Together We Thrive

Austin/Travis County Community Health Plan

Austin/Travis County Community Health Improvement Plan

ANNUAL UPDATE YEAR 2

Year in Review: July 1, 2014 – June 30, 2015

Last updated: December 29, 2015

City of Austin Founded 1839 · METRO · Seton Healthcare Family · Central Health · County of Travis State of Texas

St. David's Foundation · UTHealth The University of Texas Health Science Center at Houston School of Public Health Austin Regional Campus · Austin Travis County Integral Care Behavioral Health & Developmental Disabilities Services

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INTRODUCTION

Health is affected by where and how we live, work, play and learn.[1] Understanding these factors and how they influence the health of our community is critical in building a healthier place to live. This annual update represents progress made in the second year of Austin/Travis County's 3-year Community Health Improvement Plan (CHIP).

The Austin/Travis County CHIP, developed over the period of July 2012 – June 2013, utilizes key findings from the 2012 Community Health Assessment (CHA). The CHA, serving as the CHIP's foundation, includes qualitative data from focus groups, key informant interviews, and community forums, as well as quantitative data from local, state and national indicators to inform CHIP health priority areas. The CHIP is an action-oriented strategic plan that outlines community-driven goals, objectives, strategies and measures for addressing the following top four health priority areas:

1. Chronic Disease Focus on Obesity
2. Built Environment Focus on Access to Healthy Foods
3. Built Environment Focus on Transportation
4. Access to Primary Care and Mental/Behavioral Health Services Focus on Navigating the Healthcare System

The aim of the CHIP is to build a comprehensive plan to improve the health and wellness of Austin/ Travis County. The CHIP implementation or annual action officially began on July 1, 2013 and the first year of efforts concluded on June 30, 2014. The second year of efforts spans July 1, 2014-June 30, 2015.

Partners and stakeholders throughout Austin/Travis County are working on the CHIP's goals, objectives and strategies with the shared aim of making measureable progress in each goal. To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the Austin/ Travis County assessment and planning process engaged community members and Local Public Health System (LPHS) Partners through multi- industry, agency and community stakeholder committees.

The Austin/Travis County CHA/CHIP structure enables leadership, community voice, and participation that is open to the entire community, city, and county. The Steering Committee, providing executive oversight for the community health improvement planning and implementation process, includes the Austin/Travis County Health and Human Services Department, Austin/Travis County Integral Care, Capital Metro, Central Health, Seton Healthcare Family, St. David's Foundation, Travis County Health and Human Services and Veterans Services, and University of Texas Health Science Center (UTHSC) at Houston School of Public Health Austin Regional Campus. The Core Coordinating Committee, providing the overall management of the process, includes all aforementioned agencies as well as the Sustainable Food Center. The CHIP Workgroups and Action Item Leads, representing many partners from broad and diverse sectors of the community, are formed around each CHIP priority area to develop goals, objectives, strategies, and action items.

While the Austin/Travis County HHSD helps coordinate the community health improvement planning process, the entire effort is shared between the network of stakeholders and residents throughout the community.

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

Vision

Healthy People are the Foundation of our Thriving Community

Mission

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

Shared Values

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

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

Health Promoting: Building on current assets and developing new assets

Perseverance, Excellence, and Creativity

Shared Accountability and Ownership

It is important to understand the CHIP's purpose is to foster collaboration and monitor progress toward the goals for each priority area. The CHIP's Steering Committee, Core Coordinating Committee, Work Groups and Action Item Leads are responsible for the actions related to the CHIP priority areas. Throughout this update, these organizations are credited for their work. If there are any updates or revisions to the organizations mentioned please contact Hailey Hale at Hailey.Hale@austintexas.gov.

PURPOSE OF THE ANNUAL UPDATE

An annual report provides the CHA/CHIP Steering Committee, community residents, and other stakeholders in the Austin/ Travis County community an overview of actions taken during the past year, which will advance the CHIP's priority areas. Partners and stakeholders in Austin/ Travis County are encouraged to use this update as a resource to inform their own assessments, improvement plans, and strategic plans. Within this annual update, the following information is provided for a comprehensive overview for each of the four priority areas within the CHIP:

- **Background** – this section emphasizes why this priority area is critical to the Austin/ Travis County Community.
- **Success Stories** – this section includes updates provided by CHIP partners over the past year.
- **Indicators** – this section includes the best indicators available to demonstrate the progress made in each priority area. Due to limited availability of quantitative indicators, not all indicators reported directly measure the progress described in the success stories.

	
Community has **not** made positive progress towards achieving the target	Community has made positive progress towards achieving the target

- **Challenges/ Lessons Learned** – this section reviews issues that may be hindering progress or describes why measuring progress in each priority area is difficult.
- **Next Steps** – this section identifies actions the CHIP partners are planning to take over the next year of the CHIP.
- **Health Literacy and Health Education** – This section represents the cross cutting competencies of the CHIP, which all priority areas address in some way. Health education and literacy looks different for each priority area as they all four address a different aspect of health.
- **Appendices A, B, and C** – These sections include summaries of the CHIP Annual Update Performance Indicators, the Year 2 Objectives and Strategies, and a list of the Year 3 changes to CHIP Objectives and Strategies that came out of the annual planning summit.

This annual report as well as the complete CHA/CHIP is available for review at www.austintexas.gov/healthforum. If you have any questions about this report or would like to request a CHA/CHIP representative to present this information at your organization please call 512.972.5888 or email CHA.CHIP@austintexas.gov.

INDICATORS

SUMMARY

During CHIP Year 2, two major health indicators demonstrated improvement in Travis County – the percentage of adults with obesity and the percentage of adults reporting five or more days of poor mental health per month decreased. Because individual health is determined by many factors which include the environment, these two indicators may have been impacted by strategies identified in all four priority areas; Obesity, Access to Healthy Food, Transportation and Access to Primary Care and Mental/Behavioral Care. Additionally, there was some progress in the transportation and physical activity indicators. The number of people commuting via bicycling and walking has increased. However, due to a decline in the number of people carpooling and using public transit combined with growth in the overall population, the percentage of the total population commuting via active transportation has decreased.

Other transportation outcomes provided by the Austin Transportation Department, such as the installation of new bike lanes, increased participation in Austin's -B-Cycle trips, and the implementation of Smart Trips, an active transport education pilot program, suggest the potential for long-term success in increasing the percentage of adults who use active transportation to commute to work.

METHODS

Obesity and poor mental health prevalence estimates were obtained through the Behavior Risk Factor Surveillance System (BRFSS) survey. Obesity is defined as having a Body Mass Index (BMI) greater than or equal to 30. Poor mental health status is determined by asking the following question: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Both measures are self-reported.

The years 2012 and 2014 were chosen for comparison because these were years in which a BRFSS oversample of Travis County was conducted. BRFSS oversamples ensure that an adequate sample size of a specific population (e.g. a county) is obtained. In years in which oversamples are not conducted for specific populations, sample sizes are smaller, and population estimates are inaccurate.

Physical activity and nutrition indicators are collected only in odd numbered years of the BRFSS survey. Though data were collected in both 2011 and 2013, the estimates from 2013 are unreliable because no oversample of Travis County was conducted. Additionally, 2013 data are not comparable to 2011 or 2015. Oversamples of Travis County will be obtained in 2015 and 2016, thus allowing comparison between years 2011 and 2015 for physical activity and nutrition indicators and comparison between 2014 and 2016 for obesity and mental health indicators.

Active transportation indicators are collected through the American Community Survey (ACS) 2011-2013. Commute trips are not an accurate indicator of total active transportation in a community because they only capture how individuals travel (commute) to work and not how individuals travel for other trips. Further information regarding sample size and data quality measures (including coverage rates, allocation rates, and response rates) can be found on the ACS website in the Methodology section.

RESULTS

The percentage of Travis County adults with obesity decreased from 23.6% in 2012 to 20.5% in 2014 (NS, p>.05). This constitutes a 13.1% decrease in the prevalence of obesity in Travis County. Low income adults (annual income <$25,000) also experienced an improvement in obesity prevalence, decreasing from 28.8% in 2012 to 22.6% in 2014. This change is not significant as the p-value is greater than .05.

A p-value is the probability of obtaining a result equal to or more extreme than the one found, assuming that the null hypothesis is true. It is used to test a hypothesis (e.g. that there is a difference between two groups) and reject the null hypothesis that there is no difference. It doesn't prove a hypothesis is true but is rather a tool to decide whether to reject the null hypothesis. The standard p<.05 or p<.01 for classifying "significance" is arbitrary, but these values are generally agreed upon as the cut points or significance levels for any given test of hypothesis.

