City of Austin
Health and Human Services Department

Community Services Block Grant
Fiscal Year 2012

Community Action Plan
Parts II -IV

Texas Department of Housing and Community Affairs
October 31, 2011

Part II: Service Delivery System

1. SERVICE AREA

The only county in the City of Austin's Community Service Block Grant service area is *Travis County*.

2. MAIN OFFICE

A. The Health and Human Services Department's administrative office is located at the Betty Dunkerley Campus, 7201 Levander Loop, Austin, Texas, 78702. Administrative staff and other program staff who are non-CSBG supported are housed at this location. These employees include staff from the Director's Office; Community Services Division; Administrative Services Division (Budget & Analysis Unit, Accounting Unit; Human Resources Unit; Contract Compliance); and Vital Records.

Satellite offices are located throughout Austin/Travis County and house staff from the Disease Prevention & Health Promotion Division; Environmental Health Services Division; and Maternal & Child Health Division.

B. The Neighborhood Services Unit's delivery of services occurs at the six (6) City of Austin Neighborhood Centers and three (3) field offices. A client may be seen on a walk-in basis or request an appointment by calling any of the neighborhood centers. (Note: The Healthy Neighborhood Unit's name will be changed to Neighborhood Services Unit effective November 7, 2011)

3. NEIGHBORHOOD CENTERS/FIELD OFFICES

A. The Health and Human Services Department operates the following six (6) neighborhood centers from which CSBG-funded and supported services are provided -

Neighborhood Center	Address
Blackland Neighborhood Center	2005 Salina (78722)
East Austin Neighborhood Center	211 Comal (78702)
Montopolis Neighborhood Center	1416 Montopolis Drive (78741)
Rosewood Zaragosa Neighborhood Center	2800 Webberville Road (78702)
St. John Community Center	7500 Blessing Avenue (78752)
South Austin Neighborhood Center	2508 Durwood (78704)

Services provided at each of the centers include basic needs, case management, preventive health, and employment support:

Service Category	Type of Service
Basic Needs	Food Clothing Information and referral Notary services Transportation (bus passes) School supplies Car seat education and distribution Income tax counseling/preparation Christmas Bureau applications Blankets Fans Holiday food baskets, Pampers/toiletries Other seasonal activities
Preventive Health	Screenings for blood pressure, blood sugar and cholesterol Pregnancy testing Lead poison testing and education Health promotion & education presentations Coordination and participation in health fairs Immunizations Coordination of wellness activities such as exercise and nutrition classes Linkages to medical home providers
Case Management	Self-sufficiency case management Quality of life case management Individual/family support counseling, Household financial counseling Advocacy Crisis intervention Linkages with employers, educational opportunities and training
Employment Support	Intake, assessment and goal setting Job readiness training Job placement assistance Job retention services

The Health and Human Services Department also ensures the provision of Community Services Block Grant-funded and support services, including public health nursing services at the following three (3) field locations –

Field Office	Address
Turner Roberts Recreation Center	7201 Colony Park Loop Drive (78724)
Dove Springs Recreation Center	5801 Ainez Drive (78744)
Santa Barbara Catholic Church	13713 FM 969 (78724)

B. Delivery of services at the neighborhood centers is performed by Community Workers, Social Workers, Public Health Nurses and Community Job Counselors primarily between the hours of 8am to 6pm., Monday through Thursday and 8am to 12pm on Fridays. Delivery of services at the outreach field locations is performed by Neighborhood Liaisons in coordination with other partners during established days of the month.
See attached Healthy Neighborhood Unit organization chart for list of CSBG direct and support staff. **Name change to Neighborhood Services Unit effective 11/7/2011).**

C. A resident may be seen on a walk in basis or request an appointment by calling any of the centers. During the screening process, applicants are 1) asked to answer some basic questions concerning their situation and 2) scheduled an interview with the appropriate worker depending on the type of services being requested. An intake application is completed by the worker to determine eligibility for basic needs services and based on the needs assessment, an internal referral is made for case management services, preventive health services and/or employment support services.

