assessment indicated that teen pregnancy is a concern. Although data show that teen pregnancy in Travis County is slightly below that for the state, Texas ranks 47th compared to other states in the country. In addition, there are disparities in teen pregnancy across race/ethnicity: in Travis County, White, non-Hispanic teenage girls between 15 and 17 years old were less likely to give birth (0.4%) than their Black/African American (2.7%) and Hispanic/Latina (4.0%) peers.

Data also indicates racial disparities in prenatal health care and birth outcomes. In 2012-2014, 32.8% of Black/African American mothers and 38.7% of Hispanic/Latina mothers in Travis County received late or no prenatal care, whereas 14.4% of White, non-Hispanic mothers received late or no prenatal care. Black/African American mothers in Travis County were more than twice as likely to have babies born at low birth weight than White, non-Hispanic and Hispanic/Latina mothers.

Communicable diseases, specifically sexually transmitted infections (STIs) and human immunodeficiency virus (HIV), were mentioned as a concern in focus groups. Data indicates racial disparities in some STIs with the prevalence of gonorrhea and chlamydia cases being highest among Black/African American and Hispanic/Latino residents as comparted to White, non-Hispanic residents in Travis County. Youth ages 15-24 comprise more than 50% of new cases of gonorrhea and chlamydia in Travis County. Rates of new HIV cases were higher among Black/African American and Hispanic/Latino residents in Travis County as comparted to White, non-Hispanic residents.

To address these sexual health disparities, we need to consider the specific health issues from the perspective of the availability and distribution of resources for disparate populations, including education, interventions, and care. Residents for whom English is not their first language experience significant language barriers to health care, particularly for more recent immigrant and refugee groups. Specific populations expressed a need for providers who know and understand them. Specifically, there is a need for more education to ensure culturally competent and knowledgeable providers to serve the LGBTQ community, more Black/African American providers, and providers who are sensitive to life circumstances related to immigrant and refugee communities. CHA participants suggested an overall need for current providers to become more aware and accepting of cultural differences.

Based on these key issues identified in the CHA, the Austin/Travis County CHIP workgroup on Access and Affordability of Health Care identified the following goals and objectives:

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

Long-Term Indicator

- Travis County teen birth rates (percentage of live births to females under 20 years of age) by race and ethnicity.

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

Short-Term Indicators will be identified and reviewed through the action planning and implementation phase.

Strategies

3.1.1: Educate youth affected by health disparities about healthy choices.

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 schools.

3.1.4: Promote collaborations between organizations and programs already engaged in sex education work. (See also Strategy 3.3.2)

3.1.5: Promote support programs that provide culturally and linguistically appropriate resources for families.

3.1.6: Advocate for a bill(s)/ bill that would allow adolescents to consent to their own reproductive healthcare if they have a child already.

3.1.7: Advocate for 'Teen Friendly' or 'Youth Friendly' recognition status among clinics and providers ensuring that youth have access to clinics and providers that offer equitable affordable access to a full range of FDA-approved birth control methods and are trained to provide culturally appropriate contraceptive services. (See also Strategy 3.2.4)

3.1.8: Identify and reduce barriers to youth seeking same-day appointments for contraception. Promote LARC principles developed by National Women's Health Network and Sister Song for clinics and providers providing a full range of FDA-approved birth control methods.

3.1.9: Promote the use of a mobile app that provides personalized reproductive health recommendations.

3.1.10: Promote technologies and best practices available to increase youth access to programs, services and information. (See also Strategy 3.4.5)

3.1.11: Identify and promote awareness about cultural and societal norms that contribute to teen pregnancy.

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.

Long-Term Indicators

- STI rates among youth by race and ethnicity.

Strategies

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)

3.2.2: Advocate for inclusion of sexual health risk assessments in health assessments with youth (Primary Care Provider (PCP), CHW, Clinic, etc.).

3.2.3: Promote referral to teen-friendly providers, services and supports from Emergency Rooms 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. (See also Strategy 3.1.7)

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.

Short-Term Indicators will be identified and reviewed through the action planning and implementation phase

Strategies

3.3.1: Advocate for policy and/or policy change at the district, county and state level that could support inclusive, evidence-informed comprehensive sex education and reproductive health manipulative demonstrations in Travis County schools.

3.3.2: Promote collaborations between organizations and programs already engaged in sex education work including linkages between ISDs and local healthcare providers for referrals for students 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.

3.3.4: Provide resources to parents to help them communicate with children regarding their knowledge, values, and attitudes related to sexual activity, sexuality, and healthy relationships.

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.

Long-Term Indicators

- Percentage of births with late or no Prenatal Care in Texas and by Age, Race/Ethnicity in Travis County.

Short-Term Indicators will be identified and reviewed through the action planning and implementation phase.

Strategies

3.4.1: Promote mental health and counseling services that are available for youth and families.

3.4.2: Support pregnant women in obtaining prenatal care in the first trimester (e.g., transportation services, patient navigators, etc.). Example of possible program is home pregnancy testing designed to get women into prenatal care sooner.

3.4.3: Promote home visiting programs for pregnant women, new mothers, their partners, and families focused on education on infant care (e.g. nutrition, stress reduction, postpartum and newborn care).

3.4.4: Promote referrals to clinicians who provide evidence-based care and programs that provide resources for pregnant youth, their partners and families.

3.4.5: Promote technologies and best practices available to increase youth access to programs, services and information. (See also Strategy 3.1.10)

3.4.6: Promote programs that support the involvement of young fathers and fathers-to-be in the raising and caring of their children, including but not limited to: prenatal care, birthing classes and parenting classes, mentoring, job training, managing finances, etc.

Potential Partners/Resources for Priority Area 3: Sexual Health

- Any Baby Can
- Austin Independent School District (AISD)
- Austin Interfaith
- Austin Public Health (APH)
- AVANCE
- Catholic Charities
- Center for Health Empowerment (CHE)
- Central Texas Perinatal Coalition
- CommUnityCare Health Centers
- Diocese of Austin
- EL BUEN
- Faith-based organizations
- Family Connects (Nurse home visits for parents of newborns)
- Giving Austin Labor Support
- Healthy Families
- Healthy Youth Partnership
- Life Works
- Lone Star Circle of Care
- Mama Sana/Vibrant Woman
- Nurse Family Partnership
- People Community Clinic
- Planned Parenthood of Greater Texas
- SAFEAustin: Stop Abuse For Everyone "Expect Respect"
- School Health Advisory Council
- St. David's Hospital
- Texas Campaign to Prevent Teen Pregnancy
- Texas Freedom Network
- Texas Health Action (THA) – the Kind Clinic
- Travis County Adolescent Health Collaborative
- Travis County Transit Development Plan
- TruCare
- Women's Health and Family Planning Association of Texas

Priority Area 4:
Stress, Mental Health, and Wellbeing

E. Priority Area 4: Stress, Mental Health, and Wellbeing

Priority Area	Objective Topics	Cross-Cutting Strategies to be Addressed
Priority 4: **Stress, Mental Health, and Wellbeing**	• Lack of Mental Health providers and resources • Substance abuse with focus on binge drinking	• Workforce development • Stigma and Societal Norms

The 2017 Community Health Assessment identified Mental Health as a key priority for Travis County. CHA participants identified mental health and stress as issues, with poverty being a significant stressor. Participants and professionals expressed concern for the homeless population, which disproportionately suffers from mental illness and co-occurring conditions while lacking support to mitigate those illnesses. CHA participants also cited a lack of mental health providers, describing challenges to finding mental health providers due to restrictions on insurance networks and the difficulty of finding a provider sensitive to the needs of certain communities because of the lack of diversity of mental healthcare providers. This was specifically discussed as a concern for Black/African American, LGBTQ, and immigrant communities. Data indicate that poor mental health days affect nearly 1 in 5, and disproportionally affect Black/African American residents in Travis County. [6]

In looking at poverty as a significant stressor, it should be noted that Travis County and Austin are characterized by a more educated population and a lower annual unemployment rate. However, increasing costs of living are making it more difficult for lower-income residents to secure adequate take-home pay and find opportunities to move up the socioeconomic ladder. This change has created a pressing need to identify additional job skill development trainings and workforce development activities to bolster socioeconomic mobility.

Binge drinking and substance use were related behavioral health issues that emerged out of the CHA. An estimated, 8 to 15 percent of suicides in Travis County are reported to be related to alcohol or drug use, although the relationship is not specified. The prevalence of binge drinking is higher in Travis County than in Texas, particularly among non-Hispanic White adults. In 2011-2015, a higher percentage of adults in Travis County (22.0%) report binge drinking than in Texas (16.7%).[7] In 2011-2015, one quarter (24.8%) of White non-Hispanic adults reported binge drinking, compared to 21.3% of Hispanic/Latino adults and 9.7% of Black/African American adults. [8]

---

[6] 2017 Austin/Travis County Community Health Assessment. PDF File p.21. Web. http://www.austintexas.gov/sites/default/files/files/Health/CHA-CHIP/CommunityHealthAssessment__December_2017.pdf

[7] 2017 Austin/Travis County Community Health Assessment, Figure 6-62. PDF File p.84. Web. http://www.austintexas.gov/sites/default/files/files/Health/CHA-CHIP/CommunityHealthAssessment__December_2017.pdf

[8] 2017 Austin/Travis County Community Health Assessment, Figure 6-62. PDF File p.84. Web. http://www.austintexas.gov/sites/default/files/files/Health/CHA-CHIP/CommunityHealthAssessment__December_2017.pdf

Although seeking mental health care has to become less stigmatizing, societal norms still exacerbate health issues and prevent individuals from engaging with health care systems, especially mental health care services. The subsequent barriers to seeking care include negative perceptions of individuals who use or misuse drugs. Beliefs still persist that persons addicted to drugs are engaging in pleasure-seeking behaviors rather than for pain avoidance or escaping other life circumstances.

