PROGRAM WORK STATEMENT

FY 2017 Social Service Contract funded by Travis County Date prepared: 05/31/2016

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

Program name: Communicable Disease

2. Program Goals

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

The primary goal and objective of providing Sexually Transmitted Disease (STD), Tuberculosis (TB), and HIV Prevention/Outreach Education Services is to prevent disease morbidity and to protect the community from the spread of these communicable diseases.

3. Target Population

Briefly describe the target population of this program.

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. No other health care providers in the community provides these services and all are referred to the health department for management, treatment and public health investigation for the identification and evaluation of exposed individuals. 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.

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	*No income requirements for any of our programs.*	*NOT APPLICABLE*
Residency	*Clients must be residents of the five county area: Travis, Williamson, Hayes, Bastrop,*	*Residency verified by utility bill, lease or rental agreement, or government-issued*

	Caldwell.	*photo identification.*

Program Component (if applicable): N/A

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*

STD clinical services are provided at the RBJ Health Center, by three full-time Nurse Practitioners and two on-call staff. Our business hours are Monday-Friday 8am-5pm. This includes testing for HIV (rapid testing), syphilis, gonorrhea and chlamydia. In addition, if a client presents with symptoms of herpes, we can test for herpes at no additional cost. Treatment is also provided at no additional cost for syphilis, gonorrhea, chlamydia and genital warts (HPV). Services are also provided at the Del Valle Correctional Facility two half days a week (Monday and Wednesday afternoons) and Gardner Betts Juvenile Detention Center one half day a week (Tuesday morning).

In addition, our HIV Outreach/Prevention staff provides HIV and STD testing in satellite locations throughout the city and county to make testing accessible to all residents. They take their mobile outreach van to target areas with high risk populations. Staff frequent locations where they might engage sex workers, homeless individuals, and day laborers who are often at high risk for HIV/STD infection. Staff also distribute flyers announcing Mobile Van sites in the area and at various community HIV/STD testing events. Internet Outreach is accomplished by collaborating with universities, neighborhood centers, and other local service providers by including a link on their website that connects clients to our services via our Facebook page or the Health Department website. TTLMC continues to utilize social media sites like Facebook, Twitter, and Instagram to provide HIV/STD testing information. Clients can refer to these pages for monthly testing calendars, basic information on HIV/STDs, and local events that provide testing opportunities. Towards the end of 2014, TTLMC began utilizing apps such as Grindr, Scruff, and GROWLr to identify those in need of testing and counseling. Using a geo-locating device, such as a smart device or tablet, these clients can identify the location of our services when we are in their area. Since utilizing these apps, we've see an increase in high-risk MSM testing numbers as well as an increase in our positivity rate.

The STD services are in high demand. Having an additional fully-staffed clinic in north Austin would address some of this community need. A multi-use STD screening/PrEP clinic would also address some of the need for HIV prevention therapy.

Comprehensive TB clinical services are provided at the RBJ Health Center Monday-Friday 8 a.m.-5 p.m., by one Physician, one LVN, three Registered Nurses (RNs) and one radiology technologist. This includes medical evaluation, on-site x-ray and treatment for latent TB infection and active TB disease at no charge. It is the standard of care to provide directly-observed therapy (patients on treatment for active TB are observed taking their medications by a public health staff) in the field for all active/infectious TB cases and for those who are suspected of having active TB (pending lab confirmation) by field staff at hours and locations agreed upon by the client and 4 outreach staff. A weekly TB screening clinic is conducted for the general public who need TB screening for school, employment or other reasons. 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 seven Disease Intervention Specialists and two TB Contact Investigators. Follow-up activities include interviewing clients to obtain information on potentially-exposed individuals to conduct proper contact investigations, decrease morbidity and reduce/prevent the spread of disease. These activities are captured in City performance measures that are reported quarterly or annually as well as in annual reports to funders of the activities.

In-clinic Social Work intervention is provided as needed on a case-by-case basis for STD and TB clinic clients by seven medical social workers. 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. The social workers link individuals to a variety of services, including medical care and housing assistance, and assist individuals in adhering to their treatment plans.

