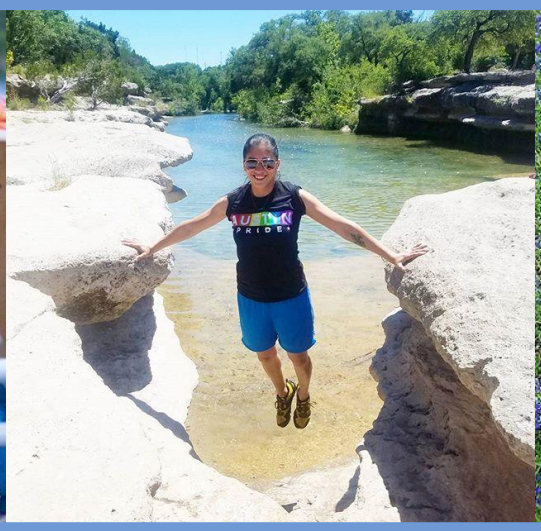
Community Health Improvement Plan

Austin/Travis County, Texas

August 2018

Year 1 Action Plan



Together We Thrive

Austin/Travis County Community Health Plan

Austin/Travis County
2018 Community Health Improvement Plan
Year 1 Action Plan

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Year 1 Action Planning for Implementation

The Austin/Travis County Community Health Improvement team, including the core agencies, CHIP workgroups, partners, stakeholders, and community residents, finalized the 2018 CHIP by prioritizing strategies for Year 1 (Y1) implementation, developing specific 1-year action steps, assigning lead responsible parties, and identifying resources for each priority area. These components form the Year 1 Action Plan for the CHIP represented in this document.

The CHIP workgroups, under the leadership of the chairs/co-chairs listed below, will work collaboratively with partners, stakeholders and community residents to implement the action steps outline in this Action Plan.

Priority Area	Chair/Co-Chairs
Priority Area 1: **Access to and Affordability of Health Care**	Vanessa Sweet, Central Health Liane Miller, Austin Transportation Department
Priority Area 2: **Chronic Disease**	Joel Gross, It's Time Texas Jill Habegger-Cain, COA Parks and Recreation Department *Core Partner: Stephanie Helfman, Austin Public Health*
Priority Area 3: **Sexual Health**	Joanna Saucedo, Austin Center for Health Empowerment Tara Carmean, Travis County Health and Human Services *Core Partner: Scott Lyles, Austin Public Health*
Priority Area 4: **Stress, Mental Health, and Wellbeing**	Rachel Toronjo, Central Health Mary Dodd, Integral Care *Core Partner: Laura Enderle, Austin Public Health*
To contact any of the Chair/Co-Chairs, please use the main CHA/CHIP mailbox: chachip@austintexas.gov	

Year 1 Action Plan At A Glance

Priority Area 1: Access to and Affordability of Health Care **Goal 1:** Every Travis County resident has access to culturally sensitive, affordable, equitable, and comprehensive health care.	
Year 1 Objectives	**Year 1 Strategies**
Objective 1.1 By 2023, increase the employment of certified Community Health Workers (CHWs) and service coordinators by 10% to help residents navigate the health care system and promote health literacy.	1.1.1 Explore funding/reimbursement options for CHWs from insurance providers or local funders, so that community health workers are able to pursue a career in community health work that includes benefits, networks of social support, flexible time off and a living wage. Allowing community health workers to be a stable presence in the community and receive sufficient funding to keep them employed.
	1.1.3 Establish or tap into an existing network for CHW/SCs to share learnings and experiences.
Objective 1.2 By 2023, increase enrollment in and use of eligible health care coverage and/or assistance programs by 10% for Travis County residents with household incomes at or below 200% Federal Poverty Level (FPL), ages 18-64	1.2.1 Utilize 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 educate 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, and Medicaid). Ensure clients are aware of special year around enrollment opportunities for life events.
Objective 1.3 By 2021, decrease no-shows for health care appointments at safety-net health care providers by 10%.	1.3.1 Work with transportation partners to expand and enhance transportation options (e.g., number of accessible vehicles in the region, variety of transportation options to health care) for members of the community who have difficulty reliably traveling to healthcare appointments.
	1.3.2 Advocate to expand care delivery in under resourced areas via options such as co-locating, building new facilities, and use of telemedicine.
	1.3.6 Promote awareness of existing transportation resources, including Capital Metro's Mobility Management program*, through a variety of communication avenues.
	1.3.7 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.

Priority Area 2: Chronic Disease **Goal 2:** Prevent and reduce the occurrence and severity of chronic disease through collaborative approaches to health that create environments that support, protect, and improve the well-being of all communities.	
Year 1 Objectives	**Year 1 Strategies**
Objective 2.1 Decrease the % of people who have risk factors leading to chronic disease by 10% by 2023.	2.1.1 Offer regular, free Community Fitness and "Healthy Living" classes (i.e. fitness, nutrition, etc.) at convenient times and diverse locations to reach target communities. Ensure that programming is culturally and linguistically appropriate.
	2.1.4 Engage worksites, schools, and early childhood education centers in developing comprehensive policies and programs that promote healthy nutrition, physical activity, tobacco free campus, and Mother Friendly worksites.
Objective 2.5 By 2023, increase by 5% the number of safe, accessible, equitable, and culturally competent assets and opportunities for healthy food and physical activity.	2.5.3 Utilize community member input to improve existing data of assets and opportunities available for physical activity (e.g., urban gardens, community gardens, green space, trails, parks, etc.) and increase access and awareness of these sites.
	2.5.7 Advocate for and support ongoing efforts (e.g. Vision Zero Action Plan) to develop and enhance safe, multimodal transportation options across the community, paying particular attention to efforts that increase healthy food access and opportunities for physical activity. Ensure that plans and development take into consideration issues of equity.

Priority Area 3: Sexual Health **Goal 3:** Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.	
Year 1 Objectives	**Year 1 Strategies**
Objective 3.1 By 2023, decrease youth pregnancy rates by 10% among populations most affected by health disparities in Travis County.	3.1.2 Promote support programs on healthy relationships and teen dating violence.
	3.1.3 Support and promote equitable pathways to higher education, to a range of diverse career paths, to workforce development and to life skill competency in all ISD, charter, and publicly funded schools.
	3.1.8 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.
Objective 3.2 By 2023, decrease the rates of sexually transmitted infections (STIs) by 10% among youth populations aged 24 and younger most affected by health disparities in Travis County.	3.2.1 Promote and offer HIV and other STI testing, education and enhanced linkage with reproductive and sexual health services.
	3.2.5 Identify and reduce barriers to youth seeking same-day appointments for STI tests and treatment.
Objective 3.3 By 2023, increase by 10% the number of schools that provide evidence-informed sex education in Travis County.	3.3.1 Advocate for policy and/or policy change at the district, county and state level that could support inclusive, evidence-informed comprehensive sex education and reproductive health manipulative demonstrations in Travis County schools.
	3.3.2 Promote collaborations between organizations and programs engaged in sex education work, including creating linkages between ISDs and local healthcare providers for referrals for students for sexual healthcare services not provided through ISD campuses.
Objective 3.4 By 2023, increase by 10% access to resources and referrals that are culturally sensitive and affordable, for youth who are pregnant and parenting, and their families.	3.4.1 Promote mental health and counseling services that are available for youth who are pregnant or parenting and their families.
	3.4.2 Support pregnant women in obtaining prenatal care in the first trimester (e.g., transportation services, patient navigators, etc.). 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).
	3.4.6 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.

Priority Area 4: Stress, Mental Health, and Wellbeing **Goal 4:** Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.	
Year 1 Objectives	**Year 1 Strategies**
Objective 4.1 By 2023, decrease by 10% the incidence of excessive drinking and other substance use disorders among Travis County residents.	4.1.1 Identify, screen and provide intervention for pre-identified at-risk populations.
Objective 4.2 By 2023, increase by 10% the number of system providers (schools, health care, etc.) who assess for adverse childhood experiences (ACEs) and other trauma informed care screening tools and refer to appropriate community supports.	4.2.1 Train providers on best use of ACEs screening and trauma informed care; linking to appropriate referrals.
	4.2.3 Develop and maintain an online resources list tool for providers to facilitate mental and behavioral health referrals
Objective 4.3 By 2023, Increase by 10% the proportion of adults aged 18 and up in Austin Travis County who receive mental health treatment or specialty treatment for substance use disorder or dependency with a focus on geographic equity.	4.3.1 Promote the adoption of a collaborative care model in Austin and Travis County to provide treatment and to coordinate medical and behavioral health providers.
	4.3.7 Develop additional teams of mobile mental health/SUD outreach workers who engage with the community at community events and maintain a visual presence in underserved areas.