Long Term Indicator: By 2016, a decrease from 24% to 22.8% the percentage of adults who report a BMI > = 30			
CHIP Goal	**Performance Measure**	**Baseline**	**Target 2016**
Reduce burden of chronic diseases caused by obesity among Austin/Travis residents.	Percentage of adults who report a BMI ≥30 (obese)	24% of adult reported a BMI≥30	22.8% of adults reporting a BMI ≥30

Health Progress Update		
2014 Performance Measures		20.5% of adults reported a BMI≥30 (2014 BRFSS)

The percentage of Travis County adults reporting 5 or more days of poor mental health in the last month decreased from 20.1% in 2012 to 16.3% in 2014, which constitutes an 18.9% decrease (NS, p>.05). The percentage of low income adults (annual income <$25,000) reporting poor mental health decreased from 26.7% to 23.5% between 2012 and 2014. This change is not significant as the p-value is greater than .05.

Long Term Indicator: Reduce prevalence of adults reporting FIVE or more days of poor mental health in the past 30 days.			
CHIP Goal	**Performance Measure**	**Baseline**	**Target 2016**
Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons	Percentage of adults reporting **five** or more days of poor mental health in the past 30 days	17.0% (2011 BRFSS)	N/A

Health Progress Update		
2014 Performance Measures		16.3% of adults reported five or more days of poor mental health in the past 30 days (2014 BRFSS)

There was no improvement in the percentage of commuters using active transportation, though there was some improvement in specific active transportation modes (bicycling and walking) used by commuters.

Long Term Indicator: Increase active transportation commute mode share by 15% by April 2016				
CHIP Goal	Performance Measure	Baseline		Target 2016
Local and regional stakeholders will collaboratively increase accessibility to community resources via safe, active transportation.	Percentages of commuters using active transportation to get to work (broken down into 4 different types of active transportation).	**Total percentage of active transportation**	**18.77% (n=100,339)**	To have 33.77 percent of people use active transportation when commuting to work
		Carpooled:	11.9% (n=63,636)	
		Public Transportation:	4.15% (n=22,167)	
		Bicycle:	.94% (n= 5,022)	
		Walked:	1.78% (n=9,524)	
		(2007-2009 American Community Survey)		

Health Progress Update			
Performance Measures 2014		**Total percentage using active transportation**	**17.5% (n=99,086)**
		Carpooled:	10.5% (n=59,539)
		Public Transportation:	3.4% (n=19,461)
		Bicycle:	1.3% (n= 7,319)
		Walked:	2.3% (n=12,767)
		(2011-2013 American Community Survey)	

Discussion

Because obesity is directly linked to engagement in physical activity and healthy eating, we predict that with the decreased prevalence of obesity both physical activity and nutrition indicators will demonstrate improvement between 2011 and 2015. If the trends reported here continue, Travis County will demonstrate a marked improvement for indicators in all four priority areas by 2016. These priority areas are chronic disease focus on obesity, built environment focus on access to healthy foods, built environment focus on transportation and access to primary care and mental/ behavioral health services focus on navigating the healthcare system. Despite neither of these

prevalence changes, adults who report 5 or more days of poor mental health in the last 30 days or adults who report BMIs greater than 30 being statistically significant, they indicate important changes and signify a downward trend in the chronic disease burden of the Travis County population.

Though there was minimal progress in the active transportation and physical activity indicators, other transportation outcomes provided by the Austin Transportation Department suggest the potential for long-term success in increasing the percentage of adults who use active transportation to commute to work as well as the percentage of adults who engage in physical activity:

1. The Smart Trips pilot program targeted 500 households in North Austin, providing them with a personalized set of transportation resources as well as encouragement and education programs focused on riding the bus, walking, and bicycling.
2. Thirty-six miles of bike lanes were installed in FY 2014-15.
3. There was a 16% increase in B-cycle trips from 2014 to 2015.
4. A Vision Zero Traffic Safety Task Force was created to identify four critical actions to reduce serious injuries and fatalities (including pedestrian and bicycle injuries and fatalities) on Austin's roadways to zero by 2025.

CHRONIC DISEASE: FOCUS ON OBESITY

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

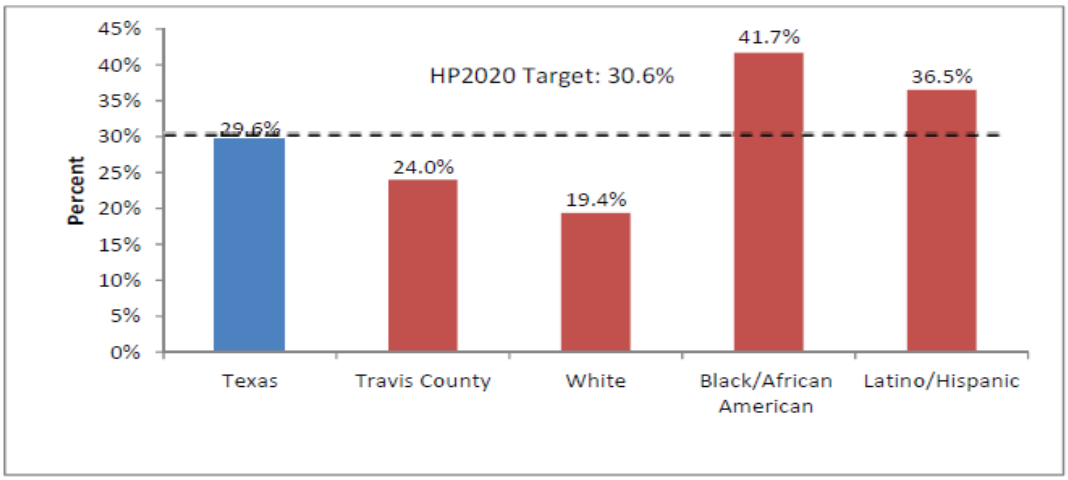
BACKGROUND

Chronic diseases carry a significant economic cost due to increased healthcare spending and lost earnings. According to the Texas Comptroller, obesity cost Texas 9.5 billion in 2009 and will cost 32.5 billion annually by 2030 if the current trend continues.[2] In 2012, Travis County chronic disease hospitalization costs totaled over $571 million.[3]

Additionally, in the 2012 CHA report there are race and socioeconomic disparities for obesity prevalence. Obesity is more prevalent among black adults (41.7%) when compared to their White (19.4%) and Hispanic (36.5%) counterparts.[4] Obesity is more prevalent in the lower income population. Since healthy foods are often more costly than foods high in calories, people with low incomes rely more on inexpensive foods with less nutritional value to meet their hunger needs.[5]

- A 3-year estimate (2008-2010) showed that 24% of adults in Travis County were obese. Although this number may sound promising when compared to the state (29.6%) and the Healthy People 2020 target (30.6%), Travis County increased from 19% in 2011 to 24% the following year.[6]
- The incorporation of physical activity into peoples' daily lifestyle is essential in reducing obesity. Higher participation in physical activity may be increased by providing access to safe neighborhoods, walkways, and parks.[7]

Figure 22: Percentage of Obese Adults (BMI≥30) in Texas and by Race/Ethnicity in Travis County, 2008-2010



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

SUCCESS STORIES

Physical Activity in the Built Environment

A new grant was awarded from the American Planning Association to COA and Capital Metro to engage populations in the Rundberg area on how to use active transportation to improve access to healthy food, local clinics, and other nearby resources which can be reached through walking or biking. The Rundberg neighborhood was selected as the implementation site because of the diversity of the population, and the identified health disparities disproportionately affecting individuals living in this area. *(Strategy 1.1.2, see Appendix B for complete strategy.)*

Increase clinical community linkages for obesity assessment and referral

CommUnity Care (CUC) is a local healthcare system with 23

locations that provide care to all Travis County residents including those whose incomes and lack of private health insurance qualifies them for enrollment. A new objective was identified at the annual summit regarding obesity assessment and referral. Strategies include a hard stop in the electronic medical record during intake to screen BMI, educate patients on obesity prevention community resources, and goal-setting to decrease BMI. This is a Medicaid 1115 Waiver program and had not been identified as an obesity initiative in the past. Moving forward, CUC partners will be engaged in the chronic disease workgroup and reporting progress on these clinical efforts.

