Austin/Travis County
Health and Human Services Department

July 31, 2013
Austin, TX

Dear Community Stakeholder,

Effective August 2011 and lasting until June 2013, the Austin/Travis County Health and Human Services Department (A/TCHHSD) partnered with many agencies to lead a comprehensive community health planning initiative, which included development of a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). Core agencies included Travis County Health and Human Services and Veteran's Services, Central Health, St. David's Foundation, Seton Healthcare Family, the University of Texas Health Science Center at Houston School of Public Health Austin Regional Campus, Austin/Travis County Integral Care, and Capital Metro. The process entailed community meetings, key informant interviews, and focus groups to gather a picture of our community's health and what we should do to address identified issues.

The results of that effort are provided in this CHA/CHIP report, the first for our community. The CHA illustrates the power of data driven evidence and the community's voice. The CHIP focuses on how Austin/Travis County will implement strategies to improve key areas affecting our health and well-being.

Leaders of the community including non-profit, for-profit, public, and private entities, began implementing Austin/Travis County's CHIP strategies and action steps on July 1, 2013. For the next 36 months, we have the opportunity to advance and positively impact our community. Through policies, education, and programs/initiatives, we can affect the many determinants of health for a better, stronger, and sustainable Austin and Travis County.

We encourage all residents, including elected officials and political and community leaders, to read the report and work with the entire community to implement its recommendations. The goal is to effectively implement these action steps over the next three to five years. We will assess and update each year as we go through this process.

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

Healthy people are the foundation of our thriving community!

Sincerely,

Shannon Jones
Chair, Austin/Travis County CHA CHIP Steering Committee

Together We Thrive

Austin/Travis County Community Health Plan

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

– ROBERT WOOD JOHNSON FOUNDATION

Community Health Assessment Austin/Travis County Texas

December 2012

CENTRAL HEALTH

St David's FOUNDATION

Seton Healthcare Family

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

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This report is available at the Austin / Travis County Health and Human Services Department's website at: http://www.austintexas.gov/healthforum.

For additional information, or comments, please e-mail CHACHIP@austintexas.gov or contact us by phone at 512-972-5888.

Dear Community Partner,

From August 2011 through July 2012, Austin/Travis County Health and Human Services Department (A/TCHHSD) partnered with Travis County Health and Human Services and Veterans Services, Central Health, St. David's Foundation, Seton Healthcare Family, and the University of Texas Health Science Center (UTHSC) at Houston School of Public Health Austin Regional Campus to lead a comprehensive community health planning initiative. The Austin/Travis County Community Health Assessment (CHA) represents a collaborative and community participatory process in order to illustrate our health status, strengths, and opportunities for the future.

Through the CHA community activities and events, the voices of our city and county contributed to an engaging and substantive process. While every person or agency may not share the same viewpoint, capturing the community's voice is essential so we, as a community, can work together to identify strengths, capacity, and opportunity to better address the many determinants of health.

The drive, diligence, and support from the core partners—our Austin/Travis County CHA team—made planning, conducting, and completing this assessment possible. This has truly been a collaborative experience.

As we move forward to develop collaborative plans and strategies to improve the health and wellbeing for all community members, remember that your story builds our story. Thank you for your ongoing contributions to this remarkable community health improvement process.

Sincerely,

Carlos Rivera
Director, Austin/Travis County HHSD

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

Philip Huang
Health Authority, Austin/Travis County HHSD

Austin/Travis County HHSD Administration and Logistics

Forum Chair: Filip Gecic

Logistics Chair: Sherryl DeCampo

Sharon Alexander

Carole Barasch

Vince Cobalis

Linda Cox

Chris Crookham

Lori Doubrava

Susan Gehring

Andrea Guerra

Kimberly Hall

Olga Hernandez

Natasha Hill

Joyce Ikkanda

David Lopez

Paul Stein

City of Austin Mayor's Office

Sly Majid

City of Austin Planning and Development Review

Gregory Claxton

Carol Haywood

Ryan Robinson

Garner Stoll

City of Austin Public Information Office

Jill Goodman

Larry Schooler

Outreach and Engagement Subcommittee (virtual)

Co-Chairs: Sherri Fleming, Travis County HHS & VS; Philip Huang, Austin/Travis County HHSD; Blanca Leahy, Travis County HHS & VS; and Paul Scott, One Voice Central Texas

Katie Coburn, Central Health

Ashton Cumberbatch, Seton Healthcare Family

Alexandra Evans, University of Texas Health Science Center at Houston School of Public Health Austin Regional Campus

Anna Lisa Fahrenthold, Travis County HHS & VS

John McNabb One Voice Central Texas

Becky Pastner, St. David's Foundation

Andrew Springer, University of Texas Health Science Center at Houston School of Public Health Austin Regional Campus

Suki Steinhauser, One Voice Central Texas

Willie Williams, Austin/Travis County HHSD

Focus Group, Key Informant, and Community Forum Participating Agencies

2Thrive4

Amerigroup Texas, Inc.

Any Baby Can

Asian American Chamber of Commerce

Austin Area Funders

Austin Community College

Austin Independent School District

Austin Lakes Hospital

Austin Partners in Education

Austin Recovery

Austin/Travis County Emergency Medical Services

Austin/Travis County Health and Human Services

Austin/Travis County Integral Care

Black Minister's Alliance Baptist Church

Blackland Community Development Center

Blue Cross Blue Shield of Texas

Central Health

Children's Optimal Health

City of Austin Council Members

City of Austin, Economic Growth & Redevelopment Services Office

City of Austin Parks and Recreation Department

City of Austin Planning and Development Review

Communities in Schools

Community Action Network

CommUnity Care

Del Valle Independent School District

Dell Children's Medical Center of Central Texas

Family Eldercare

Foundation Communities

Dell Children's Medical Center of Central Texas

Family Eldercare

Foundation Communities

Hispanic American Chamber of Commerce

Housing Authority of the City of Austin

Indicator Initiative

Interfaith Action of Central Texas (iACT)

Lone Star Circle of Care

Manor Independent School District

Mayor's Fitness Council

Meals on Wheels

Mt. Zion Baptist Church

National Alliance on Mental Illness (NAMI) Austin

National Association for the Advancement of Colored People, (NAACP) Austin Chapter

Network of Asian American Organizations

One Life One Goal

One Voice Central Texas

People Fund

Pflugerville Independent School District

SAHELI

SANDE Youth Project

Self Help Advocacy Center

Seton Healthcare Family

Sickle Cell Association of Austin Marc Thomas Foundation

St. David's Foundation

Travis County Commissioners Court

Travis County Health and Human Services & Veterans Services

Travis County Sherriff's Office

Travis County Medical Examiner's Office

United Way for Greater Austin

University of Texas at Austin Children's Wellness Center

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

University of Texas School of Nursing

Ventanilla de Salud, Consulate General of Mexico

AUSTIN/TRAVIS COUNTY COMMUNITY HEALTH ASSESSMENT

EXECUTIVE SUMMARY

Introduction

Health is affected by where and how we live, work, play, and learn.[1] Understanding these factors and how they influence health is critical to efforts aimed to improve the health of the community. Identifying the health issues of an area and their larger context and then developing a plan to address them are key steps in the larger health planning process. To accomplish these goals, Austin/Travis County Health and Human Services – in collaboration with Travis County Health and Human Services & Veterans Services**,** Central Health, St. David's Foundation, Seton Healthcare Family, and the University of Texas Health Science Center at Houston School of Public Health Austin Regional Campus – is leading a comprehensive community health planning effort to measurably improve the health of Austin/Travis County, TX residents. This effort entails two major phases:

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

This report discusses the findings from the CHA, which was conducted August 2011–June 2012, using a collaborative, participatory approach. These findings will inform discussions and priority areas for the CHIP, scheduled to take place July 2012 - December 2012.

The December 2012 Austin/Travis County CHA[1] was conducted to fulfill several overarching goals, specifically:

• To examine the current health status across Austin/Travis County as compared to state and national indicators
• To explore the current health concerns among Austin/Travis County residents within the social context of their communities
• To identify community strengths, resources, forces of change, and gaps in services to inform funding and programming priorities of Austin/Travis County

This CHA focuses on Travis County which is home to numerous communities as well as Austin, the capital city of Texas. While the largest proportion of the population in Travis County resides in Austin, given the fluidity of where people work and live in the County and that numerous service organizations in the area serve individuals across the County, a focused effort was made to include data and the community voice from across the County.

Methods

The CHA defines health in the broadest sense and recognizes numerous factors at multiple levels– from lifestyle behaviors (e.g., diet and exercise) to clinical care (e.g., access to medical services) to social and economic factors (e.g., employment opportunities) to the physical environment (e.g., air quality) – all have an impact on the community's health. Existing social, economic, and health data were drawn from national, state, county, and local sources, such as the U.S. Census and Texas Department of State Health Services, which include self-report, public health surveillance, and vital statistics data. Over 300 individuals from multi-sector organizations, community stakeholders, and residents were engaged in

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[1] The 2012 Austin/Travis County CHA was drafted in August 2012 and finalized in December 2012.

community forums, focus groups, and interviews to gauge their perceptions of the community, their health concerns, and what programming, services, or initiatives are most needed to address these concerns.

Demographics – Who lives in Austin/Travis County?
The population of Austin/Travis County is ethnically and linguistically diverse, with wide variations in socioeconomic level, and is experiencing rapid growth, including demographic shifts among the aging, Hispanic, and Asian populations.

- The population of Travis County has grown by over 25% in the past decade [2] and is expected to more than double in the next three decades, from a population of 1,024,266 in 2010 to 2.3 million residents in 2045.[3] Specifically of note is the changing composition of the population in terms of age, cultural background, and socioeconomic status.
- While Austin was often described as youthful, concerns regarding an increasing and often "*forgotten*" aging population were frequently expressed. According to the U.S. Census, from 2000 to 2010, the senior population (aged 65 years and over) in Travis County grew by over 25%.[4]
- Many participants described the region (Austin/Travis County) as ethnically and linguistically diverse. In 2010, approximately half of the population of Travis County was non-Hispanic White, with growing Latino/Hispanic and Asian populations and a proportionally decreasing Black/African American population.[5]
- Overall, the region was described by participants as highly educated; however, this was contrasted by perceived low levels of educational attainment, specifically among the economically disadvantaged. Over 40% of Travis County adults (25 years or older) had a bachelor's degree or higher compared to 25.9% of Texas adults.[6]
- While the median income was higher in Travis County ($51,743) than the State overall ($48,615), poverty disproportionately affects certain segments of the population, mainly Latinos/Hispanics (26.8% living in poverty) and Blacks/African Americans (21.2% living in poverty).[7]

Social and Physical Environment – What is the Austin/Travis County community like?
The wide variations in demographic characteristics of Austin/Travis County result in geographic disparities across the region where residents lack access to services and resources.

- The east-west divide (physically defined by I-35), as well as differences between urban and rural communities were prominent themes across interviews and focus groups.
- Participants described Travis County as a largely car-dependent region, not supporting other modes of transportation, such as walking or biking. The lack of a robust public transportation system was noted as a challenge to conducting everyday activities.
- Residents described struggling to pay high rent prices and an increasing demand for affordable housing resulting in long waiting lists to access Section 8 housing. Quantitative data confirm an increase in both housing (31.1%) and renting costs (22%) in Austin between 2000 and 2009, which were similar to or less than increases seen statewide.[8]
- The existence of food deserts was a prominent theme through key informant interviews. In 2006, 8.7% of Travis County's low-income population did not live within one mile of a grocery store.[9] Healthy food that is available was described by residents as unaffordable.[10]
- Despite a higher rate of recreational facilities in Travis County (11.1 facilities per 100,000 population) than in Texas as a whole (7.2 facilities per 100,000 population), unequal geographic and financial access to green space and recreational facilities was a concern among participants.[11]

> *"My aunt is diabetic and she has stomach problems and it's hard for her to catch the bus with three children. When she's on the bus she has to take all the groceries and carry the baby also."* – Focus group participant

Community Strengths and Resources
Focus group and interview participants identified several community strengths and assets, including social and human capital, access to services, and organizational leadership and partnerships.

- Many participants described Austin as an entrepreneurial and liberal city that is politically active and culturally rich. Neighborhood cohesion and community engagement among residents were also highlighted as assets.
- Despite the challenges to accessing services mentioned in previous sections, residents did note the multitude of resources available to them in their community, if one knows how to access them.
- Similarly, community-based and non-for-profit organizations were described as assets, especially their willingness to collaborate, and committed and innovative leadership.

Health Behaviors
A majority of key informants, including Central Health Connection interviewees, considered obesity to be a pressing health issue, particularly among children and in relation to other chronic diseases such as diabetes and heart disease.

- Interview participants discussed the importance of and challenges to nutrition and exercise, especially highlighting the disparities among Blacks/African Americans and Latinos/Hispanics.
- In 2010, the percentage of obese adults in Travis County (24.0%) was less than that of the state (29.6%); however, Blacks/African Americans and Latinos/Hispanics experienced much higher rates of obesity, 41.7% and 36.5% respectively, compared to less than 20% of Whites (19.4%).[12]

Health Outcomes
While chronic diseases emerged as a key concern among participants and represent the leading causes of death in the region, the need for mental health services was the foremost community health concern raised by residents. Additionally, it is evident that Blacks/African Americans and Latinos/Hispanics experience disproportionately higher rates of several health outcomes.

- Cancer and heart disease were the leading causes of death in Travis County between 2005 and 2009, with Blacks/African Americans experiencing disparate rates of mortality due to cancer and heart disease (Figure 1).
- Approximately 20% of Travis County adults experienced five or more days of poor mental health in the past month. A greater proportion of Blacks/African Americans (24.3%) and Latinos/Hispanics (26.6%) reported poor mental health than did Whites in the County (17.9%).[13]

Figure 1: Age-Adjusted Mortality Rate per 100,000 Population for the Leading Causes of Mortality by Race/Ethnicity in Travis County, 2005-2009
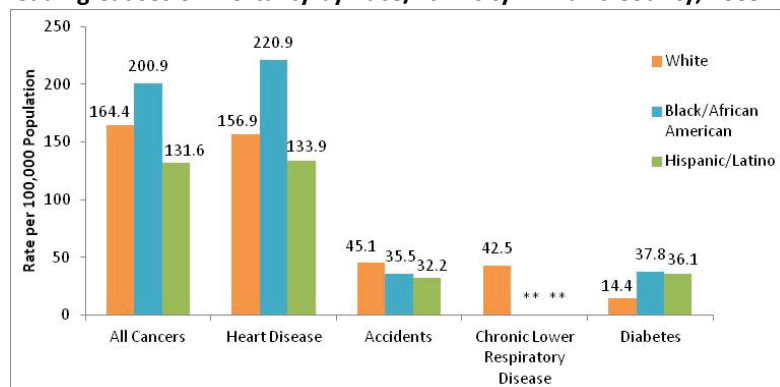
** Indicated a numerator too small for rate calculation
DATA SOURCE: Texas Department of State Health Services, Texas Health Data: Deaths (2005-2009).

Health Care Access and Affordability
Access to health care was a predominant theme among residents, specifically the availability and accessibility of health care facilities and resources, emergency room overuse, challenges of navigating a complex health care system, and health insurance and cost related barriers.

- Focus group and interview participants repeatedly cited the challenges of accessing health care, such as transportation, language, and cost barriers. Yet Travis County adults were more likely to have health insurance or their own health care provider compared to rates statewide. The Latino/Hispanic population in Travis County had disproportionately lower rates of either of these indicators.[14]

> *"People we serve have a number of jobs so they're too busy to go see doctor or employers won't let them take time off to go to the doctor or they're afraid they will lose their job."*
> – Interview participant

External Factors ("Forces of Change")
The primary external factors recognized by participants as challenges towards achieving their identified health priorities were population growth and demographic shifts, the fiscal and political environment, and fragmented organizational efforts.

- The ability of the City's and County's physical and social infrastructure to keep up with its rapid growth was of concern to many key informant interviewees and focus group participants.
- Achieving change in a weak fiscal environment was described as a challenge for both implementing new initiatives and sustaining existing ones. The political environment was described as preventing effective and efficient dialogue, especially in an election year, during which several participants indicated achieving change is particularly challenging.
- Despite numerous non-profits and service organizations in the area, the perception was that efforts could be more integrated and coordinated to reduce fragmentation and duplication of services.

Community's Vision and Identified Opportunities
When focus group respondents and interviewees were asked about their visions and hopes for the future 3-5 years from now, the overarching themes that emerged from these conversations included focusing on prevention, ensuring affordable and accessible health care, improving the built environment, and engaging in policy change and strategic city planning.

- Participants envisioned an integrated and holistic health care delivery system that focuses on prevention rather than treatment. A continuum of coordinated care was also considered critical.
- Ensuring equitable access to health care was also identified as a priority for achieving a healthy community; this included patient centered medical homes and culturally and linguistically appropriate services.
- Participants noted many opportunities to improve the built environment so that it supports a healthy and physically active community.
- Engaging in policy change and *"strategic"* city planning was also viewed as a viable option for creating a healthier community.

Key Themes and Suggestions
Through a review of the secondary social, economic, and epidemiological data in the region as well as discussions with community residents and leaders, this assessment report provides an overview of the social and economic environment of Austin/Travis County, the health conditions and behaviors that most affect the population, and the perceptions on strengths and gaps in the current public health and health care environment. Several overarching themes emerged from this synthesis:

- There is wide variation within Travis County in population composition and socioeconomic levels. Lack of transportation services and living in a walkable community are two main concerns which have affected residents' perceived quality of life, stress level, and ease of accessing services.
- Latinos/Hispanics were identified as a vulnerable population in the community whose concerns stand to be exacerbated by the population growth in the region.
- Mental health was considered a growing, pressing concern by focus group and interview participants, and one in which the current services were considered inadequate to meet the current demand.
- As with the rest of the country and state, issues around physical activity, healthy eating, and obesity are issues for Travis County residents, especially as chronic conditions are the leading causes of morbidity and mortality.
- While strong health care services exist in the region, vulnerable populations such as the socially isolated elderly, non-English speaking residents, those living with disabilities, and the poor encounter continued difficulties in accessing primary care services.
- Residents viewed prevention as critical, but they emphasized that the health care system focused more on clinical care and disease management than prevention.
- Numerous services, resources, and organizations are currently working in Austin/Travis County to meet the population's health and social service needs.

AUSTIN/TRAVIS COUNTY COMMUNITY HEALTH ASSESSMENT

INTRODUCTION

Health is affected by where and how we live, work, play, and learn.[2] Understanding these factors and how they influence health is critical to efforts aimed to improve the health of the community. Identifying the health issues of an area and their larger context and then developing a plan to address them are key steps in the larger health planning process. To accomplish these goals, Austin/Travis County Health and Human Services (ATCHHS) – in collaboration with Travis County Health and Human Services and Veterans Services, Central Health, St. David's Foundation, Seton Healthcare Family, and the University of Texas Health Science Center at Houston School of Public Health Austin Regional Campus – is leading a comprehensive community health planning effort to measurably improve the health of Austin/Travis County, TX residents. This effort, funded by the National Association of County and City Health Officials with support from the Robert Wood Johnson Foundation, entails two major phases:

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

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

This report [3]discusses the findings from the CHA, which was conducted August 2011–June 2012, using a collaborative, participatory approach. These findings will inform discussions and priority areas for the CHIP, scheduled to take place July –December 2012.

Purpose and Geographic Scope of the Austin/Travis County Community Health Assessment
The 2012 Austin/Travis County CHA was conducted to fulfill several overarching goals, specifically:
- To examine the current health status across Austin/Travis County as compared to state and national indicators
- To explore the current health priorities among Austin/Travis County residents within the social context of their communities
- To identify community strengths, resources, forces of change, and gaps in services to inform funding and programming priorities of Austin/Travis County

This CHA focuses on Travis County which is home to numerous communities as well as Austin, the capital city of Texas. While the largest proportion of the population in Travis County resides in the City of Austin, given the fluidity of where people work and live in the County and that numerous social service and health organizations in the area serve individuals across the County, a focused effort was made to include data and the community voice from across the County.

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[2] *Health Starts Where We Live, Learn, Work, and Play.* Robert Wood Johnson Foundation. (2010). Retrieved from http://www.rwjf.org/vulnerablepopulations/product.jsp?id=70928

[3] The final CHA report was published and posted online (www.austintexas.gov/healthforum) in December 2012. The draft CHA report was posted at the aforementioned website in August 2012.

This community health assessment provides a snapshot in time of community strengths, needs, and perceptions. It should be acknowledged that there are numerous community initiatives and plans, expansion of health and social services, and improvements in programs and services that have recently been undertaken. This report does not delve into these areas, but further examination of these initiatives will occur during the CHIP process when discussions will focus on specific health issues.

Structure of Engagement
As with the process for the upcoming CHIP, the CHA utilized a participatory, collaborative approach guided by the Mobilization for Action through Planning and Partnerships (MAPP) process.[4] MAPP, a comprehensive, community-driven planning process for improving health, recommends four different broad focus areas to examine for the CHA process: 1) health status, 2) community strengths and themes, 3) forces of change (external factors that affect health), and 4) the local public health system. Given the focus and scope of this effort, the Austin/Travis County CHA focuses on and integrates data on the first three MAPP-recommended assessment areas.

To develop a shared vision and plan for the community and help sustain lasting change, the Austin/Travis County assessment and planning process aims to engage agencies, organizations, and residents in the County through different avenues: a) the *Steering Committee* is responsible for overseeing the community health assessment and improvement process, b) the *Core Coordinating Committee* serves as the overall steward of the process, c) the *Data and Research Subcommittee* identifies, gathers, and analyzes key health and human service indicators, and d) the *Outreach and Engagement Subcommittee* is responsible for identifying community organizations to participate in qualitative data collection activities. Additionally, One Voice Central Texas, a network representing 54 health and human services community based organizations, was instrumental in identifying priority populations and entities to engage in qualitative data activities. In January 2012, Austin/Travis County Health and Human Services hired Health Resources in Action (HRiA), a non-profit public health organization, as a consultant partner to provide strategic guidance and facilitation of the CHA-CHIP process, collect and analyze data, and develop the report deliverables.

Vision, Mission, and Together We Thrive Logo
The Steering and Core Coordinating Committees participated in quality improvement and planning activities including brainstorming, force field analysis, and prioritization exercises to develop the vision and mission for the CHA:

> 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

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

In order to develop and market the community health improvement process, the Austin/Travis County team and Suma Orchard Consultants developed the "Together We Thrive" brand and logo to emphasize that we, the community, are working together to advance our health and wellness. To help spread the message and engage the community, the Austin/Travis County CHA team and partners promoted a one-page talking points tool highlighting the importance of the community's voice for the community to thrive.

METHODS

The following section details how the data for the CHA was compiled and analyzed, as well as the broader lens used to guide this process. Specifically, the CHA defines health in the broadest sense and recognizes numerous factors at multiple levels— from lifestyle behaviors (e.g., diet and exercise) to clinical care (e.g., access to medical services) to social and economic factors (e.g., employment opportunities) to the physical environment (e.g., air quality)—all have an impact on the community's health. The beginning discussion of this section describes the larger social determinants of health framework which helped guide this overarching process.

Social Determinants of Health Framework

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

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

Figure 2: Social Determinants of Health Framework
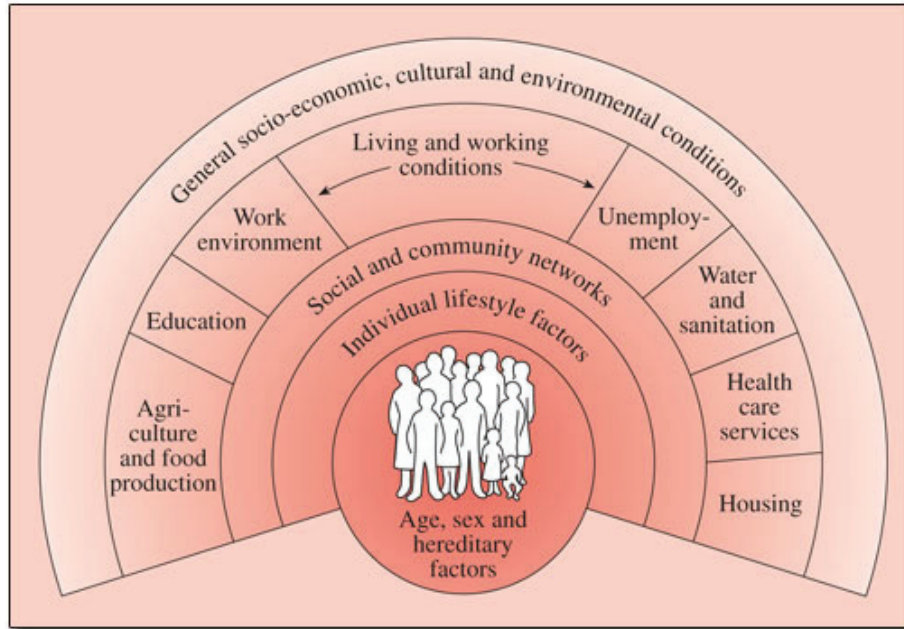
DATA SOURCE: World Health Organization, Commission on Social Determinants of Health. (2005)

Quantitative Data: Reviewing Existing Secondary Data
To develop a social, economic, and health portrait of Austin/Travis County, through a social determinants of health framework, existing data were drawn from state, county, and local sources. Sources of data included, but were not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, County Health Rankings, and Texas Department of State Health Services. Types of data included self-report of health behaviors from large, population-based surveys such as the Behavioral Risk Factor Surveillance System (BRFSS), public health disease surveillance data, as well as vital statistics based on birth and death records. The BRFSS, a telephone survey of Travis County adult residents, asks respondents about their behaviors that influence health, as well as whether they have had or currently have specific conditions.

The quantitative data collection addressed the first goal of this assessment—to examine the current health status across Austin/Travis County as compared to state and national indicators. Specifically, by following the MAPP framework, data were collected for the 11 suggested categories within the framework, including the core community health status assessment indicators outlined by MAPP.

Qualitative Data: Forums, Focus Groups, and Interviews
From February – May 2012, forums, focus groups, and interviews were conducted with leaders from a wide range of organizations in different sectors, community stakeholders, and residents to gauge their perceptions of the community, their health concerns, and what programming, services, or initiatives are most needed to address these concerns. Priority sectors and representative participants were identified based on: 1) a brainstorming session with members from the Core Coordinating and Steering Committees, 2) a survey completed by the Steering Committee nominating key informants, and 3) a survey completed by the Outreach and Engagement Subcommittee identifying focus group sectors and relevant community-based organizations. To this end, a total of 4 community forums, 14 focus groups, and 28 interviews with community stakeholders were conducted. Additionally, findings from 25 key informant interviews with senior leaders in multiple sectors including the business, education, and health fields previously conducted for the Central Health Connection's Leader Dialogue Series were

included in the analysis. Ultimately, the qualitative research engaged over 300 individuals in discussion about the health issues they deemed critical in their community.

Specifically, the qualitative data collection addressed the last two goals of the assessment: 1) to explore the current health priorities among Austin/Travis County residents within the social context of their communities and 2) to identify community strengths, resources, forces of change, and gaps in services to inform funding and programming priorities of Austin/Travis County. For this first goal which encompassed the community themes and strengths assessment, focus groups, interviews, and community precinct forums were completed. For the second goal of the forces of change assessment, focus groups and interviews discussed important external factors that have had and will have an impact on the community's health. More about these qualitative data collection methods can be found below:

Community Forums
Four community forums were held in different areas of Austin/Travis County and engaged a total of 152 participants. During each forum an overview of ATCHHS and its partners' programs and services was given, local health indicators were presented, and attendees participated in a dialogue around health and their community. Facilitators guided discussions using a set of questions (Appendix A) and note-takers captured responses. In addition, each forum had bilingual staff available to simultaneously interpret presentations, facilitate, and take notes in Spanish. On average, each community forum lasted two hours, of which the community dialogue comprised one hour. Forums were advertised to a wide variety of community entities such as schools, churches, neighborhood associations, social services agencies, and local business. Free health screenings (e.g., blood pressure, HIV, etc.) were offered before and after the forum. In addition, the first 50 participants received a $20 gift card to a local grocery store if they attended the duration of the event.

Focus Groups and Interviews
In total, 14 focus groups and 28 interviews were conducted with individuals from across Austin/Travis County. Focus groups were with the general public and with selected priority populations. For example, three focus groups were conducted with senior citizens, two groups with public housing residents, and two groups with refugees. A total of 101 individuals participated in the focus groups. Interviews were conducted with 31 individuals representing a range of sectors. These included government officials, educational leaders, social service providers, and health care providers. A full list of the different sectors engaged during the focus group and interview process can be found in Appendix B.

Focus group and interview discussions explored participants' perceptions of their communities, priority health concerns, perceptions of public health, prevention, and health care services, and suggestions for future programming and services to address these issues. A semi-structured moderator's guide was used across all discussions to ensure consistency in the topics covered (Appendix C and D). Each focus group and interview was facilitated by a trained moderator, and detailed notes were taken during conversations. On average, focus groups lasted 90 minutes and included 6-12 participants, while interviews lasted approximately 30-60 minutes. Participants for the focus groups were recruited by community and social service organizations located throughout Travis County. As an incentive, focus group participants received a $30 gift card to a local grocery store.

Analyses
The collected qualitative information was coded using NVivo qualitative data analysis software and then analyzed thematically by data analysts for main categories and sub-themes. Analysts identified key themes that emerged across all groups and interviews as well as the unique issues that were noted for specific populations. Throughout the qualitative findings included in this report the term "participants"

is used to refer to community forum, focus group, and key informant interview participants. Unique issues that emerged among a group of participants are specified as such (e.g., community forum participants, Spanish-speaking focus group participants, etc.). Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While regional differences are noted where appropriate, analyses emphasized findings common across Austin/Travis County. Selected paraphrased quotes – without personal identifying information – are presented in the narrative of this report to further illustrate points within topic areas.

Limitations

As with all research efforts, there are several limitations related to the assessment's research methods that should be acknowledged. It should be noted that for the secondary data analyses, in several instances, city-level data were not available or could not be analyzed due to small sample sizes. In some cases, data was aggregated across multiple years to increase sample size (e.g., 2005-2009). Additionally, several sources did not provide current data stratified by race/ethnicity, gender, or age –thus, these data could only be analyzed by total population. Due to the variety of sources used to conduct this assessment, it is also important to note that the term "Hispanic" could not be consistently defined throughout the report. For example, in demographic data presented, Hispanic refers to an ethnicity of any race; however, the qualitative data represents the perspectives of participants who may define the term Hispanic differently.

Likewise, data based on self-reports should be interpreted with particular caution. In some instances, respondents may over- or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys here benefit from large sample sizes and repeated administrations, enabling comparison over time. Additionally, public health surveillance data has its limitations regarding how data are collected and reported, who is included in public health datasets, and whether sample sizes for specific population groups is large enough for sub-group analyses.

While the focus groups and interviews conducted for this study provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and a small sample size. Recruitment for focus groups was conducted by community organizations, and participants were those individuals already involved in community programming. Because of this, it is possible that the responses received only provide one perspective on the issues discussed. In addition, organizations did not exclude participants if they did not live in the particular neighborhood, so participants in a specific community's focus group might not necessarily live in that area, although they did spend time there through the organization. Lastly, it is important to note that data were collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.

DEMOGRAPHICS – Who lives in Austin/Travis County?
The population of Austin/Travis County is ethnically and linguistically diverse, with wide variations in socioeconomic level, and is experiencing rapid growth, including demographic shifts among the aging, Hispanic, and Asian populations.

The health of a community is associated with numerous factors including what resources and services are available (e.g., safe green space, access to healthy foods) as well as who lives in the community. The section below provides an overview of the population of Travis County, TX. The demographics of a community are significantly related to the rates of health outcomes and behaviors of that area. While age, gender, race, and ethnicity are important characteristics that have an impact on an individual's health, the *distribution of these characteristics* in a community may affect the number and type of services and resources available.

Population

> "Austin is growing at a very fast pace which will eventually bring problems, although it is good to see the development." —Focus group participant

The City of Austin, with a population of 790,390 in 2010 has grown by over 20% since 2000, closely mirroring the increase of the state's population (Table 1). The population of Travis County has experienced even greater growth over the past decade, increasing by over 25% from 812,280 in 2000 to 1,024,266 in 2010. When focus group and interview participants were asked to describe their communities and changes that they have seen, many noted the rapid growth of the population in the region (Austin/Travis County) and specifically the changing composition of the population in terms of age, cultural backgrounds, and socioeconomic status.

Table 1: Population Change in Texas, Travis County, and Austin, 2000 and 2010

Geography	2000 Population	2010 Population	% Change 2000 to 2010
Texas	20,851,820	25,145,561	20.6%
Travis County	812,280	1,024,266	26.1%
Austin	656,562	790,390	20.4%

DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2000 Census and 2010 Census

Focus group and interview participants largely associated population growth with an influx of people attracted to the area, including retirees, immigrants and refugees. As Figure 3 demonstrates, Travis County is projected to more than double its population in the next three decades, from its present size to over 2.3 million residents. Austin is expected to see a similar upward trajectory during this time.

