PROGRAM WORK STATEMENT

FY 2017 Social Service Contract funded by Travis County Date prepared: 06/07/2016

Instructions:
- Answer the following questions as they pertain to *only those programs and services in which Travis County invests*.
- Ensure that all language (e.g. agency and program names, performance measures, etc.) is consistent across all contract forms.
- Do not delete any instructions or question descriptions.
- The information contained in this document will be used to report on your program to the Travis County Commissioners Court and the public, so the information herein should accurately explain and reflect the program and services.

1. Program Information

Provide agency name and program name as they appear on all contract documents.

Agency name: Austin/Travis County Health and Human Services Department (ATCHHSD)

Program name: Chronic Disease Prevention and Control Program

2. Program Goals

Briefly describe the goals of the services purchased by Travis County in this contract.

The Chronic Disease Prevention and Control Program (CDPC Program) activities align with the A/TCHHSD Business Plan Goal for Health Services: Improve quality of life and reduce the years of potential life lost due to preventable conditions. The CDPC Program exists 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.

3. Target Population

Briefly describe the target population of this program.

Since strategies are policy, systems and environmental changes, the target population is jurisdiction-wide. However, all service-based strategies are targeted to those individuals, primarily adults and children 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.

4. Client Eligibility

List all eligibility requirements for clients to receive services in the program, and fully describe the criteria for each requirement (see Sample Table below for examples). If eligibility requirements vary by program component, please specify in the descriptions. If your contracted program includes multiple service components with varying eligibility criteria, you may copy/paste the table below, complete one table per component, and title each table accordingly.

Sample Table:

Eligibility Requirement	Description of Criteria	Verification Method
Income level	*At least one-half of clients must be at or below 100% FPIG. Remainder can be up to 200% FPIG.*	*Income level is self-declared based on HUD 24th Code of Federal Regulations, part 5.*
Residency	*Clients must be residents of the five county area: Travis, Williamson, Hayes, Bastrop, Caldwell.*	*Residency verified by utility bill, lease or rental agreement, or government-issued photo identification.*

Program Component (if applicable):

Eligibility Requirement	Description of Criteria	Verification Method
Not Applicable		

(If program has additional eligibility requirements, insert additional rows in table. Please delete empty rows.)

5. Service Delivery

Describe the services and how they are provided through the program. This should be a clear and concise summary of how clients move from initial contact through exit and follow-up. Include all relevant components of the core services, such as:

- *Outreach*
- *Intake*
- *Eligibility determination process*
- *Service provision*
- *Duration of services*
- *Termination or discharge*
- *Coordination with and referral to/from other agencies*
- *If applicable, brief description of research or promising practice on which program is based*
- *Any other relevant components of service delivery for this program*

Obesity Prevention Initiatives

Chronic Disease Prevention and Control implements programs, and promotes policy, systems and environmental changes across multiple sectors addressing where people work, play, learn and live to promote active living and healthy nutrition. These sectors include schools, day care centers, the faith-based community, worksites, and through the media. Changes to the built environment, such as access to sidewalks, bike lanes, parks, trails and opportunities for active transit promote active living and physical activity. In addition, access to healthy and affordable foods, as well as information and education on healthy nutrition, helps facilitate individuals' ability make healthy choices. To promote these changes, the CDPC program provides training and technical assistance to schools, daycare centers, housing communities, worksites, and other organizations. In addition, a place-based chronic disease prevention mini-grant opportunity will provide these organizations with support to make community changes in these areas. This mini-grant opportunity will have a special focus in areas of highest chronic disease risk, including the zip codes of Manor and Del Valle.

Tobacco Prevention and Control

The 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. Tobacco prevention efforts focus on increasing the number of worksites that have tobacco free policies, and increasing the number of multi-unit housing communities that have smoke free policies. In addition, comprehensive media strategies promote tobacco prevention and cessation messaging in order to reduce rates of smoking across Travis County, with a focus on young adults, who have the highest prevalence of smoking.

Community Diabetes Initiative

The Chronic Disease Prevention and Control Program implements four community exercise groups yearly as well as multiple series of the Diabetes Empowerment Education Program (DEEP) self-management program. The DEEP series consists of six classes on diabetes self-management topics, and each class is 90 minutes long. Although DEEP is designed for persons living with type 2 diabetes, all are welcome to attend the classes, and many individuals who have prediabetes or who have a friend or family member with diabetes choose to attend the classes.

