PUBLIC HEALTH

FY 2017 Community Impact Report

Travis County Health and Human Services

Research & Planning Division

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Public Health

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Travis County Health and Human Services
Research & Planning Division

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TRAVIS COUNTY
HEALTH and HUMAN SERVICES

PURPOSE

Who we are:

A Department of Travis County that serves the community under the guidance of the Commissioner's Court

What we do:

Address community needs through internal and external investments and services

What we strive to accomplish:

Maximize quality of life for all people in Travis County

- Protect vulnerable populations
- Invest in social and economic well-being
- Promote healthy living: physical, behavioral, and environmental
- Build a shared understanding of our community

VALUES

We value helping people.

- We provide accessible, person-centered services with respect and care.
- We work to empower people through our service to them, always honoring the strengths and differences of the individuals and families of Travis County.

We value the accountability and integrity of our staff.

- We value the diversity of our staff and the experience each of us brings to HHS.
- We honor our collective service to the public, including the careful stewardship of public funds.
- We value the quality services we provide to the community in a spirit of shared responsibility.

We value cooperation and collaboration in the community at large and within HHS.

- We are interdependent and connected.
- We treat one another with respect and value effective communication and teamwork.
- We honor our partners in the community and engage with them to more efficiently and effectively serve our clients.

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Introduction

The Travis County Commissioners Court, through the Travis County Health and Human Services Department (HHS), annually invests over $19.5 million in community-based social service programs. These Department investments align with and supplement our direct services to meet the needs of local residents. Community-based organizations are frequently geographically and culturally embedded in the communities they serve and are often best positioned to provide needed services.

Purpose of Report

The annual Community Impact Report provides an overview of HHS investments in health and human services. The *FY 2017 Community Impact Report* offers highlights of community conditions most pertinent to the services purchased, and details investment, programmatic, and performance information on the Department's social service contracts. This information allows policy makers, program managers, and others to better understand these investments, recognize accomplishments, identify areas for improvement, disseminate lessons learned, and highlight areas warranting further research.

Organization of Report

This report addresses nine issue areas—Access to Basic Supports, Behavioral Health, Child and Youth Development, Housing Continuum, Planning and Evaluation, Public Health, Safety Intervention Services, Supportive Services for Community Living, and Workforce Development—as well as a pilot project under Holistic Family Services. The Investment Overview summarizes information from all nine issue areas and the pilot project. Each issue area section begins with community conditions information and then provides performance highlights about the programs within that issue area. Each program is classified into the issue area most closely aligned to its goals and objectives.

Although this report highlights community conditions for individual issue areas separately, each issue area must be considered in a broader context. Community conditions related to a single issue area may have similar or related root causes and broad-level consequences. Current economic conditions also have a global impact on community conditions.

This report provides detailed information about each program covered by an issue area, including an overview of program goals, services provided, eligibility criteria, and funding. Also captured are each program's performance results, compared to its contractual performance goals, and explanations of notable variance (+/- 10%) between the performance results and goals.

Notes on Methodology

Community conditions discussed in this report reflect the most recent information available at the time of writing. The majority of the social service contracts included in the report followed a fiscal year calendar (October 1, 2016 through September 30, 2017) unless otherwise noted. Program and performance highlights are drawn from contracts and reports provided by contracted service providers. Estimates from the American Community Survey have been tested at a 90% confidence level for reliability. In some cases, all noted, estimates were unreliable due to small sample sizes.

Considerations When Reading This Report

Performance results provide only a starting point for understanding the impact of these programs. These summary statistics are not necessarily an indication of the programs' overall performance, but rather a snapshot of their performance over a one-year period. Within these reports, service providers offer explanations for variance in performance, which provides context and meaning to summary results.

Performance results do not reflect programs' full value to and impact on the community. Therefore, it is important to keep the following considerations in mind when reviewing program performance.

Readers should use caution when comparing output and outcome results across programs, as participant characteristics can significantly influence a given program's performance goals and results. For example, performance results may be lower for programs with clients who face considerable challenges (e.g., serious mental illness or addiction issues) and have little social support.

Factors beyond the program's control may also impact the program's performance. For example, the relative scarcity or abundance of jobs in the local economy will impact client employment rates for a workforce development program, regardless of the quality of training and support provided. Without controlling for these factors, the true impact or efficacy of the program on outcomes cannot be discerned.

Readers should also use caution when examining outcome results for programs with less than 30 clients, in which the outcome of just a few clients can greatly affect the program's total outcome result. In these instances, examining percentages may be less helpful than examining raw numbers.

Finally, this report captures a selection of performance measures, which may not reflect the program's full impact on participants and their families, peers, and neighborhood. Performance measures may not all be equal in importance or value to the community.

Community Conditions

Public Health Goals and Services

Programs and services within this issue area work to improve the health and well-being of community members by encouraging healthy behaviors; providing health education programs; enforcing regulations that protect from injury and illness; reducing the occurrence and impact of disease; and increasing public health emergency preparedness.

Services may include: education; improving treatment, care, and support for persons living with or facing health concerns; case management and advocacy for additional or other client services; promoting environmental health; and animal control and shelter services.

Highlights of Community Conditions

What is Public Health? Public health promotes and protects the health of people and the communities where they live, learn, work, and play. It is the practice of preventing disease and promoting good health within groups of people, from small communities to entire countries.[1] Travis County invests in disease prevention and surveillance, supportive services that promote access to health care, and other services that contain local health spending and ensure the health, well-being, and productivity of Travis County residents.

Attaining Health Equity, which is defined as achieving the highest level of health for all people, requires that communities address the Social Determinants of Health (SDOH).[2] SDOH are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[3] Our health is determined in part by access to social and economic opportunities; the resources and supports available in our communities; school quality; workplace safety; quality of water, food, and air; and our social interactions and relationships.[4] The Office of Disease Prevention and Health Promotion's Healthy People 2020 initiative identified five key areas of SDOH, which include: economic stability; education; social and community context; health and health care; and neighborhood and built environment.[5]

The following sections outline some selected data points describing the public health status of Travis County residents and the current system. Public health data has varying and significant time lags;

therefore, not all years of data are consistent across this report. This report does not contain all existing data for our community but more in-depth reports are listed at the end of this report.

Leading Causes of Death

Cause-of-death statistics help authorities determine their focus for prevention and intervention efforts. The following table describes the leading causes of death in 2015.

Leading Causes of Death
U.S., Texas, Travis County, 2015

Underlying Cause of Death	*Travis County Number of Deaths*[6]	*Travis County Rank*[7]	*Texas Rank*[8]	*U.S. Rank*[9]
Malignant neoplasms (cancer)	1,149	1	2	2
Diseases of the heart	1,006	2	1	1
Accidents (unintentional injuries)	483	3	5	4
Cerebrovascular diseases (stroke)	268	4	3	5
Chronic lower respiratory diseases	202	5	4	3
Alzheimer's disease	188	6	6	6
Intentional self-harm (suicide)	156	7	*	10
Diabetes mellitus	141	8	7	7
Chronic liver disease and cirrhosis	106	9	10	**
Nephritis, nephrotic syndrome, nephrosis	104	10	9	9

*Texas Note: the eighth leading cause of death is septicemia. Suicide is not one of the ten leading causes of death.
**U.S. Note: The eighth leading cause of death is influenza and pneumonia. Chronic liver disease and cirrhosis is not one of the ten leading causes of death.
Created by: Travis County HHS/VS, Research & Planning Division, 2017
Source data: Texas Department of State Health Services, Center for Health Statistics, and the U.S. Centers for Disease Control and Prevention

Chronic Disease Prevalence

Chronic diseases are responsible for 7 of 10 deaths each year, and diseases account for 86% of the nation's annual health care costs.[10]

The following chart includes selected Behavior Risk Factor Surveillance System (BRFSS) data[a] on selected chronic diseases and related risk factors in Travis County and Texas.

a The Texas Behavior Risk Factor Surveillance System (BRFSS) is federally supported landline and cellular telephone survey that collects data regarding health-related risk behaviors, chronic health conditions, and use of preventive services. Data is used to help identify public health problems, set priorities and goals, design policies and interventions.

Selected Chronic Diseases and Related Risk Factors Travis County & Texas, 2016		
Chronic Disease: Percent with Disease		
	Travis County	***Texas***
Angina or coronary heart disease	3.7%	3.7%
Stroke	2.4%	2.6%
Diabetes	10.4%	11.2%
Chronic obstructive pulmonary disease (COPD)	2.7%	4.8%
Asthma	13.2%	12.5%
Risk Factors: Percent at Risk		
Heavy alcohol consumption	8.9%	6.9%
Inactive physical activity level*	17%%	25.2%
Overweight or obese (BMI>25)	58.4%	68.4%
Current smoker	14.3%	14.3%
Engaged in HIV risk behavior	9.1%	6.1%

*Percent of adults who reported they did not participate in any leisure time/physical activities in the past month
Created by: Travis County HHS/VS, Research & Planning Division, 2017
Source data: Texas Behavioral Risk Factor Surveillance System Summary Tables, 2016

The Travis County population is slightly healthier than that of the state per most above indicators. Austin area residents in particular are known for their healthy lifestyles. However, an analysis of these health indicators at the sub-county level—either in smaller geographic units or by race/ethnicity—shows there are clear disparities in health status[b] in nearly all of the indicators. For example, in Travis County, the infant mortality rate for Blacks is approximately twice the rate compared with Whites and Hispanics.[11]

Sexually Transmitted Diseases (STDs)

STDs and HIV/AIDS are substantial health challenges and pose a threat to individuals' immediate and long-term health and well-being.

b Healthy People 2020 define health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

Sexually Transmitted Diseases Travis County & Texas, 2016			
Sexually Transmitted Diseases[12]			
	Travis County Cases	***Travis County Rate***	***Texas Rate***
Chlamydia	8,453	704.8	494.4
Gonorrhea	2,732	227.8	147.0
Primary and Secondary Syphilis	269	22.4	6.7
HIV/AIDS[13]			
HIV Diagnoses	242	20.2	16.1
AIDS Diagnoses	80	6.7	7.5
People Living with HIV	4,716	393.2	311.1

Note: Rates represent cases per 100,000 population.
Created by: Travis County HHS/VS, Research & Planning Division, 2017
Source data: TX Department of State Health Services: Texas STD Surveillance Report, 2016 Annual Report & Texas HIV Surveillance Report, 2016 Annual Report

Travis County has higher rates of STDs and HIV than Texas. Travis County is ranked 5th out of 25 Texas counties with the highest case numbers of HIV diagnoses, AIDS, and People living with HIV, following Harris, Dallas, Bexar, and Tarrant Counties.[14] Some Travis County residents are disproportionately affected by STDs and HIV. In Travis County, Blacks are disproportionately impacted by HIV and other sexually transmitted diseases when compared to Whites.[15]

Maternal and Child Health

The health of mothers and their children is an important barometer for the health of future generations and has critical predictive value in public health planning. The following table provides a snapshot of selected Maternal and Child health indicators for Travis County and Texas.

