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President’s Message
Cindy Kilborn, MPH

Public Health: Everyone-Everywhere-Everyday. That’s right, I’m still talking about it. But what do I really mean when I say “Public Health”? Public Health Practice is what we, as a society, do collectively to assure the conditions in which people can be healthy (IOM, 1988). And what is “healthy”? Health is a dynamic state of complete physical, mental, spiritual and social wellbeing and not merely the absence of disease and infirmity (WHO, 1998). This sounds a lot like “promote the general welfare” and “insure domestic tranquility”; where have we heard that before? The Constitution of the United States. So, providing for the public’s health is the law of the land. Who is the public? EVERYONE. We have to make public health a priority for all. That is why it is imperative there must be “Health in All Policies” (HiAP), which the Centers for Disease Control and Prevention have initiated. It is a collaborative approach that integrates and articulates health considerations into policy making across sectors to improve the health of all communities and people. HiAP recognizes that health is created by a multitude of factors beyond healthcare and, in many cases, beyond the scope of traditional public health activities. Healthy people need healthy communities and vice versa. Progress towards this goal becomes impossible to support public programs, providing for the public’s health cannot afford to be without assured, sustainable resources. Without resources, it is impossible to support public programs, let alone new ones needed to keep pace with the evolving issues in our communities (M. Latshaw, APHA Environmental Section).

The future of our nation’s health depends on a strong and properly equipped public health infrastructure. Commitment to investing in public health is fundamental to the success of all people in our communities. As many public health professionals have reiterated, it is time that our nation’s health is made a priority. We should demand that our policy leaders not only restore public health funding but also assure their constituents that funding will be sustainable and able to meet evolving issues. Of 35 developed nations, the United States is ranked 34th in life expectancy at birth (WHO, 2015). Even within some US cities, life expectancy can vary as much as 20 years between neighborhoods (Baltimore Sun, 8/2015). How can we, as citizens of the United States, continue to allow these conditions to exist?

It is the goal of TPHA through our vision of “a safe and healthy Texas” and our mission of “improving the health and safety of Texas/Texans through leadership, education, training, collaboration, mentoring and advocacy” to ensure a sustainable public health system with health equity for ALL Texans -EVERYONE-EVERYWHERE-EVERYDAY. Please encourage your colleagues, co-workers, students and community members to learn more about us and join us. TPHA’s collective voice can be louder and stronger with your help. Please direct all interested to our updated website www.texaspha.org and invite them to come with you when you attend the TPHA Annual Education Conference April 11-13, 2016 in Galveston.
Vaccines are widely recognized as one of the top public health successes of the 20th century. Diseases like measles, mumps, rubella, diphtheria and polio were once widespread, but now they are rare due to thorough public health efforts to vaccinate people. And while those efforts have been successful, vaccine coverage is not 100 percent for a variety of reasons – access to services, cost, medical issues, vaccine concerns – and international travel can unwittingly expose people to diseases that we rarely see in the United States.

In late August, Tarrant County confirmed a case of rubella in a college student with recent international travel – the second case of rubella we’ve seen in Texas since 2004. The case prompted a robust local effort to trace possible contacts, assess immune status and offer immunization to people who have not completed their school-required vaccinations.

Also in late August, Dallas County issued a health advisory after a case of mumps was confirmed in a college student who acquired the disease from exposures during recent international travel. Mumps incidence is traditionally very low – 15 Texas cases last year – and usually involves adults with an unknown vaccination history.

In the last two years we’ve also seen surges of measles – one of the most contagious illnesses – and pertussis. DSHS issued statewide health alerts to help ensure doctors were on the lookout for these illnesses, even though both can largely be prevented by vaccines.

These illnesses are a real threat to the children of Texas, and every year people in Texas die from vaccine-preventable diseases or suffer from their complications. These recent cases underscore the important role we play in public health and our efforts to work together to improve our vaccine coverage levels. A highly vaccinated population reduces the incidence of disease and safeguards Texans’ health.

By far, the majority of school-aged children in Texas are fully vaccinated. Just less than 1 percent of students enrolled in school reported having a conscientious exemption, allowing them to opt out of the school requirements for immunizations. While this has been slowly but steadily increasing over time, the real concern is having high levels of unvaccinated individuals in one particular area, leaving children and communities vulnerable to vaccine-preventable diseases.

We also closely watch overall trends in immunization coverage. Real challenges clearly remain to ensuring a high level of vaccine coverage for our state. The most recent National Immunization Survey results indicate that Texas’ vaccination coverage levels for children 19 months through 35 months increased for the hepatitis B birth dose but declined for all other vaccines from 2013 to 2014. We must do better.