D. In addition to linkages to internal resources within the Health and Human Department, individuals and families are referred to other social service providers for assistance by contacting the agency directly for the applicant to schedule an appointment or by providing the applicant with a written referral indicating the reason for the referral. In most cases follow-up is conducted by the worker to determine the outcome of the referral.

4. COORDINATION BETWEEN MAIN OFFICE AND NEIGHBORHOOD CENTERS

A. The Director of the Austin/Travis County Health and Human Services Department, Carlos Rivera, is located at the Department's main office. The mission of the Department is to work in partnership with the community to promote health, safety and well being.

The six (6) neighborhood centers and three (3) field offices operate under the Department's Community Services Division, Neighborhood Services Unit. The Community Services Division Asst. Director is Vince Cobalis. The Community Services Division's goal is to promote and foster increased self-sufficiency, healthy behaviors, and healthy lifestyles to improve the quality of life for the city's most vulnerable citizens. The Neighborhood Services Unit Manager is Cathleen Rodriguez who oversees the management and coordination of all basic needs, case management, preventive health services and employment support services, including compliance with all grant requirements. Program Supervisors oversee the day-to-day operations of each of the centers and field offices, which include coordination of the

programmatic/service delivery aspect of the CSBG grant. They also supervise licensed Social Workers, Community Workers, Public Health Nurses (Registered Nurses), Community Job Counselors and Neighborhood Liaisons at each of the neighborhood centers/field offices.

Staff at each of the neighborhood centers/field offices provides basic needs, case management and employment support services, including the coordination and facilitation of activities benefiting neighborhood residents, such as job fairs, health fairs and preventive health education and screening sessions. Monthly reports of services rendered are prepared by the staff at the centers and compiled into a consolidated report, including the National Performance Indicator outcomes, which is submitted to the Texas Department of Housing and Community Affairs (TDHCA) by the 15th of each month. Data collection and reporting is performed utilizing the SHAH Client Tracking System, an ACCESS Database and internal client tracking logs. The Neighborhood Services Unit Office is responsible for completing and submitting the monthly report to TDHCA. The Unit Office is located at the Austin Health and Human Services Administrative Office, 7201 Levander Loop, Austin, Texas 78702.

The Administrative Services Division provides budget, human resources and information technology support to the Neighborhood Services Unit.

5. COUNTIES WITHOUT A NEIGHBORHOOD CENTER

A. The only county in the City of Austin's CSBG service area is Travis County where six (6) neighborhood centers and three (3) field offices exist.

6. OTHER SERVICE DELIVERY METHODS UTILIZED

A. The other means by which services are provided to residents include home visits, outreach field offices, onsite provision of services in neighborhood schools, churches and other community agencies, mobile van outreach to disseminate information and/or gather needs information, and participation at health fairs and/or job fairs.

Through a coordinated effort with other Department units, the Neighborhood Services Unit's outreach program focuses on neighborhoods where few or no medical or social services exist. The outreach team has two CSBG-funded personnel working in these neighborhoods establishing agreements with community organizations to host and/or sponsor basic needs and preventive health events at their respective sites. The activities performed by this team not only establish satellite neighborhood center operations within each of these communities, but will also provide a linkage for residents to gain services from other partners within the Health and Human Services network. The targeted areas are identified below.

Southern Target Areas	Northern Target Areas
78725 (Austin Colony) 78741/78742 (Riverside/Montopolis) 78744 (Dove Springs)	78724 (Colony Park, Pecan Brook) 78753/78757/78758 (N. Lamar/Rundberg)

Part III: Linkages and Funding Coordination

1. PROCESS FOR LINKAGES AND FUNDING COORDINATION

A. The Health and Human Services Department is involved in service coordination efforts that focus on identifying funding opportunities and improving client access to basic needs, employment and preventive health services. The Unit Manager, Site Supervisors, Social Workers, Community Workers, Neighborhood Liaisons and Public Heath Nurses participate on a number of collaboration committees with the goal of providing basic needs, promoting self-sufficiency and addressing preventive health needs.