With guidance from the 2017 CHA Findings, the 2018 Austin/Travis County CHIP workgroup on Stress, Mental Health, and Wellbeing developed the following objectives:

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

Long-Term indicators

The long-term indicators should be impacted by all three objectives.

- Emergency Department (ED) visits for alcohol poisoning.
- Suicide rates. Department of State Health Services Center for Health Statistics
- Behavioral Risk Factor Surveillance System (BRFSS) drinking question.
- Behavioral Risk Factor Surveillance System (BRFSS) poor mental health days question.
- Texas Alcoholic Beverage Commission (TABC) tickets for drinking.
- Austin Police Department (APD) alcohol and drug related arrests.

Objective 4.1: By 2023, decrease by 10% the incidence of binge drinking and other substance use disorders among Travis County residents.

Short-Term Indicators will be identified and reviewed through the action planning and implementation phase.

Strategies

4.1.1: Identify, screen and provide intervention for pre-identified at-risk populations.

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

4.1.3: Advocate for restrictions on unlimited drink specials and enhance enforcement of laws on alcohol sales to minors.

Objective 4.2: By 2023, increase by 10% the number of system providers (school, health care, etc.) who assess for adverse childhood experiences (ACEs) and refer to appropriate community supports.

Short-Term Indicators will be identified and reviewed through the action planning and implementation phase.

- The number of new locations using Adverse Childhood Experiences (ACEs)[9] to screen individuals for services.
- Demonstration of increased level of activity of screening for resilience and protective factors.
- The number of program activities developed to build individual/family resilience.
- Increase in funding for ACEs screenings, which could include federal funding programs such as the MIECHV (Maternal, Infant, Early Childhood Home Visit) program.

Strategies

4.2.1: Train providers on best use of ACEs screening and linking to appropriate referrals.

4.2.2: Promote resilience in all community settings using trauma-informed approaches.

4.2.3: Develop and maintain an online resources list tool for providers to facilitate behavioral health referrals (See also Strategy 4.3.5). Consider using the current 211 system as the platform for this resource tool.

(See also Objective 2.1, which also focuses on screenings, engagement and services in community settings.)

Objective 4.3: By 2023, Increase by 10% the proportion of adults aged 18 and up in Austin Travis County who receive treatment or specialty treatment for substance use disorder or dependency with a focus on geographic equity.

Short-Term Indicators will be identified and reviewed through the action planning and implementation phase.

Strategies

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.

4.3.2: Advocate for enhanced mental health benefits covered by the Medical Access Program (MAP).

[9] Information on the relationship between Adverse Childhood Experiences (ACEs) to substance abuse and related behavioral health issues can be found on the Substance Abuse and Mental Health Services Administration (SAMHSA) website. https://www.samhsa.gov/capt/sites/default/files/resources/aces-behavioral-health-problems.pdf

4.3.3: Advocate with insurance plans for increased coverage of services and reimburse more providers to increase access to mental health providers.

4.3.4: Advocate with state legislature to increase contract rates for behavioral health services.

4.3.5: Develop and maintain an online list of resources for people to find and access culturally and linguistically appropriate mental health providers. (See also Strategy 4.2.3). Consider using the current 211 system as the platform for this resource tool.

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.

Potential Partners/Resources for Priority Area 4: Stress, Mental Health, and Wellbeing

- Austin Independent School District (AISD) – Health Service & Trust-Based Relationship Initiative
- Austin Public Health (APH)
- Building Community Resilience Collaborative
- Catholic Charities
- Child Care Centers
- Dell Medical School (DMS) Data Integration Team
- Dioceses of Austin "Office of the Hispanic Ministry"
- Faith-based organizations
- Hogg Foundation for Mental Health
- Integral Care
- Mobilizing Action for Resilient Communities (MARC)
- National Alliance on Mental Illness (NAMI), Austin
- Pre-school Centers
- Seton Healthcare Family
- Texas Pediatric Society
- Trauma-Informed Care Consortium (TICC), through Austin Child Guidance
- Travis County Medical Society
- Travis County Underage Drinking Prevention Task Force
- United Way
- Victims of Crime Act (VOCA) – grants

F. Relationship between the CHIP and other 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. This list of potential collaborators and resources will expand when finalizing the CHIP and completing 1-year implementation plans.

The Austin/Travis County CHIP alignment with local and national priorities is illustrated in Appendix D through comparison with Healthy People 2020 objectives and the City of Austin Strategic Direction 2023.

IV. Next Steps

The components included in this report represent the strategic framework for a data-driven, community informed 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, assigning lead responsible parties, and identifying resources for each priority area. Community-wide engagement opportunities will occur through interactive public meetings. These steps will occur during the next phase between September 2018 and December 2018 resulting in a 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 provide executive oversight for the CHIP's 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. 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, share progress, solicit feedback, and strengthen the CHIP. Regular communication 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

Thank you to the Austin/Travis County community. The diversity of voices that informed this community health improvement plan was invaluable. Your collective insights and professional knowledge are the compass that guides this important work.

The dedication, expertise and leadership of the following agencies and people made the 2018 Austin/Travis County Community Health Improvement Plan a collaborative, engaging, and substantive plan that will guide our collective health planning efforts. Special thanks to all of you!

Steering Committee

Chair: Stephanie Hayden	Austin Public Health
Vice Chair: Deborah Britton	Travis County Health and Human Services
Annick Beaudet	Austin Transportation Department
William Buster	St. David's Foundation
Monica Crowley	Central Health
David Evans	Integral Care
Sherri Fleming	Travis County Health and Human Services
Alexandra Garcia	The University of Texas at Austin Dell Medical School
Jennifer Golech	Capital Metropolitan Transportation Authority
Philip Huang	Austin Public Health
Harold Kohl	The University of Texas Health Science Center at Houston School of Public Health in Austin
Lawrence Lyman	Travis County Health and Human Services
Ellen Richards	Integral Care
Geronimo Rodriguez	Seton Healthcare Family
Rob Spillar	Austin Transportation Department
Andrew Springer	The University of Texas Health Science Center at Houston School of Public Health in Austin/Dell Center for Healthy Living

Core Coordinating Committee

Chair: Cassandra DeLeon	Austin Public Health
Planner: Hailey de Anda	Austin Public Health
Planner: Mike Caudle	Austin Public Health
Ana Almaguel	Travis County Health and Human Services
Tara Carmean	Travis County Health and Human Services
Megan Cermak	Central Health
Caitlin D'Alton	Capital Metropolitan Transportation Authority
Marianna Espinoza	The University of Texas at Austin Dell Medical School
Muna Javaid	Integral Care
Halana Kaleel	Austin Public Health
Elizabeth Krause	St. David's Foundation
Scott Lyles	Austin Public Health
Liane Miller	Austin Transportation Department
Jana Whitaker	Seton Healthcare Family

Data and Research Subcommittee

Ana Almaguel	Travis County Health and Human Services
Tracy Ayrhart	Central Health
R. Patrick Bixler	The RGK Center for Philanthropy and Community Service, LBJ School of Public Affairs
Tara Carmean	Travis County Health and Human Services
Kristin Christensen	Integral Care
Caitlin D'Alton	Capital Metropolitan Transportation Authority
Cassandra DeLeon	Austin Public Health
Laura Fox	Austin Public Health
Autumn Kaewer	The University of Texas at Austin Dell Medical School
Anjum Khurshid	The University of Texas at Austin Dell Medical School
Lawrence Lyman	Travis County Health and Human Services
Shay Mooney	211 United Way
Janet Pichette	Austin Public Health
Amy Price	211 United Way
Sarah Seidel	Austin Public Health
Jessie Simmons	St. David's Foundation
Haruna Steger	Austin Public Health
Jeff Taylor	Austin Public Health

See Appendix A for a full listing of Priority Area Workgroup Members

Appendices

Appendix A: CHIP Planning Summit Workgroup Members

Priority Area 1: Access to and Affordability of Health Care

Workgroup Members

Abena Asante	St. David's Foundation
Joelynn Avendano	United Way for Greater Austin
Matt Balthazar	CommUnityCare Health Centers
Melissa Cepeda	Central Health
Coleen Christian	APH - Immunization Unit
Sarah Cook	Community Care Collaborative
Deborah Delvalle	El Buen Samaritano
Michelle Friedman	APH - Social Service Policy Unit
Kacey Hanson	The University of Texas at Austin Dell Medical School
Martin Kareithi	Capital Metropolitan Transportation Authority
Michelle Kimbrough	Travis County
Mary McDowell	People's Community Clinic
Michelle Meaux	Capital Metropolitan Transportation Authority
Linda Perez	Meals on Wheels
Miriam Rosenau	Community Care Collaborative
Brook Son	Travis County
Kit Abney Spelce	Central Health
Tabitha Taylor	APH- Planning and Evaluation Unit
Diana Trevino	Arc of the Capital Area
Scheleen Walker	Travis County - Long Range Planning
Rachel Wilcox	APH – Disease Surveillance Unit