Figure 3: Population Projections for Travis County and Austin, 2012-2045
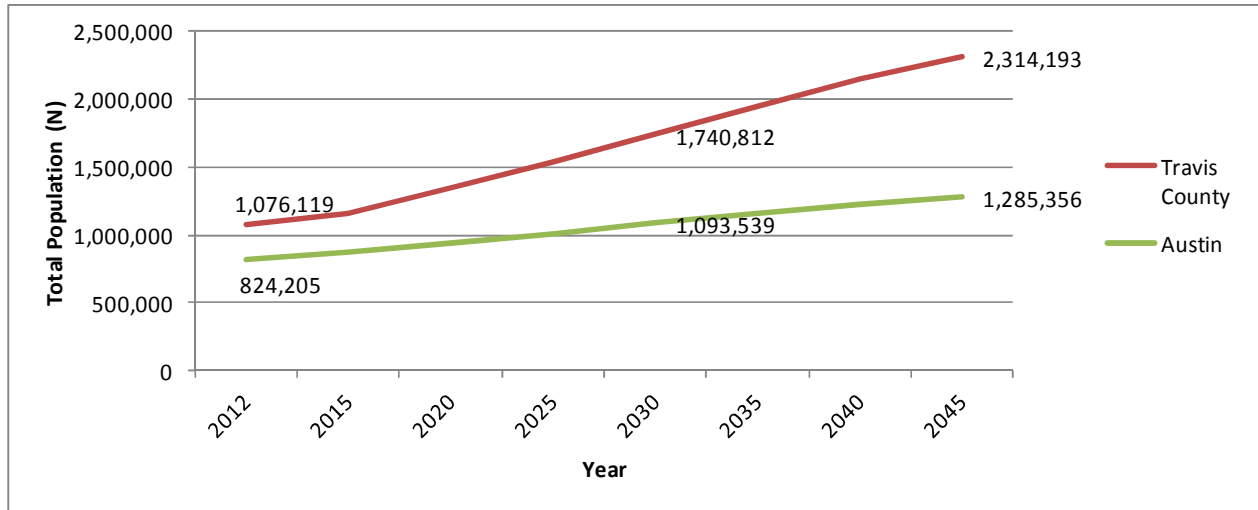
Note: At the time this CHA was developed, the Texas State Data Center had not yet released growth projections based on 2010 Census data.
 DATA SOURCE: Ryan Robinson, City Demographer, Department of Planning, City of Austin (2012). Retrieved from http://www.austintexas.gov/page/demographic-data

Age Distribution

"We have so many young people coming to Austin with the tech center and people are being pushed out [of Austin]." –Focus group participant

"Austin has a young population…as a result of having all the universities." – Interview participant

While Austin was often described as youthful, concerns regarding an increasing and often "*forgotten*" aging population were frequently expressed. The age distribution in Austin and Travis County is similar to that of Texas overall, although the statewide proportions of residents under the age of 18 and 65 years and over are higher than that of Austin and Travis County. In comparison to the nation, Austin and Travis County have higher proportions of residents between 18 and 44 years old. As illustrated in Table 2, over one-third of the populations in Austin (35.5%) and Travis County (33.9%) were between the ages of 25 and 44 years old in 2010. According to the U.S. Census, from 2000 to 2010, the senior population (aged 65 years and over) in Travis County grew by over 25% (14,204 persons).[15]

Table 2: Age Distribution in United States, Texas, Travis County, and Austin, 2010

Geography	Under 18 yrs	18-24 yrs	25 to 44 yrs	45 to 64 yrs	65 yrs and over
United States	24.0%	9.9%	26.6%	26.4%	13.0%
Texas	27.3%	10.2%	28.1%	24.0%	10.3%
Travis County	23.9%	12.7%	33.9%	22.2%	7.3%
Austin	22.2%	14.5%	35.5%	20.8%	7.0%

DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census

Racial and Ethnic Diversity

> *"Austin Independent School District, the fifth largest district in Texas, is scrambling to provide services to over so many refugee students who speak a wide range of languages."* —Focus group participant

Many participants also described the region as ethnically and linguistically diverse. Communities of color were noted as being largely comprised of Latinos/Hispanics, Blacks/African Americans, and Asians, who were also considered some of the most vulnerable populations. Several key informants highlighted a growing Latino/Hispanic population, especially among children and youth. Subsequent sections will describe how the increasing diversity of the population will impact future demand of health and other service areas.

In 2010, approximately half of the populations of Travis County (50.5%) and Austin (48.7%) were non-Hispanic White (Table 3). The Latino/Hispanic population comprised over one-third of the population and has grown substantially since 2000, whereas the non-Hispanic Black/African American population, representing approximately 8% of the total population, has proportionally decreased during that time.[16] Additionally, in the City of Austin, Latinos/Hispanics comprised more than half of the population (50.9%) under the age of 18 (Figure 4). There was also a greater proportion of non-Hispanic Asians in Travis County (5.7%) and Austin (6.0%) than in the state overall (3.8%) (Table 3); this population has also increased since 2000.

Table 3: Percent Population by Race/Ethnicity of Texas, Travis County, and Austin, 2010

Geography	White, non-Hispanic	Black/African American, non-Hispanic	Asian, non-Hispanic	Latino/Hispanic, all Races
Texas	45.3%	11.5%	3.8%	37.6%
Travis County	50.5%	8.1%	5.7%	33.5%
Austin	48.7%	8.2%	6.0%	35.0%

DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census

Figure 4: Percent Population under Age 18 by Race/Ethnicity in Austin, 2010
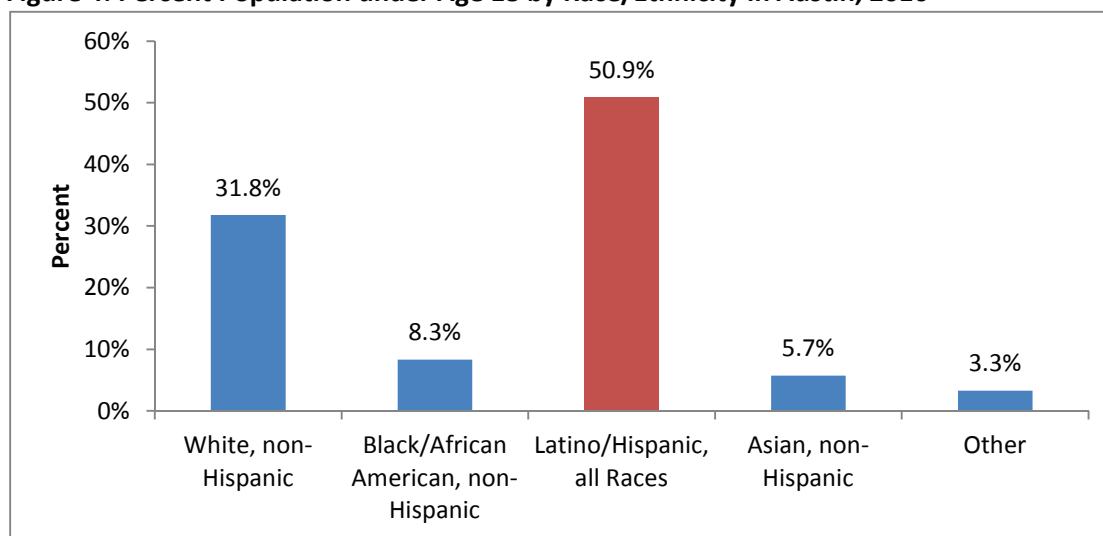
DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census. Ryan Robinson, City Demographer, Department of Planning, City of Austin, 2012

Further reflecting the diversity of the community, nearly one-third of Austin's residents spoke a language other than English at home in 2010 (Figure 5), which is greater than the national average (20.6%). Nearly 31% of Travis County residents reported speaking a language other than English at home, the majority of whom spoke Spanish (23.7%), followed by Asian or Pacific Island languages (4.1%), and other Indo-European languages (2.3%).

Figure 5: Percent Population Who Speak Language Other Than English at Home in Texas, Travis County, and Austin, 2010
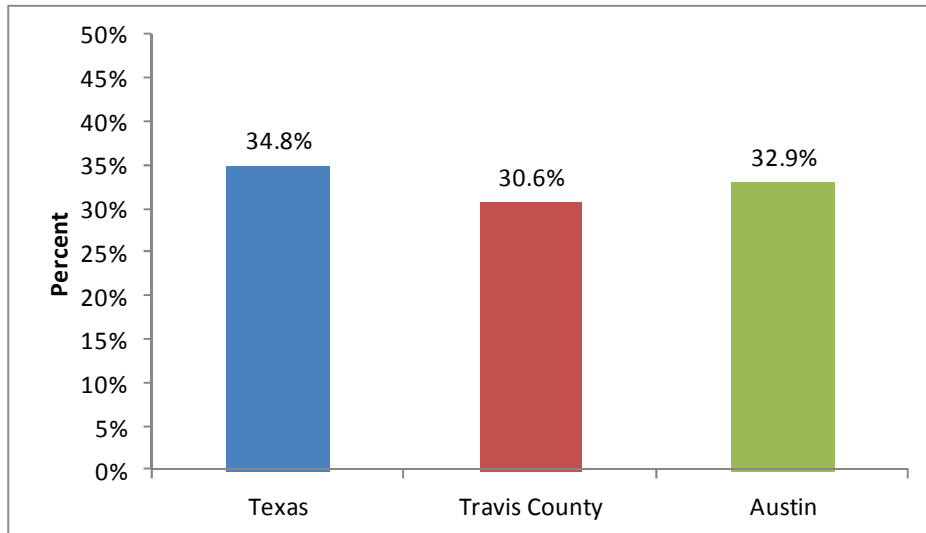
DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 1-year estimate American Community Survey, 2010[17]

Educational Attainment

> "Austin is competitive and requires that folks have a secondary education, even beyond college. The population will continue to increase, but we'll see a wider gap between those that are doing well, and those individuals that cannot get jobs." —Focus group participant

> "Job opportunities will be limited unless they get the right education." —Interview participant

> "We want to go for our GED and there are classes but in order to do the test it costs $45-$100 dollars. How are you going to afford that without a job? I think they should provide free classes and tests." —Focus group participant

Overall, the region was described by participants as highly educated; however, this was contrasted by low levels of educational attainment, specifically among the economically disadvantaged. Quantitative data demonstrate high educational attainment in the region; over 40% of Travis County and Austin adults (25 years or older) had a bachelor's degree or higher compared to 25.9% of Texas adults, as shown in Figure 6.

Figure 6: Educational Attainment of Adults 25 Years and Older in Texas, Travis County, and Austin, 2010
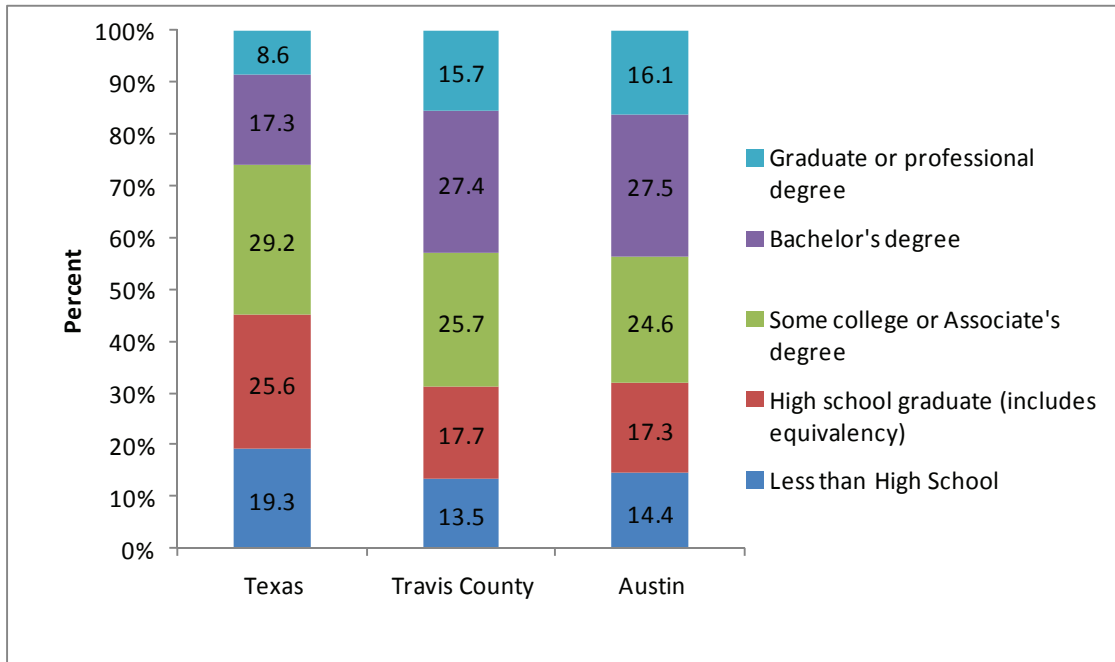
DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 1-year estimate American Community Survey, 2010

Improving low education levels among a growing Latino/Hispanic population was also seen as challenging due to linguistic barriers. Despite having a strong public school system, many key informants indicated that the system is struggling to meet the needs of disadvantaged populations; several also expressed concerns regarding an increasing high school dropout rate. Quantitative data indicate that between 2007 and 2011, the annual dropout rate for grades 7-12 decreased in seven of the nine school districts serving Travis County; Lake Travis and Manor Independent School Districts experienced an increase. Additionally, among the nine school districts serving Travis County, high school completion rates increased across racial/ethnic groups during this time, with the exception of Manor Independent School District.[18]

The presence of the University of Texas at Austin and other universities in the area was also seen as an asset for retaining a well-educated population; however, access to higher education was not viewed as equal. Supporting this sentiment, when asked what a healthy community looks like or feels like to them, community forum participants stated "*more education options*," as they cited gaps in educational attainment opportunities for more vulnerable populations, such as Hispanics/Latinos and low income groups, from primary through higher education.

Income, Poverty, and Employment

> "*More people are trading off paying bills versus buying groceries because our incomes don't cover both.*" —Focus group participant

> "*There's a bunch of unemployment. There's a bunch of 20 to 25 year old guys walking around because they got no jobs.*" —Focus group participant

<u>Income and Poverty</u>
Participants indicated that there is a broad socioeconomic spectrum in the region, ranging from low to high income. Several participants shared that there are pockets of poverty with residents who are struggling to make ends meet, the majority of whom represent minority populations. Gentrification was also described as causing a rising cost of living in the region, resulting in the displacement of residents to the outskirts of Austin and unincorporated areas in the County.

Quantitative data about income and poverty rates confirmed focus group respondents' and interviewees' perceptions of substantial variation across the region. According to the 2010 U.S. Census, median household income in Travis County was $3,128 higher than that of the State of Texas as a whole, and $4,309 higher than that of the city of Austin (Figure 7). Figure 8 illustrates that households with lower median incomes are concentrated in the eastern core.

Figure 7: Median Household Income in Texas, Travis County, and Austin, 2010
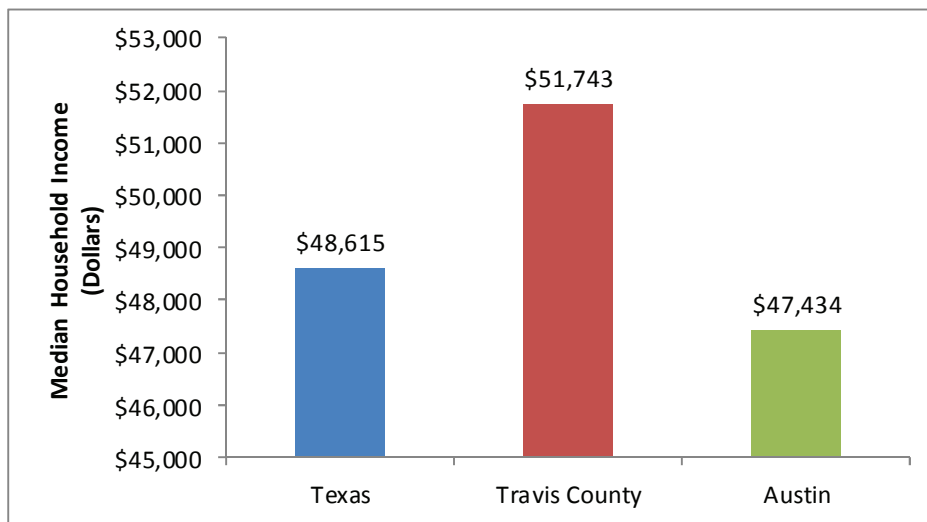
DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 1-year estimate American Community Survey, 2010

Figure 8: Median Family Income in Travis County, 2005-2009
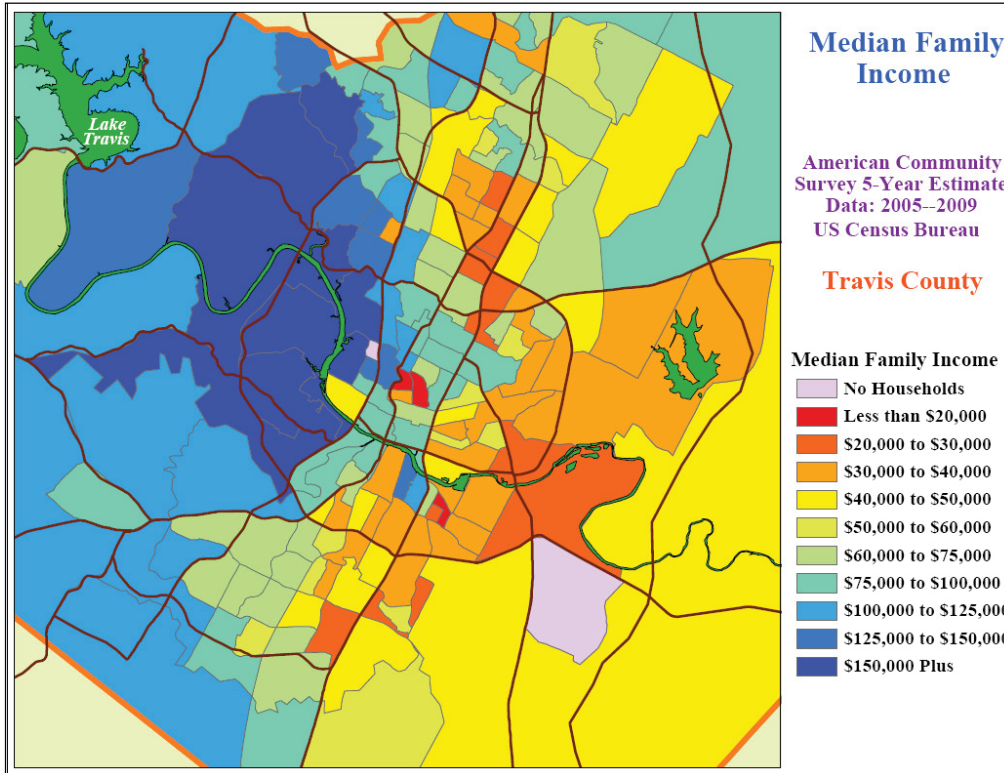
Note: 2005-2009 refers to aggregate data to increase sample size.
DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2005-2009 American Community Survey as cited by Ryan Robinson, City Demographer, Department of Planning, City of Austin, 2012

As shown in Figure 9, wealth is unevenly distributed across the population of Travis County. In 2010, the bottom fifth of households earned 3% of the income in Travis County; whereas 53% of the County's income resides among the top fifth of households.

Figure 9: Household Income Distribution among Travis County Households, 2010
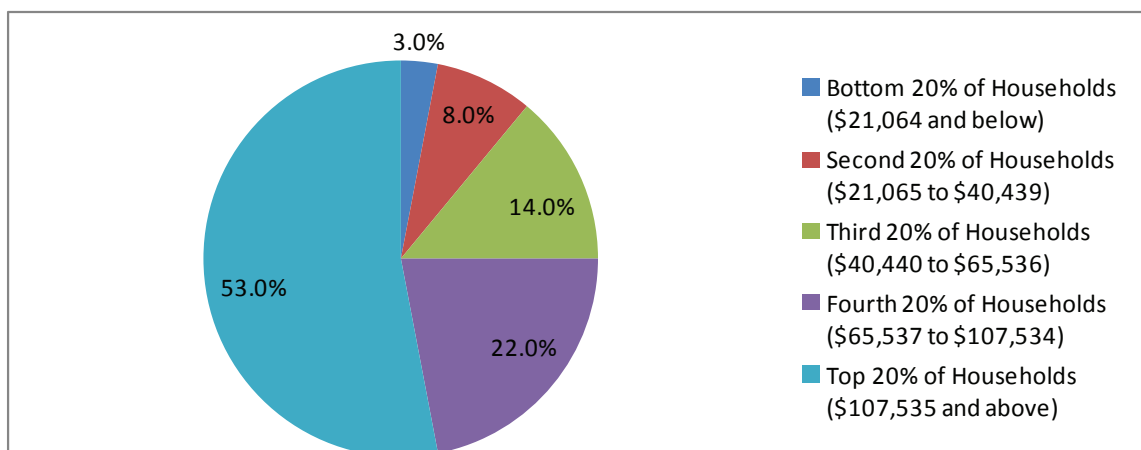
Note: In this chart, households have been separated into five groups each representing 20% of households.
DATA SOURCE: 2010 American Community Survey 1-Year Estimates as cited by Travis County HHS/VS Research & Planning Division, 2011

Poverty also disproportionately affects certain segments of the Travis County population. In 2009, the overall percentage of individuals in poverty in Travis County was 15.2%. Latinos/Hispanics were the largest proportion of the population (26.8%) living in poverty, followed by Blacks/African Americans (21.2%), both of which represent more than double the proportion of Whites (9.5%) or Asians (10.4%) living in poverty (Figure 10).[5]

Figure 10: Percent of Individuals below Poverty by Race/Ethnicity in Travis County, 2009
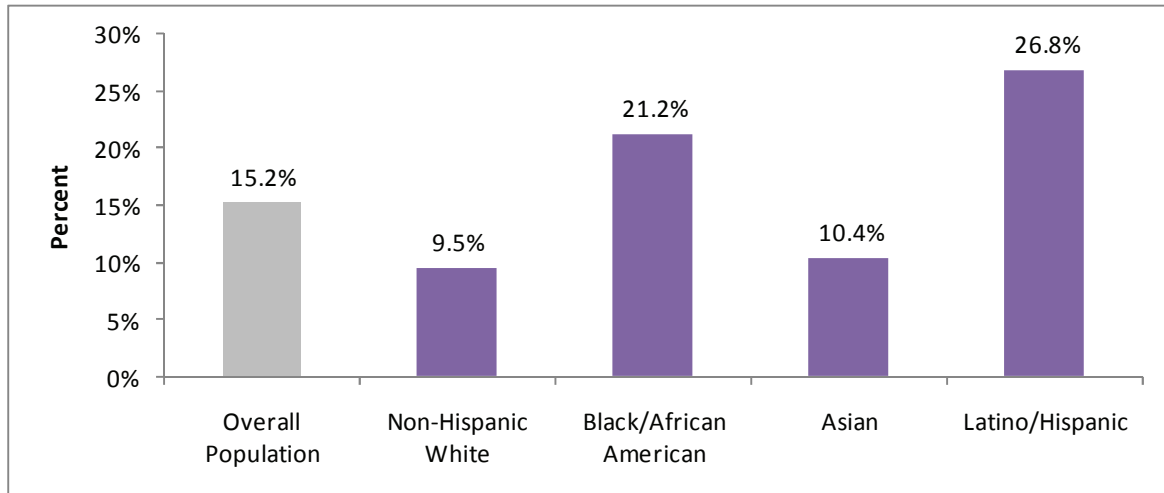
DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 1-year estimate American Community Survey (2009) as cited by Ryan Robinson, City Demographer, Department of Planning, City of Austin, 2012

There are stark racial/ethnic differences when looking at the distribution of poverty for young children. Among all children under 5 years old in poverty in the City of Austin, 82.8% of those in poverty are Latino/Hispanic (Figure 11). Among this group, 13.2% are Black/African American and 2.3% are non-Hispanic White. For further information about poverty in Travis County, see: http://www.co.travis.tx.us/health_human_services/research_planning/publications/acs/acs_focus_on_poverty_2011.pdf

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[5] Poverty level statistics indicate individuals whose income in the past 12 months fell below the federal poverty level, which is adjusted for family size. For example, in 2009, the federal poverty level was $14,570 for a family of two and $22,050 for a family of four.

Figure 11: Distribution of Poverty among Children under 5 Years Old in Poverty, by Race/Ethnicity in City of Austin, 2010
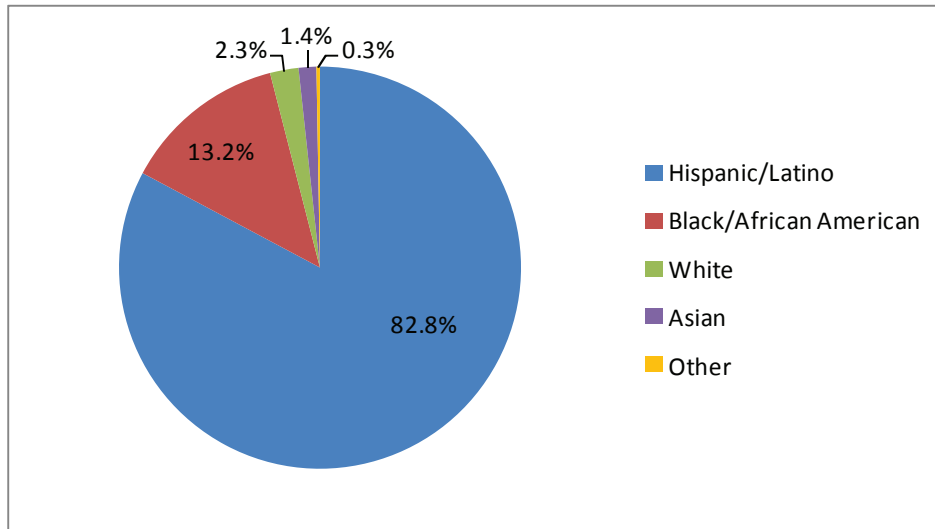
DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 1-year estimate American Community Survey (2010) as cited by Ryan Robinson, City Demographer, Department of Planning, City of Austin, 2011

Employment

In general, the workforce in the region was described as highly skilled. Several key informants indicated that Austin/Travis County was not as hard hit by the economic recession as other areas, an observation supported by quantitative data. According to the Census Bureau's 2010 American Community Survey, unemployment rates in Texas (8.8%), Travis County (8.2%), and the city of Austin (8.4%) were below that of the U.S. (10.8%) (Figure 12).

Figure 12: Unemployment in the US, Texas, Travis County, and Austin, 2006 and 2010
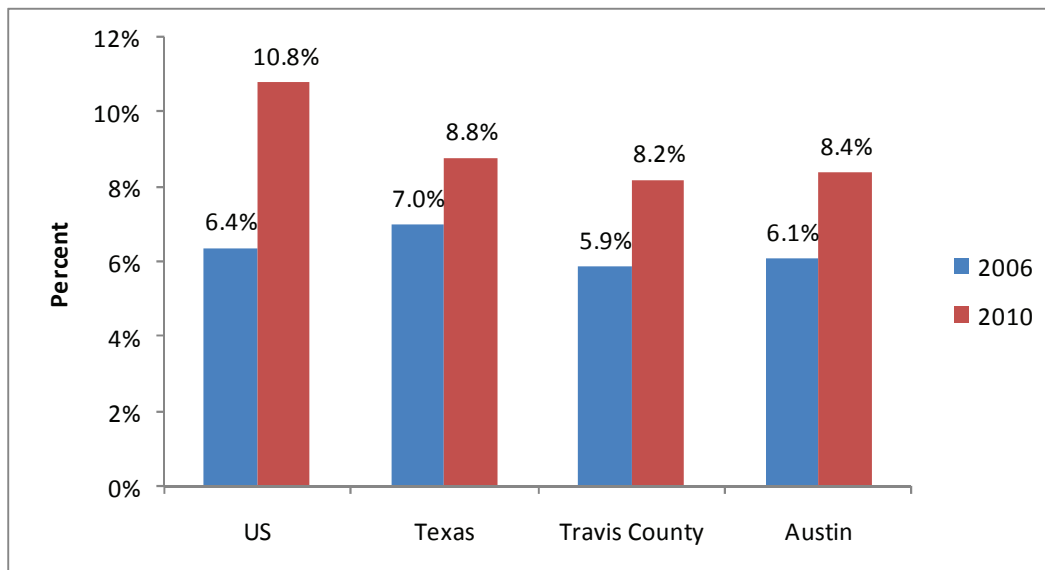
DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 1-year estimate American Community Survey, 2006 and 2010

Despite better than average employment rates, participants indicated that vulnerable populations in Travis County have been differentially affected by the economic downturn. According to key informants, while Austin's "*dynamic economy*" provides employment for residents with higher levels of education, opportunities for low-skilled residents are limited. They described that this gap in job creation is resulting in the unemployment of low-income and other high-risk populations (e.g., homeless, formerly incarcerated, disabled, or limited English proficient).

For example, several key informants indicated that, due to economic development, the technology industry (e.g., Apple) is expanding in Austin; however, there is a mismatch between job availability and skills of residents. Several participants expressed concerns for persons formerly incarcerated, explaining that residents with criminal records are struggling to find job opportunities. Spanish-speaking residents further described challenges in obtaining employment, particularly if they were not bilingual in English and Spanish, and stated that the jobs available to them (e.g., house cleaning) are low wage.

Parents and key informants also reported that the cost of childcare poses a barrier for employment as well as education. Quantitative data indicate that in Travis County the average monthly cost of child care for a family of four with two young children was 28.0% of total income, more than double what is considered affordable (10% of family income).[19]

Community forum participants discussed the economic downturn as well and identified unemployment as one of the most important issues in their communities (i.e., job losses, lack of businesses, etc.). High-risk populations, such as the homeless or previously incarcerated, were described as particularly susceptible to these issues.

The following section will further illustrate how these demographic characteristics are differentially distributed across Austin/Travis County.

SOCIAL AND PHYSICAL ENVIRONMENT – What is the Austin/Travis County community like?
There is wide variation in the demographic characteristics of Austin/Travis County resulting in geographic disparities across the region where residents lack access to services and resources.

> *"The community is very diverse and geographically and demographically dispersed throughout the city, county, and region…Many are working class and middle class citizens. Some are even high to wealthy individuals."* —Interview participant

> *"Health concerns in the unincorporated areas include poor walkability and livability. There are no sidewalks or recreation centers, and no play areas, nor access to healthy food. To get to healthy food, people have to drive a long way and gas is expensive."* —Interview participant

The social and physical environments are important contextual factors that have been shown to have an impact on the health of individuals and the community as a whole. Understanding these issues will help in identifying how they may facilitate or hinder health at a community level. For example, parks may not necessarily be able to be utilized for physical activity if residents are fearful of their safety or healthy foods may not be accessible if the public transportation system is limited. The section below provides an overview of the larger environment around Travis County to provide greater context when discussing the community's health.

Geographic Disparities

> *"When Black Americans bought houses, they bought because they could afford to buy. They bought and stayed... Other people moved in; property taxes increased; Black people couldn't afford to stay so they moved out. Now, the group coming in here is younger but the black community in the neighborhood is old. The cultures are different and there is a lack of understanding. There are too many rental properties. People who rent here should be able to buy here."* —Focus group participant

> *"East Austin is being gentrified at a fast rate; prices of homes have gone up in the past ten years. Poverty is moving out of the area of concentration and fairly well served by transit into more rural areas and far-flung suburban communities. We are being dispersed so providing service is more of a challenge."* —Interview participant

Despite the diversity of the area, many participants considered communities to be divided or concentrated geographically, with the exception of Asians who were described by focus group participants and/or key informants as being more dispersed. The east-west divide as well as differences between urban and rural communities were prominent themes across interviews and focus groups. Participants often described the division between the east and west side of Austin as delineated by interstate 35, with the west side being described as more affluent. Participants frequently identified East Austin as lacking in resources. More rural areas of communities such as Manor were described as being physically isolated. Many see the rapid growth of both Austin and Travis County as exacerbating existing disparities. Revitalization and development efforts were described as causing an outward migration of communities of color, immigrants, and urban poor to areas that lack access to services, specifically the outskirts and unincorporated areas of the City and County. Participants noted that the Black/African American community is disproportionately affected by this phenomenon. It is also important to recognize reasons for migration due to opportunity and development. City of Austin Demographer, Ryan Robinson, explains that:

> *"The large-scale suburbanization of African Americans in Austin over the past 20 years is more a function of increasing levels of affluence within the African American community and the explicit choice to move out of East Austin to places like Pflugerville and Round Rock—moves to better schools, newer housing, more middle class socioeconomic environments. The full-blown, displacing effects of gentrification are more recent than the macro-trend movement of African Americans out of East Austin."*

The following two figures geographically illustrate observations made by focus group and interview participants concerning the east-west divide in the City of Austin. In both Figure 13 and Figure 14, it is clear that the Black/African American and Latino/Hispanic populations were largely concentrated in the east. However, between 2000 and 2010, there was a notable decrease in the range and concentration of the Black/African American population in the eastern core (Figure 13). By contrast, the Latino/Hispanic population is not only expanding throughout the eastern core, but neighborhoods that were predominantly Latino/Hispanic in 2000 increased in concentration by 2010 (Figure 14).

Figure 13: Changing Black/African American Population Concentrations in Eastern Austin, 2000 and 2010
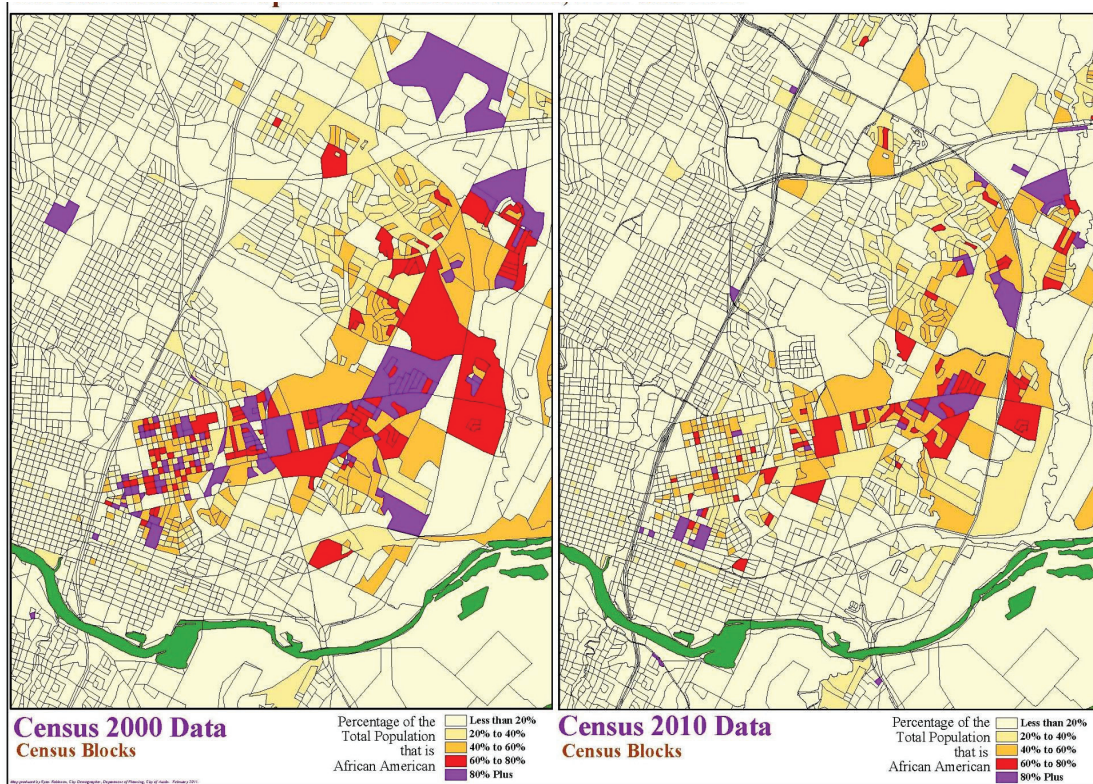
Census 2000 Data
Census Blocks

Percentage of the
Total Population
that is
African American

Less than 20%
20% to 40%
40% to 60%
60% to 80%
80% Plus

Census 2010 Data
Census Blocks

Percentage of the
Total Population
that is
African American

Less than 20%
20% to 40%
40% to 60%
60% to 80%
80% Plus

DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2000 Census and 2010 Census as cited by Ryan Robinson, City Demographer, Department of Planning, City of Austin, 2012

Figure 14: Changing Latino/Hispanic Population Concentrations in Eastern Austin, 2000 and 2010
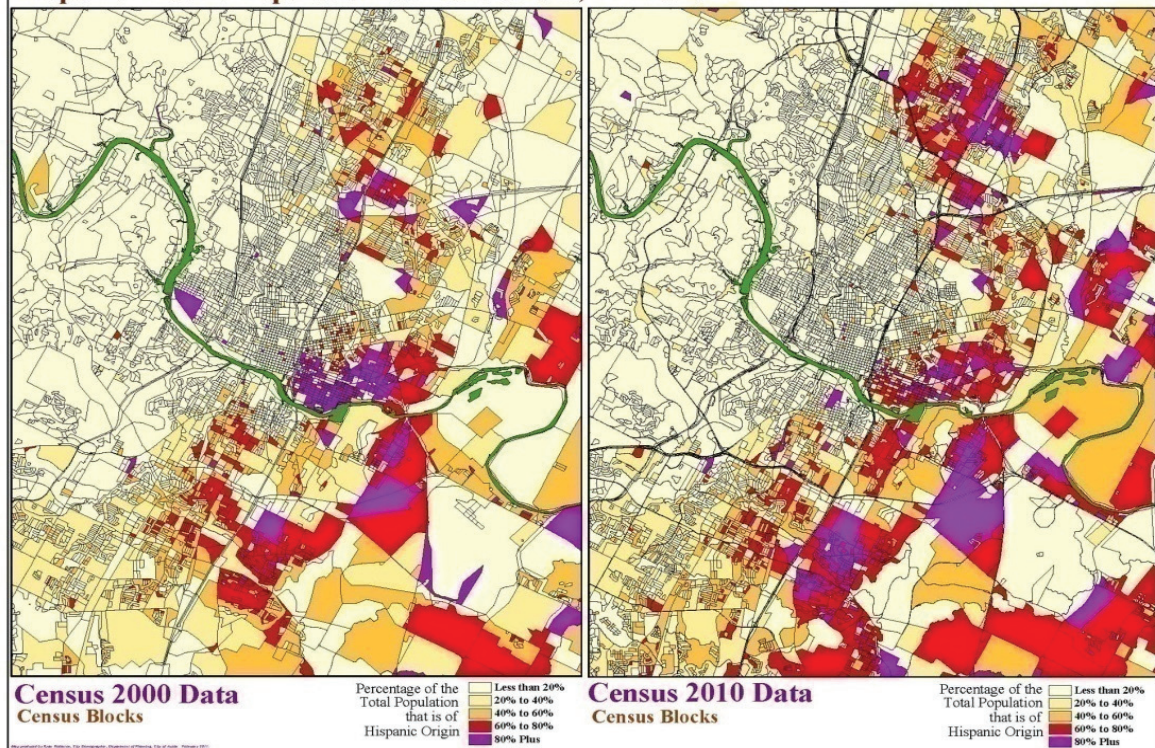
DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2000 Census and 2010 Census as cited by Ryan Robinson, City Demographer, Department of Planning, City of Austin, 2012

The rest of this section will elaborate upon how these communities are affected by lack of access to resources such as transportation and housing.