Our focus is on making sure children are fully vaccinated at their medical home, and we continue to educate the general public about the importance of children receiving all doses in each vaccine series. Our Texas Vaccines for Children Program helps increase vaccination coverage by providing vaccines to eligible children at no cost, which helps remove the financial barrier to vaccination. Last fall we ran a statewide infant vaccination media campaign to educate the general public about the importance of vaccinations. We also have a special effort in place to ensure children receive the full pertussis series by sending postcards to parents reminding them that their child is due for the fourth DTaP dose. While these efforts help support our overall goal to increase vaccine coverage, we must find and use strategies to drive sustainable increases in vaccine coverage.

The recent rubella and mumps cases not only highlight the importance of getting vaccinated, they also reinforce the strong local, state and federal public health partnerships that are required to control the spread of unexpected diseases in a community and ensure people get the vaccinations they need. Unexpected cases of vaccine-preventable diseases afford us the opportunity to spark a discussion about vaccines and reinforce the simple fact that vaccines stop the spread of disease and save lives.
Poison centers might experience changes, usually increases, in certain types of calls in relation to heavy rains and flooding. Carbon monoxide calls might increase as people use electrical generators because of power outages. Lack of power also might lead to calls about water contamination and food poisoning. Gasoline might be siphoned, leading to calls to the poison center. More bites and stings might occur as wildlife are driven from their normal habitats by rising water and people remove debris.9-14

Table 1 provides the monthly number of selected exposures reported to Texas poison centers during January-August 2015 from the 85 counties included in the federal disaster declaration. The mean monthly number of the same exposures was determined for January-August for 2012-2014 for these same counties. Comparisons were made between the monthly 2012-2014 and 2015 data. The severe rains and flooding do not appear to have caused an increase in Texas poison center calls about exposures to carbon monoxide or gasoline, something that has been observed with tropical storms. The total reported bites and stings were 38% lower in May 2015 than the 2012-2014 mean. The number of these exposures in May 2015 was lower than for any May going back through 2000. However, the 2015 exposures were lower than the 2012-2014 mean for all eight months, although the percentage difference was greatest for May. Native venomous snake bites were 31% lower in May 2015 than for the corresponding 2012-2014 mean. This contrasts with news reports of an increase in snake bites in May 2015 reported by hospitals.3

Thus, the heavy rains and flooding in May 2015 do appear to have resulted in changes in the call patterns received by Texas poison centers. However, these changes were not similar to those observed with tropical storms.

REFERENCES


Table 1. Monthly number of selected exposures reported to the Texas Poison Center Network from 85 counties included in the federal disaster declaration after heavy rains and flooding in May 2015

<table>
<thead>
<tr>
<th>Exposure and time period</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
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<tbody>
<tr>
<td>Carbon monoxide</td>
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<tr>
<td>2012-2014 mean</td>
<td>23</td>
<td>15</td>
<td>14</td>
<td>15</td>
<td>21</td>
<td>15</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>2015</td>
<td>9</td>
<td>31</td>
<td>21</td>
<td>16</td>
<td>13</td>
<td>18</td>
<td>18</td>
<td>20</td>
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<tr>
<td>Gasoline</td>
<td></td>
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<tr>
<td>2012-2014 mean</td>
<td>31</td>
<td>24</td>
<td>50</td>
<td>46</td>
<td>55</td>
<td>42</td>
<td>38</td>
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<tr>
<td>2015</td>
<td>23</td>
<td>22</td>
<td>41</td>
<td>35</td>
<td>36</td>
<td>36</td>
<td>40</td>
<td>36</td>
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<tr>
<td>Total bites/stings</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2012-2014 mean</td>
<td>57</td>
<td>54</td>
<td>129</td>
<td>271</td>
<td>395</td>
<td>456</td>
<td>403</td>
<td>546</td>
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<tr>
<td>2015</td>
<td>37</td>
<td>43</td>
<td>85</td>
<td>210</td>
<td>244</td>
<td>335</td>
<td>326</td>
<td>251</td>
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<tr>
<td>Native venomous snake bite*</td>
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<td></td>
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<td>39</td>
<td>52</td>
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<td>2015</td>
<td>4</td>
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<td>8</td>
<td>36</td>
<td>36</td>
<td>52</td>
<td>54</td>
<td>51</td>
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<tr>
<td>Total pesticides</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>175</td>
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<td>225</td>
<td>245</td>
<td>361</td>
<td>391</td>
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<td>386</td>
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<tr>
<td>2015</td>
<td>187</td>
<td>154</td>
<td>207</td>
<td>306</td>
<td>406</td>
<td>432</td>
<td>388</td>
<td>547</td>
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<tr>
<td>Insecticides</td>
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<td></td>
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<tr>
<td>2012-2014 mean</td>
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<td>174</td>
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<td>240</td>
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<tr>
<td>2012-2014 mean</td>
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<td>42</td>
<td>38</td>
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<td>35</td>
<td>39</td>
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<tr>
<td>2015</td>
<td>63</td>
<td>57</td>
<td>35</td>
<td>36</td>
<td>46</td>
<td>54</td>
<td>42</td>
<td>31</td>
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<tr>
<td>Insect repellents</td>
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<tr>
<td>2012-2014 mean</td>
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<td>7</td>
<td>11</td>
<td>14</td>
<td>28</td>
<td>49</td>
<td>50</td>
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<td>4</td>
<td>8</td>
<td>34</td>
<td>56</td>
<td>70</td>
<td>33</td>
<td>23</td>
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*Rattlesnake, copperhead, coral snake, cottonmouth/water moccasin