6. Service Accessibility

Describe any relevant strategies employed by the program to ensure service access related to the following issues:

- *Cultural competence*
- *Language and communication access*
- *Geographical access*
- *Anti-discrimination strategies*
- *Other accessibility issues relevant to the program*

All A/TCHHSD staff attend training on cultural competence. In addition, several staff are bilingual in English and Spanish. A/TCHHSD has services available through a language interpretation service in order to provide services to clients speaking languages other than Spanish or English. In addition, A/TCHHSD has policies and procedures for developing culturally and linguistically appropriate materials (CLAMS), and this policy is utilized for the selection or creation of health education materials. Services are dispersed throughout Travis County, however they are centered in areas of highest need based on data on chronic disease risk factors (such as obesity prevalence), demographic data for populations disproportionally impacted by chronic diseases (such as socioeconomic status, race/ethnicity), and data on food access. Priority areas for services have predominantly been the Eastern Crescent of Austin and Travis County, including but not limited to the following zip codes: 78758, 78753, 78752, 78723, 78721, 78702, 78741, 78744, 78745, 78617, 78725, 78724, 78653.

7. Program Staffing

List the staff positions (titles only, no individual names) that are essential to this program, and provide a brief description of duties as they relate to this program. If there are multiple staff positions with the same title and duties, you can note the number of positions with the position title, e.g. "Case Manager (5)."

Position Title	Description of Duties
Chronic Disease Program Coordinator	Coordinates all activities related to tobacco free multi-unit housing, tobacco free worksite policies, develops partnerships with key organizations and non-profits, manages contracts and provides additional support for food access, healthy nutrition, and built environment programs
Obesity Prevention Program Coordinator	Coordinates all activities related to food access and improvement of healthy food options and physical activity opportunities in schools, afterschool settings, worksites (through healthy vending policies), and other sectors; develops partnerships with key organizations and non-profits, coordinates media strategies related to promotion of healthy nutrition and physical activity
Health Educator II (worksite wellness focus)	Coordinates worksite wellness programs, including the Mayors Health and Fitness Council Business Group on Health; provides educational presentations on tobacco prevention and control with the goal of policy, environmental, and systems changes at worksites, apartment complexes, and other sectors of the community
Health Educator II (diabetes focus)	Provides exercise classes and diabetes education classes
Administrative Senior	Provides administrative support to the program to include

	purchasing, timekeeping, event planning and support, and administrative aspects of mini-grant opportunities
Program Supervisor	Responsible for programmatic and financial oversight of the program
Research Specialist II	Provides evaluation support to the project

Epidemiologist	Analyzes epidemiological data such as survey data, vital records data, hospital discharge data for surveillance and program evaluation
Diabetes Program Coordinator (grant funded)	Coordinates diabetes education classes taught by Community Health Workers in the community

(If program has additional staff positions, insert additional rows in table. Please delete empty rows.)

8. Program Evaluation

a) Information Management and Data Collection

- *Describe the **tools and processes** used to collect program data, and the **systems** used to manage program data (i.e. client data, service information, or other data relevant to the program's overall service delivery and performance).*
- *If any surveys are used to collect information used in performance reporting, please provide a description of survey procedures (such as when, how, and by/to whom the survey is distributed, received, completed, and returned) and a copy of the most recent survey as an addendum.*

Client data for the diabetes program are obtained through the pre and post-test. This survey is administered in class 1 and class 6 of the program. Data is also obtained from the participant satisfaction survey done in class 6. Please see a copy of this survey in the addendum. Media campaign efforts are evaluated through systematic evaluation of smoking prevalence rates through the behavioral risk factor surveillance system (BRFSS), as well as well as web encounters to program specific websites

b) Performance Evaluation

Describe how the agency uses the data it collects to evaluate both programmatic effectiveness (as described in questions 2 and 5 of this work statement) and progress towards performance goals (as described in 9 and 10 of this work statement).

Performance is measured through analysis of diabetes education pre and post-tests and participant satisfaction surveys, as well as data on individuals accessing tobacco cessation services. These data are used to make programmatic adjustments. Exercise classes utilize feedback forms to determine changes in participant's self-reported health and physical activity. Output measures are tracked monthly to assure that the program is on track to meet metrics for health education encounters and community changes. In addition, staff regularly meets with management to review progress towards performance measures and to determine the strategic direction of the program.

9. Quality Improvement

Describe how the agency uses its evaluation results to: identify problems or areas for improvement in service delivery; design strategies to address these problems; implement those strategies; and follow up to ensure corrective actions have been effective.

The program reports as part of the department's Continuous Quality Improvement (CQI) program. The program meets regularly on CQI and reports outcomes as required by the departmental plan. Both the diabetes and tobacco projects are utilizing rapid cycle improvement processes (Plan Do Study Act cycles) in order to utilize data to make programmatic improvements.

10. Output Performance Measures

Enter the output performance measures to be reported for the program in quarterly performance reports. You must report the number of unduplicated clients served and at least one other output. Total annual goals should be 12-month goals. Outputs should be reported quarterly unless a specific programmatic or data-driven limitation exists. Please use the comments section to specify and provide explanation for any reporting exceptions.

