OCTOBER 25, 2016

Evaluation of the Austin/Travis County Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)- Cycle I (2011-2016)

Submitted to:

Austin/Travis County Community Health Improvement Steering Committee
and the Austin/Travis County Health & Human Services (Funder)

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Executive Summary

Background: In 2011, Austin/Travis County (ATC) Health and Human Services launched the CHA/CHIP, a collaborative, 5-year community health assessment (CHA) and planning initiative (CHIP) aimed at identifying and prioritizing key health needs of residents in Austin/Travis County and developing and implementing a community-wide health improvement plan of action. In an effort to further document and evaluate the process, progress, and lessons learned of this first cycle, researchers at the Michael & Susan Dell Center for Healthy Living based at the UTHealth School of Public Health in Austin were contracted to conduct a posthoc stakeholder evaluation of the ATC CHA/CHIP (2011-2016).

Aims: The overarching aim of the evaluation was to engage stakeholders in a co-learning process to evaluate the process and outcomes of the CHA/CHIP Cycle I in order to assess achievements and identify areas for ongoing improvement of the CHA/CHIP initiative. The evaluation took place over a seven-month period, from March 1, 2016 to September 30, 2016. Specific aims of the evaluation were to: a.) evaluate the process for implementing the CHA/CHIP, including the participation of key CHA/CHIP stakeholders as well as the planning processes and activities; b.) assess progress with changes in health outcomes identified in each work stream for the four CHA/CHIP workgroups *(Chronic Disease Focus on Obesity, Built Environment Focus on Access to Healthy Foods, Built Environment Focus on Transportation, Access to Primary Care and Mental/Behavioral Health Services Focus on Healthcare Navigation); and c.)* identify additional achievements, highlights, and lessons learned from Cycle I and recommendations for CHA/CHIP Cycle II.

Methods: Guided by principles of participatory inquiry and the *CDC Framework for Program Evaluation*, the evaluation was based on a mixed methods approach that included: semi-structured interviews with CHA/CHIP stakeholders, two online surveys with organizational stakeholders and community stakeholders, two participatory evaluation sessions with organizational stakeholders and community residents, and review of existing data and literature to document trends in outcomes. The primary evaluation design was based on a stakeholder posttest only design. Analysis included content analysis for qualitative data guided by a deductive (driven by the interview schedule or participatory evaluation activity) and inductive (allowing emergence of new themes) approach, and quantitative analysis for the online surveys and assessment of progress with CHIP indicators based primarily on descriptive statistics.

Results: Findings from this evaluation document a range of key highlights and accomplishments, areas with the CHA/CHIP process and organization that merit further fine-tuning and strengthening, and recommendations and "vision" for enhancing the next cycle of the CHA/CHIP, which will begin in 2017. The valuable partnerships and collaborations that resulted from the ATC CHA/CHIP were a key accomplishment noted across stakeholder groups, including Steering Committee members and other CHA/CHIP leaders, Core Coordinating Committee members, CHIP workgroup members, and other organizational and community stakeholders. Specific areas for improvement include the need for enhanced internal and external communication, clarification of the CHA/CHIP purpose and committee roles and responsibilities; and further consideration of the CHIP approach in relation to prioritizing, catalyzing, coordinating, and tracking actions and outputs.

Conclusion: The ATC CHA/CHIP succeeded in engaging a variety of organizational and community partners in creating a structure to produce a comprehensive health assessment and improvement plan. The rich and valuable insights provided by ATC CHA/CHIP stakeholders and documented in this report provide direction for strengthening our collective capacity to advance the health of the ATC community.

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Introduction

Across the United States there has been a growing and heightened interest among health departments, hospitals and diverse government and community organizations in collective approaches to assessing the health needs and assets of their communities and developing and implementing community-wide health improvement plans and actions. Intersectoral community-led approaches to health planning and improvement hold the potential to reduce health disparities within communities, increase efficient use and delivery of resources and services, and enhance collaboration, partnerships and community involvement and action around health promotion, among multiple additional benefits that include enhanced health-promoting environment and individual health behavior (e.g., Hawkins et al., 2012; O'Mara et al., 2013; Flood et al., 2015; Welsh et al., 2016). With recent accreditation requirements for health departments (e.g., Public Health Accreditation Board, 2013) and federally-funded hospitals (IRS, 2013) to conduct a community health assessment (CHA and CHNA) and develop a community health improvement plan (CHIP), as well as a growing body of resources (NACCHO, 2016) for conducting a CHA/CHIP, there is increasing motivation and support for communities to engage in a collective assessment and planning process to improve the health of their residents and neighbors.

In 2011, a coalition of community organizations and leaders launched the Austin/Travis County (ATC) CHA/CHIP, entitled "Together We Thrive", a community health assessment and planning process aimed at identifying and prioritizing key health needs of residents in Austin and the broader Travis County and developing and implementing a three-year community-wide health improvement plan. In assessing the process, progress and accomplishments of this first cycle of the ATC CHA/CHIP (2011-2016), researchers at the University of Texas Health Science Center School of Public Health-Austin Regional Campus were contracted by the Austin/Travis County Health and Human Services to conduct a stakeholder process and outcome evaluation of the CHA/CHIP initiative.

This report presents the findings from the evaluation, which took place between March and September of 2016. The overarching aim of the evaluation was *to provide a vehicle for community and organizational stakeholders to identify key highlights, accomplishments and lessons learned of the first cycle of the Austin/Travis County CHA/CHIP* and *to provide recommendations to enhance the next CHA/CHIP cycle,* which will begin in 2017. The report is organized by the following sections:

- Intended Use & Users of the Evaluation
- Summary Description of the Austin/Travis County CHA/CHIP
- Evaluation Overview (Evaluation Aims & Questions and Approach)
- Methods
- Synthesis of Key Findings
- Findings by Evaluation Method
- Discussion and Recommendations
- Dissemination & Sharing of Evaluation

Intended Use & Users of the Evaluation

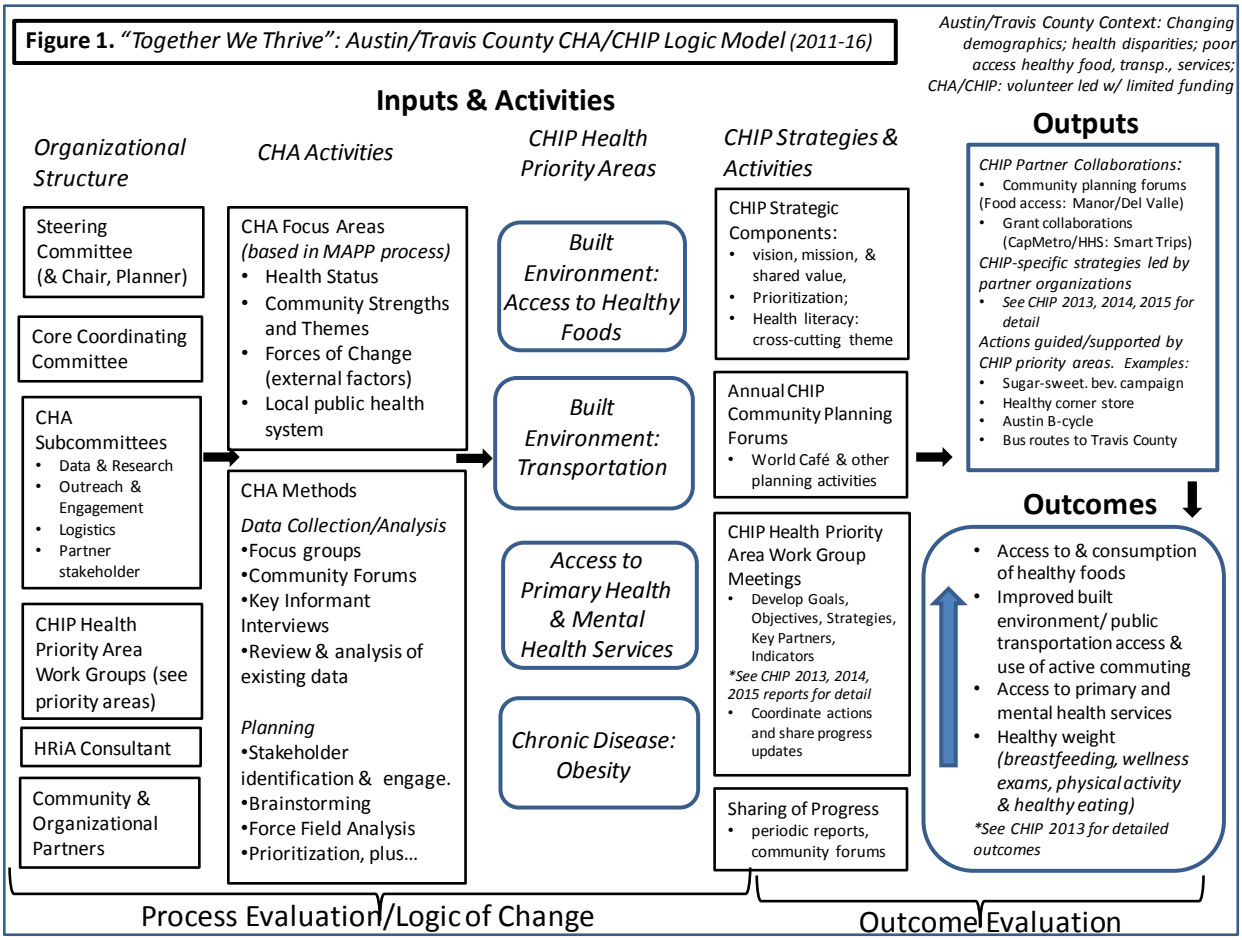
In addition to providing an assessment of highlights and lessons learned of the CHA/CHIP for the broader ATC community, we intend the findings and recommendations from this evaluation report to inform the planning process and approach for the next CHA/CHIP cycle. The intended audiences for the evaluation are those individuals and committees charged with guiding, planning, and implementing the ATC CHA/CHIP implementation, including:

- ATC CHA/CHIP Chair
- ATC CHA/CHIP Steering Committee
- ATC Core Coordinating Committee
- ATC CHA Committees
- ATC CHIP Work Group leads and members
- ATC Health & Human Services
- ATC CHA/CHIP Planner

Beyond these key individuals and groups, we hope findings from this evaluation will contribute to ongoing co-learning with the broader CHA/CHIP practitioner community by providing a constructive reflection around the benefits, challenges, and recommendations for improvement with community-wide health assessment and planning processes.

Summary Description of the Austin/Travis County CHA/CHIP

Efforts to develop the ATC CHA/CHIP began in 2011, when the Austin/Travis County Health and Human Services (ATCHHS) began preparing to meet the comprehensive objectives and standards outlined by the Public Health Accreditation Board (PHAB). Under the leadership of Mr. Carlos Rivera (Director, ATCHHS), Mr. Shannon Jones (Deputy Director, ATCHHS), and Dr. Philip Huang (Health Authority, ATCHHS), a group of health, social service, nonprofit and other community organizations and leaders were convened to develop and spearhead a community health assessment and community health improvement planning process for the City of Austin and the broader Travis County. Figure 1 presents a logic model overview of the ATC CHA/CHIP initiative, followed by a summary of its key elements. This logic model presents the organizational structure, key activities carried out during the CHA, the CHIP health priority areas and key activities carried out during the CHIP, example outputs resulting from the CHIP plan, and key environmental and health outcomes.



The primary organizational structure of this first CHA/CHIP included a 12-person steering committee chaired by Mr. Shannon Jones (ATCHHS), an inter-organizational core coordinating committee, specific CHA subcommittees, and four CHIP priority health work groups comprised of community and organizational stakeholders (for detailed description of the CHA/CHIP, see ATC

2012/13). Strategic partner organizations who co-led the initiative with Austin/Travis County HHS and served on the steering committee included: *Austin/Travis County Integral Care, CapMetro, Central Health, St. David's Foundation, Seton Healthcare Family, Travis County Health and Human Services and Veteran Service, The University of Texas Health Science Center at Houston (UTHealth) School of Public Health in Austin,* and beginning October 2015, *the Austin Transportation Department.* In addition, Health Resources in Action (HRiA) served as a key consultant for the ATC CHA/CHIP, which included providing facilitation of the community planning workshops and guidance with the overall implementation of the CHA/CHIP. Other valuable partners included One Voice Central Texas, who provided input and support with community outreach for the community forums and focus groups that took place during the CHA, the Community Advancement Network (CAN) who provided instrumental support with access to healthy foods forums during the CHIP, and City of Austin Planning and Review Department and Imagine Austin, who provided review and input for the CHA and CHIP. For a complete list of partner organizations, see ATC CHA/CHIP 2012/13 and CHIP updates from 2014 and 2015 (ATC, 2016).

The initial **Community Health Assessment (CHA)** took place between August 2011 and June 2012. Key objectives of the CHA were to: a.) examine the current health status across Austin/Travis County as compared to state and national indicators; b.) explore the current health concerns among Austin/Travis County residents within the social context of their communities; and c.) identify community strengths, resources, forces of change, and gaps in services to inform funding and programming priorities of Austin/Travis County (ATC CHA/CHIP, 2012/13). The CHA was guided by the *Mobilizing for Action through Planning and Partnerships* (MAPP) process, a collaborative and community-driven strategic planning process for improving health that has been used by local public health departments across the U.S. (MAPP, 2016). MAPP comprises six phases, which include specific activities within each phase: 1.) Organize for Success and Partnership; 2.) Visioning; 3.) Four Assessments (Community Themes and Strengths; Local Public Health System; Community Health Status; the Forces of Change (e.g., external factors that affect health); 4.) Identify Strategic Issues; 5.) Formulate Goals & Strategies; and 6.) Action Cycle (Planning, Implementation and Evaluation).

In addition to key leadership roles of the Steering Committee (oversight of process) and the Core Coordinating Committee (overall steward of process), the CHA organizational structure also included a *Data and Research Subcommittee* charged with identifying, gathering and analyzing key health and human service indicators, and the *Outreach and Engagement Subcommittee*, who partnered with One Voice, a network representing 54 health and human services organizations, to help provide outreach and recruitment for qualitative data collection activities. Community assessment methods included: a series of community forums and focus groups to learn about residents' perceived health needs, community, and assessment of programming, services and initiatives needs to address concerns; key informant interviews with leaders from health and community-based organizations; and review and abstracting of existing health statistics and other literature to document health needs. Over 300 individuals from multi-sector organizations, community stakeholders, and residents participated in the CHA assessment (ATC CHA/CHIP, 2012/13).

Findings from the CHA informed the development of the ATC **Community Health Improvement Plan (CHIP)**, which took place between July 2012 and November 2012, with a draft report published

alongside the CHA in December 2012, and the final CHIP report published in June 2013. The aims of the CHIP were to "…determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across Austin/Travis County" (ATC CHA/CHIP, 2012/13). In addition to these aims, implementation of both the CHA and CHIP fulfill current health department accreditation requirements, as noted in the CHA/CHIP reports.

As with the CHA, the MAPP community planning process also guided the development and implementation of the CHIP via a range of participatory planning methods, which included activities related to MAPP phases 5 and 6 as described above. In developing the CHIP, Steering Committee members, Core Coordinating Committee members, leaders from City of Austin Planning and Development Review Department, One Voice leaders, and other community leaders were convened in July 2012 to review findings from the CHA and to select priority areas using a participatory process. The resulting CHIP was organized by four health priority areas and led by four corresponding work groups:

- Built Environment Focus on Access to Healthy Foods
- Built Environment Focus on Transportation
- Access to Primary Care and Mental/Behavioral Health Services
- Chronic Disease Focus on Obesity

In addition to selecting priority areas, a range of participatory planning and reporting meetings took place over the 3-year period to develop and implement the CHIP. In 2012, the Steering and Core Coordinating committees engaged in planning meetings to develop the name, vision and mission of the CHIP, resulting in "Together We Thrive", with a vision of "Healthy People are the Foundation of our Thriving Community" and a mission of "Our community – individuals and organizations (public, private, non-profit) – works together to create a healthy and sustainable Austin/Travis County." In addition, the Core Planning Group held five, 3-hour planning meetings between July and October of 2012 to develop the CHIP Implementation Plan. The template for the Implementation Plan was adapted from the Wisconsin CHIP Infrastructure Project and modified for the ATC CHIP (ATC CHA/CHIP, 2012/12). The resulting template included specification of goals, objectives, strategies, key partners, and output/outcome indicators, which was developed by each work group. Subsequent to the initial planning year, an annual planning summit with work group and other community stakeholders was held in 2013, 2014, 2015 and 2016 to review and update objectives and strategies and to report on progress. In addition, individual work group meetings were held, with frequency of meetings determined by each work group. For a complete list of ATC CHIP documents and resources, see ATC Community Health Planning Resources webpage (2016).

Evaluation Overview

Aims & Questions

The overarching aim of the evaluation of this first cycle of the Austin/Travis County CHA/CHIP was to engage community stakeholders in a co-learning process to evaluate the process and outcomes of the 5-year initiative, with a focus on identifying highlights and accomplishments, lessons learned, and recommendations for CHA/CHIP enhancement. Specific aims of the evaluation and related evaluation questions are described below:

1) Evaluate the process for implementing the CHA/CHIP.

   Key Evaluation Questions

   - What were the aspects of the CHA/CHIP approach and process of implementation that worked well? What were the aspects that need to be improved?
   - Who were the key stakeholders who were not represented (but should have been)?

2) Assess progress with changes in key health indicators identified for each of the four priority health areas: *Chronic Disease Focus on Obesity, Built Environment Focus on Access to Healthy Foods, Built Environment Focus on Transportation, Access to Primary Care and Mental/Behavioral Health Services: Focus on Navigating the Healthcare System*.

   Evaluation Question

   - What progress was made in key indicators identified for each CHIP objective?

3) Identify additional achievements, highlights, and lessons learned from Cycle I and provide recommendations for enhancing CHA/CHIP Cycle II.

   Evaluation Questions

   - What were the key achievements of Cycle I as defined by CHA/CHIP stakeholders?
   - What were the key lessons learned from cycle I and recommendations from stakeholders for enhancing cycle II?

Approach

The evaluation was guided by the *CDC Framework for Program Evaluation (CFPE)*, an internationally recognized and widely used evaluation framework by public health evaluators (CDC, 2015). The Framework consists of six core steps: 1.) Engage stakeholders, 2.) Describe the program, 3.) Focus the evaluation design, 4.) Gather credible evidence, 5.) Justify conclusions, and 6.) Ensure use and share lessons learned (CDC 1999; Millstein et al., 2000). Steps 1, 3, 4 and 6 represent the key focus areas for the evaluation phase of the MAPP process (MAPP, 2016). In Figure 2, we present an overview of our evaluation approach in relation to the CFPE steps.

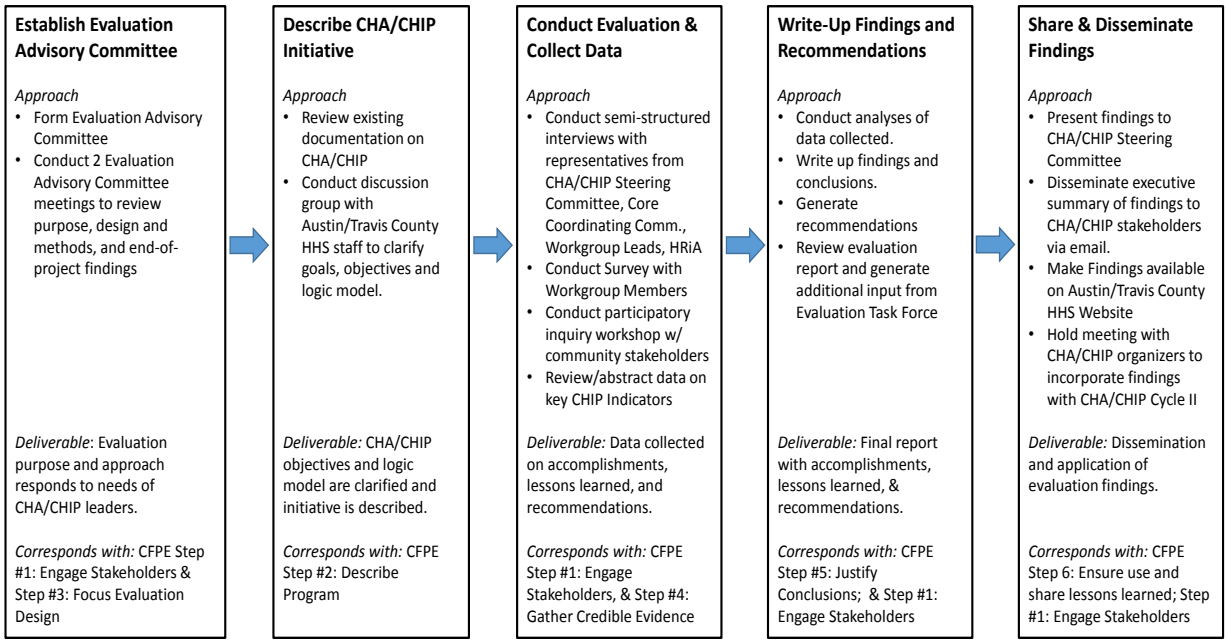


Figure 2. Flow Chart of Evaluation Activities, Approach, and Deliverables. *Evaluation of Austin/Travis County CHA/CHIP Cycle I , March-September 2016*

In following the CFPE and in recognition of the importance of stakeholder engagement, an initial step of our evaluation approach was to gather input on best approaches for focusing the evaluation aims and developing and implementing the evaluation. In doing so, we first gathered input for the evaluation from other CHA/CHIP leaders outside of Austin/Travis County as well as conducted a preliminary review of CHA/CHIP evaluations based on an internet search. We concurrently formed an advisory committee comprised of ATC CHA/CHIP stakeholders and community leaders in order to provide input on the evaluation aims and overall approach, and then also sought feedback from the CHA/CHIP Steering Committee. Below we provide a summary of these initial efforts aimed at informing and guiding our evaluation approach.

Initial Inquiry with CHA/CHIP Practitioners and Review of CHA/CHIP Evaluations: In initiating the CHA/CHIP evaluation, we contacted counties in and outside the state of Texas with completed CHA/CHIPs in order to identify best practices and recommendations around the evaluation process. Four questions were directed to the city/county health officials from Harris County, Bexar County, Maricopa County, and Norwalk, CT: framework used for their CHA/CHIP; if they had done an evaluation and, if so,

how; most important thing that came out of evaluation efforts; and, what they would do differently next time. According to interviewees, most work has been done around process evaluation, as outcome evaluation poses difficulty due to measuring changes and directly attributing those changes to the CHIP. One county had no evaluation in place; another provided a 2-page report to stakeholders reporting on two goals. All community health officials interviewed indicated a desire for sharing evaluation techniques. Two practices that came out of the discussions with counties that completed an evaluation included a collaborative monitoring system and engaged community stakeholders. Having a collaborative data monitoring system/online dashboard proved helpful in disseminating information as advancement of projects can be seen by anyone at any time. Stakeholders are encouraged to upload their own progress providing a snapshot of public health work being conducted in the community as it relates to CHA priorities. It was acknowledged that having a strong and collaborative community of stakeholders is critical to both the outcomes and a continuation of CHA/CHIP. In answering, "*What would you do differently next time?"* the following were noted:

- Institute metrics from the beginning
- Track process and progress from the beginning
- Shift from planning to implementation
- Develop ways to collect information better (shared database)

Evaluation Advisory Committee: With the aim of gathering input and guidance on the proposed evaluation approach, we also convened a group of seven community leaders representing foundations, academia, community-based organization, health care services and the Austin and Travis county health departments that included Andrea Guerra (Central Health), Ellie Haggerty (St. David's Foundation), Miyong Kim (UT School of Nursing), Courtney Lucas (Travis County Health and Human Services & Veteran Services), Marva Overton (Alliance for African American Health), and from Austin/Travis County HHS, Cassie DeLeon and Hailey Hale. The group met on April 7, 2016 and during the last phase of the evaluation, on September 14, 2016. At the first meeting, we reviewed the overall aims and approach of the evaluation and engaged the committee in a discussion to provide recommendations on our approach. Key insights from the Evaluation Advisory Committee focused on the importance of stakeholder input, and this led us to broaden our data collection approaches to incorporate both a community resident participatory evaluation workshop as well as a community resident online survey (see details below). In September, we reviewed initial findings from the evaluation with four of the seven initial members who were able to attend the session. We received valuable input from the Evaluation Advisory Committee on how to best present the findings, including a reflection on the importance of underscoring communication, both internally and externally, as a key theme from the findings and for the recommendations for CHA/CHIP Cycle II efforts (see findings below), as well as the recommendation to meet with Core Coordinating Committee and the CHA/CHIP planner to begin developing an actionable plan for addressing key recommendations.

Preliminary Input from the Austin/Travis County CHA/CHIP Steering Committee: In providing a space for exchange and input about the evaluation, our team met with the CHA/CHIP Steering Committee to present an overview of the CHA/CHIP evaluation plan on May 2, 2016 during a regularly scheduled steering committee meeting. At the end of our overview presentation, we elicited input from steering committee members on the overall evaluation approach. Key discussion points of interest for members included: the importance of assessing the strategy of development of CHIP; interest in exploring if CHIP is filling a unique space, or if it is duplicating efforts; and interest in understanding how the CHA-CHIP evaluation may inform the emerging role of the Dell Medical School. With regard to the CHA/CHIP process, one member posed the question of whether there should be more communication between work groups, including a focus on asking questions between work groups and developing priorities together. An important highlight of the CHA/CHIP noted by one member was the marriage of transportation and health; this member also emphasized that there are more opportunities to bring organizations that do not traditionally have a focus on health into the health realm through the CHA/CHIP.

Methods

Overview

The primary design of the evaluation of the Austin/Travis County CHA/CHIP was based on a stakeholder evaluation posttest only design, which focused on gathering insights about the process and impact of the ATC CHA/CHIP from program stakeholders at the end of this first cycle of CHA/CHIP in 2016. In addition, a basic pre/post design was used, to the extent possible, to assess progress of the four CHIP priority areas based on assessment of program indicators identified by four CHIP priority area work groups, using existing data. In conducting the evaluation, a mixed methods approach was employed that included: *semi-structured interviews and focus group discussion with CHA/CHIP organizational stakeholders, two online surveys with organizational stakeholders and community stakeholders, two participatory evaluation sessions with organizational stakeholders and community stakeholders,* and a *review of CHIP Implementation Plan indicators tables to document progress with the four priority health areas.* Measures for the evaluation were created for each evaluation method, based on review of previous instruments, and were primarily based on closed ended and open ended questions as well as participatory learning action-type activities. Table 1 provides a summary of the evaluation methods, measure and participants, followed by a brief description of each of the evaluation measures and data collection procedures.

