Public Health

FY 2018 Community Impact Report

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 2018 Community Impact Report* offers community context 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 context and then provides performance highlights. Each program is classified into the issue area most closely aligned to its goals and objectives.

Although this report provides community context 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 the community.

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 context discussed in this report reflects 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, 2017 through September 30, 2018) 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.

Investment Overview

Community Context

Public health is the practice of preventing disease and promoting good health within groups of people, from small communities to entire countries.[1] Investments in public health promote and protect the health of people and the communities where they live, learn, work, and play. Travis County invests in public health through two separate funding tacks:

- Through an Inter-local Agreement with Austin Public Health, Travis County invests in disease prevention and surveillance, supportive services that promote access to health care, and other public health services that ensure the health, well-being, and productivity of all Travis County residents.
- Through other direct social service investments, Travis County purchases HIV services and teen pregnancy prevention services to support People Living with HIV (PLWH) and to promote sexual health and well-being among young people. Travis County invests in HIV services as part of a Maintenance of Effort agreement with the City of Austin to pull down Federal funding through the Ryan White Part A HIV/AIDS grant. The County's and City's investment helps secure millions of dollars in annual Federal Ryan White grant funding for Austin/Travis County

The remainder of this section provides context for the County's investments in HIV/AIDS services and teen pregnancy prevention funded through direct social service investments.

For information on a range of health conditions that affect the county's population, see the *2017 Critical Health Indicators Report* by the Austin Public Health Department at: http://www.austintexas.gov/sites/default/files/files/Health/Epidemiology/CHI_Report_3.20.17.pdf.

HIV/AIDS Services

The human immunodeficiency virus (HIV) weakens people's immune system by destroying cells that fight disease and infections and can lead to acquired immunodeficiency syndrome, or AIDS. Although not curable, HIV can be controlled with medical care. When taken daily, medicines used to treat HIV, called antiretroviral therapy (ART) have shown to help PLWH live long healthy lives, and reduce the chances of transmitting HIV to others. Despite medical advances, health disparities exist. Some populations are more impacted by HIV than others as a result of HIV stigma[a] and discrimination.[b,2] In Texas, populations most impacted include: Latino, black, and white gay, bisexual and other men who have sex with men;

a HIV stigma is a negative attitude and belief about people with HIV. It is the prejudice that comes from labeling an individual as part of a group that is believed to be socially unacceptable.

b While stigma refers to an attitude or belief, discrimination is the behavior that results from those attitudes or believes. HIV discrimination is the act of treating people with HIV differently than those without HIV.

black women; and transgender individuals.[3]

PLWH require medical care, treatment, and other supportive services. The goal of medical care is to reduce patients' viral load (the amount of the virus in blood and bodily fluids), slowing the progression of the virus in the blood.[4] However, many PLWH may not receive medical care due to HIV stigma, discrimination, lack of access to health care or insurance coverage, poverty, homelessness, mental health issues, and substance use. Supportive services can help mitigate barriers to receiving medical care. In 2017, Austin Public Health released the findings from a local needs assessment and reported that the supportive services PLWH most frequently cited needing included case management, food bank, transportation, and housing.[5]

Demographics

Travis County has almost 5,000 PLWH, and a higher rate of PLWH (401.6) than Texas (320.4).[6] Travis County has a higher rate of new HIV diagnoses (18.00) than Texas (15.5), but about the same rate in new AIDS diagnosis, 6.3 and 6.8, respectively.[7] Of 25 Texas counties with the highest case numbers in 2017, Travis County ranks 5th for HIV diagnoses, new AIDS cases, and PLWH.[c] Among the 25 Texas Counties with the highest case rates in 2017, Travis County ranks 10th for new HIV diagnoses, 13th for number of AIDS diagnoses, and 4th for PLWH.[8]

HIV/AIDS Indicators
Travis County & Texas, 2017

	Travis County		*Texas*	
	Cases	***Rate****	***Cases***	***Rate****
New HIV Diagnosis	221	18.00	4,391	15.5
New AIDS Diagnosis	77	6.3	1,920	6.8
People Living with HIV	4,926	401.6	90,700	320.4

* Rates represent cases per 100,000 population.
Created by: Travis County HHS, Research & Planning Division, 2018
Source data: Texas HIV Surveillance Report: 2017 Annual Report, Texas Department of State Health Services

Some groups of people are disproportionately impacted by HIV/AIDS. In 2017, people who are Black, not Hispanic comprised 19% of all new HIV diagnosis, 22% of new AIDS diagnosis, and 22% of all PLWH[9], yet they comprise only 8% of the Travis County population.[10] People who are Hispanic comprised 41% of HIV diagnosis, 42% of AIDS diagnosis, and 33% of PLWH[11] and make up 34% of the population[12]. The following table breaks down the number and percent of cases by race and Hispanic origin for Travis County and Texas.

c The counties with case numbers higher than Travis County include Harris, Dallas, Bexar, and Tarrant.

HIV/AIDS Indicators by Race and Hispanic Origin Travis County & Texas, 2017				
	Travis County		*Texas*	
New HIV Diagnosis	***Cases***	***Percent***	***Cases***	***Percent***
Black, not Hispanic	43	19%	1,621	37%
White, not Hispanic	76	34%	845	19%
Hispanic	90	41%	1,758	40%
Multi-race	6	3%	97	2%
Other	6	3%	70	2%
Total	221	100%	4,391	100%
	Travis County		*Texas*	
New AIDS Diagnosis	***Cases***	***Percent***	***Cases***	***Percent***
Black, not Hispanic	17	22%	767	40%
White, not Hispanic	23	30%	373	19%
Hispanic	32	42%	698	36%
Multi-race	4	5%	57	3%
Other	1	1%	25	1%
Total	77	100%	1,920	99%
	Travis County		*Texas*	
People Living with HIV	***Cases***	***Percent***	***Cases***	***Percent***
Black, not Hispanic	1,076	22%	33,880	37%
White, not Hispanic	1,947	40%	23,200	26%
Hispanic	1,670	33%	29,469	32%
Multi-race	162	3%	3,091	3%
Other	71	1%	1,060	1%
Total	4,926	99%	90,700	99%

Notes: Percentage totals may not equal 100% due to rounding. The Other category includes people who are Asian, Native Hawaiian/Pacific Islander, or American Indian/Alaskan Native.
Created by: Travis County HHS, Research & Planning Division, 2018
Source data: Texas Department of State Health Services (DSHS), Epidemiology and Surveillance Branch; Justin Buendia PhD, Epidemiologist Team Lead at TX DSHS, email message to Tara Carmean, November 1, 2018.

The burden of HIV on sub-populations is also driven by other demographic characteristics and socioeconomic factors, including:

- *Gender:* In 2015, the majority of new HIV diagnoses (89%) and PLWH (86%) were among males. Most (80%) new HIV cases were in men who reported having sex with men (MSM). Gender also intersects with race: In 2015, Black MSM in the Austin Transitional Grant Area[d] had rates of new diagnoses (794

d The Austin Transitional Grant Area is comprised of 5 counties: Bastrop, Caldwell, Hays, Travis and Williamson. The majority (80%) of PLWH live in Austin/Travis County.

per 100,000) that were almost 50 times higher than in the overall population. Black women also had high rates (27.9 per 100,000) of new diagnosis.