The University of Texas School of Public Health on September 9, 2015

Michael S. Ewer, MD, MPH, JD1, Carol A Galeener, MS, MPH, PhD2
1The University of Houston Law Center, Health Law & Policy Institute
2The Fleming Center for Healthcare Management, University of Texas School of Public Health

Ms. Jennifer Bryant followed with insight into the justification of pharmaceutical costs. She explained that the cost of bringing a new agent to market cannot be isolated to the individual agent involved, but must include the cost of a far larger group of agents that did not make it to become part of the our therapeutic armamentarium. When costs related to all agents that underwent some aspect of pre-clinical and clinical scrutiny were taken into account, the total research and development costs for the group of agents resulting in a single approved drug was estimated at 2.6 billion dollars. Ms. Bryant noted further that among approved medicines, only 20% produce revenues that exceed the average costs related to research and development. She also indicated that despite these high costs the percentage of health care spending in the United States attributable to prescription medicines is about 10%, a percentage that has not changed from what it was in 1960.

Ms. Bryant pointed out that generic competition is expected to influence profits in the coming years, and that mergers among third-party payers is also expected to impact the negotiated price of pharmaceuticals. She discussed how payers are becoming more active in the marketplace including initiatives such as developing clinical pathways, demanding outcome-based contracting, considering the bundling of payments, and developing value assessment tools.

Dr. Dan McCoy provided an insurer’s perspective on prescription drugs. He noted that, with the introduction of many new specialty drugs, the insurance industry can anticipate a greater percentage of premiums will be needed to cover these new drugs. He provided data indicating, for example, that the price of agents to treat hepatitis C was substantially higher than was spent last year, and that the three most expensive drugs were all specialty agents. These very costly agents are vague and are anticipated to grow; by 2018 more than half of the medication cost was expected to pay for specialty drugs.

The last of the formal presentations was offered by Joel Lajeunesse who provided a perspective on costly drugs through the eyes of the hospital pharmacist. He noted that the cost of drugs had different connotations for the patients, providers, payers, and society at large. While the patient and physician seek the most effective and safest, the hospital provider must balance that with the economic reality and concerns about affordability and reimbursement. Industry considers the cost of developing the next agent and the odds of approval. Mr. Lajeunesse looked at hospital margins, noting that not all provided services contributed equally to hospital profit or loss, but that, along with imaging and pathology services, medication sales were a source of profit. Final medication charges are usually based on a formula that looked at both acquisition cost and administration complexity. The actual gross revenue from drugs takes into account discounts and caps that vary according to whether payment is provided by the government, an insurance plan, a full-paying self-pay, or an indigent patient who is unlikely to pay at all. While a governmental payer might allow a 6% profit, and an insurance payer a discounted price that might result in no profit, it was only the unusual self-pay patient that paid a non-discounted full price. At a large medical center, profits from drug sales, when all of the compounding factors were taken into account...
into consideration, were modest and in the single-digit percentage of revenue range.

Mr. Lajeunesse reviewed some of the ways that an institution could improve reimbursement for high cost drugs: requiring preauthorization where necessary; improving documentation to reduce payment denial; and restricting off-label or non-protocol experimental usage. These are all both useful and justifiable strategies. He ended his presentation with a discussion of how an institution addresses requests for co-pay assistance and how drug replacement programs work. He noted that the patient documentation for drug replacement programs is often very challenging.