Table 1. Summary of Methods, Measures and Sample, *Evaluation of Austin/Travis County CHA/CHIP,* March-September, 2016.

Method	Topics Explored	Measure (Time)	Sample
CHA/CHIP Leader Interview	CHA & CHIP: highlights/ accomplishments, lessons learned, recommendations	9 item interview schedule (~40 minutes)	n=23 interviews (total) *n=10 steering comm; n=10 organizers & workgroup lead; n=3 community org.*
Core Coordinating Committee Focus Group Discussion		8 item focus group guide (1.5 hrs.)	n=5 leaders/5 organizations
CHA/CHIP Organizational Stakeholder Survey		34 item online, self-administered survey (~20 minutes)	n=83/166 attendees at CHA/CHIP events
Participatory Evaluation: *CHIP Work Groups*	CHIP highlights, challenges/lessons learned & recommendations	La Ventana participatory inquiry activity (~50 minutes)	n=26 participants
Participatory Evaluation: *Community stakeholders*	CHIP Topic Areas: perceived progress & gaps	Participatory Learning Round Robin (~50 minutes)	n=37 participants
CHA/CHIP "Community Stakeholder" Survey	CHA & CHIP progress, gaps & perceived needs	15 item online, self-administered survey	n=65 participants (based on roster of community stakeholders who attended one or more health forums)
Data Review & Abstracting	Progress of 4 priority health areas	Tracking Table	*Based on existing data for Austin/Travis County

Measures, Procedures and Sample

1.) *CHA/CHIP Leader Interview.* The CHA/CHIP Leader Interview was based on a 9 item, semi-structured interview schedule that aimed to identify highlights, lessons learned, and recommendations for enhancing the process and outcomes of the ATC CHA/CHIP (see Appendix A, *CHA/CHIP Steering Committee Member and Leader Interview Schedule*). The interviews were conducted between June and September of 2016 with ATC Steering Committee members, CHA/CHIP organizers, CHA/CHIP work group leaders, key organizational partners from community-based organizations, and consultants involved in developing and implementing the CHA and CHIP. The CHA/CHIP Leader Interview was conducted by members of the evaluation team primarily by phone. Interviews took approximately 30 to 40 minutes and were digitally recorded and then transcribed.

2.) *CHA/CHIP Core Coordinating Committee Focus Group.* A focus group guide comprised of 8 open-ended questions (Appendix B) was developed to collect insights about highlights and accomplishments, lessons learned, and recommendations for the CHA/CHIP from the Core Coordinating Committee, a committee charged with planning and organizing actions for the CHA/CHIP. The focus group was conducted by three members of the evaluation team with 5 of 7 of the Core Coordinating Committee on May 4, 2016 at Central Health. The focus group lasted approximately one and a half hours and was digitally recorded. The recording was later transcribed, and key themes were identified by two Evaluation Team members.

3.) *CHA/CHIP Organizational Stakeholder Survey.* This self-administered online survey comprised 34 closed and open-ended items related to participation in CHA and CHIP activities, perceptions of the CHA/CHIP process, perceptions of the CHIP priorities, and recommendations for CHA/CHIP cycle II (see Appendix C, CHA/CHIP Organizational Stakeholder Survey). Items were created for the purpose of the CHA/CHIP evaluation and were informed in part by a CHA/CHIP process evaluation survey used in Norwalk County, California, and posted as a resource on the National Association for County & City Health Officials CHA/CHIP Resource Center (Norwalk County Process Evaluation Survey, 2011). The survey was administered to individuals who had attended one or more ATC CHA or CHIP community forums and/or work group meetings. Email addresses for these individuals were obtained from CHA/CHIP Coordinator, who had compiled a total of 209 names and email addresses of CHA/CHIP activity participants between 2011 and 16. As an incentive for participation in the survey, participants were invited to enter a drawing of 4 $25 gift cards, which were delivered at the end of the project. The survey was delivered online via Qualtrics during the months of July and August 2016, with two follow-up reminders sent during this timeframe.

4.) *CHA/CHIP Community Stakeholder Survey*: In addition to the organizational stakeholder survey described above, we also developed and administered an online survey with community stakeholders with the aim of eliciting input on perceptions related to progress and gaps with the four priority health areas (Appendix D). The survey items were created for the purpose of the evaluation and included 11 closed and open-ended questions related to perceptions of current importance of the four priority areas (which were further detailed into 7 topic areas: access to primary care services, access to mental

/behavioral health services, access to public transportation, access to bikeways (bike lanes and trails), access to sidewalks and walking paths, and obesity), in addition to 4 demographic items. Community stakeholders included those community residents, leaders and other community organizational stakeholders who attended one or more community health forum or events sponsored by the Austin/Travis County HHS but who were not directly involved with one of the CHA/CHIP work groups or planning groups. This list was obtained from Austin/Travis County HHS and included a total of 408 names and emails. Similar to the organizational stakeholder survey, participants were invited to enter a drawing of 4 $25 gift cards, delivered at the end of the project. The survey was administered online via Qualtrics during the month of September 2016, with one follow-up reminder sent during this timeframe.

5.) *Participatory Evaluation Workshops:* Two participatory evaluation workshop sessions were held during the course of the evaluation: one with CHIP work group and organizational stakeholders, held on June 6, 2015 at the Zilker Botanical Gardens in Austin, and one with community residents and community stakeholders, held on August 25, 2016 at El Buen Samaritano. Participatory evaluation falls under the broader umbrella approach of *Participatory Learning & Action* (PLA) (Thomas, 2016), which incorporates a variety of community inquiry methods and approaches that include Participatory Rural Appraisal (Chambers, 1997) and Participatory Action Research (Chevalier & Buckles, 2013). PLA methods are rooted in *participatory visual methodologies* (Mitchell & Sommer, 2016) and include the application of group-based, participatory and visual methods of inquiry, a process of collective analysis, the embracing of multiple perspectives, and the importance of local knowledge and action (Thomas, 2016). Below we describe the two workshops.

Participatory Evaluation: CHIP Stakeholders: The first workshop with CHIP organizational stakeholders provided a venue for participants to generate *key accomplishments, highlights and lessons learned of the Austin/Travis County CHA/CHIP Cycle I*, as well as *recommendations for enhancement and proposed vision* for the upcoming CHA/CHIP Cycle II. This workshop was held as part of a larger CHA/CHIP "Wrap-Up Summit". The primary evaluation method was based on a participatory inquiry activity called "La Ventana" (also known as "El Escudo" and "Johari's Window") in which CHA/CHIP organizational stakeholders, representing government, nonprofit, and other community organization groups, created a "window" into their work group processes and outcomes. Specifically, stakeholders identified CHIP highlights and accomplishments (Pane 1), lessons learned (Pane 2), recommendations for improvement of process (Pane 3), and vision for Cycle II (Pane 4) (Figure 3). In conducting La Ventana, stakeholders were divided into their four CHA/CHIP assigned work groups (*Chronic Disease Focus on Obesity, Built Environment Focus on Access to Healthy Foods, Built Environment Focus on Transportation, and Access to Primary Care and Mental/Behavioral Health Services).* The activity then consisted of having each member of the work group write key themes or ideas on sticky notes related to each 'window pane', sharing in a round robin fashion around each pane

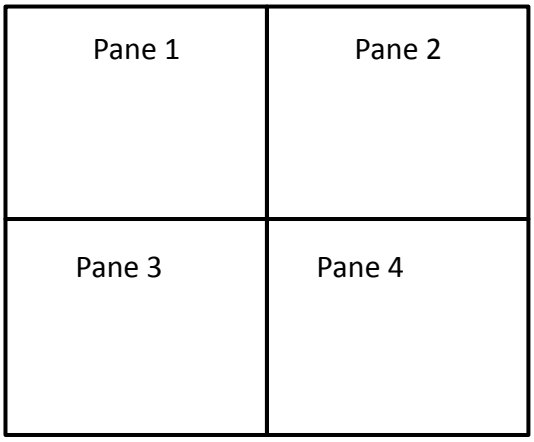


Figure 3. *La Ventana*

'domain', and then sticking their ideas on the pane. Once the ideas were presented in the panes, the small groups undertook a process of chunking similar themes, and then writing out the main themes for a given domain/pane. At the end of the *La Ventana* activity, groups were instructed to hang their *ventana* in the shared meeting area, and then to conduct a 'gallery walk' exercise in which all workshop members had the opportunity to view each other's *ventanas*, express their 'likes' using 'dotmacracy' (sticking dots to the ideas they liked), and write additional thoughts or questions next to the *ventanas*. Each small group was assigned a facilitator to guide the process. Six facilitators from the UT School of Public Health evaluation team and three interns working with the Austin/Travis County HHS, who served primarily as recorders, participated in a ~40 minute training prior to the activity to review the facilitator guide and prepare for the activity (see Appendix E: *Facilitator Guide*).

Priority Area 1		
Yes, very much a problem	Somewhat a problem	Not a problem
Round 1		
Round 2		
Round 3		
Round 4		

Figure 4: Priority Ranking

Participatory Evaluation: Community Stakeholders: The participatory evaluation workshop with community residents and stakeholders that serve the community was held as part of a larger CHA/CHIP "Community Forum", which took place between 6-8 pm. The primary evaluation method was based on a participatory inquiry activity that involved a small group Round Robin participatory reflection approach in which participants were separated into 5 groups, one for each of the 4 CHIP priority areas and one for Spanish speaking participants that included all 4 areas. Facilitators rotated between the groups for 10 minute sessions so that each group had the opportunity to discuss each priority area of the CHIP; the Spanish group facilitators remained with the same group but switched topics each round so that they discussed each priority area (see Appendix F: *Protocol*).

Facilitators initiated each round with a brief activity to determine if the group members thought the topic was still a priority problem in their community. Each facilitator had a flip-chart paper in which group members were asked to place a sticky dot or tally mark in one of the three categories: *yes very much a problem, somewhat a problem,* and *not a problem* (Figure 4).

After the first priority ranking activity, facilitators led participants in generating both progress and ongoing challenges with a given priority area, using a sticky note

Progress: *What actions/ progress have you seen in your community to address this topic?*	**Challenges:** *What are the gaps? What still needs to happen to address this issue?*

Figure 5. Progress and Challenges with Priority Areas

format to first individually generate themes and stick on flipchart paper, and then a discussion to explore themes (Figure 5).

6). *CHIP Outcome Indicator Review.* In evaluating progress with reaching CHIP goals and objectives, we reviewed CHIP Implementation Plan "Goals, Objective, Strategies, Key Partners, and Output/Outcome" tables that were developed by each of the four CHIP workgroups. In conducting the review, we developed a data abstraction table for each priority area to identify, review, and document prevalence and incidence of the key health indicators identified in the CHIP (see Appendix G). While caution is needed in assessing causality of the CHIP with specific outcomes given that the CHIP was not designed as an intervention to be evaluated using rigorous evaluation designs, an assessment of the CHIP Implementation Plan "indicator tables" holds potential to further document trends for specific health issues while also identifying process-related aspects of CHIP implementation with regard to strengths and challenges with the approach used.

Analysis

Data were analyzed using both qualitative and quantitative analytic methods. Qualitative data (interview, focus group, participatory evaluation) were analyzed using content analysis (Zhang & Wildemuth, 2009) in which key themes were coded based on both a deductive (driven by the interview schedule or participatory evaluation activity) and inductive (allowing emergence of new themes) approach. Participatory evaluation data were coded by hand; transcripts of the interview data were uploaded, coded, and analyzed using NVivo qualitative data analysis software (QSR International Pty Ltd. Version 10, 2012). The coding process included a primary and secondary coder. Quantitative analysis for the online surveys and assessment of progress with CHIP indicators was based on descriptive statistics (frequencies, percentages) using Stata (College Station, TX) and IBM SPSS (Chicago, IL).

Protection of Human Subjects

No individual names were collected as part of the evaluation, and participation in the evaluation was completely voluntary. All evaluation study protocols and consent procedures were reviewed and approved by the UTHealth School of Public Health Committee for the Protection of Human Subjects based in Houston, Texas [#HSC-SPH-15-0972].

Findings

In the following section we present a synthesis of key themes and findings that emerged from across our four primary evaluation methods of this first cycle of the Austin/Travis County CHA/CHIP (semi-structured interviews, surveys, participatory evaluation, and review and abstracting of data), followed by a more detailed reporting of findings by the specific evaluation method and stakeholder group. Evaluation findings are generally organized by highlights and accomplishments and lessons learned for both the CHA and CHIP processes.

Synthesis of Key Themes and Findings

The following synthesis of key themes and findings is based on a review of findings from across our four primary evaluation methods of the first cycle of the ATC CHA/CHIP. As a measure of triangulation of key themes, we present in Appendix H key themes and findings that were noted across evaluation methods and stakeholder groups (e.g., Steering Committee, Core Coordinating Committee, CHIP Organizational Stakeholders, and Community Stakeholders). While triangulation is an important measure of the importance of a given theme, the lack of triangulation of some themes may be a function of the specific questions that were asked via a given method (e.g., Participatory Evaluation with CHIP Organizational Stakeholders focused more on facets of CHIP vs. CHA). Furthermore, in following best practices in qualitative research, we do not exclude themes if they emerged via only one method as more diverse and innovative themes may hold specific relevance for advancing our collective understanding and approach with the CHA/CHIP.

1. Purpose of ATC CHA/CHIP "Together We Thrive" Initiative

In furthering our collective vision of the CHA/CHIP, we specifically asked CHA/CHIP Leaders, including Steering Committee members, Work Group leads, and other community leaders to share their understanding of the purpose and aims of the ATC CHA/CHIP initiative. In addition, themes about the purpose of the CHA/CHIP emerged from open-ended questions on the CHA/CHIP Organizational Stakeholder Survey.

Box A presents the primary purposes and aims that stakeholders identified for the ATC CHA/CHIP, with the most cited responses related to "assess the health needs of the community and create a plan to address those needs" and "Help health organizations (health departments and hospitals) meet accreditation standards as required by the Public Health Accreditation Board and the ACA". Importantly, stakeholders also noted increasing efficiency and use of resources and improving health outcomes in an equitable fashion as key aims.

Box A. *Purpose and aims of Austin/Travis County CHA/CHIP identified by stakeholders*

1. Assess the health needs of the community and create and implement a plan to address those needs
2. Help health organizations in central Texas (health departments and hospitals) meet accreditation standards
3. Increase efficiency and use of resources/align resources toward priorities
4. Improve health outcomes in an equitable fashion/address health disparities within our community

Challenges and opportunities with CHA/CHIP purpose: While there was general consensus about the purpose of the ATC CHA/CHIP, stakeholders from across our evaluation methods noted the need for further clarity and communication about the purpose and identity of the ATC CHA/CHIP to organizational stakeholders and the broader community. Three additional themes that emerged that should be further explored by ATC CHA/CHIP leaders regarding the CHA/CHIP purpose were:

- "Aspirational vision"/"North Star"/Guiding resource: Some stakeholders cited the importance of creating a more aspirational vision for the CHA/CHIP that can help to rally efforts and actions to specifically address a given health problem. Others noted the need to continue to explore how the ATC CHA/CHIP can be seen as the "North Star" and guiding resource for health for the ATC community.
- "Reporting mechanism vs. Catalyst/inspiration for action": Several stakeholders noted that the CHIP process seemed more focused at times on reporting what is already going on in the community versus serving as a catalyst for new action. How can the CHA/CHIP serve both needs?
- Creating space to define purpose: Some stakeholder suggested the need to create opportunities for CHA/CHIP stakeholders to help define the purpose of the ATC CHA/CHIP.

> *"So, what is the opportunity for the CHNA [CHA/CHIP] for Travis County, from a visionary and aspirational and leadership standpoint? I think there is an opportunity to start creating a compass and … kind of North Star in our community… If we really want to use the CHNA in a way that could be aspirational not duplicative, to me that could be very exciting,…and if we do make that kind of a shift, it would probably be much fewer goals related to whatever that North Star is."*
>
> *–CHA/CHIP Leader*

Lastly, one aim not specifically cited by stakeholders but noted as an important outcome of the CHA/CHIP was that of 'mobilizing partnerships for community health promotion'. Furthermore, while health literacy was cited as a key cross-cutting theme for the CHIP (ATC CHA/CHIP 2013), this aim was not specifically cited as part of the purpose of the CHA/CHIP during stakeholder interviews. If these themes are key facets of the CHA/CHIP purpose, ATC CHA/CHIP leaders may consider further intentionality with stating and communicating 'mobilizing partnerships' as well and 'increasing health literacy' as part of the ATC CHA/CHIP aims.

2. General ATC CHA/CHIP Highlights & Accomplishments

While specific highlights and accomplishments for each CHA and CHIP phase are noted below, there were also key highlights and accomplishments that emerged for the overall ATC CHA/CHIP initiative, as noted by CHA/CHIP stakeholders. These highlights and accomplishments are presented in Box B.

> *"The biggest plus has been bringing together the community collaborators and new relationships."*
>
> *–CHA/CHIP Organizational Stakeholder*

Box B. *General ATC CHA/CHIP Highlights & Accomplishments*

1. Partnerships & Collaboration
   - Opportunities for partnerships, collaboration and networking
   - Establishment of strong partnerships to implement CHA/CHIP
   - Human & financial investment to CHA/CHIP by key lead organizations (including steering committee leadership by key organizations)
   - Alignment of resources
2. Organization-related Highlights
   - Setting up of a functional structure of CHA/CHIP
   - Securing of competitive funding from NACCHO to support CHA/CHIP
   - Co-learning process that included visit to San Antonio's CHA/CHIP and participatory learning and planning activities
   - Utilization of MAPP planning process
3. Development of a comprehensive community health assessment report and community health improvement plan
4. Guidance and support for new initiatives
   - Examples: Smart Trips public transportation grant, healthy food corner stores, sugar-sweetened beverage campaign.
5. Communication about ongoing initiatives and health-specific topics, including increased awareness about the important role of social determinants (e.g., transportation) in health.

3. General ATC CHA/CHIP Lessons Learned

In addition to cross-cutting highlights, there were also several key lessons learned for the overall initiative. Key lessons learned included the need for enhanced internal and external communication of the CHA/CHIP, the need to continue to foster stakeholder reach and engagement, organizational-related enhancements- with specific focus on how to strengthen the CHIP approach and reporting process, and a need to further heighten the ATC CHA/CHIP focus on health inequities and targeting efforts to those most in need (Box C).

"It's almost like they need a PR person to communicate out to the community, the greater community, the media and elected officials about what this is, why we're doing it, why it's important, all of that."

-CHA/CHIP Leader

Box C. *General Austin/Travis County CHA/CHIP Lessons Learned*

1. Enhance internal & external communication
   - Further clarify and communicate purpose of CHA/CHIP
   - Further clarify identity and 'brand'/ Develop CHA/CHIP "elevator speech"
   - Increase CHA/CHIP communication with*: broader ATC community, between Steering Committee & Core Coordinating Committee, among CHIP workgroups*
   - Enhance ability to easily identify workgroup members and organizations as well as profile/mission of organizations working with CHA/CHIP.
2. Expand reach and stakeholder involvement
   - Specific groups cited: "broader community", school districts, SHACs, Dell Medical School, business community/chambers of commerce, foundations, faith-based organizations, comm. orgs., policy makers;
   - Be intentional with activities during forums/events that foster group cohesiveness and inter-organization communication
3. Explore ways to strengthen organizational structure
   - Further define and clarify: leadership structure; roles, responsibilities & staffing needs of committees; structure of work groups (expected meeting times and structure, selection of CHIP workgroups leads)
   - Clarify roles and 'asks' of broader community in relation to the CHA/CHIP
   - Explore further a collective impact model approach
   - Incorporate evaluation from the beginning and throughout the process
   - Consider a CHA/CHIP timeframe that is more adaptable *(timeline is long and not very flexible).*
4. Enhance and fine-tune CHIP approach
   - "Go deeper": consider fewer priority areas/objectives/strategies
   - Make CHIP Goals/objectives/Indicators planning table more user-friendly
   - Coordinate CHIP with other city and county planning efforts
   - Streamline reporting mechanism for progress with CHIP priority areas
   - Consider funding/availability of funding when developing CHIP plan
   - Consider further stratification of CHIP (geography, age, ethnicity, SES)
5. Further focus on inequities and target efforts to those most in need.

4. ATC Community Health Assessment (CHA) Highlights & Accomplishments (2011-12)

Key highlights and accomplishments of the ATC CHA cited by stakeholders are presented in Box D. Despite important lessons learned with the CHA as noted in the following page, stakeholders were generally very positive about the progress and accomplishments of this first ATC CHA experience, which included the establishment of key community partnerships and organizational structure that helped develop, lead and implement the CHA and the publication of a comprehensive community health assessment report for the Austin/Travis County community. We should also note that Austin was one of a handful of sites selected from across the U.S. for a competitive NACCHO grant to support implementation of this first CHA/CHIP.

"I think just getting it done was a pretty big accomplishment. We did an awful lot of work in a pretty short period of time. It's a good, smart, diverse group [who] really came together and pulled something off that was pretty impressive I thought."

-CHA/CHIP Leader

Box D. *Austin/Travis County CHA Highlights & Accomplishments*

1. Establishment of community partnerships to conduct CHA
   - Community leaders from 12 health, academic, and government organizations led the steering committee, with three organizations providing initial funding for the initiative.
   - Involvement of over 300 individuals from multi-sector organizations, community stakeholders and residents in the CHA process.

2. Securing of competitive grant funding from NACCHO to support CHA/CHIP implementation

3. Development of CHA as a roadmap and resource to guide health action
   - Development of a comprehensive community health profile of Austin/Travis County
   - Elevation of discussion regarding changing demographics of Austin/Travis County and need to better allocate resources and services
   - Opportunity to both drive and secure funding via citation of health needs cited in the CHA

4. Strong organizational process and structure for CHA
   - Community and volunteer-led CHA work groups
   - Application of participatory planning and needs assessment methods guided by the Mobilizing for Action through Planning and Partnerships (MAPP) process
   - Active data analysis and community outreach committees
   - Implementation of 4 community forums, 14 focus groups, 28 community stakeholder interviews, and 25 key informant interviews with organizational leaders to gather community input on community health needs, strengths and opportunities

5. ATC Community Health Assessment (CHA) Lessons Learned

Key lessons learned with the Austin/Travis County CHA process as noted by CHA/CHIP stakeholders are presented in Box E. Among the key lessons learned, stakeholders noted the need to increase communication about how individuals and organizations can engage in and support the CHA as well as the need to strengthen how CHA leaders communicate with the broader community (need to be less "researchy" and more engaging according to one stakeholder). While collaboration with community organizations was noted as a highlight of the CHA-including work with One Voice- a coalition of organizations in Austin/Travis County, some stakeholders still noted the need to work more closely with community organizations who have direct contact with diverse community groups. Several suggestions of ways to enhance both the data collection and prioritization process of health needs/health focus areas were also shared, as presented in Box E.

"..[I]t would be an ideal opportunity to hear from people what they would like to see done, and also, what they would like to do. I mean, like to hear from people not just, "oh there's not really good food in my neighborhood," but to hear, "but I would like to grow more in a community garden," or...to capture that input from people in the neighborhoods...so that we can bolster that community ownership piece."
-CHA/CHIP Work Group leader

Box E. *Austin/Travis County CHA Lessons Learned*

1. Enhance external communication about the CHA
   - Identify and communicate opportunities for individuals and organizations to engage with the CHA
   - Design events tailored for community audiences

2. Increase community engagement and partnerships
   - Work collaboratively with organizations 'close to the community'
   - Increase engagement of diverse community members, and be intentional in identifying key subgroups to include

3. Continue to enhance data collection approaches.
   - Make CHA forums/focus groups convenient for participants (place, time)
   - Expand approaches for collecting community input (surveys?)
   - Enlist help of community leaders to help conduct focus groups
   - Provide child care
   - Conduct Spanish-speaking community forums (not translated)
   - Ask for solutions, not just problems (see quote)

4. Explore strengthening of prioritization process
   - Explore further who should be in the room to prioritize
   - Provide opportunities for broader community input into prioritization process
   - Review needs and resources for priority areas/strategies proposed
   - Focus on fewer priority areas and/or objectives/strategies
   - Emphasize further how CHIP addresses health disparities

6. ATC Community Health Improvement Plan (CHIP) Highlights & Accomplishments (2012-16)

We learned of several key highlights and accomplishments that were achieved with the ATC CHIP phase of the initiative as related to process and outputs (see Box F). As with the CHA, partnerships and collaborations among individuals and organizations were a key highlight of the work with the CHIP, which included actions and collaborations that were inspired by CHIP health priority areas and the partnerships developed between and among CHIP participants.

"I think it has been hugely beneficial to have CapMetro at the table during the CHIP because I feel like in the beginning in the CHA process and at the beginning of the CHIP, you know, really, very few people understood how important transportation was in the area of health care. A lot more people come to us and say, "hey, we're thinking about building this health care facility, will it be served by transit?"