Priority Area 1: Access to and Affordability of Health Care

The Austin/Travis County Community Health Improvement Plan (CHIP) works towards every Travis County resident having access to culturally sensitive, affordable, equitable, and comprehensive health care.

objective **1.1**

BY 2023, INCREASE EMPLOYMENT OF COMMUNITY HEALTH WORKERS AND SERVICE COORDINATORS BY 10%

to help residents navigate the health care system and promote health literacy

objective **1.2**

BY 2023, INCREASE ENROLLMENT AND USE OF ELIGIBLE HEALTH COVERAGE AND ASSISTANCE PROGRAMS BY 10%

for Travis County residents with household incomes at or below 200% of the Federal Poverty Level

objective **1.3**

BY 2021, DECREASE NO-SHOWS FOR HEALTH CARE APPOINTMENTS AT SAFETY-NET HEALTH CARE PROVIDERS BY 10%

Together We Thrive
Austin/Travis County Community Health Plan

Year 1 Action Plan
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.

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

Potential Partners for this Objective

- 1.1.1: APH, Central Health, St. David's Foundation, UT Dell Med, insurance companies, hospital networks, Travis County HHS
- 1.1.3: APH, Central Health, St. David's Foundation, UT Dell Med, *Promotores*/Community Health Workers of Travis County Organization
- Local CHW Employers: DSHS will identify partners

Strategy 1.1.1: Explore funding/reimbursement options for CHWs from insurance providers or local funders, so that community health workers are able to pursue a career in community health work that includes benefits, networks of social support, flexible time off and a living wage. Allowing community health workers to be a stable presence in the community and receive sufficient funding to keep them employed.

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Collaborate with DSHS to review survey results and research best practices of reimbursement opportunities from CHW employers (determine which practices are most successful, etc.).	Beatrice Smith (DSHS) Ricardo Garay (UT Dell Medical School)				X
b. Initiate/implement research projects on looking into the impacts of CHWs on chronic disease, etc. (proving the case that funding is needed due to the effectiveness of the program).	Ricardo Garay (DMS, Dept. of Pop. Health)			X	

Resources Available/Needed for this Strategy

- DSHS survey and findings: summer

Tracking and Monitoring for this Strategy
What will success look like? What are the milestones? How will you track and monitor progress?

- Research projects are initiated, establish scope of work that makes sense and launched for Dell Medical School Projects proposed

Year 1 Action Plan Priority Area 1: Access to and Affordability of Health Care						
Strategy 1.1.3: Establish or tap into an existing network for CHW/SCs to share learnings and experiences.						
Action Steps	**Lead Person/Organization**	**Time Line**				
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb	
a. Promote conference (CHW Annual hosted by DSHS). Austin: August 2019	Beatrice Smith (DSHS) Ricardo Garay (DMS)		X			
b. Promote Cardea/UT School of Nursing Quarterly meetings.	Ricardo Garay (DMS)	X				
c. Promote existing luncheon work group meetings with training centers, employers, CHW workforce solutions (if these are being conducted).	Beatrice Smith (DSHS) Ricardo Garay (DMS)	X				
d. Promote state-wide survey of CHW employers and employees.	Beatrice Smith (DSHS)	X	X			
Resources Available/Needed for this Strategy						
• Staff time, Listserv links, distribution lists • Funding for luncheon, meeting space (DSHS space may be available, DELL may have space as well)						
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?						
• Preliminary survey findings presented (July/August) • Increased local participation in CHW trainings and networking opportunities						

Year 1 Action Plan
Priority Area 1: Access to and Affordability of Health Care

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.**

Long-Term Indicators	Source	Frequency
• Average annual MAP enrollment from 2019- 2023		
• Percentage of Travis County residents under age 65 with no health insurance-	American Community Survey	

Potential Partners for this Objective

- 1.2.1: APH, Central Health, Integral Care, St. David's Foundation, Travis County HHS, UT Dell Med, Seton, WIC, OneVoice Central Texas, GAVA (go Austin, Vamos Austin)
- 1.2.2: APH, Central Health, Integral Care, St. David's Foundation, Travis County HHS
- 1.2.3: APH, Central Health, Integral Care, St. David's Foundation, Travis County HHS, Dell Medical School, Foodbank, Foundation Communities, OneVoice, ECHO, 211, United Way
- 1.2.4: APH, Integral Care, St. David's Foundation

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

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Identify and convene partners who should be involved in implementing this strategy.	Tim Burton (Central Health) Ivan Davila (Central Health)	X			
b. Replicate the collaborated communications campaign used for ACA open enrollment (St David's Foundation (Feb 25 meeting)) for other health care coverage programs (e.g., Medicaid, MAP, CHIP, etc.); with culturally appropriate materials in multiple languages.	Tim Burton (Central Health) Ivan Davila (Central Health)		X	X	
c. Identify existing education and communication campaigns used by partners for targeted communications (i.e., social media).	Tim Burton (Central Health) Ivan Davila (Central Health)				X

Resources Available/Needed for this Strategy

- Workgroup - working on immigration and coverage (Follow-up Needed: Kit Abney Spelce, Central Health)

Tracking and Monitoring for this Strategy
What will success look like? What are the milestones? How will you track and monitor progress?

- Cross partner promotion of existing marketing campaigns and resources for enrollment
- Increase in community members enrolling in health coverage and social and public health programming/services

Year 1 Action Plan Priority Area 1: Access to and Affordability of Health Care						
Strategy 1.2.2: **Train enrollment personnel to educate residents about all health coverage options/programs for which they are eligible.**						
Action Steps	**Lead Person/Organization**	**Time Line**				
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Launch a new multi-agency program and training to encourage enrollment in health coverage and social and public health services (see also 1.2.4 a) - funded by Central Health.	Kit Abney Spelce (Central Health)	X			
b. Share learnings from the program's data collection and analysis to address disparities.	Kit Abney Spelce (Central Health)			X	
Resources Available/Needed for this Strategy					
• Data collection, funding (is this provided by Central Health?)					
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?					
• Increase in community members enrolling in health coverage and social and public health programming/services					
Strategy 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.** and **Strategy 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, and Medicaid). Ensure clients are aware of special year around enrollment opportunities for life events.**						
Action Steps	**Lead Person/Organization**	**Time Line**				
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Launch a new multi-agency program and training to encourage enrollment in health coverage and social and public health services - funded by Central Health. Consider recording training for sharing purposes. [Please note, action step is the same as 1.2.2 however timeline is different]	Kit Abney Spelce (Central Health)			X	
b. Engage with United Way to see how they can impact this strategy.	Amy Price (United Way) Kara Prior (It's Time Texas)		X		
c. Connect with APD on their community resource officers.	APD Host Team Vanessa Sweet (Central Health)		X		

Year 1 Action Plan Priority Area 1: Access to and Affordability of Health Care
Resources Available/Needed for this Strategy
•
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?
• Increase in community members enrolling in health coverage and social and public health programming/services

Year 1 Action Plan Priority Area 1: Access to and Affordability of Health Care		
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)**.**	
Outcome Indicators	**Source**	**Frequency**
• Decrease in no show rates		

Potential Partners for this Objective

- 1.3.1: Austin Public Health, Austin Transportation Department, CapMetro
- 1.3.2: APH, Austin Transportation Department, Central Health, Integral Care, St. David's Foundation, Travis County HHS, UT Dell Med, Eastside Health and Wellness
- 1.3.6: Austin Public Health, Austin Transportation Department, CapMetro, Central Health, Integral Care, Aging Services Council
- 1.3.8: APH, Austin Transportation Department, CapMetro, Central Health, St. David's Foundation, CARTS, 211/United Way
- Travis County Transportation and HHS
- Equity Office
- 311
- 211/United Way

Strategy 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.