The program continued with two commentaries: the first by Professor Chandler who reviewed some of the existing legislation that might not reflect the best public policy, but without which there would have been less incentive for innovation and some highly effective medications that might not have been developed. He credited the pharmaceutical industry with working within the framework allowed under law to achieve and even maximize their position. He offered the analogy of how basic education might change if it followed the path taken by health care, suggesting that unchallenged commercialism and profiteering would create a high quality but fantastically expensive, and totally unacceptable educational system. Professor Chandler suggests that we had not yet reached a breaking point, but that we might at some time have to consider using our governmental power of eminent domain, or have to investigate some alternate reward system that might replace patent protection in the pharmaceutical industry.

The final commentary was provided by Dr. Michael S. Ewer, who reviewed how the pharmaceutical industry interacted with physicians in the past, a history that included giving gifts to physicians, and helping them write professional papers. He noted what some consider excessive or inappropriate direct-to-consumer marketing, and drew attention to the fact that some pharmaceutical entities have a greater budget for marketing than for research and development. Dr. Ewer pointed out that our response to the cost of drugs has been largely reactive rather than pro-active. As a society, we have tried to limit inappropriate or wasteful use and maximize reimbursement. A more aggressive national policy might include negotiating drug prices, capping drug prices to a small increment above what is charged in other jurisdictions, and eliminating direct-to-consumer marketing; such measures should form part of a national pro-active policy with regard to the pricing of pharmaceuticals. He pointed out additionally that in the United States we spend more on health care than on food.

Following the invited presentations, Jake Casanova and Sarah Hamed, both students from the University Of Texas School Of Public Health were invited to the stage to ask specific questions of the speakers; questions also were opened to the audience. A lively discussion ensued after a question was raised as to whether or not an individual should be allowed to re-import pharmaceuticals back into the United States for personal use. Dr. Kantarjian suggested that insurance companies should be pleased to pay for transportation and the cost of the medication, as together it would represent a huge cost saving over what would have been expended had the drug been bought here. Ms. Bryant raised the concerns that purity might be compromised and counterfeit medications might be sold; recourse would probably not be possible. She noted further that if drugs are widely re-imported there could be limits placed on the amount of drug made available within the foreign jurisdiction. Dr. Ewer noted that none of these considerations would be necessary if we addressed the problem directly; i.e., if we paid a fair (equitable and uniform) price for what we buy.

Perspectives on Influencing Public Policy

Carol Galeener
UT School of Public Health Houston

OpenSecrets, the reporting arm of the Center for Responsive Politics, is a treasure trove of data and information on a variety of political activities. In particular, OpenSecrets provides data on what industries, organizations and individuals spend yearly to influence public policy in the United States. In some areas OpenSecrets contains more than a quarter century of data collected through government sources; it houses lobbying data dating from 1998.

The Center reports that the aggregate Pharmaceutical and Health Products (which includes medical devices and supplies) has ranked at the top of the industry lobbying spending for a number of years. Spending for Pharmaceutical and Health Products lobbying topped $229.1 million in 2014. In the same year lobbying by providers and others (primarily hospitals/ nursing homes, physician organizations, health services/ HMOs) exceeded even this large sum at $258.7 million. This brought total health sector spending for lobbying to $487.8 million.

It should be noted that total sector lobbying expenditures have declined by $69 million since peak spending in the heady days of run-up to the Affordable Care Act in 2009. However, expenditures remain at roughly the 2008 total and appear to have leveled off. In contrast, at $64.3 million for 2014 lobbying the Oil and Gas industry seems relatively parsimonious, and at $41.2 million Defense Aerospace seems positively Scrooge-like.

A word of caution about the statistics is appropriate: while Pharmaceuticals and Health Products leads the lobbying spending league table of individual industries, the aggregated total for the health sector trails both “Miscellaneous Business” and “Finance/Insurance/ Real Estate.” The take-away is that, as with any statistic, having a clear grasp on how it is defined precedes developing a clear inference from the data.

For those who might enjoy a bit of data dumpster-diving, the report facilities at www.opensecrets.org are powerful and intuitive. Data available include not just aggregated data but data at a lower level, for example lobbying expenditures by company or contributions by individual lobbyists by party. Part of OpenSecrets motto is: “We follow the money.” This has been good advice for more than forty years.
Public Health Practice Interview
Accreditation: An In-depth Interview with an Accreditation Achiever

Interviewee, Robert Hines, MSPH,
Staff Analyst/Accreditation Coordinator for the Houston Health Department (HHD) represented the team.
Robert.hines@houstontx.gov

Editorial Note:
The Houston Health Department achieved accreditation status in 2014. The interview below was conducted by the TPHJ editor with a member of the accreditation team at the health department.