-CHA/CHIP Steering Committee Member

Box F. *Austin/Travis County CHIP Highlights & Accomplishments*

1. Partnerships & Collaborations
   - Bringing together organizations who do not normally work together
   - Sustained attendance of core members and increased attendance of new members at CHIP summits over time
2. Increased communication and engagement with community stakeholders and CHIP work group members
3. Increased awareness of specific health issues, gaps in services and opportunities for actions (e.g., increased awareness of connection between built environment, transportation and health).
4. Increased resources and opportunities for health promotion action resulting from CHIP collaborations: *Examples include:*
   - Funding for positions: 1.) funding of CHA/CHIP planner; 2.) enlistment of partners to advocate for HHS funding/positions
   - Access to Healthy Foods community forum held with Manor and Del Valle in partnership with CHIP work group and CAN
   - Increased funding for healthy food retail (one-time funding from City & County); increased funding for Double Dollar incentive program
   - Vision Zero integration into CHIP and adopted by Austin City Council
   - City of Austin (Transportation Department) & CapMetro collaboration and securing of grant for Smart Trips
   - Sugar-sweetened beverage campaign (HHS)
   - Increase in mother-friendly worksites
   - Increased focus on access to health services & quality care
5. Perceived improvements in public transportation/built environment, healthy foods access and promotion, physical activity promotion, and health care services were noted by community stakeholders. In addition, improvements were documented for select CHIP indicators:
   - Decrease in BMI ≥30 among adults (23.6% in 2013 to 20.5% in 2014)
   - Slight decrease in food insecurity (18.1% in 2013 to 17.1% in 2015)
   - Increase in number of mother-friendly Travis County workplaces (2013: 61; 2014: 326)
   - Decrease in % Travis County adults reporting poor mental health days (21.7% in 2013 to 16.3% in 2014)

**Note: Several limitations were noted with CHIP Implementation Plan indicators (see p.81), including lack of available data to track indicators.*

7. ATC Community Health Improvement Plan (CHIP) Lessons Learned

In exploring lessons learned with the implementation of this first cycle of the ATC Community Health Improvement Plan, stakeholders provided constructive input related to three broad domains: *enhancing internal and external communication about the CHIP, enhancing community engagement,* and *fine-tuning the organizational structure and delivery of the CHIP* (Box G).

"I think with our community outreach we've just got to do a better job at really understanding how we're targeting each group. For the CHA, community outreach is much different than for the CHIP, and we need to get to a place where we're comfortable with what the outreach we're doing for the CHIP is and with what level of the community we're engaging and how we're engaging."

-CHA/CHIP Leader

Box G. *Austin/Travis County CHIP Lessons Learned*

1. Enhance internal and external communication about the CHIP
   - Enhance communication for prospective partners (purpose clarification, how to get involved and contribute, value proposition for participants)
   - Enhance communication about CHIP to broader community
   - Increase communication about progress and overall CHIP activities
   - Develop new and effective reporting system to track progress
2. Enhance community engagement
   - Clarify who are the different community stakeholders and how the CHIP should engage them
   - Increase engagement of diverse community members
   - Partner with community-based organizations to better reach community (school districts, community-based organizations, etc)
   - Provide instrumental support for community member participation (e.g., child care, translation)
   - Explore direct 'co-planning' of strategies with community-based organizations and community members
   - Explore how to make CHIP forums more relevant and engaging
   - Increase focus on building cohesion among CHIP participants & orgs.
   - Make connections unique to Austin (bike shops, local farming, music)
   - Consider fluidity of CHIP partnerships and turnover of members
3. Fine-tune organizational structure and delivery of CHIP
   - Explore fewer CHIP goals/strategies & indicators ("go deeper"), with attention to strategies that are 'important' (related to outcome) and "changeable" (how changeable the goal/strategy may be over time)
   - Explore "aspirational goals" and CHIP as "North Star"
   - Consider mixture of long and short-term goals
   - Lack of funding cited as limitation; consider in developing CHIP
   - Explore partners to implement CHIP/assess if 'right people at table'
   - Further coordinate actions across organizations and within organizations (& build CHIP into existing dept./government plans)
   - Coordinate with other research/planning entities (e.g. Dell Medical)
   - Strive to prioritize and limit the number of indicators
   - Consider development of a logic model for each priority area to spell out how strategies connect to the targeted outcomes/indicators
   - Confirm that indicators are measurable and specific
   - Develop tracking system to track outputs and progress
   - Consider selecting and prioritizing a select number of indicators and strategies that can be tracked and evaluated over time
   - Consider further clarification of the priority populations/settings and anchoring evaluation/data collection efforts to priority populations (see p.81: *CHIP Indicator Review* for further detail.)

8. Stakeholder Vision for ATC CHA/CHIP Cycle II (beginning 2017)

Lastly, we also explored stakeholders' visions for the development and implementation of the next cycle of the CHA/CHIP, which begins in 2017. Box H provides a synthesis of key themes that emerged during CHA/CHIP leader interviews and participatory evaluation with CHIP stakeholders.

Box H. *Austin/Travis County Stakeholder Vision for CHA/CHIP Cycle II (2017)*

1. *Aspirational Vision:* Some CHA/CHIP leaders underscored their interest in exploring how the CHA/CHIP can provide a specific aspirational vision and goal for the health of our community.
2. *Roadmap, Rallying Point and "North Star":* Stakeholders noted the importance of continuing to build the CHA/CHIP as the roadmap, rallying point and North Star that guides and coordinates our health actions in order to deliver a greater collective community health impact.
3. *Drives Action:* Stakeholders underscored their interest in furthering the CHA/CHIP's role as a catalyst for action to promote community health, in addition to serving as mechanism for communicating about ongoing health-related actions.
4. *Stronger and Broader Community Partnerships*: Stakeholders expressed interest in furthering efforts to build inclusion and involvement of diverse community groups as well as enhance network social cohesion for cycle II, including innovative approaches for engaging community members.
5. *Enhanced Internal & External Communication:* A shared interest among stakeholders was on continuing to strengthen internal communication among CHA/CHIP organizational stakeholders as well as external communication with the broader community.
6. *CHIP Priority Areas from Cycle I Continue in Cycle II.* Some stakeholders expressed interest in continuing the same priority areas (access to healthy foods, transportation, access to primary care and mental/behavioral health services, and obesity) for the next cycle.
7. *New CHIP Priority Areas for Cycle II.* Some stakeholders expressed interest in including new priority areas, including: *health literacy, tobacco, breastfeeding, critical health outcomes, diabetes, and affordable housing.*
8. *Enhanced CHIP Process:* A common theme among CHIP leaders and stakeholders for cycle II was the importance of enhancing the CHIP process, which may include:
    - fewer objectives or strategies, strengthened CHIP planning tool (consider funding, population specification, identification of strategic partners), building in evaluation, and easier reporting format to share and communicate progress
9. I*ncreased focus of CHIP on populations most in need*. While the CHA succeeded in documenting many health disparities within the central Texas community, several expressed the need to further underscore how the CHIP is specifically reaching those communities most in need.
10. *Development of a Unified Health Literacy Information Plan:* Stakeholders also expressed interest in further incorporating health literacy into the CHA/CHIP initiative, including development of a plan of action for health literacy promotion.
11. *CHA as an "Evergreen" Document:* Stakeholders shared a vision for having the community health assessment (CHA) become an evergreen document that has purposes beyond informing the CHIP and

Findings by Evaluation Method & Stakeholder Group

The following section presents specific findings organized by each evaluation method that was employed, which include:

- CHA/CHIP Leader Interview
- CHA/CHIP Core Coordinating Committee Focus Group
- CHA/CHIP Organizational Stakeholder Survey
- CHA/CHIP Community Stakeholder Survey
- Participatory Evaluation Workshop: CHIP Organizational Stakeholders
- Participatory Evaluation Workshop: Community Stakeholders
- CHIP Outcome Indicator Review (Data Review and Abstracting)

CHA/CHIP Leader Interview Findings *(Steering Committee, CHA/CHIP Planners, Work Group Leads, Community Leaders)*

Semi-structured interviews were conducted with 23 CHA/CHIP leaders who included: CHA/CHIP steering committee members (n=10), CHA/CHIP planners and work group leads (n=10), consulting agency leads who helped guide the CHA and CHIP (n=2), and community-based organization leaders who provided support with community engagement (n=1). In the following section, we present the key overarching themes that were explored in the interviews along with key subthemes that emerged from the discussion. These themes included: *the purpose and aims of the CHA/CHIP; communication of aims to stakeholders; perceptions of progress with meeting aims; CHA/CHIP highlights and accomplishments; CHA and CHIP lessons learned; CHA/CHIP organizational structure; reach and stakeholder involvement, community voice, and partnerships; and recommendations for enhancing CHA/CHIP Cycle II.*

Purpose and Aims of the CHA/CHIP

When asked about the purpose and aims of ATC CHA/CHIP, the two most common responses cited by CHA/CHIP leaders were to:

- Assess the health needs of the community and create and implement a plan to address those needs
- Help health organizations (health departments and hospitals) meet accreditation standards as required by the Public Health Accreditation Board and the Affordable Care Act

Other key aims cited included: *allowing stakeholders to work more efficiently and to better focus energy, efforts and resources toward collaborative goals to improve the health of the community*; and *helping to improve health outcomes in an equitable fashion.* Figure 6 presents a word cloud of key words cited in relation to CHA/CHIP.

Figure 6. Word cloud created using NVivo "Word Frequency Query" on the purpose and aims of the Austin/Travis County CHA/CHIP with CHA/CHIP Leaders.

In further exploring the purpose and aims of the CHA/CHIP, two subthemes emerged from the discussion related to "reporting vs. catalyzing action" and the importance of the CHA/CHIP as a "guiding resource". With regard to reporting vs. catalyzing action, some CHA/CHIP stakeholders indicated that

the CHIP, at times, felt more like a mechanism to report on actions that were already taking place instead of being a catalyst for new actions. When asked specifically about this issue, CHA/CHIP leaders expressed that the CHA/CHIP should serve to catalyze new action and initiatives to address the priority areas identified in the CHA. While some members recognized the challenges of the CHA/CHIP in terms of lack of a specific budget to support new actions, others advocated the importance of the CHA/CHIP to serve as a key community resource to guide action, to more efficiently coordinate and utilize existing resources (as stated in the theme above), and to serve as a resource to help our community better prepare to secure funding and resources. Lastly, one respondent emphasized the importance for the CHA/CHIP to provide an 'aspirational vision/goal' for promoting health in Austin/Travis County:

Communication of CHA/CHIP Aims to Stakeholders

When asked about communication of aims of the CHA/CHIP to stakeholders, respondents felt that communication of aims to *organizational stakeholders* was generally good, but that communication of aims to the *broader community could be improved*. There were also questions regarding what aspects of the CHA/CHIP should be communicated to the broader community. More clearly defining the different stakeholder groups, the goals for engaging each group, and key messages for different group could improve the next CHA/CHIP.

Perceptions of Progress with Meeting Aims

CHA/CHIP leaders were also asked about how well they feel the CHA/CHIP aims have been met. With regard to understanding the health needs of the community and creating a plan to address those needs, respondents felt that this aim was more difficult to assess, yet some progress has definitely been made. Regarding the CHA, for example, respondents felt that this aim was generally met and that the CHA represented a thorough community health assessment, which was an important accomplishment in and of itself. The consensus on the CHIP was that there has been progress on the priority areas identified, but it is difficult to fully attribute the progress to the CHIP. Some respondents also mentioned that the CHIP objectives that had funding made progress, but those without funding did not. With regard to the second most commonly cited aim related to accreditation, respondents noted that receipt of accreditation of the ATCHHS by the Public Health Accreditation Board (PHAB) clearly indicated achievement of this aim. Additional accomplishments cited:

- Increased collaboration among stakeholders
- Partnership building and sharing of resources
- Setting up a functional structure of the CHA/CHIP that can be used moving forward for the next cycle.

> *"I know one of the major outcomes and hopes for developing the process was accreditation for the health department, and I know we succeeded in that."*
> *–CHA/CHIP Leader*

CHA Highlights & Accomplishments

Several key highlights and accomplishments of the CHA were cited by CHA/CHIP leaders, which included:

- *Securing of funding from the National Association of County and City Health Officials (NACCHO).* Prior to conducting the CHA, the Austin/Travis County Health & Human Services Department (A/THHSD) allocated resources in the form of staff time to apply for a NACCHO demonstration grant to conduct a robust and comprehensive CHA Community Health Improvement Plan with local partner organizations. ATCHHSD received this competitive grant as the only site that had several core partners, which allowed for a small monetary support for conducting CHA activities and NACCHO technical assistance. ATCHHSD along with several of ATCHHSD core partners (Travis County HHS & VS, Central Health, St. David's Foundation, and Seton Healthcare Family) provided financial

and in-kind staff support which helped planning, assessment, and implementation efforts including the hiring of consultants, Health Resource in Action (HRiA), for data analysis, report writing, and qualitative data gathering. The support also helped purchase incentives for community engagement activities. During implementation of the CHIP, A/TCHHSD hired a temporary planner and eventually hired a full-time planner. Ongoing in-kind staff support from ATCHHSD and the core partners along with financial support from ATCHHSD and Travis County HHS & VS enable continued community engagement, implementation, monitoring, and evaluation of the CHA/CHIP.

- *Establishment of community partnerships to conduct CHA:* CHA/CHIP leaders cited the bringing together of a range of health, social service, and other community organizations in partnership to conduct the CHA was an important highlight of the initiative. CHA/CHIP leaders also tended to feel that the right professional stakeholders were at the table to conduct the CHA, and that they were able to engage other community organizational stakeholders who helped bring together diverse community groups via focus groups and community forums. According to the ATC CHA report (2012), over 300 individuals from *multi-sector organizations, community stakeholders, and residents* participated in various CHA data collection activities.

- *Focus on changing demographics and groups/areas of highest needs*: Several respondents also cited that the CHA helped to elevate the discussion regarding changing demographics in Austin/Travis County as well as the need to focus resources on geographic areas with the greatest need. The 'Forces of Change' activity within the CHA helped to highlight these external trends.

> *"The impact of social determinants of health were identified by the community…Obviously, I was aware that there were some factors, but to the degree that those factors kept coming up over and over again, it made it very clear to me that those built environment and other factors that impact social determinants of health were validated clearly by this CHA in this community." -CHA/CHIP Leader*

- *Publication of a Comprehensive Health Assessment for Austin/Travis County: An Important Resource to Guide Action and Funding*: Multiple CHA/CHIP leaders cited the development and publication of the CHA document itself. In addition to describing key health needs, strengths and resources, and social and external factors that affect health of the Austin/Travis County community, respondents noted the value of the CHA in terms of providing data for grant proposals and budget justifications, including requests to the Austin City Council.

CHA Lessons Learned

While CHA/CHIP leaders generally perceived the CHA as a success, some leaders recognized that this was the first time the CHA had been conducted, and that there was always room for improvement. Key lessons learned cited by CHA/CHIP leaders included:

- *Increase engagement of diverse community members.* Some CHA/CHIP leaders stated that there was a need to increase input on health needs and priorities from diverse community groups (ethnic, age, and geographic) who represent Austin/Travis County.

- *Work closer with organizations that have access to the community to get more community members engaged*. In providing constructive recommendations to the first bullet, CHA/CHIP leaders recommended enhanced partnership with various stakeholders, including school districts from across central Texas (including parent engagement specialists within school districts, SHACs and school wellness teams); churches; and community-based nonprofits such as the African American Youth Harvest Foundation and Go Austin! Vamos Austin! (GAVA).

- *Identify and communicate opportunities for engagement with the CHA.* Another theme that arose related to community partnerships was the need to further clarify and communicate how individuals and organizations can engage with the CHA.

- *Explore data collection approaches, measures and data sources*: Regarding data collection, there was mention that increased effort should be made to make participating in the CHA data collection activities (e.g., focus groups) easier and more convenient for community stakeholders (see next bullet). Also, some stated that surveys could be enhanced to gather more actionable data and that continuing to find data sources for specific subpopulations and by geographic area within the city and county is important.

- *Design events for community audiences*: In addition to making data collection more convenient for participants, some CHA/CHIP leaders also mentioned the need to further tailor community events (forums, focus groups) to community audiences and to have these events facilitated and/or led by community leaders. Specific recommendations included
    - Have community leaders such as pastors or school district parent support specialists facilitate discussion rather than health department/hospital executives
    - Make information more digestible – some PowerPoints used had too much information
    - Provide child care
    - Have entire Spanish speaking forum rather than translators

- *Ask for solutions, not just problems*. An important theme that came up in relation to the CHA data collection approach was the importance of exploring with community members and key informants not just their health needs and problems, but also their ideas for solutions. This may also help to generate more ownership and partnership with this process.

Prioritization Process

An important subtheme that emerged in exploring the CHA process was the process for prioritizing the health needs and choosing the CHIP health priority areas. In general, several CHA/CHIP leaders indicated the need to enhance how the prioritization process takes place. Key themes included:

- *Who prioritizes*. Some leaders felt like the priorities were driven too much by the people who were in the room, which may over-influence the process, while others stated that this was not necessarily a bad thing as those organizations may be able to bring resources to the issue.

- *Multiple prioritization sessions.* Some leaders suggested doing multiple prioritizing breakout sessions to get feedback on priorities from community organizations/members before finalizing.

- *Review needs & resources:* Some leaders cited the importance of determining priority areas based on review of data and resources/funding.

- *Further focus specific goals/actions*: While there were differing views about having more or fewer priority areas or strategies, one theme that emerged was the importance of going deeper with a specific vision or goal to further focus action for the CHIP.

> *"I feel like the public health community tends to go too broad and we try to do a little bit of everything. When we're very brief, that makes us ineffective, so I'm interested in, um, prioritization and putting larger resources towards one thing, rather than a tiny bit of resources towards twenty things."*
>
> *-CHA/CHIP Leader*

- *Focus on health disparities.* Some people mentioned that health disparities should be considered during prioritization. Multiple people mentioned that it would be helpful to limit the priorities so that the plan does not become too big and overwhelming.

> *"I think what's really important is that we, for health equity and for collective impact, [take into account that] strategies for certain geographic areas or certain key priority population groups could be different because we don't necessarily have to use the same community health improvement plan strategies for each of these groups because every area is different and they are different communities and different resources. So remembering that and utilizing our existing resources and building on that is important."*
>
> *-CHA/CHIP Leader*

CHIP Highlights & Accomplishments

Key highlights and accomplishments of the CHIP process cited by CHA/CHIP leaders included:

- *Roadmap & Rallying Point:* Leaders noted the value of the CHIP in providing a roadmap for health that the major health providers in the community were aware of and could follow as well as rallying point for community organizations. CHA/CHIP leaders noted the value of the CHIP in terms of presenting both direction and opportunity for future action, which include examples described below, as well as actions such as a current campaign directed at heightening sugar sweetened beverage awareness led by the ATCHHS. The value of the CHIP for painting a vision and creating an opportunity for future action is well described by one CHA/CHIP leader:

  "There were times that we had these conversations and said this is an indicator but I don't know if we can ever get to this. And that may be something we need to integrate into the CHIP planning process is [to ask] what resources are available? Is this feasible? …To a point. It's still important to put stuff in the CHIP we know may never happen [right away]…because it was important. And if it weren't in the CHIP, …we wouldn't have done some of the sugar sweetened beverage work we've done…We should still have a wish list opportunity. [This] drove decision making. [This] drove resources. "

- *Partnerships:* Convening organizations that don't otherwise interact as well as creating space for new partnerships were also noted as important outcomes of the CHIP. While recognizing that many collaborative processes lose members over time, some leaders noted the success of the ATC CHIP in

increasing participation and interest from a diverse and new group of people over time, in addition to a strong base of individuals who have stayed with the process from the beginning.

- *Resources and collaborations that arose from the CHIP*: In the best case examples, leaders noted that the new partnerships formed via the CHIP as well as the documentation of city- and community-wide goals facilitated the process of securing funding for projects related to the CHIP and/or to facilitate resources for programming in areas previously unserved. Some major accomplishments included:
  - ✓ *Grant collaborations:* CapMetro and the City of Austin together received the American Planning Association grant which was used for the Smart Trips program and some food mapping by the COA Office of Sustainability.
  - ✓ *Enhanced relationships and services:* CapMetro improved their relationship with Travis County and developed 2 new bus lines that serve the county.
  - ✓ *Funding for positions:* At some point in the 3 years of the CHIP the health department lost funding in chronic disease that was supporting a lot of CHIP initiatives. People who were involved with the CHIP, even those not at the health department, were able to recognize and advocate the need to find funding to fill in the gaps, which resulted in five positions being funded by the general fund.
  - ✓ *Planning of successful community forum* for the Access to Healthy Foods priority area in Manor where community leaders were introduced to organizations and were able to start food access programs in their community.

> *"…I think because of the CHA, because of the CHIP, we've had an improved relationship with Travis County. We've been able to start two bus routes in the last couple of years that are partially in Cap Metro service area and partially outside of Cap Metro's service area, in unincorporated Travis County." -CHA/CHIP Leaders*

CHIP Lessons Learned

Recognizing several of the successes with the CHIP, such as bringing partners together in new ways, CHA/CHIP leaders also noted aspects of the CHIP that could be improved. The following are key lessons learned and areas for improvement:

- *Clearly defined roles and responsibilities:* One common theme cited in interview responses was the need for more clearly defined roles and responsibilities of stakeholder groups. Stakeholder group roles identified in the interviews that merit clearer definition include: the steering committee, core coordinating committee, workgroups and workgroup leads, policy makers and funders, community members, and local businesses. While it should be noted that the ATC CHA/CHIP has documents that provide some definition of roles, such as the CHA/CHIP By-Laws, organizational charts, and a specific document on roles and responsibilities of the different groups, this recurring theme may point to a need for better communication about roles with stakeholders and/or a periodic review and clarification of specific roles with stakeholder groups.

- *Communication about CHA/CHIP for Prospective Partners and Broader Communities.* Some leaders noted the need for increasing how the CHA/CHIP is communicated to community stakeholders. Suggestions for engaging new partners and individuals as well as communicating to the broader community included developing an "elevator speech" that would make it easier to describe the CHA/CHIP. People mentioned that it is a lot to explain the acronym, and it would be helpful to have a way to identify and communicate what the initiative is about.

> *"To the degree that this process can be a little more visible in the overall context of Austin and Travis County, and by that I mean both from the community point of view, but to the degree you engage the media and publicize and engage and let them know these activities are going on so they know there is a comprehensive community process."*
>
> *-CHA/CHIP Leader*

- *Identification of Key Partners to Support the CHIP:* There was discussion that there were organizational and community stakeholders that were not involved in the CHIP process because they were not invited to the table or did not understand how to engage with the process. One helpful suggestion was to do a second "Circle of Involvement" style exercise after the prioritization process, once the CHIP priorities are selected, to ensure that relevant community organizations are involved in setting objectives and strategies. Finding a way to engage organizational or community stakeholders who want to become involved mid-CHIP would also be helpful.

- *Need for Increased Attention to Setting CHIP Objectives and Strategies:* CHA/CHIP leaders shared that there were often too many CHIP objectives, and that not all had strategies, and for those that did have strategies, partners to lead those strategies were not always identified or at the table. Key points provided by leaders included:

    - Some respondents suggested that consideration of objectives and strategies should be based on what organizations in the community are already doing or on the availability of funding.
    - Others recommended that the CHIP should provide for greater 'visioning' and the development of a "wish list" of objectives, even if no one is currently working on them.
    - Furthermore, some suggested that there should be a mixture of both short-term objectives and long-terms objectives. Short-term objectives might be tied to ongoing organizational efforts, be implemented over a shorter time period (e.g., 1-3 years), be trackable, and that could ideally produce some more immediate and visible wins to keep the momentum. Concurrently, the CHA/CHIP work groups would create longer term and larger objectives that take ongoing collaboration and for which current resources may not be available to address.
    - While writing the objectives, it may be helpful to explicitly state if there are resources available currently and how much or what kind of resources would be needed to complete the objective.

- *Need for Evaluation Planning*: Another common theme that came out of the question of lessons learned from the first CHIP process was that there should be more intentional plans for evaluation earlier in the process. While the process inherently incorporates indicators and data sources for tracking progress, many indicators lack data to track progress, rely on data for larger catchment areas, or lack periodic reporting of data. Providing more intentionality in evaluating progress with a

selected number of indicators, which may include increased focus on funding to collect primary data, may be a consideration for CHA/CHIP planners for cycle II. In addition, there may be other specific process-related aims of the CHA/CHIP that merit specific evaluation and tracking from the initiation of the process, such as engagement and maintenance of community partners as well as tracking of other health initiatives and actions that stem from the CHA/CHIP.

- *Communication of Progress and Resources: CHA/CHIP leaders also* identified a need for further exploration of communication channels and approaches, such as having a more interactive website and using newsletters to communicate with stakeholders about current events related to the CHA/CHIP or updates on the progress of the CHIP objectives. There was also a discussion about stakeholders entering their own progress through either the website or another IT platform.

- *Community Engagement:* Similar to the lessons learned from the CHA, leaders suggested trying different strategies to engage community members in the CHIP process. These included:

    - *Partner with Existing Community*-Based Organizations and Provide Instrumental Support for Participation of Community Members: The same two strategies were suggested to engage community members via existing community-based organizations, and providing accommodations such as child care, translation services and/or providing sessions in the language of the community group (with no translation).

    - *Direct Co-Planning with Community Members:* Additionally, people mentioned that community forum formats could be restructured so that the community members do most of the talking regarding their needs and possible strategies and then organizational stakeholders can respond with the resources they have or build partnerships with community leaders to find resources. An important difference with the current approach would be a planning of actions and sharing of resources at a level closer to community groups and geographic areas within the City and County. As described in the following quote by one CHA/CHIP partner, this was successfully done in a community forum held by Community Advancement Network and the Access to Healthy Food priority group in Manor and Del Valle during the first CHIP cycle:

> *"I think that for those of us who would go to these meetings as part of our work, as part of our jobs, we should maybe shift and more prioritize community level input and have those of us who would be there representing our organizations to listen and respond. And to be able to attach to community input what resources we are able to offer, as part of, a kind of feasibility plan."*
>
> *-CHA/CHIP Leader*

"What I liked most about those meetings is they weren't there to come up with a list of things for someone else like the government to do, they were there to come up with a list of things for them to do. They were there to identify the things that they thought would be the most important for their community and then to come up with some first steps and some next steps. We followed up with them like several months after and some of them actually kept going. Not all of them did, but some of them were actually resulting in some action." –CHA/CHIP Leader regarding Healthy Food Access community forum held in Manor & Del Valle in 2015 with CAN, CHA/CHIP Healthy Food Access group members and organizational partners.

CHA/CHIP Organizational Structure

CHA/CHIP leaders provided several reflections and constructive insights about the current CHA/CHIP organizational structure that included the following:

- *Overall satisfaction with current structure, but room for enhancement:* Leaders generally expressed that the overall structure of the steering committee, core coordinating committee and workgroups was good, but that the roles within them and the way that they relate to each other could be better defined, as mentioned above.