Healthy Eating and Physical Activity in Childcare Settings
The Coordinated Approach to Child Health (CATCH) Early Childhood program is an evidence-based curriculum shown to improve physical activity and nutrition among 3-5 year olds. CATCH Early Childhood is being used to promote adoption of policies and practices related to healthy eating and physical activity in early childcare settings. UT School of Public Health and HHSD partnered to train 12 day care teachers and five new day care providers have signed agreements to implement the CATCH curriculum in all classrooms with children ages 3-5. Methods being used to successfully implement this strategy include incentivizing the daycares who offer policies related to childcare and healthy eating as well as incentives for the employees at the facilities who are able to implement the projects (*Strategy 1.4.1, see Appendix B for complete strategy).*

Breastfeeding

New state policy leads to additional mother-friendly worksites
HB 786, relating to the right of a public employee to express breast milk in the workplace, was passed into law in June of 2015. This law requires public employers to have a Mother Friendly Policy. A presentation on HB 786 was made on 8/14/2015 to ten (10) public organizations. (Strategy 1.2.1, see Appendix B for complete strategy.)
Engaging healthcare providers

A newly developed webinar for healthcare providers has been completed. Referral cards in both Spanish and English have been distributed. An opportunity to collaborate and connect with East Austin Health and Wellness Center has been established. *(Strategy 1.3.1, see Appendix B for complete strategy.*

CHALLENGES/LESSONS LEARNED

Shared-Use Agreements
Progress on increasing opportunities to utilize local facilities and spaces by establishing new shared-use agreements and improving adherence to existing shared-use agreements was hindered due to the loss of the Community Transformation Grant which reduced our local capacity to facilitate shared-use agreements. Workgroup discussion related to this strategy still focuses on how to leverage resources to fund projects related to this strategy... *(Strategy 1.1.1, see Appendix B for complete strategy.)*

Mother Friendly Policy
DSHS has additional funds available to assist with the promotion of mother friendly facilities. These funds can be utilized by Del Valle ISD which identified needing more mother friendly facilities. The University of Texas Experienced bureaucratic barriers to adopting formal mother-friendly policy which has prevented them from achieving state certification. However, UT has been able to foster a mother friendly environment without having the policy *(Strategy 1.2.2, see Appendix B for complete strategy.)*

Sugar Sweetened Beverages and Promotion of Drinking Water
Identified need to shift from sugar sweetened beverage ban strategy to "Water First" policy promotion. This includes promoting strategies that encourage replacing sugary drinks with water. *(Strategy 1.6.2, see Appendix B for complete strategy.)*

Next Steps

Promoting Physical Activity
An APA grant targeting the Rundberg area is working to assess appropriateness of educational materials including focus groups within the community to promote the use of the existing built environment for transportation through an education and outreach campaign titled Smart Trips.

Continued Outreach to Worksites to Promote Wellness Policies
The Michael & Susan Dell Foundation became a recognized Mayor's Health and Fitness Certified Partner. The Partner Certification Program is a mutually beneficial workplace wellness recognition program for Austin-based organizations of all types and sizes. It was created by the Mayor's Health & Fitness Council in 2007 in an effort to inspire nutrition, physical activity, tobacco-free living and mother-friendly policies in workplaces. By becoming either a Standard or Gold Certified Partner, organizations get recognition for having comprehensive, promising practices and evidence-based workplace policies. To remain in good standing, organizations must get re-certified every two years. Worksite wellness forums and more outreach to organizations to expand this certification program are planned.

Healthy ATC
Healthy ATC is a collaboration of Travis County Health & Human Services & Veterans Services Department, City of Austin Health & Human Services Department, and Central Health to:

- Plan together
- Share public data
- Align goals & activities specific to priority health indicators and social determinants of health

The priority health indicators were informed by the CHA and obesity was identified as one of the Healthy ATC four indicators.

This partnership also includes a new web portal (www.healthyatc.org) that brings unbiased data, local resources and a wealth of information to one, accessible, user-friendly location. The website features CHA/CHIP reports and data highlights. The social media plan for Healthy ATC includes promotion of CHA/CHIP forums, news, and highlights.

Central Healthy Equity Policy Council
Central Health, one of the CHA/CHIP partners, is launching the Central Health Equity Policy Council. This Council is made up of key decision-makers to advance health policy in Austin/Travis County. Policies are specific to the four priority indicators from Healthy ATC, obesity being one of the policy priorities. Policy recommendations from the CHIP will be taken into consideration for the policy agenda of this Council.

HEALTH LITERACY AND HEALTH EDUCATION

APA Grantees implementing the activities in Rundberg have reviewed the community CHA to identify the area's top cultural trends. The grant also specifically states that outreach for transportation would target Spanish speakers. Translation services for materials are being investigated at this time. *(Strategy 1.1.3, see Appendix B for complete strategy.*)

BUILT ENVIRONMENT: FOCUS ON ACCESS TO HEALTHY FOODS

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

BACKGROUND

In 2010, almost 1 in 3 (28.95%) of Travis County's residents live one mile or further from a grocery store; of these residents 27.6% are low-income.[8]

Research shows there is a link between the built environment and access to affordable, high-quality produce and other healthy foods which in turn influences choices people make in their daily diet.[9]

Less than one third (30%) of Travis County and Texas adults reported eating the recommended amount of fruit and vegetable servings; five or more fruit and vegetable servings per day.[10]

When broken down by income, data show that fruit and vegetable consumption increases with income. Since healthy foods are not equally available across all communities, greater access to healthier foods may reduce health disparities.[11]

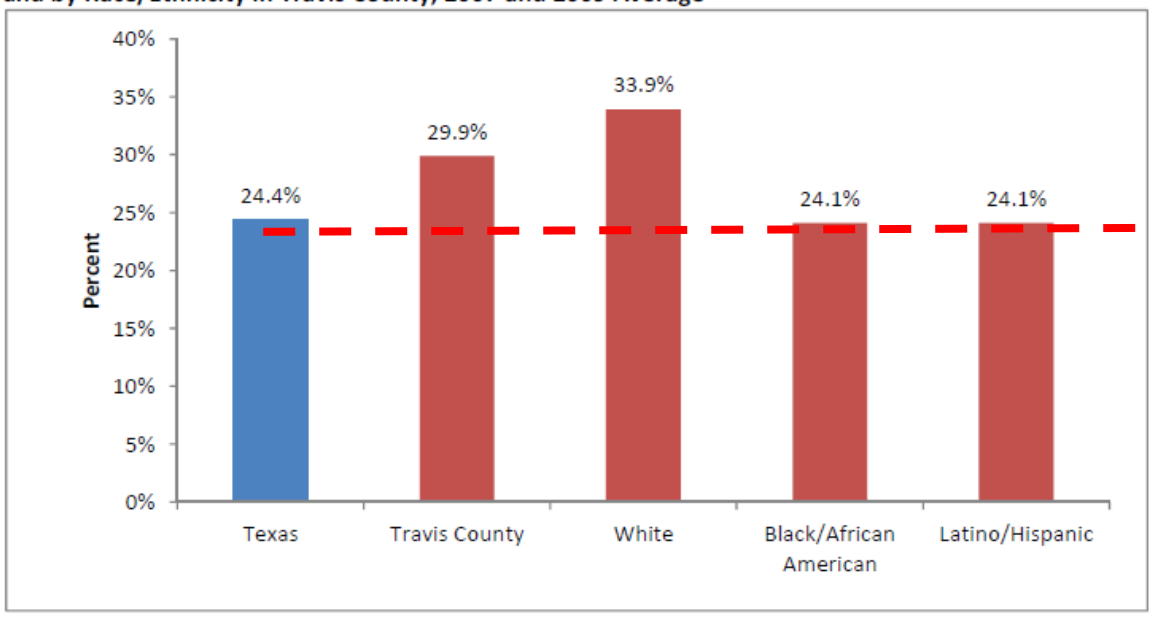
Figure 25: Percentage of Adults Reporting Eating 5+ Servings of Fruits and Vegetables per day by Income in Travis County, 2007 and 2009 Average

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

- In 2010, 16.6% of the Travis County population was considered food insecure, meaning they lacked access to enough food for an active, healthy life. Eastern Travis County, in particular, is identified as lacking proximity to stores that sell fresh produce.[12]

- 18% of Travis County residents and 26% of Travis County children live in a food insecure household.[13]
- Supplemental Nutrition Assistance Program (SNAP) has proven effective in lifting many persons out of poverty with a $1.79 local economic multiplier effect. In 2011, only 57% of eligible persons in Travis County enrolled in SNAP.[14]
- Less than 30% of Travis County adults have reported eating five or more servings of fruit and vegetables per day, with the lowest consumption being in Black/African Americans and Latino/Hispanics (24.1%) and low-income populations (24.7%).[15]
- Only 18.4% of Travis County youth reported eating the recommended servings of fruits and vegetables in 2010, with the lowest consumption rates in White youth (18.0%) and Latino/Hispanic youth (17.8%).[16]

Figure 24: Percentage of Adults Reporting Eating 5+ Servings of Fruit and Vegetables per day in Texas and by Race/Ethnicity in Travis County, 2007 and 2009 Average

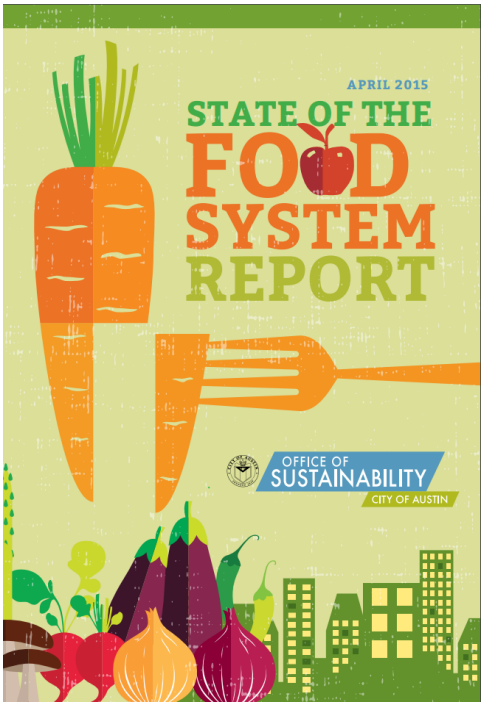


DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2007 and 2009

SUCCESS STORIES

Access to Healthy Foods/Food Insecurity
The Texas Hunger Initiative collected zip code based data and organized it to reflect highest level of food insecurity. Ten zip codes have been identified has having the highest levels of food insecurity. The food insecurity mapping report is available upon request. THI has reached out to several organizations regarding mapping software, but is still working to gain access to the technology to map the data that has been collected. *(Strategy 2.1.1, see Appendix B for complete strategy.)*