Transportation

> *"Transportation to health centers is an issue. We have a decent bus system with rates that are reasonable for the most part, but our general transportation infrastructure is deficient in all categories –public transit and highways. Increasingly, the poor have to depend on private vehicles which are just an added cost for people already overwhelmed by costs."* —Interview participant

> *"My aunt is diabetic and she has stomach problems and it's hard for her to catch the bus with three children. When she's on the bus she has to take all the groceries and carry the baby also. Why does she have to go do all that? Why doesn't someone help her out with that issue?"* —Focus group participant

Transportation emerged as one of the most common cross-cutting themes of the assessment, affecting aspects of everyday life in the region, and especially the health of the community. Participants described Austin/Travis County as a largely car-dependent region that does not support other modes of transportation, such as walking or biking. For example, the lack of sidewalks was considered a barrier to transportation, and participants expressed feeling unsafe when walking. Frustration was also expressed by focus group and interview participants regarding unfinished or incomplete roadways. Those who did drive reported that the rising cost of gasoline and heavy traffic make travel more difficult. Community

forum participants shared in these challenges, citing a lack of local public transport, crumbling infrastructure (i.e., cracked roads), and road congestion as some of the most important problems facing their communities.

Contributing to the traffic congestion, quantitative data illustrate that, consistent with the state (83.0%) and national (80.0%) figures, a majority of Travis County workers in 2010 drove alone to work (79.0%) (Table 4) and had an average commute time of 23.8 minutes.[20]

Table 4: Means of Transportation to Work for Workers 16+ Years in US, Texas, and Travis County, 2010

Transport Mean	U.S.	Texas	Travis County
Car, truck or van (Drove Alone)	80.0%	83.0%	79.0%
Car, truck or van (Carpooled)	10.0%	12.0%	11.0%
Public transportation (Excluding Taxicabs)	5.0%	2.0%	4.0%
Other Means	5.0%	0.0%	6.0%

DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 1-year estimate American Community Survey, 2010

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

Housing

> *"It is disturbing to see how much of an investment is going into developing high priced condo spaces in the downtown area and how little is going into developing and planning for more affordable housing."* —Interview participant

> *"It seems like there is a 2-year waiting list. They're backed up and the rent is expensive. Section 8 and low-income housing is backed up…People are trying to move to Austin thinking it's a bigger city and there's more opportunity, but there's not."* —Focus group participant

Challenges around access to affordable housing were frequently raised by focus group and key informant participants. Residents described struggling to pay high rent prices and an increasing demand for affordable housing resulting in long waiting lists to access Section 8 housing. As Figure 15 illustrates, Section 8 housing is concentrated largely in the eastern core. Utility costs and home repair costs were also considered prohibitive. Rising property values and taxes as a result of revitalization efforts and subsequent gentrification were described as forcing residents to move to more affordable areas outside the City. According to some participants, other residents have been negatively affected by the depreciating value of their homes and increasing foreclosures. Several long-term residents of communities observed seeing the composition of their neighborhoods change from home owners to

renters. Key informants also indicated that the lack of affordable housing is resulting in a transient population; this instability was described as creating challenges for the school system to educate frequently mobile children.

Figure 15: Distribution of Section 8 Rental Housing Units in Austin, 2010
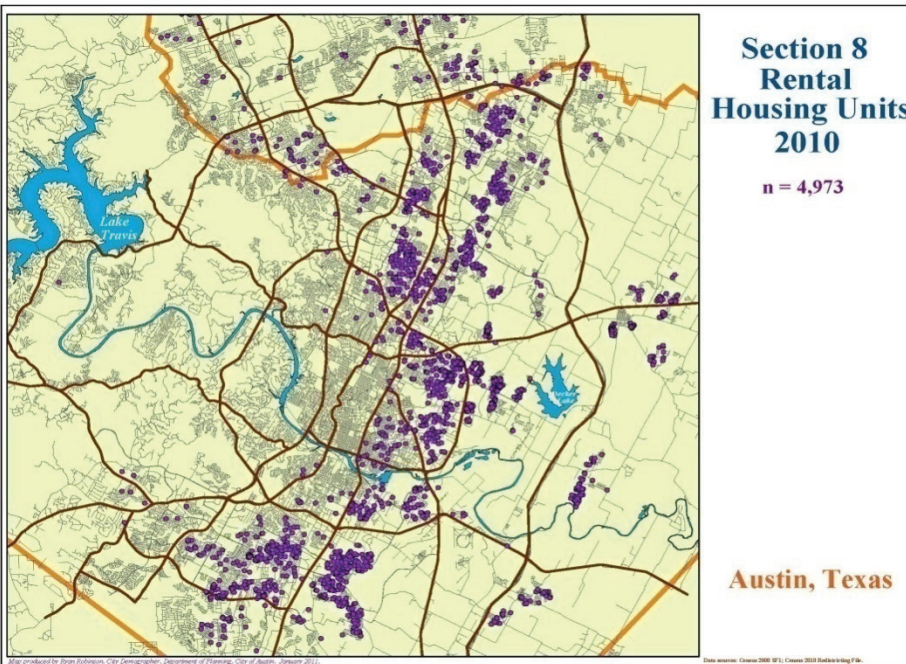
DATA SOURCE: DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010 Census as cited by Ryan Robinson, City Demographer, Department of Planning, City of Austin, 2012

Quantitative data confirm an increase in both housing and renting costs between 2000 and 2009. As illustrated in Figure 16, the median housing price increase in Austin (31.1%) was consistent with the percent increase in Texas as a whole (31.7%). Although the median rent increase in the City of Austin was not as great as it was at the state-level, it still rose 22.0% over nine years. In 2010, the percentage of residents whose housing costs were 50% or more of their household income was greater in Travis County than in Texas for both renters and homeowners (Figure 17).

Figure 16: Increase in Median Rent and Median Housing Prices in Texas and Austin, 2000-2009
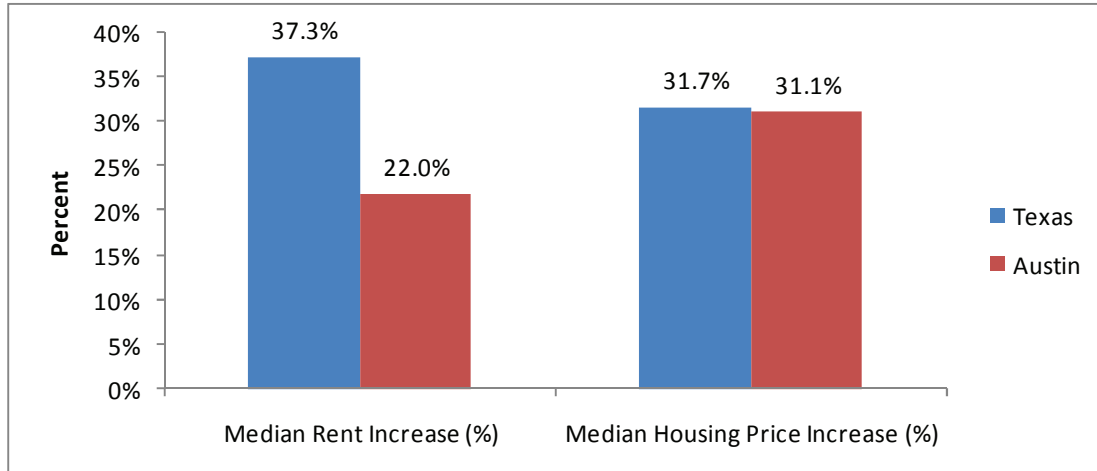
DATA SOURCE: Imagine Austin Comprehensive Plan, Imagine Austin (2000-2009) as cited in Experiencing Austin: Who are we Today?, 2012

Figure 17: Percent of Residents Whose Housing Costs are 50% or more of Household Income in Texas and Travis County, 2010
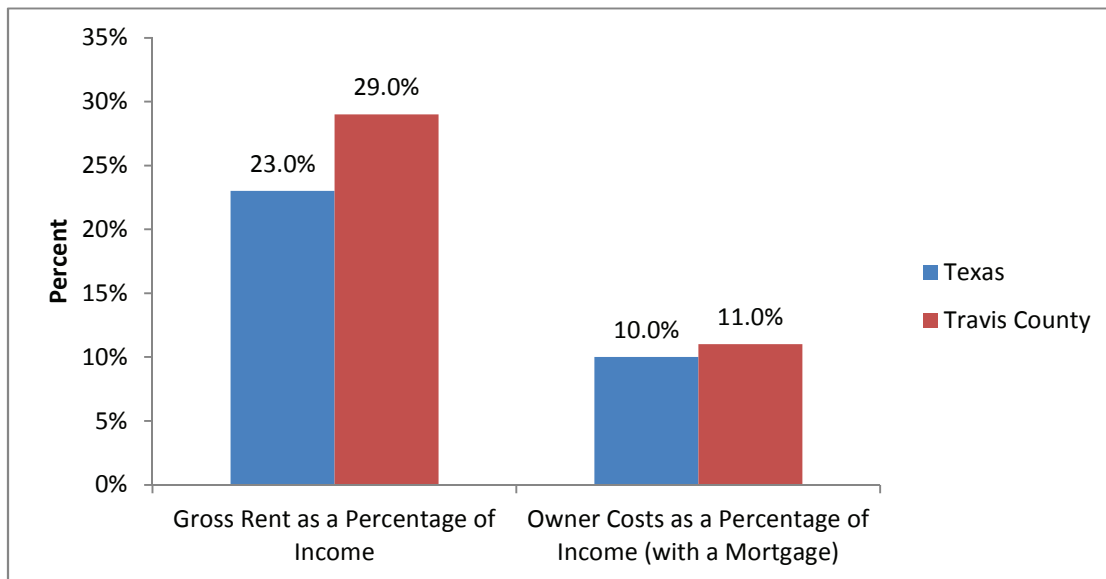
DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 1-year estimate American Community Survey, 2010

According to City Demographer Ryan Robinson, *"In addition to East Austin, the pressure from rapidly rising property values has affected middle class families throughout the urban core."* Nationally the median housing value has decreased from 2006-2010; whereas the median housing value in Travis County increased by 23.6% during this time, compared to 12.4% in Texas (Table 5).

Table 5: Median Housing Values in U.S., Texas, and Travis County, 2006 and 2010

Geography	2006	2010	% Change 2006 to 2010
U.S.	$185,200	$179,900	- 2.9%
Texas	$114,000	$128,100	12.4%
Travis County	$173,200	$214,100	23.6%

DATA SOURCE: 2006 and 2010 American Communities Surveys

In addition to affordability, substandard housing was also mentioned as a concern. Focus group participants expressed frustration with the lack of apartment and facility maintenance. Residents of senior housing and public housing as well as apartments indicated that housing issues are not promptly addressed by landlords and property owners. In a few focus groups, bed bugs were mentioned as a housing issue several residents were experiencing.

Homelessness was commonly discussed as a concern of many key informants due to the lack of affordable and supportive housing; interview participants indicated that this vulnerable population, including children who are homeless, is growing. The number of homeless persons identified through the annual Austin/Travis County Homeless Count, was 2,244 in 2012. Point-in-time count limitations traditionally undercount families and children and do not include those living in marginal conditions such as on a friend's sofa or in a motel. However, 2011 point-in-time homeless counts illustrate a 35% decrease from 2008.[23] Community forum participants identified increased costs in the housing market, retaining membership in homeowner's associations, monthly rent, and utilities bills as challenges that often lead to homelessness.

Access to Healthy Food and Physical Activity

> *"We have to go further to get fresh food and that takes more time, more gas money and a lot of driving. "*—Focus group participant

> *"Making the built environment one that works for people –making bike lanes, thinking about walkability, creating areas in which people can play and recreate are all very important. We are not building our cities in this manner."* —Interview participant

When describing their community, many participants discussed the impact of the built environment (e.g., parks, recreational facilities, traffic, etc.) on their ability to consume healthy food and engage in physical activity. The existence of food deserts was a prominent theme throughout key informant interviews. Participants identified that several communities are void of grocery stores and lack public transport to travel to supermarkets. In 2006, 8.7% of Travis County's low-income population did not live close to a grocery store (i.e., less than 1 mile), as compared to Texas' 11.6% (Figure 18). The percentage of residents in Travis County considered to be food insecure was 16.6% in 2010, lower than that of Texas (18.5%) and similar that of the U.S. (16.1%) (Table 6). East Austin and eastern Travis County in particular were identified as lacking proximity to stores that sell fresh produce. Refugees shared that in their home countries they had gardens and could produce their own food, whereas in Austin they are unable to do so. However, key informants did note that there are efforts to address food deserts, such as expanding farmers markets to disadvantaged neighborhoods.

Figure 18: Percent of Population who are Low-Income and do not Live Close to a Grocery Store, 2006
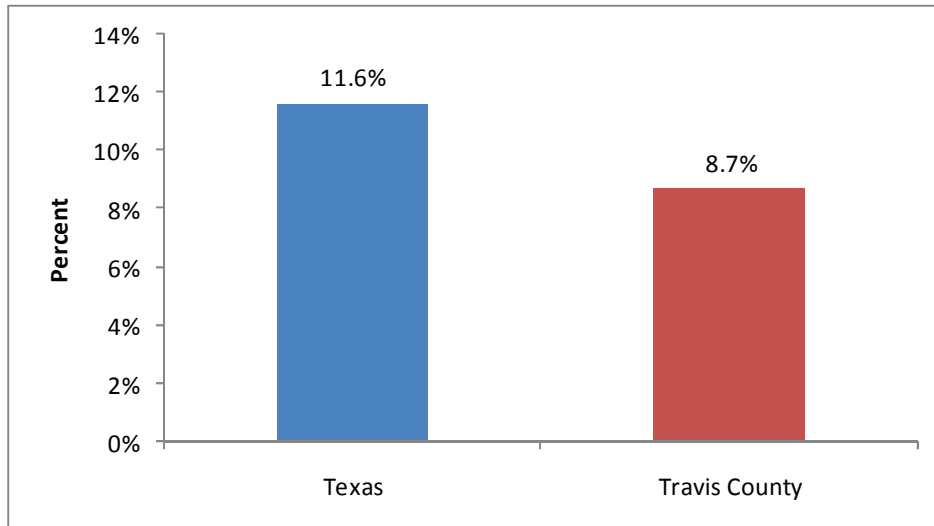
DATA SOURCE: United States Department of Agriculture, Food Environment Atlas (2006) as cited in County Health Rankings, 2012

Table 6: Percent of Residents Considered Food Insecure in US, Texas, and Travis County, 2010

Geography	Percent	Total Number of Food Insecure People
US	16.1%	-
Texas	18.5%	4,672,780
Travis County	16.6%	162,440

Note: Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food.
DATA SOURCE: Feeding America 2010, Food Insecurity and Food Cost in the United States (2010). Retrieved from http://feedingamerica.org/hunger-in-america/hunger-studies/map-the-meal-gap/child-food-insecurity-executive-summary.aspx

Furthermore, several residents shared that while healthy food may be readily available through local grocery stores and supermarkets, cost is often prohibitive. In 2010, the average cost of a meal in Travis County was $2.36, which was 5 cents greater than the Texas average ($2.31) and 16 cents less than the national average ($2.52).[24]

A few focus group participants also indicated that supermarkets in certain areas have lower quality produce than others.   Similarly, community forum participants noted that they could be healthier in their communities if they had better access to affordable, healthy food options (i.e., proximity of grocery stores, healthy food options at restaurants, community gardens, etc.). In 2009, just over half of the restaurants in Travis County (51.0%), much like in Texas as a whole (53.0%), were fast-food establishments.[25]

Participants frequently described that there is unequal access to green space and recreational facilities; while parks and recreational centers exist, they are not in close proximity or residents are unaware of how to access them. Additionally, programs offered at recreational centers were considered unaffordable by some residents. Lack of access to recreational facilities and programs (e.g., YMCA) and the need for more bike and pedestrian friendly areas was expressed by both focus group and interview

participants. In 2009, there was a higher rate of recreational facilities in Travis County (11.1 facilities per 100,000 population) than in Texas as a whole (7.2 facilities per 100,000 population).[26] While community forum participants recognized an existing presence of these facilities to promote physical activity (i.e., parks, school tracks), they ultimately concluded that additional services, such as affordable exercise programs and recreational centers, were needed in order to achieve their definitions of a healthy community.

Environmental Quality

> *"The lack of water has resulted in situations in which residents cannot flush toilets or cook so they frequently report septic tank issues. Repairs are needed for these tanks but there is no funding for these systems which are no longer code compliant."* —Interview participant

The extended drought in the region and lack of access to water were mentioned by some participants. A few key informants noted the lack of water in outlying areas—outside of Austin but within Travis County— is creating challenges around sanitation and other housing issues. Participants also expressed concerns regarding the negative impact of traffic congestion on air quality and the resulting health effects (e.g., asthma and other respiratory illnesses). While the annual number of unhealthy air quality days (due to fine particulate matter) throughout the State ranged from 0 to 6 (with an average of 1 day) in the year 2007, Travis County recorded 0 unhealthy air quality days (Table 7). As for the air pollution ozone days, which represent the annual number of days that air quality was unhealthy for sensitive populations due to ozone levels, Travis County recorded 16 days, fewer than that of the State (Table 7). According to the Imagine Austin Comprehensive Plan, although Central Texas is compliant with federal air quality standards, the area is "in danger of exceeding ground-level ozone due to stricter federal standards".[27]

Table 7: Air Pollution - Ozone and Particular Matter Days in Texas and Travis County, 2007

Geography	Particulate Matter Days	Ozone Days
Texas	1	18
Travis County	0	16

DATA SOURCE: Community Multi-Scale Air Quality Model output and Air Quality Monitor Data, Public Health Air Surveillance Evaluation (PHASE) project, Centers for Disease Control and Prevention (CDC) and the EPA (2007), as cited in County Health Rankings, 2012

Crime and Safety

> *"I live in Southeast Austin. It's a rough neighborhood with sirens and crime. I feel safe in my home, but it's not that safe outside at night. The crime in Southeast Austin has really grown a lot. Crime and gangs – it's something I am not used to. It's unfortunate that that is the way it is. I hope not to stay there long. This city has grown a lot and with growth comes crime."* —Focus group participant

The importance of feeling safe in one's community was discussed in several focus groups. While some residents indicated that crime was not an issue in their community, others expressed concerns regarding vandalism, gangs, and drug dealing. The participation of youth in crime related activities and the role of law enforcement were discussed as well. Levels of neighborhood cohesion and police presence were frequently associated with how safe one felt in their community and feelings of insecurity were most often experienced at night. Parents expressed concern for the safety of their children when playing

outside, primarily regarding traffic safety, and noted the lack of secure recreation spaces. Safety was also one of the community issues cited most often by community forum participants, particularly referring to issues around the built environment (i.e., lack of sidewalks and street lighting), teen drug use and gang activity, property crime, and police brutality.

According to 2010 FBI Uniform Crime Reports data, while the violent crime rate in Texas and the City of Austin were similar, the property crime rate was substantially higher in the City of Austin (5,754.8 per 100,000 population) as compared to Texas as a whole (3,783.0 per 100,000 population) (Figure 19). The violent and property crime rates in Travis County were 495 and 3,692 per 100,000 population, respectively; however, it is important to note that this data excludes the City of Austin. In some focus groups, a few participants expressed concern over the city's growth in population potentially causing an escalation in crime rates; however, similar to Texas, examining trends in crime data from 2006 to 2010 indicated a decrease in Austin's violent (515.3 per 100,000 population in 2006) and property crime rates (5,856.9 per 100,000 population in 2006).[28]

Figure 19: Offenses Known to Law Enforcement per 100,000 Population in Texas and Austin, 2010
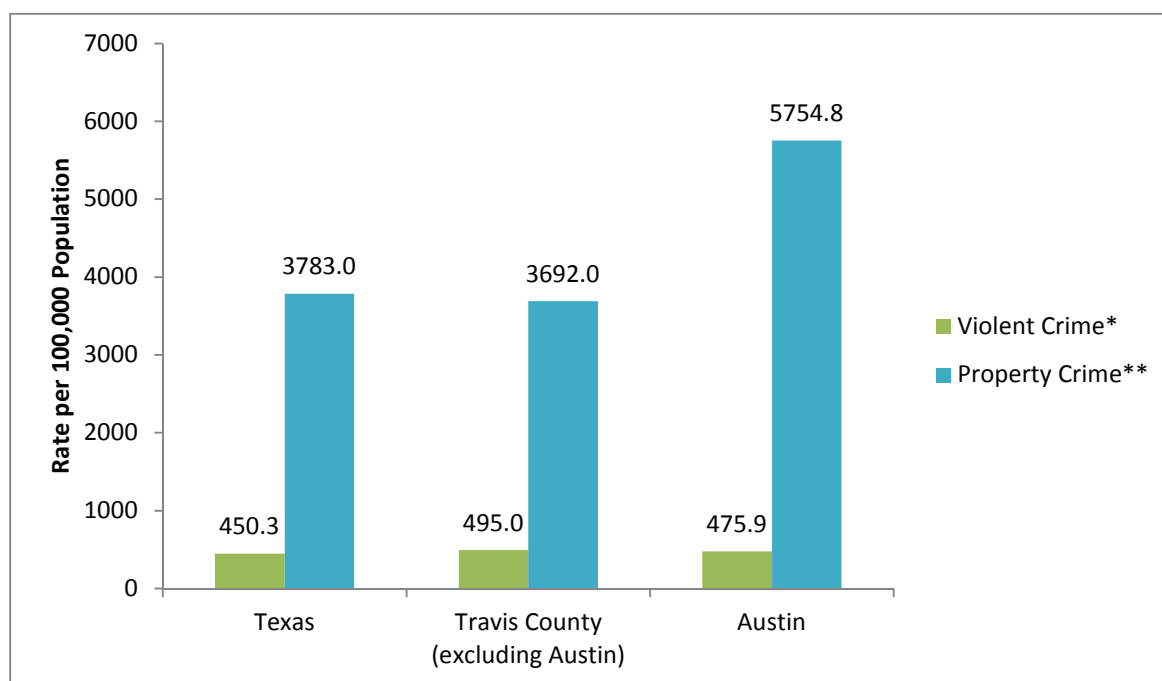
***Violent crime includes: murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.
**Property crime includes: burglary; larceny-theft; motor vehicle theft; and arson.
NOTE: The data shown for Travis County in this chart do not reflect county totals but are the number of offenses reported by the sheriff's office or county police department.
DATA SOURCE: Federal Bureau of Investigation (2010). Uniform Crime Reports. Offenses Known to Law Enforcement, by State, by City, 2010

The underreporting of domestic violence and child abuse was briefly mentioned by some residents, but these issues were not heavily discussed. Figure 20 illustrates that in Travis County and Austin, overall family violence rates were increasing up until the year 2008. In the subsequent two years for which data are available, there was a notable decrease. For example, Travis County rates fell from 1,032.5 per 100,000 population in 2008 to 866.9 per 100,000 population in 2010. It should be noted that these rates

refer to police reports and not number of unique individuals. Similarly, while the statewide rate of child abuse and neglect has remained relatively stable from 2006-2010, the rate has declined in Travis County during this time period (Figure 21).

Figure 20: Overall Family Violence Rate per 100,000 Population in Texas, Travis County, and Austin, 2006-2010

NOTE: Rates standardized to the 2010 Census population figures. Represents reports and not individuals. The data shown for Travis County in this chart do not reflect county totals but are the number of offenses reported by the sheriff's office or county police department.
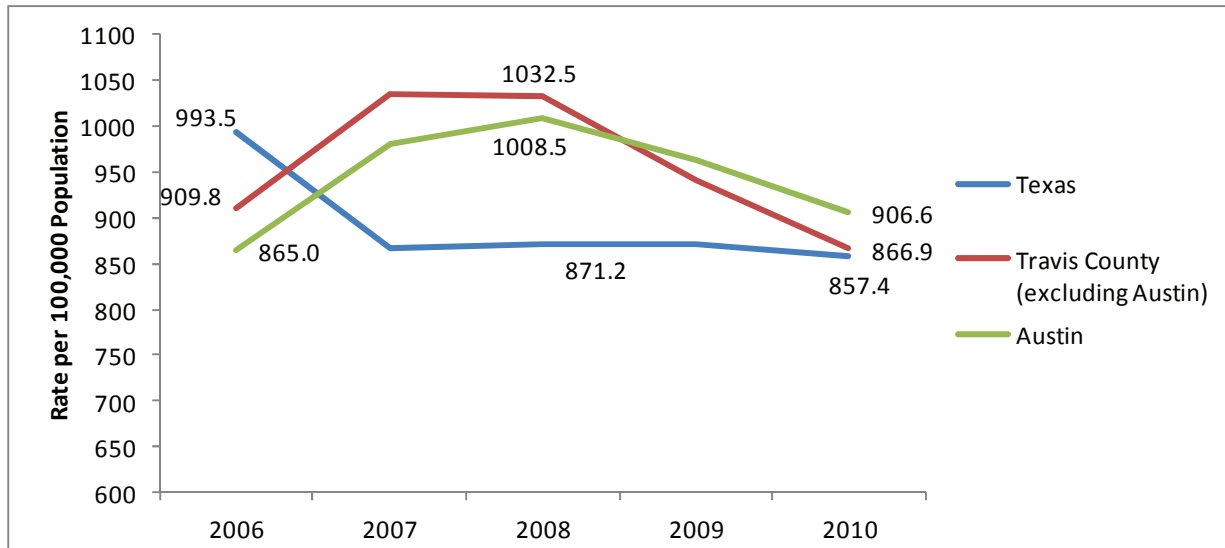DATA SOURCE: Austin data: Austin Police Department, Public Information Request (2012); Travis County data: Travis County Sheriff's Office, Public Information Request (2012); Texas data: Texas Department of Public Safety, Public information request (2012).

Figure 21: Rate of Confirmed Cases of Child Abuse and Neglect per 1,000 Children in Texas and Travis County, 2006-2010
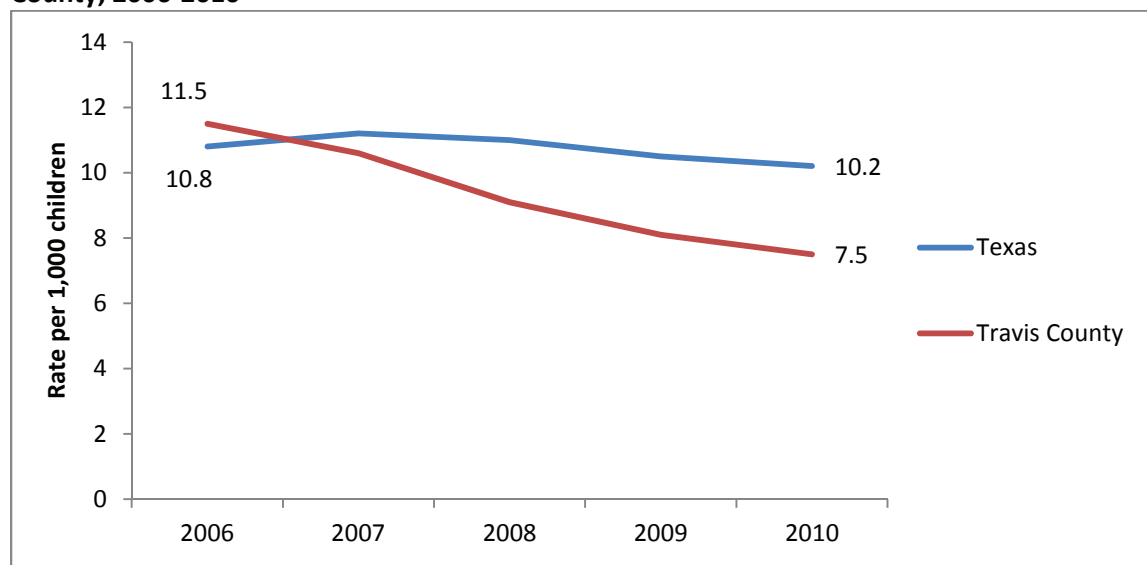
DATA SOURCE: Texas Department of Family and Protective Services, Annual Reports and Data Books, 2006-2010

COMMUNITY STRENGTHS AND RESOURCES
Focus group and interview participants identified several community strengths and assets, including social and human capital, access to services, and organizational leadership and partnerships.

> *"Breadth and depth of collaborative activities going on in the county; there are lots of people thinking about public health and working together to leverage dollars to serve folks."* — Interview participant

Participants in focus groups and interviews were asked to identify their communities' strengths and assets. Several themes emerged as discussed throughout this report. This section briefly highlights some of the key community strengths which focus group and interview participants identified.

Social and Human Capital
Many participants described Austin as an entrepreneurial and liberal city, whose open minded and creative residents benefit the community in many ways. The cultural richness and diversity of the area were noted by participants as positive aspects of their community. Participants also stated that there is a strong sense of community and pride in Austin; many residents highlighted neighborhood cohesion as a strength of their community. Participants mentioned efforts in their communities such as "Neighborhood watch" and noted that residents *"take care of each other"* or *"look out for each other,"* which enhances the safety of neighborhood. They also cited several community resources in the area, such as senior citizen centers, that were described as facilitating social cohesion. Additionally, many key informants stated that Austin is a health conscious and physically active city.

Communities were also described as being politically active; many participants highlighted the engagement of residents in efforts to improve the community as an asset, although it was noted by some that *who* is engaged is not always representative of the community. Quantitative data reporting the percentage of residents that voted in the 2008 presidential election (66.1%), which was greater than

that of the state (56.0%) and the nation (64.0%), support these observations around active civic engagement in the region.[29]

Access to Services
Despite the challenges to accessing services noted in previous sections, residents did note the multitude of resources available to them in their community, given that one knows how to access them. This included public safety, the education system, hospitals such as Seton and St. David's, and churches, among others. Residents living in more densely populated areas of the city described having easy access to transportation as well as proximity to health care facilities, supermarkets, and other resources. Several focus group participants appreciated the access to public safety services in their community, particularly law enforcement, and how it increased their sense of neighborhood safety. Austin was described as a "college town" and the presence of the University of Texas at Austin and other area universities and colleges was viewed as a valuable resource in the community, providing a well-educated workforce. Similarly, the strong public school system was also considered an asset. Austin was commonly described as a family-oriented community due to the quality of its public schools and the availability of community resources such as parks. Key informants and focus group participants noted that strong health care and social services serve the area as well. Additionally, the helpful services and support provided by area churches, such as food pantries, were mentioned by focus group participants.

Organizational Leadership and Partnerships
Similarly, community-based and not-for-profit organizations were described as assets, especially for their willingness to collaborate and their committed, innovative leadership. Several key informants stated that Austin has a *"vibrant"* nonprofit community. Residents appreciated the plethora of community-based organizations, such as Casa Marianella and El Buen Samaritano, which were noted as providing critical services for immigrants. Key informants cited many community partnerships among organizations, many of which focus on addressing the community challenges and concerns described throughout this assessment. The partnerships and collaborations among organizations were extensive and considered critical to achieving change in the region. Participants credited both elected officials and community leaders for their dedication and creativity towards addressing community challenges. For example, residents indicated that elected officials were responsive to their needs; as one participant shared*, "the commissioner here got us the bus line to come here after some phone calls."* Key informants recognized the leadership of elected officials in promoting and supporting the health of the community.

HEALTH BEHAVIORS
A majority of key informants, including Central Health Connection interviewees, considered obesity to be a pressing health issue, particularly among children and in relation to other chronic diseases such as diabetes and heart disease.

This section examines lifestyle behaviors among Travis County residents that support or hinder health. Several aspects of individuals' personal health behaviors and risk factors (including physical activity, nutrition, and substance use) result in the leading causes of morbidity and mortality among Travis County residents. Included in this analysis are specific measures that are tracked as part of the Healthy People 2020 (HP2020) Initiative, a 10-year agenda focused on improving the Nation's health. Due to data constraints, most health behavior measures are available only for Travis County as a whole, not Austin specifically. When appropriate and available, Travis County statistics are compared to those of the state as a whole as well as HP2020 targets.