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Convene partners to share information about what each is doing in this area, to share successes and challenges, and to work together to explore options, opportunities and funding (perhaps form a committee or coalition - or broaden the RTCC - Regional Transit Transportation Committee- made up of transportation, healthcare and social service providers).	Michelle Meaux (CapMetro; Vice-Chair for RTCC) Scheleen Walker (Travis County Transportation) JP Eichmiller (Central Health) Liane Miller (Austin Transportation)		X	X	X
b. Create a communication vehicle to keep partners updated on developments, successes and challenges, and sharing of data (could be part of the work of the group in Action Step a.).	(follow-up after 1.3.1 a)		X		
c. Include other transportation partners in the community engagement process for the St David's North on-demand program at CapMetro.	Martin Kareithi (CapMetro)	X			
d. Connect providers and non-profits to the CapMetro Discounted Pass Program so that they can apply (e.g., use APH ListServe).	Martin Kareithi (CapMetro) Michelle Friedman (APH)	X			

Year 1 Action Plan Priority Area 1: Access to and Affordability of Health Care					
e. Explore collaborative programs and collaborative funding options for expanding rideshare capacity.	Michelle Meaux (CapMetro)				X
f. Explore options for increasing the number of wheelchair accessible vehicles (e.g., 5310). Involve the Mayor's Committee for People with Disabilities.	Martin Kareithi (CapMetro)	X			
g. Implement Travis County Carts on-demand service in targeted areas to connect residents to existing bus routes (3-year plan, in year 1).	Scheleen Walker (Travis County) Michelle Meaux (CapMetro) Dave Marsh/Rachid Breir (CARTS)	X	X	X	X
Resources Available/Needed for this Strategy					
• Available: Travis County funding for CARTS and CapMetro (g), • APH ListServe • Needed: Funding, Data from rideshare organizations, involvement of members of the Joint Inclusion Committee, involvement of the Equity Office					
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?					
• Workgroup created • RTCC becomes a more robust organization/group (e.g., right partners involved, communications expanded) • Increased enrollment (d) • More wheelchair accessible vehicles (that are not CapMetro vehicles)					
Strategy 1.3.2: Advocate to expand care delivery in under resourced areas via options such as co-locating, building new facilities, and use of telemedicine.					
Action Steps	**Lead Person/Organization**	**Time Line** Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Identify existing/planned colocation opportunities.	Eastside Health & Wellness JP Eichmiller (Central Health)	X			
b. Create a city and county asset map of existing public facilities where people congregate for services/something (need to identify maintenance for the map).	Potential Lead(s): TC GIS Partner to PARD Jill Habegger-Cain (COA PARD) Liane Miller (Austin Transportation)			X	
c. Assess the success/feasibility of Central Health's telemedicine program for sustainability.	Community Care Collaborative (CCC) Sarah Cook (Central Health)				X

Year 1 Action Plan
Priority Area 1: Access to and Affordability of Health Care

Resources Available/Needed for this Strategy

- Staff time
- CHP - Community Health Planning group, Eastern Travis County Coalition, Restore Rundberg, Dell Medical
- Potentially invite FTC to participate in strategy to avoid duplication of efforts: co-location and telemedicine

Tracking and Monitoring for this Strategy
What will success look like? What are the milestones? How will you track and monitor progress?

- Opportunities identified, asset map complete,

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

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Track distribution of the Greater Austin Transportation Service and Senior Ride Guide (distribution points and partners)	Tina Porter (CapMetro) Michelle Meaux (CapMetro) CARTS	X	X	X	X
b. Work with partners to expand distribution of guides and identify gaps in distribution	Tina Porter (CapMetro) Michelle Meaux (CapMetro) Scheleen Walker (TNR; Travis County) Ana Almaguel (HHS, Travis County) CARTS Tabitha Taylor (APH/AHA) Liane Miller (Austin Transportation)	X	X	X	X
c. Explore options to integrate transportation resources for health care information in Smart Trips & Commute Solutions programs.	Liane Miller (Austin Transportation) Anton Cox (Commute Solutions)		X	X	X

Resources Available/Needed for this Strategy

- Staff time

Tracking and Monitoring for this Strategy
What will success look like? What are the milestones? How will you track and monitor progress?

- Broader distribution
- Austin Citizen Satisfaction Survey

Year 1 Action Plan Priority Area 1: Access to and Affordability of Health Care											
Strategy 1.3.7: **Explore options for making Capital Metro's Mobility Management program more robust (e.g., centralizing, tech/software solutions).**											
Action Steps	**Lead Person/Organization**	**Time Line**									
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
d. Identify partners to convene to discuss needs for centralized transportation navigation programs and options for funding.	Michelle Meaux (CapMetro) Caitlin D'Alton (CapMetro) Liane Miller (Austin Transportation)	X											
Resources Available/Needed for this Strategy													
• Staff time													
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?													
•													
Strategy 1.3.8: **Connect health navigators with Mobility Management services so they can refer people to the right transportation resources for their needs.**											
Action Steps	**Lead Person/Organization**	**Time Line**									
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
a. Define/identify health navigators who should be connected to Mobility Management program and other transportation resources.	RTCC: Michelle Meaux (CapMetro) Scheleen Walker (TNR; Travis County)				X								
Resources Available/Needed for this Strategy													
•													
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?													
•													

Priority Area 2: Chronic Disease

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

Chronic disease was identified among Austin and Travis County's largest health priorities.

Learn about the Austin/Travis County Community Health Improvement Plan to address health disparities and more at austintexas.gov/healthforum

PREVENTATIVE SERVICES

Use of preventative services such as wellness exams and regular health screenings varies significantly by income.

HEALTHY BEHAVIORS

Healthy behaviors such as a balanced, nutritious diet, regular exercise, and more can impact a person's likelihood of developing chronic diseases.

60%

of Travis County **women over the age of 40 making less than $25,000 received a mammogram in the past two years**, compared to 80% of women making over $75,000 △

21%

of Travis County **adults making less than $25,000 are current smokers**, compared to 7% of residents making over $75,000 △

55%

of Travis County **residents over the age of 50 making less than $25,000 have ever received a colonoscopy or a sigmoidscopy**, compared to 76% of residents over 50 making more than $75,000 △

37%

of Travis County **adults making less than $25,000 report no participation in any physical activities or exercise**, compared to 19% of residents making over $75,000 △

The Austin/Travis County Community Health Improvement Plan (CHIP) works towards preventing and reducing 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** BY 2023, DECREASE THE AMOUNT OF TRAVIS COUNTY RESIDENTS WITH RISK FACTORS FOR CHRONIC DISEASE BY 10%

objective **2.2** BY 2023, INCREASE RATES OF EARLY DETECTION OF CHRONIC DISEASE AMONG ADULTS BY 2%

with a special focus on disproportionately affected populations

objective **2.3** BY 2023, REDUCE RATES OF PERSONS UNABLE TO OBTAIN OR DELAY IN OBTAINING NECESSARY MEDICAL CARE BY 10%

through services and education provided in client's home or at a community setting

objective **2.4** BY 2023, INCREASE ADHERENCE TO CHRONIC DISEASE CARE PLANS BY 10%

objective **2.5** BY 2023, INCREASE SAFE, ACCESSIBLE, EQUITABLE, AND CULTURALLY COMPETENT ASSETS AND OPPORTUNITIES FOR HEALTHY FOOD AND PHYSICAL ACTIVITY BY 5%

Integral Care · The University of Texas at Austin Dell Medical School · METRO · UTHealth School of Public Health · St David's Foundation · Central Health · Ascension · Seton

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Austin/Travis County Community Health Plan

Action Plan
Priority Area 2: Chronic Disease

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

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	Frequency
• Obesity or overweight rate	BRFSS	
• Tobacco use prevalence	BRFSS	
• % of people who meet nutrition and physical activity goals/recommendations	BRFSS	

Potential Partners for this Objective

- Alliance for African American Health in Central Texas
- Aging Services Council
- Area Agency on Aging
- Aunt Bertha
- Austin Community College
- Austin Public Health
- Austin Transportation Dept.
- Central Health, Health Policy Board
- Central Texas Food Bank
- Children in Nature Collaborative of Austin (PARD)
- Choose Healthier
- City of Austin Parks and Rec
- Community Coalition for Health
- Common Threads
- Integral Care
- OLE! (Outdoor Learning Environments) Texas - DSHS
- St. David's Foundation,
- Sustainable Food Center
- Texas Children in Nature
- Texas DSHS Worksite Wellness Program
- Texas Business Group on Health
- Texas Rising Star Program
- Travis County HHS
- United Way
- UT Dell Med
- UT School of Public Health
- YMCA
- Youth Mapping Services

Strategy 2.1.1: Offer regular, free Community Fitness and "Healthy Living" classes (i.e. fitness, nutrition, etc.) at convenient times and diverse locations to reach target communities. Ensure that programming is culturally and linguistically appropriate. (See also Objective 1.1 and Strategy 4.1.2) [Note: Healthy Food Access is being addressed by the Food Policy Board workgroup]

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Define inventory criteria including target population/geographic area, cultural and linguistic characteristics. Conduct an inventory of existing classes and programs available. Map resources available.	Joel (It's Time Texas) Dr. Andrew Springer (DMS): may identify additional grad student	X			

Action Plan Priority Area 2: Chronic Disease					
b. Identify gaps in programming, locations and times including cultural and linguistic characteristics.				X	
c. Identify organizations to fill gaps in programming and assess feasibility of expansion.					X

Resources Available/Needed for this Strategy

- 211
- 500 Cities
- Access to remote participant technology (Skype)
- Alzheimer's Association: classes
- Bertha
- COA PARD
- CPBI: Call for Ideas, Dell Medical School
- Critical Health Indicators Report
- Cultural Centers
- Food Access workgroup
- Foundation Communities
- HACA
- National and Hispanic Medical Association
- Physical meeting space
- Students to help with inventory efforts (UT SPH?)
- Technology needs (database, etc.)
- YMCA
- Youth Services Mapping

Tracking and Monitoring for this Strategy

What will success look like? What are the milestones? How will you track and monitor progress?