Priority Area 2: Chronic Disease

Workgroup Members

Frances Acuna	GoAustin/VamosAustin
Judy Alvarado	APH - Neighborhood Services Unit
Ashley Bischoff	Vision Zero
Kathleen (Vickie) Butler	Lone Star Circle of Care
Vanessa Castro	ITS TIME TEXAS
Singying Chan	APH - Health Equity Unit
Iliana Gilman	El Buen Samaritano
Monica Guzman	GAVA/ Restore Rundberg
Stephanie Helfman	APH - Chronic Disease Unit
Ashley Hern	ITS TIME TEXAS
Janet Martinez	APH - Neighborhood Services Unit
Elizabeth McDonald	Austin Revitalization Authority
Estephanie Olivares	APH - Chronic Disease Unit
Carmen Llanes Pulido	GAVA
Sergio Ramirez	Marathon Kids Inc., / Go! Austin/Vamos! Austin (GAVA)
Freya Spielberg	The University of Texas at Austin Dell Medical School
Kellie Sorensen	The University of Texas at Austin Dell Medical School
Sam Tedford	City of Austin: Planning and Zoning
Richard Waite	APH - Administrative Services
Tammy Walker	APH - Health Equity Unit
Marsha Wier	Helping the Aging, Needy and Disabled

Priority Area 3: Sexual Health

Workgroup Members

Dominique Alexander	APH - Health Equity Unit
Janna Allen	Austin Voices for Education and Youth
Crescencia Alvarado	APH-Chronic Disease Unit
Hailey Easley	Asian American Resource Center
Ricardo Garay	The University of Texas at Austin Dell Medical School
Stephanie Hernandez	Community Care
Jennifer Johnson	APH - Health Equity Unit
Akeshia Johnson- Smothers	APH - Communicable Disease Unit
Jackie Platt	Life Works
Alda Santana	Women's Health and Family Planning Association of Texas
Fernanda Santos	APH - Austin Healthy Adolescent Unit
Alan Schalscha	CommUnityCare Health Centers
Alan Washington	APH - Family Health Unit
Sarah Wheat	Planned Parenthood
Katie Wolfe	Planned Parenthood

Priority Area 4: Stress, Mental Health, and Wellbeing

Workgroup Members

Carrie Barron	The University of Texas at Austin Dell Medical School
Jamey Bellisle	Travis County
Justin Benzer	The University of Texas at Austin Dell Medical School
Robert Dominguez	Integral Care
Laura Enderle	APH - Social Service Policy Unit
Shana Fox	Council on at risk youth
Andrea Guerra	Central Health
Shalonda Horton	The University of Texas at Austin School of Nursing
Laura Koenig	E3 Alliance
Rebecca Lott	Manor ISD
Marian Morris	Integral Care
Laura Peveto	Travis County - Office of Childrens' Services
Erica Garcia Pittman	Seton Healthcare Family
Kye Tavernier	APH - Community Services Division
Jalina Tunstill	Community Advancement Network

Appendix B: Glossary of Terms

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.

Cross-cutting strategies and themes: Issues that have been identified as key focal points for integration across all priority areas in the plan (e.g., stigma, socioeconomic inequalities, cultural competency).

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.

Evidence-based Method or Model: 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: Statements that identify in broad terms how the efforts will change things to solve identified problems.

Guiding Document: A document developed for use in identifying CHIP priorities and selecting topics for objectives, based on an in-depth review of the 2017 Austin/ Travis County Community Health Assessment (CHA) which includes four assessments from the Mobilizing for Action through Planning and Partnership (MAPP) framework and the CHA Community Assessment for Public Health Emergency Response (CASPER).

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.

Indicators: Indicators describe the baseline and target values for each objective based on data that are relevant and available and are used to track progress for each of the objectives.

Key Health Issues: Broad issues that pose problems for the community as identified by the Community Health Assessment (CHA) and summarized in the Guiding Document.

Linguistic Competence: The provision of 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 their family is foundational to that person learning to manage and organize their own care at the level they choose. 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: Those Key Health Issues that have been identified for inclusion in the CHIP via a prioritization process based on the criteria of feasibility, appropriateness, and impact.

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: Acronyms

ACA	Affordable Care Act
ACEs	Adverse Childhood Experiences screening tool
AISD	Austin Independent School District
APD	Austin Police Department
APH	Austin Public Health
ATD	Austin Transportation Department
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CARTS	Capital Area Rural Transportation System
CASPER	Community Assessment for Public Health Emergency Response
CCC	Community Care Collaborative
CCCN	Cities Connecting Children to Nature
CDC	Centers for Disease Control and Prevention
CHA	Community Health Assessment
CHE	Center for Health Empowerment
CHIP	Community Health Improvement Plan
CHW	Community Health Workers
COA-APH	City of Austin – Austin Public Health
DMS	Dell Medical School
ED	Emergency Department
EMS	Emergency Medical Services
FAST™	Facilitating Alignment and Strategic Thinking Planning Process
FC	Foundation Communities
FDA	Federal Drug Administration
FPL	Federal Poverty Level
GAVA	Go! Austin / VAMOS! Austin
HACA	Housing Authority City of Austin
HIV	Human Immunodeficiency Virus
HP2020	Healthy People 2020
HRiA	Health Resources in Action, Inc.
ISD	Independent School District
LARC	Long-acting reversible contraceptives
LEP	Limited English Proficiency
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning
LPHS	Local Public Health System
MAP	Medical Access Program
MAPP	Mobilization for Action through Planning and Partnerships
MARC	Mobilizing Action for Resilient Communities
MIECHV	Maternal, Infant, Early Childhood Home Visit
NACCHO	National Association of County and City Health Officials
NAMI	National Alliance on Mental Illness
NPS	National Prevention Strategy
PARD	Parks and Recreation Department
PCP	Primary Care Provider
PHAB	Public Health Accreditation Board
PWD	Public Works Department
SC	Service Coordinators
SDOH	Social Determinants of Health
SFC	Sustainable Food Center
SNAP	Supplemental Nutrition Assistance Program
STI	Sexually transmitted infection
SU	Substance Use
SUD	Substance Use Disorder
TABC	Texas Alcoholic Beverage Commission
THA	Texas Health Action
TICC	Trauma-Informed Care Consortium
TNC	Transportation Network Companies
TX	Texas
UT	University of Texas
VOCA	Victims of Crime Act
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Appendix D: Austin/Travis County CHIP Alignment with Healthy People 2020 and City of Austin Strategic Direction 2023

Austin/Travis County CHIP			City of Austin Strategic Plan	Healthy People 2020
Priority Area	**Cross-Cutting Competency**	**Indicator**		
Access and Affordability of Health Care		Insurance	Percentage of residents younger than 65 with no health insurance coverage	**AHS-1.1** Increase the proportion of persons with medical insurance to 100%
		Preventative Care	Percentage of residents age 65 and older who receive a core set of preventive clinical services in the past 12 months Number and percentage of clients supported through the City of Austin, including community-based preventative health screenings who followed through with referrals to a health care provider or community resource	**ECBP-19** Increase the proportion of academic institutions with health professions education programs whose prevention curricula include interprofessional educational experiences
		Primary Care		**AHS-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
		Dental Care		**OH-7** Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year by 10% **OH-8** Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year by 10%
	Transportation	Built Environment	Number and percentage of linear miles of newly constructed sidewalks and urban trails that lie within ZIP codes with disproportionate prevalence of chronic diseases and conditions or with a car-dependent walk score	
	Socioeconomic Inequalities	Race/Ethnicity Breakouts	See above indicators for insurance and prevention	
		Income Breakouts	See above indicators for insurance and prevention	
		Delayed Care		**AHS-6.2:** Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care **AHS-6.4:** Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary prescription medicines

Austin/Travis County CHIP			City of Austin Strategic Plan	Healthy People 2020
Priority Area	**Cross-Cutting Competency**	**Indicator**		
Chronic Disease Focus on risk factors and community-based disease management (Primary and Secondary prevention)		Health Outcomes	Number and percentage of clients served through COA Health Equity Contracts who achieve intended healthy outcomes	**HD S-4:** Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high **HD S-5:** Reduce the proportion of persons in the population with hypertension
		Childhood Obesity	Percentage of children whose BMI is considered obese	
		Cardiovascular Disease	Percentage of residence with cardiovascular disease	**ECBP-10.8** Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services nutrition **ECBP-10.9** Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services physical activity **ECBP-10.7** Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services chronic disease programs
	Culturally Competency			**ECBP-10.6** Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services unintended pregnancy
	Education	High School Education	Number and percentage of students graduating from high school (including public, charter, private and home schools and students earning high school equivalent if data is available)	