Obesity

A majority of key informants, including Central Health Connection interviewees, considered obesity to be a pressing health issue, particularly among children and in relation to other chronic diseases such as diabetes and heart disease. Interview participants identified disparities among racial/ethnic groups impacted by obesity, especially Blacks/African Americans and Latinos/Hispanics. While obesity was only mentioned as a community concern in a few focus groups, the importance of and challenges around nutrition and exercise were frequently discussed.

Quantitative results show that in 2008-2010, the percentage of obese adults in Travis County (24.0%) was less than that of the state (29.6%), both of which are better than the HP2020 target (30.6%); however, Blacks/African Americans and Latinos/Hispanics experienced much higher rates of obesity, 41.7% and 36.5% respectively, compared to less than 20% of Whites (19.4%) (Figure 22). This pattern is consistent for the youth population (grades 9-12) where the percentage of obese youth at the county-level was below that of Texas overall (15.6%) and the national HP2020 target (14.6%), yet higher among Blacks/African Americans (12.0%) and Latinos/Hispanics (13.0%) (Figure 23). Additionally, while female adults (25.5%) were slightly more likely to be obese than male adults (22.6%), male youth (13.8%) were more than twice as likely to be obese than female youth (6.0%).[30]

Figure 22: Percentage of Obese Adults (BMI≥30) in Texas and by Race/Ethnicity in Travis County, 2008-2010
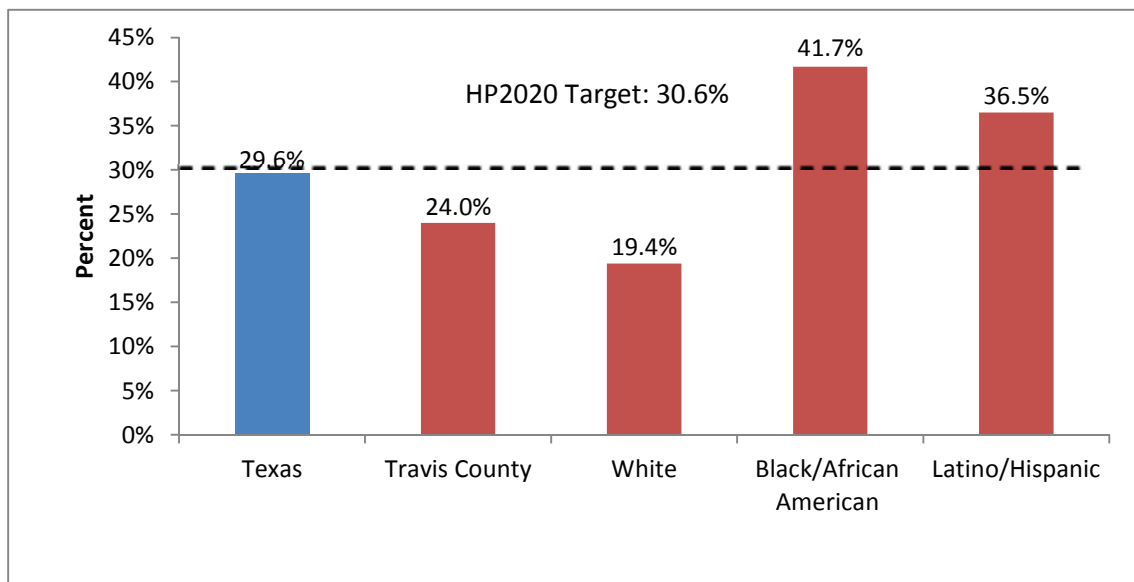
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

Figure 23: Percentage of Obese Students (9th-12th grade) in Texas (2011) and by Race/Ethnicity in Travis County, 2010
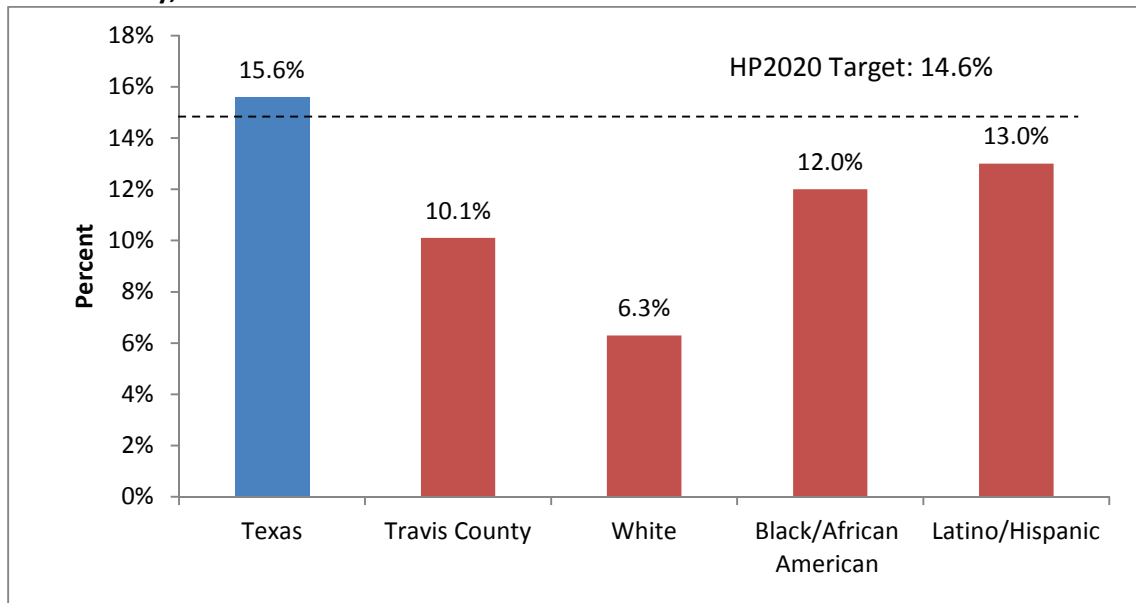
Note: Obesity defined as at or above the 95th percentile body mass index (BMI) by age
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Travis County Youth Risk Behavioral Survey*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2010 and 2011

Healthy Eating and Physical Activity

> *"We have the access but not the finances. While we have a good HEB right here, we got a raise in costs – in utilities and rent– so that's where our money goes. Also, trying to buy fresh fruits and vegetables can be difficult, but it's not an access issue it's a quality issue."* —Focus group participant

Focus group participants described struggling to afford fresh fruits and vegetables when their paycheck is depleted by housing costs (e.g., rent and utilities). Most residents expressed that healthy food is available but not affordable. Several focus group participants indicated that the availability and marketing of fast food also presents challenges to healthy eating because of its comparative convenience and affordability.

As seen in Figure 24, less than 30% of Travis County and Texas adult residents reported eating five or more fruit and vegetable servings per day (the recommended guideline). Consumption was even lower for Black/African American and Latino/Hispanic adults in Travis County (both at 24.1%). When this data was stratified by income in Travis County, it was noted that the percentage of adults who consume the recommended amount of fruits and vegetables increased with income. However, even within the highest economic bracket illustrated in Figure 25, less than one-third of the population is meeting the guideline.

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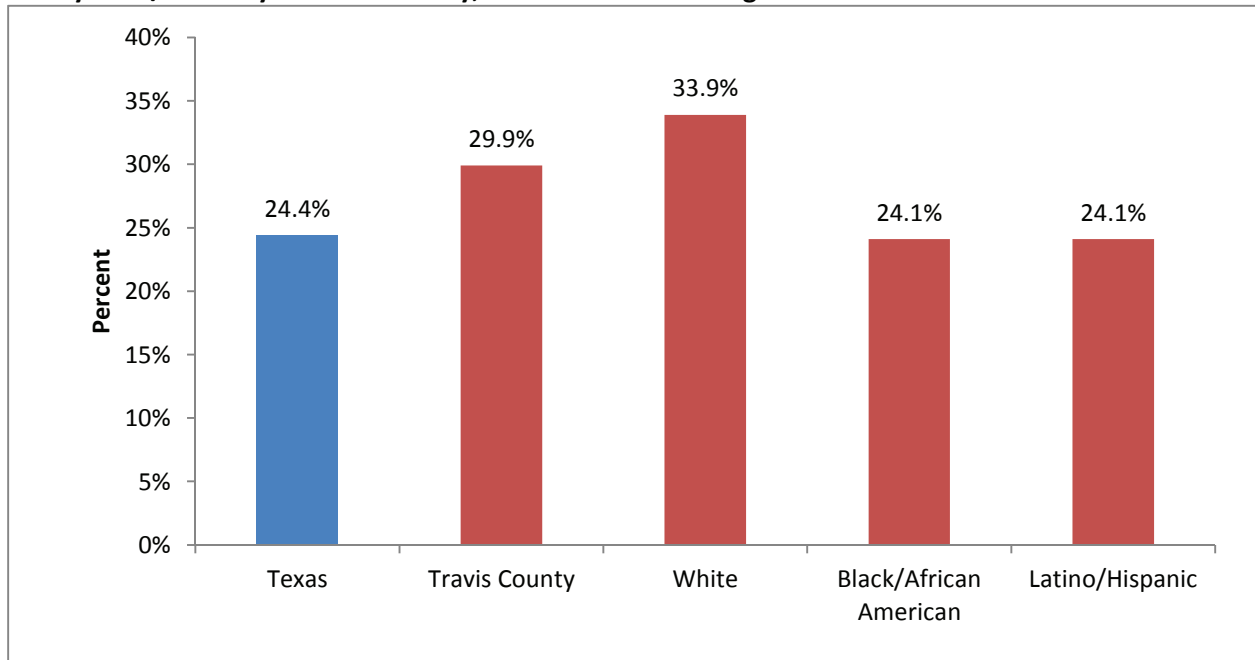
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2007 and 2009

Figure 25: Percentage of Adults Reporting Eating 5+ Servings of Fruits and Vegetables per day by Income in Travis County, 2007 and 2009 Average
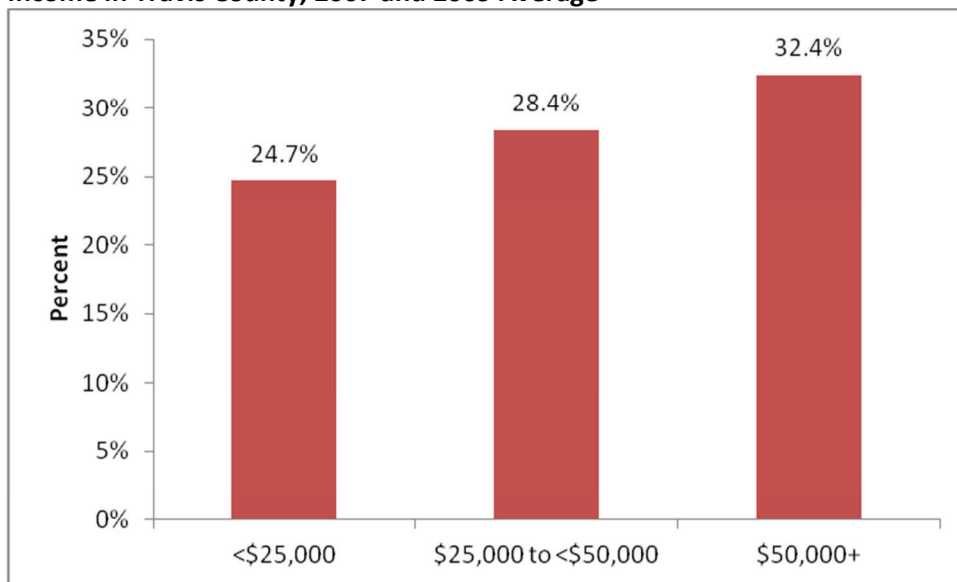
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2007 and 2009

Both focus group participants and key informants indicated that knowledge and awareness regarding the importance of healthy eating and physical activity need to be improved for residents. Schools were considered an ideal venue for promoting healthier lifestyles via physical education, healthier school lunch options, and dissemination of information to parents through children. Many agreed that healthy behaviors need to be instilled early in life to achieve lifelong wellness. Employee wellness programs were also identified as helpful.

According to the Travis County Youth Risk Behavioral Survey (YRBS), the percentage of students in Travis County eating the recommended servings of fruits and vegetables was lower than that of adults (18.4%) and consistent with what is seen statewide. When further stratified by race/ethnicity at the county-level, Black/African American students (22.5%) were more likely to report consuming five or more fruits and vegetables than their peers (Figure 26).

Figure 26: Percentage of Students (9th-12th grade) Eating 5+ Servings of Fruits and Vegetables per day in Texas (2011) and by Race/Ethnicity in Travis County, 2010

DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Travis County Youth Risk Behavioral Survey*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, Fall 2010 for Travis County and 2011 for Texas

Many focus group and interview participants discussed whether Travis County facilitated physical activity or not. Several participants across the discussions mentioned that the City of Austin, specifically, was considered to be an "active" city with many resources and active residents. However, other participants noted that the areas within Travis County that were outside of Austin were quite different. Specifically, the unincorporated areas were considered to be disproportionately affected by lack of access to recreational spaces (See Access to Healthy Food and Physical Activity). Key informants stressed the importance of creating a built environment across the entire County that is conducive to biking and walking. The park system in the County, for example, was described as disconnected and difficult to access.

Generally, quantitative data supported observations about physical activity made by focus group and interview participants. In Travis County, approximately one in five adults (20.5%) indicated that they get

no physical activity, which is lower than what is seen statewide (26.7%). More than double the proportion of Blacks/African Americans (34.5%) and Latinos/Hispanics (31.8%) reported no participation in any extracurricular physical activities or exercise than Whites (15.3%) (Figure 27). Also, Figure 28 illustrates that adults with lower incomes are more likely to be physically inactive than their higher income counterparts.

Figure 27: Percentage of Adults Reporting No Participation in Any Physical Activities or Exercise 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

Figure 28: Percentage of Adults Reporting No Participation in Any Physical Activities or Exercise by Income in Travis County, 2008-2010
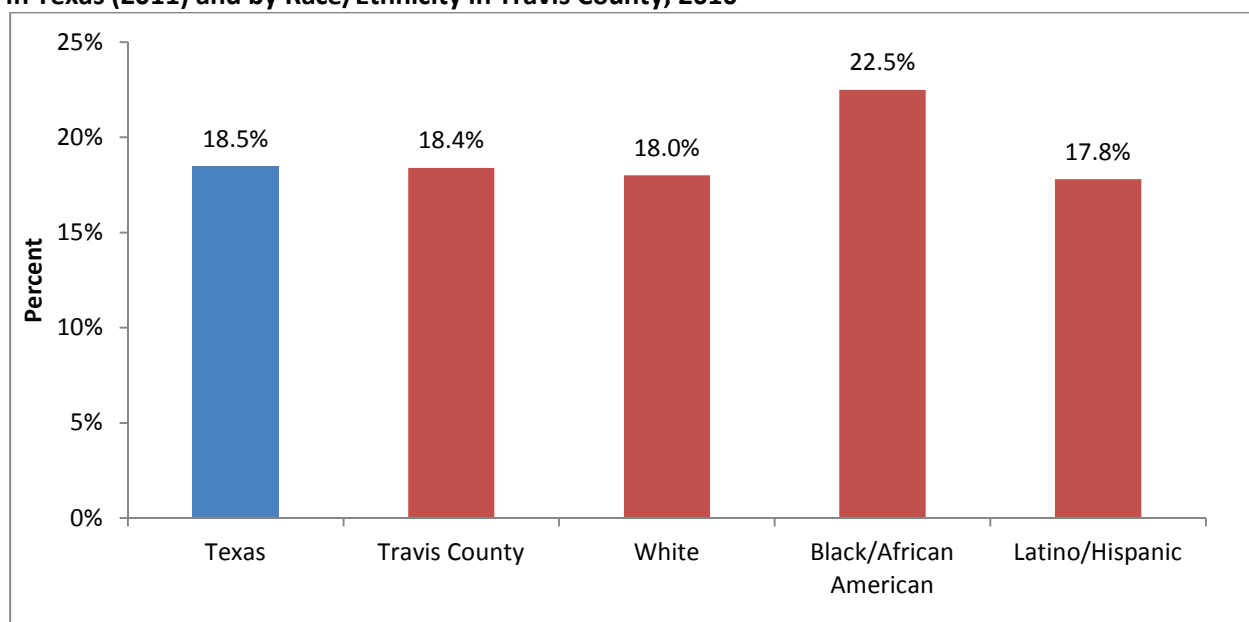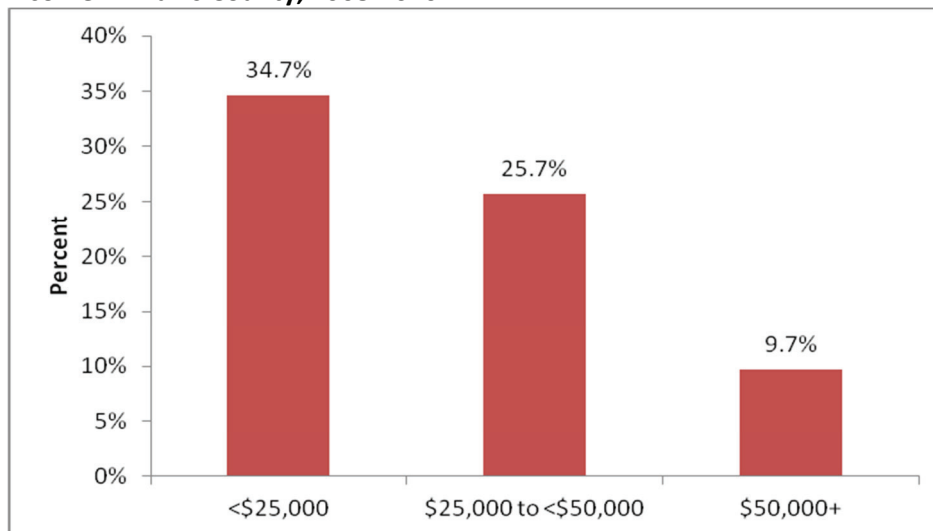

DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

According to the YRBS, in 2010 only 13.1% of Travis County students indicated that they were physically inactive as compared to 16.4% in Texas as a whole. Among racial/ethnic groups, Latino/Hispanic students were the most physically inactive, followed by Whites then Blacks/African Americans (Figure 29).

Figure 29: Percentage of Physically Inactive Students (9th-12th grade) in Texas and by Race/Ethnicity in Travis County, 2010
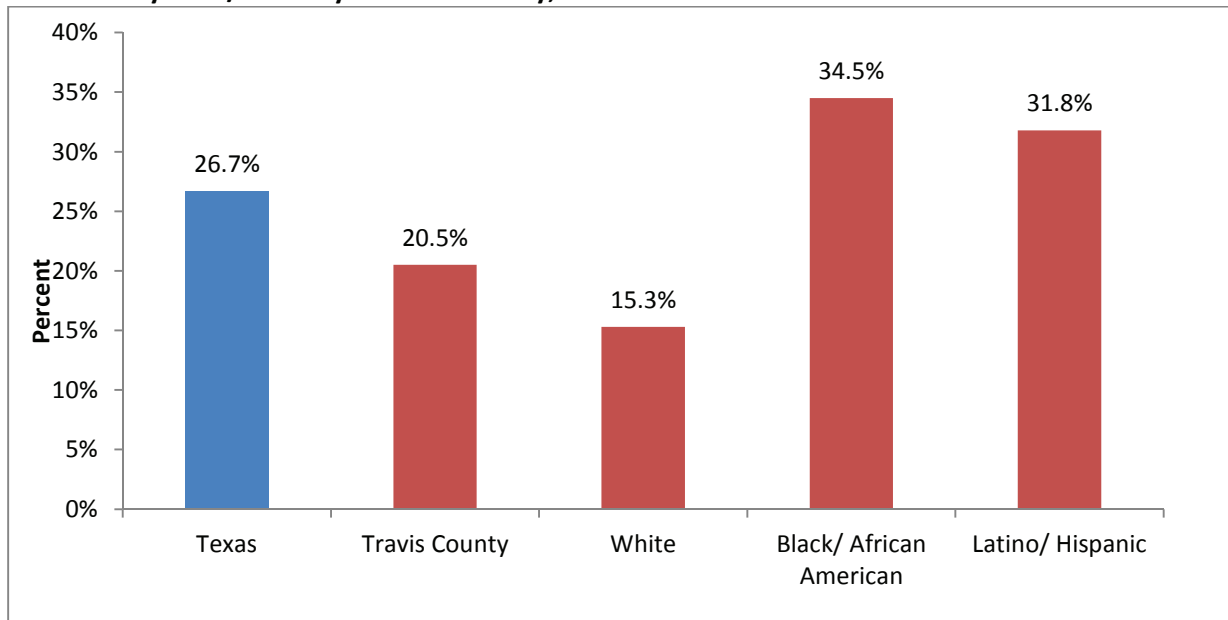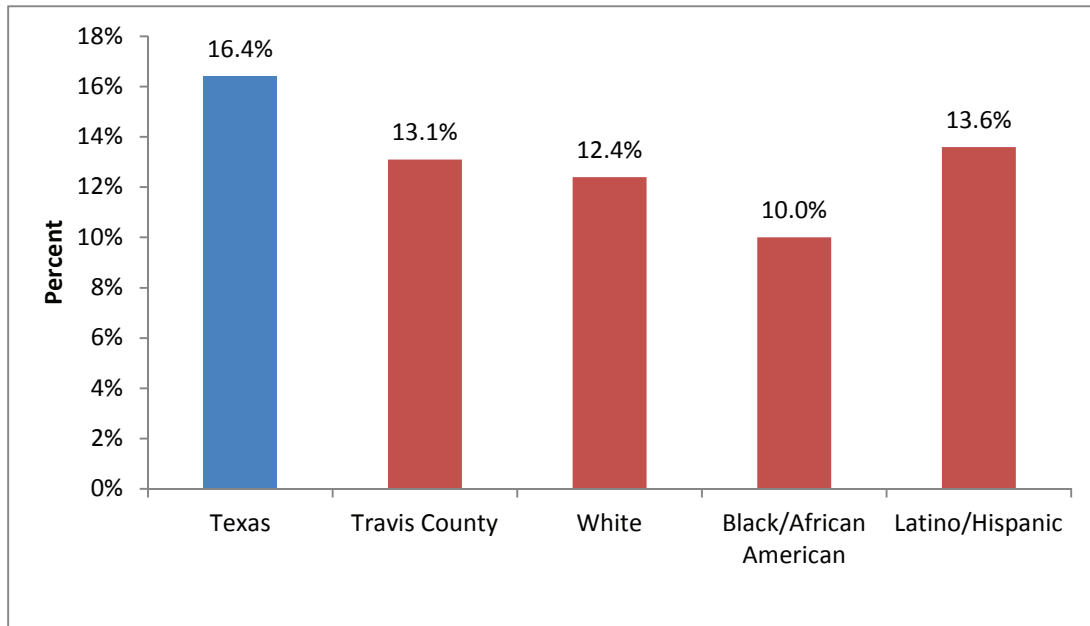

DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Travis County Youth Risk Behavioral Survey*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, Fall 2010

Substance Use

> *"Alcohol is too cheap, too easy for people to buy and abuse, and dangerous for the community."*
> —Focus group participant

Substance use was noted as a community concern in some focus groups but was not heavily discussed. When substance use was mentioned, it was often in relation to mental health and how stress or depression can drive someone to abuse drugs. The high visibility of substance use in neighborhoods was described as posing a risk to communities. For example, participants observed residents publicly drinking alcohol in their neighborhoods and stated that alcohol was too affordable and accessible in their communities. Parents expressed concern regarding second-hand smoke from tobacco and marijuana use in their neighborhoods and how it may affect their children. The limited availability of substance abuse treatment services was also noted by a few residents.

Quantitative data illustrate that there was a larger percentage of adults who reported binge drinking in Travis County (20.7%) than in Texas as a whole (15.2%). According to the BRFSS data for Travis County in 2008-2010, Whites comprised the largest percentage of the binge drinking population (24.1%), followed by Latinos/Hispanics (19.2%) (Figure 30). As for the use of tobacco products, BRFSS data illustrates that between 2008 and 2010, 14.4% of Travis County adults were current smokers. While less than the percentage of adult smokers for Texas as a whole (17.8%), this percentage was still above the HP2020

target of 12.0%. When the Travis County data was stratified by race/ethnicity, Whites (15.1%) and Latinos/Hispanics (15.2%) comprised a substantially larger percentage of adult smokers than Blacks/African Americans (11.8%) (Figure 31). Travis County data stratified by income reveal that as income increases, the percentage of adult smokers decreases (Figure 32).

Figure 30: Percentage of Adults who Report Binge Drinking in Texas and by Race/Ethnicity in Travis County, 2008-2010
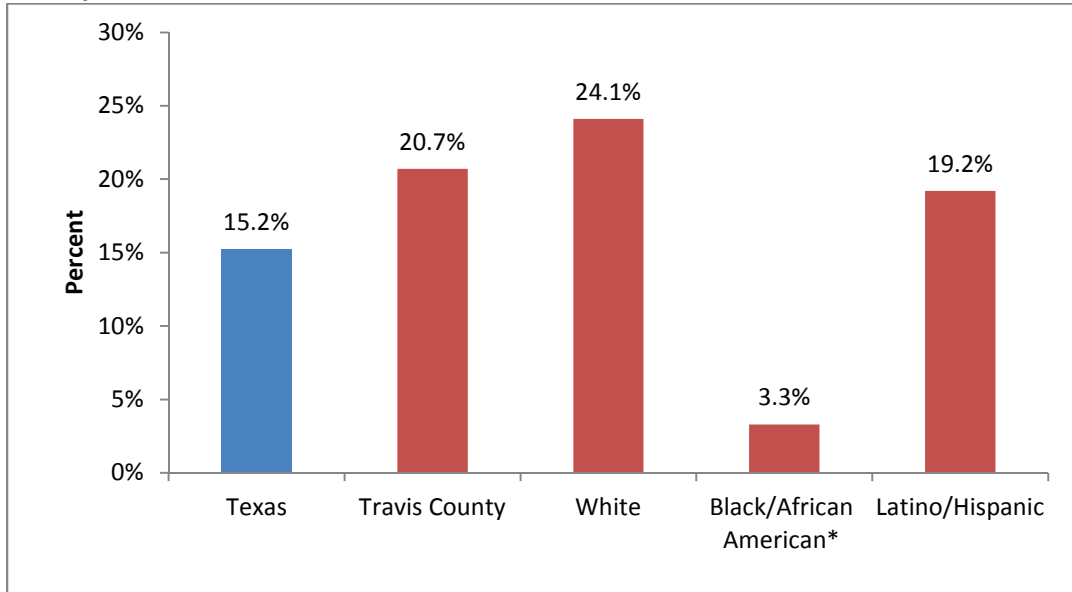
*Estimate is unstable and should be interpreted with caution (residual standard error >30%)
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

Figure 31: Percentage of Adults who are Current Smokers in Texas and by Race/Ethnicity in Travis County, 2008-2010
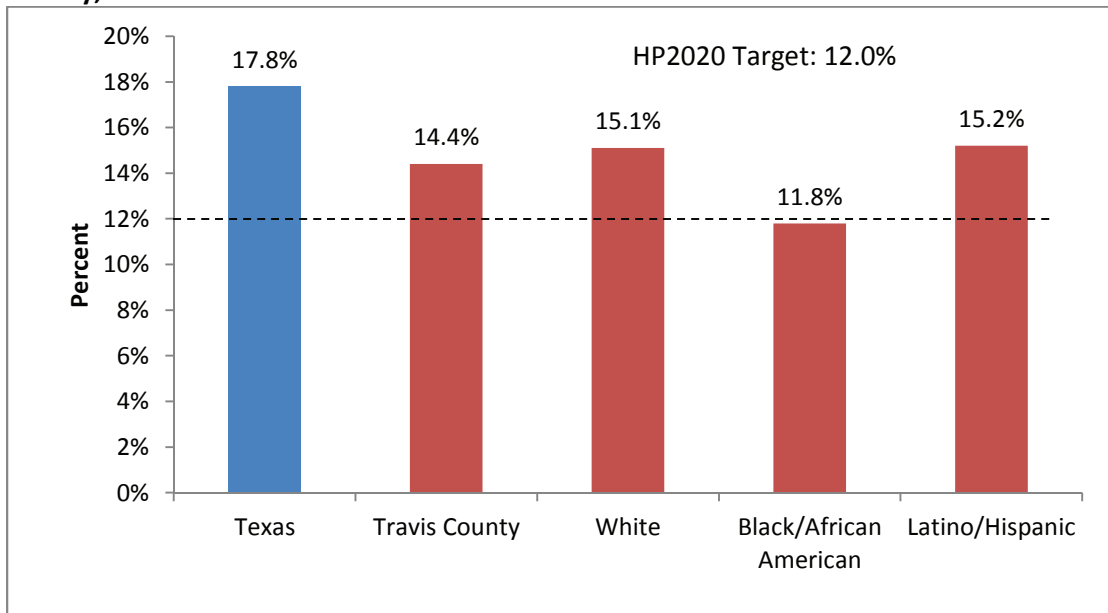
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

Figure 32: Percentage of Adults who are Current Smokers by Income in Travis County, 2008-2010
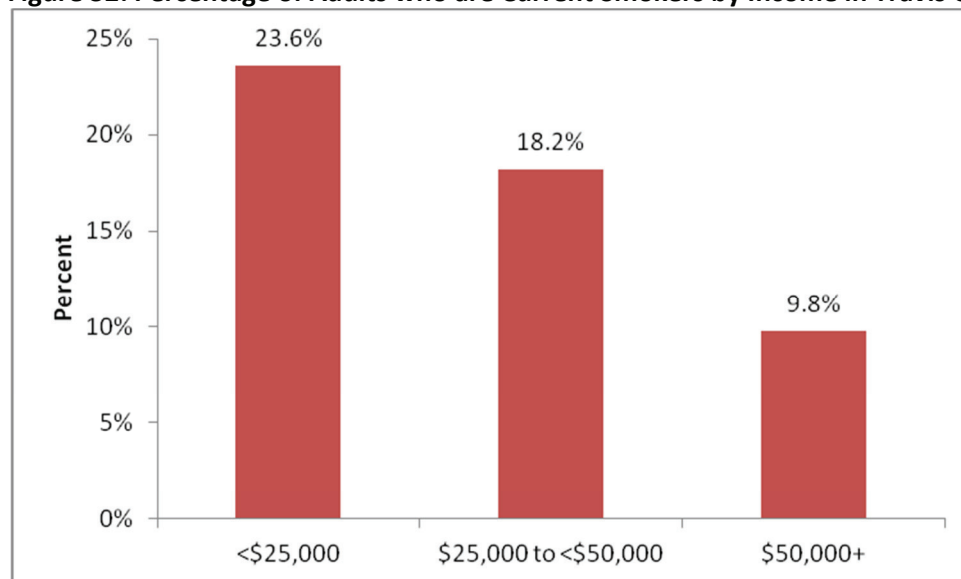
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

Issues around drug and alcohol use, particularly among youth, were mentioned by community forum participants as they relate to crime and safety. Forum participants also discussed an unmet need for rehabilitation and transitional services for individuals who wish to address their addictions. As one

participant shared, "*There need to be more outreach programs on rehab for people who want to get their lives together*."

Travis County's percentage of youth tobacco product users in 2010 (16.3%) was not only lower than the HP2020 goal of 21.0%, but substantially lower than the state percentage of approximately 29%. Race/ethnicity data at the county level showed similar percentages of White and Latino/Hispanic youth that used tobacco products (17.5% and 17.8%, respectively), which were notably higher than the percentage of Black/African American youth (10.0%) (Figure 33). While County-level data on youth alcohol use was not readily available, State-level YRBS data indicate that 39.7% of youth reported current alcohol use and 23.5% reported binge drinking in 2011, both of which are slightly higher than national rates (38.7% and 21.9%, respectively). Additionally, approximately one in five youth indicated that they currently use marijuana, which is below the national average (23.1%).[31]

Figure 33: Percentage of Youth who used Tobacco Products in the Last 30 days in Texas (2011) and by Race/Ethnicity in Travis County (2010)

DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Travis County Youth Risk Behavioral Survey*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2010 and 2011

Key informants agreed that the availability of substance abuse prevention and treatment programs needs to be improved to meet demand. Funding restrictions often present challenges to service providers due to strict eligibility requirements. They also acknowledged that substance use usually accompanies mental illness, which presents additional challenges; substance abuse recovery is often a lower priority when there are co-occurring disorders. Several key informants highlighted the success of tobacco cessation campaigns in the area, yet indicated that there is still more work to be done, especially to reach youth.

HEALTH OUTCOMES
While chronic diseases emerged as a key concern among participants and represent the leading causes of death in the region, the need for mental health services was the foremost community health concern raised by residents. Additionally, it is evident that Blacks/African Americans and Latinos/Hispanics experience disproportionately higher rates of several health outcomes.

This section of the report provides an overview of leading health conditions in Travis County from an epidemiological perspective of examining incidence, hospitalization, and mortality data as well as discussing the pressing concerns that residents and leaders identified during in-depth conversations.