- Inventory criteria list established
- Inventory conducted
- Mapping completed
- Gaps identified
- Number of Programs identified that are able to address gaps
- Classes and programs are offered and are culturally and linguistically appropriate

Strategy 2.1.4: Engage worksites, schools, and early childhood education centers in developing comprehensive policies and programs that promote healthy nutrition, physical activity, tobacco free campus, and Mother Friendly worksites. [Year 1 focus on worksites; Year 2 inclusion of schools (Consider all Travis County ISDs) and early childhood education centers]

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Explore collaborations to offer support to Mayor's Health and Fitness Council (additional engagement: follow on Twitter; engage w/webpage)	Stephanie Helfman (APH) **Torch Bearer**: MHFC	X	X	X	X
b. Engage with ongoing worksite wellness initiatives currently occurring in Austin/Travis County.	Marianna Espinoza (DMS) **Torch Bearer**: DSHS; Moody School of Communications	X			

Action Plan Priority Area 2: Chronic Disease					
c. *Year 2*: Explore opportunities for sharing best practices to participating worksites, childcare centers, or schools.					
d. *Year 2*: Provide technical assistance to develop policies as needed.					

Resources Available/Needed for this Strategy	
• APH Maternal Child Health GIS map • Austin Business Group on Health • Austin Transportation • CACFP • Central Health/Health Equity Policy Council • Chambers of Commerce • Coordinated Approach to Child Health (CATCH) program	• KinderCare, Goddard School • Mayor's Health and Fitness Council • NAPSACC approach • School Health Advisory Councils (SHAC) • United Way • Workforce Solutions

Tracking and Monitoring for this Strategy
What will success look like? What are the milestones? How will you track and monitor progress?

- Tobacco-free policy
- Healthy vending
- NAPSACC policy assessment (for childcare providers)
- Other nutrition and physical activity policies

Action Plan Priority Area 2: Chronic Disease		
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/Note: Healthy Food Access is being addressed by the Food Policy Board workgroup]**	
Long-Term Indicators	**Source**	**Frequency**
• Percent of adults that consume 5 or more fruit or vegetables per day	BRFSS	
Potential Partners for this Objective		
• Austin Transportation, Austin Public Health, Economic Development Department		
Strategy 2.5.3:	**Utilize community member input to improve existing data of assets and opportunities available for physical activity (e.g., urban gardens, community gardens, green space, trails, parks, etc.) and increase access and awareness of these sites.**	

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Collaborate with PARD to create map overlay to identify access points and barriers (See 2.1.1). [Consider community input to supplement existing data for a better understanding of lived experiences]	Marianna Espinoza (DMS) Potential Lead: Meredith (COA PARD)	X			
b. Identify specific target populations/geographic focus for implementation.	ALL: Eastern Crescent	X			
c. Identify access barriers to physical activity opportunities, especially transportation barriers [Consider community input in identifying barriers]	Potential Lead(s): Austin Transportation, CapMetro			X	
d. Encourage improvements to the build environment to promote physical activity and seek to reduce barriers (ex: active transit opportunities, sidewalk and bike lane infrastructure, urban trails) [Consider community input regarding solutions to addressing barriers]	Potential Lead(s): Austin Transportation, CapMetro				X
e. Promote physical activity and support programs use of assets (Smart Trips, Walk Texas, etc.) and sharing of data.	Potential Lead(s): It's Time Texas, Austin Transportation, APH				

Action Plan
Priority Area 2: Chronic Disease

Resources Available/Needed for this Strategy

- Austin Public Works Department
- Call for Ideas – Dell Medical School (community input)
- COA Parks & Recreation Department
- COA Planning and Zoning Department: Active transportation facilities
- Feeding Texas
- Go Austin
- Healthy Food Access working group of the Food Policy Board
- Neighborhood Associations
- Stronger Austin: It's Time Texas

Tracking and Monitoring for this Strategy
What will success look like? What are the milestones? How will you track and monitor progress?

- Attendance at events, classes or physical opportunities by the target population
- Compiling community member input with initiatives to increase access
- See City of Austin Citizen Survey

Strategy 2.5.7: Advocate for and support ongoing efforts (e.g. Vision Zero Action Plan) to develop and enhance safe, multimodal transportation options across the community, paying particular attention to efforts that increase healthy food access and opportunities for physical activity. Ensure that plans and development take into consideration issues of equity.

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Include public health stakeholders (CHA/CHIP) in ATD outreach efforts.	Potential Lead(s): Austin Transportation To contact: Lewis Leff (Vision Zero Action)				
b. Participate in equity assessment tool development and usage.	Austin Transportation	X	X	X	X

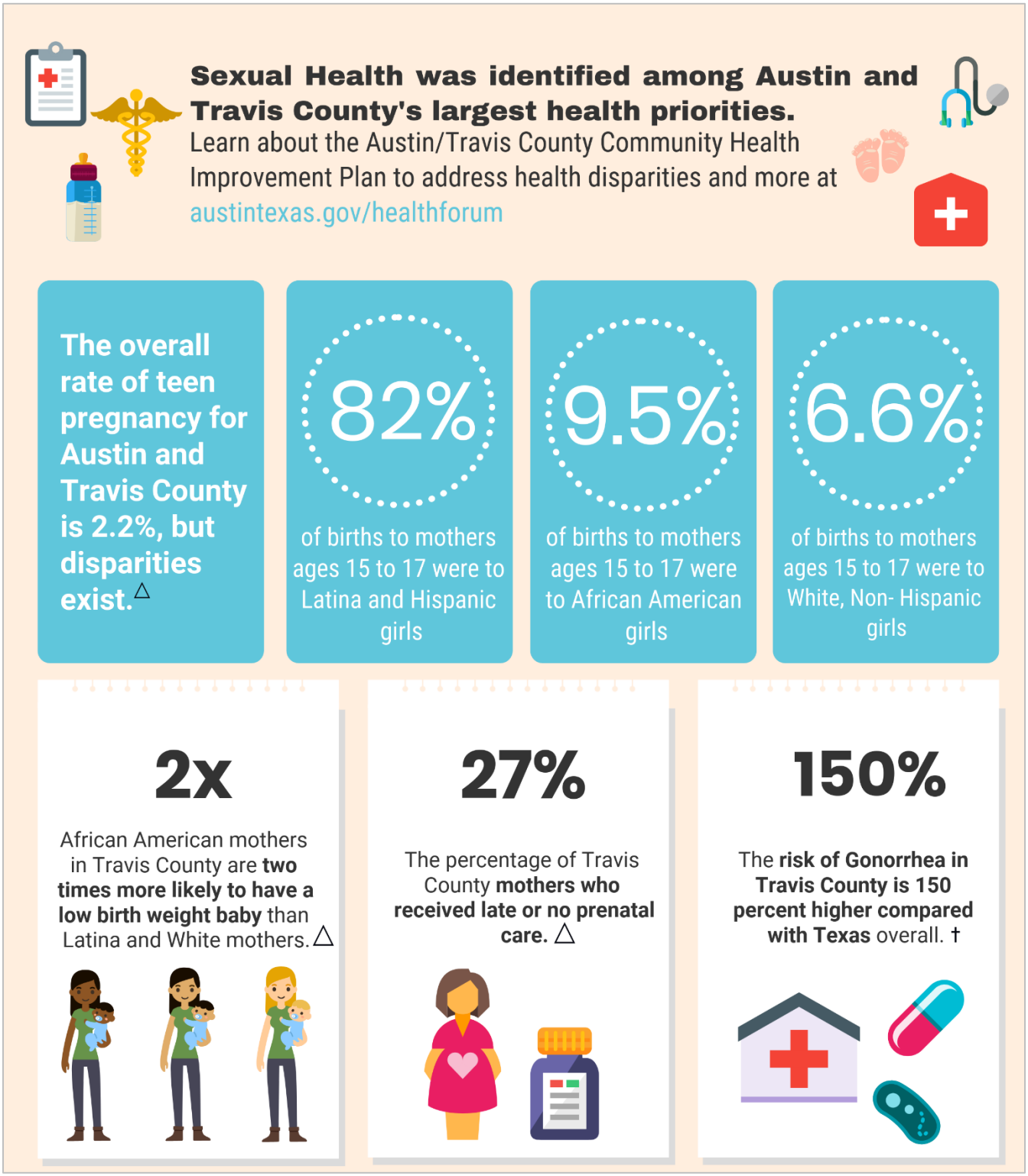
Resources Available/Needed for this Strategy

- Call for Ideas – Dell Medical School (community input)

Tracking and Monitoring for this Strategy
What will success look like? What are the milestones? How will you track and monitor progress?