How did your health department get started with the process?
HHD began pursuing voluntary national accreditation through the Public Health Accreditation Board (PHAB) in 2011 as a means to improve the quality of services at the health department. We discovered that accreditation also serves to enhance accountability and improves communication and collaboration with the residents and communities within the City of Houston.

The HHD applied for and in September 2011, received funding from the CDC National Public Health Improvement Initiative (NPHII) in order to implement performance improvement activities and support accreditation efforts.

Who were the major players in the process, did existing staff complete the process or were others hired for just this purpose?
NPHII funds were utilized to hire staff specifically for the purpose of leading Quality Improvement (QI) and accreditation. These new staff members created the Performance Improvement and Accreditation Team (PIAT) in the Office of Surveillance and Public Health Preparedness which was supervised by Dr. Raouf Arafat, who was the NPHII grant Principal Investigator at the same time, under HHD Director, Stephen Williams.

What was the next step?
The Accreditation Workgroup was then formed in March of 2012 and consisted of PIAT as well as existing staff and leadership from every division within the department. Coordinated by PIAT, the workgroup was a way to ensure that every division in the department had some level of participation in the accreditation process, and to allow the collection of a diverse pool of documentation. The workgroup was divided into “domain teams” who worked on the specific requirements of individual domains, and would meet monthly and regularly report on the status of domains and current documentation. Assistant Directors in the department were assigned domains and worked closely with the work group. On April 30, 2013, HHD submitted its Statement of Intent (SOI) to apply for accreditation to PHAB. Upon approval of the SOI the department was granted a year to submit an application for accreditation. HHD then submitted its application for accreditation on December 31, 2013, and was approved by PHAB on January 2, 2014.

The PHAB Site visit was conducted on October 16 & 17, and HHD received its accreditation on December, 9 2014.

Overall, the process took more than 3 years, was this longer than the group anticipated, or is that roughly the standard amount of time the process takes?
For a big health department our size, three years is about average. In addition to being large, we were one of the first cities to pursue accreditation, so the process for achieving accreditation was still being shaped as we were working toward the goal. In a sense, we were “building the plane while flying it.” The process has become more refined since then, and more resources have been developed to support it. The first year was a discovery period for us, which enabled us to identify gaps and training needs, and develop tools to familiarize staff with the concept and requirements of accreditation. Most of the work was done in the last 2 years.

You mentioned you received funding to cover the cost of this process. Overall, how much did it cost and did the amount you received cover those costs?
PHAB has a fee structure that is based on the size of the population served by the department. The application fee for a jurisdiction the size of Houston was $47,700 at the time of its application. However, seeking accreditation is a major commitment, and other costs must be taken into consideration. Costs such as salary, time, and materials were additional and had to be covered as well.

HHD was fortunate to be a recipient of CDC NPHII funds, which allowed full-time accreditation and QI staff mentioned above, to be employed. However only a portion of the application fee for accreditation was covered by this funding with the rest paid for by the HHD.

How were you able to get the additional funds approved by city council? Specifically, how was HHD able to convince them of the importance of accreditation?
There was no additional funding requested from city council, however, we did make a presentation to them to explain what we were about to do and how the costs would be covered.

In retrospect, why did the department decide to go forward with accreditation and what has the HHD gotten out of it thus far?
HHD decided to pursue accreditation for a number of reasons. From researching the process, administration realized that engaging in the accreditation process would be an exercise in quality improvement and would present the entire department an opportunity to examine our operations objectively in order to focus on opportunities for improvement, and bolster strengths.

The process also allowed the department to engage the community in new ways by partnering with local organizations to develop the Community Health Improvement Plan (CHIP). The department will continue to identify new avenues by which it can enhance collaboration on health improvements. The department has added new areas of focus to the CHIP and has secured community involvement from the beginning.

We have also had the opportunity to participate in the PHAB QI leaders Academy, as an accredited health department. This has allowed us to continue to build QI into the culture of the department, and will support us in improving upon our existing departmental QI planning. An annual improvement report is required to be submitted to PHAB as a means to track continued progress and improvement, and 4 years from now we will apply for reaccreditation. Costs for future reaccreditation will be budgeted for and substantiated.

Robert, thanks for telling us the accreditation story of the Houston Health Department. Our journal team is certain that the information you have provided will be useful to those who may be considering pursuing accreditation for their own departments.