Key Maternal and Child Health Indicators Travis County & Texas, 2012-2014			
	Travis County 2012-2014 Average	*Travis County 2012-2014 Rate*	*Texas 2012-2014 Rate*
Low birth weight births (less than 5 pounds, 8 ounces)	1,237	7.7%	8.3%
Prematurity (less than 37 weeks gestation)	1,676	10.5%	12.1%
Late or No Prenatal Care	4,313	27.0%	38.8%
Infant mortality (children who died before their first birthday)	71	4.4%	5.8%
Birth rate to women under 20 years old	1,056	6.6%	9.8%

Created by: Travis County Research & Planning Division, 2017
Source data: Austin Public Health, 2017 Critical Indicators Report

Health insurance status, economic factors and maternal education level are important SDOH that contribute to the disparities in Travis County birth outcomes. In Travis County, over one-third of all Hispanic infants are born to mothers with late or no prenatal care, and infant mortality rates are higher for Blacks than Whites and Hispanics.[16]

Births to teen moms: Infants born to teenage mothers are at higher risk for low birth weight, preterm birth, and death than adult age women.[17] In Travis County, there were 324 births to females 15-17 years old and 1,017 births to females under 20 years old in 2014.[18] Hispanics have the highest percentage of births to females 15-17 years old and females under 20 years old.[19]

Access to Health Care and Preventive Services

Whether or not people have access to health care can explain why some people are healthier than others. Some of the barriers to healthcare include lack of insurance, cost of care, and provider shortages.

Health insurance: In Travis County 13% of residents do not have health insurance.[20] Of these 155,628 uninsured individuals, the majority (about 131,733 people) are adults between the ages of 18 and 64. Another 22,010 uninsured individuals are children under 18 years old.[21] From 2012 to 2016, the number of Travis County residents with health insurance increased by 18% and the number of residents without health insurance decreased by 25%.[22]

Health insurance coverage varies by race/ethnicity. In Travis County, Non-Hispanic White individuals have the highest rates of health insurance (94%), while Hispanic or Latino adults have the lowest (76%).[23]

Cost of care: The cost of health care can act as a barrier to seeking medical care. About 18% of respondents reported that there was a time in the past 12 months when they needed to see a doctor but could not because of the cost.[24]

Provider access: Having a primary care provider is associated with a higher likelihood of receiving appropriate care and better health outcomes. The ratio of the Travis County population to primary care physicians is 1,170:1, which is lower than Texas (1,670:1) but higher than Top U.S. Performersc (1,040:1). The ratio of the Travis County population to other primary care providersd is 1,383:1.[25] In comparison, the ratio of other primary care providers for Texas is 1,646:1 and for Top U.S. Performers is 853:1.[26]

Travis County has one of the highest doctor-to-patient ratios in Texas, however, there is a "physician distribution issue."[27] Between 1997 and 2017, Travis County had a 155% increase in specialists holding licenses, compared to an 82% increase in primary care doctors. As of January 2017, there were 2,348 doctors licensed as specialist and 1,261 licensed in primary care. Without better distribution, Travis County will continue to have issues with people with lower income levels not having the ability to access care.[28]

Routine check-ups: Sixty-six percent of adults in Travis County reported receiving a routine check-up from a medical professional in the past year. Adults over 65 years old reported the highest prevalence of routine check-ups (91%), while uninsured adults had the lowest (49%).[29]

Public Health System

The Public Health system in Travis County includes many organizations, and agencies engaged in various health related activities.

Austin Public Health

Austin Public Health, is the local public health department for Austin and Travis County. Public health departments play a critical role in protecting and improving the health of people and communities. Austin Public Health provides a range of services such as promoting healthy behaviors, preventing diseases, providing food protection, offering immunizations and preparing for and responding to public health emergencies. Austin Public Health earned accreditation from the Public Health Accreditation Board (PHAB) in 2016, becoming the 3rd accredited public health department in Texas, joining Houston and Tarrant County.

Austin Public Health coordinates a comprehensive community planning initiative, known as the

c The County Health Rankings include Top U.S. Performers for many of the measures to display the value for which only 10% of counties in the country are doing better, i.e., 90th percentile or 10th percentile.

d Other primary care providers include nurse practitioners, physician assistants, and clinical nurse specialists.

Community Health Assessment (CHA).[e] In 2017, Austin Public Health partnered with Travis County Health and Human Services, Central Health, St. David's Foundation, Seton Healthcare Family, University of Texas Health Science Center, Capital Metro, and Dell Medical School to produce the second CHA. At the time of this report, the September 2017 draft CHA is open for public comment. Once complete, the 2017 CHA and will serve as the foundation for identifying priority areas in the next iteration of the Community Health Improvement Plan (CHIP).[f]

Central Health

Central Health is the hospital district for Travis County and was created to ensure the availability of quality health care for low-income residents. Central Health funds health care services for low-income and uninsured residents and enrolls residents into the Medical Access Program (MAP), a local health coverage program for qualified low-income residents. Central Health also supports several affiliated organizations: Community Care Collaborative, CommUnityCare, and Sendero Health Plans.[30]

- *Community Care Collaborative (CCC):* a non-profit partnership between Central Health and Seton Healthcare Family to better manage the care of shared patient populations. The partnership includes close relationships with Dell Medical School at the University of Texas and Austin Travis County Integral Care.
- *CommUnityCare:* Central Health's affiliated Federally Qualified Health Care (FQHC) System, which is the largest community health center system in Travis County.
- *Sendero Health Plans:* Central Health's local nonprofit corporation that services as the Central Texas community's local community-based health plan.

Dell Medical School and Dell Seton Medical Center at The University of Texas at Austin

Dell Medical School at The University of Texas at Austin opened to students in 2016. Dell Medical school and its teaching hospital includes three medical school buildings dedicated to education, care, and research. Dell Seton Medical Center at The University of Texas is a 211-bed teaching hospital and Level 1 trauma center that replaced University Medical Center Brackenridge. The new hospital is also expected to ease some provider shortages in the region.[31]

Affordable Care Act (ACA)

Since the implementation of ACA,[g] the number of uninsured Texans has declined. Despite progress, Texas

e The Austin/Travis County CHA represents a collaborative and community participatory process that describes the health status, strengths, and opportunities in Travis County. It includes qualitative data from focus groups, key informant interviews, and community forums, as well as quantitative data from local, state and national indicators.

f The CHIP is an action-oriented strategic plan that outlines community-driven goals, objectives, strategies and measures.

g The Affordable Care Act was signed into law by President Obama on March 23rd, 2010 and upheld in the Supreme Court on June 28th, 2012.

remains the state with the largest percentage (17.1%) and highest number (4.5 million) of uninsured residents.[32,33] In Travis County, the number of residents with health insurance increased by 18% from 2012 to 2016.[34] Although more residents have health insurance, many uninsured adults remain in a coverage gap.[h] In 2016, there were approximately 638,000 nonelderly Texan adults in the ACA coverage gap.[35]

1115 Waiver

The 1115 Waiver allows Texas to expand Medicaid managed care while preserving hospital funding, provides incentive payments for health improvements, and directs more funding to hospitals that serve large numbers of uninsured patients.[36] The waiver provided significant benefits to Travis County and Central Texas.[i] Since its inception in December 2011, the waiver has provided more than $29 billion to Travis County hospitals to care for uninsured and Medicaid patients.[37] Central Texas DSRIP projects focus on critical health needs, including behavioral health, chronic disease management, and specialty care access. The intent of these projects are to transform the delivery of health care services for the uninsured and underinsured populations.[j] Although the 1115 Waiver was set to run on a five year cycle, a 15-month extension was granted to extend the Texas 1115 Waiver through December 2017 at its current funding.[38] In January 2017, HHSC requested an additional 21-month extension of the waiver, through September 30, 2019.[39] At the time of the report, the request is pending CMS review and approval.

Legislative Issues to Watch

2017 Texas Legislative Session

Following the end of the 85th Texas Legislative session, funding implications were identified for the 2018-2019 Texas State budget on health and human services. Some of the programs impacted include:

- Medicaid: Medicaid funding is $3 billion less than what Health and Human Service Commission (HHSC) requested.
- Immunizations: Programs supporting immunizations of children and adults saw over a $4 million (2%) decrease in the budget than the requested amount.
- HIV/STD prevention: Programs saw over a $3 million (1%) decrease compared to funding requested levels.
- Women's Health Program/Healthy Texas Women: Decrease in State funding with the expectation that

h A coverage gap is when U.S. citizen adults in Texas do not get health insurance through their job and do not qualify for Medicaid or financial help in the marketplace. Texas declined a provision of the ACA that allows states to expand Medicaid coverage to individuals with family incomes at or below 133% of the federal poverty level (generally $32,319 for a family of four in 2016. If Texas expanded Medicaid, it is estimated an additional 101,000 adults would be eligible for Medicaid.)

i The 1115 Waiver operating in Regional Health Partnership (RHP) 7 comprises a six-county area: Bastrop, Caldwell, Fayette, Hays, Lee, and Travis Counties.

j Read more about RHP 7 1115 Waiver projects at http://www.texasrhp7.org/.

Federal funding (1115 Waiver) will repay $90 million of state general revenue dollars with federal Medicaid funding.[40]

Affordable Care Act (ACA)

In January 2017, the newly elected President, who vowed to repeal and replace the ACA, was sworn into office, adding urgency to repealing the ACA. During the course of 2017, several Republican health care bills were proposed but lacked the votes to pass. As a result, the White House administration took actions to undermine the marketplace, such as reducing federal funding for outreach by 90%, and terminating payments to insurers to compensate them for the ACA's requirement to provide reduced cost sharing to enrollees with incomes up to 250% of the poverty level.[41] Despite these actions, the ACA insurance marketplace continued to enroll new consumers during the open enrollment period, which lasted November 1st through December 15th, 2017. Although the ACA is alive at the time of this report, the future of the ACA continues to be uncertain as the Senate's proposed tax bill added a repeal for the ACA's individual mandate and premiums have been increasing. Furthermore, Congress could try to repeal the ACA in 2018.[42]

If Congress repeals ACA, an increase in the number of uninsured Texans and a decrease in the amount of federal funds Texas receives will add financial pressure on state and local governments, and health providers. In addition to the ACA, federal policy and funding changes for economic supports, education, and workforce development could impact the SDOH that contribute to the overall health and well-being of Travis County residents.

Further Resources

Public Health is tied to the Behavioral Health issue area. Behavior healthk is an essential component of the overall health and well-being of a population; improving the health and well-being of the community requires addressing poor behavioral health status within the community.[43]

As mentioned previously, Public Health reaches beyond health care services to include the SDOH. Therefore, Public Health has ties to each of the issues areas, including: Access to Basic Supports, Child & Youth Development, Housing, Safety intervention, Supportive Services, and Workforce Development.