Leading Causes of Death
Quantitative data indicate that the top three causes of mortality in Travis County between 2005 and 2009 were cancer, heart disease, and cerebrovascular disease (i.e., stroke) (Figure 34). Among persons aged 15-24 years, motor vehicle accidents were the leading cause of mortality in Travis County and Texas.[32]

Figure 34: Age-Adjusted Mortality Rate per 100,000 Population for the Leading Causes of Mortality in Travis County, 2005-2009
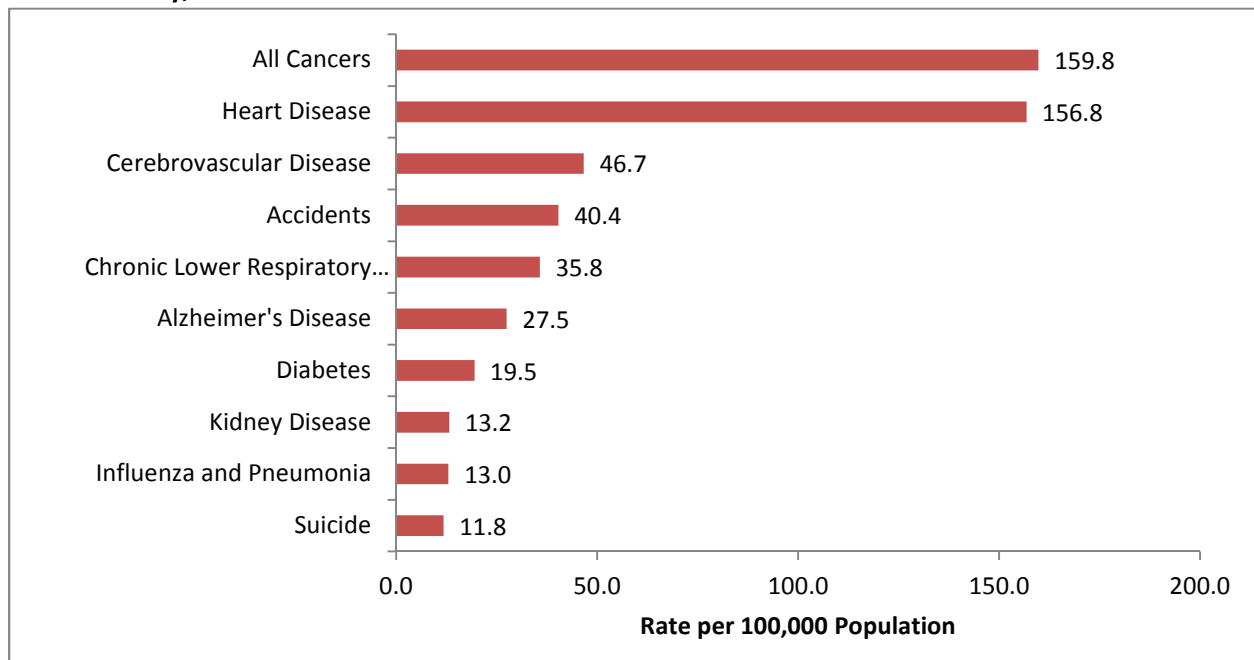
DATA SOURCE: Texas Department of State Health Services, Texas Health Data: Deaths (aggregated 2005-2009). Retrieved from http://soupfin.tdh.state.tx.us/death10.htm

Blacks/African Americans experienced disparate rates of mortality due to cancer and heart disease (200.9 per 100,000 and 220.9 per 100,000, respectively) compared to Whites and Latinos/Hispanics. Quantitative data also illustrate that while diabetes was the seventh leading cause of death in the region, Blacks/African Americans and Latinos/Hispanics disproportionately suffer from death due to diabetes (37.8 per 100,000 and 36.1 per 100,000 population, respectively) at twice the rate of Whites (14.4 per 100,000) (Figure 35).

Figure 35: Age-Adjusted Mortality Rate per 100,000 Population for the Leading Causes of Mortality by Race/Ethnicity in Travis County, 2005-2009
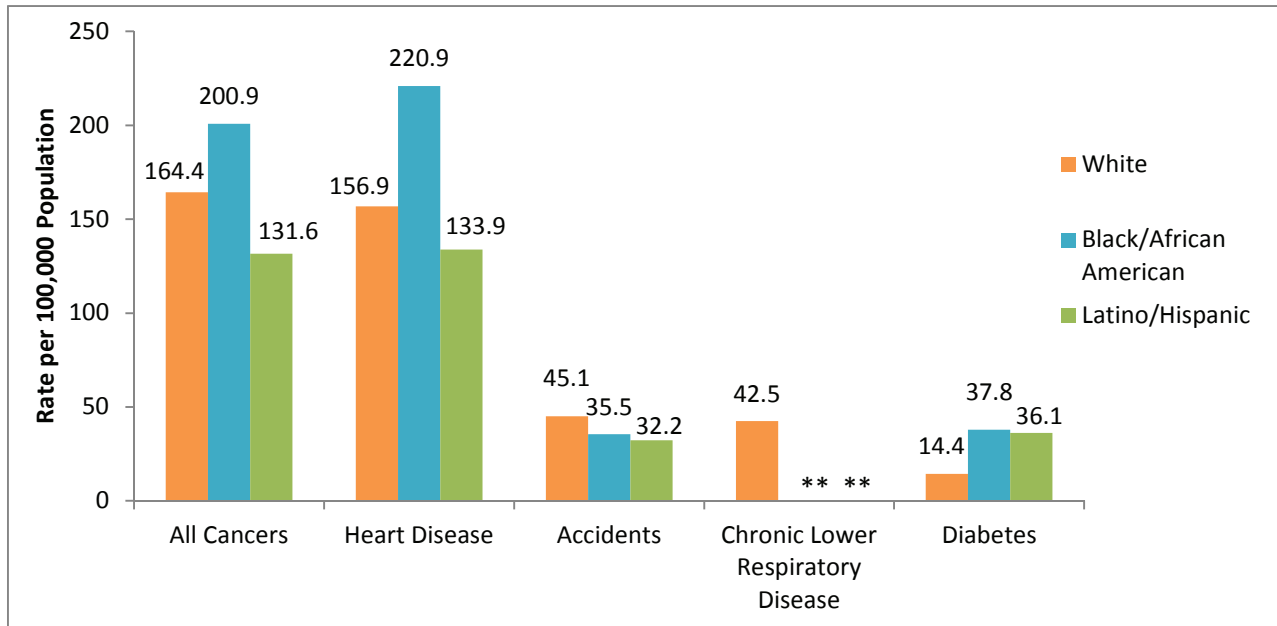
** Indicated a numerator too small for rate calculation
DATA SOURCE: Texas Department of State Health Services, Texas Health Data: Deaths (2005-2009).
Retrieved from http://soupfin.tdh.state.tx.us/death10.htm

Chronic Disease

> *"The most pressing health concerns in my community are obesity, which will lead into high blood pressure, and a lack of physical activity which leads to diabetes, depression, etc. "*—Focus group participant

When asked about health concerns in their communities, many focus group participants and interviewees cited chronic diseases, specifically diabetes, heart (cardiovascular) disease, and cancer. Central Health interviewees also identified these chronic diseases as priority health areas. Key informants and focus group participants stressed the importance and challenges of chronic disease prevention and management. Several participants noted the relationship between the emerging obesity epidemic and increasing rates of chronic disease.

Heart Disease
Among BRFSS survey respondents in Travis County, 5.3% had been diagnosed with cardiovascular disease, lower than statewide (7.3%). The proportion of Whites and Blacks/African Americans (6.6% and 6.5%, respectively) reporting cardiovascular disease diagnosis was more than double that of Latinos/Hispanics (2.7%) (Figure 36). Several focus group participants mentioned the complexity of managing high blood pressure and cholesterol (e.g., medications), often caused by diabetes.

Figure 36: Percentage of Adults with Diagnosed Cardiovascular Disease in Texas and by Race/Ethnicity in Travis County, 2008-2010
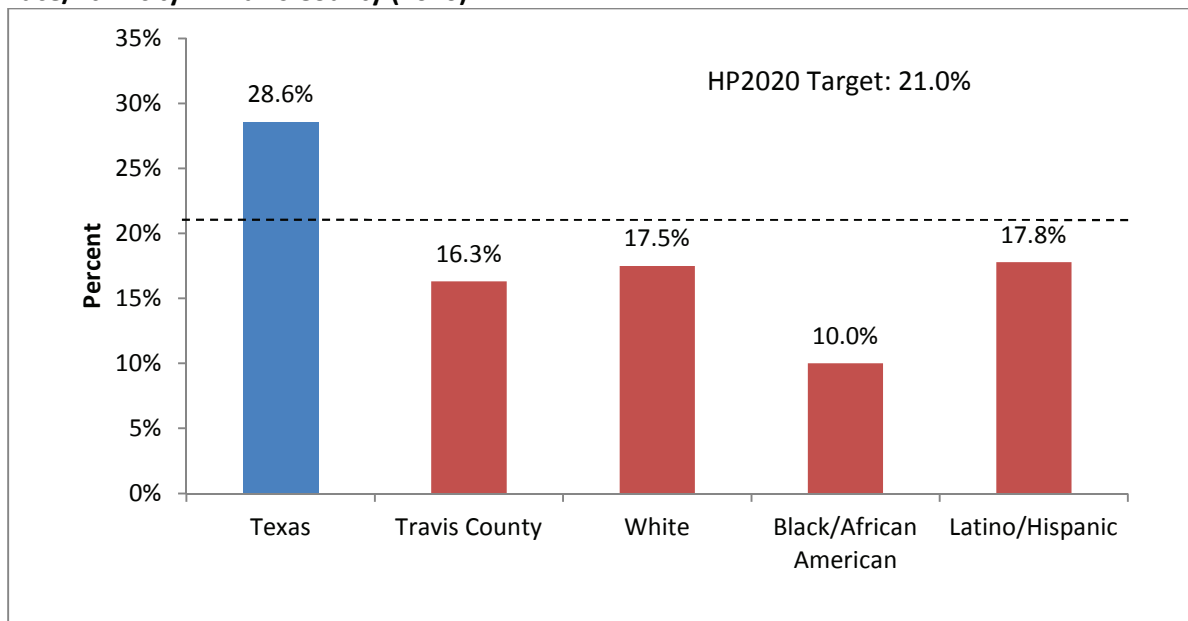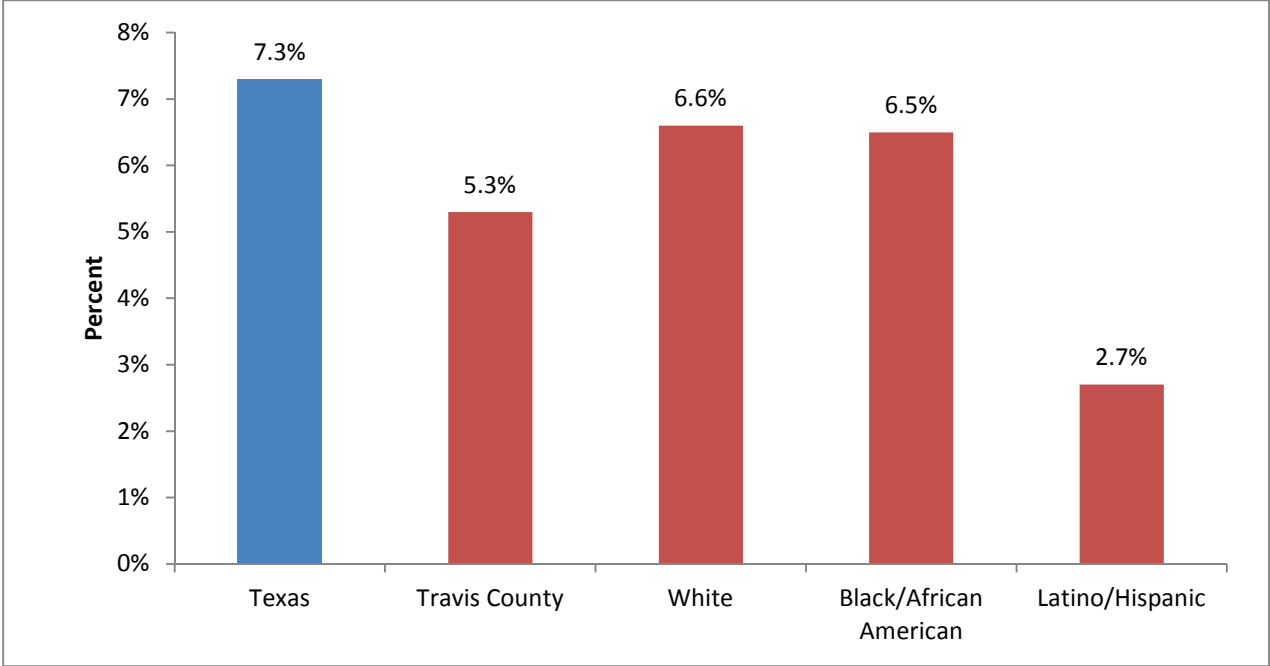

DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

Cancer
Some key informant participants identified cancer as a concern. They primarily discussed challenges to accessing cancer screening and care. Participants emphasized the need for prevention, early detection, and treatment. A few female focus group participants did mention the importance of cervical and breast cancer screening as part of women's health. Consistent with national statistics, lung cancer (42.1 deaths per 100,000) was the leading cause of cancer mortality in Travis County, followed by colon and breast cancer (15.0 deaths per 100,000 and 11.7 deaths per 100,000, respectively) (Figure 37).

Figure 37: Age-Adjusted Mortality Rate per 100,000 Population for the Leading Causes of Cancer Mortality in Travis County, 2005-2009
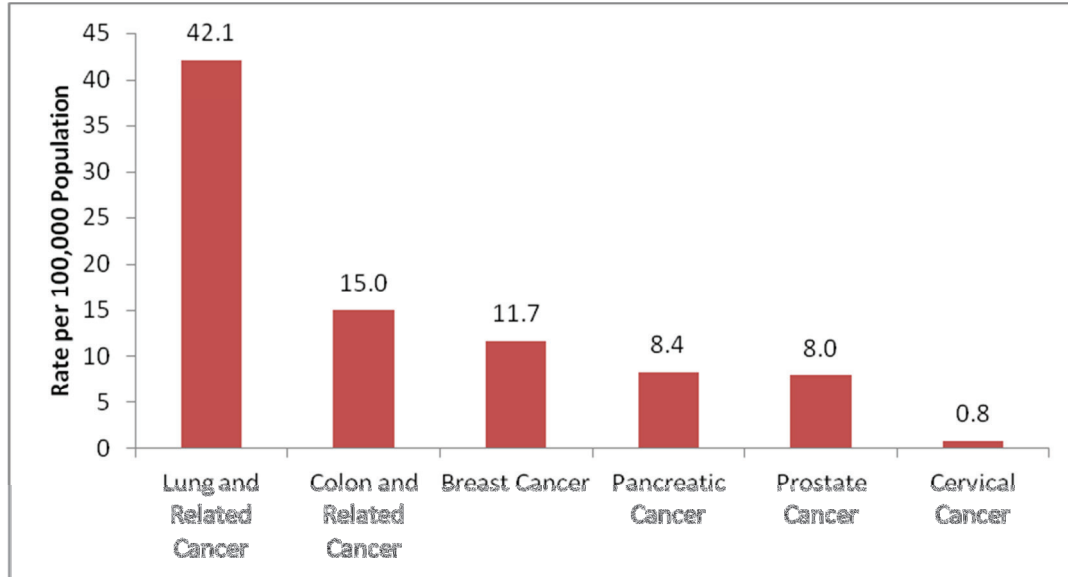
DATA SOURCE: Texas Department of State Health Services, Texas Health Data: Deaths (2005-2009). Retrieved from http://soupfin.tdh.state.tx.us/death10.htm

While colon and breast cancer were the second and third leading causes of cancer mortality (

BRFSS data indicate that 76.6% of Travis County women aged 40 years and older had received a mammogram in the past two years and 65.5% of the population aged 50 years and older had ever received a sigmoidoscopy or colonoscopy. The percentage of the population that received screenings increased along the income gradient illustrating how cost may be a barrier to accessing these preventive measures for lower income populations (Figure 38 and Figure 39).

Figure 38: Percentage of Women Aged 40+ Who Have Received a Mammogram in Last 2 Years in Texas and by Income in Travis County, 2008-2010
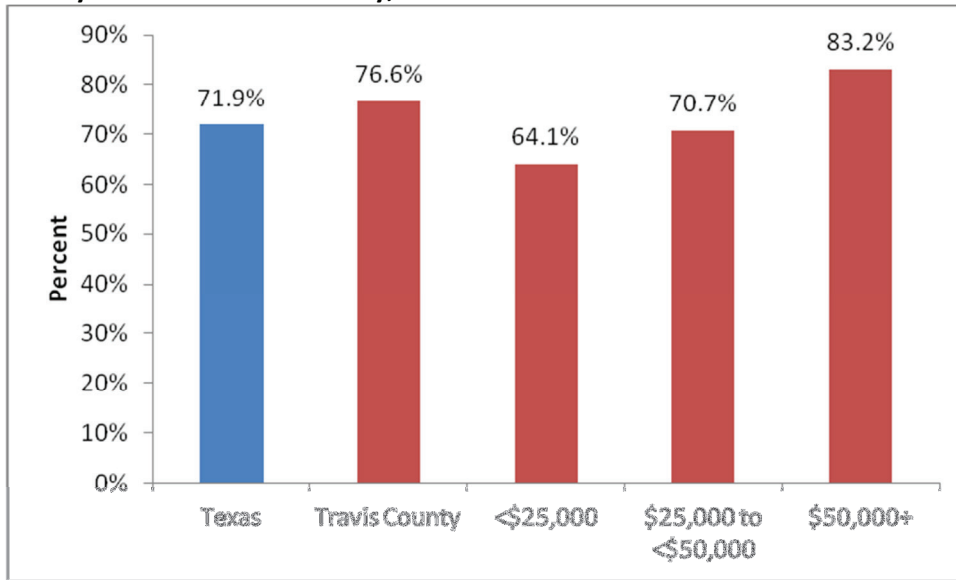
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

Figure 39: Percentage of People Aged 50+ Who Have Ever Had a Sigmoidoscopy/Colonoscopy in Texas and by Income in Travis County, 2008-2010
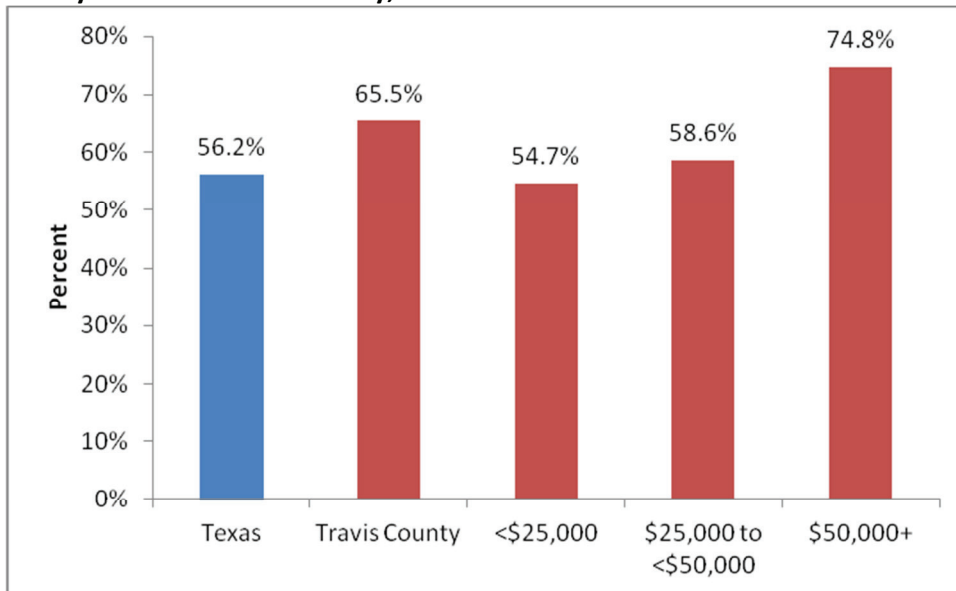
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

Diabetes

In focus groups and interviews, diabetes was the chronic condition most frequently cited as a pressing concern. Diabetes was mentioned often in the context of other chronic conditions such as high blood pressure and cholesterol as well as associated with obesity and nutrition. Participants described how diabetes disproportionately affects Blacks/African Americans, Latinos/Hispanics, and Asians. Several focus group participants shared personal experiences with diabetes, including seniors affected by the risks of uncontrolled diabetes, including eye surgery and amputations.

According to BRFSS data, in 2008-2010, the percentage of adults diagnosed with diabetes in Travis County (6.8%) was below that of the state (8.9%). However, Blacks/African Americans and Latinos/Hispanics comprised a larger percentage of Travis County's diabetic population (9.2% and 8.8%, respectively) when compared to Whites (6.3%) (Figure 40) Additionally, trend data indicate that from 2007 to 2010, Travis County experienced a greater increase in diabetes prevalence than the state overall (Figure 41).

Figure 40: Percentage of Adults with Diagnosed Diabetes in Texas and by Race/Ethnicity in Travis County, 2008-2010
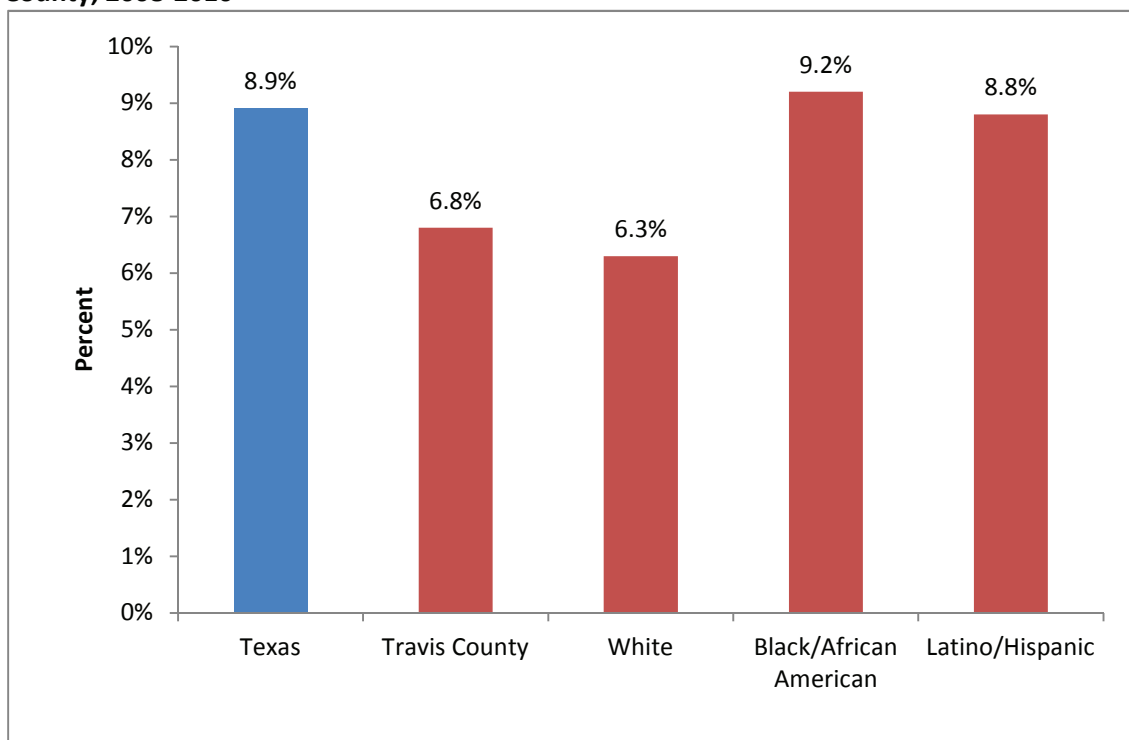
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

Figure 41: Diabetes Prevalence among Adults in Texas and Travis County, 2007-2010
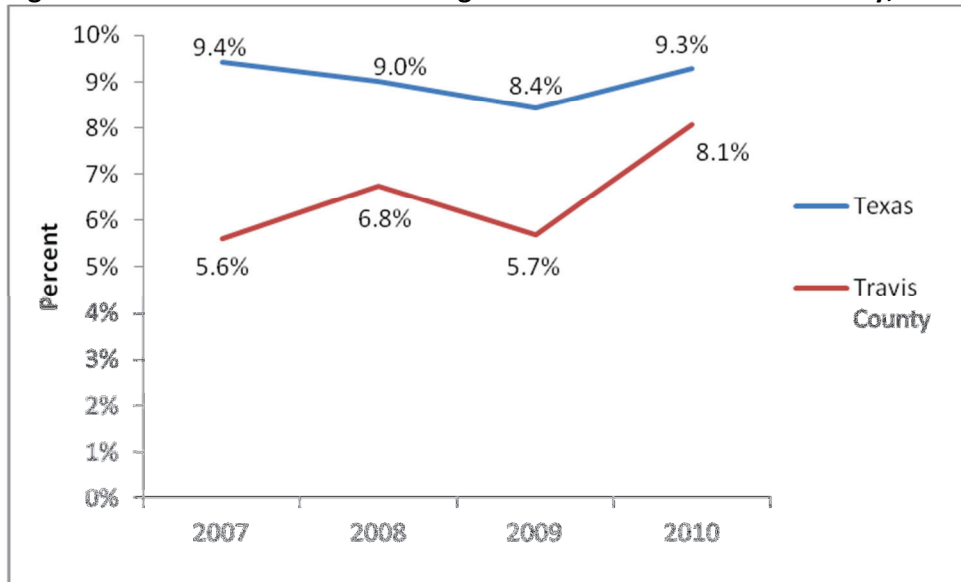
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2007-2010

Mental Health

> *"We are under a lot of stress and need more mental health services, but we never talk about this topic."* —Focus group participant

> *" If you are a single mom of color with an IV drug abuse problem, with a poly-substance use problem, and are HIV positive, then you will get immediate care; if you are 'just' a homeless male alcoholic without poly-substance use and not in crisis you could end up waiting a long time to get a bed."* —Interview participant

> *"It is not an efficient model. There is no continuum of care. If you only have a few days to take care of the problem, it won't work. An acute, psych hospital is not the answer. We need group homes and transitional living environments."* —Interview participant

Mental health was one of the foremost health concerns raised by Travis County residents. Focus group participants and interviewees reported rising rates of mental health conditions among residents in the region, its relationship with substance abuse, and the challenges of inadequate mental health services. Addressing mental health was also seen as a priority by the Central Health Connection interview participants. Consistent with the state percentage, approximately 20% of Travis County adults experienced five or more days of poor mental health in the past month. A greater proportion of Blacks/African Americans (24.3%) and Latinos/Hispanics (26.6%) reported poor mental health than did Whites in the County (17.9%) (Figure 42).

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
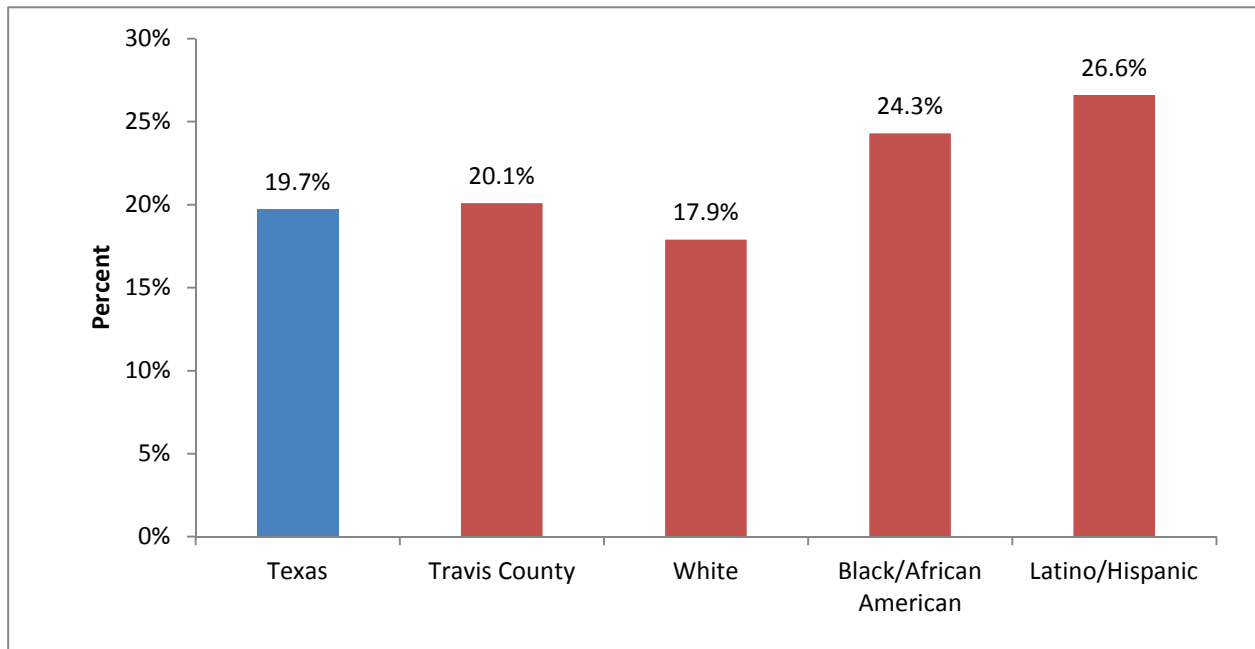

DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

The importance of addressing mental health was frequently discussed and emerged as a pressing concern for a majority of participants, particularly in the context of co-occurring disorders, namely substance abuse. Focus group participants described experiencing stress and depression as well as challenges around accessing services, especially affordable, bilingual and culturally competent services for communities of color. Some participants also expressed concern regarding suicide rates. Stigma associated with mental illness and experiences of discrimination were identified as challenges to seeking early intervention as well. As one participant shared, *"I have an aunt who won't touch me because she thinks she'll catch my mental illness."* Several focus group participants experienced challenges around employment, such as differential treatment and losing one's job due to a mental illness. The importance of improving the community's ability to understand and identify mental health needs, as well as access services, was emphasized.

Key informants and focus group participants cited an overwhelming lack of resources for people with mental illnesses, including a shortage of psychiatrists and facilities to serve community needs. The population affected by mental illness was described as complex, often accompanied by co-occurring disorders and tobacco use, and requiring resource-intensive treatment. Key informants reported that insufficient resources to handle need, such as inpatient capacity, resulted in long waiting lists. The greatest need for services was identified among minority communities due to cultural barriers around mental health. Mental health services for the recently incarcerated were also considered critical. A few key informants expressed concerns regarding the school system's capacity to address mental health among children with behavioral issues.

Quantitative data indicate that across all Travis County hospitals there was a rate of 759.4 psychiatric discharges per 100,000 population.[33] Further, in 2010 Travis County had a rate of 16.7 psychiatrists per

100,000 population, which was more than double that of Texas as a whole (6.6 psychiatrists per 100,000 population).[34]   When interpreting provider to population ratios, it is important to note that providers in Travis County may serve patients who travel from outlying counties, which would lower the effective rate of providers to population.

The mental health system was described as "*crisis driven*" by several key informants. They emphasized the need for levels of care beyond the acute care setting, with a focus on outpatient services.   While key informants did indicate that progress is being made to address inadequate mental health services in the region, the integration of mental health into public health and primary care was considered essential. They stated that improved coordination of care was needed to address multiple challenges, including providing transportation to primary care and supportive housing. Additionally, providing these wrap around services would require coordination with multiple systems, particularly the criminal justice system, to support outpatient care and facilitate reintegration. Key informants reported that sharing data and exchanging information across sectors would be required to achieve a continuum of care.

Maternal and Child Health
The health of children and mothers was discussed in focus groups and interviews particularly as it related to teen pregnancy, access to prenatal services, and other related health care for women. Among a few key informants, high teen pregnancy rates were discussed as a concern. On a related note, women's health and family planning were also mentioned as important; some key informants also indicated that these issues were suffering in light of political controversies.

Teen Pregnancy
Quantitative trend data illustrate that the percentage of births to mothers aged 17 or younger in Travis County remained relatively steady from 2005 to 2009 and below that of the state; however, there was a notably higher percentage of births to teenage Latino/Hispanic (6%) and Black/African American (5.2%) mothers than to teenage White mothers (0.5%) (Figure 43).

Figure 43: Percentage of Births to Mothers Aged 17 Years or Younger in Texas and by Race/Ethnicity in Travis County, 2005-2009
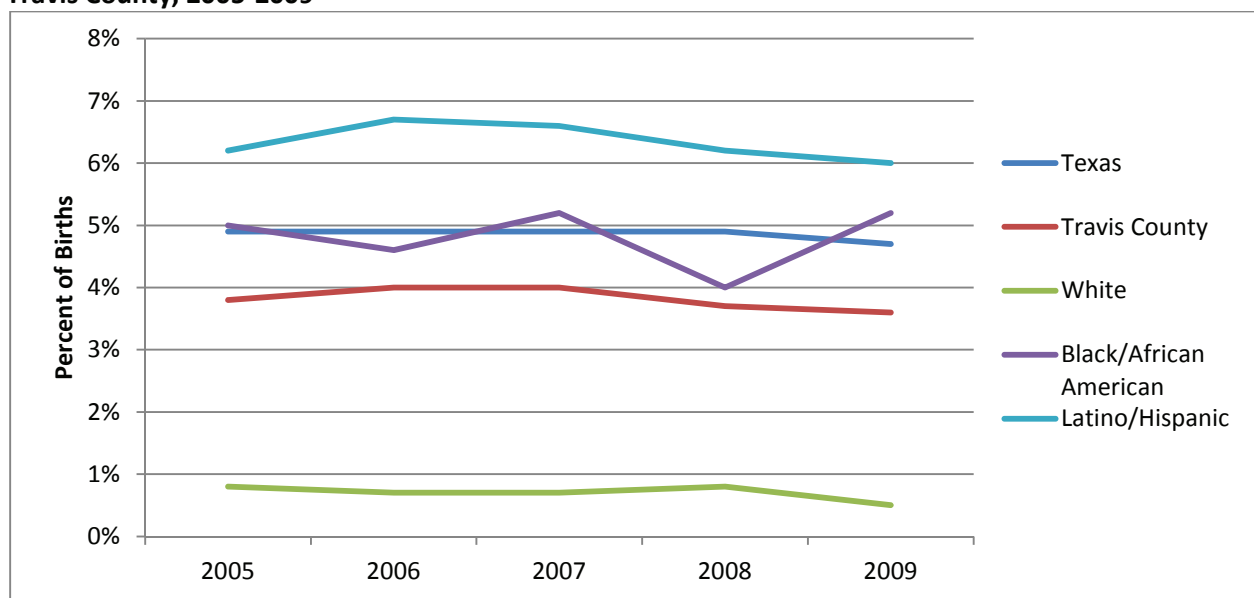
DATA SOURCE: Texas Department of State Health Services, Texas Health Data: Birth (2005-2009). Retrieved from http://soupfin.tdh.state.tx.us/birth05.htm

Prenatal Care

Travis County mothers (62.1%) were slightly more likely than mothers across the state (60.1%) to initiate prenatal care in the first trimester, yet these data vary considerably by race/ethnicity. A greater percentage of White mothers (80.9%) received prenatal care in the first trimester, than Black/African American (59.0%) or Latino/Hispanic (46.7%) mothers (Figure 44).