Austin/Travis County CHIP			City of Austin Strategic Plan	Healthy People 2020
Priority Area	**Cross-Cutting Competency**	**Indicator**		
Sexual Health (Teen Pregnancy) Focus on risk factors and community-based disease management		Teen Pregnancy		**FP-8**: Reduce pregnancies among adolescent females **FP-10**: Increase the proportion of sexually active persons aged 15 to 19 years who use condoms to both prevent pregnancy and provide barrier protection against disease **FP-11:** Increase the proportion of sexually active persons aged 15 to 19 years who use condoms and hormonal or intrauterine contraception to both prevent pregnancy and provide barrier protection against disease **FP -7** Increase the proportion of sexually experienced persons who received reproductive health services
	Culturally Competency			**ECBP-10.6** Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services unintended pregnancy
		Infant Mortality	Infant mortality rates (number of deaths of infants younger than 1 year old per 1,000 live births)	
	Education	High School Education	Number and percentage of students graduating from high school (including public, charter, private and home schools and students earning high school equivalent if data is available)	
		Sexual Health		**ECBP-2.7** Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems including unintended pregnancy, HIV/AIDS, and STD infection **FP-12:** Increase the proportion of adolescents who received formal instruction on reproductive health topics before they were 18 years old

Austin/Travis County CHIP			City of Austin Strategic Plan	Healthy People 2020
Priority Area	**Cross-Cutting Competency**	**Indicator**		
Stress, Mental Health, and Wellbeing		Suicide/ Overdose	Number of suicides and unintentional overdose deaths	
		Substance Use Disorder		**SA- 13** Reduce past-month use of illicit substances
		Binge Drinking		**SA-14** Reduce the proportion of persons engaging in binge drinking of alcoholic beverages – subcomponents broken down by age group.
		Screenings		**MHMD 11** Increase depression screening by primary care providers **MHMD 7** Increase the proportion of juvenile residential facilities that screen admissions for mental health problems **ECBP 10-3** Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services for mental illness
		Treatment		**MHMD-9** Increase the proportion of adults with mental health disorders who receive treatment **SA-8** Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year
		Mental Health	Percentage of people who report 5 or more poor mental health days within the last 30 days	
	Workforce development	Safety	Number and percentage of City of Austin responders who have completed initial and continuing training related to serving vulnerable and diverse community members (examples: mental, behavioral health, de-escalation training) related strategies	
	Stigma and Societal Norms	Social Support	Percentage of residents who report having high levels of social support through friends and neighbors outside of their home	

Appendix E: Austin/Travis County CHIP Guiding Document

This CHIP Guiding Document represents a synthesis and summary of the key themes and secondary data that are more fully detailed in the 2017 Community Health Assessment for Austin/Travis County. The goal of this document is to assist in the identification of CHIP priorities and objectives. Throughout this document, abbreviations are used to indicate from which of the five components of the Community Health Assessment the data and/or information were drawn (see table below). The order of the themes summarized in this document should not be interpreted as implying any priority or urgency to the topic area.

Abbreviation	CHA Component
CTSA	Community Themes and Strengths Assessment
CHSA	Community Health Status Assessment
FOC	Forces of Change Assessment
APHSA	Austin Public Health System Assessment
CASPER	Community Assessment for Public Health Emergency Response

Contents

Socioeconomic Inequities

The CHSA indicates that Travis County and the City of Austin have experienced significant population growth in recent years. The region is expected to continue this high rate of growth.

- From 2011 to 2015, the population of the city of Austin and Travis County grew 13.6% and 10.7%, respectively.
- Travis County's population is estimated to reach 2,011,009 by 2050, a 57% increase from 2010.

Data from the CTSA and CHSA demonstrate that the region is characterized by an increasingly diverse population, both racially/ethnically and linguistically. The racial/ethnic distribution is shifting, with the majority of youth (<18 years of age) representing a minority racial/ethnic group.

- Organizational representatives characterized the community as vibrant and multicultural, factors they described as assets for driving the region's economic growth and branding as an international community.
- In Austin, 20.9% of residents are <18 years of age, similar to Travis County (22.8%) and the US (22.9%) in 2015.
- Compared with Texas and the United States, Austin and Travis County have larger proportions of the population that are age 25-44 years (Austin: 38.7%; Travis County: 35.7%) and smaller proportions of residents that are >65 years of age (Austin: 8.1%; Travis County: 8.7%).
- In 2015, 49.3% of Travis County residents identified as non-Hispanic White, 33.9% as Latino/Hispanic, 8.0% as Black/African American, and 6.4% as Asian.
- In 2015, among persons <18 years of age, 35.3% identified as non-Hispanic White, 47.1% as Latino/Hispanic, 9.0% as Black/African American, and 5.8% as Asian.
- In 2015, 31.7% of Travis County residents spoke a language other than English at home.

The CTSA, CHSA, and FOC show that the region enjoys a strong economy, but incomes and benefits of economic growth are not distributed equally. Poverty disproportionately affects Hispanic and Black populations.

- Focus group and interview participants described the economy as strong, and CASPER survey respondents reported that they have adequate financial resources to meet their basic needs. However, income inequality and lack of affordability of health care, housing, healthy foods, and outdoor recreational space for low-income residents were also significant concerns that emerged in the CTSA.
- In 2016, the unemployment rate in Travis County (3.1%) was lower than that for Texas (4.7%) and the US (4.9%).
- The median household income in Travis County increased 16.8% between 2011 to 2015, far greater than the increase experienced for Texas (3.7%) and the US (1.6%). As of 2015, median household incomes in Travis County ($65,269) and Austin ($62,250) exceed that for Texas ($55,653) and the US ($55,775).
- The highest earning 20% of households earned half (53%) of the total income in the county, while the lowest 20% of households earned 3% of the total income in the county.
- While 16% of all Travis County residents live below the poverty level, poverty disproportionately affects Hispanic (26.4%) and Black (22.6%) populations.
- Among all children <5 years of age that are living below the poverty level, 73.7% are Hispanic.
- FOC themes included concern about the disruption that occurs in communities alongside the economic growth of the Austin region, as well as disparities in income and access to services.

Economic growth, population growth, and the high cost of living will continue to displace Hispanic and Black populations to the suburbs, as suggested by the CTSA and CHSA.

- Focus group participants voiced concerns about affordability of housing, saying housing costs and property taxes are unaffordable.
- Interview and focus group participants described, and CHSA data reflect, how Hispanic and Black residents have been displaced to the outskirts of the city of Austin or outside of Austin in Travis County during this period of economic growth, reflecting the suburbanization of poverty.
- Although housing affordability is a concern across Travis County, it has disproportionately affected east Austin, an area of the city with historic Black/African American and Latino/Hispanic neighborhoods.
- This migration further disconnects residents and families from services that are located in the city center and increases the costs of transportation such as time spent commuting, cost of fuel, or bus fares.
- Interview participants identified the need for affordable housing for all residents and for increasing the volume of subsidized housing.
- Section 8 housing, also known as the Housing Choice Voucher (HCV) program, is a federally funded housing program to assist low-income families to more easily afford quality rental housing in the private market. As of 2015, 3,011 Section 8 rental units were available, which is 1,962 less than were available in 2010. Section 8 housing voucher units are currently concentrated east of central Austin and throughout the southern and northern areas of Austin.
- Some focus group and interview participants were concerned about public service employees such as teachers, police officers, and staff at community recreation centers not earning wages sufficient to live in the county.

Education and Workforce Development

The CTSA and CHSA indicate that Travis County and Austin are characterized by a more educated population and a lower annual unemployment rate. However, increasing costs of living contribute to a need for more opportunities for lower-income residents to increase their income and move up the socioeconomic ladder.

- Participants expressed concern about barriers to social mobility and the ability to move from poverty into higher income levels.
- In 2015, among Travis County residents age 25 years and older, 11.7% had less than a high school education (17.6% in Texas), 17.5% had attained a high school diploma or equivalency (25.3% in Texas), 23.7% had completed some college or an associate's degree (28.7% in Texas), and 23.7% had attained a bachelor's degree (18.7% in Texas). Educational attainment for Austin residents was similar to that of Travis County.
- Between 2011 and 2016, the unemployment rate in Travis County declined from 6.4% to 3.1%. As of 2016, the unemployment rate in Travis County (3.1%) continued to be lower than both Texas (4.7%) and the US (4.9%).
- Between 2011 to 2015, the median contract rent in Travis County increased by 19.6% and the median home value in Travis County increased 19.8%. In contrast, for Texas the median contract rent increased by 10.5% and median home value by 12.2% between 2011 and 2015.
- In 2015, 21.3% of Travis County renters paid rent that exceeded 50% of their income (20.9% in Texas). While among Travis County homeowners, 10.1% of homeowners paid housing costs that were 50% or more their income (7.9% in Texas).

Data from the CTSA, FOC, and APHSA show a need for additional education and workforce development activities as a means of socioeconomic mobility. Additionally, these data indicate a need to ensure a competent public health workforce as the population grows, with attention to diversity and cultural competence of the health care workforce.

- In the FOC discussion, the steering committee spoke of education and workforce development in a broad sense, related to all career paths. Specific challenges discussed included responding to shortages in the current health care workforce and as the county grows, needing to train and replace retiring nurses, and having health care workers who can accommodate clients who speak various languages.
- Community members indicated gaps in the existing health care workforce, specifically diversity of the workforce and the cultural competence of providers.
- Professionals in the public health system of Travis County discussed the need for increased workforce development and education opportunities in order to provide lower-income residents of Travis County with opportunities to increase their income.