Increase the Reach of Food Assistance Programs
City of Austin Office of Sustainability developed Food System Asset maps for the Plan 4 Health grant in the North Central section of Austin. Maps will be used to stimulate conversations with the community about priorities for strengthening the local food system. We plan to expand 'Food System Asset maps' to the entire region over the next few years. *(Strategy 2.1.3, see Appendix B for complete strategy.)*



Sustainable Food Policy Board developed and submitted a request to the Austin City Council and the County Commissioners to request funding for a SNAP outreach coordinator, funding for an outreach campaign, and funding for expanding Double Dollar program. Funding was received from COA ($112,000) and from the County ($10,000). *(Strategy 2.2.1, see Appendix B for complete strategy.)*

Distribution and Production Points for Healthy Foods in High Need Areas
COA's Office of Sustainability developed a web site to house information about how to start community gardens, school gardens, backyard gardens and urban farms: www.austintexas.gov/food COA refined the Urban Farm Ordinance so that it is easier for producers to get their farms in compliance (Certificate of Compliance). The "Eligible Plots List" spreadsheet is maintained by the Sustainable Urban Agriculture and Community Gardens program and is sorted by zip code. *(Strategy 2.2.2, See Appendix B for complete strategy.)*

SFC presented four (4) organic food gardening classes, five (5) special-topic garden classes, one (1) School Garden Leadership Training, and one (1) Community Garden

Leadership Training. SFC provides fiscal sponsorship to a total of thirteen (13) community gardens, including the recently established Cherry Creek and Adelphi Acre gardens. *(Strategy 2.2.2, see Appendix B for complete strategy.(Coordinates with 2.1.2)).*

Healthy Corner Store Program
Sustainable Food Policy Board and other stakeholders developed and submitted recommendations to City Council for funding a pilot Healthy Corner Store program. Five stores in the 78744 and 78745 zip codes have committed to participate in a pilot program offering at least 4 new healthy products for at least one year.*(Strategy 2.2.4, see Appendix B for complete strategy.)*

State of the Food System Report
The State of the Food System Report was released by COA's office of sustainability. This report includes food assistance programs in Travis County, barriers to and opportunities for commercial urban farming, economic impact of Austin's food sector, and researching Austin's maximum agricultural production. *(Strategy 2.2.4, see Appendix B for complete strategy.)*

CHALLENGES/LESSONS LEARNED

Access to Food Assistance Programs
It was decided not to make an interactive mapping tool since neither the funds nor staff necessary to keep it updated are available. After meeting as an action team and at the Year 3 Planning Summit, we learned that there are other groups that could have benefitted from mapping. Collaboration with other groups should have started sooner so as to have one project with multiple groups benefitting. *(Strategy 2.1.2*, see Appendix B for complete strategy.*)*

NEXT STEPS

Access to Food Assistance Programs
Implementation of neighborhood food system planning pilot is being carried out through a partnership between several COA's departments and CapMetro. This pilot project is funded through a grant from the American Planning Association. Now that ten zip codes have been identified as having the highest level of food insecurity, as outlined in Strategy 2.1.1, these developing projects may be promoted in those ten zip codes.

Due to the unavailability of mapping technology and staff to upkeep it, existing static maps are being used to overlay some of the data. A Graduate Intern is currently completing some GIS mapping of low income and low SNAP participation. All of the data needed has been collected, and will be incorporated into visuals that will be helpful moving forward.

Development is underway for a toolkit for School Farm Stands by the Office of Sustainability.

Strategies Identified for Implementation in Year 3 of the CHIP

Strategy 2.1.4 Increase capacity of quality programs.
Strategy 2.3.4 Create a menu of strategies to implement healthy food retail along with potential impact and resource needs. (Year 3)

HEALTH LITERACY AND HEALTH EDUCATION

In collaboration with the COA Food Policy Manager, UT Public Health graduate students are developing a report on best-practice examples from other comparable cities about how to implement healthy food procurement. In addition, a plan has been developed to implement focus groups within the COA to look at how current healthy vending policies are working. *(Strategy 2.3.1, see Appendix B for complete strategy.)*

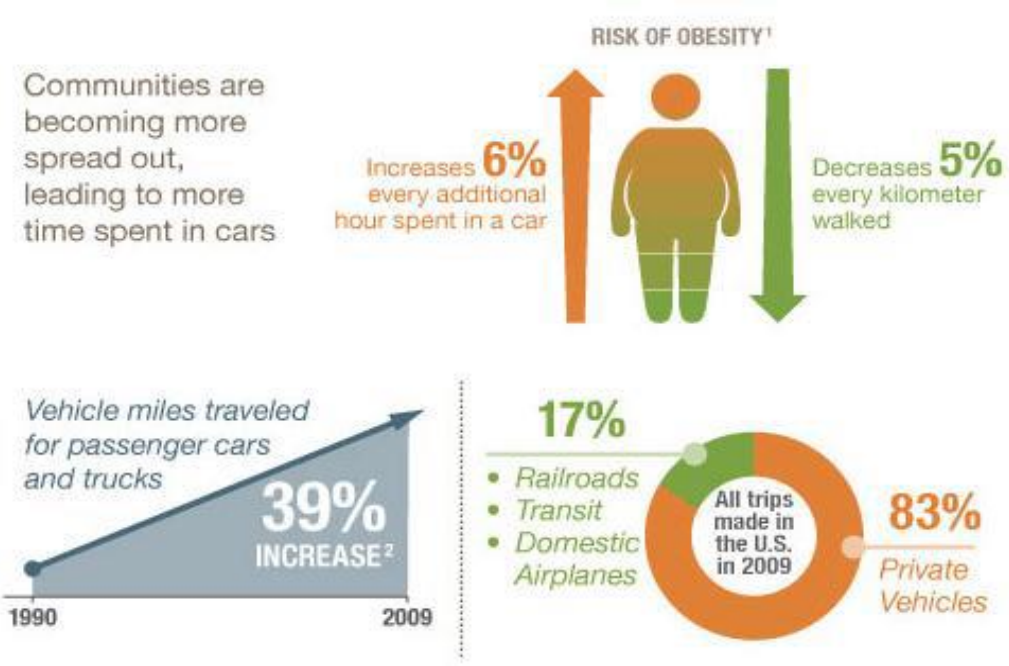
BUILT ENVIRONMENT: FOCUS ON TRANSPORTATION

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

BACKGROUND

Car-centric transportation systems have a hidden health cost. According to the American Public Health Organization, health expenditures due to collisions, air pollution, and physical inactivity resulting from automobile use cost hundreds of millions of dollars each year. Oftentimes, these health costs are not considered in transportation policy and planning decisions.[17]

- Community members and researchers alike agree that the creation of built environments that support healthy eating and active living is essential for good health.[18]



- The public health community recommends that adults spend at least 30 minutes each day being physically active, and recognize that physical activity resulting from utilitarian purposes- such as walking or bicycling to work or school- can help populations achieve their physical activity goals. According to the Austin/Travis County 2012 CHA, a majority of Travis County workers (79.0%) drive alone to work, and approximately one in five adults (20.5%) in the county indicate that they engage in no physical activity.[19]

CHA focus group participants indicated that "activating" green spaces, creating environments that support walking and biking, connecting parks, trails, and paths, creating directional signage on how to get there and use them, and having affordable resources and programs within walking distance of home are key to helping them achieve physical activity levels.[20]

- Density and street network connectivity are essential to the creation of high quality transit systems. Research also shows that route directness (a result of street network connectivity) and land used mix are related to greater rates of walking and bicycling, and walking and bicycling for transportation is approximately five times more common in high density versus low-density areas.[21] Therefore, communities that prioritize mixed land uses, density, and connectivity make it more convenient for individuals to use active transportation to go about their daily needs.
- Policies that promote alternative forms of transportation are critical to households that cannot or would prefer not to rely on a car to access food, employment, healthcare, and other essential services. According to the 2012 Austin/ Travis County Community Health Assessment, as many as 1 in 8 Austin households in certain Census tracts lack access to an automobile.[22]

SUCCESS STORIES

Active Transportation

Smart Trips, a pilot program to promote the use of active transportation, has been launched in North Central Austin thanks to a 15-month, $100,000 grant from the American Planning Association. The grant is a collaborative effort four City of Austin Departments (HHSD, PDR, ATD, and OoS) and Capital Metro. This grant will provide education on several issues related to health in the Rundberg area, including active transportation. (Strategy 3.1.1, see Appendix B for complete strategy.)