- *Staffing of CHA/CHIP:* Leaders mentioned that it was helpful when CHA/CHIP partner organizations, hosted by Austin/Travis County HHS, were able to fund a full-time CHA/CHIP planner position as this provided a dedicated leader to coordinate the meetings and efforts. At the same time, some leaders mentioned that one position was probably not sufficient, and that additional human resources would be helpful. A similar comment related to the importance of continuing to empower and share leadership and management of the workload among CHA/CHIP members, in addition to the key role of the CHA/CHIP planner.

- *Hosting of CHA/CHIP:* There was some discussion on whether this initiative should be housed within the Austin/Travis County HHS, or if there should be an independent nonprofit coalition that manages the project, following a collective impact model. As mentioned in the CHIP Lessons Learned section, people discussed that there are different roles for different stakeholder groups, and clearly defining the roles would be helpful for cycle II. Below are some of the discussion points around each of the stakeholder groups that came out of the interviews.

- *Steering committee:* Steering committee members and core coordinating members alike mentioned that the steering committee may be underutilized. There was discussion that the steering committee consists of people who have the authority to push initiatives forward in their organizations and in the community, however, that authority was not fully realized. It was also mentioned that the steering committee should have the ability to be fluid so that if an organization is needed at the table, they can be invited.

- *Core coordinating role:* Members said that they did not always understand the roles within the Core Coordinating Committee. The Core Coordinating Committee was acknowledged by steering committee members and core members as the workhorses of the initiative, really driving movement and making sure that things got done. Some members mentioned that there should be a clearer mechanism for how to take what they are working on to the steering committee so that it can be pushed forward.

- *Workgroup members and leads:* Workgroup leads did not always know what was expected of them. Similarly, workgroup members mentioned that it was not always clear what they were supposed to do in between meetings. Work group leads also shared that leading a workgroup was a big time commitment for somebody who is already busy. Having co-leads sometimes worked, but other times it complicated communication. Members discussed that it would be good to leave each meeting with clear tasks and timelines.

- *Policy makers and funders:* CHA/CHIP leaders mentioned that engaging policy makers and funders on committees is something that should be explored. They also mentioned that having roles that are specific to being a policy maker or funder would be important, so that they are being utilized for what they do, rather than being asked to do work that they do not normally engage in.

> *"There's a lot of, I think, enthusiasm at the staff level, like yeah, these are the changes that need to be made, but there isn't anyone above them that might be aware of that…[P]eople come to the summit and then they go back to their job and then just go about their regular job and it really has no official connection to the CHIP."*
>
> *-CHA/CHIP Leader*

- *New organizations:* There was some discussion from CHA/CHIP leaders on improving engagement with organizations who want to be involved mid-way through the process. If someone becomes interested, how do they get involved?

- *Community members:* Some CHA/CHIP leaders also underscored the need to clarify what the roles and 'asks' are for community members in relation to the CHIP. Furthermore, some leaders indicated that more clarification is needed in relation to what should be communicated to the broader community and community residents about the CHIP.

Reach and Stakeholder Involvement

When asked if there were any stakeholders missing in the first CHA/CHIP process, CHA/CHIP leaders mentioned that there was a concerted effort to get a wide range of partners at the table. At the same time, several leaders cited that they could continue to enhance involvement of key groups for the next CHA/CHIP cycle. It was noted that the CHA did a good job of engaging community members in focus groups and community forums- and the CHIP succeeded with increasing participation in the annual CHIP community planning forums. While workgroup meetings were generally well attended, there was a call to explore how to best maintain workgroup participation throughout the CHIP cycle. Specific groups mentioned that were either left out or were not fully engaged and should be included in Cycle II were:

- School districts & School Health Advisory Councils (SHACs)
- Dell Medical School
- Business Community & Chambers of Commerce
- Foundations
- Faith Based Organizations

Community Voice

Community voice was a common theme that emerged from our CHA/CHIP leader interviews. While many noted that community voice is always the most difficult to get, they emphasized the importance of the CHA/CHIP being owned and informed by the community. In exploring how to best engage the community, some leaders shared that there may be other methods for communicating to the community beyond community forums, including online surveys, phone calls and discussion groups that could be interwoven with existing meetings. Similar to discussions in other sections, it came up that having a more concise way of communicating about the CHA/CHIP to community members would also be helpful. There was also discussion on how much the community needs to know about the CHAP/CHIP; the plan itself was considered dry and fairly overwhelming, so exploring what parts should be communicated back to the community is important. Lastly, some also cited the need to better understand how to best incorporate community voice in order to inspire community action.

Partnerships

Being a partner in the CHA/CHIP was recognized as a potentially large organizational commitment. In the best case scenario, partners of the CHA/CHIP fold the priorities of the CHIP into their own organization's strategic plans. Leaders also cited the importance of flexibility in inviting new partners and in differing levels of involvement. Partnerships in the CHA/CHIP were also stated to be an opportunity to work together to do more, rather than duplicating efforts. Lastly, one theme that emerged is the potential to reach more community stakeholders via CHA/CHIP organizational partners and their different constituents.

CHA/CHIP Leader Recommendations for CHA/CHIP Cycle II

While recommendations for CHA/CHIP cycle II were asked as a final question in the interview, they came up organically throughout the interview. In Table 2a we share a summary list of these recommendations from CHA/CHIP leaders that aim to enhance the CHA/CHIP cycle II, which begins 2017:

Table 2a. CHA/CHIP Leader Recommendations for CHA/CHIP Cycle II

1) Visibility & communication of CHA/CHIP to the community
    - Engage council members, state elected officials, commissioner of courts with the CHA/CHIP process.
    - Have clearer message of "what the CHA-CHIP is" (e.g., provide an elevator speech).
    - Have clearer reporting and communication of progress. Make communication accessible and lay it out in a way that is easy to follow.
    - Prepare presentation for nonprofit boards and other professional groups.

2) Community engagement and stakeholder participation:
    - Include other stakeholders such as school districts (AISD, MISD, DVISD).
    - Be creative to get more public participation.
    - Have an Imagine Austin representative on the steering committee.
    - Think about how to engage other sectors.
    - Think about how to bring in new organizations during the process.
    - Be clearer about what is expected from partners and what they will get out of being involved.

3) CHA/CHIP internal organization & communication:
    - Provide clear direction to Steering Committee about how they can influence participation.
    - Be more purposeful in using the influence of the Steering Committee members to get rid of road blocks or invite new participants who are needed.
    - The CHIP should be reflected in the budget of organizations involved (e.g. Health Department, Hospitals).
    - Make an effort to align with other plans. Everyone has a lot of plans already. It would be better to put a lot of resources toward one thing rather than spreading it out over a ton of things.
    - If the CHIP is the overarching health plan of the community, organizations should be able to consult it to find other groups working in the same space to learn more about what they are doing specifically.
    - Improve communication within the process to keep partners engaged throughout different stages.
    - Improve communication within organizations who are working on CHIP (e.g. reporting back from the person involved back into the organization).
    - Consider having succession plans for senior level employees.

4) CHA/CHIP implementation & evaluation
    - Create priorities and plans around measures that exist and are accessible so that they can be tracked.
    - Limit to fewer priorities and go deeper on them.
    - Have subject matter experts and epidemiologists in each work group as they are developing plans to determine measurability.
    - Build in evaluation component to show "x action item affected x community members".
    - Consider having multiple prioritization sessions; one with steering committee and then bring it to partner groups and community groups before finalizing.
    - After prioritization is complete, consider what organizations should be invited who work in those areas.
    - Utilize student and volunteer groups more.
    - When designing plan, state how much funding each piece would need, if there is funding available, etc.
    - Explore collective impact approaches and results-based accountability scorecard.
    - Align with Healthy ATC.

> *"I think I'd just like to have a clearer outcome. I know we have a bunch of goals and objectives, but just one clear one. Even if we could just have what is that an elevator speech for the CHA/CHIP that makes sense and that we can knead." -CHA/CHIP Leader*

5) Make a conscious effort to focus on social and health inequities within the CHA/CHIP.

CHA/CHIP Core Coordinating Committee Focus Group Findings *(Organizational Leaders)*

In early May 2016, we held a focus group discussion with five of the 7 leaders of the Core Coordinating Committee to explore CHA and CHIP highlights, lessons learned and recommendations. The Core Coordinating Committee serves as the steward if the initiative in terms of planning and coordinating CHA/CHIP actions and activities- with current members focused on the CHIP and now gearing up for the next CHA/CHIP cycle. The Core Coordinating Committee leader participants brought rich experience and insights with the CHA/CHIP to the discussion, with the collective experience of the group spanning 2011 to present. Members represented five different organizations that included government service and health and healthcare organizations. Three of the four CHIP work groups were represented; the lead for the fourth group (Access to Healthy Food) was included in a subsequent interview. Below we share key highlights and accomplishments of the CHA and CHIP along with lessons learned as noted by core committee leaders.

CHA & CHIP Highlights and Accomplishments

- *Formation of Strong Community Partnerships*: An important highlight of the formation of the CHA and CHIP was the formation of strong partnerships across health, social service, education, and other community organizations and individuals representing those organizations. One specific highlight of the CHA partnerships was the financial and human resource investment into the CHA/CHIP of key health care organizations (Central Health, Seton and St. David's) in Austin/Travis County as well as participation of other key players, such as ATHHS and TCHHSVS and UTHealth School of Public Health. Strong partnerships and relationships were also underscored as a key highlight for the CHIP. Some Core Coordinating Committee leaders noted that CHIP provided the venue for other collaborations ("the CHIP knits together" different efforts) and also allowed folks to get to know each other and the various actors in this space. It also allowed a 'clearinghouse' for learning more about ongoing efforts. Committee leaders agreed that the most positive thing that came out of the first CHA/CHIP cycle were the positive relationships.

> *"The biggest plus has been bringing together the community collaborators and new relationships." –Core Leader*

- *Co-Learning Process about CHA/CHIP*: Core Coordinating Committee ("Core") leaders underscored the value of their learning process about the CHA/CHIP, which included going to San Antonio to learn more about their CHA/CHIP efforts and approaches prior to developing the ATC CHA/CHIP.

- *Focus groups and community forums:* Focus groups and forums were noted as a very valuable contribution to the CHA, recognizing at the same time that they were time and labor intensive. HRiA's help facilitating community forums and providing guidance with focus groups was also very valuable: "Working with HRiA has been great!". Community forums were also noted to have 'gotten better' as they went, as initial forums may have been too 'researchy' and not geared toward a community audience.

- *Application of participatory planning activities:* Core leaders also noted the use of various participatory planning activities, several of which came from the Mobilizing for Action through Planning and Partnerships, including the "Spoke and Wheel" exercise to identify community

partners and stakeholders, use of "dotmocracy" to identify priority areas, "forces of change" activity, among others.

- *Overall strong organizational structure and approach for CHA:* Core leaders highlighted some of the organizational approaches that were used for the CHA, including an organizational structure comprised of various work groups (e.g., data and analysis committee, community engagement group), as well as a systematic approach in guiding the placement of focus groups and collection of data from a variety of sources. With help from HRiA, quantitative and qualitative data were combined to help identify a list of key health priority areas, which led to a participatory prioritization process. HRiA had recommended three areas; the group pushed and received four priority areas.

- *Potential for securing grant funding and other resources.* It was also noted that the CHA is and can be used as a source for securing grant funding and other resources for populations and services in need, and therefore "…doing it well is really important" (Core leader).

CHA & CHIP Lessons Learned

- *Stratification of Austin/Travis County population:* Core leaders shared that it was a struggle to bring all populations together in one big broad range of goals. Questions arose such as "Can you focus on some groups more than others and have the whole community rally behind the plan?". While the CHA underscored the higher risk for health issues for some subgroups and underserved populations were always a focus of discussion, Core leaders noted that there is room for greater highlighting of underserved populations in the CHIP.

- *Engagement of broader community:* Some discussion focused on the recognition that community residents and the broader Austin/Travis County may not be fully engaged in the CHA/CHIP process, but rather engaged through proxy organizations and agencies. A question that should be further explored is what level of engagement should the CHA/CHIP strive for, and how should community residents and the broader Austin/Travis County Community be engaged?

- *Is the next CHA/CHIP a clean slate?* An important question that arose during the discussion was whether the initial CHA/CHIP (cycle I), including the current four priority areas, should inform and influence the actions and focus areas of the next iteration of the CHA/CHIP (cycle II).

- *CHA/CHIP focus group and community forum approach*:
    - *CHA focus groups:* One suggestion that came up was for greater creativity in recruiting community residents and stakeholders for discussion groups in order to reach the voices that are less likely to be heard. A more 'ground up' approach was recommended, which may involve working more directly with community leaders and members who directly reach populations of interest. Another member noted the need for more focus groups for the next cycle, and for training people from within the community on how to conduct them.

    - *Format of community forums during CHIP*. There was some discussion that community forums seemed at times to be more obligatory (i.e., to fulfill requirements). There is need to continue to explore how to make community forums relevant and engaging for all stakeholders.

- *Challenges with addressing the comprehensiveness of the CHA via the CHIP.* Some Core leaders noted that the CHA provides a very comprehensive perspective on health needs of the community, yet it was difficult to develop a CHIP with its limited focus to address those needs. This leads to an important question: How can the CHA continue to be 'activated' beyond its role for informing the four priority areas of the CHIP?

- *Needs for Enhancing Internal and External Communication of the CHA/CHIP*
    - *Branding and CHA/CHIP Logo:* Branding was cited as an issue that merits ongoing focus. Although efforts were invested in branding the CHA/CHIP and coming up with the "Together We Thrive" name and logo, some felt that the name was more of a statement or slogan and could be strengthened. Another issue one member shared was that the "role" of the CHA-CHIP warrants further clarification for individuals involved and for the broader community.

    - *Communication with broader community:* Some members noted that communication approach with the broader community needs to be further explored. "What was the communication to community; what should it be?"

    - *Elevator Speech:* Related to the above bullet, some noted the need for a type of 'elevator speech' to ensure key vision and messages about the CHA/CHIP mission are being clearly communicated. On a related note, one participant suggested that this type of communication might be modeled off of Sen. Kirk Watson's 10 goals in 10 years and/or Imagine Austin.

    - *How to get involved with the CHIP?* Some Core leaders indicated that it is not clear how to get involved in the CHIP when one is an outsider. It may be problematic that the CHIP feels like it is not modifiable and that 5 years is a long time to be static.

    - *Communication between the Core Coordinating Committee and the Steering Committee*: Some noted an opportunity to further strengthen communication between these groups, with some recommending the possibility of having a steering committee member present at core meetings, and/or workgroup meetings.

    - *Communication within agencies:* Some noted the need for better communication even within agencies that are participating with the CHA/CHIP.

- *Reporting mechanism vs. inspiring action*. Some Core leaders noted that they felt like the CHIP was more about reporting what is already going on in the community and with various organizations than inspiring new action. Some suggested the need for more inspirational vision for the CHA/CHIP. On a similar note, one leader stated: "CHIP became more about filling in the forms vs. face-to-face" interaction/exchange. In further highlighting the need to clarify the role of the CHIP, one leader indicated the need to address whether the CHA/CHIP is aimed at addressing compliance, or strategy, or another function.

- *CHA/CHIP organizational structure and approach*: Several opportunities were noted regarding enhancement of the CHA/CHIP organizational structure and approach, including:
    - *Considering how to continue to activate the role and contributions of the Core and other work groups:* While there is appreciation for the role the ATHHS is playing with coordinating

the effort, there may have been a decrease in the role with planning and coordination by community leaders and volunteers. Furthermore, with a great emphasis on "reporting back" during CHIP meetings, ownership of the process may be decreasing. Need to explore ways to continue to build from stakeholder leadership and contributions.

- *Defining role of the Core would be helpful*: One member noted that CHA/CHIP has by-laws for steering group, yet further clarity is needed for Core Coordinating Committee.

- *Challenges with the CHIP structure:* Core leaders also noted that the CHIP structure regarding the approach for defining objectives, indicators, strategies merits further consideration. Some noted that too many objectives were identified, which sometimes lacked cohesiveness. While some noted that good strategies were identified to address the objectives, a challenge across groups was identifying who would carry out the strategies.

- *Length of CHA/CHIP Timeframe:* One leader noted that the five-year time frame seems long (and others, as noted above, stated that it is unclear when others can come into the process- even midway through). On related note, another leader noted that we need an 'evolving vision'.

- *Targeting efforts to those most in need and raising awareness about social determinants*. Core leaders also discussed the importance for further enhancing the focus on those communities within Austin/Travis County most in need, as well as continuing to raise awareness and action around the role of social determinants of health: *"I think there needs to be a deliberate education… 'Social Determinants' are not what people understand. We need to target intervention to individuals who really need it."*

Recommendations

While several themes discussed above should be considered in enhancing the next cycle of the CHA/CHIP, Core leaders also shared key recommendations when asked about the next cycle of the CHA/CHIP (Table 2b).

Table 2b. CHA/CHIP Core Coordinating Committee Recommendations for Cycle II

1. *Build off and incorporate other community needs assessments*: Leaders highlighted the importance of coordinating with/incorporating other needs assessments for the CHA process.

2. *Be strategic with utilizing our CHA data for grants and other activities*. Beyond the specific purpose of the CHA related to informing the CHIP, leaders recommended that the CHA should be promoted and utilized for informing grant applications and guiding health action. In this sense, the CHA should be an "evergreen" resource to document and raise awareness of community health needs, strengths and opportunities outside of the CHIP priority areas.

3. *Strengthen CHIP planning and implementation process*: In addition to exploring further how to best rank and prioritize objectives and strategies (e.g., utilizing the MAPP process and perhaps others that rank based on importance and changeability of a priority area focus or strategy), the group emphasized the importance of identifying the 'who' will be in charge of a specific action item/activity. While it should be noted that the current CHIP template specifically includes a space for identifying who is the lead, this recommendation relates to the general need for further clarification for what it entails to be a lead on an action item as well as the need to re-

evaluate during the process the person or organizations charged with an action item to ensure they are able to implement a given action or strategy.

4. *Continue to explore evaluation approaches of the CHA/CHIP*: For example, some leaders suggested the importance of further emphasizing the 'narratives' of the positive outcomes of the CHA/CHIP, in addition to our quantitative indicators. One leader shared: *"I look at the bicycle plan of Travis County and I know that was informed by some of the work we've done, and in regards to sidewalks – we're now having sidewalks in our development. You realize this was set off by [the CHA/CHIP]."*

5. *Explore approaches for enhancing communication between and among CHA/CHIP entities*, such as including steering committee member liaison with the Core leader group or work groups.

6. *Continue to foster in-person and periodic meetings for work groups:* One Core leader noted: "Meeting in person to accomplish both reporting and collaboration and continued engagement is important." The structure, frequency and approach of work group meetings merits further consideration.

7. *Continue to explore strategies for reaching and involving diverse stakeholder groups:* As noted above, Core leaders recognized that it was not always clear how people can contribute to the CHA/CHIP or how to get involved. Some mentioned that their work groups saw a lot of drop off over time, which may have been due to a lack of understanding of what the CHA/CHIP is all about. They also noted that stakeholder group began with broad representation of the community, but became less so. *"There was probably a misunderstanding in the community about the fact that this is not something where there is funding and resources to do new things, but rather an opportunity to come together and understand what exists and how those resources can be utilized to work toward common goals."* On a related noted, one leader emphasized the importance of clarifying what the value of the CHIP is to organizations involved.

CHA/CHIP Organizational Stakeholder Survey Findings

The CHA/CHIP Organizational Stakeholder Survey was sent to organizational representatives and community leaders from a range of backgrounds (healthcare, academic, social services, nonprofit and government) who participated in one or more CHA/CHIP community forum, work group meetings or events. Of the n=209 emails that were sent the survey, n=43 emails were not valid, bringing the final sample invited to participate in the survey to 166. Of those invited, n=83 individuals filled out the survey, representing a 50.0% response rate. We should note that sample sizes drop below 83 for specific questions related to the CHA and CHIP, as a skip pattern was included for those who indicated "not at all involved" related to these two phases of the ATC CHA/CHIP.

Characteristics of Respondents

Respondents were majority female (75.7%) with a mean age of 49 years, with a range of ages between 26 and 72 years old (data not shown in figures). The majority of respondents self-identified as having white ethnic/racial background (83.3%), followed by Hispanic/Latino (8.3%), African American (2.8%), and Asian/other/combined (5.6%) (Figure 7a). Respondents' primary organizational affiliations included local/state government (30.1%), nonprofit (23.3%), local/state health department (20.5%), and school/college/university (11.0%), Hospital/medical facility (4.1%), and "involved as a community member" (4.1%) (Figure 7b).

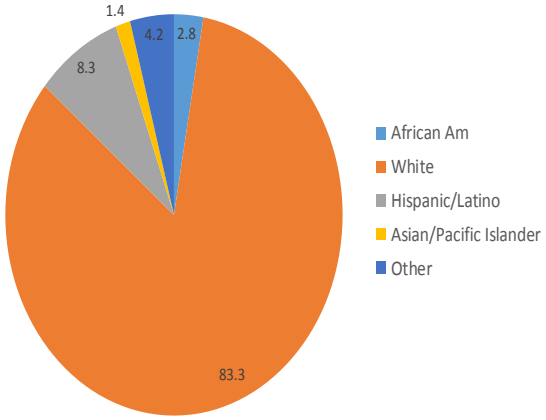


Figure 7a. Ethnicity of respondents (%). *CHA/CHIP Organizational Stakeholder Survey- Evaluation of the Austin/Travis County CHA/CHIP Cycle I,* Summer & Fall 2016 (n=83)

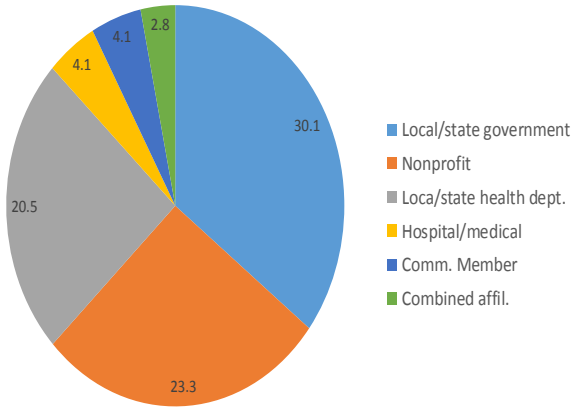


Figure 7b. Organizational affiliation of respondents (%). *CHA/CHIP Organizational Stakeholder Survey- Evaluation of the Austin/Travis County CHA/CHIP Cycle I,* Summer & Fall 2016 (n=83)

Involvement with the Austin/Travis County CHA/CHIP

CHA Involvement: Just over half of the respondents (50.7%) reported being a 'little involved' (26.0%) to 'somewhat or very involved' (24.7%) in the Community Health Assessment (CHA), with 17.8% reporting 'not very involved' and 28.8% reporting 'not at all involved' (Table 3). The top reasons for not being involved included: 'I did not have enough time to spare'(20.6%), 'my organization did not think it was a priority for me to be involved' (10.3%), and 'I did not see how I fit in/I didn't understand my role' (8.8%). For those who were somewhat or very involved with the CHA, the main reasons for involvement based on open-ended responses were: 'assigned as part of job' (50.6%), 'CHA is an important tool to coordinate services and address gaps in services' (12.6%), and 'to improve community health outcomes' (12.6%). Open-ended reasons for not being involved in the CHA included: 'another team member was participating (18.6%), 'wasn't working for organization/came in late to process' (15.5%), and 'hard to attend meetings/time conflicts/not sure how to engage' (15.5%).

CHIP Involvement: With regard to the CHIP, the majority of respondents (73.9%) reported being "a little involved" to "somewhat' (27.4%) or 'very involved' (46.5%) (Table 3). As with involvement in the CHA, the top reason for not being more involved with the CHIP was not having enough time to spare (26.1%), followed by 'my organization did not think it was a priority for me to be involved' (10.1%) and 'I did not see how I fit in; I did not understand my role.' (4.3%). Top reasons for being somewhat or very involved with CHIP based on open-ended responses included: 'assigned as part of job' (39.6%), 'aligned with interests in community health/health disparities' (25.2%) and 'CHIP is a high priority to my organization'

Table 3. Respondent participation in the CHA and CHIP - *CHA/CHIP Organizational Stakeholder Survey, Evaluation of the Austin/Travis County CHA/CHIP Cycle I.* Summer & Fall 2016. (n=83)

	%
Level of Involvement in CHA	
Very Involved	11.00
Somewhat Involved	13.70
A little Involved	26.00
Not Very Involved	20.50
Not At All Involved	*28.80*
What prevented you from being more involved in CHA?	
Nothing, I was already highly involved	16.20
I did not have enough time to spare	20.60
My organization did not think it was a priority for me to be involved	10.30
I did not see how I fit in; I did not understand my role.	8.80
Other	44.10
Level of Involvement in CHIP	
Very Involved	20.50
Somewhat Involved	26.00
A little Involved	27.40
Not Very Involved	*17.80*
Not At All Involved	*8.20*
What prevented you from being more involved in CHIP?	
Nothing, I was already highly involved	27.50
I did not have enough time to spare	26.10
My organization did not think it was a priority for me to be involved	10.10
I did not see how I fit in; I did not understand my role.	4.30
Other	31.90
What were your primary reasons for being somewhat or very involved in the CHA?	n=16
Assigned as part of my job.	50.40
CHA is an important tool to coordinate services, ensure gaps in service and health disparities are addressed	12.60
Improve community health and wellness outcomes	12.60
What were your primary reasons for being a little or not very involved in the CHA? (top responses)	n=32
Another team member was participating	18.60
Wasn't working for organization/came in late to process	15.50
Hard to attend meetings/time conflicts/not sure how to engage	15.50
What were your primary reasons for being somewhat or very involved in the CHIP? (top responses)	n=28
Part of my job	39.60
Aligned interest in community health/health disparties/social determinants of health	25.20
CHIP is a high priority to my organization	21.60
What were your primary reasons for being a little or not very involved in the CHIP? (top responses)	n=25
Not part of my primary job	12.00
Other staff involved	8.00
Must balance demands of heavy workload	8.00
Switched positions	8.00

(21.6%). Top responses for reasons for not being more involved included: 'not part of my primary job' (12.0%), 'other staff involved' (12.0%), 'having to balance demands of heavy workload' (8.0%), and 'switched positions' (8.0%).