B. The Basic Needs Coalition of Central Texas (BNC) is a citywide collaborative group working on increased information sharing among providers, identifying where new resources can be applied and making basic needs a funding priority. The coalition is comprised of public, private, nonprofit and faith based organizations and has a total membership of forty-one (41) agencies. (refer to **Attachment B**). The City of Austin Health and Human Services Department is a member of the Basic Needs Coalition of Central Texas and has been active with the Food Security Committee. The Food Committee identifies and describes existing community food service programs; such as emergency food pantries and soup kitchens and their availability to the public. One of the goals is to bring together food service providers to share information, discuss gaps, challenges, other related issues, and to explore opportunities to collaborate to improve food service delivery in Travis County.

The mission of the coalition is "to lead the community in creating solutions that secure the basic resources – food and housing- of our neighbors in need." The Basic Needs Coalition of Central Texas (BNC) is recommending a fundamental change in the way we, as a community, provide for the basic needs of individuals and families in crisis. The purpose of the coalition is to 1) assist, advise, and educate community policymakers, service providers, funders, community groups and citizens in addressing basic needs in Austin and Travis County; 2) maximize services and resources through the development, coordination and implementation of effective strategies for service delivery; and 3) serve as an advisory body of the Community Action Network (CAN). (www.basicneedscoalition.org)

As basic needs service providers (emergency food, clothing, housing, rent, mortgage, utility assistance) the members of the BNC are collaborating to provide ease of access to services for clients; to identify and maximize community resources; and increase the level of community investment to meet the growing need for basic need services.

C. The ARRA funds provided the neighborhood centers the opportunity to establish workforce resource centers and to partner closely with Workforce Solutions Capital Area Program Specialists to provide on-site services to clients who are struggling to secure employment in the current job market. These are households whose income is below the income poverty level either due to unemployment or under-employment, including residents who are receiving state benefits such as food stamps and/or cash welfare benefits. Short-term plans are for neighborhood center staff to continue to provide referrals to Workforce Solutions with a designated contact person to be assigned to staff for direct linkage. A team approach of working with the individuals who are seeking services will continue between City and Workforce Solutions staff even though the centers will not have an on-site program specialist and workforce development services. The long term plan is to seek and secure other funding that will allow for neighborhood based workforce development services to be accessible through the centers.

D. As a partner in the Community Action Network Streamlined Common Eligibility Work Group, the goal is for neighborhood center staff to connect families to all available resources while maximizing public assistance enrollment.

E. The City of Austin has been a partner with Austin Free-Net (AFN) since 2006. This partnership has afforded AFN to provide computer access through the neighborhood centers. Five of the six neighborhood centers have computer labs in operation. As a member of the Texas Connects Coalition, AFN received funding through a technology grant to replace and increase the number of workstations with current partners and provide onsite instructors for technology training. The benefit to the neighborhood centers in continuing this partnership with AFN is the enhancement of computer access, technical support, digital literacy, workforce development and other services to the low-income and vulnerable populations.

F. The City of Austin has a long standing history of supporting and funding social services in the community. Through social service contracts, these dollars have supported the issue areas of basic needs, early children and childcare, homeless services, mental health/mental retardation/developmental disabilities, substance abuse, victim services, workforce development and youth development. The plan is to work with these social service agencies to expand services within the neighborhood centers resulting in a one-stop service delivery system.

G. Linking households to the City of Austin's Permanent Supportive Housing program that not only addresses affordable housing for certain targeted populations but also includes the provision of support services that enable tenants, especially the homeless, to live independently and participate in community life.

2. LINKAGES WITH OTHER SERVICE PROVIDERS

A. In Travis County, we coordinate with a number of social service, health and faithbased providers. Coordination efforts are performed by either referring the clients directly to the service provider for assistance or service providers are on-site at a neighborhood center during special events or established days of the month. Coordination efforts also include the public health nursing staff providing onsite services such as screenings and health presentations. The following list represents the level of coordination and leveraging of resources to meet the needs of clients.