Output Measure	Total Annual Goal	Quarters Reported
Number of Public Health Encounters	420	4
Number of Community Changes	3	4

(If approved for additional Output measures, insert additional rows in table. Please delete empty rows.)

Comments (for reporting exceptions, if applicable):

11. Outcome Performance Measures

Enter the outcome performance measures (numerators, denominators, and outcome rates) to be reported for the program in quarterly performance reports. Total annual goals should be 12-month goals. Outcomes should be reported quarterly unless a specific programmatic or data-driven limitation exists. Please use the comments section to specify and provide explanation for any reporting exceptions.

	Outcome Measure		Total Annual Goal	Quarters Reported
1.	Number of tobacco-related deaths		700	Reported in Quarter 4 (annual measure)
2.	Number of adults currently smoking in Travis County	(numerator)		Reported in Quarter 4 (annual measure)
	Total responses from representative sample of Travis County residents	(denominator)		
	Percent of adults currently smoking in Travis County	(rate)	10%	
3.	Number of deaths related to heart disease in Travis County		800	Reported in Quarter 4 (annual measure)
4.	Number of individuals enrolling in tobacco cessation services	(numerator)		Reported quarterly
	Total number of individuals receiving tobacco cessation outreach	(denominator)		
	Percentage of individuals receiving tobacco cessation outreach that enroll in cessation services.	(rate)	25%	
5.	Number of participants who self-report lifestyle changes made as a result of attending diabetes education classes	(numerator)		Reported quarterly
	Total number of persons attending diabetes classes	(denominator)		
	Percentage of participants who self-report lifestyle changes made as a result of attending diabetes education classes	(rate)	75%	

If approved for additional outcome measures, insert additional rows in table. Please delete empty rows.)

Comments (for reporting exceptions, if applicable):

12. Community Planning

a) Community Planning Group Participation

If the agency participates in any community planning groups relevant to the issue area and services under this contract, please list them here, along with the name and title of agency representatives who participate and a brief description of their role and participation in that planning group.

Community Planning Group	Agency Participant Name/Title	Participation Role/Description
CHA/CHIP Obesity Prevention workgroup and Evaluation/Epi	Austin Steeves, Sarah Stein-Lobovits, Sabrina McCarty,	Provide Input

Planning workgroup	Stephanie Helfman, Ashley LeMaistre, Sarah Seidel	
Imagine Austin Healthy Austin	Austin Steeves, Ashley LeMaistre, Sarah Stein-Lobovits, Stephanie Helfman, Sabrina McCarty	Provide Input

(If agency is involved in additional planning groups, insert additional rows in table. Please delete empty rows.)

b) Community Plan

If the agency aligns itself with a Community Plan, provide the name of the plan and its authoring body, and a brief description of how you align your agency with and respond to the plan's shared community goals. If there is not an established community plan in this issue area, describe what the agency uses to orient itself to community needs and goals.

CHA/CHIP- Obesity Prevention Workgroup- Coordinated by the City of Austin Health and Human Services Dept. This improvement plan lists strategies to prevent obesity through education and policy, systems, and environmental changes. Program staff participate in this process in order to determine programmatic priorities and to assure coordination of services with other organizations.

Imagine Austin Healthy Austin Priority Area - Coordinated by the City of Austin Health and Human Services Department. This improvement plan lists strategies to prevent obesity and chronic diseases. Program staff participate to identify strategies related to the built environment, active transportation, healthy nutrition and physical activity opportunities, and promotion self-management of chronic diseases and overall promotion of healthy lifestyles.

c) Response to Community Change

Have there been, or do you anticipate, any changes to the community plan or community goals, that will impact how you provide services over the remainder of your contract period?

No, there are not any anticipated changes at this point.

Addendum
Survey

☐3rd class
☐6th class

CLASS FEEDBACK FORM

We value your feedback. Your responses will be anonymous and will help us improve our program.

Facilitator:_____ Date:_____

1) The instructor was knowledgeable about the topics covered.

☐Strongly Agree ☐Agree ☐Uncertain ☐Disagree ☐Strongly Disagree

2) I have learned new information in the classes to help me manage diabetes or prevent diabetes.

☐Strongly Agree ☐Agree ☐Uncertain ☐Disagree ☐Strongly Disagree

3) Many things go into controlling/preventing diabetes, such as making healthy food choices, checking blood sugar levels, being physically active, controlling stress, and more. Since coming to these classes, have you made any changes?

☐Yes, I have made changes, ☐No, I have not made changes

Please tell us more about the changes you have made since coming to these classes:

_____

_____

4) What did you like best about the classes?_____

_____

5) How can we improve the classes?_____

_____

Thank You

Updated 1/2015