Below are a few selected resources that provide more information about public health data, research, and local planning efforts.

k Behavioral health expands the term "mental health" to include substance use, behaviors, habits, and external forces that contribute to mental or emotional well-being.

Austin/Travis County Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP)

www.austintexas.gov/healthforum

This community planning effort examines the health of the Austin/Travis County community. Work on CHIP strategies and objectives are ongoing.

City of Austin Critical Health Indicators Report

http://www.austintexas.gov/sites/default/files/files/Health/Epidemiology/CHI_Report_3.20.17.pdf

The 2017 Critical Health Indicators Report includes information on the current health indicators of Travis County's population, including trends and health disparities.

Chronic Disease in Travis County: A Surveillance Report of Disease Indicators

http://www.austintexas.gov/sites/default/files/files/Health/Chronic_Disease/Chronic_Disease_in_Travis_County_October_2016_Final.pdf

The Chronic Disease in Travis County report includes mortality data from the Texas Department of State Health Services, prevalence of chronic disease & risk behaviors from the BRFSS, and hospital discharge data from the Texas Health Care Information Collection.

Healthy ATC

http://www.healthyatc.org/

Healthy ATC is a partnership between Central Health, Austin Public Health, and Travis County Health and Human Services. Healthy ATC works to help community members and policy makers learn about the health of the community by providing local health data, resources, best practices, news articles, and information about community events.

Healthy People 2020

https://www.healthypeople.gov/

Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans.

Regional Healthcare Partnership 7: 2017 Community Needs Assessment

http://www.texasrhp7.org/wp-content/uploads/2017/09/Final-Report-with-Appendix-10-31-17.pdf

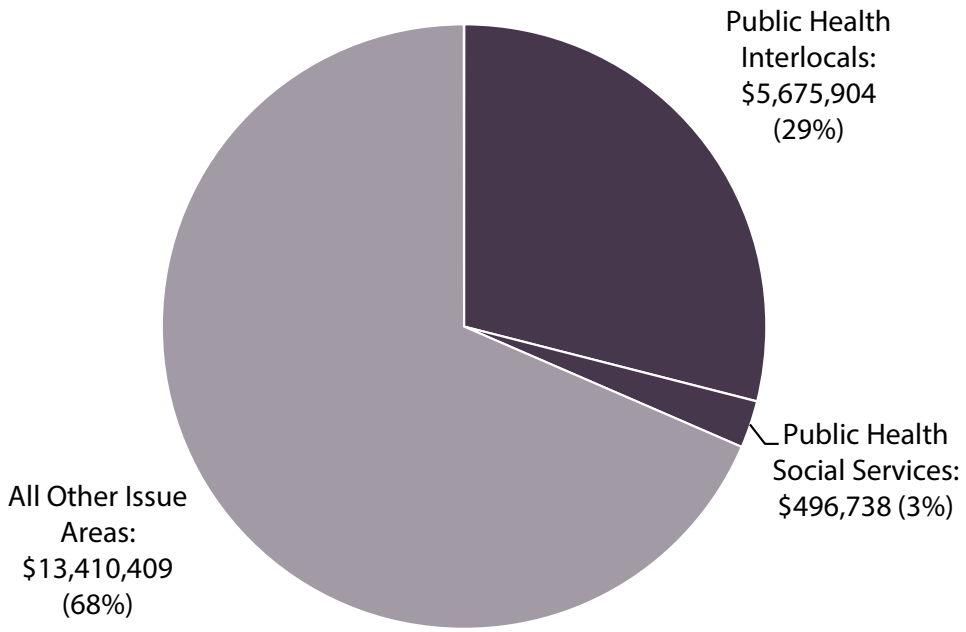
In 2017, Central Health, as the anchor organization for Regional Health Partnership 7 (RHP 7), updated its 2012 community needs assessment (CNA) to gain a greater understanding of the health issues facing low-income communities in Travis, Hays, Caldwell, Bastrop, Lee, and Fayette counties and how those needs are currently being addressed.

Investment Overview

Our Investment

HHS has departmental and contracted programs that offer public health services. A significant portion of our Public Health investments go to the Austin Public Health, as they carry out the county's responsibilities for public health on our behalf. The City of Austin also provides Animal Services for the entire county. Other services contracted through non-profits in this issue area focus their efforts on prevention of teen pregnancy and HIV/AIDS and improving outcomes for people living with HIV/AIDS. Please note that the scope of this summary does not include the roles and responsibilities assumed by Central Health (the Travis County Healthcare District).

Investment in Public Health and Other Issue Areas, FY 2017



Funding Summary

The FY 2017 Funding Amount reflects 12–month funding (October 1, 2016 through September 30, 2017) unless otherwise noted.

Agency Name	Program Name	FY 2017 Funding Amount
AIDS Services of Austin	Mpowerment	$135,000
AIDS Services of Austin	Non-Medical Case Management	$193,937
AIDS Services of Austin	The Helping Hands Food Bank	$62,500
Planned Parenthood of Greater Texas	Teen Health Program	$29,601
The Wright House Wellness Center, Inc.	HIV Case Management	$75,700
Austin Public Health	Public Health Interlocal	$4,034,822
City of Austin Animal Services Department	Animal Services	$1,641,082

Public Health Client Demographics

The table below summarizes the demographics for clients served across Public Health service providers. Note that clients participating in more than one public health program are counted multiple times.

Gender	Num.	Pct.
Female	3,824	55%
Male	2,686	39%
Transgender	35	1%
Other or Not Specified	309	4%
Unknown	39	1%
Total	*6,893*	*100%*

Ethnicity		
Hispanic or Latino	2,423	35%
Not Hispanic or Latino	3,854	56%
Unknown	616	9%
Total	*6,893*	*100%*

Race		
American Indian and Alaska Native	15	0.2%
Asian	644	9%
Black or African American	2,235	32%
Native Hawaiian and Other Pacific Islander	1	0.01%
White	1,753	25%
Some other race	1,529	22%
Two or more races	55	1%
Unknown	661	10%
Total	*6,893*	*100%*

Age	Num.	Pct.
Under 5	178	3%
5 to 11	7	0.1%
12 to 14	440	6%
15 to 17	730	11%
18 to 24	315	5%
25 to 39	410	6%
40 to 54	406	6%
55 to 64	188	3%
65 to 74	33	0.5%
75 and over	3	0.04%
Unknown	4,183	61%
Total	*6,893*	*100%*

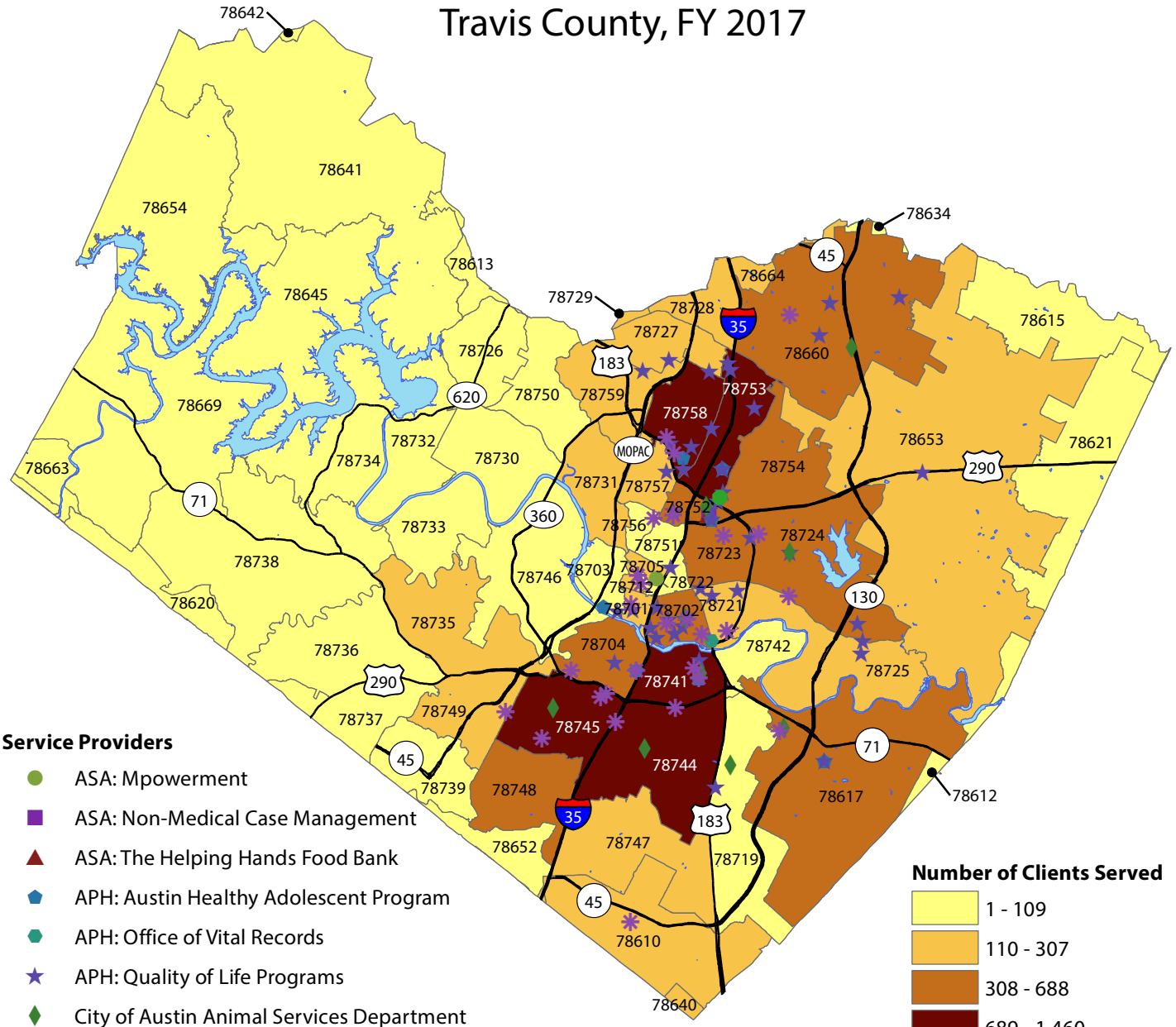
Income		
<50% of FPIG	254	4%
50% to 100%	279	4%
101% to 150%	110	2%
151% to 200%	28	0.4%
>200%	16	0.2%
Unknown	6,206	90%
Total	*6,893*	*100%*

Note: Percentages may not total to 100% due to rounding.

See Appendix for specific income guideline levels.

Public Health

Service Provision Locations and Clients Served by ZIP Code
Travis County, FY 2017



Service Providers

- ASA: Mpowerment
- ASA: Non-Medical Case Management
- ASA: The Helping Hands Food Bank
- APH: Austin Healthy Adolescent Program
- APH: Office of Vital Records
- APH: Quality of Life Programs
- City of Austin Animal Services Department
- Planned Parenthood of Greater Texas
- The Wright House Wellness Center, Inc.