AARP
Austin Independent School District
American Cancer Society
American Heart Association
American Youth Works
AMERIGROUP Community Care
Any Baby Can
Austin Community College
Austin EMS
Austin Energy
Austin Fire Department
AustinFree Net
Austin Housing Authority
Austin Police Department
Austin Learning Academy
Austin Library Services
Austin Stone Church
Blackland Community Development Corporation
Blue Santa (Christmas Bureau)
CommUnity Care
Capital Area Food Bank
Caritas
DARS (Tx Dept of Assistive and Rehabilitative Services)
Dell's Children Hospital – SafeKids Program
El Buen Samaritano
Family Eldercare
Foundation Communities
Hispanic Bar Association
Huston Tillotson University
Light of Hope (Children's Shelter)
LiveStrong

Mexican Consulate
Parks and Recreation Department – recreation centers and senior activity centers
Physician Health Choice
Planned Parenthood
Rising Star Baptist Church
Roger Hughes Masonic Lodge
Salvation Army
Seton Healthcare Family
Smile Dental
Southwest Keys
Superior Health
Susan G. Komen Breast Cancer Foundation
Sustainable Food Center
Travis County AgriLife Extension
Travid County Health and Human Services
Travis County Sheriff's Department
UT School of Nursing
UT School of Social Work
Womens Infants and Children -WIC
Workforce Solutions

3. EXISTING GAPS OR UNMET NEEDS

A. The Community Needs Assessment identified the following existing gaps or unmet needs:

- Basic Needs - food, rent, utility assistance
- Employment – jobs for people with criminal records, good paying jobs with benefits, jobs skills training programs
- Housing – affordable rental housing, affordable homeownership, emergency shelter
- Health Care - dental care, affordable prescriptions, and access to clinics
- Education – GED classes, financial assistance for classes, English as a Second Language classes
- Youth Development – affordable summer activities, summer youth employment, after school programs
- Preventive Health Services – blood pressure screenings, domestic violence education, and family planning

Contributing factors impacting a family's ability to meet the identified critical unmet needs -

- low wage paying jobs to meet basic needs
- affordable childcare that will enable individuals to work and/or attend training programs and education classes
- inability for previously incarcerated individuals to find employment
- funds to pay for educational classes
- must work therefore cannot attend training programs
- gentrification.

In addition, an assessment of the current health services indicated the following:

- Many services are not community focused
- A disconnection exists between what people feel they need and what is available
- Current public health delivery system is not understood by general public and many providers
- Preventive services are fragmented or do not exist
- One stop service delivery for preventive services that is community based does not exist.

The overall goal of the Unit is to promote a healthy community, which reflects social equity. This will be achieved by:

- The increase in the availability or preservation of community services to improve public health and safety
- Promoting and fostering increased self sufficiency, healthy behaviors and lifestyles among targeted populations
- Delivering quality, safety-net health service in partnership with the community

Special projects during 2012 will focus on the following -

- Developing and implementing a healthy eating project. The project will focus on addressing policy changes to ensure consistency among the six neighborhood centers and three field offices when ordering food from the Capital Area Food Bank for food pantry operations. The goal is for all food pantries to have an array of healthy food items available for distribution to residents in need of assistance, including recipes focused on healthy food preparation.
- Looking at the feasibility of piloting a client job readiness project
- Collaborating with social service agencies to expand services at the neighborhood centers

PART IV: CASE MANAGEMENT SYSTEM

1. INTAKE AND SELECTION PROCESS

A. The process for selecting clients to participate in case management is as follows:

Step 1: Intake Process – The client makes the initial contact with the Community Worker. The Basic Needs intake form is completed at this time. The Community Worker completes the Needs Assessment form to determine the need for case management, public health and/or employment support services. The client may be referred to an outside service at this point if they seek a service that is not provided at the Neighborhood Center.

Step 2: Referral for Case Management Services- A client is referred to the Social Worker. The Social Worker receives a copy of the needs assessment and the referral for services form to review the reason for the referral.