- *Age:* Since 2011, new diagnoses in people under 35 have grown in comparison to other age groups. In 2015, more than one-half (62%) of people newly diagnosed with HIV were 13 – 34 years old.
- *Poverty status:* Of 5,521 PLWH residing in the Austin TGA, about 37% (2,043) live below 200% of the federal poverty level.
- *Health Insurance status:* In 2015, 1,358 PLWH in the Austin TGA were uninsured.
- *Criminal history:* Recently incarcerated individuals are vulnerable of losing medical care upon their release. Between 2011 and 2015, 43 to 55 HIV positive inmates whose legal county of residence is Travis County were released from the Texas Department of Criminal Justice (TDCJ).[13]

Gender identity, which refers to a person's internal understanding of their own gender[14], is an additional risk factor and people who are transgender are at higher risk for getting HIV/AIDS. Among 3 million HIV testing events reported to the CDC in 2015, the percentage of transgender people who received a new HIV diagnosis was more than 3 times the national average.[15] Disparities persist for people who are transgender because many of them face stigma, discriminating, social rejection, and exclusion.[16]

Teen Pregnancy Prevention

Teen pregnancy is considered a public health issue in that it is common, preventable, and can result in health concerns for both teen mothers and their children. Babies born to teenage mothers are more likely to have low birth weights, increased infant mortality, increased risk of hospital admission during early childhood, less supportive home environments, and poorer cognitive development.[17] In turn, teenage mothers may be socially isolated, have mental health concerns, and have fewer or more limited educational and employment opportunities than other teenagers.[18]

Teen pregnancy rates are decreasing in the U.S., yet the U.S. teen pregnancy rate continues to be higher than other western industrialized nations.[19] In 2015, Texas was ranked 5th highest out of 51 (50 states plus the District of Columbia) on teen birth rates among females age 15-19. Texas has a higher teen birth rate for females aged 15-19 (35%) than the U.S. (22%), and a higher repeat birth rate (20%) for females under 20 years old than the U.S. (17%).[20]

Even though teen pregnancy rates have declined, racial/ethnic and socioeconomic disparities persist.

Demographics

In 2015, 6% of all births in Travis County were to females under 20 years old. Of all births to females under 20 years old, 34% (302) of females were under 17 years old and 66% (598) were 18 and 19 years old.

Births by Age for Females Under 20 Years Old Travis County, 2015					
Total Births by Age	*14 and under*	*15-17 years*	*18-19 years*	*Total*	*Percent*
Total births to mothers under 20 years	19	283	598	900	6%

Created by: Travis County HHS, Research & Planning Division, 2018
Source data: Texas Health Data, TX Department of State Health Services, Center for Health Statistics, accessed 10/31/2018 using Cross Tab Data Table Builder at: http://healthdata.dshs.texas.gov/VitalStatistics/Birth

Travis County has a lower teen birth rate[e] (31 births per 1,000) than Texas (41).[21] Within Travis County, teen birth rates vary among sub-populations. In Travis County, teen birth rates are higher for Black females (35) and Hispanic females (57) than White females (8).[22] The differences in teen birth rates point to how institutional and structural conditions may create disparities by effecting access to education, health care, and social supports.

In 2015, over one-half (55%) of births to females under 20 years old were to women who lacked a high school degree. Although some young mothers may continue their education to obtain their high school diploma (or equivalency) and further credentials, others may not continue their education due to the challenges of raising a young child. Obtaining a high school diploma and further credentials is positively associated with economic stability for women and their families.

Births by Age and Educational Attainment for Females Under 20 Years Old Travis County, 2015					
Educational Attainment by Age	*14 and under*	*15-17 years*	*18-19 years*	*Total*	*Percent*
High School Graduation	0	39	302	341	38%
No HS Graduation	19	241	235	495	55%
Some College	0	---	61	61	7%
Total	19	280	598	897	100%

Low values are masked with "---"
Created by: Travis County HHS, Research & Planning Division, 2018
Source data: Texas Health Data, TX Department of State Health Services, Center for Health Statistics, accessed 10/31/2018 using Cross Tab Data Table Builder at: http://healthdata.dshs.texas.gov/VitalStatistics/Birth

Teen pregnancy prevention efforts addressing these disparities should include reducing the effects of racism and a community-level focus on the social determinants of health. The CDC recommends eliminating disparities in order to achieve health equity, improve life opportunities, improve health outcomes of young people and reduce the economic costs of teen childbearing.[23]

e The teen birth rate is the number of births per 1,000 female population ages 15-19.

State and Local Planning Efforts

Public health is an area that benefits from extensive, ongoing, collaborative planning. To that end, several local planning efforts are working to address HIV/AIDS and teen pregnancy prevention in Travis County, some of which are listed below.

Initiatives and groups working to address HIV/AIDS:

- Fast Track Cities – Getting to Zero
- Austin/Travis County Community Health Improvement Plan (CHIP)
- Achieving Together: A Community Plan to End the HIV epidemic in Texas

Initiatives and groups working to address teen pregnancy prevention:

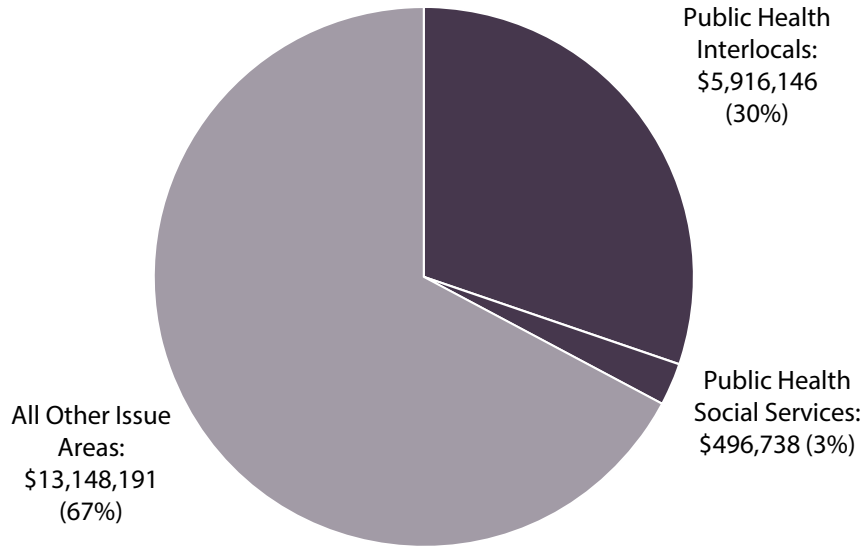
- Austin/Travis County Community Health Improvement Plan (CHIP)
- Healthy Youth Partnership

Goals and Services

Programs and services within this issue area work to improve the health and well-being of community members; protect from injury and illness; reduce the occurrence and impact of disease; and increase public health emergency preparedness. Social Services programs provide services to residents living with HIV/AIDS to reduce new infections; increase access to care and improve health outcomes for people living with HIV/AIDS; reduce HIV-related health disparities and health inequities; and achieve a more coordinated response to the HIV epidemic. Social Services programs also work to prevent teen pregnancies, sexually transmitted infections, and associated sexual risk behaviors.

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; animal control and shelter services; supportive services that promote linkage to and maintenance in care; and teen pregnancy and sexually transmitted diseases prevention services.

Investment in Public Health and Other Issue Areas, FY 2018



Funding Summary

The FY 2018 Funding Amount reflects 12–month funding (October 1, 2017 through September 30, 2018) unless otherwise noted.