Educate, Incentivize, and Encourage the Use of Active Transportation

The Community Advancement Network (CAN) assisted with the development of a baseline for active transportation commute share mode by including American Community Survey commuting mode-share data under the "Vehicle Miles Traveled" indicator within their Community Dashboard for Austin/Travis County. *(Strategy 3.1.1.*, see Appendix B for complete strategy.*)*

Active Transportation Safety

A Vision Zero Traffic Safety Task Force has been formed with the goal of reducing the number of traffic fatalities and serious injuries to zero. The Task Force is made up of a diverse agency and

public stakeholder group that convenes around traffic safety themes/data in order to assess Austin's current problems and identify opportunities for improvement. The Task Force's findings are expected to be presented to City Council by end of 2015. *(Strategy 3.1.2, see Appendix B for complete strategy.)*

Identifying Funding Sources

UT School of Public Health master's student Tira Hanrahan successfully updated an inventory of existing active transportation plans across agencies and organizations within Austin/Travis County. Included in her update to the inventory was the identification of resources needed to implement the particular plans, and a description of potential funding sources, including traditional (federal, state, and local grants) and non-traditional (crowdfunding, TIFs, VMT fees, etc.) approaches to funding. *(Strategy 3.2.1, see Appendix B for complete strategy.)*

The City's long range CIP Strategic Plan includes active transportation as a component of its inputs for the 2015-2016 Long-Range CIP Strategic Plan updates. Coordination with CHIP lead area planners took place over the summer 2015 to identify data sets to represent the CHIP in the COA FY 2016-17 Long-Range CIP Strategic Plan. *(Strategy 3.2.1, see Appendix B for complete strategy.)*

CHALLENGES/LESSONS LEARNED

Incorporating Active Transportation into New Development/Incentivizing Development that Includes Active Transportation

While appropriate points of contact for area municipalities were obtained, the same is not true for development community contacts, and it's unclear how completion of this component of the Strategy can/should be measured. This strategy was evaluated for rewording in the Year 3 Action Plan update. *(Strategy 3.3.2 , see Appendix B for complete strategy.*

The priority area had difficulty in identifying key points of contact for policy adoption related to this strategy. Imagine Austin workgroup members attended the Year 3 CHIP Planning Summit to help progress this strategy and others. In addition, a meeting with the COA's Transportation Department Director and the CHA/CHIP chair was held. As a result of this meeting, staff from the transportation department is expected to join the CHA/CHIP process and help progress this and other strategies during Year 3 of the CHIP. *(Strategy 3.3.3*, see Appendix B for complete strategy.*)*

NEXT STEPS

Incorporating Active Transportation into New Development
CAN (Community Advancement Network) will be holding a Regional Forum in September 2015, which will discuss a number of important regional issues, including transportation and housing. Members of the planning committee for this forum have begun discussions with CAN to leverage this opportunity to accomplish action steps for this objective and its strategies.

Incentivize Development that Includes Action Transportation
The administrative draft of the revised Land Development Code is expected to be ready in November 2015. This will be an internal draft for staff review and comment. The public draft is expected to be ready in the summer of 2016. These dates are tentative due to ongoing negotiations. The seven Imagine Austin priority program project managers, including Cassie DeLeon for Healthy Austin, have been asked to provide input and feedback on the CodeNEXT work products. It is anticipated that many of the CHIP goals, including for active transportation, will be facilitated by the implementation of CodeNEXT.

HEALTH LITERACY AND HEALTH EDUCATION

Capital Metro, in collaboration with UT School of Public Health Austin Regional Campus, engaged a student to update the inventory of existing active transportation plans and identify gaps and prioritizing needs of the disadvantaged. The inventory was completed in July of 2015. Resources needed to implement active transportation plans identified in the above-mentioned inventory were identified *(action step a)*. This action steps was identified as "health literacy and health education" because it demonstrates awareness on behalf of the Austin/Travis County community about population health and the importance of understanding infrastructure gaps and prioritizing the needs to the disadvantaged. In short, this is an example of the stakeholder's in the community improving their health education.

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

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

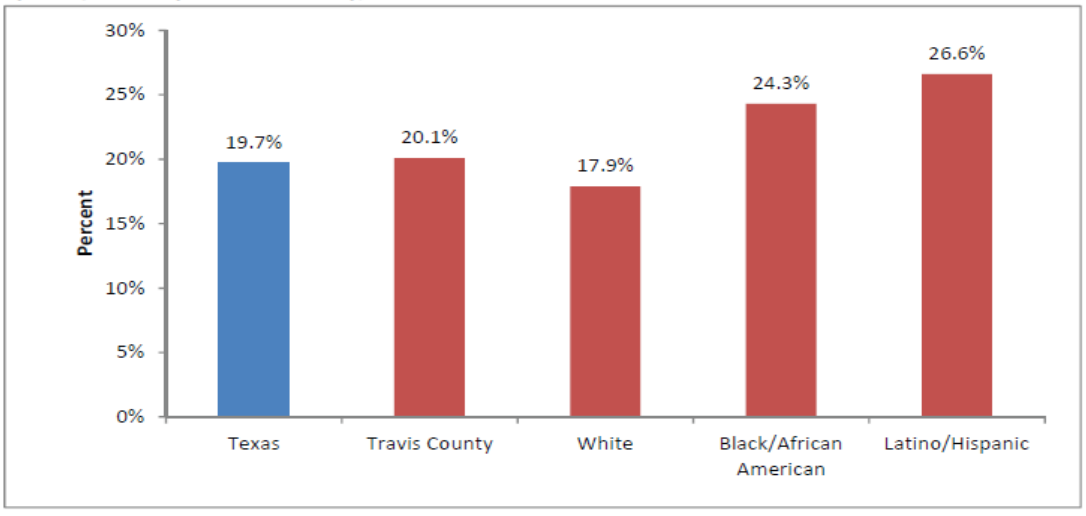
BACKGROUND

As reported in the 2012 Austin/Travis County Community Health Assessment:

> Approximately 20% of adults in Travis County reported experiencing five or more days of poor mental health in the past month.[23]
>
> In Travis County, a greater number of Latinos/Hispanics (26.6%) and Blacks/African Americans (24.3%) experienced five or more days of poor mental health compared with Whites (17.9%).[24]
>
> Texas ranks 49th in per capita mental health funding at $ 34.6 per person, well below the national average of $103.50.[25]

- Integration between primary health care and behavioral health care can improve the treatment of behavioral health issues. Successful integration requires the support of a robust primary care delivery system.[26]

Figure 42: Percentage of Adults Reporting 5+ Days in Past Month of Poor Mental Health in Texas and by Race/Ethnicity in Travis County, 2008-2010



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

- Based on BRFSS data from 2008 to 2010, 80.9% of adults in Travis County reported having private or public health care coverage this coverage period. Only 58.6% of the Latino/Hispanic population reported having health care coverage and 73.4% of the Black/African American population reported having health care coverage.[27]

SUCCESS STORIES

Austin/Travis County has been fortunate to receive federal funding through the Medicaid 1115 Waiver program, making possible dozens of new and expanded healthcare projects. The CHIP's Access to Care Area is aligned with these projects and many of the following success stories are due to this funding. For more information about the 1115 Waiver, go to www.hhsc.state.tx.us/1115-waiver.shtml or www.texasrhp7.org.

Community Care Collaborative (CCC) served 59 women with similar gestational ages. These women meet together, learn care skills, participate in a facilitated discussion, and develop a support network with other group members. *(Strategy 4.1.1, see Appendix B for complete* strategy.)