-

Priority Area 3: Sexual Health



The Austin/Travis County Community Health Improvement Plan (CHIP) works towards empowering youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.

objective **3.1** BY 2023, DECREASE YOUTH PREGNANCY RATES AMONG POPULATIONS MOST AFFECTED BY HEALTH DISPARITIES IN TRAVIS COUNTY BY 10%

objective **3.2** BY 2023, DECREASE RATES OF SEXUALLY TRANSMITTED INFECTIONS BY 10%

among youth populations aged 24 and younger most affected by health disparities in Travis County

objective **3.3** BY 2023, INCREASE THE NUMBER OF SCHOOLS THAT PROVIDE EVIDENCE INFORMED SEX EDUCATION IN TRAVIS COUNTY BY 10%

with a focus on geographic equity

objective **3.4** BY 2023, INCREASE ACCESS TO RESOURCES AND REFERRALS THAT ARE CULTURALLY SENSITIVE AND AFFORDABLE BY 10%

for youth who are pregnant and parenting, and their families

Together We Thrive
Austin/Travis County Community Health Plan

△ Texas Department of State Health Services, Texas Health Data: Birth (2012-2014).
† TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services

Year 1 Action Plan Priority Area 3: Sexual Health		
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.		
Objective 3.1: By 2023, decrease youth pregnancy rates by 10% among populations most affected by health disparities in Travis County.		
Long Term Indicators (for Goal)	**Source**	**Frequency**
• Travis County teen birth rates (percentage of live births to females under 20 years of age) by race and ethnicity.	Office of Vital Statistics - DSHS	Annually

Potential Partners for this Objective	
• APH/AHA	• Lonestar Circle of Care
• Any Baby Can	• Other PrEP Clinics & Providers
• APH/HIVSTD Prevention	• Out Youth
• ASA	• People's Community Clinic
• Austin CHE	• People's Community Clinic YAC
• AVANCE	• Planned Parenthood
• Capital Idea	• SHAC (AISD; Manor; Del Valle, Eanes, Leander, Lake Travis, Pflugerville, Elgin, etc.)
• Central Health	• SAFE
• Community Care Collaborative (CCC)	• Teen Health Collaborative
• CommUnityCare	• The Q
• Higher Education: UT, St. Eds, & HT Student Health	• Travis County Adolescent Health Collaborative
• El Buen Samaritano	• UT & St. David's Foundation
• Engender Health	• Women's Health and Family Planning Association of Texas
• Kind Clinic	• Workforce Solutions
• LifeWorks	• YWCA

Year 1 Action Plan Priority Area 3: Sexual Health					
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.					
Strategy 3.1.2: Promote support programs on healthy relationships and teen dating violence.					
Action Steps	**Lead Person/Organization**	**Time Line**			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Gather and document information from the SAFE alliance, and other partners on services they're performing to meet this strategy.	Potential Lead(s): Barri Rosenbluth and Agnes Aoki (SAFE) Jackie (Lifeworks): Travis county adolescent health coalition Crescencia Alvarado (APH): Communities in School				
b. Discuss and decide if it's possible to collaborate to move their work forward.					
Resources Available/Needed for this Strategy					
• Communities in School • SAFE • Travis County Adolescent Health Coalition • YWCA					
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?					
•					

Year 1 Action Plan Priority Area 3: Sexual Health						
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.						
Strategy 3.1.3: Support and promote equitable pathways to higher education, to a range of diverse career paths, to workforce development and to life skill competency in all ISD, charter, and publicly funded schools.						
Action Steps	**Lead Person/Organization**	**Time Line**				
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb	
a. Identify programs or organizations doing this work.	Crescencia Alvarado (APH) – AVANCE, Any Baby Can, Capital Idea, Maya Program, AISD, Mama Sana Jackie Platt (Lifeworks): Austin Opportunity Youth Collaborative – Resource matrix	x				
b. Identify individuals who are working on programs and get specifics on who, what, where they offer services.	Crescencia Alvarado (APH) – AVANCE, Any Baby Can, Capital Idea, Maya Program, AISD, Mama Sana Jackie Platt (Lifeworks) - Austin Opportunity Youth Collaborative – Resource matrix	x				
c. Invite key program staff to participate in moving this priority area forward (since they're informed on the programs) – helping them see their value to joining this group.						
d. Identify what or how to promote said programs.						
e. Work with key program staff to list and identify support areas (e.g. space, technology, time, staffing, who can provide the support) in order to offer these programs to audience.						
Resources Available/Needed for this Strategy						
• AVANCE • Any Baby Can • Capital Idea • Maya Program • AISD • Mama Sana • Austin Opportunity Youth Collaborative – Resource Matrix						

Year 1 Action Plan Priority Area 3: Sexual Health					
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.					
Strategy 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. [See strategy 3.2.5 regarding STI tests and treatment]					
Action Steps	**Lead Person/Organization**	**Time Line**			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Identify providers that currently offer family planning services	Potential Lead(s): Stephanie McDonald (Central Health) Torch Holder: El Buen Samaritano, People's Community Clinic Joanna Saucedo (CHE) **Torch Holder**: YAC Jackie Platt (Lifeworks) Torch holder: Texas Campaign Youth Friendly Clinics	x			
b. Identifying barriers to offering and accessing same-day services by both providers and youth, including information on how and where youth learn about STI's and family planning resources (e.g. surveys or interviews).	Potential Lead(s): Stephanie McDonald (Central Health) – CommUnity Care				
c. Provide technical support to address barriers so that clinics can provide same day services. Consider advocacy opportunities to influence policy.	Stephanie McDonald (Central Health)				
d. Provide technical support to clinics ensuring compliance to LARC principles and national best practices.					
e. Promote LARC and STI testing services to youth (based on findings).					
Resources Available/Needed for this Strategy					
• El Buen Samaritano • Texas Campaign - Youth Friendly Clinics • Women's Health and Family Planning Association of Texas • People's Community Clinic - Youth Advisory Council (YAC) • Central Health: Community Care LARC trainings					

Year 1 Action Plan Priority Area 3: Sexual Health
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?
•

Year 1 Action Plan
Priority Area 3: Sexual Health

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

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-Time Indicators	Source	Frequency
• STI rates among youth by race and ethnicity		

Potential Partners for this Objective

- AHA
- ALLGO
- Austin CHE
- Central Health
- Central Texas Transgender Health Coalition
- CommUnityCare
- Fast Track Cities
- Higher Education: UT, St. Eds, & HT Student Health
- Lonestar Circle of Care
- People's Community Clinic
- The Q

Strategy 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).

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Identify organizations that currently offer these services. [Engage with current workgroups addressing sexual and reproductive health: Social Media Workgroup (addressing stigma; targeting populations); Prevention Workgroup; Testing and Rapid Linkage to Care Workgroup; Retention and Reengagement and Viral Suppression Workgroup; Stigma Workgroup]	Joanna Saucedo, Austin CHE	X			
b. Conduct quarterly check-ins with organizations that currently provide these services to in order for them to identify the services that exists and gaps to accessing those services (by their clients).					

Year 1 Action Plan Priority Area 3: Sexual Health					
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.					
c. Create a resource document of programs and services that exist (information gathers at quarterly check-ins).					
d. Develop a marketing plan and product to market programs that exists for providers (e.g., flyer or newsletter).					
e. Develop a marketing plan and product to market programs that exists for clients themselves (e.g., flyer).					
f. Assess where additional navigation services or support exists.					
Resources Available/Needed for this Strategy					
•					
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?					
•					
Strategy 3.2.5: Identify and reduce barriers to youth seeking same-day appointments for STI tests and treatment. [See strategy 3.1.8 regarding contraception]					
Action Steps	**Lead Person/Organization**	**Time Line**			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Identify providers that currently offer STI services.	Stephanie McDonald (Central Health)	X			
b. Identifying barriers to offering and accessing same-day services by both providers and youth, including information on how and where youth learn about STI's and family planning resources (e.g. surveys or interviews). [See 3.1.8] *Note barriers to providing access to youth and adolescents specifically.					
c. Provide technical support to address barriers so that clinics can provide same day services. Consider advocacy opportunities to influence policy.					
d. Explore options to create a referral system between STI-specific service providers and family planning providers.					
e. Promote STI testing services to youth (based on findings).					