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*

The STD and TB Clinics were recently recognized as a Leader in LGBT HealthCare Equality by the Human Rights Campaign Foundation, the educational arm of the country's largest lesbian, gay, bisexual and transgender (LGBT) civil rights organization. The Communicable Disease Unit's Non-Discrimination Policy and Client Bill of Rights are two anti-discrimination strategies in place to ensure equal access to quality care. In efforts to increase cultural competency, online trainings/webinars on topics of LGBT and other cultural issues are made available to staff. In addition, phone or in-person translators are available and utilized when providing services to clients who are hearing impaired and/or are non-English speakers. Clinic supervisors/managers have completed training on the Department's new Culturally Linguistic and Appropriate Materials (CLAMS) Policy to ensure educational materials provided to clients are culturally appropriate.

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
Medical Social Workers (7)	link individuals to a variety of services including medical care and housing assistance, assist individuals in adhering to their treatment plans
Disease Intervention Specialists (7)	Interview newly diagnosed HIV and syphilis clients, elicit partner information on potentially-exposed individuals, screen or link to screening and preventive therapy
Physician (1)	Medical director of the Unit. Oversee medical operations of TB and STD clinics
Nurse Practitioner (3)	Provide medical examination and evaluation of STD patients
LVN (1)	Provide medication to TB patients including preventive meds, provide medical examination of TB Clinic patients
RN (3)	Provide medical examination and evaluation of TB Clinic patients. Provide medical case management for active TB patients.
Radiology Tech (1)	Provide radiology services to TB clinic patients
TB Contact Investigator (2)	Interview newly diagnosed or suspects of active TB disease, provide TB contact investigations, test contacts and refer to care if needed
TB Outreach Worker (4)	Provide directly observed therapy and preventive therapy to TB patients, suspects, and high-risk latent TB infection patients
HIV Prevention/Outreach (5)	Provide HIV/STD testing and counseling to high-risk individuals outside of the clinic setting
Patient Representatives (9)	Register patients, make appointments, enter data, manage reporting and medical records, answer questions, etc. for both TB and STD clinics

(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.*

STD clinic data (client, medical, service) is collected in an HHSD-managed database. The information is entered by patient representatives. Other Texas Department of State Health Services (DSHS) databases are used for public health follow-up teams. TB data is collected in a third-party database (medical, investigation, case management) and in an HHSD-managed database (medication). A DSHS databases is used for ordering medication from DSHS.

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).

Monthly reports are submitted to Unit Manager and HHSD Budget, and semiannual reports are also completed to look at program performance and submitted to grantors.

c) 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.

Chart reviews are conducted semiannually, incidents are investigated and systems/processes are evaluated to determine if changes need to be made (all submitted to Division QI Coordinator). Clients and staff are able to voice concerns/complaints and they are investigated to determine if system/process changes are necessary, and annual customer satisfaction surveys are conducted and the feedback is used to improve services.

9. 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
1. Number of STD patient visits at the RBJ and Correctional Facility clinics	13,000	
2. Number of TB clinic patient visits at RBJ	8,500	
3. Number of HIV/STD tests provided in outreach settings	1,700	
4. Number of units of medical social work services provided by Medical Social Workers (units are measured in 15 minute increments)	26,000	

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

Comments (for reporting exceptions, if applicable):

10. 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.	a. Number of clients served by the STD clinic on a daily basis	(numerator)	13,000	
	b. Total number of clients presenting for STD services (daily demand)	(denominator)	14,444	
	c. Percentage of clients who come into the STD clinic who are examined, tested and/or treated the same day	(rate)	90%	
2.	a. Number of active TB cases completing therapy in 12 months	(numerator)	N/A	

	b. Number of TB cases closed (# completed therapy + lost before completing treatment)	(denominator)	N/A	
	c. Percentage of patients with active TB that complete therapy in 12 months	(rate)	100%	
3.	a. Number of TB contacts evaluated (for active TB disease)	(numerator)	N/A	
	b. Total number of TB contacts identified (as having had contact with active TB case)	(denominator)	N/A	
	c. Percentage of TB contacts evaluated (for active TB disease)	(rate)	90%	

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

Comments (for reporting exceptions, if applicable):

11. 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.

Central Texas HIV Provider Network Group	CDU Social Workers and Stephanie Eaton, Social Work Supervisor.	Participant
HIV Task Force	Katherine Cantrell, Outreach Supervisor	Co-creator; co-lead

(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.

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?