Access and Affordability of Health Care

The CTSA, FOC, and CHSA indicate that health insurance enrollment outreach has improved access to health care, but there is much room for further improvement.

- The proportion of Travis County residents under the age of 65 with no health insurance has fallen from 21% in 2011 to 16% in 2015. During this same time period, the Affordable Care Act (ACA) was implemented and uninsured rates have declined locally, in Texas, and nationwide.
- Despite this progress, the cost of health care and health insurance and barriers to accessing health care were common themes in the CTSA and were identified by professionals in the FOC as threats to the health of Travis County residents.

According to the CTSA and CHSA, affordability and physical access to health care remain some of the most significant barriers to care.

- Participants explained that uninsured residents have limited options for accessing health care.
- Insured individuals discussed challenges with insurance networks and finding providers that are in-network or finding providers that accept Medicaid.
- Middle-class residents struggle to afford health insurance and health care costs and do not qualify for assistance (e.g., Medicaid, federal insurance subsidies). Parents expressed the difficulty of working multiple jobs to make ends meet for their families, but still not qualifying for assistance and not being able to cover medical costs.
- Focus group participants discussed that some treatments are not covered by insurance and can be very expensive; one example discussed was hormone therapy treatment for transgender patients.
- In 2011-2015, only 48.7% of Travis County residents with incomes <$25,000 had health insurance, compared to 96.0% of residents with incomes of $75,000+.
- In 2011-2015, 55.2% of Latino/Hispanic residents reported having health care coverage, compared to 75.2% of Black/African American and 89.0% of White residents.

Many residents forego seeing doctor due to cost, as indicated by the CTSA and CHSA. Black/African American, Latino/Hispanic, and lower income residents are disproportionally affected by the cost of a doctor's visit.

- While a lower percentage of Travis County residents (15.4%) than Texas residents (19.7%) reported cost as a factor in seeing a doctor in 2011-2015, 19.5% of Blacks/African Americans and 21.9% of Latinos/Hispanics in Travis County reported that they needed to see a doctor, but did not due to cost.
- In 2011-2015, 30.6% of residents with incomes of <$25,000 reported not seeing a doctor due to cost compared to 4.6% of residents with incomes of $75,000+.
- In 2011-2015, 59.7% of Travis County women aged 40+ with incomes <$25,000 reported having a mammogram in the past 2 years, compared to 80.3% among women with incomes >$75,000.
- In 2011-2015, 54.9% of Travis County residents 50+ years of age with incomes <$25,000 reported ever having a sigmoidoscopy or colonoscopy, compared to 76.1% of Travis County residents with incomes >$75,000.

Other barriers to health care access identified in the CTSA included some types of services being less available geographically and hours of operation in clinics being limited to regular business hours.

- Focus group participants noted that for individuals who live within the city of Austin, some neighborhoods (e.g., east side of Austin) have fewer available health clinics. Community members also described some types of services having fewer clinics in these areas as well, such as mental health services or vision and dental providers. Participants suggested Travis County needed to increase services and clinics to meet community demand and reduce wait times.

- Among focus groups participants, a commonly discussed barrier to access was clinic hours. Participants noted that clinics are usually open during regular business hours when residents are working and cannot access services. Weekend and evening hours were perceived as being a key need among residents.
- The challenge of affordability of Travis County and displacement to the suburbs constrains access to health centers located in the city center. Residents suggested there was a clear need for transportation to health care services.
- Focus group participants mentioned the recent closure of a CommUnityCare clinic that served communities in Del Valle (e.g., Austin's Colony and Creedmoor) and eastern Travis County. Since the closure, some participants reported having to travel up to 40 minutes by car to get to a clinic. Some noted that in outlying areas, the most efficient way of getting medical service is by calling an ambulance.
- Participants identified a lack of in-home or mobile services for homebound elderly or disabled, especially for individuals who have limited incomes.

As indicated by the CTSA, the Medical Assistance Program (MAP) was identified as a strength, but location is a barrier for those living outside of Austin.

- As indicated by the CTSA, participants familiar with MAP, a local, publicly supported health care assistance program for low-income persons and families, considered the program a strength in the community.
- Residents outside of Austin (e.g., Jonestown, Manor, Austin's Colony and Creedmoor) live far from MAP providers. It takes multiple buses and several hours to travel to Austin MAP providers.
- Middle-class residents may not be eligible for MAP.

In the CTSA, benefits for immigrants were identified as a strength, but they expire after 6 months which is too soon.

- Focus group participants who were refugees noted that although refugee assistance, provided to refugees upon arrival including benefits such as Medicaid and Supplemental Nutrition Assistance Program (SNAP) benefits, are very helpful, the benefits expire after six months, which they felt was too soon.

According to the CTSA, health clinics were identified as a strength, however schedules are inconsistent and therefore unreliable.

- In the CTSA, participants identified free screenings available through health clinics as a strength in serving the uninsured population. However, focus group participants and interviewees stated that there are long wait times for some of these services.
- Professionals interviewed considered the network of providers to be fairly robust with a good Federally Qualified Health Center (FQHC) network through CommUnityCare. They also considered the ongoing collaboration and commitment by local public health partners to improve services based on community needs to be a strength in Austin and Travis County.
- FOC discussions included the identification of the Dell Medical School at The University of Texas as an asset and opportunity in the community and an innovation center for community health practices.

Cultural Competency

CTSA participants noted a lack of diversity among health care providers in the community. Participants discussed the need for greater cultural competency of and non-judgement from providers, programs, and resources.

- Focus group participants noted a lack of diversity among the current providers in the community.
- Focus group participants discussed the need for providers who serve the LGBTQ community and are non-judgmental, the desire in the community for more Black/African American providers, and the need for providers who are sensitive to life circumstances related to immigrant and refugee communities. Participants further suggested the need for current providers to become more aware and accepting of cultural differences.
- Community members praised the Kind Clinic, which is the first gender affirming primary care clinic in Austin for transgender and gender non-conforming individuals. Other examples of progress in this area which garnered praise included the development of the Austin Health Equity Unit within APH.

The CTSA indicates that residents for whom English is not their first language experience significant language barriers to health care as well as their day to day lives, particularly for more recent immigrant and refugee groups.

- Language barriers were a major concern related to a general lack of cultural competency of providers and community resources.
- This concern was discussed in relation to health services, transportation, and social services. In one focus group of refugees, participants who were speaking Karen languages (a group of Tibeto-Burman languages spoken in lower Myanmar and Thailand) and Burmese expressed extreme difficulty communicating with landlords, doctors, and using public transportation.
- In focus groups and interviews, the increasing need for Arabic language translation was also discussed.
- Currently, most services that provide translation do so through a telephone language-line service, however, the service is not available in some languages and, according to focus group participants and professional representatives, are not always helpful.
- Examples of progress in this area are the use of community health workers who are members of the community for which services are being provided. Community health workers were further identified as a practice that could continue to grow in order to meet the need for cultural competency in health and social services.

Health Literacy and Knowledge

According to the APHSA, professionals perceived that the public health system does a good job of informing, educating, and empowering people about their health.

- Professionals who are part of the public health system in Travis County described that, as a whole, the public health system does a good job of informing, educating, and empowering people about health issues.

While many services exist, the CTSA indicates that the community lacks knowledge about many services. Additionally, CTSA participants described challenges interacting with the healthcare system, including navigating health insurance, finding in-network doctors, legal aspects of medical paperwork, and terminology.

- Residents and organizational representatives noted that many services and programs are available in the community. However, according to participants, the community lacked knowledge about these services. Participants believe a gap exists between services provided and community awareness of the existence of those services.
- Participants mentioned the difficulty they experience navigating their health insurance, including finding in-network doctors and suggested better service coordination support for individuals who are navigating the health system and their insurance.
- Professionals called for a more robust social service infrastructure to provide support services including navigation, housing assistance, and outreach in communities with disproportionate needs.
- Another concern related to navigating health information was the legal aspect of medical paperwork. Focus group participants noted difficulty understanding forms because of the medical and legal terminology and suggested the need for free or low-cost legal services to help them understand insurance and medical paperwork.
- Better communication and marketing of health programs was a common suggested solution to close the gap between available services and community awareness of such services.

In the CTSA, residents discussed challenges to adopting healthier eating habits, understanding health information, and understanding prescription medications.

- Participants noted that although many people try to eat healthy food, it can be difficult to know how to do so. Outside of previously mentioned concerns related to physical and financial access to healthy food, participants also discussed learned food habits, such as using sauces that are high in sodium, or not learning cooking skills needed to make healthy food. Additionally, some participants mentioned that it can be difficult to know what food is healthy because of conflicting messages in food marketing and package labels.
- Other challenges identified by focus group participants include limited understanding of health information, such as diagnoses and disease management. Specifically, participants in focus groups discussed not understanding what having diabetes or high blood pressure means, and therefore not knowing how to manage their condition.
- A focus group of seniors mentioned that they have trouble understanding prescription information and have experienced serious adverse effects from mixing medications due to not having enough information or instructions on medication side effects.
- Participants also discussed the need for providers who will take time to discuss potential medication interactions and medical histories with patients.
- CTSA focus group discussions also identified the need to support existing culturally appropriate cooking and physical activity classes, and to increase the availability of such classes.