Year 1 Action Plan Priority Area 3: Sexual Health
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.
Resources Available/Needed for this Strategy
• ASA • APH Sexual Health Clinic • CHE • Fast Track Cities
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?
•

Year 1 Action Plan
Priority Area 3: Sexual Health

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

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

Potential Partners for this Objective

- APH/AHA
- LifeWorks
- Out Youth
- Planned Parenthood
- School Districts SHAC (i.e. AISD, Del Valle, Manor, etc.)

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

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Research what bills have passed related to this strategy at the state level (year one to focus on legislature; year 2 can be district by district).	Joanna Saucedo (CHE) **Torch Bearer**: Katie Wolfe, (Planned Parenthood)	X	X		
b. Identify key partners to help identify next steps based on what happens in the legislature.					

Resources Available/Needed for this Strategy

- Texas Campaign to Prevent Teen Pregnancy

Tracking and Monitoring for this Strategy
What will success look like? What are the milestones? How will you track and monitor progress?

-

Year 1 Action Plan Priority Area 3: Sexual Health					
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.					
Strategy 3.3.2: Promote collaborations between organizations and programs engaged in sex education work, including creating linkages between ISDs and local healthcare providers for referrals for students for sexual healthcare services not provided through ISD campuses. (See also Strategy 3.1.4).					
Action Steps	**Lead Person/Organization**	**Time Line**			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Identify key point/stakeholders at ISDs that could enable sexual health referrals on ISD campuses	Jackie Platt (LifeWorks): Tracy Spinner or Glory (AISD) , Michelle Resnick (Health Education) Stephanie McDonald (Central Health) Angelica Benton-Molina (APH): Del Valle ISD (High Priority) Stephanie McDonald: Pflugerville ISD (High Priority) Stephanie McDonald, Angelica Benton Molina: Manor ISD (High Priority) Lago Vista Westlake	x	x	x	
b. Identify and utilize teen leaders to be involved in this process (e.g., make this process youth friendly).	Year 2				
c. *Y2: Utilize data that indicates high need populations in need of these referral services.*	Year 2				
Resources Available/Needed for this Strategy					
• Tracy Spinner, AISD Health Director • Del Valle ISD • Pflugerville ISD • Manor ISD • UT School of Nursing (Del Valle ISD) • Central Health Equity Policy Council -					

Year 1 Action Plan Priority Area 3: Sexual Health
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?
•

Year 1 Action Plan Priority Area 3: Sexual Health		
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.		
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-Time Indicators	**Source**	**Frequency**
• Percentage of births with late or no Prenatal Care in Texas and by Age, Race/Ethnicity in Travis County		
Short-Time Indicators	**Source**	**Frequency**
• Short-Term Indicators will be identified and reviewed through the action planning and implementation phase		
Potential Partners for this Objective		
• APH • APH/AHA • APH/MIOP • CCC • Central Health • CommUnityCare • El Buen Samaritano • Integral Care • Lonestar Circle of Care • Mama Sana Vibrant Woman • People's Community Clinic • Strong Start • WIC		

Year 1 Action Plan Priority Area 3: Sexual Health						
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.						
Strategy 3.4.1: Promote mental health and counseling services that are available for youth who are pregnant or parenting and their families.						
Action Steps	**Lead Person/Organization**	**Time Line**				
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb	
a. Gather information (Kids Living Well/Children's mental) health plan (18 and under) on services performed to meet this strategy.	Crescencia Alvarado (APH): People's Community Clinic Jackie Platt (LifeWorks): Tandem Collaboration – Services for Pregnant/Parenting teens; Parenting Education (PEP) Program Joanna Saucedo (CHE): St. David's Foundation – 4th Trimester funding; Shannon Moody (Jerimiah Program)	x				
b. Discuss and decide if it's possible to collaborate to move their work forward.						
Resources Available/Needed for this Strategy						
• Jeremiah Program • Parenting Education Program (PEP) • People's Community Clinic • St. David's Foundation – 4th Trimester Funding • Tandem Collaboration – Services for Pregnant/Parenting Teens						
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?						
•						
Strategy 3.4.2: Support pregnant women in obtaining prenatal care in the first trimester (e.g., transportation services, patient navigators, etc.). Example of possible program is home pregnancy testing designed to get women into prenatal care sooner.						
Action Steps	**Lead Person/Organization**	**Time Line**				
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb	
a. Gather information from the Central TX Perinatal Coalition on services they're performing to meet this strategy.	Rory Hall, Perinatal Coalition					

Year 1 Action Plan Priority Area 3: Sexual Health					
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.					
b. Discuss and decide if it's possible to collaborate to move their work forward.					
Resources Available/Needed for this Strategy					
• Neighborhood Centers • WIC					
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?					
•					
Strategy 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).					
Action Steps	**Lead Person/Organization**	**Time Line**			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Identify programs or organizations doing this work (See MIECHV Grantees: Family Connects)	Cecilia (GALS) Crescencia Alvarado (APH): Any Baby Can; Maya Program; AVANCE Joanna Saucedo (CHE): United Way 2 Gen Tara Carmean (TC HHS) - Healthy Families with Travis County HHS	x			
b. Identify individuals who are working on programs and get specifics on who, what, where they offer services.			x		
c. Invite key program staff to participate in moving this priority area forward (since they're informed on the programs) – helping them see their value to joining this group.			x		
d. Identify what or how to promote and/or expand said programs.					
e. Work with key program staff to list and identify support areas (e.g., space, technology, time, staffing, who can provide the support) in order to offer these programs to audience.					

Year 1 Action Plan
Priority Area 3: Sexual Health

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

Resources Available/Needed for this Strategy

- Any Baby Can
- AVANCE
- Family Connects
- GALS
- Healthy Families with Travis County HHS
- Maya Program
- United Way - 2 Gen

Tracking and Monitoring for this Strategy
What will success look like? What are the milestones? How will you track and monitor progress?

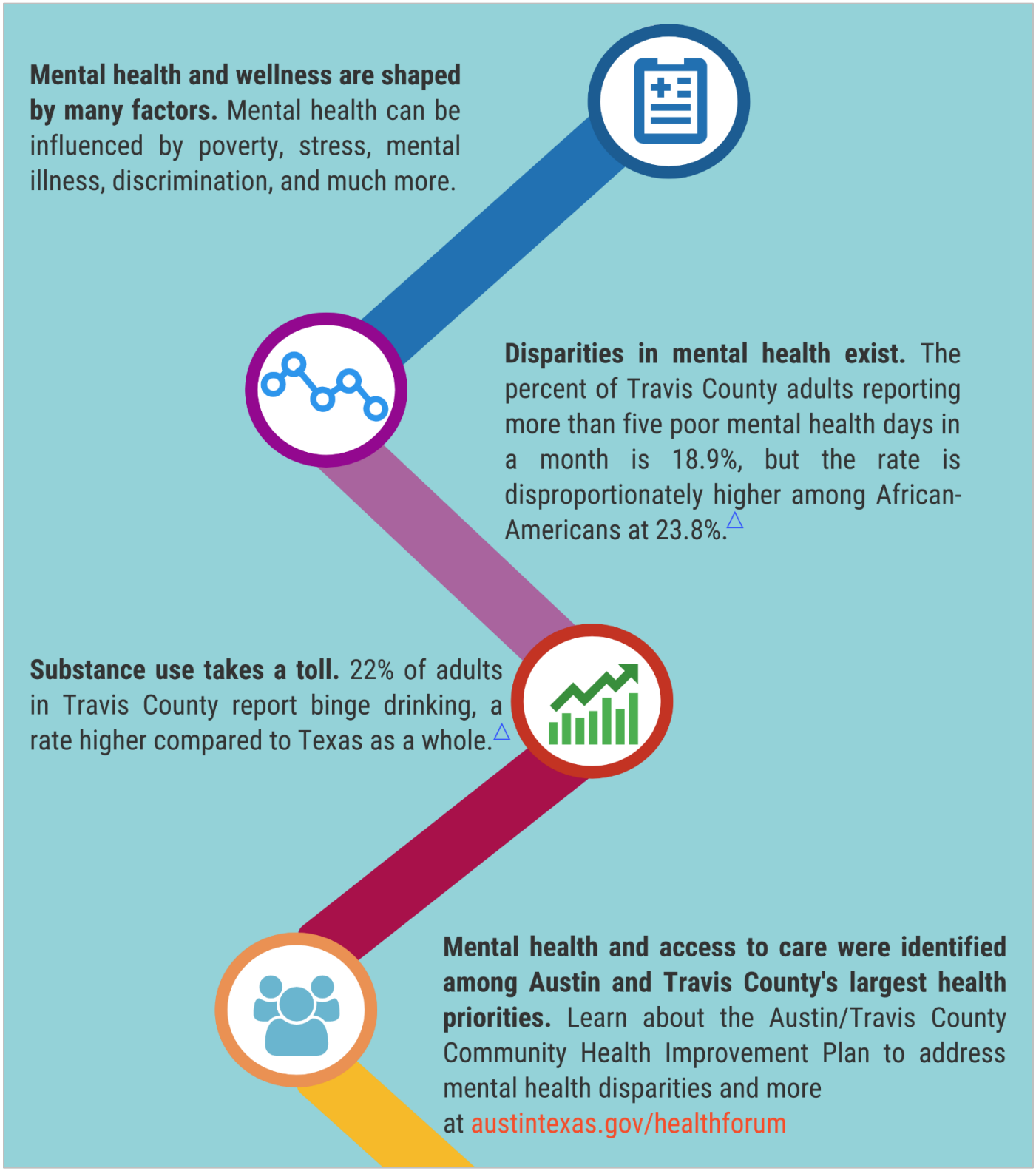
-

Strategy 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.