Stakeholder Perceptions of CHA Process

Among those who responded (n=35), the majority of respondents strongly agreed (44.1%) or somewhat agreed (38.2%) that the goals for the CHA process were clear, with 17.6% indicating that they neither agreed nor disagreed (Figure 8a). While most respondents felt that the right people were involved in the CHA process (82.8% indicating somewhat or strongly agree) and that their contributions were meaningful (81.2%), 12.5% were neutral on whether their contributions were meaningful, and 6.3% somewhat disagreed that their contributions were meaningful. Lastly, the majority felt that the CHA reflects an accurate picture of health in our Austin/Travis County community(85.7%), with 11.4 % indicating 'neither agree nor disagree' and 6.3% indicating 'somewhat disagree'.

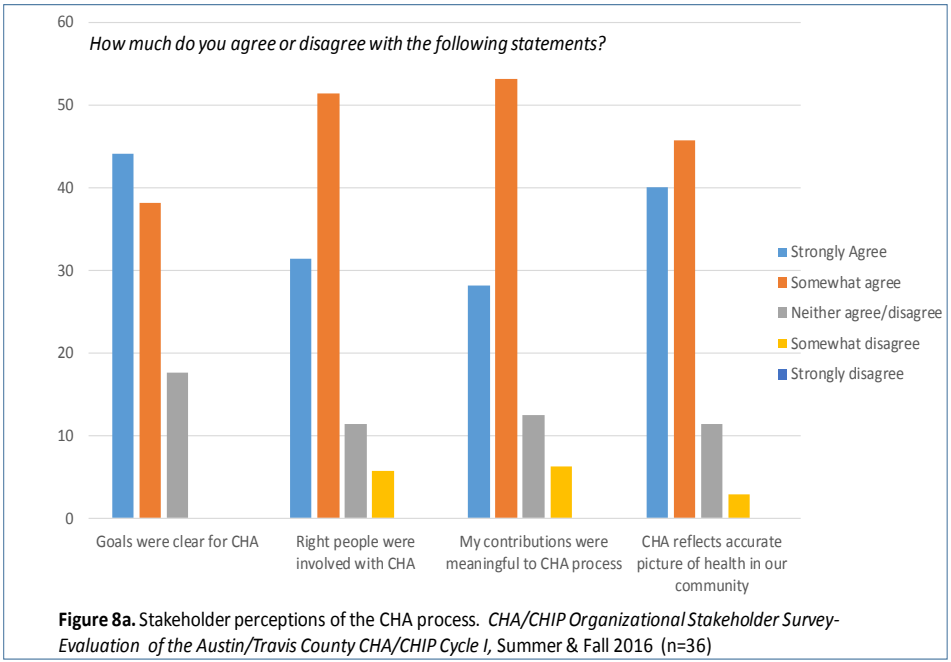


Figure 8a. Stakeholder perceptions of the CHA process. *CHA/CHIP Organizational Stakeholder Survey-Evaluation of the Austin/Travis County CHA/CHIP Cycle I,* Summer & Fall 2016 (n=36)

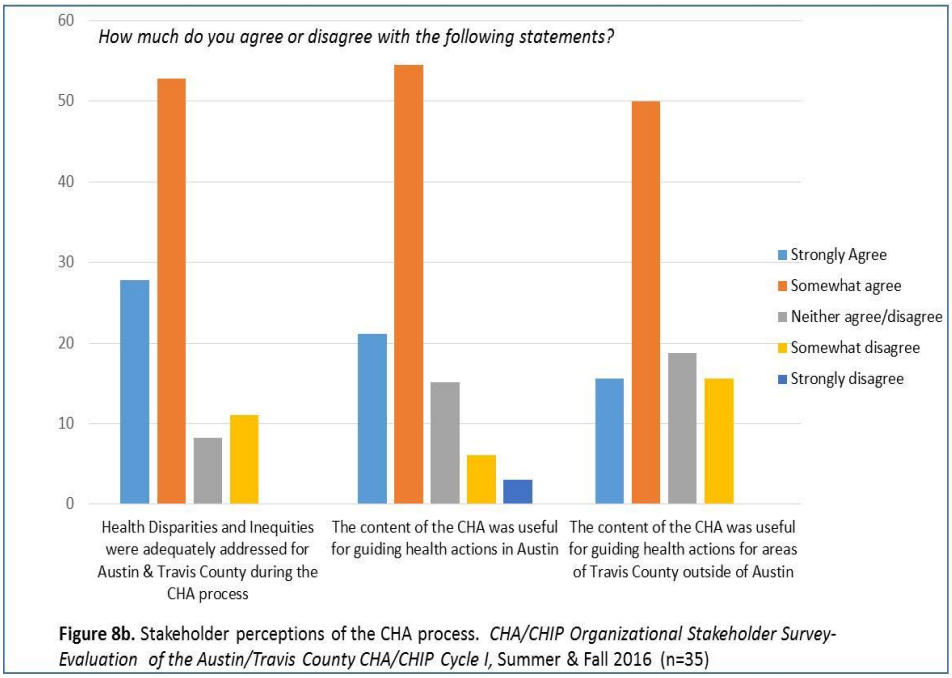


Figure 8b. Stakeholder perceptions of the CHA process. *CHA/CHIP Organizational Stakeholder Survey-Evaluation of the Austin/Travis County CHA/CHIP Cycle I,* Summer & Fall 2016 (n=35)

While the majority of respondents strongly agreed or somewhat agreed that health disparities were adequately addressed in the CHA (80.6%), roughly 20% were neutral or disagreed with this statement (Figure 8b). Three quarters of respondents (75.7%) strongly agreed or somewhat agreed that the prioritization process was sufficient for selecting and prioritizing the health needs of Austin; 66.6% of respondents agreed that the prioritization process was adequate for areas outside of Austin in Travis County, with 15.6% somewhat disagree with that statement (Figure 8b).

Stakeholder Perceptions of CHIP Process

Among those responding (n=49), just over three quarters (77.6%) strongly or somewhat agreed that the goals for the CHIP process were clear, with 12.2% expressing neutrality and 10.2% indicating 'somewhat disagree' (Table 9a). While most respondents felt that the right people were involved with the CHIP process (77.6% indicating strongly or somewhat agree), 22.4% expressed neutrality or disagreed that the right people were involved. A lower percentage strongly agreed or somewhat agreed that their contributions to the CHIP were meaningful (68%), with 32% expressing neutrality, somewhat disagree, or strongly disagree.

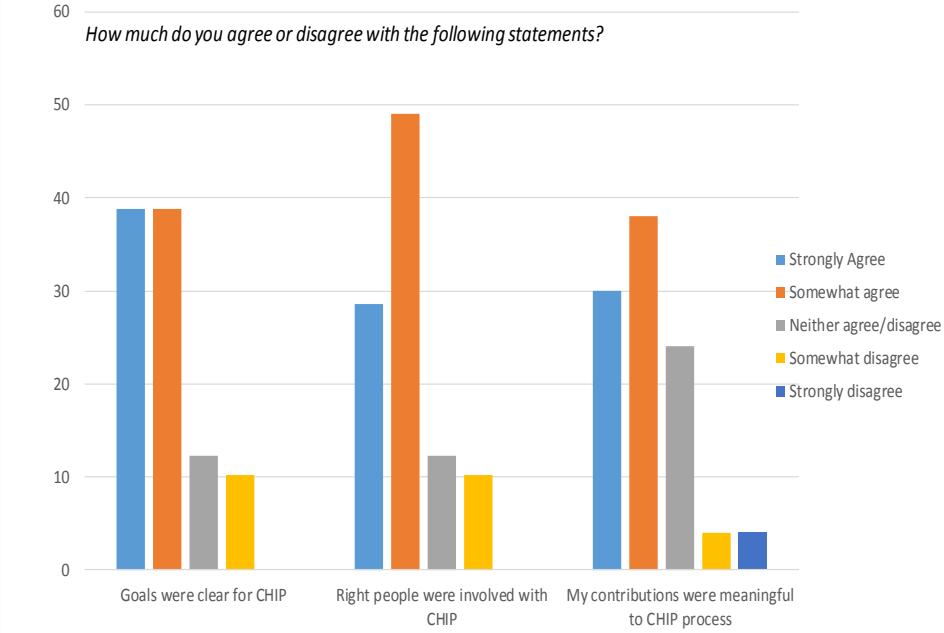


Figure 9a. Respondent Perceptions of *CHIP* Process. CHA/CHIP *Organizational Stakeholder Survey, Evaluation of the Austin/Travis County CHA/CHIP Cycle I*. Summer & Fall 2016 (n=49)

With regard to addressing health disparities, 67.4% strongly agreed or somewhat agreed that the CHIP adequately addresses health disparities, while 11.6% somewhat or strongly disagreed with that statement and 20.9% were neutral (Table 9b). These findings suggest more focus may be needed on how the CHIP addresses health disparities. Lastly, while the majority of respondents indicated that the CHIP was useful for guiding health actions in Austin (64.6%) and Travis County outside of Austin (62.2%), findings were mixed, with over a third of respondents expressing neutrality or disagreeing with this statement (Table 9b).

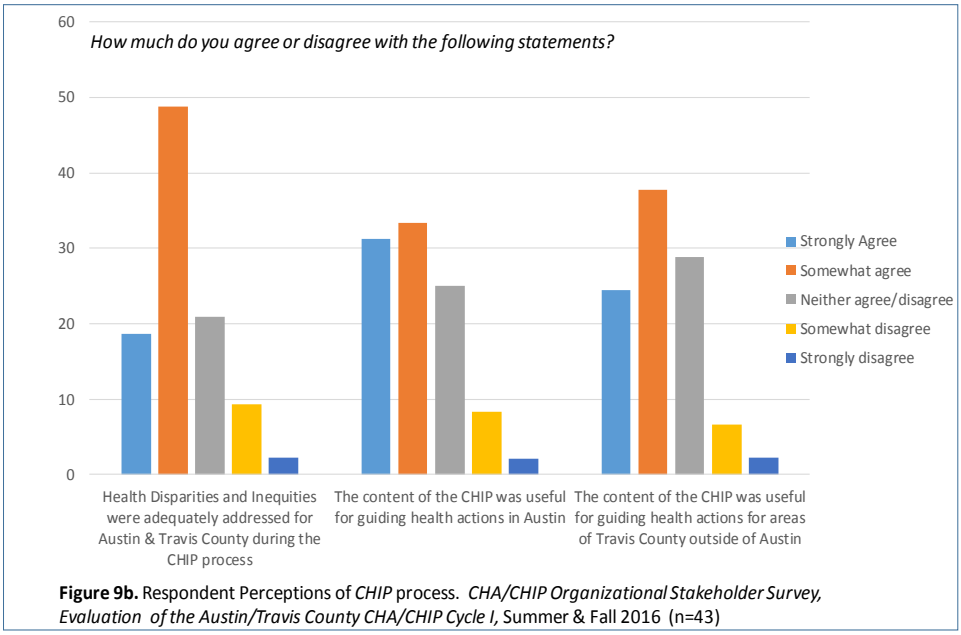


Figure 9b. Respondent Perceptions of *CHIP* process. *CHA/CHIP Organizational Stakeholder Survey, Evaluation of the Austin/Travis County CHA/CHIP Cycle I*, Summer & Fall 2016 (n=43)

Alignment of CHIP Priorities with Respondent

Respondents overwhelmingly felt the CHA/CHIP priorities aligned with their own interests and/or the interests of their organizations (Table 4). Furthermore, respondents generally agreed that the four CHIP priority areas accurately represent the top health priorities for Austin and Travis County (94.2% strongly or somewhat agreed) (data not shown in tables).

Table 4. Alignment of CHIP Priorities with Respondent and his/her Organization (n=83).
CHA/CHIP Organizational Stakeholder Survey, Evaluation of the Austin/Travis County CHA/CHIP Cycle I. Summer & Fall 2016.

Which of these priorities do you or our organization align most with?	Myself % Yes	My Organization % Yes	Both % Yes
Chronic Disease Focus on Obesity	14.30	57.10	28.6
Built Environment focus on Access to Healthy Food	12.80	51.30	35.9
Built environment focus on transportation	20.00	45.70	34.3
Access to primary care and mental/behavioral health services focus on navigating the healthcare systems	14.70	50.00	35.3
None of These	1.20		

Stakeholder Perceptions of CHIP Process, Progress and Lessons Learned

Table 5 presents the top three responses to open-ended questions related to the CHIP process, overall benefits of CHIP to the Austin/Travis County community, lessons learned, and ideas for sustaining efforts. When asked what went well during the CHIP process, respondents cited the collaboration with other organizations and partners, community engagement, and alignment of goals. Similarly, respondents also cited collaboration between groups, partnerships and combined resources as top benefits/outcomes of the CHIP process as well as an increased awareness of the connection between the built environment, transportation and health. With regarding to lessons learned, respondents underscored the need to further increase the focus of CHIP efforts and simplify reporting of efforts. Other key themes cited in lessons learned included the need to identify and increase participation of key partners who can contribute to CHIP implementation and to further increase community involvement with the CHIP. Lastly, the top ideas for sustaining efforts of the current CHIP included increased community input and communication, further integration of partnerships and resources as well as increased community linkages to support CHIP action areas.

Table 5. Respondent Perceptions of the ***CHIP Process, Progress, Lessons Learned.*** *CHA/CHIP Organizational Stakeholder Survey, Evaluation of the Austin/Travis County CHA/CHIP Cycle I.* Summer & Fall 2016.

Top 3 responses…	%
What do you think went well during CHIP process?	n=29
Collaboration with other organizations and partners	47.60
Community engagement	10.20
Alignment of goals	10.20
What overall benefits or outcomes has Austin/Travis County community experienced through the CHIP process?	n=27
Better collaboration between groups/synergy of different public health partners	25.90
Improved communication across groups/ partnerships/combined resources	22.20
Raised awareness of conection between built environment, transportation and health	7.4
What do you believe are overall lessons learned /done differently?	n=21
More focus/simplicity of efforts and reporting	48.00
Increase participation and buy in of the right players	33.60
Further community involvment	33.60
What ideas do you have for sustaining the efforts of the current CHIP?	n=20
Expand community input through forums/dialogue/communication	30.00
Integrate partnerships and resources (Imagine Austin, Dell, Central Health)	25.00
Expand membership and linkages to match CHIP priority issues	15

Recommendations for Stakeholder Participation in CHA/CHIP

When asked how the Austin/Travis County Health and Human Services could improve participation in the CHA/CHIP from a list of possible options, respondents most recommended engageing more community stakeholders and community members as well as improve communication (Table 6). Of note, few people expressed the need to reduce the number of meetings. In exploring how to engage more stakeholders or community members using an open-ended response format, the most common recommendations included: expanding community outreach and engage where the community is, recruit community leaders that include retailers, religious leaders, school leaders, and articulate clear goals and benefits of CHA/CHIP to organizations and broader community. In support of the need to expand stakeholder participation in the CHA/CHIP, respondents overwhelmingly (91.3%) affirmed that there were stakeholders missing from the meetings and committees.

Table 6. Stakeholders and Participation in CHA/CHIP**.** *CHA/CHIP Organizational Stakeholder Survey, Evaluation of the Austin/Travis County CHA/CHIP Cycle I. Summer & Fall 2016.*

	% Yes
What could the City of Austin/Travis County Health and Human Services do better to improve participation?	n=52
Improve Communication	43.33
Increase the amount of meetings	3.61
Decrease the amount of meetings	4.81
Engage more community stakeholders	45.78
Engage more community members	38.55
Other	*13.25*
How do you suggest we achieve the goal of engaging more stakeholders or community members?	n=34
Engage in expanded community outreach;engage with where they already are	23.20
Enlist/Recruit retailers, religious leaders, schools, and other community members	11.60
Articulate clear goals and benefits of the CHA/CHIP to organizations and community	11.60
Do you think there were any stakeholders missing from the meetings or committees?	n=23
no	8.70
yes	91.3

Perceptions about CHA/CHIP Cycle II (2017)

In exploring perceptions about the next ATC CHA/CHIP cycle beginning 2017, the top open-ended responses included the importance of digging deeper to identify community members' top areas of concern for their health as well as identifying actionable goals, continuing priority areas from this first CHIP cycle, and engaging diverse communities and addressing social and economic inequalities (Table 7). Similarly, respondents indicated the need to focus further the scope and simplify the CHIP with smaller number of objectives/strategies in focus areas as well as the importance of further aligning the CHIP with other groups such as Imagine Austin. Insightfully, respondents also recommended to just keep moving forward and recognizing that this work is an ongoing process. Lastly, respondents provided overall positive final notes about the CHA/CHIP, with positive and constructive statements about the process, including "valuable" and "positive experience".

Table 7 Respondent perceptions about CHA/CHIP Cycle II (beginning 2017)**.** *CHA/CHIP Organizational Stakeholder Survey, Evaluation of the Austin/Travis County CHA/CHIP Cycle I. Summer & Fall 2016.*

Top 3 responses...	%
What do you think the goal/purpose of the CHA/CHIP Cycle II should be?	n=31
Dig deeper to identify community members top areas of concern	25.60
Assess Phase 1/identify additional actionable goals/revise/continue CHA/CHIP 1 prioriti	25.60
Engage diverse communities/address social and economic inequities	9.60
What would you like to see regarding the process of implementation of the CHA/CHIP Cycle II?	
Focus scope and simplify/smaller amount of tasks in focus areas	16.00
Align with other groups, such as Imagine Austin	16.00
Continue doing what we're doing/recognize it is an ongoing process	12.00
Is there anything else you would like to share with us about the Austin/Travis County CHA/CHIP?	
Continues to be refined and improved/Valuable/ positive experience	42.60
No	21.30
Increase community engagement/involvement	14.20

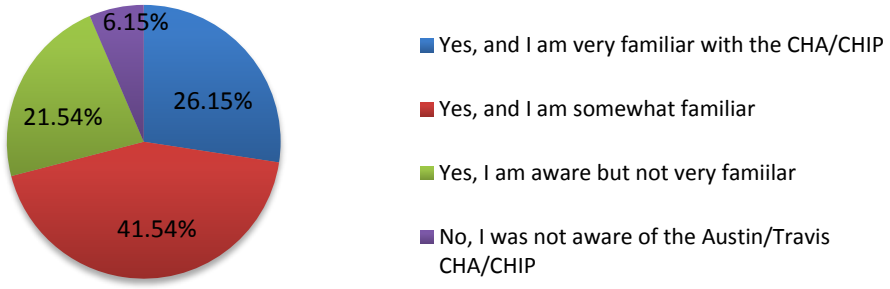
CHA/CHIP Community Stakeholder Survey Findings *(Community residents and stakeholders)*

The CHA/CHIP Community Stakeholder Survey was sent to community residents, leaders and other community organizational stakeholders who attended one or more community health forum sponsored by the Austin/Travis County HHS but who were not directly involved with one of the CHA/CHIP work groups or planning groups. Of the n=408 emails that were sent the survey, n=15 emails were not valid, bringing the final sample invited to participate in the survey to n=393. Of those invited, n=65 individuals completed the online survey (16.5% response rate).

Characteristics of Respondents

Respondents were majority female (73.8%), with 53.8% identifying as Hispanic, 26.2% as white and 20% as African American. Majority of respondents (86.5%) live in Travis County representing 32 different zip codes while others reside in Dallas, Fort Bend, Hidalgo, Bastrop, and Williamson Counties. When asked if heard about the CHA/CHIP before the survey, 41.5% answered "Yes, and I am somewhat familiar." (Fig. 10)

Figure 10. Have you heard about the CHA/CHIP before this survey?



Community Perceptions of Importance and Progress of CHIP Health Priority Areas

The evaluation team asked the community if the four priority areas identified in the CHIP were still relevant to Austin/Travis County. Over 80% of respondents found access to healthy foods, access to primary care and mental/behavioral health care services, and obesity as "very important". Only the 'access to bike lanes and trails' was not as seen as important as the other issues. Table 8 lists health issues inquired about.

Table 8. How important are the following health issues for the Austin/Travis County community? *CHA/CHIP Community Stakeholder Survey, Evaluation of ATC CHA/CHIP Cycle I*- September 2016. (n=65)

	Not important (%)	Somewhat important (%)	Very important (%)
Access to healthy food	0	16.92	83.08
Access to primary health care services	0	16.92	83.08
Access to mental health services	0	14.06	85.94
Access to public transportation	0	26.15	73.85
Access to bikeways (bike lanes and trails)	13.85	36.92	49.23
Access to sidewalks and walking paths	3.08	24.62	72.31
Obesity	1.54	10.77	87.69

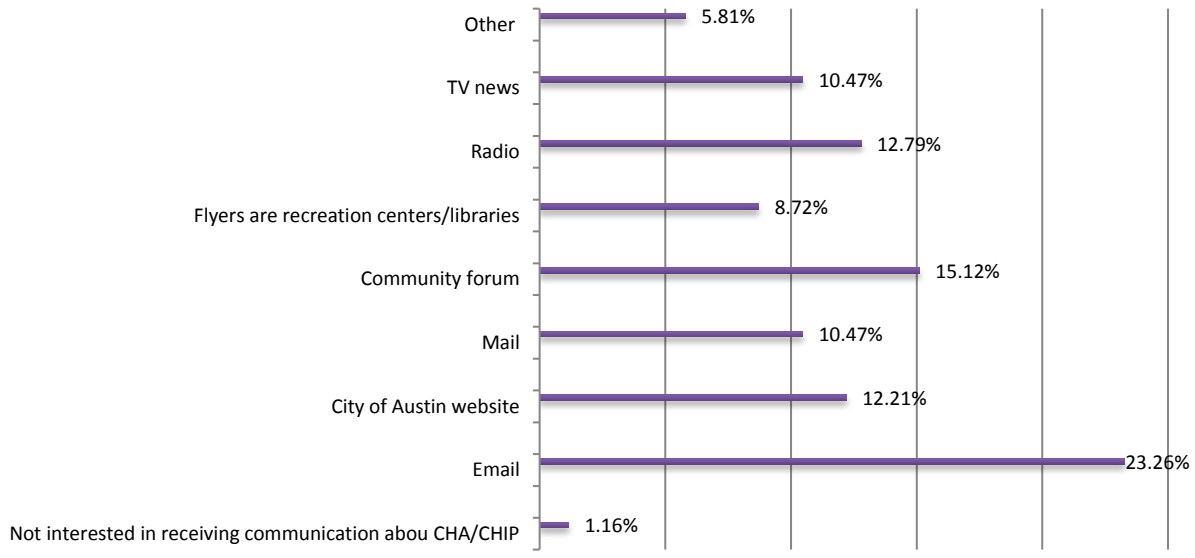
It could be hypothesized that the access to bikeways was not seen as important due to community members noticing most improvement in that domain. Almost 83% saw "some" or "a lot" of improvement when it came to accessing bike lanes and trails in Austin/Travis County. The top three domains in which respondents saw "no improvement" were obesity (53.2%), access to mental health services (49.2%), and access to transportation (46.2%). Regarding *access to healthy food*, *primary care and mental/behavioral health services*, and *access to sidewalks and walking paths*, between 72.3% and 75.4% respondents saw "some" or "a lot" of improvement. Asked to provide examples of improvements seen, respondents (n=48) mostly cited bike lanes (n=15), opening of healthcare facilities and increased offerings of mental, behavioral, and primary care (n=13), and additional bus stops and routes (n=11).

The evaluation team further probed on health issues listed in Table 8 by asking the respondents to consider those issues within their *community* versus the broader Austin/Travis County. All of the health issues were seen as "somewhat" or "very important" (82.3% - 93.8%) (data not shown in tables). Just as for Austin/Travis County, respondents said that in their community the most improvement seen was in the access to bikeways domain. The highest domains for 'no improvement' seen were in the access to mental health services (71%) and obesity (70.2%). The examples provided for the improvement seen in the community corresponded to those seen in the greater Austin/Travis County: increased bike trails, opening of clinics, and increased bus routes.

Communication

The most effective way to communicate to community members about the progress of Austin/Travis County CHA/CHIP is via email (Figure 11). The least effective is posting flyers at recreation centers and/or libraries. Only two respondents were not interested in receiving communication about the CHA/CHIP. Almost 6% of respondents listed other ways of communicating with them on ATC's CHA/CHIP progress, which included the following: Nextdoor.com, reaching out to apartment complexes, Facebook, community meetings with local government officials and community leaders, churches, and community organizations (data not shown in figure).

Figure 11. What is the best way to communicate to you and your neighbors about the progress with the CHA/CHIP?



Participatory Evaluation Workshop Findings *(Organizational & Community Stakeholders)*

CHIP Organizational Stakeholder Participatory Evaluation Workshop

Zilker Botanical Garden, Austin, Texas - June 6, 2016

Twenty-six organizational stakeholders, representing government (health and transportation), hospital, and nonprofit and community-based organizations, participated in a participatory evaluation workshop held at Zilker Botanical Gardens on June 6, 2016. This participatory evaluation workshop session was incorporated into a scheduled CHA/CHIP community event and recognition ceremony, with the workshop taking place during the second half of the event and lasting approximately one hour. Members of the UTHealth School of Public Health evaluation team along with three interns and an AmeriCorps volunteer co-facilitated the session.

Photo*: CHIP Work Group exploring their "Ventana"*

The participatory evaluation consisted of an exploration and discussion *of highlights, lessons learned, recommendations for enhancement of CHIP process,* and *vision for the next CHA/CHIP cycle* via a small group "Ventana" activity, with each topic area explored within one of the four window panes (see photo of example 'Ventana" and further description in methods section).

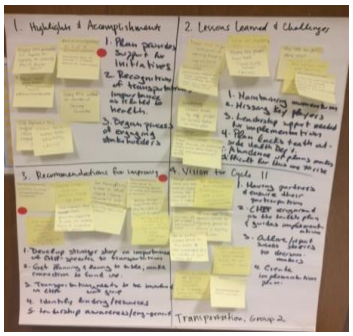


Photo*: Example "Ventana"*

Participants self-selected into four groups, with each representing one of the four CHIP priority health areas (access to healthy foods, access to primary care and mental/behavioral health services, built environment: transportation, access and chronic disease focus on obesity). Each small group (ranging from 3-10 individuals each) had members who had been involved with the CHIP work groups, although participants had varying levels of experience with the CHIP. Two of the work groups divided into two smaller groups, and two of the work groups maintained their same composition for the activity. While a "gallery walk" activity was planned for the last segment, the rich conversations took longer than expected, and two groups were not able to fully participate in the final activity.