Austin/Travis County Health and Human Services Department (A/TCHHSD) has implemented a peer-to-peer pregnancy prevention program to address Latina teen pregnancy. At least 260 youth were served. Six of those served were trained as Peer Educators. From October 1, 2014 - March 31, 2015, 126 youth were served. (*Strategy 4.1.1, see Appendix B for complete strategy.*

Improved Access to Service
Austin Travis County Integral Care increased access to behavioral health services by establishing a new outpatient clinic in south-southeast Austin, which provided integrated primary and behavioral health care for over 2,100 unduplicated individuals as of March 2015. The high demand for services demonstrates the importance of continuing to develop integrated models of access that meet community needs. *(Strategy 4.1.5, see Appendix B for complete strategy.)*

University Medical Center Brackenridge (UMCB) successfully opened the Seton Psychiatric Emergency Department (SPED) on April 29, 2014. The Department is well ahead of schedule for meeting all of its required metrics. The Provider continues to meet monthly with community partners/stakeholders providing services to individuals with behavioral health needs to ensure the SPED will complement existing crisis stabilization services within the community. *(Strategy 4.1.5, see Appendix B for complete strategy.)*

Additional Access to Care for the Safety Net
The Community Care Collaborative (CCC) expanded hours at several clinics as well as opened the new Southeast Health and Wellness Center location which offered additional access to care for the safety net. Over 116,300 encounters were provided at this clinic as of March 2015. (*Strategy 4.1.5, see Appendix B for complete strategy.)*

Residency and Training Programs
University Medical Center Brackenridge (UMCB) successfully recruited qualified faculty to support the additional trainees and the development of a sustainable resident training program with increased focus on patient engagement and patient-centered care. UMCB successfully expanded the

clinical interventions that psychiatry residents have been able to provide to the community and continues to seek out opportunities for future expansion. This project is on track to meet its targets. The eight students who started in fall 2014 passed Level I and are doing well in Level II this semester. Nine new students enrolled in the spring 2015 semester and are progressing well. *(Strategy 4.3.1, see Appendix B for complete strategy.)*

Capital IDEA signed an MOU with Austin Community College (ACC) to increase their capacity to train additional students through the Associate Degree in nursing curriculum. In the fall of 2014, 8 students enrolled in ACC with the intention of working in a Medically Underserved Area after graduation. (*Strategy 4.3.1, see Appendix B for complete strategy.)*

Telemedicine

Three Austin Travis County Integral Care clinic locations are providing telemedicine encounters to ensure that more people can access care. Integral Care provided 1,277 telemedicine encounters between October 1, 2014 and September 30, 2015. This project has become well integrated into Integral Care's service delivery, helping to reduce wait times for access to prescriber services. Consumers and staff have adapted well to this model of care and consumer satisfaction surveys indicate consistently high satisfaction rates. *(Strategy 4.3.2, see Appendix B for complete strategy.)*

University Medical Center Brackenridge (UMCB) successfully rolled out operational capacity to all Travis County Seton facilities. UMCB has developed an internal network of psychiatrists to conduct telemedicine consults after hours and on weekends in Travis County as well as initiated several pilots that will expand telemedicine to new sites. UMCB also established an intranet page for telemedicine services to act as a resource for staff utilizing the service and developed and distributed a provider satisfaction survey for psychiatric telemedicine services. As a result of this project, 734 psychiatric telemedicine consults were provided in the first year of the project. During the remainder of this year, UMCB will focus on continuous quality improvement. *(Strategy 4.3.2, see Appendix B for complete strategy.)*

St. David's telepsychiatry program is focusing on crisis situations in the Emergency Department. Success stories related to this project include an improved relationship between Social Workers and Psychiatrist leading to greater likelihood of adoption of social service recommendations. The project successfully expanded the availability of psychiatrists. *(Strategy 4.3.2, see Appendix B for complete strategy.)*

The Community Care Collaborative (CCC) implemented telepsychiatry at ten clinic sites by providing equipment and training staff in the telepsychiatry model. (*Strategy 4.3.2, see Appendix B for complete strategy.)*

Certified Safety Net Health Care Providers

Community Care Collaborative' s (CCC) work to construct a "neighborhood" of patient-centered homes has resulted in the creation of a Patient Experience Survey Plan; the generation and adoption of CCC Patient Centered Medical Home (PCMH) principles; and thousands of CCC patients seen under these PCMH principles. One FQHC has received accreditation and the local multi-site FQHC is preparing to submit its application. (*Strategy 4.4.1, see Appendix B for complete strategy.)*

Use of Evidence-Based Models
The Chronic Care Management Model was launched as the Community Care Collaborative CCC developed, approved, published and implemented clinical care protocols for diabetes and hypertension. The CCC's clinical steering committees also developed protocols for depression and anxiety. *(Strategy 4.5.1, see Appendix B for complete strategy.)*

Austin Travis County Integral Care's Integrated Primary Care and Behavioral Health Clinic is:

- Using the Plan-Do-Study-Act model to implement and test strategies to improve access and engagement and decrease no-show rates
- Reviewing patient flow protocols and needs in order to develop a tracking tool to measure efficiency

Behavioral Health in Manor, Pflugerville, and Del Valle ISDs
Austin Travis County Integral Care and primary care partners provide integrated primary and behavioral health care to youth in the Manor, Pflugerville, and Del Valle Independent School Districts (ISDs). Integrated care was previously unavailable in these locations, so parents often were forced to take time from their jobs and take children out of school in order to access the care they need. This project has therefore greatly expanded children's access to primary and behavioral health care in outlying regions of the county. The ability to access care in a school setting also reduces stigma. Together, these programs are helping kids stay healthy and improving their overall school experience.

(Strategy 4.5.1, see Appendix B for complete strategy.).

Focus on individuals with multiple complex medical conditions
The Community Care Collaborative (CCC) projects working in this area have made significant impact on those with multiple complex medical conditions through the creation of a disease management registry, implementation of telepsychiatry, development of a chronic care management model and community paramedic efforts to divert individuals from emergency departments. *(Strategy 4.5.3, see Appendix B for complete strategy.).*

Highlights include:
– Enrollment of over 6,000 patients into a disease management registry,
– 10 clinics with telepsychiatry,
– Development of protocols for chronic diseases and enrollment of over 3,500 patients in the care management model, and
– Additional staff and vehicles for the community paramedic program

Austin Travis County Integral Care's Behavioral Health Prescriber Expansion project has expanded access, enabling more people with serious and persistent mental illnesses to engage in ongoing services. Additional prescribers have allowed for expanded clinic hours during which individuals can be seen and prescribed any necessary psychiatric medications. This increase in access improves

individuals' experience of care and helps them achieve improved health outcomes. *(Strategy 4.5.3 e, see Appendix B for complete strategy.)*

As part of Austin Travis County Integral Care's efforts to improve care and provide appropriate community-based services and supports for individuals diagnosed with both an intellectual and/or developmental disability and a mental illness, Integral Care staff have received START (Systemic, Therapeutic, Assessment, Resources, & Treatment) training and certification. Staff on this project work collaboratively with many other organizations, providing outreach and training to help caregivers and others become better-equipped to respond to individuals' needs. This helps to avoid crises and enables individuals to continue to receive care in the community, rather than in costly emergency or criminal justice settings. To further educate stakeholders about the mental health needs of individuals with intellectual and/or developmental disabilities, Integral Care hosted a symposium and training in which more than 100 professionals participated. The training featured national experts on the specific needs of this population, including therapeutic group engagement, collaborative service planning and medication regimens. *(Strategy 4.5.3 f, see Appendix B for complete strategy.)*

Dell Children's Medical Center is implementing a project focused on Chronic Care Management for pediatrics. A Primary Care Provider (PCP) case review process has been established to ensure pediatricians are kept up to date on their patients. The provider used rapid cycle and continuous improvement to minimize wait times from enrollment to first intervention, improve family engagement through utilization of Liberating Structures approach to group participation, and reducing specialist office visits through the implementation of specialist case reviews. Over 230 pediatric patients have been served with greater than 85% being Quantifiable Patient Impact eligible. The program continues to refine health care delivery, both in the primary care medical home setting and the community pediatrician setting. The program continues to provide wrap-around individualized care for the child and family. Individualized treatment plans are developed for the child and family to increase the number of "well days." Support systems have been formed among families who share similar challenges; this methodology is referred to as "Centering". Additional group meetings called "anchoring" are provided to maintain family engagement, solidify relationships and assist families in maximizing the overall function of the child's support system. *(Strategy 4.5.3 h, see Appendix B for complete strategy.)*

Provider at University Medical Center Brackenridge (UMCB) utilized the multidisciplinary model for the Diabetes Chronic Care Management program and continued to implement process changes to this model in order to meet performance goals. Quality diabetes care management and education is being provided to patients and their families. The provider communicates care to outpatient Primary Care Provider (Strategy 4.5.3i, see Appendix B for complete strategy).

University Medical Center Brackenridge's (UMCB) Care Transition Project Provider established a dedicated liaison with case management, increased data accuracy and integrity, increased services delivered to the patient during the hospital visit, initiated patient group education classes and added after hours triage coverage. 1,532 patents were served as of January 2015 (Strategy 4.5.3j, See Appendix B for complete strategy).

For the adult chronic care management program, University Medical Center Brackenridge (UMCB) collaborated with Seton's psychiatry department to develop a fellowship with Seton Total Health Partners; this new service will help address psychosocial needs and barriers to care. Provider also expanded available services by implementing Point of Care Testing (POCT), EKG screening, and telemedicine capability within the clinic as well as contracting with Austin Radiological Association to provide complex imaging services to program patients. 790 patients have been served. Provider continues to work with clinical and administrative leadership at an organizational level to design a process that will allow patients to receive necessary laboratory and imaging services as outpatients in order to reduce costs to the care delivery system. UMCB has identified opportunities for improvement in operational processes that will decrease the amount of staff time spent on non-patient care activities. Project leadership has also actively pursued partnerships within the network and within the community to increase patient access to necessary services and improve the coordination of care throughout the continuum (Strategy 4.5.3k, see Appendix B for complete strategy).