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How a Student Run Clinic Can Address Gaps in Access to Mental Health Services

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ABSTRACT

Background: St. Vincent’s Student Run Free Clinic (St. Vincent’s Clinic) provides primary care and specialty services to uninsured and underinsured individuals of Galveston, Texas, and surrounding areas. Patient care at this clinic is provided by medical and allied health professional students. St. Vincent’s Clinic offers a psychiatry specialty clinic twice a month which helps fill the gap between clinical- and public health-related mental health services provided by the state-funded outpatient mental health services. This study aims to describe the demographics, clinical, and treatment modality of patients receiving mental health services at St. Vincent’s Clinic.

Methods: Retrospective secondary analysis of electronic medical records (EMR) for all patients seen at the psychiatry clinic from September 2013 through August 2014. EMR was reviewed for patient demographic information, psychiatric diagnoses, medications, comorbidities, and follow up time-period.

Results: In one year, St. Vincent’s Clinic saw a total of 708 patients, 117 (16%) of whom received treatment at the psychiatry clinic. Depression (55.4%) and anxiety disorders (42.2%) were the two most common diagnoses of psychiatric patients. Selective serotonin reuptake inhibitors, fluoxetine, and citalopram were the most commonly prescribed medications. Almost 33.3% of psychiatry patients utilized counseling services while 38.5% of psychiatry patients had only one psychiatric visit at St. Vincent’s Clinic.

Conclusion: St. Vincent’s Clinic provides free mental health services to uninsured psychiatric patients, primarily in the form of medication management. Student volunteers are able to use their training skills to deliver mental health services in Galveston and surrounding counties for patients not covered by existing public health services. The high prevalence of comorbid conditions and poor follow-up among psychiatric patients have greater implications on student-run free clinics with limited resources. More institutional support is needed to deliver integrated care and proper follow-up of patients with a psychiatric diagnosis.

INTRODUCTION

The Centers for Disease Control and Prevention (CDC) estimates 22% of the US population has a diagnosed mental disorder, and many do not seek treatment.1 In 2005, the estimated prevalence of a diagnosed mental illness in the state of Texas was 19.6% among the adult population.2 In 2013, 28% of Texans aged 19-64 years were uninsured, and only 7% were covered by Medicaid.3 Being on the border with Mexico, Texas has a large undocumented immigrant and uninsured population.4,5 Approximately 1.4 million people currently living illegally in Texas are not covered under the Affordable Care Act.6 As undocumented individuals are unable to access Medicaid or participate in the Affordable Care Act,7 this population adds strain to the current public health resources providing mental health services to uninsured individuals in Texas. Outpatient mental health services in Texas are in great need but in short supply, especially for uninsured or underinsured individuals. In 2010, an estimated 488,520 Texas adults had serious and persistent mental illness.8 In Galveston County, Texas, 12.3% of the population live in poverty; 20.5% of the population are uninsured.9 Uninsured Emergency Department (ED) visitors are a significant driver of health costs in the United States.10 Studies have shown that safety net services and free clinics play a significant role in reducing ED visits and reducing health care cost.11,12

St. Vincent’s Student-Run Free Clinic (St. Vincent’s Clinic) is a private donation and grant-supported clinic that provides primary care and continuity of care to the uninsured and indigent population of Galveston and Brazoria counties in southeastern Texas. The student-run clinic is physically located at St. Vincent’s House, a non-profit social service agency. While focusing on primary care, St. Vincent’s clinic also offers specialty care in areas such as gynecology, rheumatology, neurology, dermatology, and psychiatry. The clinic operates three days a week with two evening clinics and a Saturday clinic. Health care services are provided by student volunteers, in all years of their health professional schooling, pursuing degrees in medicine, physician assistant, nursing, physical therapy, and clinical laboratory sciences. The clinic is directed by upper-level students. Student volunteers are supervised by a board-certified medical director and other physician volunteers.

A psychiatry clinic is held twice a month and treats patients with a wide range of psychiatric conditions. Student volunteers conduct the clinic visits by collecting a history of present illness, conducting a physical and mental status exam, and presenting the case findings to an attending volunteer physician. Physicians then assess the patients and discuss management plans with the students and patients. All faculty and students are associated with the University of Texas Medical Branch (UTMB) in Galveston, Texas. UTMB provides the malpractice and liability insurance of those involved in patient care. In addition to medication management, St. Vincent’s Clinic has four counselors supported by local grants awarded to St. Vincent’s House to provide free counseling services.