Agency Name	Program Name	FY 2018 Funding Amount
Public Health Social Services		
AIDS Services of Austin	Helping Hands Food Bank	$62,500
AIDS Services of Austin	Mpowerment Project (The Q Austin)	$135,000
AIDS Services of Austin	Non-Medical Case Management	$193,937
Planned Parenthood of Greater Texas	Teen Health Program	$29,601
The Wright House Wellness Center, Inc.	HIV Case Management	$75,700

Agency Name	Program Name	FY 2018 Funding Amount
Public Health Interlocals		
Austin Public Health	Public Health Interlocal	$4,242,742
City of Austin Animal Services Office	Animal Services Interlocal	$1,673,405

Client Demographics

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

Gender	Num.	Pct.
Female	831	45%
Male	978	53%
Transgender	31	2%
Other or Not Specified	6	0.3%
Total	*1,846*	*100%*

Ethnicity		
Hispanic or Latino	877	48%
Not Hispanic or Latino	922	50%
Unknown	47	3%
Total	*1,846*	*100%*

Race		
American Indian and Alaska Native	22	1%
Asian	20	1%
Black or African American	405	22%
Native Hawaiian and Other Pacific Islander	1	0.1%
White	1,316	71%
Some other race	11	1%
Two or more races	23	1%
Unknown	48	3%
Total	*1,846*	*100%*

Age	Num.	Pct.
5 to 11	111	6%
12 to 14	365	20%
15 to 17	128	7%
18 to 24	185	10%
25 to 39	370	20%
40 to 54	424	23%
55 to 64	211	11%
65 to 74	46	2%
75 and over	5	0.3%
Unknown	1	0.1%
Total	*1,846*	*100%*

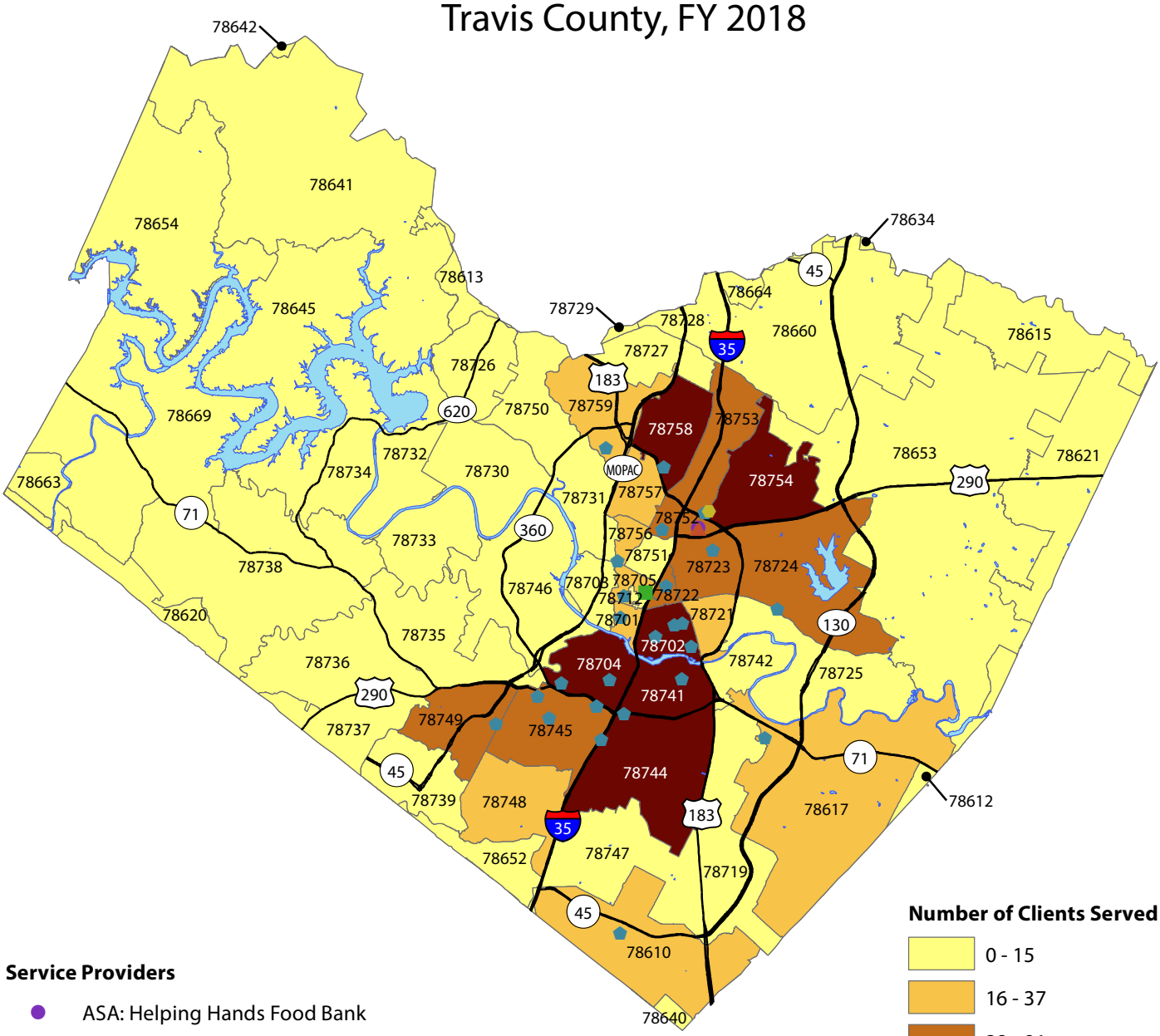
Income		
<50% of FPIG	256	14%
50% to 100%	325	18%
101% to 150%	135	7%
151% to 200%	39	2%
>200%	17	1%
Unknown	1,074	58%
Total	*1,846*	*100%*

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

See Appendix for specific income guideline levels.

Public Health Social Services

Service Provision Locations and Clients Served by ZIP Code
Travis County, FY 2018



Service Providers

- ASA: Helping Hands Food Bank
- ASA: Mpowerment
- ASA: Non-Medical Case Management
- Planned Parenthood of Greater Texas
- The Wright House Wellness Center, Inc.

Number of Clients Served

- 0 - 15
- 16 - 37
- 38 - 91
- 92 - 180

Notes: This map shows 1,775 clients by ZIP code. 71 clients (4% 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.

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

N
0 2.5 5 Miles

AIDS Services of Austin

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

Once a client meets with a case manager or intake and eligibility staff and receives their initial food allotment, the client may access supplemental food allotments twice per month during business hours. Clients 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 Helping Hands Food Bank program from October 1, 2017 through September 30, 2018 was $62,500. This investment comprised 22.6% of their total program budget. HHS also funds the Mpowerment Project (The Q Austin) and Non-Medical Case Management programs, which are both described later in this report.

Eligibility Criteria

The target population for the Helping Hands Food Bank is low-income individuals with annual incomes at or below 150% of the Federal Poverty Income Guidelines (FPIG), living with HIV/AIDS 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 the 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: Helping Hands Food Bank

The Helping Hands Food Bank exceeded all performance goals. Staff reported that the need for food bank services continues to grow year over year. Due to the efforts of staff at AIDS Services of Austin and case managers with other AIDS Service Organizations, the program was able to reach and serve a larger number of clients and provide more units of service than projected (see the first and second outputs). Staff noted that these numbers will continue to increase, as efforts to identify and serve more clients is a primary goal of these services. Finally, staff recruited and trained additional volunteers to help administer the client satisfaction survey, resulting in a greater number of surveys being completed (see the outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	417	320	130%
Total Number of Units (unit of service equals food and hygiene products) delivered to unduplicated clients	4,748	4,200	113%
Outcomes			
Percentage of clients surveyed who report satisfaction with quality of services	95% (127/134)	90% (81/90)	105%

AIDS Services of Austin

Mpowerment Project (The Q Austin)

Program Description

The Q Austin 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, and increase knowledge and skills of participants to support positive cultural norms for engaging in safer sex.