Health Outcomes and Health Disparities

CHSA data indicate that Travis county has not met the Healthy People 2020 target for smoking, which is disproportionately concentrated among low income residents.

- In 2011-2015, 13.5% of adults in Travis County reported being current smokers, a smaller proportion than that for Texas (16.6%). However, neither the county nor that state meets the Healthy People 2020 target of ≤12%.
- Of adults with incomes <$25,000, 20.8% reported being a current smoker, whereas 7.1% of adults with incomes of $75,000+ reported being a current smoker.
- In 2011, the percentage of Travis County youth reporting use of tobacco products including cigarettes, chewing tobacco, snuff, or cigars (16.3%) was lower than Texas (28.6%). In 2010, use of tobacco products in Travis County among White (17.5%) and Latino/Hispanic (17.8%) youth was similar to the county as a whole, while use of tobacco products among Black/African American youth is lower (10.0%).

Data from the CHSA show substantial disparities in preventive health screenings and immunizations by income level.

- In 2011-2015, the percentage of women over 40 years of age who received a mammogram in the past two years was similar for Travis County (71.5%) and Texas (69.7%). However, only 59.7% of women in Travis County who earn <$25,000 received mammograms in the past two years, compared to 80.3% of women with incomes $75,000+.
- In 2011-2015, 66.5% of Travis County residents age 50 and older reported having had a sigmoidoscopy or colonoscopy (a screening test for colorectal cancer), compared to 63.1% for Texas. However, only 54.9% of residents who earn <$25,000 reported having a sigmoidoscopy/colonoscopy, compared to 76.1% of residents with incomes $75,000+.
- In 2011-2015, Influenza vaccination rates for adults ages 65 and older were comparable for Travis County (63.4%) and Texas (60.9%). Rates ranged from 61.0% among Black/African Americans to 66.4% among Latinos/Hispanics in Travis County.
- In 2011-2015, pneumococcal vaccination rates for adults ages 65 and older are higher in Travis County (74.8%) than Texas (69.5%). Rates ranged from 65.7% among Black/African Americans to 75.9% among White, non-Hispanics in Travis County.
- Focus group participants and professionals suggested increasing the availability of free health care screenings.
- Residents also recommended accompanying health screenings with follow-up health care, information about available resources to address identified health needs, and information about diagnosed conditions.

CHSA data indicate that chronic disease is a major contributor to mortality and morbidity. The leading causes of death are cancer and heart disease, and diabetes and obesity were priorities identified by CTSA participants. While the incidence of obesity, diabetes, cancer, and heart disease has declined, these health issues disproportionally affect communities of color, as indicated by CHSA data and echoed in the CTSA.

- Health professionals reported that communities they work with frequently suffer from obesity, high blood pressure, and diabetes. Professionals described widespread childhood obesity and expressed concern about implications for the future health and longevity of children who experience obesity.
- Over the period of 2010-2014, all-cause cancer and heart disease were the top two leading causes of death in Travis County, though the rates of both had declined since 2005-2009.

- When examined by cancer type, lung cancer was the leading cause of cancer mortality in Travis County in 2009-2013 and both breast cancer and prostate cancer mortality rates had risen since 2005-2009. In every racial/ethnic group, men experience higher cancer mortality rates than women.
- Mortality data further indicated that Black residents experienced higher mortality rates for cancer, heart disease, and stroke relative to White and Hispanic residents between 2010-2014. Both Black and Hispanic residents had a higher diabetes mortality rate than White residents. In contrast, mortality due to chronic lung disease was greater for White residents relative to Black and Hispanic residents.
- In 2011-2015, a smaller proportion of adults in Travis County (4.9%) than in Texas (7.6%) reported being diagnosed with cardiovascular disease. The percentage of Blacks/African Americans (7.5%) reporting a cardiovascular diagnosis was over twice that for Latinos/Hispanics (3.2%) and greater than that for Whites (5.8%).
- The prevalence of self-reported diabetes had increased for Texas, from 10.2% in 2011 to 11.4% in 2015. However, for Travis County the rate was more stable (8.0% in 2011 and 7.5% in 2015). For the period 2011-2015, Black/African American adults (13.4%) were more likely to report having a diabetes diagnosis than Latino/Hispanic (11.2%), White (5.4%), and Asian (4.4%) adults in Travis County.
- In 2011-2015, the percentage of adults in Travis County who were obese (21.9%) was less than Texas (32.4%) and had met the Healthy People 2020 target of <30.5%. However, a larger percentage of the Black/African American population was obese (40.1%) compared to Latino/Hispanic (27.2%) and the White (17.8%) residents.
- In 2010, the rate of obesity among high school students was lower in Travis County (10.1%) than in Texas (15.6%). However, Latino/Hispanic students (13.0%) and Black/African American students (12.0%) are more likely to be obese than White students (6.3%).
- Participants voiced the continuing need to provide culturally appropriate classes in the community to support prevention of disease and health maintenance. A community strength that focus group participants discussed was the free cooking and exercise classes offered through apartment complexes, recreation centers, and other organizations.

CTSA discussions indicate a link between obesity and hunger, lack of access to healthy foods, and food deserts.

- Some interviewees identified the link between obesity and hunger in impoverished communities who are often living in food deserts with minimal access to full-service grocery stores and recreation facilities, but with access to inexpensive junk food at convenience stores or fast food restaurants.

Communicable diseases, specifically sexually transmitted infections (STIs) and human immunodeficiency virus (HIV), were mentioned as a concern in focus groups as part of the CTSA. CHSA data indicate racial disparities in some STIs.

- Rates of gonorrhea cases increased in both Travis County and Texas from 2011 to 2015. However, number of new cases increased at a greater rate during those five years in Travis County than in Texas. Rates in Travis County have been higher than Texas for the past 10 years.
- In 2015, the prevalence of both gonorrhea and chlamydia cases were highest among Black/African American (502.5 and 994.0 per 100,000 population, respectively) and Latino/Hispanic (147.7 and 451.0 per 100,000 population, respectively) residents compared to White, non-Hispanic residents (115.3 and 252.0 per 100,000 population, respectively) in Travis County.
- In 2015, rates of new HIV cases were higher among Black/African American (54.5 per 100,000 population) and Latino/Hispanic (30.3 per 100,000 population) residents of Travis County, relative to White, non-Hispanic residents (16.8 per 100,0000 population).
- Community members recommended reducing stigma by normalizing STI screenings.

Discussions as part of the CTSA indicate that teen pregnancy is a concern, though CHSA data show that teen pregnancy in Travis County is slightly below that for the state.

- Two focus groups discussed and identified teen pregnancy and repeat pregnancy to teen mothers as a health concern in the community.
- In 2012-2014, the percentage of births to teenage mothers aged 15 to 17 years in Travis County (2.2%) was lower than the state percentage (8.8%).
- In Travis County, White, non-Hispanic teenage girls between 15 and 17 years old were less likely to give birth (0.4%) than their Black/African American (2.7%) and Latina/Hispanic (4.0%) peers.

CHSA data indicate racial disparities in prenatal health care and birth outcomes.

- In 2012-2014, 32.8% of Black/African mothers and 38.7% of Latina/Hispanic mothers received late or no prenatal care, whereas 14.4% of White, non-Hispanic mothers received late or no prenatal care.
- The percentage of White, non-Hispanic mothers (7.1%) and Latina/Hispanic mothers (6.8%) in Travis County who deliver low birth weight infants was slightly lower than the overall county percentage (7.7%). Whereas, Black/African American mothers in Travis County were more than twice as likely to have babies born at low birth weight (14.7%).

Stress, Mental Health, and Wellbeing

Mental Health was a priority that emerged in the CTSA, particularly for racial/minority and homeless populations. CHSA data indicate that poor mental health days affect nearly 1 in 5 and disproportionally affect the Black/African American residents.

- Mental health and stress were both identified by community members as priorities during the community participation process.
- In 2011-2015, 18.9% of Travis County residents reported 5+ poor mental health days in the past month, similar to Texas (18.8%).
- In 2011-2015, 23.8% of Black/African American adults reported 5+ poor mental health days, compared with 18.8% of White adults, 17.6% of Latino/Hispanic adults, and 16.8% of Asian adults in Travis County.
- CTSA participants and professionals expressed concern for the homeless population, which disproportionately suffers from serious mental illness and co-occurring conditions and the lack of support to mitigate those illnesses.
- Professionals interviewed discussed the lack of mental health beds for serious mental illness in the community.
- Professionals additionally noted there was a lack of quantitative data regarding mental health needs in the community, and suggested that a coordinated effort to strengthen mental health data collection in Travis County could improve local solutions.
- In the CHSA, data showed that Integral Care arranged for 1,396 episodes of inpatient care in FY15, which increased by 40% in FY16 to 1,949 episodes. Service utilization rates further showed that the average daily census for Integral Care clients at all state mental health facilities was 140% of target usage.
- CHSA data show that suicide is the ninth leading cause of death in Travis County (12.4 per 100,000 population).

CTSA participants identified mental health and stress as priorities, with poverty being significant stressor.