B. The Social Worker does an initial assessment to determine the following:

- If the client is appropriate for services
- The level of assistance to be provided to the client
- Other concerns that may need to be addressed

C. The following factors are considered when choosing a client for Case Management services:

- Unemployed: seeking employment, TANF, and Disability;
- Underemployed: expressing a need for a higher paying job; client feels there is a need for additional employment skills; quality of life improvement;
- Homelessness; living in a shelter or other temporary place (hotel, motel, or Salvation Army); unstable living environment (living with family or friends);
- Person with multiple crisis at home: problems with children, spouse, and/or employer; problems with the home (need repairs); medial concerns and how to address those issue; people who live in abusive homes or abusive relationships;
- Applying for disability;
- Elderly: problems with adult children, spouse or other; problems with home; medical concerns and how to address those issues; people who are in abusive situations.

2. CASE MANAGEMENT DELIVERY PROCESS

A. The Initial Assessment note is a progress note that will be written in narrative form using the Data, Assessment, and Plan (D.A.P.) format for documentation. The Assessment looks at all the needs of the household as well as the individual needs of the client. The Social Worker determines at this point if the client is willing to participate, if so the Social Worker and the client develop a service plan.

B. The areas of the Integrated Assessment and Case Management Services Assessment Levels I (Intensive Case Management) and II (Moderate Case Management) are used initially to build a baseline for services. In addition, the case management assessment is used throughout services to examine any further goals that need to be set and achieved by the client with the assistance of the Social Worker.

C. The Release of Information is used by the Social Worker when providing Case Management services. This agreement basically gives permission to the Social Worker and this agency to communicate with any other service provider. The Social Worker may release information with a client's signed consent.

   Social Workers must complete the Release of Information during the initial assessment with the client. The Release of Information allows the Social Worker to discuss with other agencies about the case and/or needs in which other providers can assist the client. The Social Workers document any contact in the chart with the client or other service providers. Social Workers have in-services with providers from different Social Services Providers during their monthly meetings. Some agencies provide a special referral for the Social Workers to complete in order to expedite the services for the client.

3. FOLLOW-UP AND CLOSURE

A. The Social Worker reviews the plan every 90 days or sooner if the worker agrees that a change needs to be made in the plan. The Social Worker monitors the client by face to face and telephone contact. Depending on the level of case management of the client, the Social Worker would determine the frequency of the contact. For example, if the client is in the Intensive Case Management Intervention level, the Social Worker must have weekly contact with this individual. The Social Worker must also have a minimum of one face-to face contact with the client on a monthly basis. If the client is on the Case Monitoring level, the client will need to have one contact per month with the Social Worker.

B. When the Social Worker places the client on the Case Monitoring level for services, the Social Worker has to have one contact a month with the client by phone or face to face during the next 90 days. The clients are informed after

the 90-day monitoring to come in one last time to close the case. The client is instructed to bring in documentation of their income for the last visit. The client and the Social Worker mutually agree to close the case. Clients will be given the option to call if they have changes to their level of functioning/self sufficiency after closure.

C. The Social Workers also provide a Client Comment Card, which is given to the client and reviewed by the Social Services Supervisor. The Social Services Supervisor reviews the comment card and reports to the Social Worker, Site Supervisor and Unit Manager. The comments from the card are shared at the monthly meeting when clients make suggestions for improvement for the Case Management program.

4. CASE MANAGEMENT STAFF

A. Refer to **Attachment E**, Staff Providing Case Management Services.

5. EVALUATION OF CASE MANAGEMENT SYSTEM

A. As a part of the Unit's reorganization, a centralized Social Services Program was created to strengthen our case-management focus. This program consists of all of the Social Workers within the Neighborhood Services Unit. The Social Workers have several years of experience and expertise, and a commitment to their area of practice. The Social Services Coordinator conducts monthly meetings with the Social Workers which allow for stronger coordination of services and ensures consistency in our delivery of case management services.

B. An area for improvement in the Social Services Program case management system would be to increase partnerships with community social service providers to ensure the provision of emergency financial assistance. In addition, the Social Workers have a goal to increase the number of collaborations with area service providers. To reach this goal, the Social Services Program added an outreach component.

C. Continued plans to monitor and evaluate the programs' data collection process to ensure an ability to assess overall results and efficiency and obtain a base of information for continued refinement and improvement. These improvements will be made during the program year.