Figure 44: Percentage of Births with Onset of Prenatal Care in First Trimester in Texas and by Race/Ethnicity in Travis County, 2005-2009
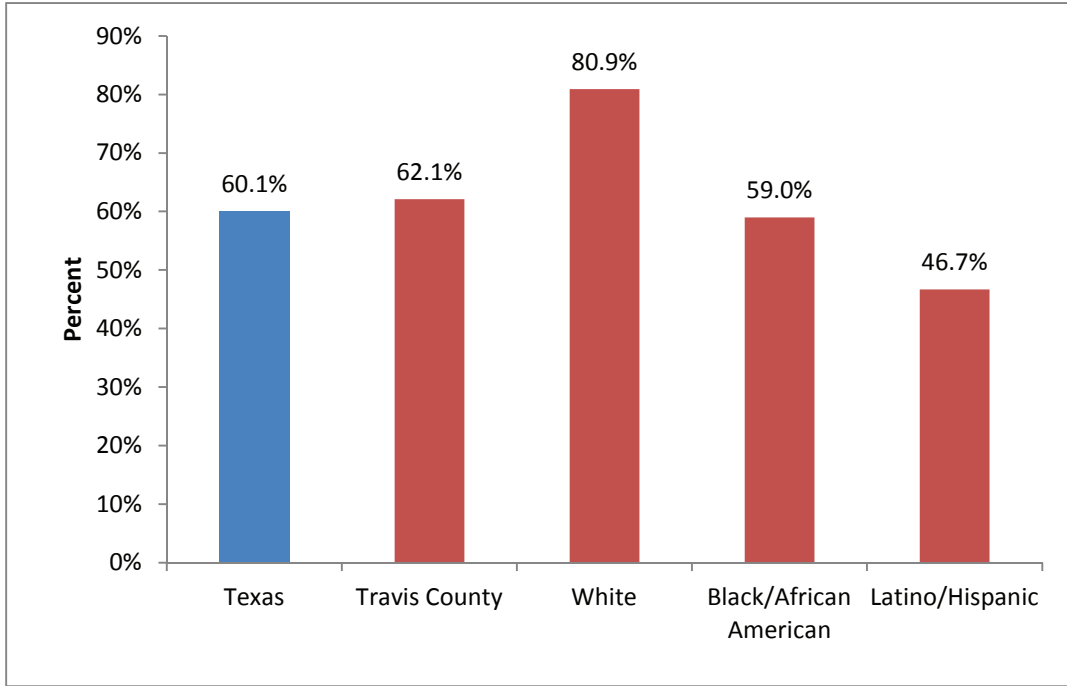
DATA SOURCE: Texas Department of State Health Services, Texas Health Data: Birth (2005-2009). Retrieved from http://soupfin.tdh.state.tx.us/birth05.htm

Very Low Birth Weight
Very low birth weight (less than 1,500 grams or 3 pounds 5 ounces) outcomes were slightly lower in Travis County than Texas; however, the percentage of very low birth weight babies born to Black/African American mothers in Travis County was substantially higher (3.6%) than those born to White or Latino/Hispanic mothers (1.2% each) (Figure 45). It is noteworthy that despite receiving prenatal care at a lower rate than their White and Black/African American counterparts, Latino/Hispanic mothers were less likely to give birth to very low birth weight babies.

Figure 45: Percentage of Babies Born with Very Low Birth Weight in Texas and by Race/Ethnicity in Travis County, 2005-2009
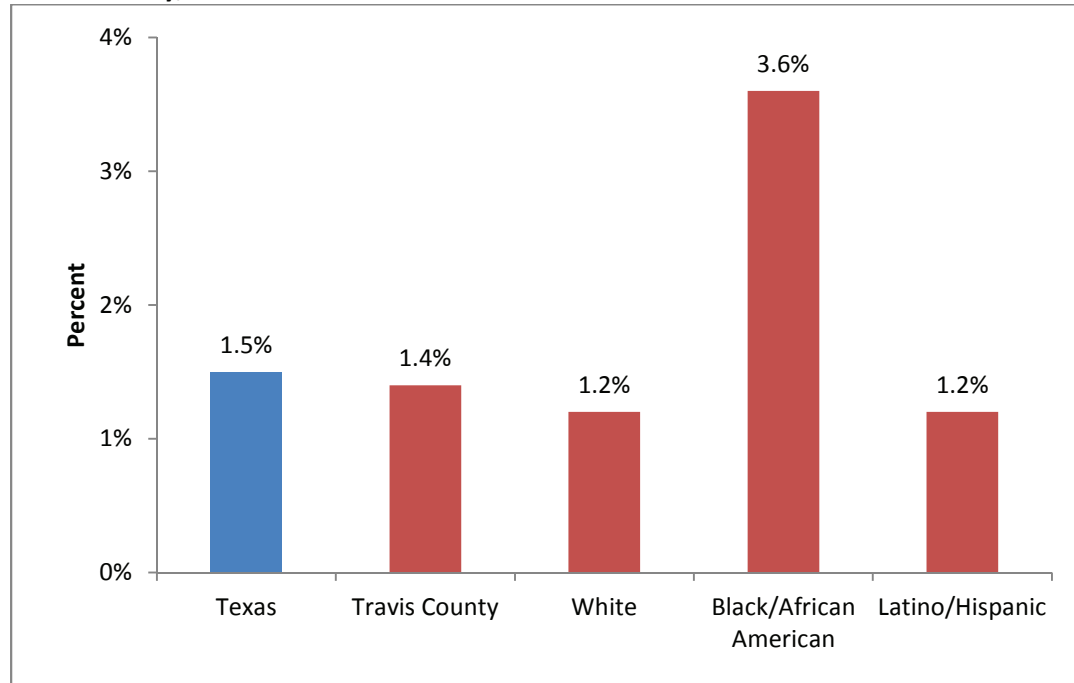
DATA SOURCE: Texas Department of State Health Services, Texas Health Data: Birth (2005-2009). Retrieved from http://soupfin.tdh.state.tx.us/birth05.htm

Oral Health

> *"A number of folks we serve have dental issues and challenges accessing dental services."* — Interview participant

While not heavily discussed, many participants mentioned the importance of dental care in the community and described challenges in accessing dental health services. Focus group participants indicated that if they have public health insurance, such as Medicaid, it does not cover dental care. However, it is important to note that Texas Medicaid does cover dental care. The contradicting perspective among focus group participants may indicate that Medicaid recipients need to be better informed about their benefits or that they experience difficulties accessing Medicaid providers due to insufficient reimbursement rates. Regardless of whether residents had dental insurance, they described difficulties finding dentists who are accepting patients and long wait times for scheduling appointments. Some key informants also shared that clients they serve have trouble accessing care to address their dental health issues. Quantitative data report that in 2011, Travis County had a higher rate of general

dentists (51.3 per 100,000 population) than did Texas as a whole (38.3 per 100,000).[35] Further, the total number of dentists accepting Medicaid in Travis County (N=813) amount to an average number of 109 Medicaid patients per dentist for the County.[36]

Communicable Diseases
While a few parents mentioned the importance of immunizations for their children, communicable diseases were not discussed in focus groups or interviews. Of note is that, despite a decline from 2009 to 2010, pertussis infections were eight times that of the 2010 state incidence rate.[37]

Vaccine-Preventable Diseases
In 2008-2010, percentages of adults aged 65 years and older who reported receiving the influenza and pneumococcal vaccines were slightly higher in Travis County than for the state as a whole (Figure 46). Race/ethnicity stratified data was essentially consistent with the county and state data; however, an interesting piece to note is that substantially fewer Latinos/Hispanics received the pneumococcal vaccine (63.3%) versus the influenza vaccine (73.3%) –a discrepancy not seen in the other racial/ethnic, county, or state data.

Figure 46: Percentage of Adults Aged 65+ who Report Receiving Influenza Vaccine in Past 12 Months and Pneumococcal Vaccine in Lifetime in Texas and by Race/Ethnicity in Travis County, 2008-2010
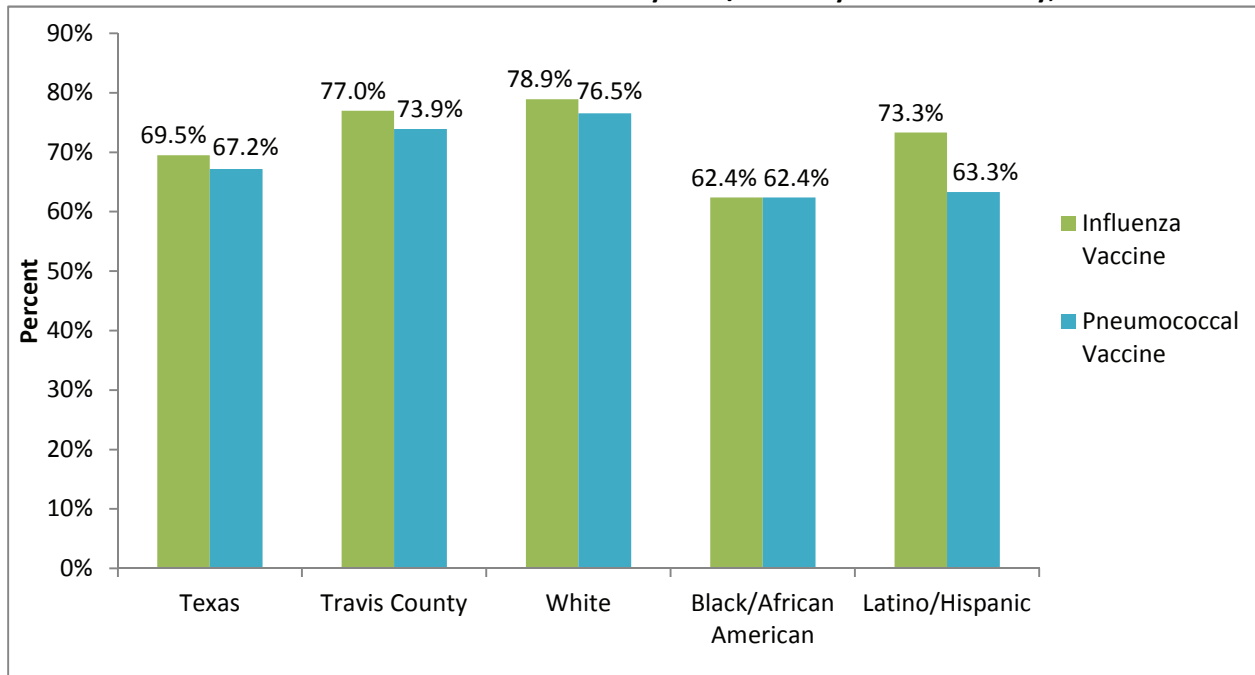
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

HIV/AIDS

Central Health Connection interviewees identified HIV/AIDS as a health priority for the region. Quantitative data for Travis County indicate that, while the overall rate of newly diagnosed HIV (21.3 per 100,000 population; N=1,035) and AIDS (14.2 per 100,000 population; N=690) cases were only slightly above the state rate, the vast majority of those cases were among Blacks/African Americans (Figure 47). Further, rates of newly diagnosed HIV and AIDS cases among men were substantially higher than the rates recorded for women (Figure 48). However, trend data suggest that overall, newly diagnosed HIV and AIDS cases are remaining stable or decreasing at both the county and state level (Figure 49).

Figure 47: Rate of Newly Diagnosed HIV and AIDS Cases per 100,000 Population in Texas and by Race/Ethnicity in Travis County, 2006-2010
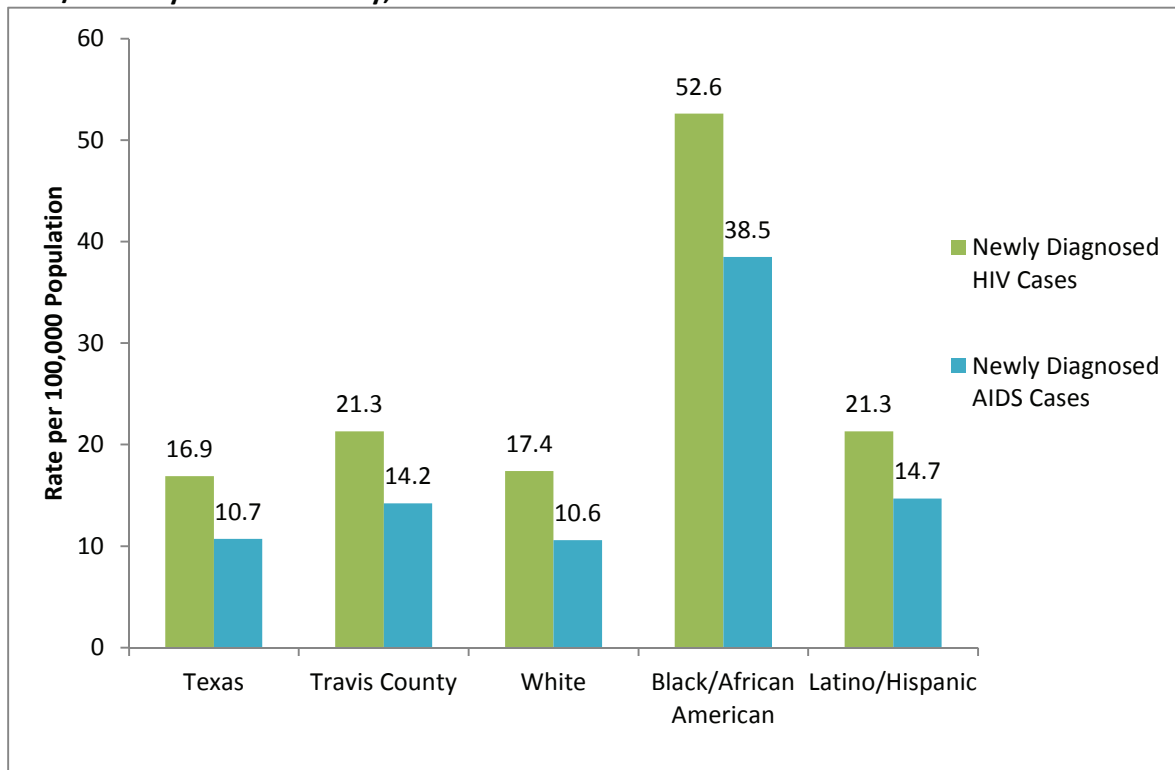
DATA SOURCE: Texas Department of State Health Services, Texas Health Data HIV/STD Program (2006-2010). Retrieved from http://soupfin.tdh.state.tx.us/death10.htm

Figure 48: Rate of Newly Diagnosed HIV and AIDS Cases per 100,000 Population in by Gender in Travis County, 2006-2010
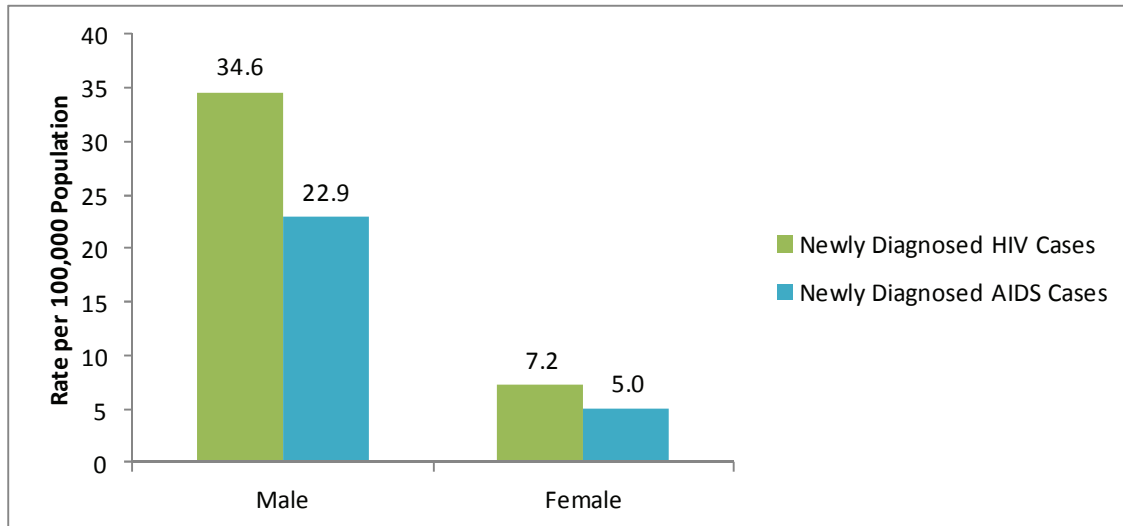
DATA SOURCE: Texas Department of State Health Services, Texas Health Data HIV/STD Program (2006-2010). Retrieved from http://soupfin.tdh.state.tx.us/death10.htm. Travis County data current as of November 2011. Texas data retrieved from
http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&itemID=8589956963
POPULATION DATA SOURCE: Texas Department of State Health Services, Texas Health Data: Population (2006-2009). Retrieved from http://soupfin.tdh.state.tx.us/pop2000a.htm. U.S. Department of Commerce, Bureau of the Census, 2010 Census (2010)

Figure 49: Rate of Newly Diagnosed HIV and AIDS Cases per 100,000 Population in Texas and Travis County, 2006-2010
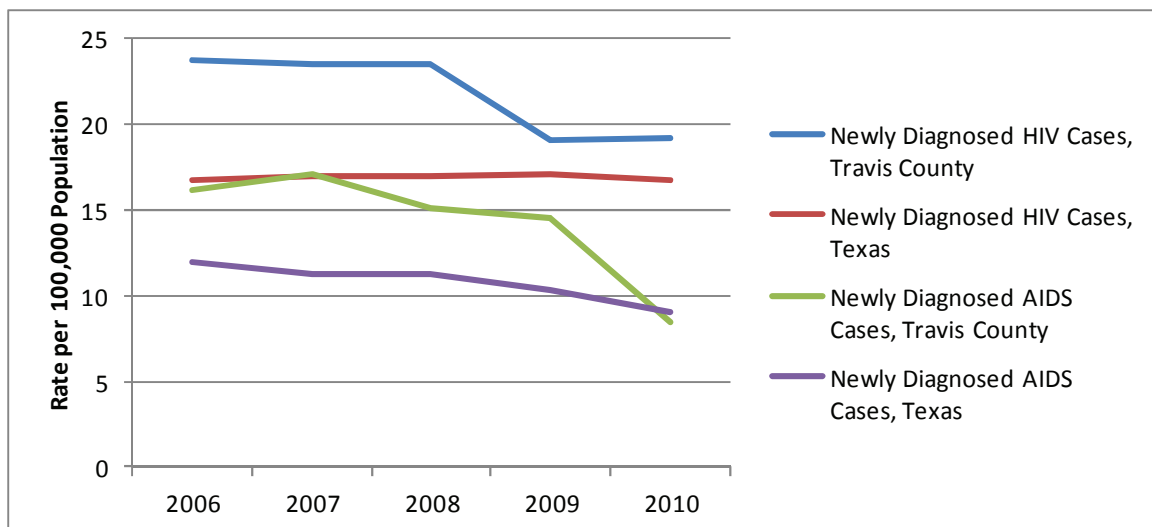
DATA SOURCE: Texas Department of State Health Services, Texas Health Data HIV/STD Program (2006-2010). Retrieved from http://soupfin.tdh.state.tx.us/death10.htm. Travis County data current as of November 2011. Texas data retrieved from
http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&itemID=8589956963
POPULATION DATA SOURCE: Texas Department of State Health Services, Texas Health Data: Population (2006-2009). Retrieved from http://soupfin.tdh.state.tx.us/pop2000a.htm. U.S. Department of Commerce, Bureau of the Census, 2010 Census (2010)

According to the Texas Department of State Health Services HIV/STD Program, among sexually transmitted diseases (STD) the most notable was Chlamydia, which had a significantly higher infection rate in Travis County (569.4 per 100,000) than in Texas as a whole (394.8 per 100,000). The rate was particularly high among the Black/African American population (1383.4 per 100,000). Similarly, the Gonorrhea rate was highest among the Black/African American population (738.1 per 100,000), while the overall county rate was slightly higher than the state rate (Figure 50). Chlamydia and Gonorrhea both affected youth (aged 15-19 years old) at substantially higher rates than adult or elderly populations (Figure 51).

Figure 50: Rate of Chlamydia and Gonorrhea Cases Reported Per 100,000 Population in Texas and by Race/Ethnicity in Travis County, 2006-2010

DATA SOURCE: Texas Department of State Health Services, Texas Health Data HIV/STD Program (2006-2010). Retrieved from http://soupfin.tdh.state.tx.us/death10.htm. Travis County data current as of November 2011. Texas data retrieved from
http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&itemID=8589956963
POPULATION DATA SOURCE: Texas Department of State Health Services, Texas Health Data: Population (2006-2009). Retrieved from http://soupfin.tdh.state.tx.us/pop2000a.htm. U.S. Department of Commerce, Bureau of the Census, 2010 Census (2010)

Figure 51: Rate of Chlamydia and Gonorrhea Cases Reported per 100,000 Population in Texas and by Age Group in Travis County, 2006-2010
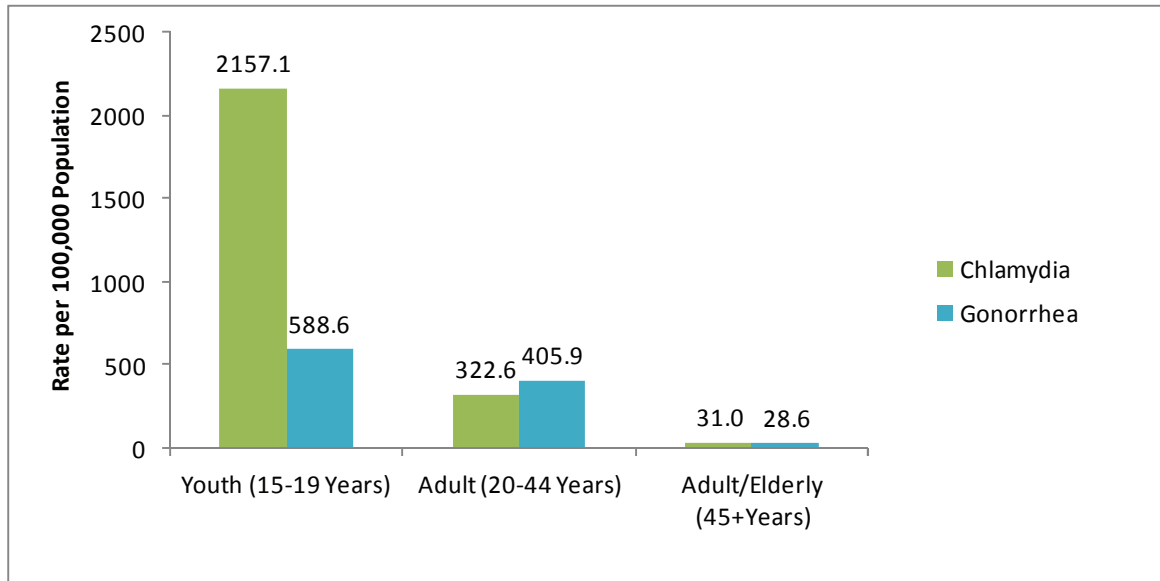
DATA SOURCE: Texas Department of State Health Services, Texas Health Data HIV/STD Program (2006-2010). Retrieved from http://soupfin.tdh.state.tx.us/death10.htm

HEALTH CARE ACCESS AND AFFORDABILITY
Access to health care was a predominant theme among residents, specifically the availability and accessibility of health care facilities and resources, emergency room overuse, challenges of navigating a complex health care system, and health insurance and cost related barriers.

Access to health care was reported as a challenge in nearly every focus group and interview. It was also a predominant theme among community forum participants. For some key informants, representing various sectors, access to health care and affordability was considered the primary issue facing low-income residents. This section will discuss the themes that arose around health care facilities and resources, emergency room use, navigating the health care system, and health insurance and cost.

Health Care Facilities and Resources

> *"My Mother-in-law has health problems and is disabled. She has to get a doctor that's way away from here…but how's she going to get around when's got a bad back, diabetes, and high blood pressure…how is she going to get on the bus when she can barely walk."* —Focus group participant

> *"People we serve have a number of jobs so they're too busy to go see doctor or employers won't let them take time off to go to the doctor or they're afraid they will lose their job."* —Interview participant

While community forum participants recognized a presence of facilities and programming, the majority of participants noted that health care resources are greatly lacking. According to key informants, lack of access to health services was of particular concern for low-income and aging populations. Although, some focus group and key informant participants indicated that *"lower income populations have better*

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access to health care services" while those who are middle income have greater difficulties accessing care due to affordability. As one key informant shared, *"That middle is getting squeezed – the safety nets don't take care of them – if health insurance is too expensive they will opt out completely."* Most senior focus group participants indicated that they have access to both primary and specialty care. The one exception was those seniors who reported losing Medicaid due to their citizenship status.

Focus group participants indicated that there are not enough clinics and hospitals to meet demand and thus one needs to travel great distances to receive care. According to participants, the location of facilities often posed barriers due to limited and costly transportation options.   Additionally, health care was considered more accessible in downtown Austin where clinics were described as closer and scheduling appointments as easier, compared to rural areas, such as Manor. Although, East Austin was seen as lacking high quality health care; residents described needing to travel outside of the area to seek such care.

Focus group participants reported mixed experiences regarding quality of care when accessing health care. A few participants reported having negative experiences of mistreatment and misdiagnoses, while other participants shared positive experiences. For example, a participant said, *"I didn't like the way they treated my Mom at the hospital…My main concern is the hospitals in Travis County – they don't care."* Some participants described the resources at University Medical Center Brackenridge as being strained due to high demand of their services.

Additional health care resources discussed included the public school system, which was noted as a source of health care, yet is inaccessible during the summer, thus creating a gap in services. A few key informants expressed concern regarding a shortage of primary and specialty care physicians to meet demand, especially in the context of a rapidly growing and aging population. Several participants also noted that Austin lacks a medical school, which impacts the level of care available. The accessibility of pharmacies was also noted as a concern, partially due to hours of operation. Similarly, residents described difficulties finding after hours care, which led to use of the emergency room during the weekend or evenings.

BRFSS data from 2008-2010 showed that adults in Travis County report having private or public health care coverage at a rate (80.9%) slightly higher than the state (75.9%). However, the Black/African American population, and especially the Latino/Hispanic population, had fewer adults reporting health care coverage (Figure 52).

Figure 52: Percentage of Adults Reporting Having Health Care Coverage (Private or Public) in Texas and by Race/Ethnicity in Travis County, 2008-2010
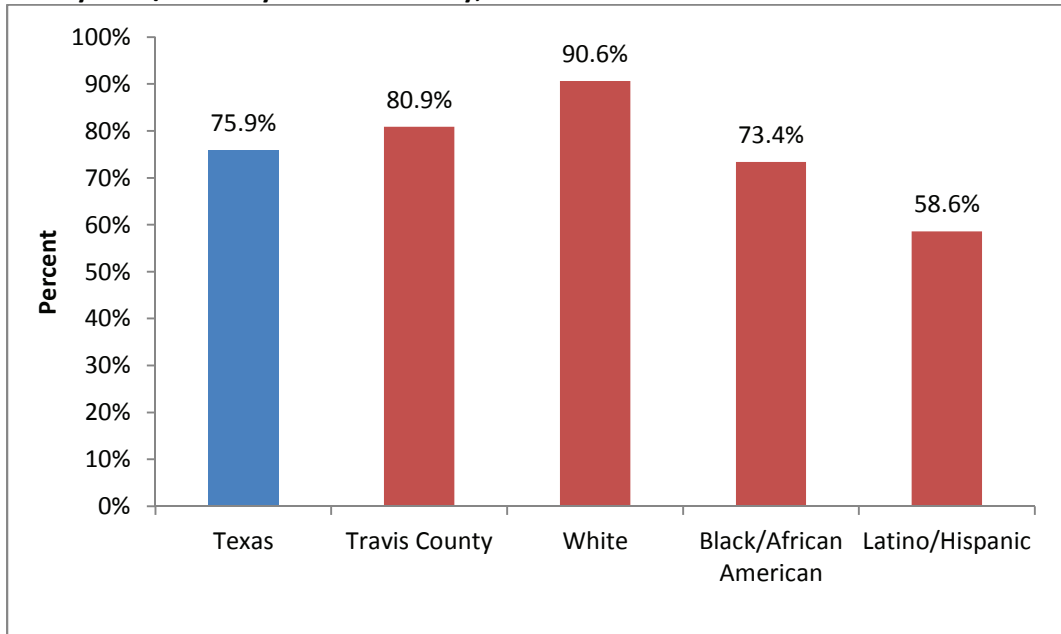
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

Consistent with key informant concerns about the lack of access to health services particularly affecting low-income populations, quantitative data demonstrate that as the income level of Travis County resident decreased, so did the percentage of adults in the County reporting that they had private or public health care coverage (Figure 53).

Figure 53: Percentage of Adults Reporting Having Health Care Coverage (Private or Public) by Income in Travis County, 2008-2010
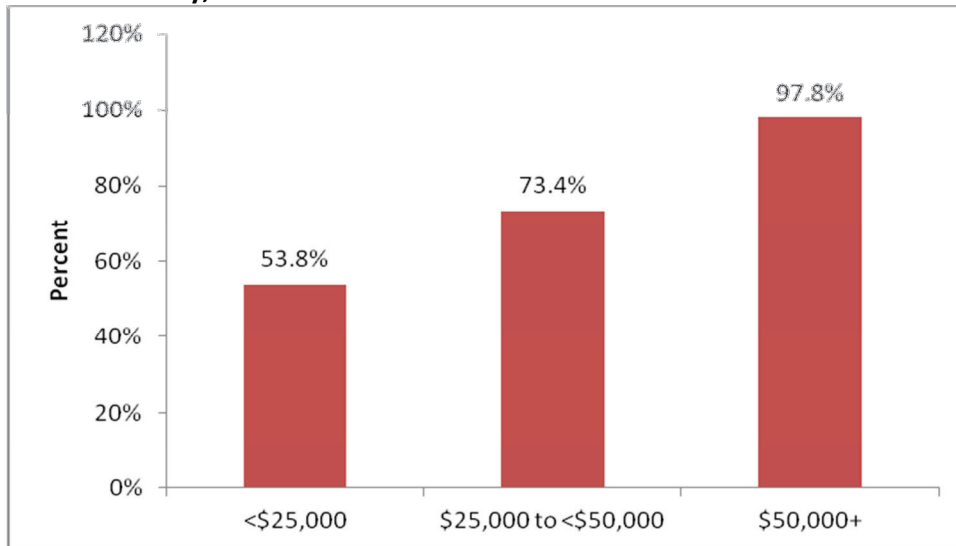
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

Travis County has a rate of 96.4 primary care physicians per 100,000 population, which is substantially higher than the statewide rate (69.5 per 100,000).[38] Additionally, according to BRFSS data, approximately three-fourths of Travis County adults reported that they had a personal doctor or health care provider in 2008-2010, which was slightly higher than that of the state. As seen with health care coverage rates, the Latino/Hispanic population of Travis County had a notably lower percentage of adults reporting having a doctor (60.9%) than other racial/ethnic groups (Figure 54). Similarly, as income decreased among Travis County adults, fewer adults reported having a doctor (Figure 55).

Figure 54: Percentage of Adults with a Personal Doctor or Health Care Provider in Texas and by Race/Ethnicity in Travis County, 2008-2010
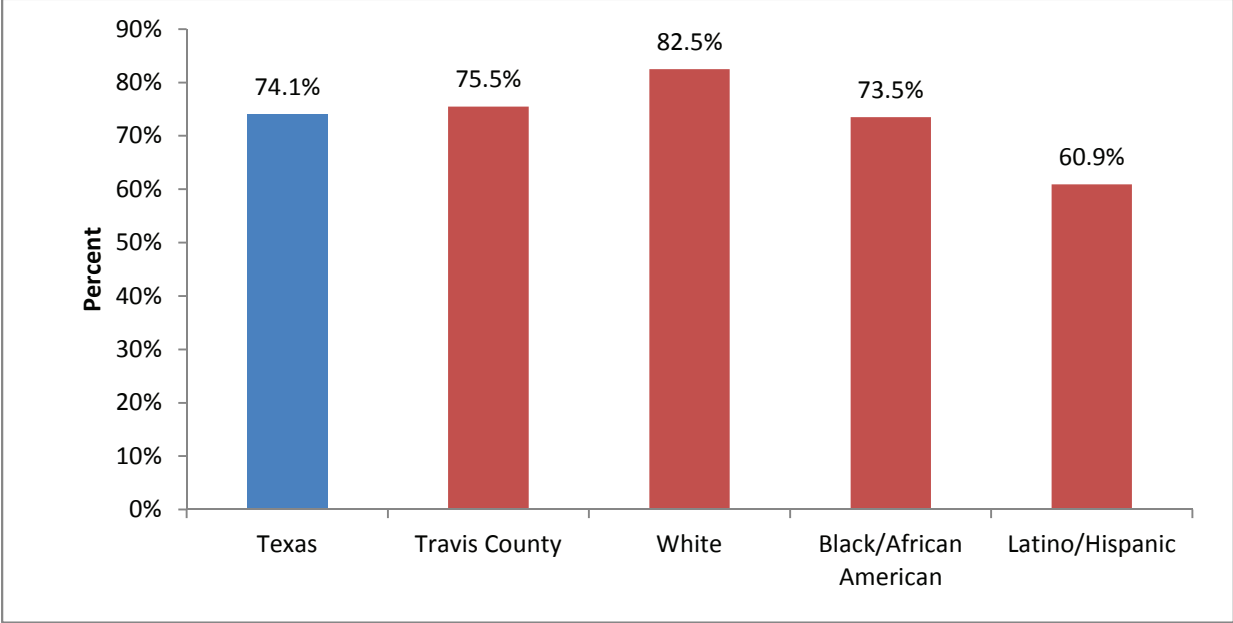
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010.

Figure 55: Percentage of Adults with a Personal Doctor or Health Care provider by Income in Travis County, 2008-2010
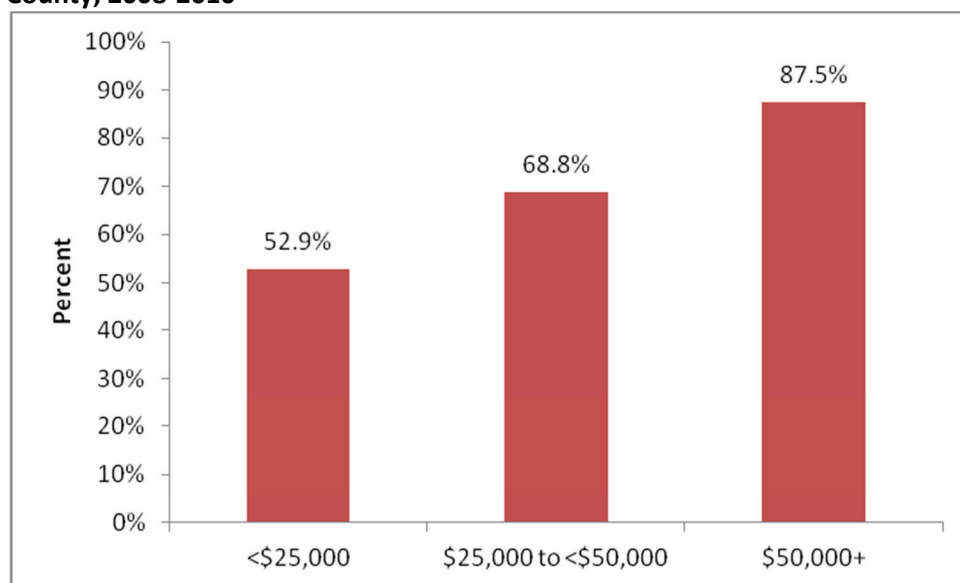
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

Emergency Room Use

Across focus groups and interviews, concerns regarding overuse of the emergency room (ER) were raised. Inappropriate use of the ER was considered an indicator of the pressure on the health care system; key informants described that the inability to access community clinics resulted in increasing ER visits. Many attributed the overuse of the ER to the inadequacies of the health care system overall. Some residents identified the ER as a more affordable and convenient source of care. Participants utilizing the ER as a regular source of care positively described the service delivery and appreciated receiving care in a timely manner. Key informants stated that many residents use Emergency Medical Services *"as their entry point into the health care system."*

Navigating the Healthcare System

> *"It's hard to understand doctors. I need someone who can break information down for me so I can understand it."* —Focus group participant

Focus group participants described the health care system as complicated and fragmented. Additionally, obtaining information from doctors was described as cumbersome. Participants felt like they were getting "the run around", particularly when trying to coordinate care between doctors and pharmacists. Frustrations with the need to change doctors frequently and schedule multiple appointments were associated with a lack of continuity of care. For some participants, difficulty scheduling appointments was seen as one of the major problems with accessing health care. Focus group participants particularly expressed aggravation regarding the difficulties of scheduling appointments in urgent or emergency situations. As a participant illustrated, *"There is a problem to get an appointment with the doctor. The receptionist makes us wait two weeks. We have to fill out forms. When you need a doctor right away, it hurts to not be able to see one."*

Many focus group and interview participants highlighted health literacy and lack of knowledge as adding to the challenges of navigating a complex health system. With health literacy creating a significant barrier to accessing services, focus group participants described having difficulty understanding complicated paperwork, such as medical bills written in *"medicalese"*. As one focus group participant shared, *"health care services are very confusing; as one ages, things get more confusing."*

Key informants indicated that their clients do not have the knowledge and skills to navigate the system and access available resources. For example, they described that parents are unaware of how to connect with a pediatrician and obtain wellness visits for their children. Participants emphasized the importance of educating both providers and patients about the programs and services available for the uninsured. While resources such as the 211 call center were considered helpful, residents expressed that to navigate the system they needed more than just information or a list of resources. Focus group participants specifically requested help to navigate the Medicaid system.