As of September 30, 2014, Austin/ Travis County Health and Human Services (A/TCHHSD) provided 15 individuals with Assertive Community Treatment (ACT) for Permanent Supportive Housing. Of those 15, ten were housed by September 30, 2014. By expanding the original 1115 ACT project, 16 additional individuals were able to receive services from the ACT team. Of those 16, an additional seven were housed by September 30, 2014. As of March 31, 2015, 21 new individuals are receiving ACT team services. Services for 5 of these individuals are provided through the 4-year ACT program and 16 are receiving services through the ACT expansion program. *(Strategy 4.5.3 i, see Appendix B for complete strategy.)*

CHALLENGES/LESSONS LEARNED

Future Funding of the 1115 waiver is uncertain

On October 1, 2015, local 1115 providers began their final year of the initial 5-year 1115 Waiver. Without successful negotiations of an extension and/or renewal between the Texas Health and Human Services Commission and the Center for Medicare and Medicaid Services, no additional 1115 Waiver funding would be available

Coordination of a large complex multifaceted healthcare system

Many factors impact healthcare and healthcare outcomes, to name a few patient navigation, health insurance status, hospital funding, mental health, behavioral health and social services. Many of these areas are undergoing innovations due to the Affordable Care Act and 1115 waiver, which as a major funding source, significantly shaped these areas over the past couple of years. Due to these forces of change and the already complex nature of the healthcare system, implementing a Community Health Improvement Plan (CHIP) focused on primary care and mental/ Behavioral Health Services proved to be difficult.

NEXT STEPS

Linguistically Competent and Culturally Appropriate Providers
University Medical Center Brackenridge (UMCB) continues to operationalize video remote interpretation with the new device of choice by Ascension Health Information Services (AHIS), the Samsung Tablet. UMCB looks forward to working in close collaboration with AHIS partners and hope that these goals will be completed in a timely manner. UMCB will implement the online training module and continue to extend training opportunities to address special population needs such as the LGBT community and victims of human trafficking.

Residency and Training Programs
University Medical Center Brackenridge (UMCB) continues to work with stakeholders on recruitment targets and strategies for both faculty and trainees.

Other strategies will be part of the Year 3 CHIP Implementation:

Strategy 4.4.2 Expand community navigation staff with access to Health Information Exchange (HIE) data across entire healthcare delivery system defined as contributors to ICare.

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

Health Literacy and Health Education

There are several success stories to highlight from community partners addressing health literacy and education as part of patient centered strategies. Medicaid 1115 Transformation Waiver has been instrumental in making progress on the strategies and action steps of Objective 4.1, under Priority 4. *(Objective 4.1, see Appendix B for complete objective.)*

Linguistically Competent and Culturally Appropriate Providers
Language services were expanded to the Seton Healthcare Family. There were at least 23,432 interpreter encounters with patients.

University Medical Center Brackenridge (UMCB) continues to operationalize video remote interpretation with the new device of choice by Ascension Health Information Services, the Samsung Tablet. The provider is working in close collaboration with Ascension Health Information Systems (AHIS) and the language services vendor to improve delivery of interpretation, translation services and expand language services across Seton Healthcare Family. The provider has added two more Spanish professional healthcare interpreters and one American Sign Language interpreter to the project team.

University Medical Center Brackenridge (UMCB) hired two culturally competent training specialists, and operationalized the training of 800 staff. Because of this project, patients had 256,215 encounters with trained providers in the first year of the project.

Austin Travis County Integral Care has developed a training structured to promote healthcare equity through a cultural competency curriculum that includes education on customer service and personal wellness. Over 100 employees received training in 2015, and ultimately cultural competency training will be provided to all employees. Four staff (3 peers, one parent partner) were hired and trained to

facilitate consumer engagement and consistently collect satisfaction data at 4 clinic sites. The curriculum undergoes repeated customization based on feedback from staff completing the training and training ratings in evaluations have risen with each successive iteration.

APPENDIX A

SUMMARY OF CHIP ANNUAL UPDATE PERFORMANCE INDICATORS

Summary of CHIP Year 2 Annual Update Indicators							
	Year of Data Used					Target	Data Source
	2008-2010	2011	2012	2013	2014	2016	
Priority One: Chronic Disease Focus on Obesity							
Percent of adults with obesity (BMI >=30) in Travis County	24%	19.1%	23.6%	23.3%	20.5%	22.8%	Behavioral Risk Factor Surveillance System (BRFSS)
Number of mother-friendly worksites in Travis County	---	---	61	326*	---	64	Mother-Friendly Worksite Program Directory
Priority Two: Build Environment Focus on Access To Healthy Foods							
Percent of low-income residents who are not living within 1 mile of a grocery store in Travis County		---	9%	8%	8%	N/A	County Health Rankings
Percent of adults reporting eating 5+ servings of fruits and vegetables/day in Travis County		23.9%	---	18.4%	---	N/A	Behavioral Risk Factor Surveillance System (BRFSS)

Summary of CHIP Year 2 Annual Update Indicators								
		Year of Data Used					Target	Data Source
		2007-2009	2010-2012	2011-2013	2011	2013	2016	
Priority Three: Build Environment Focus On Transportation								
Percent of adults who use active transportation to commute to work	Total percentage of active transportation	18.8%	17.8%	17.5%			37.8%	American Community Survey
	Carpooled	11.9%	10.8%	10.5%			N/A	
	Public Transportation	4.2%	3.5%	3.4%			N/A	
	Bicycle	0.9%	1.2%	1.3%			N/A	
	Walked	1.8%	2.4%	2.3%			N/A	
Percent of adults that engage in aerobic physical activity for 150 minutes per week in Austin/Travis County					51.1%	48.9%	56.1%	Behavioral Risk Factor Surveillance System (BRFSS)

Summary of CHIP Year 2 Annual Update Indicators							
	Year of Data Used				Target	Data Source
	2011	2012	2013	2014	2016	
Priority Four: Access to Primary Care and Mental/Health Behavioral Health Services Focus on Navigating the Healthcare Systems						
Funded ACGME/AOA Resident Physicians	4911	5022	5246	5456	N/A	Texas Higher Education Coordinating Board
Percent of adults reporting FIVE or more days of poor mental health over a one month period	17.0%	---	21.7%	16.3%	N/A	Behavioral Risk Factor Surveillance System (BRFSS)

APPENDIX B

SUMMARY OF CHIP Y2 OBJECTIVES AND STRATEGIES

Year 2 Action Plan PRIORITY AREA 1: Chronic Disease- Focus on Obesity	
Goal 1:	**Reduce burden of chronic disease caused by obesity among Austin/Travis County residents.**
Objective 1.1:	**By June 2016, increase by 5% the percentage of adults and children in Travis County who meet or exceed physical activity guidelines for health.**
Strategy 1.1.1	Increase opportunities to utilize local school facilities, fields, basketball courts, community recreational facilities, parks, play grounds, etc. by establishing new shared- use agreements and improving adherence to existing shared- use agreements by focusing on disparate populations.
Strategy 1.1.2	Engage the community to create opportunities for physical activity in the built environment through multiple settings (incl. worksites, places of worship, schools, parks, neighborhoods).
Strategy 1.1.3	Conduct a community-wide physical activity media campaign that promotes physical activity and provides concrete steps on how to do so (e.g. walk or bike with your kids to take them to school instead of driving).1
Objective 1.2:	**By June 2016, increase the number of Travis County workplaces that have family supportive breastfeeding by 5%.***
Strategy 1.2.1:	Promote mother friendly worksite breastfeeding policy
Strategy 1.2.2:	Increase sensitivity for breastfeeding in the workplace through employee/employer training, flexible work schedule, etc.
Strategy 1.2.3	Increase awareness of breastfeeding benefits across the community through media and community campaign.
Objective 1.3:	**Increase the number of healthcare organizations with breastfeeding supportive policies.**
Strategy 1.3.1	Promote the model policies that were developed in year 1
Objective 1.4:	**Increase by 5% the number of Travis county early child care settings that promote healthy eating + physical activity. (Added new objective re: out of school setting.)**
Strategy 1.4.1	Promote adoption of policies and practices related to healthy eating and physical activity in early child care settings
Objective 1.5:	**Increase by 5% the number of Travis county out of school settings (elementary – middle school) that promote healthy eating + physical activity.**
Strategy 1.5.1	Promote adoption of policies and practices related to healthy eating and physical activity in early child care settings
Objective 1.6:	**By June 2016, reduce the percentage of children and adults who consume sugar sweetened beverages (SSB) by 5% (as defined by BRFSS.**
Strategy 1.6.1	Increase the number of public and private locations with food procurement policies that reduce access to SSB.
Strategy 1.6.2	Increase the number of public and private locations that promote the availability of non-bottled drinking water.