Service provision locations are not included for Austin Public Health's Chronic Disease Prevention and Control, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services, Epidemiology and Health Statistics, Immunizations, Injury Prevention, or Sickle Cell and Health Equity-SC Programs due to the nature of the services provided.

N

0 2.5 5 Miles

Number of Clients Served

- 1 - 109
- 110 - 307
- 308 - 688
- 689 - 1,460

Notes: This map shows 14,903 clients by ZIP code. 1,223 clients (8% of the total) from all service providers were not included because their ZIP codes were unknown or outside of Travis County boundaries or they were homeless. Client ZIP codes are not included for the City of Austin Animal Services Department. Client ZIP code data was only available for three Austin Public Health programs: Austin Healthy Adolescent, Immunizations, and Sickle Cell and Health Equity-SC Programs.

Source data: Contracted service providers, FY 2017.
This map was created using ArcGIS Online shapefiles.
Created by: Travis County HHS, Research & Planning Division, 2018.

AIDS Services of Austin

Mpowerment

Program Description

The Mpowerment program is designed to reach young, gay, bisexual, and questioning men ages 18 to 29 with peer-based programming to build a community in which safer sex is the norm, develop peer leaders to supplement HIV/STD prevention messages, increase knowledge and skills of participants to support positive cultural norms for engaging in safer sex. The primary intervention delivered in this space is a community-level evidence- based intervention endorsed by the Centers for Disease Control and Prevention (CDC) known as Mpowerment. AIDS Services of Austin (ASA) branded the Austin Mpowerment program as The Q and it is known and referred to as The Q in the community that ASA is working to reach. The Q collaborates with ASA's Testing and Linkage to Care team by offering three weekly HIV testing clinics within the project space. Young MSM who test positive at The Q are immediately linked to a staff member who can provide information about Q+, the HIV+ support group for young men who have sex with men MSM, in addition to receiving referrals to other ASA programs like CLEAR, the Healthy Relationships Program, and case management services. Increased testing opportunities along with linkage services imbedded in this unique program assist with supporting prevention services along the HIV continuum of care.

Funding

The total HHS investment in the Mpowerment program from October 1, 2016 through September 30, 2017 was $135,000. This investment comprised 40.9% of the total program budget. HHS also funds the Non-Medical Case Management and The Helping Hands Food Bank, which are both described later in this report.

Eligibility Criteria

In order to be eligible for the program, a client must be a young man age 18-29, MSM, bi-sexual, transgender, or queer, and reside in Travis County. The program specifically targets African American, Latino, and White MSM, ages 18 to 29, however any individual in this age group is eligible.

AIDS Services of Austin: Mpowerment

The Mpowerment program met or exceeded performance goals for this contract year. According to staff, the number of Core Group unduplicated participants was higher than expected due to continuous recruitment by program staff utilizing multiple forms of outreach (see second and fifth output and second outcome). Both the number of new Facebook "likes" and new Twitter followers was higher than expected due to innovative post ideas and promotional boosts for upcoming events (see sixth and seventh output). The percentage of unduplicated men who attended one Below the Belt session and report an HIV risk reduction strategy other than condoms they can attempt was higher than expected due to the adaptation of the training, which included updated information including the great success rate among people using Pre Exposure Prophylaxis (PrEP) and Treatment as prevention (see first outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of Core Group duplicated participants	339	350	97%
Number of Core Group unduplicated participants	43	34	126%
Number of unduplicated men who attend one Below the Belt session	92	102	90%
Number of social event participants	1,176	1,250	94%
Number of outreach activity participants	3,359	2,200	153%
Number of new FaceBook "likes"	373	300	124%
Total number of new Twitter followers	915	450	203%
Outcomes			
Percentage of unduplicated men who attend one Below the Belt session and report an HIV risk reduction strategy, other than condoms, they can attempt.	95% (87/92)	75% (77/102)	125%
Percentage of unduplicated Core Group participants who attend two or more events.	72% (31/43)	76% (26/34)	94%

AIDS Services of Austin

Non-Medical Case Management

Program Description

The Non-Medical Case Management program links clients to primary medical care and psychosocial, legal, financial, and other support services and coordinates and advocates for needed services. The goals of the Non-Medical Case Management program are achieved by:

- Providing eligibility screening and ongoing assessment to HIV positive individuals in order to link them to appropriate services and ensure clients receive the optimal benefits that they are eligible for;
- Facilitating the intake process for individuals eligible for the Non-Medical Case Management program and referring individuals to the most appropriate HIV case management services in the community;
- Ensuring that HIV positive individuals have access to, enter into, and remain in primary HIV medical care in order to improve and maintain health;
- Ensuring that HIV-positive individuals have access to health care and medications through both private insurance or other public benefits;
- Linking HIV positive individuals to social and other support services in order to assist clients in remaining in primary HIV medical care;
- Providing ongoing eligibility and benefit screening to ensure that case managed clients maintain access to or become enrolled in eligible assistance programs and services;
- Working with clients accessing Health Insurance Continuation services to help them to maintain private insurance to ensure clients maintain access to primary medical care and have access to HIV related medications; and
- Working with clients to help them meet individualized service plan goals, and increase self-sufficiency by addressing barriers to client needs through advocacy, assisting in applying for social and primary medical services, and teaching clients the appropriate skills for successful self-advocacy and treatment adherence.

Funding

The total HHS investment in the Non-Medical Case Management program from October 1, 2016 through September 30, 2017 was $193,937. This investment comprised 47.1% of the total program budget. HHS also funds the Mpowerment program, which is described earlier in this report, and The Helping Hands Food Bank, which is described later in this report.

AIDS Services of Austin

Non-Medical Case Management

Eligibility Criteria

The target population for the program is primarily low-income people residing in City of Austin and/or Travis County. In order to be eligible for services, a client must show documentation of HIV status, City of Austin and/or Travis County residency, proof of identity, income verification, and health insurance coverage or declare they are uninsured.

AIDS Services of Austin: Non-Medical Case Management

The Non-Medical Case Management program had mixed performance results. Staff report that the program case manager's case loads were at capacity due to high intensity clients requiring longer engagement in services (see first output). Despite lower than expected number of clients served, program exceeded the outcomes (see first and second outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	160	250	64%
Number of Units of Service	12,630	12,760	99%
Outcomes			
Percentage of clients making progress on service plan objectives	98% (117/120)	80% (160/200)	122%
Percentage of clients receiving primary medical care based on "In-Care Verification"	98% (118/120)	85% (170/200)	116%

AIDS Services of Austin

The Helping Hands Food Bank

Program Description

The mission of the Helping Hands Food Bank is to offer nutritious food—for eating, for cooking, and for life. The primary goals of the grocery program are to:

- Increase access to nutritional products and supplements that enable low-income HIV/AIDS positive persons to improve or maintain their health; and
- Offer educational information on nutrition and healthy dietary options to low-income people living with HIV/AIDS to enhance overall well-being.

Once a client meets with case manager, determines eligibility and completes a food bank menu, the client is allowed to access supplemental food allotments twice per month during business hours and are provided with a unit of service of food that last 7-10 days. If a client is homebound, case managers deliver food, and personal and household hygiene items

Funding

The total HHS investment in the The Helping Hands Food Bank program from October 1, 2016 through September 30, 2017 was $62,500. This investment comprised 22.3% of the total program budget. HHS also funds the Mpowerment and Non-Medical Case Management programs, which are both described earlier in this report.

Eligibility Criteria

The target population for the Helping Hands Food Bank is low-income individuals with annual income at or below 150% of Federal Poverty Income Guidelines (FPIG), living with HIV/AIDS disease who reside in Travis County, and who are case managed at AIDS Services of Austin or a partnering AIDS service organization. Preference is given to individuals who are symptomatic with HIV/AIDS. To be eligible for services, a client must show documentation of HIV status, residency in five county target area (Travis, Williamson, Hays, Bastrop, and Caldwell), income verification, proof of identity, and health insurance coverage or declare they are uninsured.

AIDS Services of Austin: The Helping Hands Food Bank

The Helping Hands Food Bank exceeded performance goals. According to staff, the program served more unduplicated clients than anticipated due to an increase in the number of individuals with food insecurity and/or nutrition needs receiving services with the agency (see first output). The increase in clients served resulted in an increase in the number of clients completing the client satisfaction survey (see outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	381	320	119%
Total Number of Units (unit of service equals food and hygiene products) delivered to unduplicated clients	4,305	4,200	103%
Outcomes			
Percentage of clients surveyed who report satisfaction with quality of services	97% (114/118)	90% (81/90)	107%

Planned Parenthood of Greater Texas

Teen Health Program

Program Description

The Teen Health Program provides youth with the tools to avoid risky behaviors and become self-sufficient, productive members of society through the prevention of unintended pregnancy and sexually transmitted diseases, and encouraging personal development. The program provides health education programming designed to prevent pregnancy and STDs among teens (both boys and girls); educates teens about behaviors that can put them at risk for pregnancy and STDs; and helps them learn about making informed and responsible decisions about their sexual behavior, setting boundaries, and developing healthy communication with parents and potential partners. This strategy utilizes best practices, evidence-based interventions, and has demonstrated success.

Funding

The total HHS investment in the Teen Health Program from October 1, 2016 through September 30, 2017 was $29,601. This investment comprised 30.6% of the total program budget.

Eligibility Criteria

The target population is young people ages 12 to 21 who reside in the City of Austin and/or Travis County, however eligibility is open to all residents of the five county area: Travis, Williamson, Hays, Bastrop, and Caldwell. At least one-third of clients are considered economically disadvantaged as indicated by the Texas Education Agency or are being reached at community service organizations that serve primarily economically disadvantaged families (below 200% FPIG).

Planned Parenthood of Greater Texas: Teen Health Program

The Teen Health Program met or exceeded the performance goals for FY17. Staff report that the quality of the evaluation instrument and the skill of the program staff led to a higher percentage of participants demonstrating improved knowledge (see first outcome).

Note: The fourth quarter data on percentage of Sisters Saving Sisters, Making Proud Choices, and Get Real clients indicating intent to use effective methods of birth control and/or condoms is not included here because the program had external evaluators analyze the data and it was not finalized at the time of this report (see second outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	899	891	101%
Number of Sisters Saving Sisters, Making Proud Choices, or Get Real clients from output one served	82	75	109%
Outcomes			
Percentage of unduplicated clients demonstrating increased knowledge of how to prevent teen pregnancy or STDs	92% (809/879)	80% (713/891)	115%
Percentage of Sisters Saving Sisters, Making Proud Choices, or Get Real clients indicating intent to use effective method of birth control and/or condoms if they have intercourse in the next year	84% (52/62)	80% (60/75)	105%

The Wright House Wellness Center, Inc.