The Q Austin is the physical project space for AIDS Services of Austin (ASA) HIV prevention programming targeting young gay/bisexual men. 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. ASA has branded the Austin Mpowerment program as The Q Austin and it is known and referred to as The Q Austin in the community that ASA is working to reach. The Q Austin collaborates with ASA's Testing and Linkage to Care team by offering three weekly HIV testing clinics within the project space. Young men who have sex with men (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 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 program assist with supporting prevention services along the HIV continuum of care.

Funding

The total HHS investment in the Mpowerment Project (The Q Austin) from October 1, 2017 through September 30, 2018 was $135,000. This investment comprised 41.0% of their total program budget. HHS also funds the Helping Hands Food Bank program, which is described earlier in this report, and the Non-Medical Case Management program, which is described later in this report.

Eligibility Criteria

To be eligible for the program, a client must be a young man age 18-29, MSM, bisexual, transgender, or queer, and reside in Travis County. The program specifically targets African American, Latino, and White MSM, ages 18 to 29; however, all MSM in this age group are eligible.

AIDS Services of Austin: Mpowerment Project (The Q Austin)

This program met or exceeded all but one performance goal, falling slightly short of projections on the number of new Twitter followers (see the seventh output). Staff explained that Facebook became the program's platform of choice, due to increased interactions and ease of successful event promotions (see the sixth output).

Staff reported that participation in the Core Group was higher than expected due to consistent and focused recruitment, as well as working to stay relevant to the priority population (see the second output). Participation in Below the Belt sessions was also higher than expected due to previous program participants recruitment of new program participants (see the third output). Social event and outreach activity participation exceeded targets, which staff attributed to casting a more inclusive/wider net while specifically seeking recruitment results in priority populations (see the fourth and fifth outputs).

Staff noted that performance was higher than expected for the first outcome due to staff inclusion of program participants coming up with additional ways, other than condoms, to have fun and reduce HIV risk. Finally, the Core Group actively and consistently worked on planning events and staying relevant to priority population(s), which led to their higher attendance at events (see the second outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of Core Group duplicated participants	334	350	95%
Number of Core Group unduplicated participants	45	34	132%
Number of unduplicated men who attend one Below the Belt session	134	102	131%
Number of social event participants	2,141	1,250	171%
Number of outreach activity participants	3,143	2,200	143%
Number of new Facebook "likes"	648	300	216%
Number of new Twitter followers	360	450	80%
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	99% (133/134)	75% (77/102)	131%
Percentage of unduplicated Core Group participants who attend two or more events	89% (40/45)	76% (26/34)	116%

AIDS Services of Austin

Non-Medical Case Management

Program Description

The Non-Medical Case Management program provides guidance and assistance to clients in accessing medical, social, community, legal, financial, and other needed services. Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, other state or local health care and supportive services, or health insurance Marketplace plans. 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 for which they are eligible.
- 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.
- Assisting HIV-positive individuals to access social and other support services.
- 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 to access Health Insurance Assistance services to help them to maintain private insurance in order to maintain access to primary medical care and have access to HIV-related medications.
- 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, 2017 through September 30, 2018 was $193,937. This investment comprised 43.9% of their total program budget. HHS also funds the Helping Hands Food Bank and Mpowerment Project (The Q Austin) programs, which are both described earlier in this report.

AIDS Services of Austin

Non-Medical Case Management

Eligibility Criteria

The target population for this program is primarily low-income people residing in Travis County and/or the City of Austin and living with HIV disease. 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 (NMCM) program exceed goals for both outcome measures but fell short of targets for both outputs. Staff explained that the program experienced two full-time employee case manager position vacancies between end of May through the beginning of June 2018, which caused a reduction in the overall number of clients served and units of service provided during the contract year (see the first and second outputs). One new case manager completed training in June 2018 and took on a caseload July 2018. The second position was filled at the end of June 2018 and the case manager took on a caseload in August 2018.

The program exceeded the goal for clients who had a NMCM service plan developed and/or updated two or more times in the contract year (see the first outcome). Staff reported that the agency revised several Case Management policies the contract year, including the Care Plan policy. Case Managers made increased concentrated efforts to successfully engage clients in care planning and assist clients with navigating systems.

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	224	250	90%
Number of Units of Service	11,687	13,750	85%
Outcomes			
Percentage of Non-Medical Case Management clients who had a Non-Medical Case Management service plan developed and/or updated two or more times in the measurement year	93% (115/124)	80% (160/200)	116%
Percentage of Non-Medical Case Management clients who had at least one medical visit in each 6 month period of the 12 month measurement period	91% (113/124)	85% (170/200)	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 (STDs), 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, 2017 through September 30, 2018 was $29,601. This investment comprised 35.0% of their total program budget.

Eligibility Criteria

The target population is males and females 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% of the Federal Poverty Income Guidelines).

Planned Parenthood of Greater Texas: Teen Health Program

The Teen Health Program met or exceeded performance goals across all measures. Staff attributed the quality of the program and the skill of program staff to the high percentage of participants indicating intent to use an effective method of birth control and/or condoms if they have intercourse in the next year (see the second outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	895	891	100%
Number of Sisters Saving Sisters, Making Proud Choices, or Get Real clients from output one served	75	75	100%
Outcomes			
Percentage of unduplicated clients demonstrating increased knowledge of how to prevent teen pregnancy or STDs	85% (760/895)	80% (713/891)	106%
Percentage of Sisters Saving Sisters, Making Proud Choices, or Get Real clients indicating intent to use an effective method of birth control and/or condoms if they have intercourse in the next year	93% (70/75)	80% (60/75)	117%

The Wright House Wellness Center, Inc.

HIV Case Management

Program Description

The Wright House Wellness Center's (WHWC) HIV 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 resource assistance, medication adherence and health literacy education, care coordination, logistical support such as transportation resource 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, 2017 through September 30, 2018 was $75,700. This investment comprised 24.6% of their 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. 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

The HIV Case Management program met or exceeded the targeted range of performance across all measures. Staff reported that all clients now receive a care plan on their first visit; therefore, care plan updates happen faster (see the first outcome). Staff also noted that most clients now have consistent medical visits since The Wright House Wellness Center, Inc. has its own clinic (see the second outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	131	125	105%
Number of Case Management Units of Service	6,283	6,991	90%
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	91% (83/91)	80% (60/75)	114%
Percentage of HIV+ clients who had two or more medical visits in an HIV medical setting in a six month period	96% (87/91)	80% (60/75)	120%

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 Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, 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, 2017 through September 30, 2018 was $4,242,742.

Eligibility Criteria

Eligibility criteria vary by program. Please see the individual program pages for eligibility criteria information.

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 the 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 program utilizes peer health educators 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 lessons of the curricula.

Funding

The total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

Eligibility Criteria

This program serves youth who reside in Austin/Travis County. The majority of youth (12 to 17 years) served come from low- to moderate-income neighborhoods in central and eastern Travis County. Youth attending Del Valle, Reagan, Austin, Travis, Lanier and Eastside Memorial High Schools are served through the program. Youth attending community programs in Travis County are also 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 exceeded both output goals but fell short of targets for the outcome measure. Staff reported that the number of encounters provided to youth, as well as the number of clients served, were both higher than projected because two additional schools were added in the fiscal year (see the first and second outputs).

The percentage of participants improving their score following completion of the curriculum was lower than expected (see the outcome). Staff explained that this result could be due to using True/False knowledge questions from a different, previously used curriculum. To reduce this discrepancy in the future, a new, evidence-based curriculum has been selected for the 2018-19 year, which includes pre- and post-tests directly related to the curriculum.