Photo*: CHIP Work Group exploring their "Ventana"*

In Table 9 we present the major themes identified by workshop participants, organized by each "window pane" of the Ventana and each of the four work groups (*Built Environment Focus on Access to Healthy Foods, Built Environment Focus on Transportation, Access to Primary Care and Mental/Behavioral Health Services,* and *Chronic Disease Focus on Obesity).* A summary of these themes from across the four work groups precedes the specific input from each work group presented in Table 9.

Summary of Themes Explored at CHIP Organizational Stakeholder Participatory Evaluation Workshop

CHIP Highlights & Accomplishments

- ✓ Increased collaboration and engagement of organizations, groups and community stakeholders
- ✓ Increased communication in general and specifically around community initiatives and partner organization activities
- ✓ CHIP provides guidance and direction for funding of actions and new initiatives
- ✓ CHIP raised awareness about specific health issues, gaps in services, and opportunities for action
- ✓ Progress with specific CHIP actions, including implementation of new policies and practices that were guided by the CHIP

CHIP Lessons Learned

- ✓ Need to explore further how to best communicate with and engage with community stakeholders and CHIP work group members
- ✓ Turnover of staff who were participating in CHIP workshops, lack of succession plan and need to explore further how to retain group members "and maintain momentum"
- ✓ "Focus on less and do more": discussion of how many objectives and strategies are the right number
- ✓ CHIP framework may warrant further fine-tuning to make more user friendly.
- ✓ Lack of budget/ funding was a limitation
- ✓ Need leadership support for implementation of actions
- ✓ Need to ensure the right people are at the table in the work groups (missed some essential partners with some CHIP work groups)
- ✓ Need to explore further how to coordinate CHIP actions with organizations and actions/programs within organizations

CHIP Recommendations

- ✓ Explore and identify funding sources for CHIP actions
- ✓ Develop new and efficient reporting system on CHIP progress
- ✓ Strengthen CHA/CHIP communication, including clarification of purpose, mission, messaging for specific groups, creation of a recognition plan for partners
- ✓ Link to existing community-wide initiatives
- ✓ Build CHIP actions into existing department plans (e.g., government)
- ✓ Grow CHA/CHIP partnerships, continue to explore ways to engage community stakeholders, including community residents, and focus on building cohesion among participants and organizations
- ✓ Explore ways to better evaluate and capture CHIP progress

Vision for Cycle II

- ✓ Fewer goals/objectives/strategies for CHIP in order to go deeper
- ✓ Recognition of CHIP across agencies and organizations as "THE HEALTH PLAN"
- ✓ Use of innovative approaches to engage community
- ✓ Increased and enhanced partnerships, with partners knowing their roles
- ✓ "CHA/CHIP drives action"
- ✓ Enhanced communication and marketing plan
- ✓ Continue specific priority areas from CHIP I such as healthy eating, transportation, obesity
- ✓ Specific topics of interest (in addition to current priority areas): health literacy, tobacco, breastfeeding, critical health outcomes, diabetes

Table 9. Looking through the "CHIP" *Ventana* to explore highlights, lessons learned, recommendations, and vision for Cycle II. *Participatory Evaluation Workshop - CHIP Organizational Stakeholders, Evaluation of Austin/Travis County CHA/CHIP,* Austin, TX June 2016. (n=26)

"Window Pane" Discussion Topic	**Built Environment: *Focus on Access to Healthy Foods*** (n=6 participants)	**Built Environment: *Focus on Transportation*** (n=3 participants)	**Access to Primary Care & Mental/Behavioral Health Services** (n=7 participants)	**Chronic Disease Focus on Obesity** (n=10 participants)

Highlights & Accomplishments	• Increased communication and collaboration between agencies
	  ○ Getting key stakeholders together in the same room to share ideas and find ways to work together
	  ○ Better communication and identification of gaps in food access
	  ○ Cross-COA and community grant collaboration, working towards bringing funding and projects to Austin/Travis County
	• Increased funding for healthy food access
	  ○ Healthy food retail one-time funding from council
		• Process of engaging stakeholders
		  ○ City Planning and Zoning's work on Vision Zero was integrated into the CHIP and adopted by the City Council
		  ○ Austin Transportation Department now a committed member of the steering committee
		• Community Health Improvement Plan provides support for initiatives
		  ○ CHIP partnership as impetus for grant application
		  ○ Success of Smart Trips pilot program and launch of the program into a second neighborhood
			• Collaboration across organizations/groups: Increased opportunities for collaboration/ Found commonalities between different organization's efforts
			• Communication established through new relationships with other entities working on similar issues/ Sparked new ideas from new partners
			• CHIP reporting showed magnitude of the problems: Good way to track success and areas needing improvement/ "connected all the plans"
			• Successes in priority areas were seen as "greatly benefiting the community"
				• Collaboration across organizations/groups: Collaboration among Community Stakeholders/ Connecting various organizations and nonprofits within the City/ Breaking down silos within organizations such as City of Austin Health and Human Services/Cohesiveness to Our Work at HHSD: sense of different components, projects, initiatives across departments and community.
				• Communication between organizations about various initiatives
				• Specific policies and initiatives that arose over the time period of the CHA/CHIP, which included:
				  ○ promotion of mother-friendly (breastfeeding) worksite policies and practices (ongoing lactation training for health care professionals

	○ Funding from City & County for food access ○ Increased funding for Double Dollar incentive program • <u>Increased identification of needs</u>	• <u>Broader view of health</u> ○ Recognition of transportation importance as related to health ○ Diverse group of participants		and providers; annual community-wide breastfeeding support initiative summit; and community-based initiatives such as ○ raising awareness of health promotion/obesity prevention in ATX/Travis County ○ Physical activity initiatives such as 8-week "yoga beginner series', "diabetes empowerment & education program, "Walk TX Active Austin 10-Week Challenge" now on website; ○ GAVA/Resident-led coalition brought to life in last 3 years; now 8 organizations and more than 1,600 residents have been involved working on improving; 32 community assets; 100s of strategies in motion. • <u>Connection with broader and ongoing initiatives</u>: "Good that [CHA/CHIP] tied to Imagine Austin, Comm. Transformation Grant, Office of Sust., HHS, PARD activities. • <u>New resources identified</u> /coordinated progress (see Annual Report)

Lesson learned & challenges	• CHIP document and framework was not easy to understand and contained difficult language
	  ○ Reporting was challenging and difficult to follow
	  ○ A lot of language between strategies was similar and overlapping making it difficult to differentiate
	  ○ Document/action steps were overwhelming – hard to focus energy
	  ○ Objective/Strategy numbering system very difficult to work with - complicated and burdensome
	• Funding impacted capacity to reach goals
	  ○ Lack of funding for strategies
	  ○ Action items moved forward when a specific person owned them
	• Retaining Participation & Consistency of Partners
		• Momentum needs to be maintained
		  ○ There needs to be communication regarding work completed and next action steps once staff turnover within participating group occurs
		  ○ Suggest integrating CHIP into departments' work plans
		  ○ "Establishing a cohesive sense of different players as working together on this plan"
		• Key players missed in the work group
		  ○ Key transportation partners either absent in the CHA/CHIP process or "late to the table"
		• Crucial to receive leadership support for implementation
		  ○ Participation in CHA/CHIP must be viewed as priority in participating departments/stakeh
			• Budget/Funding Challenges: "Connecting with DSRIP may have been too limiting" / providing materials in preferred languages to improve language access was "difficult at times"
			• Fluidity/Turnover of Work Groups:
			  ○ Challenges to staffing and recruitment of new participants within organization
			  ○ "Role of participants was unclear"
			  ○ Need for "a sell or a why" for new recruits
			  ○ Frequent turnover led to a " loss of knowledge"
			• Need to explore how to best engage with other stakeholders: Important to convene with other stakeholders to collaborate and share efforts and results/ "learn from each other"
			• Evaluation of Impact
			  ○ Participants were not certain they were "capturing all the success"
			  ○ "Focus on less and do more!"
				• Budget/Funding Challenges
				  ○ CHIP initiatives should not be driven by grant initiatives/
				  ○ Funding Gaps to Support Plan/
				  ○ "We need to find more opportunities to tie our planning and sharing to funding – alignment with budget process. Also can combine resources across organizations at the table
				• Fluidity/Turnover of Work Groups: Turnover of work groups made communication difficult/ Fluidity of work groups and individuals involved with CHA/CHIP: Need opportunities for reconnecting more often
				• CHA/CHIP Plan as Guide for Community: "Continue ongoing communication and referral back to CHA/CHIP plan"/community realize the direct tie to the CHIP (how activities/initiatives fit within CHIP)
				• Need to explore how to best engage and communicate with stakeholders
				  ○ Communication between organizations

	○ Partners would join, others would drop off ○ You can't assume all partners know the work of each other ○ There were many partners identified that should have been brought to the table (Austin ISD, Travis County school districts, Sustainable Food Center) • <u>Communication remained a success and a challenge</u> ○ Not all City of Austin departments are in regular communication and could benefit from increased coordination ○ Difficulty of reporting was also a communication barrier	olders; buy-in of the directors sought ○ "Very little can get done without institutional investment/commitment" • <u>Abundance of plans within an organization or a department</u> ○ Much simultaneous planning that potentially could be combined and coordinated ○ Find a way to streamline scarce resources ○ "How do we effectively move from plan to implementation?"		○ How to best engage stakeholders/community/ "Challenge to have stakeholders/ ○ Collaboration is key: Need to have an identified key staff person [from each organization/department] • <u>Evaluation of Impact</u>: ○ "Hard to identify our results so that we know our contributions/how contributions affect us"/ ○ "Assessing progress or outcomes for objectives can be difficult due to limited data sources"
Recommendations	• <u>Link to funding and diversify funding</u> ○ Connect research to strategies to funding ○ Diversify funding sources beyond just	• <u>Essential for transportation work group to be involved in the CHA</u> ○ Investment from key players in the beginning	• <u>Grow CHA/CHIP Partnerships</u> ○ Establish and seek out new relationships and representation from communities that	• <u>Grow CHA/CHIP Partnerships</u> ○ Grow the workgroup to include additional stakeholders but also maintain ability to manage and capture

	City of Austin (foundations, investors, etc.) to not rely on only one large source of funding • Develop a new reporting system with an online platform and usable format for reviewing and reporting on action items • Increase Public Acknowledgement for Participation from city leadership (i.e. Mayor) as a means to increase participation and retention • Link to other existing programs, stakeholders, and community partners ○ Matching efforts with Imagine Austin, AISD, UT Master Plan etc. • Educate and engage policy makers in CHA/CHIP	• Create a stronger message on importance of transportation ○ Educate on connection between health and active transportation • Stakeholder involvement ○ Planning and Zoning should be on the Steering Committee; connection to land use needs to be recognized ○ CHIP to be built into department work programs ○ Leadership not only needs to be aware, but engaged ○ "Show value to participating groups to make this process a priority" • Funding ○ Identify lending sources and funding for the implementation process	are not "big players"/ include other organizations "to get a more complete picture of changes" ○ Coordinate with other "research and planning entities (Comm. Care Collab, Dell Medical School, Department of Population Health, etc)" • Clarify purpose of CHIP • "Create opportunities to define value" • "Establish more defined roles of partners" • Keep focus on existing priorities: "Streamline the reporting process"/ Provide a process to capture or add new "efforts/strategies DURING the 3 year CHIP" • Community input: Explore/broaden ways to gain more community input	everything in the community/ ○ Recruit additional organizations that can contribute/Connect with more organizations such as local shops and coalitions. ○ Make connections more unique to Austin (i.e., bike shops, local farming). ○ Relationship mapping (Who are we missing?) ○ Expand to other clinic systems (FQHCs: do they collect #s? Do they use motivational interviewing? Send our recommendations to them?) • More group cohesiveness • Communication: More follow-up and communication between workgroup meetings • Need to consider Sustainability and Accountability (also vision for cycle II)

Vision for CHA/CHIP Cycle II	• Use innovative approaches to engage community
	  ○ Increase awareness, participation, feedback, and buy-in
	  ○ Collaborate with other initiatives
	• Integrate with other CHA/CHIP groups at the non-profit hospitals
	• Maintain access to healthy food as a priority area
	• Fewer goals may be easier to drive toward and show measurable success
	• Ensure continuity for ongoing programs/updates from current CHIP
		• Participation
		  ○ Agency partners represented throughout the CHA/CHIP creation and implementation
		  ○ Committed partners for implementation who understand their roles
		• Recognition of CHIP across agencies as THE health plan that guides implementation
		  ○ CHIP recommendations to be integrated and to "drive participants' work plans"
		• Success stories
		  ○ Capture and report back on action items
		• Creation of an implementation plan
		  ○ Outline the implementation process
		  ○ "Ensure a review of existing efforts is conducted and is thorough before developing action"
			• Specific health topics/priorities that should be considered:
			  ○ Development of a unified Healthy Literacy Information Plan: Identify language and translation needs and "coordinate access"
			• Stakeholder Engagement:
			  ○ Develop strategies to "recruit and involve steering committee members in substantive work which requires their input and influence"
			  ○ Expand partnerships: Explore non-traditional partnerships
			  ○ Recruit annually for key roles: define jobs
			• Create clearer and fewer metrics for measures
				• Specific health topics/priorities that should be considered:
				  ○ For chronic disease priority: include tobacco prevention
				  ○ Continue to include breastfeeding strategies awareness and health care professional engagement, training, etc. & hospitals to be baby friendly
				  ○ Include critical health outcomes that may not have been included [in previous CHA/CHIP or identified by community]
				  ○ Include diabetes with obesity
				• Build on recently released community health needs assessment (CHNA)
				• Large scale social marketing and invitation to get involved in various ways
				• Ensure we are meeting the needs of the community/Buy in from community and partners/Partners commitment and support is

				ongoing and mutual/Check issues/strategies and goals with community – validate to see if useful to them • <u>CHA/CHIP drives action</u>: "More action (programs or policy change) as a direct result of workgroup work" • <u>Look for opportunities to scale</u> [other successful initiatives] • <u>Evaluation and Data-Driven Actions</u>: Data informed best practices based to meet community needs/ How can data/evaluation person (and others with these skills) be involved from the beginning to support the CHIP process? • <u>Stakeholder Engagement</u>: ○ Internal staff members/community members: What skills/roles are we missing: make part of staff's job description (e.g., HHS) ○ How do we tie in/align with the new medical school?

Community Stakeholder Participatory Evaluation Workshop

El Buen Samaritano, Austin, Texas – August 25, 2016

A total of 37 individuals participated in the community stakeholder participatory evaluation workshop session held at El Buen Samaritano in Austin, Texas on August 25, 2016. Participants included community residents and a range of community stakeholders representing social service, health and healthcare, academic/educational, government and community-based organizations. The workshop lasted approximately one hour, with roughly 40 minutes dedicated to a small group round robin style participatory learning session in which two facilitators per CHIP priority health topic rotated among the groups for a 10 minute exploration. At the end of the round robin, facilitators shared a key highlight or lesson learned from each CHIP priority health topic identified by the group.

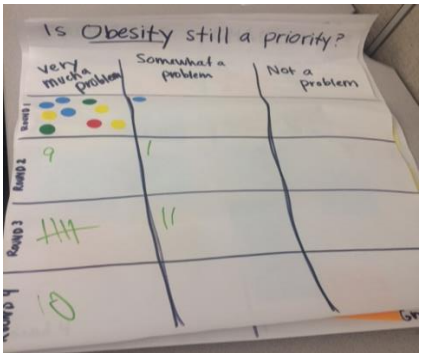


Photo*: Group Rating of Priority: CHIP Health Topic*

In Table 10 we present tallies on participant perceptions about the level of current priority of the CHIP health topic as well as the key themes identified for each priority area, organized by the two topic areas explored: 1.) perceived progress with CHIP health topic area; and 2.) challenges and ongoing needs for CHIP health topic area. Under the progress and challenges/ongoing needs columns, we include the individual and group input recorded on the "progress and challenges" flip chart used during the session and organize this input under key thematic categories. In introducing Table 10, we provide a brief synopsis of the findings for each CHIP topic area.

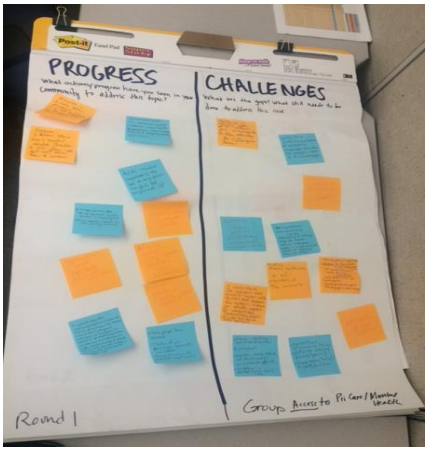


Photo*: CHIP Priority Area "Progress & Challenges"*

Synopsis of Findings

Built Environment: Access to Healthy Foods

Priority: The majority of participants (n=32/37) felt that access to health foods was still an important priority topic for Austin/Travis County community, with five participants rating the topic as 'somewhat a problem', and none rating the topic as 'not a problem'.

Progress: Participants mentioned that in the last three to four years they noticed more organizations in the community making access to healthy foods a priority and doing programs such as farm stands, healthy corner stores and farmers markets that do double SNAP dollars. They also mentioned that there is a greater awareness and discussion with health professionals that nutrition is an important part of staying healthy.

Ongoing Challenges: Participants cited cost as a barrier to buying healthy food, and that some areas of town have very limited access to healthy foods because of land use and transportation issues. People who work on the corner store initiative have had challenges getting smaller stores to carry healthy items in neighborhoods that have otherwise limited access. There was discussion that American culture promotes unhealthy food and uses unhealthy foods as a reward. Participants discussed a knowledge gap

on understanding how to eat healthy, and cultural differences that need to be incorporated into nutrition education.

Built Environment: Transportation

Priority: Most people thought that access to active transportation including public transportation, bike lanes and pedestrian walkways, is still a problem in the community (n=32/35), with two people rating this issue as "somewhat a problem" and one person rating transportation as "not a problem".

Progress: In the past three to four years participants cited several improvements with transportation, including increased bike lanes and paths and the new city B-cycles that have been popping up around town. Participants also cited noticeable improvements for pedestrians at crosswalks. In addition, participants mentioned that Austin is a recreation friendly city, and that there have been improvements on the Ladybird Lake Hike and Bike trail boardwalk for access on the east side. Participants mentioned that CapMetro has added new routes including the rapid routes that come more frequently, and that on main streets, there are bus-only lanes that help busses go faster through traffic. Some participants also mentioned specific transportation improvement campaigns including Vision Zero and Smart Trips. There was also some discussion of car transportation and road improvements.

Ongoing Challenges: Participants shared that although there have been improvements in bike lanes, bike lanes are still not continuous throughout the city and sometimes they will just stop, which is a safety concern. Participants also discussed that although some improvements have been made for pedestrians, there are areas of town that are still not safe for a pedestrian. People mentioned that not having a vehicle is difficult, and that it is getting worse for those who are moving out of the city core due to rising costs. Participants also shared that people who are moving further out and do not have cars have to make multiple transfers on busses that are sometimes unreliable to get into town. Participants mentioned that the one metro rail line is not enough, and that although there are a lot of busses that run north-to-south, there are very limited busses running east to west. There was discussion of congested traffic and needed road improvements. Ride sharing came up, especially since Uber and Lyft have left, and people mentioned that cost has gone up and that there are fewer options.

Access to Primary Care and Mental/Behavioral Health Services

Priority: The majority of participants (n=34/36) felt access to primary care and mental/behavioral health services was still a problem for our community, with two participants voting that it was 'somewhat of a problem', and zero saying that this priority area was not a problem.

Progress: When discussing progress over the past 3years in this area, participants mentioned that more people are insured thanks to the Affordable Care Act, and that there seems to be a slow but important trend of recognizing that integrated care is a good approach to take. Participants cited health facility and service improvements in Austin, including the opening of new clinics, shorter wait times, some mobile health units that reach underserved communities, and more doctors who speak Spanish. School based mental health and social-emotional learning (SEL) were also noted as a point of progress in the community. For mental health, people discussed that there is less stigma than there was before.

Ongoing Challenges: Although participants mentioned that they have seen more doctors that speak Spanish, people also mentioned that language barriers were an ongoing challenge and that there are not enough doctors who speak languages other than English or can relate to clients from other cultures.

Similarly, although integrated care was mentioned in the progress section, people still mentioned that it needed improvement. In particular, participants cited that navigating the insurance and healthcare system can be very difficult, especially for those with low literacy, and even with insurance it can be difficult to find providers because of complicated reimbursement networks. A knowledge gap between what is available and what people know is available was also discussed. Participants also mentioned that health equity is a challenge. Affordability was discussed as was the issue of transportation, which is further complicated by lower income people who rely on public transportation, moving outside the city core and farther away from clinics. Some participants mentioned that schools do not have comprehensive health education, and that is an opportunity for improvement. Another institutional challenge in Texas is the fact that the State did not expand Medicaid. Although participants said that over time stigma has decreased around mental health, they still cited stigma for mental health as a challenge that merits further attention and action.

Chronic Disease Focus On Obesity

Priority: The majority of participants thought that obesity was still a problem for the community (n=32/36), with four participants indicating that it was somewhat a problem and zero participants said that it was not at all a problem.

Progress: With regard to progress, participants shared that there are many free fitness opportunities through the city libraries and parks, and that Austin has good outdoor spaces for free exercise. Schools were also cited as a setting where there has been implementation of programs around physical activity and nutrition, and that workplaces have started to incentivize healthy behavior due to insurance plans.

Ongoing Challenges: Participants mentioned that although Austin has great outdoor spaces, there are some neighborhoods that do not have access to them. There was discussion about the cost of eating healthy and access to healthy foods. People mentioned that in the U.S. culture, doctors do not take the time to discuss obesity, and that we are challenged by very busy schedules and the feeling of rushing to eat, coupled with sedentary lifestyles at home. The concern of health literacy and cultural competency came up as an ongoing challenge to reaching the community.

Table 10. Community perceptions of level of priority, progress, and challenges & ongoing needs with CHIP health topic area. *Participatory Evaluation Workshop - Community Stakeholders, Evaluation of Austin/Travis County CHA/CHIP,* Austin, TX August 2016. (n=37)

CHIP Health Priority Area	**CHIP topic still a priority/problem in community?**	**Progress**	**Challenges & Ongoing Needs**
Built Environment: Access to Healthy Foods	Yes, very much a problem: 32 Somewhat a problem: 5 Not a problem: 0	*Availability of Produce* • Produce • More fresh produce purchasing • More diverse selection of produce *Increased awareness of issue* • It's a conversation • More awareness of health impacts of nutrition • Initiatives more available in health clinics/making it more a health issue • Availability of nutrition information • Increased awareness of diabetic nutrition • More awareness of food deserts *Organizations working toward improving* • Community organizations making it a priority • Healthy corner store initiative • Brighter Bites provides thousands of pounds of fresh produce to thousands of families in Austin • School community gardens • Central Health summer food program • Created community food plan in Rundberg • More usage of meals on wheels (mobile loaves and fishes) • New AISD food manager is focusing on health more • Schools: summer feeding program, backpack of food • Community garden movement	*Challenges/needs work* • Healthy food in small stores • Lack of access at smaller stores or markets • What are barriers to smaller stores carrying healthy food *Areas with very limited access* • Transportation and land use issues create food deserts • Food deserts • Lack of access east of 183 • Transportation • Lack of availability of farmers' markets *Cost* • Poverty • Food assistance programs do not allow for access to fresh foods • Affordability • Inequitable access • Cost • Cash on hand to buy food • Affordability *Knowledge of nutrition and nutrition resources* • Knowledge: cooking recipes • Education about what eating healthy really means

		Farmers Markets • More farmers' markets • Double dollar (SNAP dollars on produce at farmers' markets) • Double dollars • WIC/SNAP at farmers' market, for those who can easily get to them *Other* • Personal self-control • Policy improvements • Growing support for breast feeding • Increased public support (from community) • Food system manager • More access to organic food	• Lack of communication about resources • Need more nutrition education • Linking nutrition and health *American Culture* • American culture promoting unhealthy choices • Food messaging • Over eating • "reward foods" are cheap, sweet foods, change celebratory culture of unhealthy food *Ensuring programming meets resident needs* • Culturally appropriate food options • Culturally appropriate recipes • Lack of understanding around residents' needs • Presenting resources in a sensitive way *Sustainability* • Comprehensive approaches to addressing food needs (e.g. growing, education, etc.) • Increase support for sustainability

CHIP Health Priority Area	**CHIP topic still a priority/problem in community?**	**Progress**	**Challenges & Ongoing Needs**
Built Environment: Transportation	Yes, very much a problem: 32 Somewhat a problem: 2 Not a problem: 1	*Improvements (Bike lanes, paths, pedestrian)* • Bike & pedestrian improvements • More bike paths • Awareness: more bikes/path/ B Cycle • Increase in bike lanes • Improved bike lanes • More paths for bikes/pedestrians • adding bike lanes when re-doing roads • more bike lanes • More bike trails • Some bike lanes in areas • Improved walkway signs (crosswalk/peds) *Recreation* • Austin enticing and pretty: want to be active • Boardwalk was made easier to get to on the east side • More bikers/walking/canoeing *Bus improvements* • Busses are air conditioned • Added more busses to system • More people using busses • CapMetro app • Clean busses • CapMetro app • See more busses operating • Rapid bus line • Bus only lanes • Express bus – but needs more • 801, 803, 15: more routes *Importance relating to other priorities*	*Biking-specific challenges* • Biking • Bike paths not continuous, unprotected • Need more bike lanes • Lack of bike lanes and infrastructure • More bike lanes but sometimes they just end • Not enough employers offer showers *Pedestrian* • No sidewalks • Older neighborhoods have no sidewalks • Issues sidewalks and parking • Sidewalks • Safety walking • We need more sidewalks for walking • Not enough lighting/pedestrian crosswalks • Many pedestrian accidents • Cars driving over the crosswalk • Cracked sidewalk *Urban sprawl/gentrification* • Sprawl: people moving out into suburbs are not connected, hard to serve outlying areas • Gentrification driving people out, making it harder to reach those who need transit • People are being pushed out of the city and if they have bus access at all it takes 3 or 4 transfers to get where they need to go