HIV Case Management

Program Description

The Wright House Wellness Center's (WHWC) Case Management program assists HIV-positive clients in accessing and maintaining primary medical care and adhering to medical treatment regimens to improve health outcomes, increasing self-sufficiency (as defined by the client and case manager in each client's individualized care plan), reducing the spread of HIV, and maintaining or improving quality of life for individuals and their communities.

Case management activities include intake and assessment, care planning, housing assistance, medication adherence and health literacy education, care coordination, logistical support such as transportation assistance, information and referral, client advocacy, psychosocial support, and follow-up/re-assessment. Services are primarily provided at WHWC offices, but a significant percentage of services are delivered in other locations such as in clients' homes, at client medical appointments, and in other community social service settings.

Funding

The total HHS investment in the HIV Case Management program from October 1, 2016 through September 30, 2017 was $75,700. This investment comprised 24.6% of the total program budget.

Eligibility Criteria

Services are offered to HIV-positive individuals living within Travis County who are not enrolled in any other HIV case management program. The target population includes: men, women and transgender persons; White, African American, Latino/a, and others; individuals with current or previous substance abuse, including injection drug users; individuals with current or previous mental illness; and recently incarcerated individuals. In order to be eligible for services clients must be HIV positive, reside in Travis County, and present proof of income.

The Wright House Wellness Center, Inc.: HIV Case Management

Performance Goals and Results

The HIV Case Management program exceeded the performance goals. Staff report that increased outreach resulted in an increase in unduplicated clients served (see first output). The number of units of service was higher than anticipated due to serving more high-needs clients (see second output). Due to serving more clients with high-needs, care plans were updated more often and clients had to visit their doctors more frequently (see first and second outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	147	125	118%
Number of Case Management Units of Service	8,487	6,991	121%
Outcomes			
Percentage of HIV+ clients who had a case management Care Plan developed and/or updated two or more times in a six month period	96% (66/69)	80% (60/75)	120%
Percentage of HIV+ clients who had two or more medical visits in an HIV medical setting in a six month period	94% (65/69)	80% (60/75)	118%

Austin Public Health

Public Health Interlocal

Program Description

The Public Health Interlocal with Austin Public Health provides public health services through a number of programs: Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Health Statistics, the Health Authority, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Program, and Sickle Cell and Health Equity-SC Programs. Information on each program is provided in the following pages.

Funding

The total HHS investment in the Public Health Interlocal from October 1, 2016 through September 30, 2017 was $4,034,822.

Program Name	FY 2017 Funding Amount
Austin Healthy Adolescent Program	$154,085
Chronic Disease Prevention and Control Program	$278,790
Communicable Disease	$1,069,826
Comprehensive Public Health Planning	$167,526
Health Authority	$136,989
Environmental Health Services Division	$872,977
Epidemiology and Health Statistics	$339,229
Immunizations	$507,423
Injury Prevention Program	$28,007
Office of Vital Records	-$164,125 [j]
Quality of Life Programs	$611,856
Sickle Cell and Health Equity- SC Programs	$32,241

j This funding amount is negative due to fees for service collected for the Office of Vital Records program.

Austin Public Health

Public Health Interlocal: Austin Healthy Adolescent Program

Program Description

The Austin Healthy Adolescent (AHA) program works to increase the number of Travis County youth who are active decision makers engaged in their own health and the health of their communities. AHA achieves this by providing opportunities for youth to engage in leadership, increasing awareness of Travis County youth concerning their personal health and the health of their community, and building the capacity of youth service providers to implement best practices in youth leadership programming. The program provides direct sexual health education and skill development using the Making Proud Choices and Gender Matters curricula for youth in central and eastern Travis County zip codes with higher than average rates of teen pregnancy. The peer-to-peer health education model utilizes adolescents as community health workers to improve the sexual and reproductive knowledge of their peers. A full-time professional health educator works with a team of peer health educators to implement the six lessons of the evidenced-based sexual health curriculum.

Funding

The HHS investment in the Austin Healthy Adolescent Program from October 1, 2016 through September 30, 2017 was $154,085. The investment comprised 27.3% of the total program budget. This program is part of the HHS investment in the Public Health Interlocal, which includes the Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Health Statistics, the Health Authority, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Program, and Sickle Cell and Health Equity-SC Programs.

Public Health Interlocal: Austin Healthy Adolescent Program

Eligibility Criteria

Austin Healthy Adolescent Program serves youth who reside in Travis County. The majority of youth (12 to 17 years) served will come from low to moderate income neighborhoods in central and eastern Travis County. Youth attending Del Valle, Reagan, Austin, Travis, Lanier and Eastside High Schools as well as youth attending Dobie Middle School will be served through the program. Youth attending the central and eastern Travis County recreation centers as well as youth enrolled in the City of Austin Parks and Recreation department Roving Leaders program will be reached through AHA. The only eligibility requirement is that youth must reside in Austin/Travis County.

Austin Public Health: Austin Healthy Adolescent Program

The Austin Healthy Adolescent Program met or exceeded the performance goals. Staff report that due to increased goals for other funding sources, the number of sexuality education encounters provided to youth and the number of clients served though delivery of an evidence based curriculum was higher than expected (see outputs). The number of clients participating in the pre and post-test was lower than expected due to difficulties with obtaining parental consent and following up with clients. The post-test is obtained only annually due to cohort classes overlapping (see outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of sexuality education and skills development encounters provided to youth	3,624	1,200	302%
Number of unduplicated clients served through the delivery of an evidence informed curriculum	797	500	159%
Outcome			
Percentage of clients showing improvement on at least 2 out of 3 intended behavior questions on the post-test compared to the pre-test	79% (127/161)	80% (320/400)	99%

Public Health Interlocal: Chronic Disease Prevention and Control

Program Description

The Chronic Disease Prevention and Control program strives to inspire people to take steps to adopt healthy lifestyles through promoting and modeling healthy behaviors, preventing and managing chronic disease, and promoting policy, systems, and environmental change. Program components include:

- Obesity Prevention Initiatives promote policy, systems, and environmental changes across multiple sectors addressing where people work, play, learn, and live to promote active living and healthy nutrition.
- Tobacco Prevention and Control efforts subscribe to the Centers for Disease Control model for comprehensive tobacco control programs with an emphasis on policy, systems, and environmental changes. Program goals are: prevent youth initiation of tobacco, increase cessation among youth and adults, ensure compliance with all tobacco laws, eliminate secondhand smoke, and reduce health disparities.
- Community Diabetes Program implements four community walking/exercise groups through free exercise programs, Diabetes Empowerment Education Program classes and nutrition education, which promotes healthy food options and implementation of Texas Diabetes Council best practices.

Funding

The HHS investment in the Chronic Disease Prevention and Control Program from October 1, 2016 through September 30, 2017 was $278,790. The investment comprised 27.3% of the total program budget. This program is part of the HHS investment in the Public Health Interlocal, which includes the Austin Healthy Adolescent Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Health Statistics, the Health Authority, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Program, and Sickle Cell and Health Equity-SC Programs.

Public Health Interlocal: Chronic Disease Prevention and Control

Eligibility Criteria

Since strategies address policy, systems, and environmental changes, the target population is jurisdiction-wide. However, all service-based strategies are targeted to those individuals, primarily adults and youth ages 5-17 years old, who suffer disproportionately from chronic disease or risk factors for chronic disease. Strategies are targeted in areas of Travis County with high rates of health disparities, and include more low socioeconomic health status individuals.

Austin Public Health: Chronic Disease Prevention and Control

Performance Goals and Results

The Chronic Disease Prevention and Control program exceeded performance goals for the fiscal year. Staff report that over performance in the number of Public Health Encounters is due to a DSRIP grant for diabetes education classes (see first output). The number of community changes is due to the successful launch of the Mayor's Healthiest Workplaces and Schools program and through administration of 8 chronic disease prevention mini-grants to create sustainable changes to reduce chronic disease (see second output). The tobacco cessation outreach team has honed in on the most effective locations and approaches for outreach, resulting in over performance (see fourth outcome). Diabetes education classes demonstrate a higher than expected percentage of participants who self-report lifestyle changes possibly due to the effectiveness of the Community Health Workers teaching the classes (see fifth outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of Public Health Encounters	2,735	420	651%
Number of Community Changes	18	3	600%
Outcomes			
Number of tobacco related deaths in Travis County	801	<700	Did Not Meet Goal
Percentage of adults currently smoking in Travis County	14%	<10%	Did Not Meet Goal
Number of deaths related to heart disease in Travis County	971	<800	Did Not Meet Goal
Percentage of individuals receiving tobacco cessation outreach that enroll in cessation services	85% (872/1,020)	25%	355%
Percentage of participants reporting lifestyle changes as a result of attending diabetes education classes	90% (333/370)	75%	120%

Public Health Interlocal: Communicable Disease

Program Description

The Communicable Disease program provides Sexually Transmitted Disease (STD), Tuberculosis (TB), and HIV prevention/outreach education to prevent disease morbidity and to protect the community from the spread of these communicable diseases.

STD comprehensive clinical services include testing for HIV (rapid testing), syphilis, gonorrhea, and chlamydia. If a client presents with symptoms of herpes, testing is available at no additional cost. Treatment is provided at no additional cost for syphilis, gonorrhea, chlamydia, and genital warts (HPV). HIV and STD testing is also provided in satellite locations throughout the city and county to make testing accessible to all residents, and the mobile outreach van targets areas with high-risk populations.

Comprehensive TB clinical services include medical evaluation, on-site x-ray and treatment for latent TB infection and active TB disease at no charge. Field staff provide directly-observed therapy, where all clients on treatment for active TB and those suspected of having active TB are observed taking their medications by a public health staff person. A weekly TB screening clinic is conducted for the general public one afternoon a week. If a clearance chest x-ray is needed for entry into a rehab facility or for immigration applications, a clearance x-ray can also be provided.

Public health follow-up for newly-identified HIV, syphilis, and TB cases/suspects is conducted by Disease Intervention Specialists and TB Contact Investigators. Follow-up activities include interviewing clients to obtain necessary information on potentially-exposed individuals in order to conduct proper contact investigations, decrease morbidity, and reduce/prevent the spread of disease.

In-clinic social work intervention is provided as needed on a case-by-case basis for STD and TB clinic clients. HIV prevention case management is provided for individuals identified as HIV positive who continue to engage in high-risk behavior, and HIV medical case management is available for individuals who are identified as being HIV positive and who may be homeless, pediatric cases, or pregnant women.

Austin Public Health

Public Health Interlocal: Communicable Disease

Funding

The HHS investment in the Communicable Disease Program from October 1, 2016 through September 30, 2017 was $1,069,826. The investment comprised 27.3% of the total program budget. This program is part of the HHS investment in the Public Health Interlocal, which includes the Austin Healthy Adolescent Environmental Health Services Division, Epidemiology and Health Statistics, the Health Authority, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Program, and Sickle Cell and Health Equity-SC Programs.