- Participants identified linkages between stress and mental illness, safety, and the ability to live a healthy lifestyle.
- Participants noted that poverty is a stressor and a significant contributor to mental health and suggested there was a need for various types of support groups to address mental health needs.

Data from the CTSA indicate that stress related to immigration and fear of deportation affects mental health, and further compounds opportunities to be physically active and access to healthy food.

- In multiple focus groups and interviews, people discussed stressors facing immigrant families, such as fear of deportation. Community members explained that these concerns impact immigrants' decision to be physically active or go to the grocery store.
- Health and social service professionals noted a recent drop in use of services by immigrant communities due to fear of deportation.
- Professionals and residents noted that the fear of strict immigration enforcement is not limited to families who are undocumented, and causes additional stress for all immigrant and refugee families, regardless of immigration status.
- Participants expressed hope that the community would continue to be open and affirming, and advocate for marginalized communities to alleviate stress and trauma.

Residents who have been displaced face stress related to gentrification and anger linked with their displacement, as identified in the CTSA.

- Participants discussed how displacement of families due to gentrification has caused stress and anger in displaced communities.
- Focus group participants and interviewees explained that members of the Black/African American community in east Austin have long felt overlooked and unheard.

According to the CTSA, there is a lack of mental health providers. Participants described challenges to finding mental health providers due to restrictions on insurance networks and the need for providers who make patients from marginalized communities (e.g., Black, LGBTQ, immigrant) feel safe.

- Focus group participants and professionals interviewed noted a lack of mental health providers.
- Participants described difficulty finding mental health providers, particularly with restrictions related to insurance networks.
- Participants discussed the importance of trusting and feeling safe with a mental health provider.
- For sensitive topics related to life stressors and mental health, participants noted the difficulty of finding a provider sensitive to the needs of certain communities because of the lack of diversity of mental healthcare providers. This was specifically discussed as a concern for Black/African American, LGBTQ, and immigrant communities.
- In the CTSA, participants discussed the stigma attached to mental health which restricts help-seeking behaviors

Safety from violence is also a concern identified by CTSA participants, including racial and gender identity discrimination and growing bias and racism nationally toward Asian American and Muslim communities

- Safety from violence and threats of violence was also a concern raised by focus group participants and interviewees. This was discussed as it related to racial and gender identity discrimination. An example provided was bullying and threats toward transgender individuals related to use of gendered bathrooms.
- Professionals interviewed noted a growing bias and racism nationally toward Asian American and Muslim communities that can be frightening, especially for refugees who came from violent regions

The prevalence of binge drinking is higher in Travis County than in Texas, particularly among non-Hispanic White adults, according to the CHSA.

- In 2011-2015, a higher percentage of adults in Travis County (22.0%) report binge drinking than in Texas (16.7%).
- In 2011-2015, one quarter (24.8%) of White non-Hispanic adults reported binge drinking, compared to 21.3% of Latino/Hispanic adults and 9.7% of Black/African American adults.
- In 2012, Austin and Travis County Emergency Management Services (EMS) identified 2,951 patients for whom alcohol or drug abuse was the primary issue.
- In 2014, the Austin Police Department reported reductions from the previous year in driving while intoxicated (DWI) offences (5.3% decrease) and narcotics offenses (8.6% decrease).
- An estimated, 8 to 15 percent of suicides in Travis County are reported to be related to alcohol or drug use, although the relationship is not specified.

Transportation

In the CTSA, CHSA, and FOC, transportation was a concern and identified as an issue that is getting worse as people move further outside of the city to find affordable housing.

- In the CTSA, residents and professionals discussed displacement of low-income Black/African American and Latino/Hispanic residents to more affordable areas outside of central Austin with less access to affordable health care, healthy food retailers, outdoor recreation space, and means of transportation.
- In the CHSA, maps of projected geographic changes in population also show a migration of Black/African American and Latino/Hispanic residents from central east Austin to the north and further east of the city. Areas expected to continue increasing in population include Pflugerville and far east Travis County.
- In the CTSA, transportation was a concern discussed in almost every focus group, by many community forum participants, and in many interviews. Participants reported that transportation concerns are compounded by the fact that residents are moving further outside of central Austin to find affordable housing.
- Through the FOC process, the executive leadership from the Austin public health system noted that growth in Travis County increases issues with traffic and with traffic congestion related to construction.

In the CTSA, public transportation was identified as a critical need for those without access to a vehicle. Public transportation does not serve some rural communities, and may be difficult to use because of inconvenient hours and amount of time it takes to travel via public transportation.

- Residents of rural Travis County regions that are expected to grow noted that public transportation does not serve some rural communities. Residents also described that it takes significant time it takes to travel into town on public transportation.
- Outlying communities in Travis County experience concerns related to public transportation such as infrequent buses or inconvenient hours, such as buses that do not run during the evenings and on weekends.
- Most people use a personal vehicle for transportation in Austin and Travis County. In 2015, 74.6% of workers in Travis County, 73.7% of workers in Austin, and 80.8% of workers in Texas travel to work alone using a motorized vehicle.
- More workers in Austin (4.0%) than in Texas (1.5%) identify public transportation as a way to get to work. However, when comparing to other metropolitan areas in the state, Austin residents use public transportation to get to work at the same rate as Houston residents (4.0%) and slightly less than Dallas residents (4.2%).
- Focus group participants expressed difficulty scheduling health care appointments around the bus schedule to ensure they did not miss the last bus home. Participants suggested there was a clear need for additional transportation options to health care services.
- Participants who do not speak English as their first language discussed difficulty understanding public transportation signage and maps and expressed a fear of getting lost in the city.

Access to Safe Recreational Spaces

In the CTSA and CASPER, community members identified outdoor spaces for physical activity as a factor that is important for promoting health.

- Residents discussed public spaces for recreation as important for both psychosocial well-being and physical health for all ages.
- Although financial and physical access to gyms was also mentioned, focus group participants generally discussed physical activity as it relates to the built environment and outdoor recreational opportunities, referring to access to parks, trails, and public recreation facilities. This distinction was also present in the CASPER responses: When asked about the most important factor that makes Travis County healthy, outdoor spaces for physical activity was one of the three main themes.
- CASPER responses indicated that access to places to be physically active near residents' homes was a community strength. However, as described in the following sections, residents also described several communities and populations with limited access to safe places to engage in physical activity.

CTSA respondents indicated that some neighborhoods are well served with access to parks, trails, and recreation centers, but other neighborhoods are underserved and lack access to facilities and infrastructure to support physical activity and well-being.

- Focus group participants discussed that although some Austin neighborhoods have access to many trails and parks, other areas have very little or no access to safe and attractive outdoor recreation space, particularly for residents who have been displaced from the city.
- Participants noted the lack of public spaces for community gathering and recreation in some communities as a concern. They pointed out that some areas of the city and county are lacking in facilities such as public libraries, parks, trails, and recreation centers.
- In small Travis County communities with growing populations, residents discussed homeowners' associations in the area which operate independently of each other and provide facilities such as public pools and recreation areas that are not available for use by the broader community, which are in need of such facilities.

Data from the CHSA indicate that physical inactivity is more prevalent among low-income and racial/ethnic minority populations. In the CTSA, these same populations are asking for additional and safer parks and recreation facilities.

- In 2011-2015, 28.6% of Travis County adults reported they did not participate in physical activity, compared to 34.6% in Texas.
- During the 2011-2015 period, 37.2% of adults who earn <$25,000 were not engaging in physical activity compared to 19.4% of adults with incomes $75,000+.
- Latino/Hispanic adults (35.4%) were more likely to be physically inactive compared with 30.0% of Blacks/African Americans and 24.8% of Whites in 2011-2015.

Issues of safety include traffic, pedestrian safety, lack of sidewalks, and other physical components of the neighborhood such as lighting and maintenance, which CTSA participants described as contributing to unsafe settings for youth and gang activity.

- Although 49.3% of CASPER respondents strongly agreed that they feel safe in Travis County, safety was a commonly discussed theme in CTSA focus groups.
- Participants explained that characteristics of the built environment, including traffic, lack of sidewalks, and other physical components of their neighborhood limit their ability to utilize public spaces for physical activity.

- A major safety concern for many focus group participants was related to traffic and pedestrian safety. Two Travis County focus groups outside the city of Austin discussed the dissection of their community by a highway with increasing traffic as a result of population growth. Participants in both focus groups discussed safety concerns related to increased traffic on highways and roads including the need for stoplights, crosswalks, and lighting to keep pedestrians safe.
- Community members in Austin discussed the increase in traffic in neighborhoods, lack of sidewalks or poorly kept sidewalks, and lighting on streets as safety concerns.
- Participants noted that the lack of recreational facilities in neighborhoods with poorly lit and poorly maintained streets creates an unsafe environment for youth. One focus group in Del Valle noted that these conditions contribute to gang activity and risk for predatory activity such as sex trafficking. Community members discussed solutions such as having a youth or recreation center nearby that provides youth with a safe place to play, and having security guards at apartments.

Access to Healthy Food

Data from the CASPER indicate that access to healthy food is important for promoting the health of residents across the County.

- When asked about the most important factor that makes Travis County healthy, access to healthy food was one of the three main themes identified in CASPER responses.
- Residents surveyed during the CASPER said that the primary reason they shop at the place where they purchase most of their groceries is because it is in a convenient location, and most respondents indicated that they had access to affordable, healthy food near their homes.