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	3,818	2,300	166%
Number of unduplicated clients served through the delivery of an evidence informed curriculum	907	750	121%
Outcome			
Percentage of participants who improved their score on a True/False test following the completion of a sexual education curriculum	59% (181/306)	80% (320/400)	74%

Public Health Interlocal: Chronic Disease Prevention and Control Program

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 Initiative and Physical Activities Initiatives include a beginner yoga series, a walking/physical activity program, and multiple series of the Diabetes Empowerment Education Program (DEEP) self-management program.
- "Fresh for Less" Health Food Access Initiative consists of three projects to address healthy food access and reduce food insecurity: Mobile Market, Farm Stands, and Healthy Corner Store Initiative.

Funding

The total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

Public Health Interlocal: Chronic Disease Prevention and Control Program

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

The Chronic Disease Prevention and Control Program exceeded most output goals but had mixed performance across its outcome measures. Staff explained that the number of community changes exceeded goals due to tobacco free worksite policies, mini grants, and new childcare centers implementing Coordinated Approach to School Health (see the third output). The program also exceeded expectations for operating days and customer transactions at farm stands and mobile markets due to exceptional contractor performance (see the fourth and fifth outputs). The number of healthy choices at corner stores is slightly below goal, and staff noted that the project experienced some staff turnover this year (see the sixth output).

Staff attributed the higher than projected number of tobacco-related death and heart disease deaths to the population growth for Austin and Travis County (see the first and third outcomes). Numbers presented for heart disease and tobacco deaths are from 2015, the most recent data that is available from Texas Department of State Health Services (DSHS). The program had much higher enrollment in tobacco cessation services than expected, and exceeded goals for participants reporting lifestyle changes following diabetes education classes (see the fourth and fifth outcomes).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of Public Health Encounters	2,319	2,000	116%
Number of Public Health Activities	284	175	162%
Number of community changes	20	15	133%
Total number of days in operation for farm stands and mobile markets	412	180	229%
Total customer transactions at the farm stands and mobile markets	5,203	2,000	260%
Total number of healthy items stocked as a result of Healthy Corner Store Initiative	32	40	80%
Outcomes			
Number of tobacco-related deaths in Travis County	778	<700	Did Not Meet Goal
Percentage of adults currently smoking in Travis County	11% (111/1,000)	<10%	Did Not Meet Goal
Number of deaths related to heart disease in Travis County	1,006	<800	Did Not Meet Goal

Austin Public Health: Chronic Disease Prevention and Control

Performance Goals and Results

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Percentage of individuals receiving tobacco cessation outreach that enroll in cessation services	86% (476/556)	25%	342%
Percentage of participants who self-report lifestyle changes made as a result of attending diabetes education classes	81% (183/226)	75%	108%

Public Health Interlocal: Communicable Disease

Program Description

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

STD 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. The program provides directly-observed therapy, where active TB patients are observed taking their medications by a public health staff, for all active and infectious TB cases, and for those who are suspected of having active TB. A weekly TB screening clinic is conducted for the general public. If a clearance chest x-ray is needed for entry into a rehab facility or for immigration applications, it can also be provided.

Public health follow-up for existing HIV and newly-identified HIV, syphilis, and TB cases is conducted by Disease Intervention Specialists and TB Contact Investigators. Follow-up activities include interviewing clients to obtain 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, as well as HIV medical case management for HIV positive individuals who may be homeless, pediatric cases, or pregnant women.

Public Health Interlocal: Communicable Disease

Funding

The total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

Eligibility Criteria

The STD clinic and HIV outreach prevention programs serve 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 provided to individuals who reside or work 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 the targeted range of performance across all but two measures. The program had fewer STD patient visits and TB clinic patient visits than projected (see the first two outputs). Staff explained that implementation of the Electronic Health Records (EHR) system slowed patient flow and reduced the number of possible patient visits per medical provider, especially at the onset.

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of STD patient visits at the RBJ and Correctional Facility clinics	9,236	13,000	71%
Number of TB clinic patient visits at RBJ	5,400	6,500	83%
Number of HIV/STD tests provided in outreach settings	2,430	1,700	143%
Number of units of medical social work services provided by Medical Social Workers	30,091	30,000	100%
Outcomes			
Percentage of clients who come into the STD clinic and receive services the same day	93% (8,909/9,570)	90% (13,000/14,444)	103%
Percentage of patients with active TB that complete therapy in 12 months	100% (28/28)	100%	100%
Percentage of TB contacts evaluated	86% (989/1,148)	90%	96%

Austin Public Health

Public Health Interlocal: Comprehensive Public Health Planning

Program Description

Austin Public Health (APH) earned national public health accreditation in May 2016 and will re-apply for accreditation from the national accrediting body, the Public Health Accreditation Board (PHAB) in 2020-21. Accreditation illustrates that APH meets or exceeds the ten essential public health services and twelve domains of public health accreditation, meaning that APH has the capacity to ensure processes are in place to carry out essential public health programs, activities, and administration. On an annual basis, APH submits reports to PHAB on improvement areas. These reports, along with PHAB's oversight, helps ensure that APH is held accountable to meet gaps/focus areas, improve performance, and maintain capacity.

During FY 2018, efforts focused on the development of the 5–year Community Health Assessment (CHA) and 3–year Community Health Improvement Plan (CHIP), two essential requirements of Accreditation. These efforts included assessment, qualitative and quantitative data collection, community engagement, partner and stakeholder communication, action planning, quality improvement, report writing, and dissemination of results. In FY 2018 and throughout the lifecycle of the 3–year CHIP, efforts focus on implementation of the CHIP, including community engagement, partner/stakeholder engagement, quality improvement, and reporting. APH, along with its partners, stakeholders, and community members, coordinates the CHA and CHIP development in order to:

1. Engage community members on health issues.
2. Address health disparities in communities.
3. Differentiate needs in various communities.
4. Enable leaders to allocate resources for the health priorities based on the community needs.
5. Assist local public health system to focus on programs/services that address community health needs.
6. Meet and maintain requirements for Public Health Accreditation.
7. Strengthen viability to successfully compete for funding opportunities.
8. Enable collaboration with partners and create opportunities for new partnerships.
9. Promote action planning among partners and stakeholders to achieve healthy communities and healthy behaviors.

Public Health Interlocal: Comprehensive Public Health Planning

Funding

The total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

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 met or exceeded all performance goals. Staff noted that the number of Steering Committee meetings convened was higher than projected due to the need for more Steering Committee participation to inform the Community Health Improvement Plan (CHIP) process (see the second output). Staff reported that new opportunities to promote CHIP and participate in events that were not anticipated, including the Texas Public Heath Association (TPHA) and National Association of County & City Health Officials (NACCHO) conferences, as well as more local community engagement events, led to a larger than expected number of community health planning events (see the third output). Finally, the program exceeded the targeted rate of identifiable changes made, which staff explained was due to more progress made on addressing evaluation findings through implementation of the CHIP development cycle than was anticipated (see the first outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of Core Coordinating Committee meetings convened	8	8	100%
Number of Steering Committee meetings convened	6	2	300%
Number of community health planning events to include forums, focus groups and key informant interviews	4	2	200%
Maintain Public Health Accreditation	Yes	Yes	Met Goal
Outcomes			
Rate of identifiable changes made based on evaluation findings and Public Health Accreditation Board (PHAB) accreditation feedback	39% (9/23)	20%	196%
Rate of identifying issues based on After Action Reports	800% (16/2)	N/A	N/A

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. EHSD programs include:

- Consumer Health: Staff Sanitarians inspect restaurants, grocery stores, food manufacturers, mobile food vendors, temporary event food vendors, farmers markets, plan reviews, and custodial care foodservices. 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. The program also permits and inspects all public and semi-public pools and spas for compliance with state health and safety laws and County Orders.
- Environmental and Vector Control: The program performs routine vector (mosquito/rodent) control and provides consultative outreach to residents and community groups.
- Customer Service: City of Austin Customer Service support staff provides all of the administrative services and maintenance of the programs in the following areas: permit application intake; permit issuance, complaint, and request processing; reception services; cashiering; data entry; and records management.