Eligibility Criteria

The STD clinic and HIV outreach prevention serves all clients 13 years of age and older. The TB clinic serves all clients in the community requiring evaluation for TB infection and active disease. TB services are generally provided to individuals who reside in Travis County/City of Austin, and no one is refused services due to their inability to pay for the services.

Austin Public Health: Communicable Disease

The Communicable Disease program met or exceeded most performance goals. Staff report that the lower number of TB clinic patient visits to RBJ is attributed to the 4-month preventative therapy compared to a 9-month therapy (see second output). The number of units of medical social work services was greater than expected due to higher need (see fourth output).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of STD patient visits at the RBJ & Correctional Facility clinics.	12,740	13,000	98%
Number of TB clinic patient visits at RBJ	6,812	8,500	80%
Number of HIV/STD tests provided in outreach settings	1,613	1,700	95%
Number of units of medical social work services provided by Medical Social Workers (units are measured in 15 minute increments)	30,334	26,000	117%
Outcomes			
Percentage of clients who come into the STD clinic who are examined, tested and/or treated the same day	96% (12,546/13,040)	90% (13,000/14,444)	107%
Percentage of patients with active TB that complete therapy in 12 months	100% (38/38)	100%	100%
Percentage of TB contacts evaluated (for active TB disease)	85% (1,594/1,869)	90%	95%

Austin Public Health

Public Health Interlocal: Comprehensive Public Health Planning

Program Description

Austin Public Health Comprehensive Public Health Planning's long-term goal is to improve community health by having strong planning, collaboration, communication, systems, networks, workforce, and services in place. The planning effort includes creating a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP). A CHA identifies health-related needs and strengths of Austin/Travis County and the CHIP determines major health priorities, overarching goals, and specific strategies to be implemented in a coordinated way across Austin/Travis County. Austin Public Health is evaluating the first iteration of CHIP (2011-2016) and will begin the new iteration, producing a new CHA and CHIP, in 2017 and 2018.

Specific program service delivery includes:

1. Continue to serve as the coordinator for the CHA/CHIP Implementation activities. Information provided helps CHA/CHIP partners and stakeholders optimize their resources.
2. Coordinate CHA/CHIP Core Coordinating Committee meetings where partners and stakeholders will monitor and manage the CHA/CHIP Implementation
3. Coordinate CHA/CHIP Steering Committee meetings where executives representing partner agencies and stakeholders will review, discuss, and approve CHA/CHIP Implementation activities.
4. Coordinate CHA/CHIP Community meetings and other opportunities where community members, partners, and stakeholders will review the CHA/CHIP and provide feedback/public comments on the CHA/CHIP.
5. Provide in-person training and presentations at conferences and/or meetings related to the CHA/CHIP. Presentations and trainings include speaking at existing community events, health fairs, and/or at the request of community members to conduct a session.
6. Facilitate meetings with community and partner work groups in collaboration with Steering and Core Coordinating partners.
7. Coordinate CHA/CHIP efforts in alignment with Public Health Accreditation Strengthen viability to successfully compete for funding opportunities.
8. Provide County with ongoing written updates of the CHA/CHIP process, including the CHA and CHIP reports.
9. Continue to share research, data, and information through A/TCHHSD website, community presentations, media/press releases, and other appropriate venues.

Public Health Interlocal: Comprehensive Public Health Planning

Funding

The HHS investment in Comprehensive Public Health Planning from October 1, 2016 through September 30, 2017 was $167,526. The investment comprised 27.3% of the total program budget. This program is part of the HHS investment in the Public Health Interlocal, which includes the Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Environmental Health Services Division, Epidemiology and Health Statistics, the Health Authority, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Program, and Sickle Cell and Health Equity-SC Programs.

Eligibility Criteria

The development of the Community Health Assessment (CHA) and subsequent Community Health Improvement Plan (CHIP) will not provide direct services to clients. The CHA and CHIP partners, stakeholders, and community members provide planning and assessment in order to develop the CHA and strategic prioritization based on the CHA results and action planning in order to develop the CHIP.

Austin Public Health: Comprehensive Public Health Planning

The Comprehensive Public Health Planning program exceeded most performance goals. According to staff, the high number of Core Coordinating Committee meetings convened was unexpected (see first output). The Steering Committee was convened a total of seven times this year due to the Community Health Assessment (CHA) process (see second output). The number of community health planning events was surpassed due to data gathering events for the CHA (see third output). The number of identifiable changes/proposed recommendations made based on community feedback was higher than expected because of high attendance at public forums and high attendee engagement (see first outcome). The number and percentage of entities represented at Steering Committee and Core Coordinating Committee meetings was higher than anticipated due to the CHA process this year. This process was very engaging and partners may have been more incentivized than usual to participate (see second outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of Core Coordinating Committee meetings convened	12	8	150%
Number of Steering Committee meetings convened	7	2	350%
Number of community health planning events to include forums, focus groups and key informant interviews	44	2	2,200%
Outcomes			
Percentage of identifiable changes/proposed recommendations made based on community feedback submitted at CHA/CHIP community input events	18% (11/60)	20% (2/10)	92%
Percentage of entities represented at Steering Committee and Core Coordinating Committee meetings.	79% (127/161)	60% (9/15)	131%

Austin Public Health

Public Health Interlocal: Environmental Health Services Division

Program Description

Environmental Health Services Division (EHSD) operates programs designed to promote and protect the public health. The EHSD administratively performs inspections and investigates complaints to ensure compliance with various state laws and local codes in the City of Austin, unincorporated areas of Travis County, and other smaller municipalities throughout Travis County. Environmental Health Services programs include:

- Consumer Health: Staff Sanitarians inspect restaurants, grocery stores, food manufacturers, mobile food vendors, temporary event food vendors and custodial care food services. Requested annual environmental health and safety inspections of custodial care facilities are also conducted.
- Environmental Health: General environmental complaints involving improper disposal of solid waste, high grass and weeds, animal pens, junk and abandoned vehicles, substandard buildings, and other public health and nuisance issues are investigated and compliance actions taken when required.
- Rodent and Vector Control: The program performs routine vector (mosquito) control and provides consultative outreach to residents and community groups.
- Customer Service: City of Austin Customer Service support staff provide all of the administrative services and maintenance of the programs including permit application intake, complaint and request processing, reception services, cashiering, data entry, and records management.

Austin Public Health

Public Health Interlocal: Environmental Health Services Division

Funding

The HHS investment in Environmental Health Services Division from October 1, 2016 through September 30, 2017 was $872,977. The investment comprised 14.9% of the total program budget. This program is part of the HHS investment in the Public Health Interlocal, which includes the Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Epidemiology and Health Statistics, the Health Authority, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Program, and Sickle Cell and Health Equity-SC Programs.

Eligibility Criteria

Environmental Health Services provides services to the following:

- Any persons operating or patronizing food enterprises located in Travis County that store, prepare, package, serve, vend, or otherwise provide food for human consumption, whether it is conducted in a mobile, stationary, temporary or permanent facility or location;
- Travis County residents using public or semi-public pools located in Travis County;
- Travis County residents submitting complaints concerning any general environmental or public health nuisance occurring within Travis County;
- Travis County residents wanting to adopt or foster a child, and day care operators; and
- Travis County residents requesting consultation and education on rodent and mosquito control measures.

Austin Public Health: Environmental Health Services Division

The Environmental Health Services Division had mixed performance results. Staff report that a higher number of food permits were submitted for review and inspection than anticipated (see first output). Additional funding to address Zika allowed for the purchase of traps and increase in number of trappings (see third output and third outcome). An increase in depends of the food safety program has reduced proactive surveillance and investigations are initiated on a complaint basis only (see fourth output). Initiation of changes to Pool/Spa inspection protocols has resulted in an increase of non-compliance (see first outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Total number of food permits issued	14,485	12,500	116%
Number of Mobile Vending permit renewal and routine inspections conducted	2,062	2,000	103%
Number of surveillance traps set in the Environmental and Vector Control Program	2,055	800	257%
Number of General Environmental complaint investigations	524	600	87%
Outcomes			
Percent of public pools and spas in compliance	80% (1,384/1,724)	90% (1,733/1,926)	89%
Percent of inspections resulting in a score of 80 or greater	92% (8,702/9,458)	90% (8,989/9,988)	102%
Percent of field services conducted that result in control measures being applied in the Rodent & Vector program	3% (72/2,174)	25% (200/800)	13%
Number of routine inspections per fixed food establishment in the County	1.9 (827/438)	2.0 (900/450)	94%

Austin Public Health

Public Health Interlocal: Epidemiology and Health Statistics

Program Description

The Epidemiology and Health Statistics Unit (EHSU) protects the public health of citizens and visitors of Travis County through a number of activities including epidemiologic surveillance and investigation, data collection and analysis, toxicological evaluation and risk assessment, and emergency preparedness and response planning. EHSU supports Travis County by:

- Analyzing health data to examine the burden of disease within the county for a variety of diseases, conditions and risk factors;
- Providing epidemiologic support for disease and outbreak investigations, which includes study design, survey design, data collection, analyses and interpretation, and report dissemination;
- Identifying, monitoring, and preventing the spread of disease in the community through the implementation of preventative measures and interventions;
- Conducting epidemiologic response and preparedness planning activities related to diseases and conditions, and public health disasters (both natural and man-made) such as hurricane response, response to weapons of mass destruction, extreme weather events, and disease pandemics;
- Developing, revising, maintaining, and exercising public health emergency response plans; and
- Conducting and providing toxicological evaluations, consultations, and recommendations for environmental permitting, monitoring and enforcement activities to ensure the protection of human health.

Funding

The HHS investment in Epidemiology and Health Statistics from October 1, 2016 through September 30, 2017 was $339,229. The investment comprised 27.3% of the total program budget. This program is part of the HHS investment in the Public Health Interlocal, which includes the Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, the Health Authority, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Program, and Sickle Cell and Health Equity-SC Programs.

Public Health Interlocal: Epidemiology and Health Statistics

Eligibility Criteria

Persons served by EHSU are all residents or visitors of Travis County. For some emergency response plans, pre-established agreements exist for response activities (e.g., mass sheltering for citizens of Galveston County, TX). The EHSU supports follow-up services of all employed and volunteer first responders exposed to blood and body fluids resulting from transport exposures.