The mission of St. Vincent’s Clinic is twofold: first, to serve the Galveston indigent community by providing health care to individuals with no other means of access to health care services; and second, to promote a service culture among medical and allied health students by providing a comprehensive view of social determinants of health, environment, and community medicine. Student volunteers learn how to work with socioeconomically disadvantaged patients who face many barriers in accessing health care and maintaining a healthy lifestyle.

St. Vincent’s Clinic complements the state-funded mental health services provided in the area by providing care to patients without Medicaid or ability to pay and irrespective of the severity of psychiatric illness. In Galveston and Brazoria counties, state-funded outpatient mental health services are covered by the Gulf Coast Center, a Local Mental Health Authority (LMHA). Gulf Coast Center services are not free; they are offered with reimbursement on an income-based sliding scale for uninsured patients, and copays are required for those
with insurance. Gulf Coast Center is required to provide services to individuals with serious mental illness or those insured by Medicaid; thus, clients with Medicaid are treated before those without insurance.¹³,¹⁴ Many residents of Galveston are undocumented immigrants and do not qualify for the county- or state-funded resources.⁴,⁶ The purpose of this study was to describe the patient population served by the student-run psychiatry clinics of St. Vincent’s Clinic and how gaps between existing clinical and public health services can be addressed.

**METHODS**

The retrospective secondary analysis was performed using electronic medical records of all patients seen at the psychiatry clinic from September 2013 to August 2014 to avoid periodic bias. The data collected were de-identified to remove all personal health information before analysis. This study was approved by the UTMB Institutional Review Board.

Information collected in the database included: patient’s age, gender, primary diagnosis, comorbidities, source of referral to the clinic, psychiatric conditions, the status of the patient’s condition (controlled/uncontrolled), up to five medications prescribed over the course of treatment, length of follow-up, and the number of psychiatry clinic visits within the period of the study. All data management and analyses were conducted in MS Excel, and ArcGIS 10.2 software was used to construct a map in order to demonstrate the regional distribution of psychiatric patients.¹⁵ Patients’ residential zip codes were geocoded for the geospatial analysis in Figure 1.

**RESULTS**

A total of 708 distinct patients and a total of 1,760 patient encounters were reported from September 2013 through August 2014. Overall, 16% (n=117) of the total sample were psychiatry patients, resulting in 264 psychiatric encounters. The mean age of the psychiatric patients was 43 years (standard deviation [SD] 12.8), and 65.8% of the study sample were female (Table 1). The GIS map shows the distribution of St. Vincent’s Clinic patients throughout the Galveston and Brazoria counties, with the highest concentration coming from Galveston Island (Figure 1).

Of the St. Vincent’s Clinic psychiatry patients, 34.2% had comorbid hypertension, 12.0% had Type 2 diabetes mellitus, 11.1% had hyperlipidemia and 6.8% had psychogenic non-epileptic seizures. Approximately 61.0% of psychiatric patients also received other medical care at St. Vincent’s Clinic; 36.8% of patients received only mental health services at St. Vincent’s Clinic and sought primary care elsewhere, and 33.3% utilized the free counseling services offered at St. Vincent’s House (Table 1).

The most common psychiatric diagnosis was a depression-related disorder, followed by anxiety disorders. Selective serotonin release inhibitors (SSRI) were the most commonly prescribed medications at the psychiatric clinics. Fluoxetine was the most commonly prescribed SSRI, followed by citalopram. Risperidone was the third most commonly prescribed medication and the most commonly prescribed antipsychotic medication. Lithium was the most commonly prescribed mood stabilizer. Trazodone was the most commonly prescribed sleep-aid medication. Almost 46.6% of the psychiatric patients were in a controlled condition with low safety risk and stable on their current medications. Of the psychiatric patients, 39.0% were documented as having only one psychiatric visit and no follow-up visits at St. Vincent’s Clinic (Table 1). An average of 15.4 students volunteered at psychiatry clinics and 14 at primary care clinics while the average number of faculty volunteers at psychiatry clinic and primary care clinics were 3 and 3.7, respectively.