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Gather information from the Central TX Fatherhood Coalition on services they're performing to meet this strategy	Crescencia Alvarado (APH): Partners in Parenting; Any Baby Can; Catholic Charities – Father Support Program Jackie Platt (LifeWorks): Central Texas Fatherhood Coalition Angelica Benton – Molina (APH): Austin Youth Development				
b. Discuss and decide if it's possible to collaborate to move their work forward					

Year 1 Action Plan Priority Area 3: Sexual Health
Goal 3: Empower youth to make informed decisions about their sexual and reproductive health that result in positive health outcomes.
Resources Available/Needed for this Strategy
• Any Baby Can • Austin Youth Development • Catholic Charities – Father Support Group (To be contacted by Crescencia Alvarado) • Central Texas Fatherhood Coalition • Kenneth Thompson, Fatherhood Program Specialist – DSHS (To be contacted by Fernanda Santos and Angelica Benton-Molina) • Partners in Parenting
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?
•

Priority Area 4: Stress, Mental Health, and Wellbeing



The Austin/Travis County Community Health Improvement Plan (CHIP) works towards advancing mental wellness, recovery, and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.

objective **4.1** BY 2023, DECREASE THE INCIDENCE OF BINGE DRINKING AND OTHER SUBSTANCE USE DISORDERS AMONG TRAVIS COUNTY RESIDENTS BY 10%

objective **4.2** BY 2023, INCREASE THE NUMBER OF SYSTEM PROVIDERS WHO ASSESS FOR ADVERSE CHILDHOOD EXPERIENCES AND REFER TO APPROPRIATE COMMUNITY SUPPORTS BY 10%

objective **4.3** BY 2023, INCREASE PROPORTION OF TRAVIS COUNTY ADULTS RECEIVING TREATMENT FOR SUBSTANCE USE DISORDERS OR DEPENDENCY BY 10%

with a focus on geographic equity

Together We Thrive
Austin/Travis County Community Health Plan

Year 1 Action Plan Priority 4: Stress, Mental Health, and Wellbeing		
Goal 4: Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.		
Objective 4.1 By 2023, decrease by 10% the incidence of excessive drinking and other substance use disorders among Travis County residents.		
Long Term Indicators - The long-term indicators should be impacted by all three objectives	**Source**	**Frequency**
• Emergency Department (ED) visits for alcohol poisoning • Emergency Department (ED) visits for substance overdose	Austin Public Health epidemiology	Annual
• Indicator Definition: Binge drinking in the past month (5 or more drinks for males, 4 or more drinks for females on one occasion)	Behavioral Risk Factor Surveillance System (BRFSS) Available for Texas and for Region 7 (30 counties including Travis) http://healthdata.dshs.texas.gov/CommunitySurveys/BRFSS	Annual
• Alcohol and drug related arrests. • Traffic fatalities that involve suspected substance impairment. APD reports 62% of all fatal traffic crashes in 2018 involved a driver, bicyclist or pedestrian who was suspected of impairment by drugs or alcohol.	Austin Police Department https://data.austintexas.gov/Public-Safety/2018-APD-Traffic-Fatality-Data-021219/9jd4-zjmx	Annual
• Travis County Traffic Fatalities involving driver alcohol impairment	Fatality Analysis Reporting System	5-year
• Excessive Drinking ranking (binge and heavy drinking)	County Health and Rankings	Annual
• Alcohol or drug induced deaths	CDC Wonder	
• Texas Youth substance use	Youth Risk Behavior Survey	
• AISD student survey: drinking and drug behavior	AISD Survey	

Year 1 Action Plan
Priority 4: Stress, Mental Health, and Wellbeing

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

Potential Partners for this Objective

- CommUnity Care
- Community Care Collaborative
- Integral Care
- Integrated Care Collaborative (Data)
- LifeWorks
- Lone Star Circle of Care
- NAMI – Austin
- Phoenix House
- Texans Standing Tall
- United Way
- YWCA

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

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Compile existing data on excessive drinking: What's already happening? Identify at-risk populations. Identify providers. Identify current screening tools in place and by whom. : Screening Tools: SBIRT, Motivational Interviewing, CRAFFT	Follow-up Needed: Maren Lujan (APH) to seek contact Laura Enderle (APH)	X			
b. Compile existing substance abuse data: What's already happening? Identify at-risk populations. Identify providers. Identify current screening tools in place and by whom. : Screening Tools: SBIRT, Motivational Interviewing, CRAFFT	Potential(s) Lead: Mary Dodd (Integral Care)	X	X		
c. Select agreed upon screening tool(s) and model (excessive drinking and substance use disorder). Consideration of linguistics, cultural competence, provider's work context.	Group consensus		X		
d. Educate providers on excessive drinking data.					

Year 1 Action Plan Priority 4: Stress, Mental Health, and Wellbeing					
Goal 4: Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.					
e. Identify trainers, train on the tool with considerations of linguistics, cultural competence, and empathy (including but not limited to community health workers, ECHO, faith-based organizations). *Year 2*: Include Seton Healthcare	Charles Moody (C2H): community groups/faith-based orgs <u>Potential Lead(s)</u>: Kacey Hanson (Dell Medical School - Psychiatry and Population Health and Internal Medicine, UT Austin, Community Care Collaborative)		X	X	X
f. *Year 2*: Build a community-wide data system for screening data.	<u>Follow-up Needed</u>: Laura Enderle (APH) Kacey Hanson (DMS - Data Core: Population Health)				X

Resources Available/Needed for this Strategy

- AA – Allen
- Celebrate Recovery: Charles Moody
- Communities for Recovery: Rachel Toronjo will reach out to Robyn Peyson (retired)/Darin Acker, Interim Executive Director
- Community Care Collaborative
- Continuing Education Dept., Dell Medical School
- Dell Medical School Data Core: Kacey Hanson
- Integral Care
- Mothers Against Drunk Driving (MADD)
- SHIFT Happens - Lori Holleran-Stieker: Mary Dodd has the contact
- UT Student/Staff Group: Jelina Tunstill (Students)
- VA – Aaron Andrews: Rachel Toronjo will contact

Tracking and Monitoring for this Strategy

What will success look like? What are the milestones? How will you track and monitor progress?

- Establish baseline.
- Number of providers trained on the tool (establish X by Q2)

Year 1 Action Plan Priority 4: Stress, Mental Health, and Wellbeing		
Goal 4: Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.		
Objective 4.2: By 2023, increase by 10% the number of system providers (schools, health care, etc.) who assess for adverse childhood experiences (ACEs) and other trauma informed care screening tools and refer to appropriate community supports.		
Long-Term Indicators	**Source**	**Frequency**
• 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 or other trauma informed care screening tools, which could include federal funding programs such as the MIECHV (Maternal, Infant, Early Childhood Home Visit) program.		
Potential Partners for this Objective		
•		

Strategy 4.2.1: Train providers on best use of ACEs screening and trauma informed care; linking to appropriate referrals.					
Action Steps	**Lead Person/Organization**	**Time Line**			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Identify screening tools available. Develop list of trauma informed care screening tools. Considerations of tools and appropriateness for children and/or cultural context.	Seanna Crosbie (ACGC/TICC)				
b. Provider assessment: providers' knowledge of ACEs and other tools' conceptual framework and screening practice; which providers are providing or not providing trauma informed care or screenings. Existing data of number of providers trained in trauma informed care/ACEs; number of organizations screening for trauma	Marian Morris (Integral Care, Steering Committee Member for Trauma-Informed Care Consortium of Central Texas) Rachel Toronjo (Central Health) Laura Enderle (APH)	X	X		
c. Develop awareness of ACEs and other trauma informed care tools through provider education campaign and training on screening tools; develop linkage to appropriate provider referrals; articulate how ACEs connects to TIC (trauma informed care) and building resilience.	Marian Morris (Integral Care, Steering Committee Member for TICC): linkage Laura Enderle (APH)	X	X	X	X