[1] Media campaign was identified as cross cutting action step

Year 2 Action Plan PRIORITY AREA 2: Built Environment – Focus on Access to Healthy Foods	
Goal 2:	**All in our community have reasonable access to affordable, quality, nutritious foods.**
Objective 2.1:	**By June 2016, increase by 50% access to participation of eligible people in food assistance programs (ex. SNAP, WIC, school breakfast and lunch program, summer food service, Elderly Nutrition Program) that increase access to healthy food.**
Strategy 2.1.1	Conduct assessment to establish baseline of the following: A. Current programs and services to determine which do support access to healthy foods B. Current capacity of relevant programs C. Participation (#/%) in relevant programs to determine which could absorb additional participants versus those that would require additional capacity before further enrollment could take place D. Gap analysis – population, geographic areas that are underserved – to understand what barriers seem to prevent participation and what means exist to overcome those barriers. E. Utilize State of the Food System Report from the Office of Sustainability for food insecurity information.
Strategy 2.1.2	Work with government and local community organizations to increase ease of access to food assistance program applications, local offices, and eligibility requirements so as to connect as many people to benefits as possible (application assistance, use electronic applications or call centers, roving case workers, Benefits Bank, extending office hours, additional accommodations to applicants with language barriers or disabilities). Programs to be targeted will be identified through the assessment process described in strategy 2.1.1.
Strategy 2.1.3	Develop and implement an education/outreach strategy to increase the reach of Food Assistance Programs (as identified in 2.1.1) by enhancing awareness of the program's existence, eligibility requirements, and benefits may include: radio ads, brochures, community education, cooking demonstrations, community partnerships and retailers. A. Increase demand for nutritious food B. Reduce stigma of participation
Strategy 2.1.4	Increase capacity of quality programs. (Year 3)
Objective 2.2:	**By June 2016, ensure that 2 new distribution and production points for healthy foods are available and accessible in each of the high need areas.**
Strategy 2.2.1	Implement assessment to inform strategies and targeting a) where people travel/gather and b) where and what food is available.
Strategy 2.2.2	Build partnerships (with schools, parks, faith-based community, businesses, community centers, etc.) to establish distribution and production sites (e.g., community gardens, farmers' markets, farm to site programs) in public or private spaces and organizations. (Coordinate with 2.1.2)
Strategy 2.2.3	Incentivize private enterprise to provide healthy, nutritious, and affordable food by establishing full-service grocery stores in low-income communities.
Strategy 2.2.4	Develop/implement education/messaging strategy to a) increase demand and b) ensure cultural relevance
Objective 2.3:	**By June 2016, develop recommendations for city/county government and industry to promote access to healthy food and beverages in retail settings.**
Strategy 2.3.1	Research case studies of established programs and engage with key informants to find lessons learned, progress/impact and sustainability of healthy food retail initiatives.
Strategy 2.3.2	Develop an outreach plan to business owners/industry to discuss potential opportunities to promote healthy, affordable food and beverages.
Strategy 2.3.3	Identify resources to expand capacity in the development of a healthy food retail initiative (HFRI). (Year 3)

Year 2 Action Plan PRIORITY AREA 2: Built Environment – Focus on Access to Healthy Foods	
Goal 2:	**All in our community have reasonable access to affordable, quality, nutritious foods.**
Strategy 2.3.4	Create a menu of strategies to implement healthy food retail along with potential impact and resource needs. (Year 3)

Year 2 Action Plan PRIORITY AREA 3: Built Environment - Focus on Transportation	
Goal 3:	**Local and regional stakeholders will collaboratively increase accessibility to community resources via safe, active transportation.**
Objective 3.1:	**By 2016, increase Travis County Active transportation commute mode share by 1%.**
Strategy 3.1.1	Work with school districts, community colleges, universities, businesses, and city and county governments to implement programs that educate, incentivize, and encourage the use of active transportation (i.e., public transportation, walking, biking, and carpooling) among commuters with a specific target on the disadvantaged.
Strategy 3.1.2	Enhance enforcement of/compliance with existing policies/laws that ensure the safety of active transportation users
Strategy 3.1.3	Develop and implement policies that level the playing field between active transportation and other modes of transportation (e.g. Changes to parking policies to reflect the true cost of providing the real estate to allow this function; Dedicating travel lanes on public right-of-ways (where appropriate) to allow transit travel times to be competitive with the private cars, etc.)
Objective 3.2:	**By June 2016, our community through its local authorities will coordinate funding plans for implementation of the active transportation master plans (i.e., sidewalks, bike, trail and transit).**
Strategy 3.2.1	Develop partnerships with municipal and county departments to identify potential funding sources for implementation of active transportation plans (e.g., federal, state, municipal, county and private)
Objective 3.3:	**By 2016, municipalities and unincorporated Travis County will establish standards and incentives for active transportation connections for all new development outside of the activity centers identified in local and regional plans.**
Strategy 3.3.1	Convene municipal governments, unincorporated Travis County, and the development community to incorporate active transportation into new development and increase connectivity with existing development.
Strategy 3.3.2	Identify and modify policies in Travis County municipalities and unincorporated Travis County to incentivize development that includes active transportation. (REVISED)
Strategy 3.3.3	Adopt a policy to require accommodation for active transportation in new public facility location decisions.
Strategy 3.3.4	Work with government and non-government organizations to implement a complete streets policy in the municipalities and Travis County.

Year 2 Action Plan PRIORITY AREA 4: Access to Primary and Mental/Behavioral Health Services – Navigating the Healthcare System	
Goal 4:	**Expand access to high-quality behaviorally integrated patient centered medical homes for all persons.**
Objective 4.1:	**By June 2016, increase the adoption of patient-centered strategies within the safety net.**
Strategy 4.1.1	Expand the number of providers serving the safety net that are linguistically competent and expand the number of providers serving the safety net that are culturally appropriate.
Strategy 4.1.2	Expand the # of safety-net health care providers that are joint commission or NCQA certified medical homes. (Year 3)
Strategy 4.1.3	Expand health literacy training to # of unduplicated patients served by Travis County safety net providers. (Year 3)
Strategy 4.1.4	Training # if providers at each participating agency on health literacy principles and effective patient-provider communication strategies. (Year 3)
Strategy 4.1.5	Expand the number of providers serving the safety net who have locations, contact points, hours and appointment availability that meet the needs of that population.
Objective 4.2:	**By June 2016, expand by 10% the number of entities serving safety net populations that are utilizing health IT systems. – In Year 1 of the CHIP it was noted that those serving the safety net population were in process or already adopted health IT systems.**
Objective 4.3:	**By June 2016, expand by 5% primary care and behavioral/mental health workforce capacity who will care for safety-net population.**
Strategy 4.3.1	Increase the size of residency and training programs for primary and mental/behavioral health care providers (including physicians, nurses, social workers, and others).
Strategy 4.3.2	Implement and expand the number of locations telemedicine is offered to increase access to MH/BH services.
Objective 4.4	**By June 2016 increase the adoption of coordination strategies among partner agencies within the safety net. (REVISED)**
Strategy 4.4.1	Expand the number of safety net health care providers who are Joint Commission or NCQA certified medical homes.
Strategy 4.4.2	Expand community navigation staff with access to HIE data across entire healthcare delivery system defined as contributors to ICare. (Y3)
Strategy 4.4.3	Increase the knowledge of existing health and social service resources among providers and the community. (Y3)
Objective 4.5	**By June 2016 expand comprehensive care strategies among the partner agencies within the safety net. (REVISED)**
Strategy 4.5.1	Increase the use of evidence based models to integrate primary and mental/behavioral care, including substance use disorders.
Strategy 4.5.2	Expand the # of safety-net health care providers that are Joint Commission or NCQA certified medical homes. (Year 3)
Strategy 4.5.3	Increase the ability of safety net providers to treat and manage complex co-occurring medical conditions.

APPENDIX C

LIST OF YEAR 3 CHANGES TO THE AUSTIN/TRAVIS COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

The changes the Steering Committee will be asked to vote to accept or reject in the addition of underlined words and removal of words that have a line through them.

Priority 1: Chronic Disease Focus on Obesity

- New Objective: Implement evidence-based clinical system changes to decrease the number of obese adult patients in CommUnity Care by June 2016

Priority 2: Built Environment focus on Access to Healthy Foods

- No change to the strategies and objectives

Priority 3: Built Environment focus on Transportation

- Revised Objective 3.3: Establish standards and incentives for active transportation connections for all new development inside of the activity centers identified in the local and regional plans, with emphasize on municipalities and areas outside the city of Austin.
- Revised Strategy 3.3.2: Identify and modify policies to require and/or incentivize development that include active transportation infrastructure, with emphasize on municipalities and areas outside the city of Austin.
- Revised Strategy 3.3.3: Adopt, implement and/or enforce policies to require accommodation for active transportation in new public facility and site location decisions

Priority 4: Access to Primary Care and Mental Health/Behavioral Health Services focus on improving access to primary care, focus on navigating the healthcare system.

- Revision Strategy 4.1.2: Increase the number of safety-net health care providers that achieve and maintain Joint Commission or National Committee for Quality Assurance (NCQA) certified medial home status.
- Revised Strategy 4.1.4: Increase health and social service providers who are trained on health literacy principles and effective patient-provider communication strategies.

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