While CASPER respondents characterized access to affordable, healthy foods as a strength, CTSA participants observed that unhealthy food is often closer and less expensive than healthy food options. CTSA participants identified a lack of nearby grocery stores as a concern, particularly in eastern Travis County.

- CASPER respondents characterized access to affordable, healthy food near their homes as a strength of the community, though this was a substantial concern that emerged in focus groups demonstrating how certain population groups experience inequitable access to healthy foods.
- Focus group participants noted the significant expense of buying healthy food such as fresh produce and organic foods, while unhealthy options such as fast food, chips, and sodas were less expensive.
- In focus groups, participants described healthy food as available further away from where they live, whereas unhealthy food is on every corner at fast food restaurants and in convenience stores.
- The lack of nearby grocery stores was mentioned in many focus groups throughout Austin and Travis County, especially outside the city center. In eastern Travis County, focus group participants mentioned the unique challenge of one store serving the many scattered communities.

CHSA data indicate that despite economic growth in the region, food insecurity and limited access to grocery stores are barriers to healthy eating.

- According to Feeding America, in 2014, 17.1% of Travis County residents experienced food insecurity. The percentage of people considered food insecure in the county is consistent with Texas (17.0%), but higher than the United States (15.4%). Another data source, the Food For All report, suggests the food insecurity rate in Austin is closer to 25%.
- According to USDA data, in 2010, 8.0% of Travis County's low-income residents did not live close to a grocery store, a slight reduction from 8.7% in 2006.

Lower-income and Black/African American residents are burdened by disparities in vegetable consumption, as indicated by the CHSA.

- In 2011-2015, the proportion of adults who reported eating less than one serving of vegetables per day in Travis County (17.7%) was less than the proportion for Texas (21.0%).
- Adults in Travis County with incomes <$25,000 (24.0%) were twice as likely to report eating less than one serving of vegetables per day compared to adults with incomes $75,000+ (10.4%) in 2011-2015.
- A higher proportion of Black/African Americans adults (36.4%) reported eating less than one serving of vegetables per day compared to Latino/Hispanic adults (22.6%) and White, non-Hispanic (13.4%) adults in 2011-2015.
- In 2011, Travis County high school students (18.4%) reported eating the daily recommended amount of fruits and vegetables at a rate that was consistent with Texas (18.5%).

In the CTSA, mobile food distribution services were identified as a strength. However, schedules are inconsistent and therefore unreliable.

- Mobile clinics and mobile food distribution services were cited as a strength in the community. However, focus group participants mentioned that the schedules are inconsistent and they could not rely on the services.
- CTSA participants recommended building new grocery stores and hosting farmers' markets in underserved areas to improve access to healthy food in Austin and Travis County.

Environmental Health

In the CTSA, cleanliness and upkeep, including public and private spaces, was identified by residents as contributing to health. Many focus group participants expressed concerns related to the home environment.

- Low-income seniors identified poor conditions of their homes and pest control as concerns. Seniors on fixed incomes who often have older homes discussed challenges with getting home maintenance assistance (e.g., weatherization) and adequate repairs in a timely manner.
- Low-income participants and community members who do not speak English proficiently described landlords as unresponsive to maintenance and pest control requests.
- Participants suggested that landlords should be encouraged to keep facilities in better condition. Low-income homeowners would like to see more services with shorter wait times for assistance with home weatherization and repair.

Participants in the CTSA described water quality and availability as a concern for low-income residents, rural residents relying on well water, and among the homeless population that lacks access to public water for drinking and bathing.

- Water quality and availability was a concern in rural residents, seniors on fixed-incomes, and other low-income residents.
- Rural and fixed-income residents who do not have access to a city water source and instead use well water expressed water quality concerns and financial concerns related to the higher cost of using private water sources.
- Additionally, low-income rural residents noted that the cost of connecting to municipal water and sewer if, or when, it becomes available in their location would be a financial burden.
- Participants also noted a lack of access in the homeless community to public water sources for drinking and bathing.

In the CTSA and CASPER, environmental concerns for neighborhoods included litter, pollution, allergens, and air quality. Air quality was a concern due to industrial facilities and power plants, particularly those in eastern Travis County.

- Pollution was mentioned as an environmental issue in multiple focus groups and from community members at the community forum. Residents discussed trash on the streets that contributes to an unsanitary environment.
- Air pollution was discussed, specifically where power plants and other industrial facilities are in eastern Travis County.
- For CASPER respondents, allergies were cited as a major concern related to air quality in Travis County.

Homelessness

Discussions during the CTSA suggest that individuals experiencing homelessness encounter numerous barriers to accessing mental health care, lack of affordable housing, safety concerns (violence and environmental), and water access challenges.

- Many of the issues discussed in focus groups to be generally affective populations within Travis County were identified as having a disproportionately large impact on individuals experiencing homelessness, such as the limited availability of mental health care, challenges in accessing affordable housing, threats to safety (violence and environmental), and restricted water access.
- According to focus group participants, in central Austin basic needs such as the availability of public drinking water and water sources for bathing and using the restroom are not sufficiently available to the homeless community. Participants believed water resources for the homeless community would provide a sense of dignity and respect to those affected, and it would also improve the cleanliness of public spaces.
- Safety from the elements such as sun and storms, as well as from violence, are a concern in the homeless community.
- Professionals who work with individuals experiencing homelessness discussed that the population is often times taken advantage of or scammed due to their vulnerability.

The CTSA indicates that many in the homeless population are affected by the challenges of serious mental illness, issues of substance abuse and dependence, and a lack of mental health beds for mental and behavioral treatment.

- Professionals participating in interviews discussed the lack of mental health beds for serious mental illness in the community and the challenges related to serious mental illness in the homeless population.
- The lack of services for co-occurring mental health and substance use disorders was discussed, which participants mentioned disproportionately affects the homeless population.

CTSA discussions highlighted the need for low-barrier affordable housing for the homeless population.

- Providers recommended increasing low-barrier housing options for the homeless community, citing stable housing as a factor in improving adherence to treatment plans and medication management for severe mental illness.
- Low-barrier housing is otherwise known as Housing First, which is an approach to ending homelessness that “embraces the idea that people participating in a PSH [permanent supportive housing] program should be given housing even if they are struggling with issues of chemical dependency, mental health, or other barriers to housing that might render them ineligible under more traditional models of housing.”
- Providers also identified the need for a respite center for the homeless and homeless shelters outside of downtown Austin to support the shelter and housing needs of the homeless population.

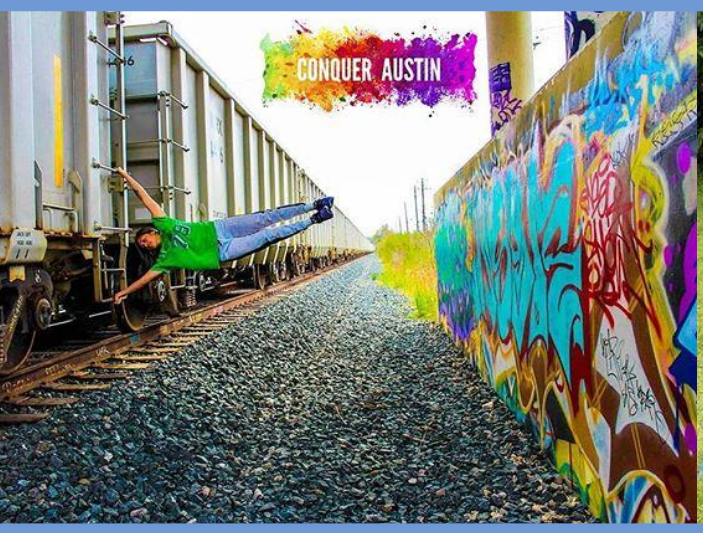
Societal Norms and Stigma

CTSA discussions identified several societal norms that exacerbate health issues.

- Discussion participants described large portion sizes for food, long work hours, acceptance and sometimes encouragement of teenage pregnancy, violence toward women, and lack of health education in schools as norms that impede health promotion.
- Community members identified several strategies to shift societal norms to promote health and well-being and to reduce stigmas such as healthy eating and cooking educational activities, particularly culturally competent classes focused on learning how to cook traditional foods in a healthier way.

CTSA participants also discussed how stigma can exacerbate health issues and prevent engagement with health care systems, particularly screening for sexually transmitted infections (STIs), seeking mental health care services, and perceptions of individuals who use or misuse drugs.

- Participants discussed stigmas related to some behaviors or groups of people that prevent individuals from seeking health care services and may affect the quality of care they receive.
- Stigmas discussed in focus groups included stigma related to seeking screening services for sexually transmitted infections, seeking mental health services, and believing that persons addicted to drugs are engaging in pleasure-seeking behaviors rather than for pain avoidance or escaping other life circumstances.
- The potential for health campaigns to sometimes stigmatize groups of people was also identified as a concern among participants. They suggested creating campaigns that are inclusive, with imaging and messaging to reflect broad populations that are at risk.
- Community members suggested that STI screening or seeking mental health care had to become more normalized in order to reduce the stigma and subsequent barriers to seeking care.




Together We Thrive

Austin/Travis County Community Health Plan