Austin Public Health: Epidemiology and Health Statistics

The Epidemiology and Health Statistics program had mixed performance for the year. According to staff, the number of potential human rabies exposure consultations provided was lower than expected possibly due to efforts to educate the public not to touch or pick-up bats (see first output). The reason that the number of cases investigated by the program was greater than estimated is not known (see second output). The larger number of emergency bioterrorism drills conducted is due to the need to address gaps in preparedness and experience (see third output). The number of permits reviewed was greater than anticipated due to more permits submitted than expected (see fourth output).The percentage of emergency plans reviewed and updated was lower than expected due to shelter management and other activities related to hurricane Harvey (see first outcome). The incidence rate for measles, pertussis, mumps, and rubella was lower than expected. There were fewer pertussis cases reported during the year compared to prior years, which contributed to the lower incidence rate (see fourth outcome). Austin Public Health has 7 funded epidemiologists, which is lower than the goal due to additional funding not being available to hire more (see fifth outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of potential human rabies exposure consultations provided	1,946	2,500	78%
Number of cases investigated by Epidemiology and Health Statistics	2,579	1,500	172%
Number of emergency bioterrorism drills conducted	18	8	225%
Number of Air, Hazardous Waste and Water Quality Permits reviewed	42	30	140%
Outcomes			
Percent of emergency plans reviewed and updated	63% (5/8)	100% (8/8)	63%
Percent of salmonellosis cases for which a three-day food history is collected	77% (186/243)	75%	102%
Percent of all infectious diseases reported that result in intervention strategies implemented	82% (2,109/2,579)	80%	102%
Incidence rate of measles, pertussis, mumps and rubella in community served	10	<28	Met Goal
Number of epidemiologists per 100,000 population	7	10	70%

Austin Public Health

Health Authority

Program Description

Under Texas Health and Safety Code the City of Austin shall provide the duties of the health authority, which may include:

- Establishing, maintaining, and enforcing quarantine
- Aiding in relation to local quarantine, inspection, disease prevention and suppression, birth and death statistics, and general sanitation in the health authority's jurisdiction
- Reporting the presence of contagious, infectious, and dangerous epidemic diseases in the health authority's jurisdiction,
- Reporting on any subject on which it is proper to direct that a report be made; and
- Aiding in the enforcement of the following in the health authority's jurisdiction
  - proper rules, requirements, and ordinances;
  - sanitation laws,
  - quarantine rules,
  - vital statistics collections

Funding

The HHS investment in the Health Authority from October 1, 2016 through September 30, 2017 was $136,989. The investment comprised 27.3% of the total program budget. This program is part of the HHS investment in the Public Health Interlocal, which includes the Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Health Statistics, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Program, and Sickle Cell and Health Equity-SC Programs.

Eligibility Criteria

Services and activities are provided to areas within the jurisdiction of Travis County.

Austin Public Health

Public Health Interlocal: Immunizations

Program Description

The Immunizations program works to improve immunization coverage levels and to prevent diseases which are vaccine-preventable. Program services include:

- Shots for Tots/Big Shots: Two immunization clinics located within (and in close proximity to) high need/low income ZIP codes serve children and adults.
- Information, referral and appointment phone line: The program accepts between 16,000 and 18,000 phone calls annually for appointments, information, and referrals pertaining to immunizations for Travis County.
- Population assessment and audits: The program meets state requirements by regularly auditing immunization records at private and public childcare centers and schools assigned annually by Texas Department of State Health Services. The team reviews over 10,000 immunization records annually and provides a follow-up to each audited facility.
- Public education and awareness: The program supports over 15 community public health fairs and significant functions annually and collaborates with partners to raise awareness about the importance of immunizations and vaccine preventable diseases.
- High risk adult populations: The program provides on-site, direct service to very high risk and high need clients county-wide seeking care in Health and Human Service Department Sexually Transmitted Disease clinics. In addition, the program's mobile clinic immunizes clients at elevated risk for vaccine preventable diseases through a series of collaborations with 17 social service organizations. Populations at targeted include: homeless, men who have sex with men, substance abusers, uninsured, undocumented laborers, non-English speaking.
- Perinatal Hepatitis B prevention: The program provides specific harm reduction outreach to pregnant mothers at risk for transmitting Hepatitis B to their children. A Nurse (RN) Senior provides case management to clients in addition to providing technical assistance and educational sessions to local hospitals.
- Vaccines for Children (VFC): VFC is a federal program that guarantees vaccine availability for uninsured and low-income children. The program provides vaccine ordering and inventory support for all VFC providers. The program provides technical support and trainings to approximately 100 Travis County providers. The program provides special training and assistance to ensure proper storage and handling techniques to providers. Staff perform unannounced visits and auditing of VFC facilities to ensure Centers for Disease Control recommended storage and handling of vaccines.

Public Health Interlocal: Immunizations

- Flu Clinics: The current budget for flu provides approximately 4,000 doses of quadrivalent flu which is targeted to adults and children that experience multiple barriers to medical care and/or experience financial hardship. All flu doses purchased will be given through targeted flu clinics and/or distributed to our internal partner organizations serving the uninsured. Partner recipients agree that no one will be turned away based on inability to pay.
- Texas Statewide Immunization Registry Support: Provide quality assurance, data support, and data entry activities to the ImmTrac electronic immunization system.

Funding

The HHS investment in Immunizations from October 1, 2016 through September 30, 2017 was $507,423. The investment comprised 27.3% of the total program budget. This program is part of the HHS investment in the Public Health Interlocal, which includes the Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Health Statistics, the Health Authority, Injury Prevention Program, Office of Vital Records, Quality of Life Program, and Sickle Cell and Health Equity-SC Programs.

Eligibility Criteria

Clinical immunizations are targeted to both children and adults including: uninsured or underinsured children and adults, children covered by CHIP, children who are Native American or Native Alaskan heritage, children on Medicaid, populations identified at significant increased risk for vaccine preventable disease.

Austin Public Health: Immunizations

The Immunizations program met or exceeded the performance goals for the year. Staff report that the over performance in the number of adults immunized is due to launching a new program targeting vulnerable and high risk populations (see second output).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of children immunized	8,381	8,000	105%
Number of adults immunized	6,717	3,000	224%
Outcomes			
Percent of Perinatal Hepatitis B clients who receive follow-up education within 60 days of referral	100% (40/40)	100%	100%

Austin Public Health

Public Health Interlocal: Injury Prevention

Program Description

The Injury Prevention program strives to reduce the frequency and severity of injuries by adopting evidence-based programs and by assisting community partners with incorporating injury prevention strategies into their ongoing efforts. Services include:

- Vision Zero/Reduction or traffic-related deaths and serious injuries: An action plan created to eliminate traffic related deaths and serious injuries by 2025. The plan focuses on engineering, education, and enforcement as the key mechanisms to reduce injuries and fatalities.
- Car Passenger Safety: Child Passenger Safety Fitting Stations provide monthly servicing totaling about 600 seats collectively per year. The stations are held at Austin/Travis County HHSD Neighborhood Centers, which provide the site and staff for the monthly event. The program also conducts classroom presentations on car seat safety and conducts a 32–hour Child Passenger Safety Certification training to increase the number of Child Passenger Safety Technicians in Travis County.
- Bike Safety: The program staff is certified by the League of American Bicyclists as a league cycling instructor and conducts Youth Instructor Training quarterly to school staff, nonprofits, agencies, and individuals. The program also conducts bike safety classes and bike skills rodeos for elementary schools.
- Infant Suffocation: The program staff is an active participant in the Safe Kids Austin Safe Sleep Task Force, which analyzes infant suffocation deaths to determine exact causes and identify prevention activities.
- Drowning Prevention: The program staff is an active participant in the Central Texas Water Safety Coalition, which completes analysis of drowning deaths to determine exact causes and identify prevention activities.
- Child Fatalities: The program works with the Travis County Child Fatality Review Team, which reviews all child deaths in Travis County.
- Safe Kids Austin: The program was a founding member of the Coalition, which focuses on bringing together stakeholders for Travis and surrounding Counties to identify specific causes of unintentional injuries and provides networking opportunities with partner agencies to strategize and implement injury prevention activities for children.

Public Health Interlocal: Injury Prevention Program

Funding

The HHS investment in the Injury Prevention Program from October 1, 2016 through September 30, 2017 was $28,007. The investment comprised 27.3% of the total program budget. This program is part of the HHS investment in the Public Health Interlocal, which includes the Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Health Statistics, the Health Authority, Immunizations, Office of Vital Records, Quality of Life Program, and Sickle Cell and Health Equity-SC Programs.

Eligibility Criteria

All Travis County residents are eligible, however the program targets underserved communities as identified by health and demographic data sources.

Austin Public Health: Injury Prevention Program

The Injury Prevention program exceeded the performance goals. According to staff the performance results were higher than expected due to an increase in injury prevention classes and car seat check up events in the first three quarters of the year (see outputs).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of health promotion and education encounters in the area of injury prevention (car seat events, bike safety classes, safe sleep for infants classes)	1,548	1,000	155%
Number of health promotion/health education activities or programs conducted and/or facilitated in the area of injury prevention	53	35	151%

Austin Public Health

Public Health Interlocal: Office of Vital Records

Program Description

The Office of Vital Records (OVR) is the Local Registrar for the City of Austin. The Registrar of Vital Records ensures proper registration of every birth, death, and fetal death within the city limits of Austin to record occurrence of event and to capture demographic and medical data used in public health planning. The OVR also provides a location alternative to the Department of State Health Services for added customer accessibility in obtaining certified copies of City of Austin deaths and births that occur within the State of Texas.

The OVR registers, archives, and issues certified copies of birth, death, and fetal death records, and reports demographic and medical data for the City of Austin area that falls in Travis, Hays, and Williamson Counties. Supplemental to these duties, OVR offers multi-level technical assistance to the general public as well as social workers in order to facilitate navigating the legal systems associated with the modification and/or proper use of these documents. These systems include issues on paternity, dual citizenship, apostilles, adoptions, amendments, name changes, jurisdictional boundaries, and more. Technical assistance expands to multi-jurisdictional agencies and organizations; some of the most prevalent customers are law enforcement representatives who call for verifications on fraud-related issues.

Funding

The HHS investment in the Office of Vital Records from October 1, 2016 through September 30, 2017 was -$164,125 due to fees received for services. This program is part of the HHS investment in the Public Health Interlocal, which includes the Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Health Statistics, the Health Authority, Immunizations, Injury Prevention Program, Quality of Life Program, and Sickle Cell and Health Equity-SC Programs.

Eligibility Criteria

The Office of Vital Records office serves the general public without consideration of residency, income level, or age; the medical community; funeral home/mortuary representatives; and city, county, state, and federal agencies and organizations.

Austin Public Health: Office of Vital Records

The Office of Vital Records had mixed performance results. Staff report that the number of birth and death records registered or amended was lower than anticipated because of a lower number of births occurring (see second output). In August 2015, staff modified the definition of a supplemental record service by discontinuing one of the items previously included in the count (see third output).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of certified copies of death and birth certificates issued	47,559	43,500	109%
Number of birth and death records registered or amended	28,006	31,500	89%
Number of supplemental record services performed	1,140	2,000	57%

Austin Public Health

Public Health Interlocal: Quality of Life Programs

Program Description

The A Quality of Life Programs work to reduce health disparities in vulnerable populations through implementation of strategies being employed both regionally and nationally to address health disparities. These best and promising practices are:

- Culturally and linguistically appropriate
- Community based in order to maximize family and social supports
- Holistic in nature, addressing basic needs and other barriers to care

Quality of Life Programs will provide community-based prevention, education, health promotion and referral services in community settings through the mobile health van program and participation in community events and health fairs. Activities will not only increase personal awareness of individual health status, but provide resources, tools, information and referral to primary care and other support services to support healthy living.