Funding

The total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

Public Health Interlocal: Environmental Health Services Division

Eligibility Criteria

Environmental Health Services Division 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.
- Travis County day care operators.
- 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 met most performance goals. Staff reported that a higher number of permit applications were submitted for review and inspection than anticipated (see the second output). Staff noted that the number of field services conducted also included mosquito trapping and activities, which boosted the overall number reported (see the third output). Increase in demands of the food safety program has reduced proactive surveillance, and investigations are initiated on a complaint basis only (see the fourth output). Finally, staff explained that corrective actions were put in place without the need for biological or chemical agent, and there was a lower number of requests for rodent assessments during this reporting period, which led to a lower percentage of control measures being applied (see the third outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Total number of food permits issued	13,561	13,000	104%
Number of Mobile Vending permit renewal and routine inspections conducted	2,606	2,100	124%
Number of field services conducted in the Environmental and Vector Control Program	1,849	800	231%
Number of General Environmental complaint investigations	494	650	76%
Outcomes			
Percentage of public pools and spas in compliance upon inspection	87% (1,825/2,096)	85% (1,679/1,975)	102%
Percentage of food establishment inspections resulting in a score of 80 or greater	94% (8,786/9,323)	90% (9,180/10,200)	105%
Percentage of field services conducted that result in control measures being applied in the Environmental and Vector Control Program	4% (81/1,849)	25% (200/800)	18%
Number of routine inspections per fixed food establishment in the County	1.9 (833/436)	2.0 (900/450)	96%

Public Health Interlocal: Epidemiology and Public Health Preparedness

Program Description

The Epidemiology and Public Health Preparedness Unit (EPHP) 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. EPHP 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.
- Conducting and providing toxicological evaluations, consultations, and recommendations for environmental permitting, monitoring and enforcement activities to ensure the protection of human health.

Funding

The total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

Public Health Interlocal: Epidemiology and Public Health Preparedness

Eligibility Criteria

Persons served by EPHP are all residents or visitors of Travis County and the City of Austin. For some emergency response plans, pre-established agreements exist for response activities (e.g., mass sheltering for citizens of Galveston County, TX). All employed and volunteer first responders are eligible for transport exposures services.

Austin Public Health: Epidemiology and Public Health Preparedness

The Epidemiology and Public Health Preparedness program met most performance targets, falling short of goals for one output and one outcome. Staff explained that fewer rabies virus exposures were reported than historically expected (see the first output). Staff noted that it is possible people are more aware and knowledgeable concerning the dangers of touching or handling a bat. More cases were investigated by staff in the Epidemiology and Public Health Preparedness Division, which could be explained by the increasing Travis County population (see the second output). Staff reported that more drills were conducted than anticipated, as these drills enhance staff skills and abilities to respond to emergencies (see the third output).

Staff were more successful in contacting persons with salmonellosis and completing an interview than projected (see the second outcome). Few cases of measles, mumps, rubella, and pertussis have been reported. These are vaccine-preventable diseases, and staff explained that efforts by the public and medical community to ensure persons are vaccinated contributes to the low number of reported cases (see the fourth outcome). Finally, funding has not been available to increase the number of epidemiologists to achieve a goal of one epidemiologist per 100,000 population (see the 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	2,030	2,500	81%
Number of cases investigated by Epidemiology and Public Health Preparedness	2,420	1,500	161%
Number of emergency bioterrorism drills conducted	13	8	163%
Number of Air, Hazardous Waste and Water Quality Permits reviewed	31	30	103%
Outcomes			
Percentage of emergency plans reviewed and updated	100% (8/8)	100% (8/8)	100%
Percentage of salmonellosis cases for which a three-day food history is collected	85% (212/250)	75%	113%
Percentage of all infectious diseases reported that result in intervention strategies implemented	80% (1,927/2,420)	80%	100%
Incidence rate of measles, pertussis, mumps and rubella per 100,000 population	18	<28	Met Goal
Number of epidemiologists per 100,000 population	7	11	64%

Austin Public Health

Public Health Interlocal: Health Authority

Program Description

Austin Public Health provides the services of the Health Authority as described in Section 121.024 of the Texas Health & Safety Code. The duties of the health authority include: establishing, maintaining, and enforcing quarantine in the health authority's jurisdiction; 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; and vital statistics collections.

Funding

The total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

Eligibility Criteria

Services provided are limited to activities occurring in those areas within the jurisdiction of Travis County.

Performance Goals and Results

The Health Authority does not report performance due to the nature of this function.

Austin Public Health

Public Health Interlocal: Health Equity Social Service Contracts Program

Program Description

The goal of the Health Equity Social Service Contracts Program is to reduce health disparities in vulnerable populations through social service contracts. Current contracts include:

- University of Texas' Mama Sana/Vibrant Woman Maternal Health Equity program works to improve birth outcomes and maternal/infant health among vulnerable communities of color in Travis County by addressing the unique barriers faced by low-income African American and Latina women.
- University of Texas' Alliance Wellness Program – African American Health works to increase awareness of and engagement in existing health-promotion programs, provide support to sustain engagement in healthy lifestyle behaviors, demonstrate impact of its health promotion program through biometric measures and self-assessments, and reduce risk for chronic disease within the African American community.
- allgo's LGBTQ People of Color (POC) Sexual Health and Wellness Program works to increase physical, emotional, mental, and social health and well-being of LGBTQ POC in Austin/Travis County through implementation of nontraditional community-based interventions, including: culturally and linguistically appropriate services to increase accessibility and utilization of health and wellness services by LGBTQ POC; community-based services to maximize social supports that lead to greater access and more appropriate service design and delivery, including services conducted in venues where LGBTQ POC feel most comfortable; and services designed to consider social and institutional barriers to care and holistic health and wellness of LGBTQ POC.
- Austin Revitalization Authority's Austin Outreach & Community Service – African American Health program works to reduce, and ultimately eliminate, racial/ethnic health disparities, with a vision of social equity, a diverse population, and with Austin as a place where the necessities of life are affordable and accessible to all. This project targets HIV prevention to African American women residing in low-income housing developments and the surrounding neighborhoods.

Funding

The total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

Public Health Interlocal: Health Equity Social Service Contracts Program

Eligibility Criteria

The target population and eligibility criteria for each program include:

- Mama Sana/Vibrant Woman Maternal Health Equity
  - This program focuses on women of color, LGBTQ and gender non-conforming women, immigrant, and young women. All women of color who reside within Travis County are eligible to receive services.
- Alliance Wellness Program
  - This program targets African American individuals and individuals of African descent who are at least 18 years old and residents of Travis County. Individuals must have a willingness to commit to the following program requirements: completing a baseline and quarterly assessment; quarterly measurements including height/weight, blood glucose level/HgA1C, and blood pressure; working with a coach to provide a weekly update regarding progress toward goal; in-person meeting with coach once a month; and remaining in the program for one year. To be eligible for the program, individuals must complete and sign a participation agreement document stating that they meet the guidelines and are willing to commit to these program requirements.
- LGBTQ People of Color (POC) Sexual Health and Wellness Program
  - All LGBTQ POC that live within Travis County are eligible to receive services.
- Austin Outreach & Community Service
  - This program targets African American women residing in low-income housing developments or in the surrounding neighborhoods, primarily in zip codes 78701, 78702, 78704, 78723, 78745, 78752, 78753, 78756, and 78758. To be eligible for services, clients must reside in Travis County.