Cultural and linguistic differences were identified as creating additional barriers to navigating the health care system. Both key informants and Spanish-speaking focus group participants stated that there is a lack of bilingual doctors. Despite the availability of some bilingual staff, Spanish-speaking focus group participants described experiences of discrimination based on language. Immigrant and refugee populations also described challenges in accessing services due to language barriers, such as being unable to communicate with doctors or complete paperwork. They also cited a lack of interpreters and incorrect interpretation as barriers. For example, one participant shared *"I was at the doctor's and pointed to the middle of my chest to show where it hurt. However, the interpreter translated that there was a problem in my breasts."*

Health Insurance and Cost

> *"I can't keep afloat. I don't meet the threshold. I'm trying to receive services but I make $62.50 too much to qualify for WIC or something to keep afloat. But, there are no exceptions. If I don't get that help to keep me afloat then you (the system) will have to pay for me later."* – Focus group participant

> *"The MAP card is good if you're sufficiently low-income, but if you work insurance is very expensive."* – Focus group participant

> *"You have to pay a monthly an annual deductible and a co-pay. I will probably never get to go to the doctor again because I can't afford it. So I have to go to the ER but that overloads the emergency system. But if I could just go to the doctor, that would take care of it."* – Focus group participant

Affordability of health care was also of significant concern to Travis County residents, including the cost of insurance deductibles, co-payments, and prescriptions. Lack of insurance and underinsurance was the most frequently cited barrier by focus group and interview participants to accessing health care. As one key informant stated, *"We have a very high uninsured population."* Focus group participants indicated that they were fearful of using the health care system due to the unexpected cost, especially if they do not qualify for public assistance (e.g., Medicare or Medical Access Program). Eligibility requirements, extent of coverage, and cost of prescriptions were frequently raised as barriers to care. Those who do not have insurance or are not eligible for free or subsidized insurance were considered an at-risk population. Several participants shared that due to cost they do not have a regular doctor or that

they utilized self-care instead of accessing expensive health care. Many found the coverage provided by public assistance programs to be limited (e.g., no dental services).

According to the 2010 American Community Survey, over three-fourths of the non-institutionalized civilian populations in Austin (77.9%) and Travis County (79.4%) had health insurance, slightly higher than that of the Texas (76.3%).[39] Quantitative data also indicate that the percentage of adults who needed to see a doctor but did not due to cost was lower in Travis County (16.5%) than for the state as a whole (19.3%). However, the county data varied substantially by race/ethnicity with a far higher percentage of Blacks/African Americans (36.5%) and Latinos/Hispanics (27.2%) reporting cost as a barrier than Whites (10.2%) (Figure 56). When this BRFSS data are stratified by income at the county-level, percentages of the population experiencing cost as a barrier to care decreased as income increased (Figure 57). Additionally, according to the Texas Medical Association 2010 Survey of Texas Physicians, 38.0% of Travis County physicians did not accept Medicaid, as compared to 32.0% statewide. Meanwhile, 32.0% of Travis County physicians and 26.0% of Texas physicians did accept Medicaid but with certain limitations.[40]

Figure 56: Percentage of Adults who Needed to See a Doctor but Did Not Due to Cost in past 12 Months in Texas and by Race/Ethnicity in Travis County, 2008-2010
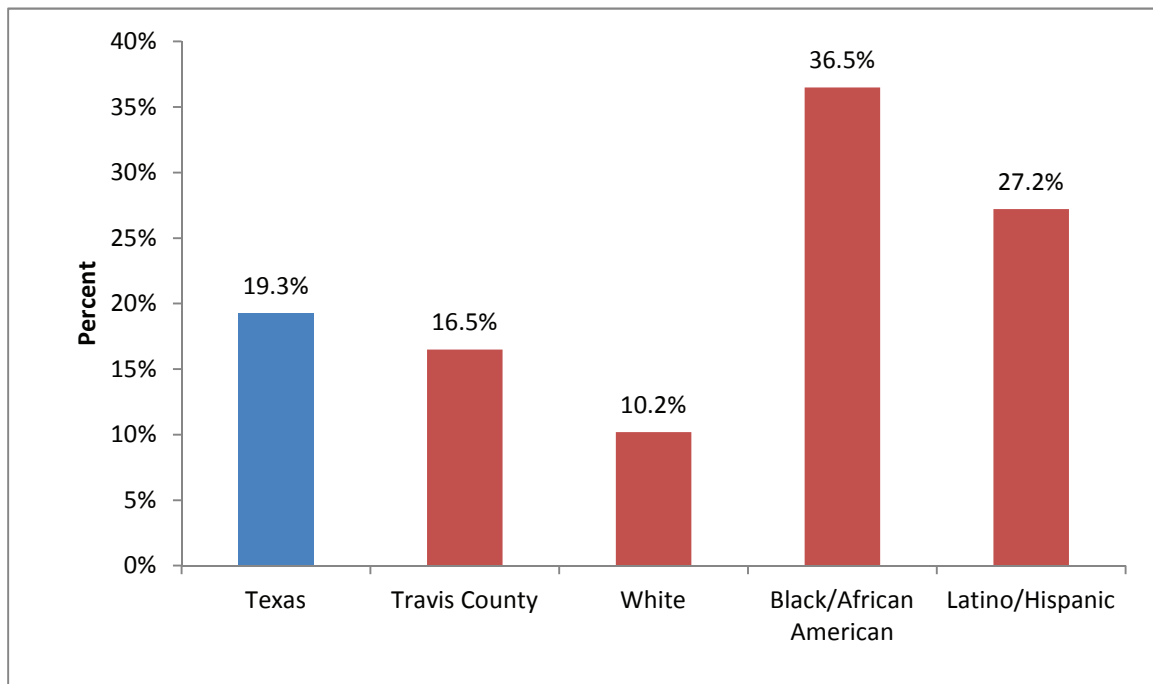
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

Figure 57: Percentage of Adults who Needed to See a Doctor but Did Not Due to Cost in past 12 Months in Texas and by Income in Travis County, 2008-2010
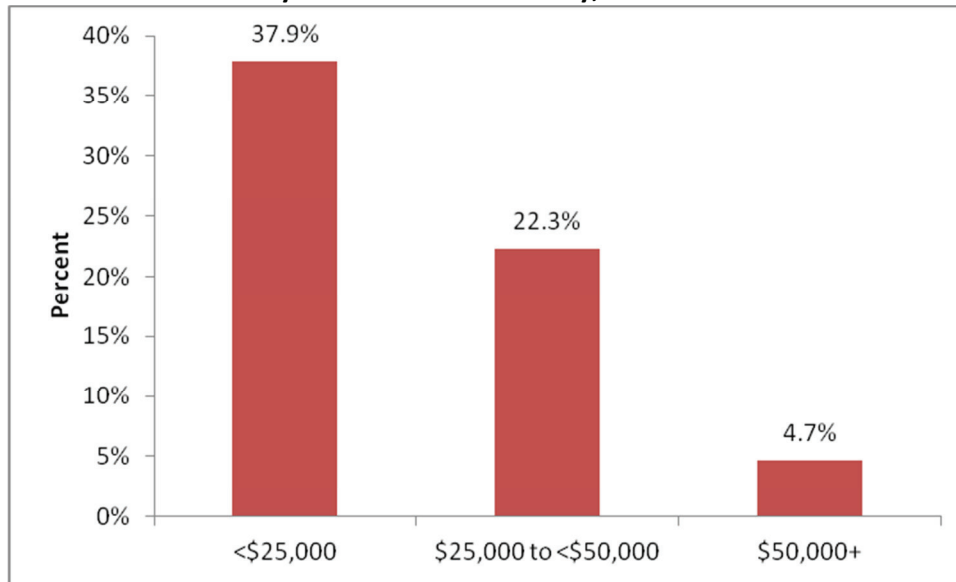
DATA SOURCE: Centers for Disease Control and Prevention (CDC). *Texas Behavioral Risk Factor Surveillance Survey Data*. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2008-2010

In addition to Medicaid and Medicare, participants frequently discussed the Medical Access Program (MAP) when describing challenges regarding their ability to afford care. Perceptions of MAP were mixed. Some participants felt that MAP limited their choice of hospital, whereas others indicated that MAP provides a "decent level of community care." Residents using MAP described challenges in accessing the health care system in a timely manner, including finding a doctor who will accept their health insurance. As a community forum participant explained, "It's really hard to get appointments that don't make you wait a month or two at the MAP clinics." While some residents said they had positive experiences with MAP, the program was frequently described as unhelpful. For example, one participant shared that the *"MAP system is not user friendly, and not helpful, not easy to use...you have to go through a lot of hoops to get care via the MAP system."*

EXTERNAL FACTORS ("Forces of Change")
The primary external factors recognized by participants as challenges towards achieving their identified health priorities were population growth and demographic shifts, the fiscal and political environment, and fragmented organizational efforts.

> *"Certainly the demographics have shifted dramatically...the Hispanic population is growing exponentially and coupled with economically disadvantaged neighborhoods, the impact is going to be astronomical in terms of services this population will need."* —Interview participant

> *"The population is aging...organizations and services are not equipped to handle that growth."* —Interview participant

> *"We need to better coordinate planning groups. There are hours and hours of meetings that are not effective. A lot of groups are doing similar things."* —Interview participant

Population Growth and Demographic Shifts

The ability of the City's and County's physical and social infrastructure to keep up with its rapid growth was of concern to many key informant interviewees and focus group participants. As one key informant shared, *"There is a mismatch between the capacity of the [health care] system and presenting need of the community."* Reflecting a primary challenge shared by many organizations, a leader of a community-based organization described struggling with *"the sheer numbers of people we need to serve"* and *"acknowledging that we don't have the resources to do it."* Additionally, organizations described grappling with suburban sprawl and serving communities that are not near existing resources. As one key informant shared, *"Many of those requiring assistance are physically and perhaps linguistically isolated and are living in substandard conditions. They don't know what services are available."* Key informants indicated that because populations in unincorporated areas are diffuse, serving them requires a different approach to delivering services. Furthermore, demographic and cultural shifts were described as creating challenges for services to meet the needs of segments of the population (i.e., aging, youth, and racial/ethnic groups). As many participants identified, there is a growing demand for culturally and linguistically appropriate services. One participant explained, *"[We] are not as equipped as we need to be to address primary Spanish-speaking audiences – there are not nearly enough bilingual staff."*

Fiscal Environment

Achieving change in a weak fiscal environment was described as a challenge for both implementing new initiatives and sustaining existing ones. As one key informant shared, *"We're still operating in a less than perfect economic environment. It's still hard to make big things happen."* Across interviews and focus groups, participants shared how the economic recession has caused financial constraints as a result of state, county, and city level funding cuts. Limitations regarding funding were mentioned by most key informants who described how financial constraints were creating a dilemma of where to invest already limited funds. Several key informants also indicated that siloed funding sources and stringent eligibility requirements fuel competition among organizations and agencies for limited funds and creates barriers to providing services. On a related note, a weak and fragmented philanthropic community was also considered a challenge.

Political Environment

The political environment was described as preventing effective and efficient dialogue, especially in an election year, during which several participants indicated achieving change is particularly challenging. Many key informants noted that the location of Austin, a liberal city, in a conservative state, also poses challenges to the implementation of progressive ideas. Additionally, key informants highlighted that there is a lack of effective policy or there is the existence of outdated and ineffective policies, which must be updated to meet the needs of a changing environment. Yet, policy change is difficult to implement due to bureaucratic barriers. As one participant shared, *"our policies around planning have not evolved because of bureaucracies that have always done it the same way."*

Fragmented Organizational Efforts

Despite numerous non-profits and social service organizations in the area, the perception was that efforts could be more integrated and coordinated to reduce fragmentation and duplication of services. However, as key informants noted, several collaborative partnerships have been formed to address this issue (e.g., Integrated Care Collaboration) on a small scale that should be expanded. While organizations were described as engaged in collaborative efforts, participants expressed that the lack of a cohesive and focused vision hinders forward progress, resulting in more dialogue than action. The need for a coordinated approach to maximize limited resources was stressed.

COMMUNITY'S VISION AND IDENTIFIED OPPORTUNITIES
When focus group respondents and interviewees were asked about their visions and hopes for the future 3-5 years from now, the overarching themes that emerged from these conversations included focusing on prevention, ensuring equitable health care, improving the built environment, and engaging in policy change and strategic city planning.

> *"Good health involves good mental health and we need to integrate mental health into overall public health approaches and health care delivery."* –Interview participant

> *"Basic public health care needs to be available and affordable."* – Focus group participant

> *"Providing an urban environment that is conducive to physical activity is probably the most important thing that we can do to prevent many issues."* – Interview Participant

Focus on Prevention
Participants envisioned an integrated and holistic health care delivery system that focuses on prevention. Perceptions were that the health care system focuses much more on treatment than prevention. If efforts were implemented earlier on and at a population level, and addressed the social determinants of health, then prevention or delay of many conditions would ease the cost burden on the health care system and the region overall. Providing a continuum of coordinated care, especially for behavioral health services, was considered critical. In addition to integrating mental health services into primary care, coordinated care included providing wrap-around social services (e.g., housing, employment, etc.). Essential to coordinated care was sharing data and exchanging information, such as through electronic medical records. In addition, tying funding to collaborative efforts (e.g., *"funders insisting on coordinated and integrated care"*) was viewed as critical for reducing competition for limited resources.

Equitable Access to Health Care
Ensuring equitable access to health care was also identified as a priority for achieving a healthy community. As one key informant described, health care access "should be like getting a haircut" – easy and routine. Residents were interested in seeing more centrally located, community-based clinics to facilitate a patient centered medical home. Furthermore, health facilities should be capable of providing culturally and linguistically appropriate services through staff who are knowledgeable of the resources available. Similarly, residents requested additional information and education to improve their awareness of existing community resources to assist them with navigating the complex health care system. As one focus group participant shared, *"There are a lot of resources out there…that's what a lot of people are not aware of…they don't know how to find the resources."* Several participants identified the initiative to bring a teaching hospital or medical school to Austin as a critical step towards addressing health equity. Another participant indicated that, "a teaching hospital would help the disadvantaged community and people with mental health conditions." However, many participants noted that funds must be sought to increase health insurance coverage and make health care more affordable.

Improved Built Environment
Participants noted many opportunities to improve the built environment – one that supports a healthy and physically active community. Almost all participants discussed how the current built environment is often prohibitive of leading a healthy lifestyle. Key approaches included *"activating"* green spaces, supporting multiple modes of transportation, providing affordable and supportive housing, and increasing food security. For many participants, increasing access to healthy food was considered important; this included produce that was affordable and of high quality. There was also a strong desire

for the community to be more physically active by creating an environment that encourages walking and biking. Similarly, focus group and key informants would like to see resources and programs that are within walking distance. For example, one participant shared, *"I would like to see more retailers being closer to the community so people don't have to get on the bus and go 20-30 miles to shop."* Additionally, green spaces, such as Lady Bird Lake, were frequently described as isolated and difficult to access. As one focus group participant noted, *"I'm one block away from the lake, and it's not evident how to get there."* Participants suggested attracting residents to existing green spaces by incorporating art and cultural events and physically connecting communities to parks (e.g., greenways, bike paths). The integration of all sectors ranging from arts and culture to transportation and health was considered necessary to transform the built environment.

Policy Change and Strategic City/County Planning
Engaging in policy change and *"strategic"* city/county planning was also viewed as a viable option for creating a healthier community. From the resident's perspective, this included advocating for seniors and other vulnerable or underrepresented populations to ensure their voices are heard in the political process. The involvement of elected officials in creating a healthier community was viewed as critical. For example, one key informant suggested *"having a serious conversation where the mayors get together and address how you develop the 'fittest cities' and then create policy change as a low-hanging fruit."* In light of existing fragmented and uncoordinated approaches, participants expressed the need for a unified community with a common goal and shared vision, which would require the broad participation of stakeholders in action-oriented planning with defined goals and focused application of resources. As one key informant described, *"collaborations need to be better defined to get the right people that make sense around the table."* Some participants did identify Senator Watson's 10 in 10 plan as a positive example of a cohesive, collaborative approach and encouraged its promotion. Furthermore, as the population of the region continues to grow, engaging in thoughtful and comprehensive development efforts that examine the health impacts of land use will be essential. For example, participants indicated that it would be important to improve the quality of housing stock in unincorporated areas as well as supportive infrastructures such as access to roads, water, and social services.

KEY THEMES AND SUGGESTIONS
Through a review of the secondary social, economic, and epidemiological data in the region as well as discussions with community residents and leaders, this assessment report provides an overview of the social and economic environment of Austin/Travis County, the health conditions and behaviors that most affect the population, and the perceptions of strengths and gaps in the current public health and health care environment. Several overarching themes emerged from this synthesis:

- **There is wide variation within Travis County in population composition and socioeconomic levels.** While the West side of Austin/Travis County is highly affluent, communities in the East experience lower median incomes and fewer health-related outlets (e.g., grocery stores and recreational facilities). This bifurcation between the *"haves and the have not's"* is physically divided by I-35. These factors have a significant impact on people's health priorities, their ability to seek services, access to resources, stress level, and opportunities to engage in healthful lives. Additionally, the cultural, language, and economic diversity across Austin/Travis County presents significant challenges when delivering services and care that aim to meet the multitude of needs across the region.

- **Lack of transportation services and not living in a walkable community are two main concerns which have affected residents' perceived quality of life and ease of accessing services.** In many focus groups and interviews, transportation or walkability was discussed as a critical issue in the community. Except for downtown Austin, Travis County is a lower density area where residents are reliant on their cars. For those who do not have a car, it is difficult to walk to services and retail due to distance and lack of infrastructure for pedestrians. Public transportation was discussed as being unreliable and limited. For vulnerable populations such as the elderly and lower income, these limited transportation options have a severe impact on their time, ease of getting to employment, appointments, and going about their daily lives, such as going to the grocery store. These discussions repeatedly identified the interconnections between transportation and its challenges to maintaining good health. As Travis County's population grows, the issue of transportation will become even more critical to address.

- **Hispanics were identified as a vulnerable population in the community whose concerns stand to be exacerbated by the population growth in the region, particularly among youth.** In many interviews, concerns around meeting the needs of a growing Hispanic population were at the forefront of conversations. Discussions focused on how current challenging issues in the community– specifically, lack of culturally and linguistically appropriate care and limited educational and employment opportunities– disproportionately affect the Hispanic population. In addition, Travis County is likely to see increases in chronic conditions that disparately affect Hispanics, such as diabetes. If the aforementioned challenges are not addressed, the growth of Travis County's Hispanic population will likely have a significant impact on health care and other services as a larger proportion of the community is at higher risk for health problems.

- **Mental health was considered a growing, pressing concern by focus group and interview participants, and one in which the current services were considered inadequate.** Many participants noted that the issues of substance abuse and mental health are intricately intertwined. This situation makes addressing these issues even more challenging. Current treatment programs do exist, but the demand exceeds what is currently available. Integrating health care services and providing a continuum of care (e.g., wrap around social services) were seen as viable options for improving the capacity of behavioral health to serve this complex population.

- **As with the rest of the country and state, issues around physical activity, healthy eating, and obesity are issues for Travis County residents, especially as chronic conditions are the leading causes of morbidity and mortality.** Travis County's rates related to physical activity, nutrition, and obesity are better than what is seen statewide, yet with heart disease, cancer, and diabetes as top issues in relation to morbidity and mortality, these issues are considered critical to address. While Travis County has many grocery stores, parks, and recreational facilities, concerns were related to the accessibility and affordability of these outlets. The high cost of healthier foods, limited transportation to services, fees for recreational facilities, and reduced walkability within some communities due to traffic and lack of sidewalks were cited as challenges related to these issues. While it acknowledged that efforts to address these issues exist, participants commented that it was critical to address this issue through a comprehensive and focused approach, in that multiple sectors– including health care, education, public works, transportation, local government, and the business community– needed to be involved and collaborate together to impact current conditions.

- **While strong health care services exist in the region, vulnerable populations– such as the socially isolated elderly, non-English speaking residents, those living with disabilities, and the poor– encounter continued difficulties in accessing primary care services.** Numerous challenges for these populations were identified during the focus groups and interviews: limited or slow public transportation options in some communities, language and cultural barriers, complexity of navigating the health care system, lack of health insurance coverage, time or cost constraints (e.g., limited hours of operation of health care services), and funding cuts. These issues have a strong impact on a range of services including prenatal care and preventive health visits. Some approaches that have been suggested to help address the numerous challenges to accessing care include transportation programs, greater supply of primary care providers, and greater coordination across health care settings.

- **Residents viewed prevention as critical, but they emphasized that the health care system focused more on clinical care and disease management than prevention.** Discussions with community residents and key informants commonly revolved around the issue of prevention. Participants repeatedly mentioned that many health conditions, especially chronic diseases, could be avoided or minimized if programs and services focused on disease prevention and preventive behaviors, particularly among children and adolescents. However, the current health care system is not set up in this manner. Between reimbursement barriers, provider time constraints, and a system built around a biomedical— rather than public health—model, clinical services currently emphasize secondary and tertiary care and not prevention. There was consensus among those involved in the assessment discussions that prevention needed to be more in the forefront of health care services and programs.

- **Numerous services, resources, and organizations are currently working in Austin/Travis County to meet the population's health and social service needs.** Throughout the discussions, interview and focus group participants recognized the strong work related to health in which many community-based and regional organizations are involved. However, several interviewees commented that many efforts and services in the area are fragmented, uncoordinated, and under-funded. There was strong interest for these issues to be addressed via a more strategic, coordinated approach with multiple organizations and agencies working together. Overall, participants were hopeful for the future and saw that the discussions occurring in the region would create momentum for moving forward with innovative, collaborative approaches towards health.

APPENDIX A. COMMUNITY FORUM QUESTIONS

1) I could be healthier if...
2) What are the most important issues/problems in your community?
3) What types of services/ resources exist in your community that keep you/your family healthy?
4) What additional services do you/your family need?
5) What would a healthy community look like/feel like to you?

APPENDIX B. FULL LIST OF FOCUS GROUP AND INTERVIEW SECTORS

Focus Group Sectors
Asian American
Black/African American
Latino/Hispanic
Aging/Elderly/Disabled
Behavioral and Mental Health
Housing
Parents
Refugees

Interview Sectors
Economic Development/Business
Philanthropic
Public Safety
Faith Community
Education
Behavioral and Mental Health
Hospital/Health Care
Housing
Health Promotion
Culture/Arts
Government/Political

APPENDIX C. FOCUS GROUP GUIDE

<div align="center">

Austin/Travis County Community Health Assessment
General Focus Group Guide for Community Residents

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Goals of the focus group:
- To determine perceptions of the health strengths and needs of Austin/Travis County
- To explore how these issues can be addressed in the future
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

<div align="center">

[NOTE: QUESTIONS IN THE FOCUS GROUP GUIDE ARE INTENDED TO SERVE AS A GUIDE, NOT A SCRIPT.]

</div>

I.   BACKGROUND (10 minutes)

- Hi, my name is _____ and I am with [ORGANIZATION]. Thank you for taking the time to speak with me today.

- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.

- In collaboration with community members and partners, Austin/Travis County Health and Human Services is undertaking a comprehensive community health assessment effort to gain a greater understanding of the health of area residents and how health needs are currently being addressed. The assessment looks at health in the broadest sense, recognizing that where we live, learn, work, and play all have a significant impact on population health.

- As part of this process, we are having discussions like these around the county with community members, government officials, health care providers, and staff from a range of community organizations. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future.

- As you can see, I have a colleague with me today, [NAME], who is taking notes during our discussion. She works with me on this project. I want to give you my full attention, so she is helping me out by taking notes during the group and she doesn't want to distract from our discussion.

- [NOTE AUDIOTAPING IF APPLICABLE] Just in case we miss something in our note-taking, we are also audio-taping the groups tonight. We are conducting several of these types of groups, and we want to make sure we capture everyone's opinions. After all of the groups are done, we will be writing a summary report of the general opinions that have come up. In that report, we might provide some general information on what we discussed tonight, but I will not include any names or identifying information. Nothing you say here will be connected to your name.

- Lastly, please turn off your cell phones, beepers, or pagers or at least put them on vibrate mode. The group will last only about 80-90 minutes. If you need to go to the restroom during the discussion, please feel free to leave, but we'd appreciate it if you would go one at a time.

- Any questions before we begin our introductions and discussion?

II.   INTRODUCTIONS (10 minutes)

Now, first let's spend a little time getting to know one another. Let's go around the table and introduce ourselves. Please tell me: 1) Your first name; 2) what city or town you live in; and 3) something about yourself you'd like to share– such as how many children you have or what activities you like to do in your spare time. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III.   COMMUNITY ISSUES (30 minutes)

1.   Tonight, we're going to be talking a lot about the community that you live in. How would you describe your community?

  a.   When I say the words, "your community" – what comes to mind? How do you define your community?

2.   If someone was thinking about moving into your community, what would you say are some of its biggest strengths or the most positive things about it? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]

  a.   What are some of the biggest problems or concerns in your community? [PROBE ON ISSUES IF NEEDED – HEALTH, ECONOMIC, SOCIAL, SAFETY, ETC.]

    i.   [IF NOT DISCUSSED] What challenges around transportation have you faced or you believe others in the community face day-to-day?

    ii.   How about around housing? Employment? Education? Environment (e.g., climate change, green space, etc.)? Discrimination (e.g., by race, gender, or class), etc.?

  b.   Over the past 2-3 years, what changes have you seen in your community? (e.g., demographic shifts and particularly related aging population, impact of the recession, etc.)

3.   What do you think are the most pressing <u>health</u> concerns in your community?

  a.   How have these health issues affected your community? In what way?

  b.   Are there things about your community that make it easier for you to be healthy? What specifically?

  c.   Are there things about your community that make it harder for you to be healthy? What specifically?

    i.   [PROBE ON FOOD ACCESS IF NOT YET BROUGHT UP] In our discussion, you have/have not mentioned issues related to healthy eating. How hard is it to buy healthy foods in your community? [PROBE ON ACCESS, TRANSPORTATION, COST, ETC.]

IV.   PERCEPTIONS OF PUBLIC HEALTH/PREVENTION SERVICES AND HEALTH CARE (30 minutes)

4. Let's talk about a few of the issues you mentioned. [SELECT TOP HEALTH CONCERNS] What programs, services, and policies are you aware of in the community that currently focus on these health issues?

   a. What's missing? What programs, services, or policies are currently not available that you think should be?

   b. What do you think the community should do to address these issues?

5. I'd like to ask specifically about health care in your community. If you or your family had a general health issue that needed a doctor's care or prescription medicine – such as the flu or a child's ear infection– where would you go for this type of health care? [PROBE IF THEY GO TO PRIVATE PRACTICE, COMMUNITY HEALTH CLINIC, E/R, ETC]

   a. What do you think of the health care services in your community? [PROBE ON POSITIVE AND NEGATIVE ASPECTS OF THE HEALTH CARE SERVICES]

6. Have you or someone close to you ever experienced any challenges in trying to get health care? What specifically? [PROBE FOR BARRIERS: INSURANCE ISSUES, LANGUAGE BARRIERS, LACK OF TRANSPORTION, ETC.]

   a. [PROBE IF NEEDED] What part of getting health care was the most challenging? Was it finding a doctor? Making an appointment? Getting to the office/clinic? Being at the office/clinic and understanding the doctor?

7. [NAME BARRIER] was mentioned as something that made it difficult to get health care. What do you think would help so that people don't experience the same type of problem that you did in getting health care? What would be needed so that this doesn't happen again? [REPEAT FOR OTHER BARRIERS]

V.   VISION OF COMMUNITY AND PROGRAM/SERVICE ENVIRONMENT (10 minutes)

8. I'd like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what do you see as the priorities for a healthy community?

   a. What is your vision specifically related to people's <u>health</u> in the community?

      i. What do you think needs to happen in the community to make this vision a reality?

         1. Who do you think needs to be involved in these efforts?

9. CLOSING (2 minutes)

Thank you so much for your time. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today? Thank you again. Have a good afternoon.

APPENDIX D. KEY INFORMANT INTERVIEW GUIDE

<div align="center">

Austin/Travis County Community Health Assessment
General Key Informant Interview Guide

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Goals of the Key Informant Interview
- • To determine perceptions of the health strengths and needs of Austin/Travis County
- • To explore how these issues can be addressed in the future
- • To identify the gaps, challenges, and opportunities for addressing community needs more effectively

[NOTE: QUESTIONS FOR THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, NOT A SCRIPT.]

I.   BACKGROUND (5 minutes)

- • Hi, my name is _____ and I am with [ORGANIZATION]. Thank you for taking the time to speak with me today.

- • Austin/Travis County Health and Human Services is undertaking a comprehensive community health assessment effort to gain a greater understanding of the health of area residents and how health needs are currently being addressed. The assessment looks at health in the broadest sense, recognizing that where we live, learn, work, and play all have a significant impact on population health.

- • The assessment is being conducted in collaboration with our partners – Travis County Health and Human Services & Veterans Services, Central Health, St. David's Foundation, Seton Healthcare Family, and the University of Texas Health Science Center at Houston School of Public Health Austin Regional Campus. In addition to guiding future planning for these agencies and the area overall, the assessment is also the first step for the health department to earn accreditation, showing that the agency is meeting national standards.

- • We are conducting interviews with leaders in the community and focus groups with residents to understand different people's perspectives on these issues. We greatly appreciate your feedback, insight, and honesty.

- • Our interview will last about _____ minutes [EXPECTED RANGE FROM 30-60 MINUTES, DEPENDING ON INTERVIEWEE]. After all of the interview and focus group discussions are completed, we will be writing a summary report of the general themes that have emerged during the discussions. No names or organizations will be connected to anything that any one particular person said in a discussion. Additionally, nothing sensitive that is said in these discussions will be reported out. However, at the end of the report, we do hope to provide a list of all the organizations engaged in this effort, including those from the key informant interviews, focus groups, and community dialogue sessions.

- • Any questions before we begin our introductions and discussion?

II.   THEIR AGENCY/ORGANIZATION
1.   Can you tell me a bit about your organization/agency? [TAILOR PROBES DEPENDING ON AGENCY]

   a.   [PROBE ON ORGANIZATION: What is your organization's mission? What communities do you serve? Who are the main clients/audiences for your programs?]

      i.   What are some of the biggest challenges your organization faces in providing these programs/services in the community?

   b.   To what extent do you currently partner with any other organizations or institutions in any of your programs/services?

III.   COMMUNITY ISSUES
   2.   How would you describe the community which your organization serves?
   c.   What do you consider to be the community's strongest assets/strengths?

      i.   What are some of its biggest concerns/issues in general? What challenges do residents face day-to-day?
            1.   [IF NOT DISCUSSED] What challenges around transportation do residents face that affect their day-to-day lives? How about around housing? Employment? Education? Environment (e.g., climate change, green space, etc.)? Discrimination (e.g., by race, gender, or class), etc.?

      ii.   Over the past 2-3 years, what changes have you seen in your community? (e.g., demographic shifts, impact of the recession, etc.)

   d.   Recognizing that where we live, learn, work, and play affect health, what do you think are the most pressing <u>health</u> concerns in the community? Why? [PROBE ON SPECIFICS]

      i.   How have these health issues affected your community? In what way?

      ii.   Who do you consider to be the populations in the community most vulnerable or at risk for the pressing health conditions/issues you identified?

   e.   From your experience, what are residents' biggest challenges to addressing these health issues?

      i.   [PROBE ON RANGE OF CHALLENGES]: What challenges around transportation do residents face to addressing these health issues? How about around housing? Employment? Education? Environment (e.g., climate change, green space, etc.)? Discrimination (e.g., by race, gender, or class), etc.?

   f.   What are residents' biggest strengths to addressing these health issues?

IV.   PERCEPTIONS OF PUBLIC HEALTH/PREVENTION SERVICES AND HEALTH CARE

3. Let's talk about a few of these issues you mentioned. [SELECT TOP HEALTH CONCERNS PROVIDED IN Q2b ABOVE] What programs, services, or policies are you aware of in the community that currently focus on these health issues? [PROBE FOR SPECIFICS]

> i.   In your opinion, how effective have these programs/services been at addressing these issues? Why?

> b.   Where are the gaps? What programs, services, or policies are currently not available that you think should be?

> c.   What do you think needs to be done to address these issues?

>> i.   Do you see opportunities currently out there that can be capitalized on to address these issues? For example, what are some "low hanging fruit" – current collaborations or initiatives that can be strengthened or expanded?

4. In general, what do you see as the overall strengths and limitations related to the public health/prevention-related services, programs, or policies in your community?

> a.   What challenges do residents in your community face in accessing prevention services or programs?

>> i.   What do you think needs to happen in your community to help residents overcome or address these challenges?

5. What do you see as the strengths of the health care services in your community? What do you see as its limitations?

> a.   What challenges do residents in your community face in accessing health care?

>> i.   What do you think needs to happen in your community to help residents overcome or address these challenges?

V.   VISION OF COMMUNITY AND PROGRAM/SERVICE ENVIRONMENT

6. I'd like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what do you see as the priorities for a healthy community?

> a.   What is your vision for the future related to people's <u>health</u> in the community?

>> i.   What do you think needs to happen in the community to make this vision a reality?