		• There seems to be an awareness between lack of transportation and health, e.g. accessing primary care or healthy food • Access to transportation is a key ingredient to addressing the other priority issues *Mention of specific projects* • Vision zero (3 times stated) • Smart Trips (3 times stated) *Roads & cars* • MoPac expansion • 130 relieving • TNC • Toll ways – too bad you have to pay though • More transportation options	• Due to gentrification on the east side many people have been from their communities do not have access to food and needs *Public Transportation* • Better bus routes/more connecting routes • Buses run north to south but not really east to west • Access to bus routes • Bus schedules inadequate • We have no access from east to west or surrounding areas (like Round Rock, Pflugerville) • Bus routes insufficient • Inefficient transit maps and connections make traveling somewhere that isn't downtown difficult • Limited transit outside Austin city limits • Facilities at transit centers (bathrooms) • Not all busses have wheelchair lifts • No west to downtown bus • Lack of bus routes, light rail • No rapid east to west bus • Cost at times for families • Reliability • Not all bus stops have a shelter (rain, lights) • Late buses on CapMetro • Rude drivers on CapMetro • Transit center with indoor facilities for inclement weather and bathrooms • Weekend route need greater frequency • Need more bike racks on bus (hard to travel when you're not solo)

			• Negative stigma attached to transit (and sometimes biking too) • Rail failure • Limited rail • Our rail was described as a massive failure • Inadequate train times/routes • We need a train system • Lack of emphasis on funding transit and alternative modes as opposed to expanding auto infrastructure *Not having vehicle is difficult* • Without a car it's just plain difficult to get around Austin and it takes a long time • Clinics are often too far from people who need them • Transport for people who can't drive – ex. Seniors • People needing personal transportation to appointments *Toll roads* • Nobody uses tolls because of the cost • Traffic congestion in downtown area near hospitals • Toll roads • Cost of toll roads *Ride sharing* • TNC longer wait, more expensive since Uber/Lyft left • "Ride sharing" efficiency/cost • Now "ridesharing" more expensive than Uber/Lyft

			Vehicle traffic/roads • Pollution and traffic in cars • Traffic • Parking limited • Traffic prohibits outdoor/active transportation • Traffic • Traffic • Street repairs needed • Bad drivers/accidents • Traffic congestion • Bad road design

CHIP Health Priority Area	**CHIP topic still a priority/problem in community?**	**Progress**	**Challenges & Ongoing Needs**
Access to Primary Care and Mental/Behavioral Health Services	Yes, very much a problem: 34 Somewhat a problem: 2 Not a problem: 0	*Affordable Care Act* • More people have insurance • With ACA there appears to be a big push to get people signed up • Affordable care act • ACA *Integrated care* • Slow but progress in recognition that primary care access reaps significant benefits to whole community • Greater awareness of the need for integrated primary care and behavioral health care • Integrated approach to healthcare • Integrated care *Facilities* • Creation of new facilities (Herman Center, new hospital) • Promise of community centered medical school • I would say the implementation of mental health promotion has made significant progress throughout the years in terms of representation on social media (which is an effective way to reach out in our society today) e.g. TV ads, billboards, YouTube, etc. • Able to access employment, got a job recently • Community Care access, more clinics, ER clinics last year • Investment in community health centers – people's community clinic expansion, Southeast Health and Wellness Center • Community Care SE Health and Wellness Center • More FQHCS in underserved areas	*Language and Cultural Barriers* • Language barrier • Literacy services • Lack of behavioral health providers who speak Spanish • Lack of providers who speak Asian languages or other languages • Limited providers who can work with families who do not speak English • Cultural insensitivity • Not enough providers who look like the people they serve *Health Equity* • I would like to see everyone have access to mental health services that address the systemic trauma our society creates for marginalized communities, people of color, and those that benefit • Health equity • Health disparities *Navigating System and Insurance* • Navigation of the system • System is confusing • System is confusing • Can take hours and an advocate to be with you to help navigate • Providers that only accept certain insurance • Confusion about health insurance and accessing it • Too much criteria to follow • High copays

		• CommunityCare expansion and growth • I know there are more mental health facilities, but not sure how to access • Access to a multitude of walk in clinics • Access to high quality medical care • SE Health and wellness center • Increased clinics • Many free clinics available throughout the city for different populations • Shorter wait times for behavioral health providers within CommunityCare *Regarding Mobile Health Clinics/Outreach in communities* • Mobile health teams being able to go out to underserved populations • Mobile teams • Outreach to communities not being reached by services • Mobile health *Reducing language barriers* • Providers that can speak Spanish • Care is available in Spanish for most primary services • Multi-lingual outreach to new immigrants regarding healthcare *In schools* • AISD early intervention with SEL • School based mental health services *Regarding stigma of mental health* • For mental health – decreased stigma for some diagnoses (esp. depression, anxiety, bipolar), increased awareness of impact of trauma	• Personally I've found the new marketplace to provide fewer, less affordable options than I had before • Rising healthcare costs • Battles with insurance to pay for mental health • Even for people with private insurance, the process of reimbursement for mental health is cumbersome • Difficulty obtaining specialty referrals • Referral system between services • Level of coordination of programs working together • Wait list to see providers • Difficulty getting appointments • Long wait times at community clinics • Not enough behavioral health providers • Not enough access to good mental health practitioners • Not a broad enough health provider network • System is difficult to figure out • Timely access to services *Stigma* • Stigma to utilizing mental health services • Emphasizing confidentiality and the normality of seeking help for mental health. Everyone needs it, it can only be beneficial, breaking the stigma • People afraid to disclose • Stigma • Stigma associated with mental/behavioral health • Stigma and fear of healthcare system • Depression, stress, anxiety not recognized as having health effects

		• Society does not see it as a bad thing to ask for help • More public awareness and willingness to talk about mental health as a component of overall health • Burgeoning awareness of the comorbidity of physical disease and mental instability • Talking about the issue! *Other/personal* • People seem to be more accountable • Can be an invisible disease until crisis erupts, make awareness • 1115 waiver programs • 1115 waivers • Access to care for UT students • Successful health education campaigns • Increased access • I have seen progress, enrolled in clinic and now have primary care physician • I've heard some folks, especially older individuals have had more positive experiences overall • Building new places for people to live • New programs currently running	*Schools/education* • Lack in quality health education in schools *Transportation* • With the suburbanization of poverty, transportation to access care is a challenge • Transpiration (lack of) to health facilities • Getting people to/from places (i.e. that don't have a car, don't know how to ride the bus, etc.) • Transportation to clinics • Actually getting people access to primary care physician and transportation for them *Knowledge gap of what is available* • Knowledge of clinics and services available • Knowledge of where to go to seek help • Lack of awareness • Awareness of services available • How to qualify for services • Lack of knowledge • Lack of knowledge of how to access • Intake doesn't ask the right questions *Affordability* • Real affordability • Real transparency in fees and access to services without health insurance • Absence of free/cheap counseling resources *State funding problems*

			• State denial of Medicaid funding • Medicaid expansion • State legislature does not support healthcare for low income families • Not expanding Medicaid in TX • Funding • Not enough beds in the state hospitals *Condition Specific* • Homelessness • Substance abuse • Homelessness • Poor management of addiction *Other opportunities/thoughts* • Health information exchanges that talk to each other • Coordinated integrated care • Adoption of telehealth can increase access to more patients by using tech solutions • Access in areas outside of Austin • Crisis counseling at community centers • Access to more groups • Support for family of people needing services • Limitations in mental health crisis care • Providing mental healthcare to all members of the community • Behavioral health still not enough • Too many barriers • Too many programs with different levels of assistance and income levels • High turnover with ATCIC staff, especially psychiatrists • Very little progress, not enough education

CHIP Health Priority Area	**CHIP topic still a priority/problem in community?**	**Progress**	**Challenges & Ongoing Needs**
Chronic Disease Focus on Obesity	Yes, very much a problem: 32 Somewhat a problem: 4 Not a problem: 0	*Free classes around town* • Free fitness classes around town • Free yoga classes and others through My Library Keeps me Healthy program – we need steady/reliable funding and open communication to make as inclusive as possible • Fitness classes free at library, some parks, clinic etc. • Popularity of exercise classes at library and PARD • City of Austin programs in high need areas: my library keeps me healthy, PARD summer playground programs • Health and human services equity unit provides physical activity sessions, health educator Darrell • My library keeps me healthy program *Austin's outdoor spaces* • Town lake trail always packed with runners (but these people are usually already in shape) • There are lots of parks and outdoor areas, depending on where you live • Nature activities in Austin (no cost) • Being outdoors an active is fun and social and often affordable or free • Built environment allows for mobile transportation and exercise venues • Fairly active community: walking/running/biking by river, parks etc. • Focus on public activity spaces and parks • Increasing awareness about impacts of walking and biking on daily health • Increase in access to parks and recreation *Nutrition/healthy food resources*	*Doctors* • Most MD appointments are time restricted, they do not approach the subject • Medical students are not trained to prevent obesity – hopefully that will change • Need for holistic care that addresses why people are obese/challenges • Western (AMA) approach results in sick care versus holistic health care that is preventative. • Health prevention teaching not maintaining • Our health experts don't always practice what they preach *Health Disparities* • Obesity like many chronic diseases disproportionally affects people of color and people with low socioeconomic status • People of color are hurt most • Diabetes in populations (African American and Hispanic) *Schools* • Need to increase PE time in AISD *Built Environment/Public Space* • There are less parks and lower quality parks in zip codes with low income • Not every neighborhood feels safe to residents (re: outdoor activity)

		• SFC programs, farmers' markets, farm to work, gardening, cooking classes • Farmers market • Increase of healthier foods in brand name grocery stores • So many restaurants offer healthy eating options at mid-price point and up • Access to healthy eating • Organic food *Schools* • Unstructured 30 minutes of play at AISD schools • More kids walking to school • Brighter bites in AISD elementary schools and camps • Schools participating in fitness gram, marathon kids, cool school health and CATCH • Coordinated school health program at AISD • Healthy eating is being encouraged at school and in workplaces • Brighter bites programming in AISD • Improvement in coordinated school health • Food changes in cafeteria *Insurance/workplace* • Most work places now have insurance plan incentives for prevention and proof of increased activity • Incentives in the job market to meet certain hours of exercise then company eats cost • Insurance incentives for healthy behavior *Specific organizations mentioned* • YMCA exercise and weight loss • Marathon kids • GAVA – food/exercise • WeViva	• Built environment is not adequate • Lack of sidewalks • Limited or lack of funding for healthy infrastructure (biking, walking, transit) • Not enough sidewalks • Need public access to bike on main roads • Structural obstacles *Issues of Access* • Access to healthy foods • Access to teaching/knowledge of physical exercise • Cost of foods • Food deserts still a huge problem for many parts of A/TC • Grocery stores not accessible and south and east Austin • Unhealthy food still plentiful • Sodas are cheaper than bottles of water • Limited access to fresh food in many communities • Economic issues *Education & Culture/Language* • Education and culture • Education • More language diversity • Language • Cultural relevance • Family/culture eating habits *American culture* • People are busier than ever, feel they don't have time to be active • Culture of rushing to eat • Reframing ideas around obesity: health and body size stigma

		• Ure Action yoga • Primero Health • YMCA • GAVA work • YMCA/parks/library..access to physical activities • GAVA in 78744 and 78745 *Active transportation* • Bikes around town • B-cycle opportunity for riding a bike • More active transportation networks emerging (still disconnected) *General Awareness* • Awareness • Greater awareness • Realizing obesity is an epidemic – community engagement • Michelle Obama's emphasis on kids and activity • There's more of an awareness everywhere, which is progress *Other* • Austin is ranked one of healthiest cities in the US • Physical activity (soccer, walking) • Healthy at every size movement • Obesity is down in kids • Fitness apps (and Pokemon Go!)	• Pleasure in eating modern • Sedentary lifestyles • Lack of education around video games impact on health • Stigma around eating healthy *Other* • Available times • Transpiration • Library: people/patrons complain that exercise doesn't belong in library/it's noisy • Gym access for children of all disabilities • Policy change is hard, but needed • Diabetic complications, connection with obesity and diabetes • Tap water vs. bottled water • Social ecological obstacles to healthy choices

CHIP Outcome Indicator Review

Review Summary

As part of the evaluation, we conducted a review of the CHIP Implementation Plan "Goals, Objectives, Strategies, Key Partners, and Outcome/Output" indicator tables. These tables were developed by each of the CHIP work groups with the aim of identifying goals and strategies and tracking outcomes over the three year CHIP implementation period, from 2013 to 2015/16. In conducting the review, the UTSPH evaluation team completed a table with outcome indicators and related information such as baseline data and data gathered during the 3-year period. Tables for each of the four priority areas are presented in Appendix G.

For the *Chronic Disease/Obesity health priority area*, most of the data for the year 2 and year 3 time periods were not available (or at least not available to the UTSPH group in publically-available data sets). The long-term indicator related to decreasing adult obesity levels indicated a positive trend toward healthy weight, with a decreasing prevalence of adults with a BMI≥30 ("obese" classification) from 23.6% in 2013 to 20.5% in 2014. For the *Access to Healthy Foods* priority health area, many data points for baseline and subsequent years were not publically available. However, this is an area in which much work is being done by the City of Austin and the Austin/Travis County Food Policy Board and data will be forthcoming. One positive trend was seen for the number of people who are food insecure with a small decrease in the prevalence of insecure individuals in Travis County (from 18.1% in 2013 to 17.1% in 2015). For the *Transportation* and the *Access to Primary Care and Mental/Behavioral Health Services* priority health tables, baseline data were provided for some indicators, yet almost none of the indicators had any data for the 3-year period. The one indicator in which data were provided was for active transportation commute mode, which indicated stability (no or little change) between 2010-12 (17.79%) and 2011-13 (17.48%). Lastly, similar to the above priority areas, data were also lacking for most of the indicators identified for the *Access to Primary Care and Mental/Behavioral Health Services*. Despite this challenge, there were notable success stories, including the securing of federal funding via the Medicaid 1115, which made possible expanded healthcare projects, as well as a heightened focus on quality of care and patient-centered strategies (see ATC CHIP Annual Report Year 2, 2015 for specific examples). In addition, the percentage of adults in Travis County reporting five or more days of poor mental health over a one-month period decreased from 21.7% in 2013 to 16.3% in 2014 (Appendix G).

Challenges and Limitations with CHIP Outcome Indicator Review

In general, assessing the success of the CHIP based on review of the CHIP Implementation tables presented several obstacles, with a primary obstacle being the paucity of information available to determine progress of CHIP health priority areas in a quantitative manner. Below we share some of the key gaps and challenges that arose when trying to complete our independent review:

1. For many of the indicators, no local data were available. While it was possible to obtain state-wide data for some of the indicators, data for many of the indicators were not available at the county or city level. In the Access to Primary Care and Mental/Behavioral Health Services tables, while many indicators were rooted in key process-related changes that hold potential to improve health service

delivery (e.g., “increase % of providers trained on health literacy”), data and details were lacking on how to measure these outcomes. Furthermore, in conducting the review, we searched the CHA and CHIP reports as well as annual reports, yet data were not presented on most of the indicators.

2. Sources for data were often not clearly documented, and sometimes sources changed over the 3 years.

3. Indicators were not always easily measurable (e.g., “the % of environmental/policy changes that promote physical activity”) and not always specific (e.g., “increase % of utilized patient centered best practices”).

4. Some indicators/strategies were dropped in the 3-year period, but it was not clear which ones were dropped. Enhanced documentation is needed to indicate when an indicator is dropped.

5. In some cases, the listed indicator would have been more appropriately classified as a strategy (for example, the indicator “By April 2016, the City of Austin and Travis County will require and incentivize active transportation connections for all new development outside of the activity centers identified in the Capital Area Metropolitan Planning Organization’s (CAMPO) 2035 Plan” may be more appropriately classified as a strategy).

6. For some indicators, there were no baseline data, and sometimes data available for baseline did not align with the CHIP baseline period.

7. Indicators were not always directly aligned with specific strategies. In addition, while evidence was cited in support of strategies in the CHIP Annual Report (2013), the evidence cited was not directly connected to specific strategies. Furthermore, while recognizing the need for inclusion of best practices, it appears that some strategies were not evidence-based. Further clarification of strategies that are evidence-based would enhance the CHIP Implementation Plan template.

8. There were no data tracking outputs or documenting whether strategies were implemented.

Despite the challenges noted above, we still see great value in the proposed CHIP Implementation goal setting and indicator tracking framework that was created for this first cycle of the ATC CHA/CHIP. Recognizing that lack of data may be an inherent challenge with this process, some considerations for enhancing this approach for the next cycle may include:

1) Strive to prioritize and limit the number of indicators in order to further focus and deepen impact of actions, as recommended by other CHA/CHIP stakeholders cited in this review.
2) Further prioritize strategies to impact indicators, with attention paid to ‘important’ (related to outcome) and “changeable” (how changeable the strategy may be over time). In addition, clearly indicate when strategies are evidence based, and cite the evidence.
3) Consider development of a logic model for each priority area to spell out how strategies connect to the targeted outcomes/indicators.
4) Confirm that indicators are measurable and specific.

5) Consider development of a tracking system to track outputs and progress with strategies.
6) Clearly document when data are not available, and explore alternative approaches. For example, consider selecting and prioritizing a select number of indicators and strategies that can be tracked and evaluated over time via securing of funding to support evaluation.
7) Consider further clarification of the priority populations/settings and anchoring evaluation/data collection efforts to those priority populations/settings.

Discussion & Recommendations

"Learning is a treasure that will follow its owner everywhere". –Chinese Proverb.

In 2011, a group of community leaders and organizations in Austin and Travis County, Texas came together to launch a five-year journey aimed at assessing their community's health needs and assets and developing and implementing a community health improvement plan. The title of this initiative, "Together We Thrive", reflects a key value of this effort: that together we can do more for the health of our community than working alone. In building from this key value, this posthoc evaluation of the "Together We Thrive" Austin/Travis County Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) aimed to provide a vehicle for stakeholders to co-learn around the highlights and accomplishments of this initiative as well as the lessons learned about the process of implementation. The rich and valuable insights gleaned from Austin/Travis County CHA/CHIP stakeholders about our collective work over the past five years, as presented in this evaluation report, underscore the power of embracing a *culture of learning* and allowing space for collective reflection. Ultimately, these findings aim to contribute to an ongoing building of capacity to deliver the important ATC CHA/CHIP mission of "work[ing] together to create a healthy and sustainable Austin/Travis County".

Austin and Travis County's rich initial experience the CHA/CHIP responds to a long tradition in public health that has recognized the importance and potential to promote health across the community via cross-sector collaboration. The declaration of Alma-Ata, which resulted from the International Conference on Primary Health Care held at Alma-Ata, USSR in 1978, formally recognized that promoting health requires "…the action of many other social and economic sectors in addition to the health sector" (WHO, 1978). In more recent years, the Institute of Medicine reaffirmed the importance of an intersectoral public health approach to improve population health (IOM, 1988), which has included the proposed *intersectoral public health system* framework *(health care delivery system, employers and business, the media, academia and the community)* (IOM, 2001) and *circle of system partners* (IOM, 2003, 2011; Tessler Lindau et al., 2016). While a recent review by the Cochrane Collaboration concluded that community coalitions aimed at connecting health and human service providers and increasing community engagement with ethnic and racial minority communities may hold benefits for individual health outcomes and health behavior, findings were generally mixed, and the authors call for increased attention to describing coalition characteristics and process that may lead to better health outcomes (Anderson et al., 2015). In harnessing the potential for community collaborations to advance health, we need to continue to create spaces to reflect on what works with the collaborative process.

In responding to calls for greater description of the coalition process and in providing insights into this first Austin/Travis County Community CHA/CHIP experience, this evaluation documents highlights and accomplishments along with key lessons learned within the CHA/CHIP process and organization that merit further fine-tuning. In addition, we cite several recommendations and "vision" for enhancing the next cycle of the ATC CHA/CHIP, which will begin in 2017. Among the key highlights identified in this report, a main accomplishment noted across stakeholder groups, including Steering Committee members and other CHA/CHIP leaders, Core Coordinating Committee members, CHIP workgroup members, and other organizational and community stakeholders, was the valuable partnerships and collaborations that resulted from the ATC CHA/CHIP. These partnerships resulted not

only in the successful development of the ATC Community Health Assessment report and Community Health Improvement plan, but also in:

- creation of an organizational structure for implementing the CHA and CHIP- with important participation by key health, social service, government and nonprofit organizations;

- increased communication and awareness about stakeholders' organizations and missions, which included increasing attendance at the annual CHIP planning summits, with the highest attendance noted for Year 3; increased recognition among stakeholders of key social determinants that affect health such as transportation; and

- specific health-related actions and collaborations inspired in part by the CHA/CHIP that include the Smart Trips grant- aimed at promoting public and active transportation, increased bus routes to Travis County, healthy food access forums, and healthy food corner store initiative and sugar-sweetened beverage campaign.

In addition to documenting highlights and accomplishments, stakeholders identified a number of important lessons learned that merit further consideration as we move into the next cycle of the CHA/CHIP. Among the primary lessons learned was the importance of enhancing our internal and external communication, which included: further clarifying and communicating the purpose of the CHA/CHIP, clarifying and enhancing the CHA/CHIP identity and brand (e.g., are we a coalition? How do we relate to other ongoing efforts? Is there a need for further branding of our identity and name?), increasing communication about how to get involved with the CHA/CHIP and the value proposition for getting involved, increasing communication among and between the CHA/CHIP stakeholders-including sharing and coordinating efforts across workgroups as well as clarifying roles and responsibilities for the different CHA/CHIP groups, and identifying key stakeholders groups and the appropriate messaging needed for different groups, including the broader community. Furthermore, key themes surfaced around the need to strengthen specific aspects of the CHA and CHIP. With regard to the CHA, while stakeholders generally felt this was a successful first effort, exploring further how we partner with organizations to reach communities, make participation in the CHA easier for community members, and engage in the prioritization process may continue to strengthen this phase of the initiative.

Despite important achievements with the CHIP, including well attended annual planning summits among CHIP members, development of a strong workgroup structure and planning tools, and prioritization of key health topic areas and proposed strategies, stakeholders indicated the need to continue to strengthen and fine-tune the CHIP process in order to increase our potential impact. Based on our conversations with other CHA/CHIPs from around the country during our initial learning phase for this evaluation, the challenges with moving from assessment to the development and implementation of an action plan are not unique to the ATC CHA/CHIP. A contribution of this evaluation was the identification of specific areas that merit further attention, including:

- moving the CHIP from a mechanism for reporting of ongoing actions to one that catalyzes action;

- exploring further the prioritization process with regard to prioritizing key goals and strategies- noting that many stakeholders suggested reducing the number of objectives/strategies and going deeper;

- identifying strategies that are evidence-based- and documenting that evidence in relation to the strategy;

- developing a 'streamlined' CHIP Implementation planning table, enhanced tracking mechanism for documenting outputs that directly result from the CHIP workgroups, and easier reporting mechanism to share progress; and

- exploring ways to enhance the structure and expectations of workgroup meetings outside the annual planning summit as well as ways to increase and maintain stakeholder participation and ownership of the CHIP activities. Other key lessons learned are noted within this document.

Recommendations

In this last section, we share key recommendations that build from the lessons learned as well as direct input from CHA/CHIP leaders, organizational partners, and community stakeholders that emerged from this first cycle of implementation. These recommendations aim to both inform and enhance the upcoming cycle of the ATC CHA/CHIP, beginning in 2017. In addition, we hope these recommendations can provide insights to the broader CHA/CHP practitioner community and contribute to the sharing of best practices for CHA/CHIP design, implementation and evaluation. In sharing these recommendations, we preface this section by underscoring the multiple accomplishments of this first cycle of the ATC CHA/CHIP as noted in the section above and in the findings section. Among those accomplishments includes an approach that embraces a 'culture of learning' and engagement with stakeholders who provided constructive and positive feedback for how the CHA/CHIP can continue to evolve and grow.

Purpose & Identity

1. *Develop an aspirational vision and "reach" goal to improve health in the Austin/Travis County community.*

   Some CHA/CHIP leaders underscored the opportunity for the ATC CHA/CHIP to provide aspirational vision and goal(s) to promote the health of the ATC community. While it is important to note that the ATC CHA/CHIP has embraced aspirational goals that are ongoing for Austin/Travis County, such as "Vision 0" and its focus on eliminating traffic-related fatalities, and many of the indicators in the CHIP are aspirational, further attention to how these visions and goals are communicated is warranted. This recommendation relates to stakeholder input on the possibility of reducing the number of goals/strategies and sharpening and deepening the focus on fewer goals/strategies (see CHIP recommendations below).

2. *Continue to build and promote the ATC CHA/CHIP as the roadmap, rallying point and "North Star" for health needs, priorities and collective action for the Austin and Travis County community.*

Similar to recommendation #1, stakeholders noted the importance of continuing to build the CHA/CHIP as the roadmap, rallying point and North Star that prioritizes, guides and coordinates our health actions in order to deliver a greater collective community health impact. Specific considerations for this recommendation include:

a) *How to communicate the CHA and CHIP to stakeholders* whose organizations have similar goals/mission or hold potential to contribute to CHA/CHIP's goals/mission as well as the broader community, including:
   - funders who may consider aligning their funding priorities based on the CHA/CHIP;
   - health departments, hospitals, nonprofits, schools and others who provide direct health-related services and may consider aligning their activities with the CHA/CHIP; and
   - the broader community, in order to provide guidance on how to get involved and support the CHA/CHIP.

b) *How to create the CHA to become an 'evergreen' North Star* that presents a comprehensive assessment of the health needs and assets of the community and can serve to inform other health action in the community beyond informing the CHIP, which is limited to few priority areas (see further discussion under "CHA" below).

c) *How to continue to develop the CHA/CHIP from being a mechanism for communicating about ongoing health actions to one that catalyzes, coordinates and drives health action.* While recognizing its value, a critique from CHIP stakeholders was that the process at times felt more like one of sharing existing actions, instead of one of stimulating and driving action (see CHIP section below).