Austin Public Health: Health Equity Social Service Contracts Program

This program had mixed performance results. Staff reported that allgo is not on the standard fiscal year cycle, and the previous program period fulfilled the goal of health care providers provided training in July through September 2017 (see the third output). This agency has two remaining quarters in their program period to fulfill the output goal (October 2018 through March 2019) per the Austin Public Heath program period. The remaining three providers all exceeded goals in terms of courses offered, clients served, and intervention sessions (see the first, second, and fourth outputs).

Fewer participants initiated breastfeeding than projected; staff explained that participants dropping out of the program and stillbirths contributed to a lower than expected outcome (see the first outcome). Finally, a majority of clients self reported not achieving their physical activity and nutrition goals (see the second outcome). Staff noted that additional follow-up is required to identify barriers to achieving goals.

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of 16–week long prenatal education courses offered in a 12–month contract period (Mama Sana)	9	8	113%
Number of clients served (Alliance Wellness)	60	40	150%
Number of health care providers provided training to address stigma and access (allgo)	0	20	0%
Number of Healthy Love small group intervention sessions (AOSC)	26	12	217%
Outcomes			
Percentage of participants who initiate breastfeeding	69% (36/52)	90% (54/60)	77%
Percentage of physical activity and nutrition goals achieved	26% (15/57)	60% (48/80)	44%
Percentage of individuals who achieve healthy outcomes as a result of receiving services through Health Equity Social Service Contracts	98% (85/87)	89% (67/75)	109%
Percent of individuals who complete an educational program and demonstrate improved knowledge	100% (54/54)	90% (86/96)	112%

Total Program Performance Goals reflect an annual (12–month) goal; however, Total Program Performance Results only reflect performance achieved over a 9–month period due to the implementation calendar of programmatic changes.

Austin Public Health

Public Health Interlocal: Immunizations

Program Description

The Immunizations program works to improve immunization coverage levels and to prevent disease that is vaccine preventable in Travis County. 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.
- Public education and awareness: The program implements and/or supports over 15 community public health fairs and significant public health events annually and collaborates with internal and community 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 Austin Public Health's 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 targeted include: homeless, men who have sex with men, substance abusers, uninsured, undocumented laborers, and non-English speaking residents.
- Perinatal Hepatitis B prevention: The program provides specific harm reduction outreach to pregnant mothers at risk for transmitting Hepatitis B to their children. A registered nurse (RN) case manages clients in addition to providing technical assistance and educational sessions to local hospitals.
- Vaccines for Children (VFC): 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, including special training and assistance to ensure proper storage and handling techniques. Staff perform unannounced visits and auditing of VFC facilities to ensure Centers for Disease Control recommended storage and handling of vaccines.
- Flu clinics: The program provides approximately 3,500 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 are given through targeted flu clinics and/or distributed to internal partner organizations serving the uninsured. Partner recipients agree that no one will be turned away based on inability to pay.
- 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.
- Texas Statewide Immunization Registry Support: The program provides quality assurance, data support, and data entry activities to the ImmTrac electronic immunization system.

Public Health Interlocal: Immunizations

- 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 program audits and monitors to ensure that children receive their vaccinations, providing optimal protection for themselves and the community. The team reviews over 10,000 immunization records annually and provides a follow-up to each audited facility.

Funding

The total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

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 all performance goals. Staff noted that they continue to increase immunization services to uninsured and at-risk adult populations and will adjust future targets accordingly (see the second output).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of children immunized	7,422	8,000	93%
Number of adults immunized	5,668	3,000	189%
Outcomes			
Percent of Perinatal Hepatitis B clients who receive follow-up education within 60 days of referral	100% (49/49)	100%	100%

Public Health Interlocal: Injury Prevention Program

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 of traffic-related deaths and serious injuries: An action plan was 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 these injuries and fatalities.
- Child Passenger Safety: Child Passenger Safety Fitting Stations provide monthly servicing totaling about 600 seats collectively per year. Seats are provided through a partnership with Safe Kids Austin free to clients. 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 and community groups.
- 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. The program intends to increase focus in this area by identifying data related to suffocations, conducting train-the-trainer sessions to provide information to staff who have contact with parents of infants, and work with partners to expand the reach of safe sleep messages.
- 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. The program intends to increase focus in this area by utilizing this data to inform programming and partnering with other organizations on programmatic efforts to reduce drownings.
- 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.
- Elderly Fall Prevention: The program staff is a certified instructor for the Stepping On Fall Prevention Course and partners with other agencies to conduct trainings in Senior Centers and other community-based locations.

Public Health Interlocal: Injury Prevention Program

Funding

The total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

Eligibility Criteria

All Travis County residents are eligible for services; however, the program focuses on serving underserved communities as identified by health and demographic data sources.

Austin Public Health: Injury Prevention Program

The Injury Prevention Program exceeded goals for injury prevention encounters but fell short of targets for clients served (see the first and second outputs). Staff explained that clients served was a new performance measure, so the goal established may not have been realistic for the year.

Staff noted that the age adjusted mortality rate is calculated from the Centers for Disease Control and Prevention (CDC) Wonder query system (see the outcome). The most recent data is from 2016 and reflected a lower than anticipated rate for the year.

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	913	1,300	70%
Number of health promotion and education encounters in the area of injury prevention	975	650	150%
Number of health promotion/health education activities or programs conducted and/or facilitated in the area of injury prevention	39	40	98%
Outcomes			
Age adjusted mortality rate due to unintentional injuries (per 100,000 population)	43.7	<52.9	Met Goal

Total Program Performance Goals reflect an annual (12–month) goal; however, Total Program Performance Results only reflect performance achieved over a 9–month period due to the implementation calendar of programmatic changes.

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 that occurs 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 of 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. The OVR also 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 vital records 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. One of the most prevalent customers is law enforcement representatives who call for verifications on fraud-related issues.

Funding

The total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

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 met the targeted range of performance for two of three measures. Staff reported that customer volume was overestimated for this year, resulting fewer death and birth certificates issued than projected (see the first 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	43,642	56,750	77%
Number of birth and death records registered or amended	27,412	30,000	91%
Number of supplemental record services performed	1,082	1,200	90%

Public Health Interlocal: Quality of Life Programs

Program Description

The 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 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 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 total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

Eligibility Criteria

The target population of Quality of Life Programs is Blacks, Hispanics, and Asians living in Austin and Travis County; however, due to the nature of services, there are no eligibility requirements nor are clients asked to verify any identifying information. All services are offered free of charge. Youth under 18 years of age need parental consent for screening services.

Austin Public Health: Quality of Life Programs

The Quality of Life (QOL) Programs exceeded both output goals but fell short of targets on one outcome measure. Staff reported that with the growth of the team, diversification of the target population, and addition of new sites, the program was able to serve more clients than projected (see the first output). Because of this increase in clients served, coupled with additional services such as HIV testing and educational classes, staff were also able to provide more units of service (see the second output). Finally, staff explained that barriers persist that prevent clients from connecting with a primary care physician, leading to fewer clients who followed through with referrals (see the second outcome).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of clients served	4,998	4,500	111%
Number of units of preventative health service	8,206	6,000	137%
Outcomes			
Percentage of clients that report improved awareness of health status resulting from QOL prevention team initiative	98% (3,000/3,073)	95% (1,710/1,800)	103%
Percentage of clients who followed through with referrals to healthcare provider or community resource	55% (49/89)	86% (43/50)	64%

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

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 newborn has 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.