>>> 1.   Who do you think needs to be involved in these efforts?

>>> 2.   What current or emerging events or trends do you see as having an impact on this vision? (e.g., social/economic/demographic trends, legislation, funding shifts, political events, etc.)

ii. What steps do you think should be taken to promote sustainability of these efforts?

1. What are biggest challenges to sustainability?

VI.   CLOSING (2 minutes)
Thank you so much for your time. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today? Thank you again. Have a good afternoon.

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Together We Thrive
Austin/Travis County Community Health Plan

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

– ROBERT WOOD JOHNSON FOUNDATION

Community Health Improvement Plan

Austin/Travis County
Texas

June 2013

METRO

CITY OF AUSTIN · FOUNDED 1839 ·

CENTRAL HEALTH

COUNTY OF TRAVIS · STATE OF TEXAS · 1840

Austin Travis County Integral Care
Behavioral Health & Developmental Disabilities Services

Seton Healthcare Family

St David's FOUNDATION

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

Dear Community Partner,

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

From August 2011 through December 2012, Austin/Travis County Health and Human Services Department (A/TCHHSD) partnered with Travis County Health and Human Services and Veterans Services, Central Health, St. David's Foundation, Seton Healthcare Family, and the University of Texas Health Science Center (UTHSC) at Houston School of Public Health Austin Regional Campus to lead a comprehensive community health planning initiative and establish the Austin/Travis County Community Health Improvement Steering Committee. The community health improvement planning process was completed in December 2012 with a Community Health Assessment (CHA) and a draft Community Health Improvement Plan (CHIP) for Austin/Travis County. The CHIP was finalized in June 2013 by collaborating with CHIP partners, stakeholders, and community members, working through a Planning Summit, and expanding the Steering Committee to include Austin/Travis County Integral Care and Capital Metro. The CHIP implementation or annual work plan officially begins in July 2013.

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

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

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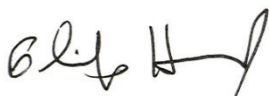
Sincerely,

Carlos Rivera
Director, Austin/Travis County HHSD

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

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

Table of Contents

EXECUTIVE SUMMARY

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

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

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

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

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the Austin/ Travis County assessment and planning process engaged community members and Local Public Health System (LPHS) Partners through different avenues:
   a. the Steering Committee was responsible for overseeing the community health assessment, identifying the health priorities, and overseeing the development of the community health improvement plan
   b. the Core Coordinating Committee provided the overall management of the process, and
   c. the CHIP Workgroups, which represented broad and diverse sectors of the community, were formed around each health priority area to develop the goals, objectives and strategies for the CHIP.

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

Vision

Healthy People are the Foundation of our Thriving Community

Mission

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

Shared Values

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

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

Perseverance, Excellence, and Creativity

Health Promoting: Building on current assets and developing new assets

Shared Accountability and Ownership

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

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

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

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

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

Austin/Travis County Community Health Improvement Plan

BACKGROUND

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

The community health improvement planning process includes two major components:

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

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

Moving from Assessment to Planning

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

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

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

a) the **Steering Committee** was responsible for overseeing the community health assessment, identifying the health priorities, and overseeing the development of the community health improvement plan

b) the **Core Coordinating Committee** provided the overall management of the process, and

c) the **CHIP Workgroups**, which represented broad and diverse sectors of the community, were formed around each health priority area to develop the goals, objectives and strategies for the CHIP.

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

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

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

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

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

I.   OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PLAN

A. What is a Community Health Improvement Plan?

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

B. How to use a CHIP

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

C. Methods

Building upon the key findings and themes identified in the Community Health Assessment (CHA), the CHIP aims to:
  - Identify priority issues for action to improve community health
  - Develop and implement an improvement plan with performance measures for evaluation
  - Guide future community decision-making related to community health improvement

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

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

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

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

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

Figure 1: The Cyclical Nature of the Core Public Health Functions
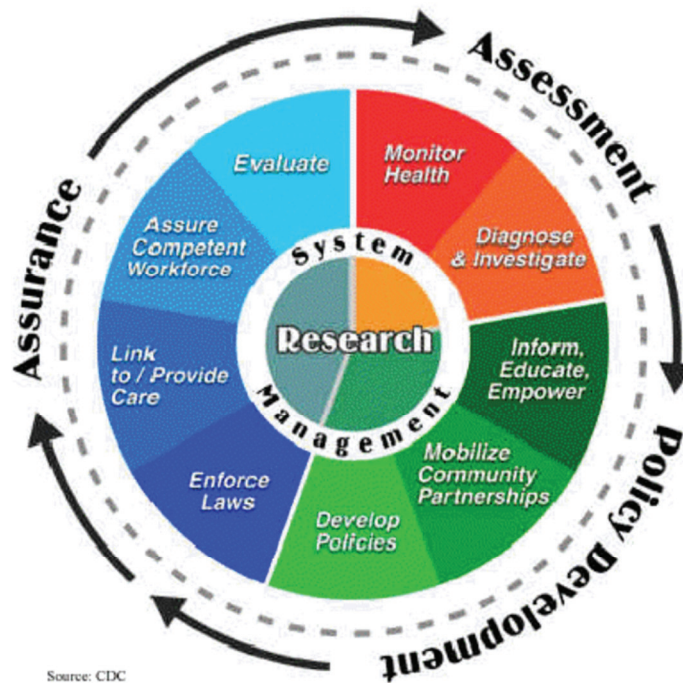
Source: Centers for Disease Control and Prevention (CDC), Ten Essential Public Health Services

II. PRIORITIZATION OF HEALTH ISSUES

A. Community Engagement

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

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

B. Strategic Components of the CHIP

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

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

---

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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

Perseverance, Excellence, and Creativity

Health Promoting: Building on current assets and developing new assets

Shared Accountability and Ownership

C. Development of Data-Based Community Identified Health Priorities

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

Health Priority Areas
- Built Environment
- Transportation
- Affordable Housing
- Food Access
- Physical Activity Access

Chronic Disease and Related Conditions
- Obesity
- Diabetes
- Heart Disease
- Cancer

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

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

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

Political will exists to support change

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

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

Achievable/doable
- Feasible and realistic

Resources available or likely
- Builds on or enhances current work

Measurable outcomes

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

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

This process was followed by a show of hands vote, which resulted in the selection of the same issues and sub categories identified during the multi voting process. The dot voting

process was one that was conducted in a short amount of time with a sizable group of people made up of both Steering Committee and Core Leadership members.

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

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

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

D. Development of the CHIP Strategic Components

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

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

The Core Planning Group and HRiA provided sample evidence based strategies from a variety of resources including *the Community Guide to Preventive Services, County Health Rankings*, and the *National Prevention Strategy* for the strategy setting sessions. As policy is inherently tied to sustainability and effectiveness, workgroups indicated whether or not strategy

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[4] The World Health Organization
  http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html
[5] Brennan Ramirez LK, B.E., Metzler M., Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, Centers for Disease Control and Prevention, Editor. 2008, Department of Health and Human Services,: Atlanta, GA.)
[6] The Wisconsin CHIP Implementation Plan is accessible via the following link.
  http://www.walhdab.org/documents/TemplateImplementationPlanv1.0.doc

implementation would necessitate policy changes. In addition, as noted by a one of the local content experts Andrew Springer, PhD "the strategies were meant to be broad enough to allow for creative thinking in terms of how to operationalize the strategy".

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

III. CHIP IMPLEMENTATION PLAN

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

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

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

A. Priority One: Chronic Disease – Focus on Obesity

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

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

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

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

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

PRIORITY AREA 1: CHRONIC DISEASE – FOCUS ON OBESITY

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

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

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

PRIORITY AREA 1: CHRONIC DISEASE – FOCUS ON OBESITY
Goal 1: Reduce burden of chronic diseases caused by obesity among Austin/Travis County residents.
Objective 1.1: By June 2016, increase by 5% the percent of adults and children in Travis County who meet or exceed physical activity guidelines for health.

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

Source: The Community Guide, NPLAN: Joint-Use Agreements

http://changelabsolutions.org/sites/phlpnet.org/files/Playing_Smart-National_Joint_Use_Toolkit_FINAL_20120309.pdf

Centers for Disease Control and Prevention Guide to Strategies for Increasing Physical Activity in the Community

https://www.myctb.org/wst/npaoeval/Shared%20Documents/Guidance%20Document%201.%20Physical%20Activity.pdf

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

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

Strategies:

Strategy 1.1.1: Increase access to local school facilities, fields, basketball courts, community recreational facilities, parks, play grounds, etc. by establishing new joint- use agreements and improving adherence to existing joint-use agreements.

Strategy 1.1.2: Enhance the built environment in multiple settings (including worksites, places of worship, schools, parks, neighborhoods) to create opportunities for physical activity.

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). [this strategy is being woven as an action step throughout the plan]

Strategy 1.1.4: Increase access and enhance quality of existing programs that promote physical activity among youth. **(Y2)**

Strategy 1.1.5: Increase the number of settings with policies that promote/support physical activity (including worksites, schools, etc.). **(Y2)**

Potential Partners

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

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

PRIORITY AREA 1: CHRONIC DISEASE – FOCUS ON OBESITY
Goal 1: Reduce burden of chronic diseases caused by obesity among Austin/Travis County residents.
Objective 1.2: By June 2016, increase the number of Travis County workplaces that have family supportive breastfeeding by 5%.

BACKGROUND ON STRATEGY/OBJECTIVE: Breastfeeding **Source**: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm **Evidence Base:** Breastfeeding has been linked to decreased risk of pediatric overweight in multiple epidemiologic studies. **Policy Change (Y/N): Yes,** Local government has a policy requiring local government facilities to provide breastfeeding accommodations for employees that include both time and private space for breastfeeding during working hours.

Strategies:
Strategy 1.2.1: Develop mother friendly worksite breastfeeding policy.
Strategy 1.2.2: Increase sensitivity for breastfeeding in the workplace through employee/employer training, flexibility in work schedules, etc.
Strategy 1.2.3: Increase awareness of breastfeeding benefits across the entire community through media and community wide campaigns.
Strategy 1.2.4: Promote mother friendly worksite policies among small business, hospitality industries, and employers of hourly wage earners. **(Y2)**
Strategy 1.2.5: Promote mother-friendly spaces in commercial business property potentially through certification program. **(Y2)**

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

PRIORITY AREA 1: CHRONIC DISEASE – FOCUS ON OBESITY
Goal 1: Reduce burden of chronic diseases caused by obesity among Austin/Travis County residents.
Objective 1.3: By June 2016, increase by 5% the number of Travis County child care settings that promote healthy eating. [objective and related strategies to be implemented in Y2]
BACKGROUND ON STRATEGY: Obesity prevention strategies in child care settings   **Source:** Institute of Medicine, http://www.iom.edu/Reports/2011/Early-Childhood-Obesity-Prevention-Policies/Recommendations.aspx   **Evidence Base:** A wide range of environmental factors can influence a child's risk for obesity in the first years of life. There is a growing evidence base that emphasizes the importance of assessing the beginnings of obesity and instituting preventive measures in the early years.   **Policy Change (Y/N):** Yes, policy change would occur at the local childcare settings
Strategies: Strategy 1.3.1   Build capacity of child care settings to promote healthy eating. **(Y2)**   Strategy 1.3.2   Implement policies that increase access to drinking water and healthy food procurement. **(Y2)**   Strategy 1.3.3   Publicize child care settings that meet requirements. **(Y2)**   Strategy 1.3.4   Build capacity among caregivers of children in childcare settings to advocate for healthy food options. **(Y2)**
Potential Partners
• Texas Department of State Health Services, Texas Department of Family & Protective Services, (See) Community Transformation Grant strategy on child care settings, Michael and Susan Dell Center for Healthy Living Coordinated Approach to Child Health (CATCH) in preschool, Deanna Hoelscher – University of Texas School of Public Health (UTSPH), Children's Optimal Health, Success by 6, Workforce Development Board, Early Childhood Council, Centex After School Network, Look at best practices from San Antonio
Objective 1.4: By April 2016, reduce the percent of children and adults who consume sugar sweetened beverages by 5%.
BACKGROUND ON STRATEGY Access to Sugar Sweetened Beverages   **Source:** http://www.cdph.ca.gov/SiteCollectionDocuments/StratstoReduce_Sugar_Sweetened_Bevs.pdf   **Evidence Base:** Several social and environmental factors are linked to the purchase and consumption of SSBs. These factors include advertising and promotion; increased portion sizes; fast food consumption; television watching; permissive parenting practices; parental SSB consumption; and increased access to SSBs in the home and school. Evidence that increasing water can reduce calories consumed from SSB: Giles et al., 2012. Am J Prev Med 2012;43(3S2):S136 –S142   **Policy Change (Y/N):** Yes, in settings that offer beverages or provide access to beverages
Strategies: Strategy 1.4.1   Increase the number settings with food procurement policies that reduce access to sugar sweetened beverages.   Strategy 1.4.2:   Increase the number of settings that promote the availability of drinking water.
Potential Partners
• Independent School Districts in city of Austin and Travis County   • Austin Water Utility, Youth Sports Leagues, Michael and Susan Dell Center for Healthy Living

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Performance Measures - How We Will Know We are Making a Difference		
Short Term Indicators (by objective)	**Source**	**Frequency**
Increase % of farms, community gardens, private gardens (count of farms and community gardens regulated by City of Austin)	Austin/Travis County Health and Human Services Department (ATC HHSD)	Annual
Increase % of Travis County low-income residents who are living within 1 mile of a grocery store or a non-traditional distribution site.	County Health Rankings (CHR)	Annual
Increase in the number of non-traditional distribution sites (i.e. farm-to-site programs, farmers markets)	ATC HHSD	Annual
Increase in the # of traditional distribution sites	ATC HHSD	Annual
Increase % of the municipalities that adopt healthy food zone policy	ATC HHSD	Annual
Increase % of land area covered by healthy food zone policy (calculated and mapped, ATC HHSD)	ATC HHSD	TBD
Long Term Indicators (for Goal)	**Source**	**Frequency**
% of adults reporting eating 5+ servings of fruits and vegetables/day	BRFSS	Annual
% of youth reporting eating 5+ servings of fruits and vegetables/day	YRBS	Varies (contingent on resources)
% of (individuals or families, depending on what unit Feeding America reports) that are food insecure	Feeding America	Annual

PRIORITY AREA 2: BUILT ENVIRONMENT – FOCUS ON ACCESS TO HEALTHY FOODS
Goal 2: All in our community have reasonable access to affordable quality nutritious food.
Objective 2.1: By June 2016, increase by 50% access to and participation of eligible people in food assistance programs (ex. SNAP, WIC, school breakfast and lunch program, summer food service, Elderly Nutrition Program) that increase access to healthy food.[16]
BACKGROUND ON STRATEGY/OBJECTIVE: **Source**: From Food Research and Action Center Issue Briefs for Child Nutrition Reauthorization | Number 1, February 2010; http://www.frac.org/pdf/CNR01_qualityandaccess.pdf **Evidence Base**: There is considerable evidence about the effective role that participation in the federal nutrition programs plays in providing the nutrients children need for growth, development, and overall health. There also is a growing body of research on how the programs impact obesity. For these reasons, increasing participation in the federal nutrition programs is one of the healthy eating and physical activity strategies recommended in the Institute of Medicine's report Local Government Actions to Prevent Childhood Obesity. **Policy Change (Y/N):** No

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

PRIORITY AREA 2: BUILT ENVIRONMENT – FOCUS ON ACCESS TO HEALTHY FOODS
Goal 2: All in our community have reasonable access to affordable quality nutritious food.

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

Strategies:

Strategy 2.1.1: Conduct assessment to establish baseline of the following:
   a) current programs and services to determine which do support access to healthy foods
   b) current capacity of relevant programs
   c) participation (#/%) in relevant programs to determine which could absorb additional participants versus those that would require additional capacity before further enrollment could take place
   d) gap analysis – population, geographic areas that are underserved –to understand what barriers seem to prevent participation and what means exist to overcome these barriers.

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

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

Strategy 2.1.4: Increase capacity of quality programs (programs identified in Strategies 2.1.1a and 2.1.11d) **(Y2)**

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

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

PRIORITY AREA 2: BUILT ENVIRONMENT – FOCUS ON ACCESS TO HEALTHY FOODS
Goal 2: All in our community have reasonable access to affordable quality nutritious food.

Objective 2.2:	By June 2016, ensure that 2 new distribution and production points for healthy food are available and accessible in each of the five high need areas (The 5 areas currently without a full service grocery store are: 78723,78724,78725,78744, and 78754). "Distribution Point" in this context refers to a physical location where affordable quality nutritious food can be accessed, including, but not limited to, grocery stores, farmers markets, and farm-to-site programs. "Production points" include, but are not limited to, farms and community gardens.

BACKGROUND ON STRATEGY/OBJECTIVE
Source: CDC
Evidence Base: http://www.policylink.org
Policy Change (Y/N): N

Strategies:

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

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

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

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

Potential Partners

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

PRIORITY AREA 2:   BUILT ENVIRONMENT – FOCUS ON ACCESS TO HEALTHY FOODS
Goal 2:   All in our community have reasonable access to affordable quality nutritious food.
Objective 2.3:   **By June 2016, all local municipalities will establish a healthy food zone ordinance around schools, municipal parks, child care centers, libraries and recreation centers.**
BACKGROUND ON STRATEGY/OBJECTIVE **Source:** The National Policy & Legal Analysis Network to Prevent Childhood Obesity [18] **Evidence Base:** http://changelabsolutions.org/sites/phlpnet.org/files/nplan/HealthyFoodZone_Ordinance_FINAL_091008.pdf **Policy Change (Y/N):** Y

Strategies:
 	
Strategy 2.3.1:   Develop model policy(s) for city/county government promoting healthy food zones
 	
Strategy 2.3.2:   Engage the following to develop and support the health food zone ordinance
         −   advocacy groups
         −   grass roots/residents
         −   policy/thought leaders
         −   community residents

Potential Partners
•   Travis County municipalities, Travis County, child care centers, independent school districts, colleges and universities

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

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

C. Priority Three: Built Environment – Focus on Transportation

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

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

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

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

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

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

PRIORITY AREA 3: BUILT ENVIRONMENT – TRANSPORTATION

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

Performance Measures - How We Will Know We are Making a Difference		
Short Term Indicators (by objective)	**Source**	**Frequency**
2% increase in the number of adults that engaged in aerobic physical activity for 150 minutes per week in Austin/Travis County	BRFSS	Annual
2% increase in the number of students that have engaged in physical activity for at least 60 minutes per day on 5 or more days per week in Austin/Travis County.	YRBS	Annual
Long Term Indicators (for Goal)	**Source**	**Frequency**
15% increase in daily walking and cycling duration (minutes per capita per day) from the 2009 data, across all the population subgroups in Austin/Travis County.	National Household Travel Survey	Every 5 years (next survey year – 2015)
15% increase in daily walking and cycling distance (miles per capita per day) from the 2009 data, across all population subgroups in Austin/Travis County.	National Household Travel Survey	Every 5 years
15% increase in prevalence of 30 minutes of walking per day and 30 minutes of cycling per day from the 2009 data, across all population subgroups in Austin/Travis County.	National Household Travel Survey	Every 5 years
15% increase in active transportation commute mode share.	American Community Survey	Every 5 years

PRIORITY AREA 3: BUILT ENVIRONMENT – TRANSPORTATION
Goal 3: Local and regional stakeholders will collaboratively increase accessibility to community resources via safe, active transportation.

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

BACKGROUND ON STRATEGY/OBJECTIVE
Source: CDC, APHA
Evidence Base: http://www.cdc.gov/transportation/references.htm;
http://www.apha.org/advocacy/priorities/issues/transportation
Policy Change (Y/N) Yes

Strategies:

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

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

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

Potential Partners

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

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

BACKGROUND ON STRATEGY/OBJECTIVE
Source: Plans housed in City of Austin and CAMPO. The majority of the active transportation master plans already exist. However, our community needs to find ways to fund them
Evidence Base: Promote Active Transportation, http://www.cdc.gov/transportation/references.htm;
http://policy.rutgers.edu/faculty/pucher/pucher_dill_handy10.pdf
Policy Change (Y/N): No

Strategies:

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

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

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

Potential Partners

- City of Austin, Safe Routes to School

PRIORITY AREA 3: BUILT ENVIRONMENT – TRANSPORTATION
Goal 3: Local and regional stakeholders will collaboratively increase accessibility to community resources via safe, active transportation.
Objective 3.3: By June 2016, the City of Austin and Travis County will require and incentivize active transportation connections for all new development outside of the activity centers identified in the Capital Area Metropolitan Planning Organization's (CAMPO) 2035 Plan.
BACKGROUND ON STRATEGY/OBJECTIVE **Source:** CDC; Complete Streets; Active Transportation Policy **Evidence Base:** Encourage Healthy Community Design; www.completestreets.org; http://www.atpolicy.org/reforming-land-use-and-zoning-regulations-promote-active-transportation **Policy Change (Y/N):** Yes
Strategies:
Strategy 3.3.1: Convene local government and the development community to identify policies to incentivize development with active transportation and disincentivize development without it. Strategy 3.3.2: Modify development policies to encourage active transportation. Strategy 3.3.3: Adopt a policy to require active transportation in new public facility location decisions. Strategy 3.3.4: Work with government and non-government organizations to implement a Complete Streets policy in the City of Austin and Travis County.
Potential Partners
• Municipalities in Travis County, Homebuilder Association, Real Estate Council, Chambers of Commerce, Urban Land Institute

Transportation Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

PRIORITY AREA 4:		
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES		
- FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM		
Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.		
Performance Measures - How We Will Know We are Making a Difference		
Short Term Indicators (by objective)	**Source**	**Frequency**
4.1, 4.4 Increase % of utilized patient centered best practices	local safety net provider survey	Annual
4.1 - 4.4 Increase % of patients connected to a Joint Commission or NCQA certified medical home	Joint Commission, NCQA (to establish baseline)	Annual
4.1, 4.4 Increase % of providers trained on health literacy	Literacy Coalition of Central Texas/other known providers of health literacy training (organizational records, e.g. provider sign in sheet); and/or local provider survey	Annual
4.1, 4.4 Increase %of patients trained on health literacy	Literacy Coalition of Central Texas/other known providers of health literacy training (organizational records, e.g. provider sign in sheet); and/or local provider survey	Annual
4.2 Increase % of providers serving safety net population using Health IT system	local safety net provider survey	Annual
4.2 Increase % of HHS providers using HIE	Centex Systems Support Services (CSSS)	Annual
4.2 Increase % of primary care and behavioral health providers using EHRs	local safety net provider survey, CSSS	Annual
4.3 Expand residency and training programs	Council on Graduate Medical Education (CGME); or DSHS, Health Professions Resource Center, Center for Health Statistics	Annual (If using CGME, may require a special query request)
4.3 Implementation of telemedicine within UMCB (University Medical Center Brackenridge), CHCs (Community Health Centers) and in support of MCOT (Mobile Crisis Outreach Team)	local safety net provider survey	Annual
4.5 Increase use of evidence based models	local provider survey	Annual

PRIORITY AREA 4:		
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES **- FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM**		
Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.		
Performance Measures - How We Will Know We are Making a Difference		
Short Term Indicators (by objective)	**Source**	**Frequency**
4.1-4.5 The HEDIS measures below are the precursors to long term system indicators. HEDIS measures were selected based on their impact on reducing "downstream" hospital admissions for ambulatory care sensitive conditions. Several measures were also selected to proxy for integration of primary medical and behavioral health. – Frequency of ongoing prenatal care – Comprehensive adult diabetes care – Use of appropriate medications for people with asthma – Medication management for people with asthma – Asthma medication ratio – Follow-up after hospitalization for mental illness – Antidepressant medication management – Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications – Diabetes monitoring for people with diabetes and schizophrenia – Cardiovascular monitoring for people with cardiovascular disease and schizophrenia – Adherence to antipsychotic medications for individuals with schizophrenia – Follow-up care for children prescribed ADHD medication	Healthcare Effectiveness Data and Information Set (HEDIS) 2013 and Centex Systems Support Services(CSSS) (Electronic health record chart audit)	Annual

PRIORITY AREA 4:		
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES		
- FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM		
Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.		
Performance Measures - How We Will Know We are Making a Difference		
Long Term Indicators (for Goal)	**Source**	**Frequency**
Increase the proportion of persons with a usual primary care provider	Local provider survey	Annual
Increase the proportion of persons who have a specific source of ongoing care	AHRQ (national)	Annual
Decrease in ambulatory care sensitive conditions	Texas Department of State Health Services (Texas Hospital Discharge Dataset: recommended measures: low birth weight, hypertension, adult asthma, pediatric asthma, diabetes short-term, complications, diabetes – long-term, complications, uncontrolled diabetes, lower-extremity amputation, among patients with diabetes)	Annual
Reduce utilization of hospital, emergency room and psychiatric emergency services	Texas Department of State Health Services – Texas Hospital Discharge Dataset recommended measures: TBD	Annual
Reduce % of adults reporting one or more days of poor mental health over a one month period	BRFSS	Annual
Reduce % of hospital admissions that are potentially preventable	Texas Department of State Health Services – Texas Hospital Discharge Dataset recommended measures: TBD	Annual
Reduce % of emergency room visits that are potentially preventable	Texas Department of State Health Services – Texas Hospital Discharge Dataset recommended measures: TBD	Annual

PRIORITY AREA 4:
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES
- FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM
Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.
Objective 4.1: By June 2016, increase the adoption of patient-centered strategies within the safety net.

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

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

Evidence Base:

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

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

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

Policy Change (Y/N): Yes

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

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

Strategies:

Strategy 4.1.1: Expand the 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. **(Y2)**

Strategy 4.1.3: Expand health literacy training to # of unduplicated patients served by Travis County safety net providers. **(Y2)**

Strategy 4.1.4: Train # of providers at each participating agency on health literacy principles and effective patient-provider communication strategies. **(Y2)**

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. **(Y2)**

Potential Partners

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

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

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

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

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

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

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

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

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

Policy Change (Y/N): Yes

Strategies:

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

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

Potential Partners

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

PRIORITY AREA 4:
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES **- FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM**
Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.
Objective 4.3: By June 2016, expand by 5% primary care and behavioral/mental health workforce capacity who will care for safety-net population. (Y2)

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

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

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

Evidence Base: HRSA Health Professional Shortage Areas

Policy Change (Y/N): Yes

Strategies:
Strategy 4.3.1: Increase the size of residency and training programs for primary and mental/behavioral health care providers (including physicians, nurses, social workers, and others) (This is an 1115 Waiver Strategy).
Strategy 4.3.2: Develop and implement telemedicine to increase access to MH/BH services (This is an 1115 Waiver Strategy).
Strategy 4.3.3: Develop and implement improved local reimbursement strategies.
Potential Partners
• Seton Healthcare Family, Central Health, UT, ATCIC, Community Care, Lone Star Circle of Care, Workforce Solutions, Austin Community College

PRIORITY AREA 4:
ACCESS TO PRIMARY CARE AND MENTAL/BEHAVIORAL HEALTH SERVICES
- FOCUS ON NAVIGATING THE HEALTHCARE SYSTEM
Goal 4: Expand access to high-quality behaviorally integrated patient-centered medical homes for all persons.

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

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

Source: Agency for Healthcare Research and Quality

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

Policy Change (Y/N): Yes

Strategies:

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

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

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

Potential Partners

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

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

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

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

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

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

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

Policy Change (Y/N): Yes

Strategies:

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

Strategy 4.5.2: Expand the # of safety-net health care providers that are Joint Commission or NCQA certified medical homes. **(Y2)**

Strategy 4.5.3: Increase the ability of safety-net providers to treat and manage complex co-occurring medical conditions. **(Y2)**

Potential Partners

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

<u>**DEFINITIONS**</u>

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

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

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

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

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

ELEMENTS OF PCMH OBJECTIVES: RATIONALE

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

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

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

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

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

QUALITY AND SAFETY. PCMHs are committed to continuous quality improvement as demonstrated by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families; engaging in performance measurement and improvement; measuring and responding to patient experiences and patient satisfaction; and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

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

The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the public health of Austin/Travis County. Rather than conflicting with or duplicating the recommendations and actions of existing frameworks and coalitions, the participants of the CHIP development process identified potential partners and resources wherever possible.   Austin/Travis County expanded the list of potential collaborators and resources when finalizing the CHIP and completing the CHIP Action Plan for Year 1 in June 2013.

IV. NEXT STEPS

The components included in this report represent the strategic framework for a data-driven, community-enhanced Community Health Improvement Plan. To finalize this strategic framework, members of the Steering Committee revised and refined the suggested activities and timelines drafted by workgroup members to complete the action plans for the CHIP. As part of the action planning process, partners and resources will be solidified to ensure successful CHIP implementation and coordination of activities and resources among key partners in Austin/Travis County.

V. SUSTAINABILITY PLAN

The Austin/Travis County Community Health Improvement team, including the core agencies, CHIP workgroups, partners, stakeholders, and community residents, finalized the CHIP by developing specific 1-year action steps, assigning lead responsible parties, and identifying resources for each priority area. These steps occurred between January 2013 and June 2013 resulting in a final CHIP and **I-CHIP Year 1 Action Plan (See Appendix C).** An annual CHIP progress report will illustrate performance and will guide subsequent 1-year implementation planning.

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

VI. ACKNOWLEDGEMENTS

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

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

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

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

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

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

Steering Committee

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

at Houston
School of Public Health Austin Regional Campus

Carlos Rivera   Director, Austin/Travis County Health and Human Services Department

Core Coordinating Committee

Ana Almaguel	Planning Project Manager Travis County Health and Human Services & Veterans Services
Victoria Bailey	Public Health Nursing Coordinator Austin/Travis County Health and Human Services Department
Katie Coburn	Healthcare Planner, Central Health
Dana Craven	Director of Analytics, Integrated Care Collaboration (ICC)
Filip Gecic	Business Consultant Manager Austin/Travis County Health and Human Services Department
Jennifer Golech	Transportation Planner, Capital Metro
Teresa Griffin	Director of Planning, Seton Healthcare Family
Vella Karman	Grants Coordinator, Austin/Travis County Health and Human Services Department
Lawrence Lyman	Planning Manager, Travis County Health and Human Services & Veterans Services
Becky Pastner	Program Officer for Health Policy and Healthy Living, St. David's Foundation
Ellen Richards	Director of Planning, Central Health
Andrew Smiley	Deputy Director, Sustainable Food Center
Elizabeth Vela	Planner, Travis County Health and Human Services & Veterans Services
Veena Viswanathan	Project Manager, Austin/Travis County Health and Human Services Department

Appendices

APPENDIX A: CHIP PLANNING SESSION WORKGROUP MEMBERS

Priority Area One: Chronic Disease – Focus on Obesity

Content and Process Facilitators

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

Workgroup Members

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

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

Content and Process Facilitators

Ashton Cumberbatch	VP Advocacy and Community Relations, Seton Healthcare Family
Lawrence Lyman	Planning Manager, Travis County Health and Human Services & Veterans Services (Travis County HHS & VS)
Becky Pastner	Program Officer for Health Policy and Healthy Living, St. David's Foundation
Gina Saenz	
	Program Manager, City of Austin Parks and Recreation Department

Workgroup Members

Laura Belew	Treasurer, Sickle Cell Association of Austin
Maureen Britton	President/Executive Director, Children's Optimal Health
Megan Crigger	Cultural Arts Program Manager City of Austin Economic Growth & Redevelopment Services Office
Joy Casnovsky	Program Director for the Happy Kitchen/La Cocina Alegre®
Vincent Delisi	Assistant Division Manager, Austin/Travis County HHSD
Alexandra Evans	Professor , UTHSC at Houston School of Public Health Austin Regional Campus
Kathy Golson	Capital Area Food Bank
Dr. Aliya Hussaini	Michael and Susan Dell Foundation
Shannon Jones	Chair of Steering Committee and Deputy Director, Austin/Travis County Health and Human Services
Robert Kingham	Program Supervisor, Austin/Travis County HHSD
Clifford May	Advisory Board Member of Partnership and Affordable Cohousing
Dusty McCormick	City of Austin, Economic Growth & Redevelopment Service Office
Paula McDermott	Chair of Sustainable Food Policy Board
Vanessa Sarria	Executive Director, Community Action Network
Andrew Smiley	Deputy Director of the Sustainable Food Center
Linda Terry	Policy Aide, Austin/Travis County HHSD
Veena Viswanathan	Chair of Core Coordinating Committee and Project Manager, Austin/Travis County Health and Human Services

Priority Area Three: Built Environment – Focus on Transportation

Content and Process Facilitators

John-Michael Cortez	Manager of Community Involvement, Capital Metro
Filip Gecic	Business Consultant Manager, Austin/Travis County HHSD
Teresa Reddy	Contract Compliance Manager, City of Austin Fire Department

Workgroup Members

Robert Anderson	CTG Planner, City of Austin Planning and Development Review

	Department
Pharr Andrews	Environmental Program Coordinator, Austin Climate Protection Program, City of Austin
Jean Barrett Teel	Executive Director, Faith in Action Caregivers
Chelsea Donahue	City of Austin Public Works, Neighborhood Connectivity Division
Paul DiGiuseppe	Principal Planner City of Austin Planning and Development Review Department
Lawrence Deeter	Planner, Capital Metro
Jennifer Golech	Transportation Planner, Capital Metro
Kris Hafezizadeh	Director of Transportation, Austin ISD Transportation
Deborah Lowndes	Practice Administrator, CommUnityCare
Sly Majid	Executive Assistant, City of Austin Office of Mayor Lee Leffingwell
Julia Mazur	Planner, Capital Area Metropolitan Planning Organization
John McNabb	Executive Director, Vaughn House, Inc.
Abiodun Oluyomi	Professor, UTHSC at Houston School of Public Health Austin Regional Campus
Jessica Tunon	Project Consultant Specializing in Creative and Effective Solutions
Tom Wald	Executive Director, Bike Austin

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

Content and Process Facilitators

Ana Almaguel	Planning Project Manager, Travis County HHS & VS
Theresa Griffin	Director of Planning, Seton Healthcare Family
Dawn Handley	Chief Program Operations Officer, Austin/Travis County Integral Care
Stephanie Hayden	Assistant Director of Community Services, Austin/Travis County HHSD
Vella Karman	Grants Coordinator, Austin/Travis County HHSD
Rhonda Mundhenk	Chief Operating Officer of Clinical Services, Lone Star Circle of Care
Ellen Richards	Director of Planning, Central Health
Larry Schooler	Public Information Consultant, City of Austin Public Information Office
Elizabeth Vela	Planner, Travis County HHS & VS

Workgroup Members

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

APPENDIX B: GLOSSARY OF TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Areas: broad issues that pose problems for the community

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

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

APPENDIX C: I-CHIP YEAR 1 ACTION PLAN

This Appendix is a working document and is available in a separate paper.

This report prepared by:

Health Resources in Action
Advancing Public Health and Medical Research