Year 1 Action Plan Priority 4: Stress, Mental Health, and Wellbeing					
Goal 4: Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.					
d. Identify and develop a list of key stakeholders of early champions of ACEs screening and referrals; tailor approaches to engage with different sector providers; decide level of screening and targeting. Include school providers	Marian Morris (Integral Care, Steering Committee Member for Trauma-Informed Care Consortium of Central Texas) Kacey Hanson (DMS)	X			
e. Establish evaluation cycle (assess, plan, evaluate, revise).	Laura Enderle (APH) <u>Follow-up Needed</u>: Dell Medical School			X	X
Resources Available/Needed for this Strategy					
• AISD: Frances Acuna • Austin Child Guidance Center – Seanna Crosbie • Behavioral Health Criminal Justice Committee – Rachel Toronjo • CAN • Del Valle ISD: Mia Greer will follow-up • Dell Medical School, Department of Population Health – Kacey Hanson • Pflugerville & Manor ISD: Kacey Hanson will follow-up • Trainer for trauma screening - Marisol Acosta, oversaw trauma grant [action step b.]: Kacey Hanson will follow-up • Trauma-Informed Care Consortium of Central Texas [TICC]: Seanna Crosbie (Austin Child Guidance Center) • United Way • UT – Beth: Laura Enderle will contact					
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?					
• The number of new locations using Adverse Childhood Experiences (ACEs)1 or other trauma informed care tools to screen individuals for services. • Action item b.: 2015 CAN survey; could possibly repeat survey to measure change over time. • Number providers trained (by sector) [identify the metric number by Q2] • Traumatexas.org: access data					

[1] 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

Year 1 Action Plan Priority 4: Stress, Mental Health, and Wellbeing					
Goal 4: **Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.**					
Strategy 4.2.3: **Develop and maintain an online resources list tool for providers to facilitate mental and behavioral health referrals (See also Strategy 4.3.5). Consider using the current 211 system as the platform for this resource tool.**					
Action Steps	**Lead Person/Organization**	**Time Line**			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Identify place/agency where list would live. Could live at United Way (online) – includes 211 and Early Childhood Resource Referral.	Thomas Trinh (United Way for Greater Austin) Cristina Alvarado (United Way)	X			
b. Identify and expand list of behavioral service providers. Identify geographic focus of these providers.	Louise Lynch (Integral Care): Muna Javaid will follow-up	X			
c. Promote the use of the tool to people who could make behavioral health referrals (i.e., teachers, physicians (such as primary care physicians, DOs, PCP, Pas, Travis County Medical Society, Travis County Pediatric Society, faith based organizations, community health workers, social workers, nurses, LPCs, case managers, social services offices etc.).	Thomas Trinh (United Way for Greater Austin) Cristina Alvarado (United Way)	X	X	X	X
d. Identify the individual who will maintain, scrub, and monitor the list.	Thomas Trinh (United Way for Greater Austin) Cristina Alvarado (United Way)	X			
e. Assess use of the tool by referring providers to capture how many referrals are made through the system. Ex. Focus Group: usefulness of tool; Beta test, pilot, ongoing, MOU Currently: Sample follow-up only. There is little follow-up to referrals through 2-1-1, so they do not know how many reach the resource they requested.	Thomas Trinh (United Way for Greater Austin) Cristina Alvarado (United Way)			X	X
Resources Available/Needed for this Strategy					
• Texas Health and Human Services (BHAC) • United Way					

Year 1 Action Plan Priority 4: Stress, Mental Health, and Wellbeing
Goal 4: Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?
• Number of providers using the online resource to make referrals. • Number of resulting referrals. • Number of individuals accessing referrals/reaching resources

Year 1 Action Plan Priority 4: Stress, Mental Health, and Wellbeing		
Goal 4: **Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.**		
Objective 4.3: **By 2023, Increase by 10% the proportion of adults aged 18 and up in Austin Travis County who receive mental health treatment or specialty treatment for substance use disorder or dependency with a focus on geographic equity.**		
Long-Term Indicators	**Source**	**Frequency**
• Emergency Department (ED) visits for suicide attempts (if available)	Austin Public Health epidemiology	Annual
• Indicator Definition: Five or more days of poor mental health within the past month	Behavioral Risk Factor Surveillance System (BRFSS) Available for Texas and for Region 7 (30 counties including Travis) http://healthdata.dshs.texas.gov/CommunitySurveys/BRFSS	Annual
• Suicide rates – by age groups	Department of State Health Services Center for Health Statistics	Annual
Potential Partners for this Objective		
•		

Strategy 4.3.1: **Promote the adoption of a collaborative care model in Austin and Travis County to provide treatment and to coordinate medical and behavioral health providers.**						
Action Steps	**Lead Person/Organization**	**Time Line**				
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb	
a. Identify which organizations/agencies already are using collaborative care models; consider geographic span.	Laura Enderle (APH)			X		
b. Identify how to promote collaborative care model to providers (e.g., UT psych. Grand rounds)	Erica Garcia-Pittman (DMS)	X	X	X		
c. Increase awareness of existing evidence based collaborative care models through multi media campaign (print, social media, presentation) to funders, potential influencers, providers, community members, CHWs etc.	Jorge Almeida (DMS IPU)			X	X	
d. Identify fiscal, regulatory and licensing barriers to promoting and implementing collaborative care models.	Marlene Buchanan (Integral Care) Darilyn Cardona-Beiller (Integral Care)					
e. Train providers promoting Collaborative Care Model	Erica Garcia-Pittman (DMS)	X	X	X	X	
f. Establish network of integrated collaborative care model providers.	Follow-up Needed: Central Health, UT Dell Medical School			X	X	

Year 1 Action Plan
Priority 4: Stress, Mental Health, and Wellbeing

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

Resources Available/Needed for this Strategy

- Future Resource: Collaborative Care Clinic at DMS
- Grants to go out in the summer; funding

Tracking and Monitoring for this Strategy
What will success look like? What are the milestones? How will you track and monitor progress?

- Number of providers receiving training
- Number of organizations (newly) training on collaborative care models
- At least one funded pilot collaborative care effort
- Established network of collaborative care model providers

Strategy 4.3.7 Develop additional teams of mobile mental health/SUD outreach workers who engage with the community at community events and maintain a visual presence in underserved areas.

Action Steps	Lead Person/Organization	Time Line			
		Mar Apr May	Jun Jul Aug	Sep Oct Nov	Dec Jan Feb
a. Identify existing mobile teams providing mental health/SUD services and potential existing services that can become mobile.	Laura Enderle (APH)	X			
b. Identify and develop funding streams to expand existing teams and create innovative programs that can evolve into mobile access.		X	X		
c. Collaborate and develop system of coordination (e.g. a workgroup community of practice, providers, school districts, city, county, Dell Medical School, Central Health).	Sandra Chavez (Austin Harm Reduction)		X	X	X
d. Identify additional populations that could benefit from mobile outreach (e.g., food deserts, homelessness services, health care deserts, and transportation deserts).	Follow-up Needed: Eastern Travis County Collaborative Execs: Ana Almaguel will communicate with Execs	X	X		

Year 1 Action Plan Priority 4: Stress, Mental Health, and Wellbeing					
Goal 4: Advance mental wellness, recovery and resilience through equitable access to responsive, holistic, and integrated community and healthcare systems.					
e. Expand scope of service or geographic area served by mobile team.	Follow-up Needed: ECHO, DMS, Dept. of Population Health APH CommUnity Care Potential Lead(s): Andy Hoffmeister (EMS Community Paramedics): Mary Dodd to contact				X
f. Coordinate data sharing.	Laura Enderle (APH) Kacey Hanson (DMS) Follow-up Needed: Community Care Collaborative (CCC)		X	X	X
Resources Available/Needed for this Strategy					
• Commission on Seniors: Community health workers funded pilot; work with EMS: Erica Garcia-Pittman has contact • Existing mobile teams: Dell Med mobile unit, St. David's Foundation Mobile Dental Clinic Integral Care's Mobile Crisis Outreach Team (MCOT), Homeless Outreach Street Team (HOST), Assertive Community Treatment (ACT) • Needs: Funding sources					
Tracking and Monitoring for this Strategy What will success look like? What are the milestones? How will you track and monitor progress?					
• Expand existing mobile mental health team engagement with the community at community events and maintain a visual presence in underserved areas: Number of community events attended by mobile health units • Number of new mobile health units • New areas covered by expanding mobile health units or span of mobile outreach					