For a portion of clients, designated on an as-needed basis, intensive case management services are provided and are designed to support the overall health and well-being of the sickle cell survivor and the survivor's family.

Funding

The total HHS investment in the Public Health Interlocal, which includes Austin Healthy Adolescent Program, Chronic Disease Prevention and Control Program, Communicable Disease, Comprehensive Public Health Planning, Environmental Health Services Division, Epidemiology and Public Health Preparedness, Health Authority, Health Equity Social Service Contracts Program, Immunizations, Injury Prevention Program, Office of Vital Records, Quality of Life Programs, and Sickle Cell and Health Equity-SC Programs, from October 1, 2017 through September 30, 2018 was $4,242,742.

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

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; however, individuals must be residents of the City of Austin or Travis County.

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

The Sickle Cell and Health Equity-SC Programs met or exceeded the targeted range of performance across all but one measure. The number of unduplicated clients with sickle cell trait or sickle cell disease provided with notification and hemoglobinopathy education was slightly below goal, which staff explained was due to the changes in reporting by the State's Department of State Health Services to Sickle Cell Mark Thomas Foundation (see the second output). The State stopped providing the agency with notifications of sickle cell disease or trait following newborn birth and screening due to HIPAA requirements. The agency is conducting its own screenings at various sites and testing a new model for identifying individuals with the trait and disease. The goal for FY 2019 has been adjusted accordingly.

The number of clients provided case management services exceeded the goal due to FY 2018 being the first year that the agency tracked this measure, and staff did not have historical performance data to base the target on (see the third output). The goal has been adjusted for FY 2019.

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients who engage in community-based education	2,850	2,500	114%
Number of unduplicated clients with sickle cell trait or sickle cell disease provided with notification and hemoglobinopathy education	328	400	82%
Number of clients provided case management services	61	20	305%
Outcomes			
Percentage of unduplicated clients with sickle cell disease or sickle cell trait who engage in navigation services	86% (282/328)	87% (348/400)	99%
Percentage of individuals who achieve healthy outcomes as a result of receiving services through Health Equity Social Service Contracts	87% (238/274)	90% (18/20)	97%

City of Austin Animal Services Office

Animal Services Interlocal

Program Description

The Animal Services Interlocal with the City of Austin Animal Services Office provides animal services through two programs: Sheltering and Prevention Services and Wildlife Services. Information on each program is provided in the following pages.

Funding

The total HHS investment in the Animal Services Interlocal from October 1, 2017 through September 30, 2018 was $1,673,405.

Eligibility Criteria

Eligibility criteria vary by program. Please see the individual program pages for eligibility criteria information.

City of Austin Animal Services Office

Animal Services Interlocal: Sheltering and Prevention Services

Program Description

The Sheltering and Prevention 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 Protection & Control Services: rabies control activities; training Animal Protection Officers and Travis County Sheriff's Office personnel; responding to calls for sick and injured stray animals and transporting those animals to the shelter or afterhours 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 for service 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/microchips, sterilization and immunization, euthanasia, and adoption. Sterilization and immunization is performed in the shelter and at clinics in targeted areas of Travis County. Pets of owners residing in these neighborhoods can receive free rabies vaccinations and microchip. 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 proactively reduce the number of pets entering the shelter, to improve health and welfare of pets, and to improve neighborhood safety. 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 targeted neighborhoods (education about pet responsibility issues and animal welfare issues is offered while conducting the clinic), free sterilization services in targeted neighborhoods, 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 Interlocal: Sheltering and Prevention Services

Funding

The total HHS investment in the Animal Services Interlocal, which includes Sheltering and Prevention Services and Wildlife Services, from October 1, 2017 through September 30, 2018 was $1,673,405.

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 are provided through mobile clinics and off-site clinics in targeted areas of Travis County. Targeted areas include neighborhoods with large numbers of stray animals, low return to owner rates, or other health and safety concerns.

City of Austin Animal Services Office: Sheltering and Prevention Services

The Sheltering and Prevention Services program met the targeted range of performance across all measures. Staff noted that Animal Protection exceeded the goal for average response time due to improved data entry in categorizing and completion of priority activities (see the first output).

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Average response time (in minutes)	94	<140	Met Goal
Number of companion animals sheltered	15,710	16,500	95%
Number of animals adopted	7,737	7,095	109%
Number of companion animals returned to owner	3,142	3,465	91%
Number of spay/neuters performed at Austin Animal Center	5,647	6,000	94%
Number of animals sterilized at community clinics	10,714	11,000	97%
Number of spay/neuter community clinics	204	200	102%
Outcomes			
Percentage of priority calls completed	99% (13,974/14,160)	100% (15,000/15,000)	99%

City of Austin Animal Services Office

Animal Services Interlocal: Wildlife Services

Program Description

The Wildlife Services program has a dedicated employee serve as the primary point of contact for wildlife calls from the unincorporated areas of Travis County. Responsibilities include call analysis and response, field response including data collection, yard audits, and a comprehensive outreach program. Wildlife calls that pose potential public safety risks have a two-hour or same-day response, depending on the time of day the call is received, and calls that pose imminent public safety threats are forwarded to 9-1-1. Calls that do not demonstrate a possible public safety threat are returned within three days. Coyote calls are reviewed for potential public safety threats using the City's Coyote Behavior, Behavior Classification and Recommended Response Guide and escalate to Animal Protection Supervisors as needed. Program staff also conduct quarterly follow up with callers to evaluate resident satisfaction with response.

Funding

The total HHS investment in the Animal Services Interlocal, which includes Sheltering and Prevention Services and Wildlife Services, from October 1, 2017 through September 30, 2018 was $1,673,405.

Eligibility Criteria

The City of Austin provides wildlife management services to the unincorporated areas of Travis County.

City of Austin Animal Services Office: Wildlife Services

The Wildlife Services program met its goal for average response time, with an average of a one-day response (see the first output). Because this was the first year of the program, goals were not established for the remaining measures.

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Average response time	1 day	3 days	Met Goal
Number of outreach hours	193	N/A	N/A
Number of calls requiring an escalated response	534	N/A	N/A
Outcomes			
Percentage of calls returned within response time	100% (808/808)	N/A	N/A

Total Program Performance Results reflect performance achieved over a 9–month period due to the start date of this program.

Appendix

2018 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	$6,070	$12,140	$15,175	$18,210	$24,280
2 persons	$8,230	$16,460	$20,575	$24,690	$32,920
3 persons	$10,390	$20,780	$25,975	$31,170	$41,560
4 persons	$12,550	$25,100	$31,375	$37,650	$50,200
5 persons	$14,710	$29,420	$36,775	$44,130	$58,840
6 persons	$16,870	$33,740	$42,175	$50,610	$67,480
7 persons	$19,030	$38,060	$47,575	$57,090	$76,120
8 persons	$21,190	$42,380	$52,975	$63,570	$84,760
For families/households with more than 8 persons, add $4,320 for each additional person.					

Data source: "2018 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 13, 2018, https://aspe.hhs.gov/poverty-guidelines.

2018 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	$18,100	$30,100	$48,200
2 persons	$20,650	$34,400	$55,050
3 persons	$23,250	$38,700	$61,950
4 persons	$25,800	$43,000	$68,800
5 persons	$29,420	$46,450	$74,350
6 persons	$33,740	$49,900	$79,850
7 persons	$38,060	$53,350	$85,350
8 persons	$42,380	$56,800	$90,850

*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.

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Endnotes

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