Funding

The HHS investment in the Quality of Life Programs from October 1, 2016 through September 30, 2017 was $611,856. The investment comprised 27.3% of the total program budget. This program is part of the HHS investment in the Public Health Interlocal, which includes the Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Health Statistics, the Health Authority, Immunizations, Injury Prevention Program, Office of Vital Records, and Sickle Cell and Health Equity-SC Programs.

Eligibility Criteria

The target population is Blacks, Hispanics, and Asians living in Austin and Travis County, however, due to the nature of services there are no eligibility requirements.

Austin Public Health: Quality of Life Programs

The Quality of Life programs had mixed performance. Staff report that due to staffing reassignment, the program was unable to meet the goal for total clients served (see first output). Due to a new Culturally and Linguistically Appropriate Materials policy, the program staff made changes to the survey, including simplifying language and translating it into two additional languages, which greatly increased the response rate (see first outcome). The percentage of clients who followed through with referrals to healthcare provider or community resources is lower than anticipated due to clients reporting difficulty getting an appointment within 90 day follow up period (see second outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of clients served	3,918	4,500	87%
Number of units of preventative health service	5,934	6,000	99%
Outcomes			
Percentage of clients that report improved awareness of health status resulting from QOL prevention team initiative	95% (2,203/2,312)	95% (1,710/1,800)	100%
Percentage of clients who followed through with referrals to healthcare provider or community resource	68% (56/82)	85% (43/50)	79%

Austin Public Health

Public Health Interlocal: Sickle Cell and Health Equity-SC Program

Program Description

The Sickle Cell Anemia Association of Austin (a subcontractor for Austin Public Health) is the only referral organization to provide resources, peer navigation assistance and education to populations affected by sickle cell disease in the Austin/Travis county region. Sickle Cell Anemia Association of Austin staff acts as navigators to help individuals, caregivers, and family members to gain access to resources, respite, newborn sickle cell trait notification, and other support. By educating those affected, along with at risk populations, the program provides resources that are essential to public health. The agency provides services in two categories:

1. Notification, Hemoglobinopathy Education and Navigation Services: intake and navigation services, including doctor recommendations and hospital or clinic referrals for treatment; financial assistance for prescription medications, life situation hardships, and bereavement; monthly support group meetings for adults and children; liaison for clients and their medical doctors or nurses; newborn screening notification and education to new parents whose newborns have tested positive for sickle cell trait; sickle cell summer camp opportunities for children; and certified hemoglobinopathy education (in English and Spanish) for parents, individuals, groups, and families about sickle cell disease and sickle cell trait in regards to symptoms, treatment and management.
2. Community Based Education: health education about sickle cell disease and sickle cell trait through facilitation of health fairs and health presentations to community organizations; and outreach, awareness, and advocacy.

Funding

The HHS investment in the Sickle Cell and Health Equity-SC Program from October 1, 2016 through September 30, 2017 was $32,241. The investment comprised 22.9% of the total program budget. This program is part of the HHS investment in the Public Health Interlocal, which includes the Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Health Statistics, the Health Authority, Immunizations, Injury Prevention Program, Office of Vital Records, and Quality of Life Programs.

Public Health Interlocal: Sickle Cell and Health Equity-SC Program

Eligibility Criteria

The Sickle Cell Anemia Association of Austin program is targeted to the City of Austin/Travis County parents of newborns, children, adults and individuals with sickle cell disease, those that carry sickle cell trait, or those who may carry the silent trait. All individuals with sickle cell disease or sickle cell trait are eligible to receive program services, regardless of income, race, ethnicity, sexual orientation, or religious affiliation.

Austin Public Health: Sickle Cell and Health Equity-SC Program

The Sickle Cell and Health Equity program met or exceed all the performance goals. Staff report that an increase in staff has increased capacity to attend health fairs and there has been an increase in community requests to have Sickle Cell representatives available at community events (see first output). The number of unduplicated clients with sickle cell trait or sickle cell disease provided with notification and hemoglobinopathy education is higher than anticipated due to the number of infants born with the trait or disease (see second output and the outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients provided with community-based education	7,669	2,260	339%
Number of unduplicated clients with sickle cell trait or sickle cell disease provided with notification and hemoglobinopathy education	456	123	371%
Outcomes			
Percent of unduplicated clients with sickle cell disease or sickle cell trait who were provided with navigation services	86% (390/456)	87% (107/123)	98%

City of Austin Animal Services Office

Animal Services

Program Description

The Animal Services program allows the City of Austin and Travis County to combine resources and capabilities in providing a collaborative animal control enforcement and shelter services program that serves a regional populace in the identification and vaccination of domestic pets, the maintenance of shelter facilities, and the control of animals at large (both domestic and wild). The program has three components:

- Animal Control Services: rabies control activities; training Animal Control and Travis County Sheriff's Office personnel; responding to calls for sick and injured stray animals and transporting those animals to the shelter or after hours emergency clinic for care; conducting dangerous dog investigations and hearings; providing customer service either by telephone or directly to residents who visit the shelter; dispatching personnel to resolve customer complaints/calls associated with enforcement of the "Regulations of Travis County, Texas Governing Animal Control" and referring customers to the appropriate agency when the issues or service request is outside the scope of the regulations or when the service required to resolve the issue is provided by another agency; and providing dispatch services, including management of field resources while in the field, distribution of service requests to field resources, customer service resolution by telephone, filing of citations, and bite report tracking for all reported animal bites requiring rabies quarantine.
- Shelter Services: The Austin Animal Center accepts every Travis County lost animal delivered to the shelter by animal control, emergency service personnel, and those brought in/dropped off by residents. Each animal is provided food, water, shelter, waste management, and veterinary care. Additional shelter services include acceptance and maintenance of animals, quarantine, medical care, vaccinations, sterilization and immunization, euthanasia, and adoption. Sterilization and immunization is performed in the shelter and at clinics in low-income areas of Travis County. Pet owners in low-income neighborhoods can receive free rabies vaccinations and microchip if they are residents of Travis County. A mobile veterinary service provides sterilization services; animals are sterilized and also receive a rabies vaccination and microchip at no cost to the owner. Services are provided in convenient locations within the neighborhood in order to eliminate transportation barriers.
- Prevention Services: education/outreach and prevention programs to impact animal welfare and reduce shelter intake. Programs are designed to improve the conditions and standards of care that animals experience, as well as reduce the number of unwanted animals coming into the shelter. Programs include: responsible pet owner class, providing speakers for education opportunities in neighborhoods (e.g., group meetings, newsletters, church meetings, schools, clubs, etc.), free rabies vaccinations in economically disadvantaged neighborhoods (education about pet responsibility issues and animal welfare issues is offered while conducting the clinic), free sterilization services in east Austin neighborhoods on a weekly basis, and free microchips and identification tags for all Travis County residents so that pets can avoid being impounded at the shelter.

City of Austin Animal Services Office

Animal Services

Funding

The total HHS investment in the Animal Services program from October 1, 2016 through September 30, 2017 was $1,641,082.

Eligibility Criteria

The City of Austin provides animal protection and control, sheltering, and prevention services including sterilization, vaccinations and microchipping to Travis County residents. These services will be provided through mobile clinics and offsite clinics in targeted areas of Travis County

City of Austin Animal Services Office: Animal Services

The Animal Services program met most of the performance goals. Staff report that the average response time was higher than anticipated due to a change in call priority assignment, which more accurately reflects the actual response time for Priority 1 & 2 activities (see first output). Fewer animals were brought into the shelter from the field which resulted in fewer overall intakes (see second output). More dogs were returned to their owners in the field, which decreased the number of animals at the shelter needing reclamation (see fourth output). Since fewer companion animals were sheltered, there was a decrease in the need for sterilization (see fifth output).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Animal Control Services			
Average response time (in minutes)	173	140	123%
Number of companion animals sheltered	15,581	17,500	89%
Number of animals adopted	7,858	7,425	106%
Number of animals returned to owner	2,800	3,600	78%
Number of spay/neuters performed at Austin Animal Center	5,736	6,400	90%
Number of animals sterilized at community clinics	10,410	11,000	95%
Number of spay/neuter community clinics	202	200	101%
Outcomes			
Percent response to priority calls completed	95% (15,419/16,229)	94% (14,100/15,000)	101%

Appendix

2017 Federal Poverty Income Guidelines

Most HHS contracts require programs to serve participants with household incomes at or below 200% of the Federal Poverty Income Guideline (FPIG) level. Some programs have chosen to follow a more stringent threshold. The following table presents the federal poverty thresholds by household size and income.

Household Size	Income Limits by Household Size				
	50%	100%	125%	150%	200%
1 person	$6,030	$12,060	$15,075	$18,090	$24,120
2 persons	$8,120	$16,240	$20,300	$24,360	$32,480
3 persons	$10,210	$20,420	$25,525	$30,630	$40,840
4 persons	$12,300	$24,600	$30,750	$36,900	$49,200
5 persons	$14,390	$28,780	$35,975	$43,170	$57,560
6 persons	$16,480	$32,960	$41,200	$49,440	$65,920
7 persons	$18,570	$37,140	$46,425	$55,710	$74,280
8 persons	$20,660	$41,320	$51,650	$61,980	$82,640
For families/households with more than 8 persons, add $4,160 for each additional person.					

Data source: "2017 Poverty Guidelines for the 48 Contiguous States and the District of Columbia," Office of The Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services, January 26, 2017, https://aspe.hhs.gov/poverty-guidelines.

2017 Austin Median Family Income Guidelines

Some programs may also use Austin MFI guidelines when measuring client incomes. The following table presents the median family income limits established by the U.S. Department of Housing and Urban Development (HUD) for the Austin-Round Rock, TX Metropolitan Statistical Area (MSA).

Household Size	Income Limits by Household Size		
	Extremely Low*	Very Low (50%)	Low (80%)
1 person	$17,100	$28,500	$45,600
2 persons	$19,550	$32,600	$52,100
3 persons	$22,000	$36,650	$58,600
4 persons	$24,600	$40,700	$65,100
5 persons	$28,780	$44,000	$70,350
6 persons	$32,960	$47,250	$75,550
7 persons	$37,140	$50,500	$80,750
8 persons	$41,320	$53,750	$85,950

*The FY 2014 Consolidated Appropriations Act changed the definition of extremely low-income to be the greater of 30/50^{ths} (60%) of the Section 8 very low-income limit or the poverty guideline as established by the Department of Health and Human Services, provided that this amount is not greater than the Section 8 50% very low-income limit.

Data source: "Austin-Round Rock, TX MSA FY 2017 Income Limits Summary," U.S. Department of Housing and Urban Development, https://www.huduser.gov/portal/datasets/il/il2017/2017summary.odn.

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