3. *Strengthen the purpose, identity, and branding of the ATC CHA/CHIP and increase communication with community stakeholders.*

Stakeholders noted an ongoing need to further clarify and communicate the purpose of the CHA/CHIP, including its role in relation to other ongoing efforts. While there was general consensus about the CHA/CHIP's role in providing a community health assessment and developing and implementing a community health plan- as well as its role for accreditation purposes, there is need to clarify and communicate the CHA/CHIP's role in terms of 'mobilizing partnerships' for action and the focus of the CHA/CHIP on reducing health disparities. Specific considerations include:

a) *Enhance identity of ATC CHA/CHIP:* While the purpose and approach of the CHA was relatively clear, several stakeholders, including those in leadership positions, struggled with what the role the CHIP should serve (convener? catalyst for new action? communicator of existing action?). While many recognized the value of the partnerships that emerged from

the CHA/CHIP, some suggested the need for further intentionality with this focus, including the importance of promoting these collaborations and investing in activities that build cohesion among stakeholders. One stakeholder recommended engaging stakeholders in further defining the purpose of the ATC CHA/CHIP.

b) *Explore coalition approaches and place emphasis on 'network'*: While the CHA/CHIP implicitly consists of a coalition, network and partnership of individuals and organizations, the concept of a coalition or 'alliance' is not communicated well to partners, despite the positive title of "Together We Thrive". Further consideration of how the CHA/CHIP provides an opportunity to be part of an 'alliance', 'network', or 'coalition' as well as the value proposition for joining this network merits consideration in the branding and marketing of this work.

c) *Strengthen the name and branding of the ATC CHA/CHIP*: Some CHA/CHIP leaders indicated that the name "Together We Thrive" may require strengthening as it isn't widely used by stakeholders and does not directly communicate what the CHA/CHIP is.

Communication

4. *Enhance internal and external communication of the ATC CHA/CHIP*.

Related to the previous section, the importance of strengthening internal and external communication was a common theme that emerged across stakeholders in this evaluation. It is important to note the multiple achievements with this first CHA/CHIP initiative in terms of communication activities, which includes multiple community forum events, annual summit planning with CHIP work groups, annual reports on progress, creation of Healthy ATC-a more recent collaboration among Travis County HHS & Veteran Services, Austin/Travis County HHS, and Central Health that provides a web portal and aims to increase sharing of data and coordination of health activities, and other communication channels such as the ATC CHA/CHIP webpage. These achievements notwithstanding, several stakeholders noted the need to develop a more strategic and focused communication plan, with specific recommendations that include:

a) *Define stakeholder groups and messaging needed for different groups*: Stakeholders underscored the need for further defining who CHA/CHIP stakeholders are, what messaging and communication channels are most appropriate for reaching diverse stakeholder groups, and what the value proposition of the CHA/CHIP is for different groups.

b) *Develop an "elevator speech"* about what CHA/CHIP is, and tailor to different stakeholder groups. Consider Sen. Kirk Watson's 10 by 10 approach as an example for communication about ATC CHA/CHIP goals.

c) *Ensure that community presentations are appropriate for the audience.* Develop presentations tailored for different audiences, including community groups, city officials, and nonprofit boards and other groups.

d) *Develop streamlined reporting and communication mechanism of CHIP progress*. Make communication accessible and lay it out in a way that is easy to follow.

e) *Clarify and communicate roles, responsibilities, and expectations for CHIP work groups and leaders.* Several leaders noted that communication was lacking between certain groups (e.g., between and among CHIP work groups, between Core Coordinating Committee and Steering Committee), and that at times it was not clear what the specific roles were for different groups and group members.

Partnerships and Collaborations

5. *Continue to build diverse and cohesive community and organizational partnerships*.

Stakeholders expressed interest in furthering efforts to build inclusion and involvement of diverse community groups as well as network social cohesion for cycle II, including innovative approaches for engaging community members. Specific recommendations include:

a) *Increase partnerships with organizations and community stakeholders and groups* who directly reach the community: Stakeholders noted several groups that should be invited to participate in the CHA/CHIP, including: school districts, groups and leaders (SHACs, parent support specialists, school wellness teams); faith-based community; Dell Medical Hospital; business community; "unique Austin and Travis County partners" such as bike shops, farmers markets; other community-based organizations (afterschool programs, preschools) that directly reach community.

b) *Explore ways to further engage stakeholders and keep stakeholders engaged, including succession planning*. Several stakeholders noted that it was not clear for how individuals and organizations new to the initiative can get involved, as well as what their roles should be once they join. In addition, further consideration of best practices to maintain workgroup participation should be explored, which may include providing a preset calendar of meeting dates and places, activities to build group cohesion, and guidance on succession planning for ongoing participation from a given workgroup member's organization.

Overall Approach

6. Explore further coalition and collective impact approaches, and incorporate best practices.

In addition to exploring further the identity of the CHA/CHIP in relation to framing the ATC CHA/CHIP in terms of a coalition, network, or alliance- which holds the potential to further engage members under a 'collective identity', some stakeholders recommended further exploration and incorporation of best practices from coalition (Butterfoss & Kegler 2009; Butterfoss and Kegler, 2012) and collective impact approaches (Kania & Kramer, 2011; Hanleybrown et al, 2012; Flood et al., 2015). While reviewing best practices of coalitions and collective impact approaches is beyond

the scope of this report, the ATC CHA/CHIP may benefit from further exploration of both theory (e.g., Community Coalition Action Theory, Butterfoss & Kegler, 2009) and practice of coalitions (e.g., Butterfoss & Kegler, 2012; Brown et al., 2014; Brown et al., 2015). The collective impact (CI) approach has received increased attention in recent years in relation to its potential utility for community-wide health promotion planning and action (Flood et al., 2015). CI consists of five core tenets: *a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone organization* (Hanleybrown et al., 2012; Flood et al., 2015). While these tenets are reflected to varying degrees in the ATC CHA/CHIP, further intentionality with each of these tenets, along with consideration of the prerequisites for CI *(initiating action, organizing for impact, and sustaining action and impact)* and other coalition best practices, may provide further direction for ATC CHA/CHIP efforts, with specific application for the CHIP action phase.

7. Further activate the Steering Committee.

Despite a recognition across stakeholders of the valuable role CHA/CHIP Steering Committee members have played in structuring and leading the ATC CHA/CHIP, some CHA/CHIP leaders noted the need to structure more opportunity to allow Steering Committee members to better share their leadership and organizational resources with the CHA/CHIP. One recommendation is to consider further structuring the Steering Committee meetings to allow space for more interaction and dialogue among and between Steering Committee members. Other recommendations include creating specific liaison roles for Steering Committee members with the various committee (Core Coordinating Committee, Workgroups) and to identify specific needs in terms of resources and support and then explore how Steering Committee members and their organizations may be able to help meet those needs. Lastly, stakeholders recommended a greater role for Steering Committee members to help promote and recruit stakeholder participation with the CHA/CHIP, which may include direct involvement in the CHA/CHIP or involvement of a CHA/CHIP leader's organization (and various departments) with supporting different facets of the CHA/CHIP.

CHA & CHIP Approach

8. *Grow the purpose of the CHA as an "Evergreen" Document.*

Stakeholders shared a vision for having the community health assessment (CHA) become an evergreen document that has purposes beyond informing the CHIP and that is updated on a more periodic basis. A specific recommendation is to:

a) *Explore and promote the use of the CHA beyond informing the CHIP*: Stakeholders recommended that the CHA should be promoted and utilized for informing grant applications and guiding health actions for topics beyond those selected for the CHIP.

9. *Identify and explore ways to enhance CHA approach and process.*

Specific recommendations related to CHA enhancement included:

a) *Build off and incorporate other community needs assessments*: Leaders highlighted the importance of collaborating with and incorporating other needs assessments into the CHA process, which may include cross-referencing with indicators from other community initiatives such as Imagine Austin, CAN, and the CHNA (Seton and St. David's Foundation).

b) *Enlist support of community leaders* and organizations in both reaching and facilitating community forums and focus groups.

c) *Increase community input and make participation easier* for community members in CHA activities. For example, interweave forums/focus groups within existing settings/meetings (e.g., parent coffees at schools), provide child care, and hold meetings in the language of the audience (instead of providing translation services).

10. *Identify and explore ways to enhance the CHIP approach and process (General CHIP Recommendations).*

A common theme among CHIP leaders and stakeholders for cycle II was the importance of enhancing the CHIP process in order to increase efficiency, collaboration and collective impact of members. Specific recommendations include:

a) *Develop fewer CHIP objectives or strategies* in order to go deeper and increase impact. Note that this recommendation should be balanced with valuable input from some stakeholders who noted the value of including more goals and strategies, even if funding was not available at the beginning, in order to prepare CHA/CHIP stakeholders for opportunities that may arise for specific topics via a 'wish list' type approach.

b) *Make reporting mechanism for progress easier:* Stakeholders noted that a lot of time in meetings was spent reporting on progress, and that expectations for reporting were not always clear. Further exploration of best approaches for reporting as well as engaging stakeholders in sharing of information and coordinating actions should be considered.

c) *Increase focus of CHIP on populations most in need*. While the CHA succeeded in documenting many health disparities within the central Texas community, several stakeholders expressed the need to further highlight the CHIP's focus on reaching those communities and subgroups most in need.

d) *Continue to foster in-person and periodic meetings for work groups:* One Core leader noted: "Meeting in person to accomplish both reporting and collaboration, and continued engagement is important."

e) *Further clarify the structure and approach for the CHIP workgroups.* Aspects that merit further clarification include: how workgroup leaders are selected and how this is communicated to the network, proposed meeting structure and frequency of meetings outside of annual planning summit, how organizations and individuals can get involved in process, communication of who is involved in workgroups- including member organizational profiles, and expectations for communication and cross-workgroup planning.

f) *Strengthen cross-workgroup planning and communication.* Some workgroup leaders expressed the need for further communication and coordination of actions across workgroup and priority areas. This fits well with Phase 5 of the MAPP planning process: *Formulate Goals & Strategies,* which recommends the inclusion of an interrelated set of strategy statements. While the ATC CHA/CHIP succeeded with including some interrelated strategies, including health literacy and a focus on decreasing health disparities, further consideration should be given to providing the space for cross-workgroup communication and planning around these and other strategies that could be shared.

g) *Build in evaluation from the beginning of the CHIP*: A challenge for our evaluation was being able to distinguish what was directly stimulated by CHIP, and what was an indirect output from CHIP. Exploring how to further capture and track outputs and outcomes of the CHIP is warranted, including how to track:

- *outputs and activities specific to CHIP planning efforts* (e.g., community forums that were driven by workgroup planning, etc.);
- *outputs that indirectly resulted from CHIP collaborations among partners* (e.g., grant applications between work group members; collaborations with each other's missions and events);
- *member-specific outputs and outcomes t*hat stem from being part of the CHA/CHIP (e.g., increased awareness about activities, how CHA/CHIP may have been incorporated into an organization's mission and across an organization's departments, etc).
- *process-related aspects of the network*, including: level of network cohesion, awareness of purpose and mission, organizational member profiles, level of participation.

Lastly, CHA/CHIP leaders may consider *Incorporation of a specific outcome evaluation for selected goals/strategies.* A challenge with evaluating the impact of the ATC CHA/CHIP, which has also been noted by other CHA/CHIP practitioners, was being able to assess and attribute outcomes to CHA/CHIP actions. In addition, many of the data sources identified for assessing indicators are at a population level that may be disconnected with the specific population for whom the strategy is targeted (e.g., using BRFSS data to assess changes in obesity for strategies targeted to services specific to a subpopulation of adults). CHA/CHIP leaders may consider identifying funding sources and allocating funding for a limited number of goals in order to evaluate the impact of strategies within a specific population over time.

11. *Explore further the overall approach for selecting and prioritizing CHIP health topic areas and strategies and implementing the CHIP plan of action.*

Building from the initial achievements obtained with the ATC CHIP for the first cycle, stakeholders expressed the need for further consideration of how priority health topics and the strategies to improve them are chosen as well as the process for implementing the CHIP. Specific recommendations based on stakeholder input include:

a) *Expand input for prioritization of topic areas as well as further specification by subgroups:* Some stakeholders noted that the prioritization process was limited to only the Steering Committee and selected community partners and encouraged planners to consider how to obtain additional input from different community stakeholders once the initial list of topics is developed. Furthermore, planners should give some consideration to how the topics relate to and are equitable by different subpopulations, for example, by age (priority areas for adolescents may be very different than those for adults), and by geographic area (topic areas for residents outside of Austin may be different than those within Austin, and topic areas may also differ within Austin).

b) *Strengthen approach for selecting and prioritizing proposed strategies that address CHIP health priority areas.* A success of some coalitions such as the Communities That Care approach, which has found significant and positive effects of community-led approaches on youth drug use (Hawkins et al., 2012), has included the implementation of evidence-based programs backed by a coalition. Further exploration of how to best rank and prioritize objectives and strategies, which may include consideration of evidence for a given strategy, should be considered. In addition to following the MAPP process for prioritization, CHA/CHIP leaders may consider incorporating approaches such as *Intervention Mapping* (Bartholomew et al., 2016), which ranks strategies based on their importance (level of strength/evidence for changing an outcome) and changeability (level of changeability of strategy and/or outcome over a given period of time and based on resources needed).

c) *Recruit partners to help lead specific actions/activities.* Stakeholders indicated the need for a subsequent 'circle of involvement' type activity once health priority areas are selected in order to identify and recruit community and organizational partners working with these topics who can help lead, coordinate and collaborate on CHIP strategies.

d) *Streamline and enhance the CHIP planning tool:* Stakeholders mentioned that the CHIP planning tool was at times cumbersome and that it lacked some key content areas. Consider enhancing the format for this tool as well as content areas related to: funding, population specification, and identification of strategic partners to carry out actions. Further consideration is also needed for the indicators and data for tracking progress, as many gaps were found in the CHIP workgroup indicator tables, with data not always available or

indicators not clear. Tracking of outputs and strategies, and the process for doing so, should also be considered.

e) *Explore how to address the current CHIP focus areas for the upcoming CHA/CHIP cycle.* Several stakeholders expressed interest to provide continuity with our current topic areas into cycle II (access to healthy foods, transportation, access to primary care and mental/behavioral health services, and obesity), and these priority areas were perceived to still be very relevant and important for the health of the Austin/Travis Community based on our participatory evaluation and community stakeholder survey. At the same time, stakeholders also expressed interest in including new priority areas, such as: *health literacy, tobacco, breastfeeding, critical health outcomes, diabetes.* CHA/CHIP leaders need to consider whether the CHA/CHIP begins anew with a clean slate, or whether there will be efforts to continue to support current topic areas.

12. *Develop a unified health literacy plan of action across CHIP priority areas.*

While health literacy was a cross-cutting theme and received important highlighting in the Access to Primary Care and Mental/Behavioral Health Services CHIP tables, we lacked data on how to best assess the incorporation of health literacy and its impact within the CHIP plan of action. Stakeholders expressed interest in the development of a unified plan of action for health literacy promotion across the CHIP work areas.

Evaluation Limitations & Strengths

As with all evaluations, our evaluation approach was not without its limitations. A key limitation of the current evaluation was our inability to fully assess the impact of the ATC CHA/CHIP on health-related outcomes. Challenges with outcome evaluation were noted by other CHA/CHIP practitioners from across the U.S. during our initial learning phase, and we concur with recommendations from those colleagues who emphasized the importance of planning for evaluation from the inception of the initiative. In addition to our posttest evaluation approach- which severely limits the ability to assess changes over time, there were several other barriers to outcome evaluation, which included: the need for greater clarity in the specific strategies being proposed, clarification of the intended priority populations, and ideally the creation of a logic model that connects strategies with outputs and outcomes for specific priority areas; the lack of a consistent and coherent data collection and tracking system of CHA/CHIP strategies and outputs; and the need for further clarification of strategies that are ongoing vs. those that were stimulated by the CHIP. Recognizing that a randomized controlled trial may be beyond the resources of a CHA/CHIP, we also faced challenges with the proposed approach for assessing changes based on review of existing data, which included: lack of data connected to key CHIP indicators, data not at the level of our impact area (e.g., state-level), and lack of data that corresponds to the CHA/CHIP time periods, among other limitations noted in the CHIP Indicator Review section.

Beyond our limitations with assessing impact, we recognize the following limitations with the primary data collected for this evaluation:

- *Selection bias and generalizability*: While we were able to obtain a response rate of 50% of CHIP stakeholders in the CHA/CHIP Organizational Survey, our response rate was low for the CHA/CHIP Community Stakeholder Survey (16.5%). A low response rate limits generalizability of the findings back to the sampling frame while increasing the possibility of selection bias (e.g., those who respond may be different than the broader sampling frame). Despite this important limitation, we were able to reach all key CHA/CHIP leader stakeholder groups- with half or more of each stakeholder group (with the exception of community residents) represented in the findings. Furthermore, the evaluation provides some level of triangulation of findings across stakeholder groups and methods.

- *Community "voice" with the evaluation*: While we intended to elicit community input on the CHA/CHIP via both the community stakeholder survey and the participatory evaluation community stakeholder workshop, we recognize that our samples were small and that they lean more toward community organizational stakeholders. As we move forward with defining how to best to measure impact of our efforts with community residents, consideration of balancing evaluation needs with other activities of the CHA/CHIP, such as gearing up for the next round of CHA community forums and focus groups, will be needed in order to not over-tax community residents. Exploring how to best combine evaluation efforts with other CHA/CHIP data collection needs may be a fruitful direction.

- *Utilization of other Evaluation Approaches:* Some CHA/CHIP leaders suggested the importance of further emphasizing the 'narratives' of the positive outcomes of the CHA/CHIP, in addition to the quantitative indicators. One leader shared: *"I look at the bicycle plan of Travis County and I know that was informed by some of the work we've done, and in regards to sidewalks – we're now having sidewalks in our development. You realize this was set off by [the CHA/CHIP]."* While we aimed to provide a mixed methods approach, we recognize that there are other evaluation methods, such as gathering narratives and further spotlighting initiatives, that hold potential to further capture the outputs and outcomes of the CHA/CHIP. In pursuing such an approach, we recommend greater exploration of how to best track outputs that stem directly from the work of the CHIP in order to best identify those success stories that deserve further highlighting.

These important limitations notwithstanding, we also note key strengths of the evaluation, which include:

- A mixed methods approach that allowed for triangulation of themes

- Incorporation of voice of various stakeholder groups *(Steering Committee, Core Coordinating Committee, CHIP Work Groups, Community stakeholders & residents, CHIP Planners & Organizers)*

- Use of a robust evaluation framework (CDC), with input from CHA/CHIP practitioners and organizational stakeholders on evaluation approach

Conclusion and Next Steps

This evaluation of the Austin/Travis County CHA/CHIP, which took place between March and September of 2016, documents a variety of highlights and accomplishments that were achieved during the five-year implementation of this first CHA/CHIP experience along with specific lessons learned. We greatly appreciate the opportunity to engage with the Austin and Travis County community and CHA/CHIP stakeholders to co-learn about these successes and areas for improvement. Findings from this evaluation will be shared with the ATC CHA/CHIP leaders, including the Steering Committee, Core Coordinating Committee, and Workgroup leads, in addition to the broader Austin/Travis County Community, via: CHA/CHIP steering committee meetings, community forums, and electronic communication (email, Austin/Travis County Health and Human Services' website). In addition, we will collaborate with the ATC CHA/CHIP planner and Core Coordinating Committee to explore the best approach for developing an action plan to address the recommendations from this report. We look forward to continuing to foster a culture of learning within the ATC CHA/CHIP network in order to further our collective capacity to positively impact the health of the Austin and Travis County community.

"Alone we can do so little; together we can do so much."

—Helen Keller

References

Anderson LM, Adeney KL, Shinn C, Safranek S, Buckner-Brown J, Krause LK. Community coalition-driven interventions to reduce health disparities among racial and ethnic minority populations. *Cochrane Database of Systematic Reviews* 2015, Issue 6.

Austin/Travis County CHA-CHIP (2012, 2013). Austin/Travis County Health and Human Services Community Health Planning. The *Community Health Assessment* (CHA, 2012) and the *Community Health Improvement Plan* (CHIP, 2013) reports are combined into a single document that can be downloaded at: http://www.austintexas.gov/healthforum.

Austin/Travis County Health and Human Services, *Community Health Planning Resources* (2016). http://www.austintexas.gov/page/community-health-planning-resources

Bartholomew Eldredge LK, Markham CM, Ruiter RAC, Fernández, ME, Kok G, Parcel GS, editors. *Planning health promotion programs: An Intervention Mapping approach* (4th ed.). San Francisco, CA: Jossey-Bass; 2016.

Brown LD, Feinberg ME, Shapiro VB, Greenberg MT. Reciprocal relations between coalition functioning and the provision of implementation support. Prevention Science 2015; 16(1): 101-09.

Brown EC, Hawkins JD, Rhew IC, Shapiro VB, Abbott RD, Oesterle S, et al. Prevention system mediation of Communities that Care effects on youth outcomes. Prevention Science 2014; 15(5): 623-32.

Butterfoss, FD, & Kegler, MC. The community coalition action theory. In R. DiClemente, R. A. Crosby, & M. C. Kegler (Eds.), *Emerging theories in health promotion practice and research* (2nd ed., pp. 238-274). San Francisco, CA: Jossey-Bass; 2009.

Butterfoss, FD, & Kegler, MC. A coalition model for community action. In M. Minkler (Ed.), *Community organizing and community building for health and welfare* (3rd ed., pp. 309-328). New Brunswick, NJ: Rutgers University Press; 2012.

Centers for Disease Control and Prevention (CDC). Program Performance and Evaluation Office (PPEO): Program Evaluation. Accessed on October 30, 2015 at http://www.cdc.gov/eval/framework/index.htm.

Centers for Disease Control and Prevention (CDC). Framework for Program Evaluation in Public Health. MMWR 1999; 48(RR-11).

Chambers R. *Whose Reality Counts? Putting the First Last* Intermediate Technology Publications, London; 1997.

Chevalier, JM & Buckles, DJ. *Participatory Action Research: Theory and Methods for Engaged Inquiry*, Routledge UK/ 2013.

Flood J, Minkler M, Hennessey Lavery S, Estrada J, Falbe J. The Collective Impact Model and Its Potential for Health Promotion: Overview and Case Study of a Healthy Retail Initiative in San Francisco. Health Education & Behavior 2015; 42(5): 654-68.

Hanleybrown, F, Kania, J., & Kramer, M. Channeling change: Making collective impact work. *Stanford Social Innovation Review*; 2012. Retrieved from www.ssireview.org.blog .channeling_change_making_collective_impact-work

Hawkins JD, Oesterle S, Brown EC, Monahan KC, Abbott RD, Arthur MW, Catalano RF. Sustained decreases in risk exposure and youth problem behaviors after installation of the Communities That Care prevention system in a randomized trial. Archieves of Pediatrics & Adolescent Medicine 2012; 166(141-8).

Institute of Medicine. The Future of Public Health. Washington, DD: National Academies Press; 1988.

Institute of Medicine. The Future of the Public's Health in the 21st Century. Washington DC: National Academies Press; 2003.

Institute of Medicine. For the Public's Health: The Role of Measurement in Action and Accountability. Washington, DC: National Academies Press; 2011.

Internal Revenue Service (IRS), 2013. New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act. Available at: https://www.irs.gov/charities-non-profits/charitable-organizations/new-requirements-for-501c3-hospitals-under-the-affordable-care-act

Kania, J., & Kramer, M. (2011) Collective impact. *Stanford Social Innovation Review*. Retrieved from *https://ssir.org/articles/entry/collective_impact*

MacDonald, G. (2013). Criteria for selection of high-performing indicators: A checklist to inform monitoring and evaluation. Available from The Evaluation Center Checklist Website: https://www.wmich.edu/sites/default/files/attachments/u350/2014/CDC_Eval_Framework_Checklist.pdf

Millstein B, Wetterhall S, CDC Evaluation Working Group. A Framework Featuring Steps and Standards for Program Evaluation. Health Promotion Practice 2000; 1(3)221-228.

Mitchell CM & Sommer M. Participatory visual methodologies in global public health*, Global Public Healt*h 2016; 11:5-6, 521-527, DOI: 10.1080/17441692.2016.1170184

Mobilizing Action for Planning and Partnerships (2016). Available from the NACCHO website: http://www.naccho.org/programs/public-health-infrastructure/mapp

National Association of City and County Health Officials (NACHHO). Community Health Assessment and Improvement Planning. Accessed on October 25, 2016 at: http://www.naccho.org/programs/public-health-infrastructure/community-health-assessment

Norwalk County Process Evaluation Survey (2011). http://www.naccho.org/programs/public-health-infrastructure/community-health-assessment/resources

O'Mara-Eves A, Brunton G, McDaid D, Oliver S, Kavanagh J, Jamal F, et al. Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. *Public Health Res* 2013;1(4).

Public Health Accreditation Board Standards & Measures, Version 1.5. 2013. Available at: http://www.phaboard.org/wp-content/uploads/PHABSM_WEB_LR1.pdf

Tessler Lindau S, Diaz Vickery K, Choi H, Makerlarski J, Matthews A, Davis M. A community-powered, asset-based approach to intersectoral urban health system planning in Chicago. AJPH 2016; 106(1)): 1872-78.

Thomas S. What is Participatory Action and Learning (PLA): An Introduction. University of Wolverhampton, Centre for International Development and Training. Accessed on June 8, 2016 at: http://idp-key-resources.org/documents/0000/d04267/000.pdf

Wageningen UR. Participatory Planning, Monitoring and Evaluation. http://portals.wi.wur.nl/ppme/?Participatory_Learning_and_Action

Welsh JA, Chilenski SM, Johnson L, Greenberg MT, Spoth RL. Pathways to sustainability: 8-year follow-up from the PROSPER Project. The Journal of Primary Prevention 2016; 37 (3): 263-86.

WHO. Declaration of Alma-Ata. Alma-Ata, USSR. 1978. http://www.who.int/publications/almaata_declaration_en.pdf?ua=1

Zhang Y, Wildemuth BM. Qualitative Analysis of Content. In: B. M. Wildemuth, Ed., *Applications of Social Research Methods to Questions in Information and Library Science*, Libraries Unlimited, 2009. pp. 1-12.

Appendix
[See attached Appendix document]