**DISCUSSION**

This study examines the full spectrum of psychiatric services offered by a student-run free clinic. Although descriptive in nature, the study results demonstrate health service utilization of uninsured psychiatric patients at a student-run free clinic. The majority of patients are seen by the psychiatry clinic for medication management and are referred from St. Vincent’s primary care services. The most commonly treated diagnoses at St. Vincent’s Clinic are depression and anxiety disorders, conditions that primarily do not cause functional impairment seen in serious mental illness.¹⁴

![Figure 1. Geospatial distribution of psychiatric patients visiting St. Vincent’s Student Clinic by neighborhoods and counties.](image)
St. Vincent’s Clinic fills a gap in public health services for patients with a mental health diagnosis from the surrounding region who cannot access state- or federally-funded services. GIS findings demonstrate a need for mental health services for uninsured individuals in the Galveston-Houston region. Our study found that uninsured psychiatric patients have a high prevalence of multiple comorbidities, including other chronic medical conditions, which is consistent with other study results.16 Psychiatric patients, especially those multiple comorbidities, need continuity of care with follow-up for monitoring of patients’ physical and mental health symptoms combined with medication management and behavioral modification to optimize health outcomes. Poor follow-up and tracking patient outcomes are major challenges faced by students at St. Vincent Clinic. Almost 40% of patients are lost to follow-up after their first psychiatric visit, and it is unclear from the data if these patients seek treatment elsewhere or are unable to or choose not to follow up St. Vincent’s Clinic.

St. Vincent’s Clinic provides healthcare to patients who might have gone to UTMB-Galveston Emergency Departments (ED). Baillargeon et al., found that uninsured patients with a psychiatric diagnosis have a high risk of multiple ED visits and hospitalization at the UTMB affiliated hospital in Galveston.17 A 2008 study of 25 Harris County hospitals demonstrated uninsured patients are the most likely payer group to visit the ED for solely behavioral and mental health complaints, and they are less likely than Medicare or Medicaid patients to be hospitalized for further mental health treatment.18

For patients of St. Vincent’s Clinic, low-cost medication is paramount to ensure treatment adherence. The clinic’s main strategy is to prescribe medications listed on pharmacy discount lists; Walmart, Target, and HEB regularly update their discounted medication lists. The most commonly prescribed SSRIs are on the Walmart $4 prescription list or are available for less than $10 for a one-month prescription. The clinic uses several strategies to provide affordable medications. For example, the cash price of risperidone in Galveston, Texas, is listed at several pharmacies as $100-105 for one month.19 Student volunteers investigate several options: 1) check the cash price on a discount prescription list; 2) offer a coupon for the medication from goodrx.com; 3) offer to enroll the patient in a pharmaceutical patient assistance program; or 4) give the patient medication from the clinic stock. However, difficulty accessing reduced-priced medications arises with mood stabilizers and second-generation antipsychotic medications, which are not commonly available on these discount lists.

The St. Vincent’s Clinic psychiatry clinic exists for patients who have reached a peak at which a psychiatrist, compared to a general practitioner, is better able to manage mental illness, medication trials, and drug regimens. Not all uninsured patients with mental illness will qualify for treatment through their LMHA. Of the indigent and Medicaid patients in Texas with mental illness who receive full mental health services, primarily through an LMHA, 35.6% were diagnosed with major depressive disorder (MDD), 36.9% with bipolar disorder, and 25.8% with schizophrenia.20 In 2014, approximately 87,182 patients received community mental health services in Texas.21 These numbers do not include patients with mental illness who were not eligible for treatment in an LMHA, usually due to lack of proper diagnosis or insurance eligibility. In 2010, 156,880 Texans received mental health services through NorthStar, a group of publicly-funded managed care clinics that serve seven counties. However, Galveston, Brazoria, and Harris Counties are not among the counties that are served by NorthStar.21

St. Vincent’s Clinic addresses gaps in mental health care by providing educational opportunities involving community clinical medicine; however, it faces several structural challenges in providing patient care. The student clinic would benefit from more support from their parent institution to increase faculty volunteer involvement such as professional advancement incentives for mentorship and community service. Other student-run clinics have demonstrated the benefit of utilizing student volunteers from diverse professional backgrounds.16 UTMB does not have social work, dental, and pharmacy graduate programs to provide student volunteers from these disciplines. In an effort to create interdisciplinary teams to improve patient outcomes, with the support of the UTMB medical school administration, St. Vincent’s Clinic should consider starting student internship or clerkship programs with other universities. Specifically, St. Vincent’s Clinic should aim to incorporate social work students in assisting patients who experience difficulty navigating healthcare and social services systems. Social work students could carry out community-based interventions such as home visits and follow-up phone interviews. Also, the Department of Preventive Medicine and Community Health at UTMB has a population health program, and many public health students could play a significant role in promoting evidence-based community health interventions. The Association of American Medical Colleges (AAMC) recommends teaching medical students about the non-biological determinants of poor health, the organization and delivery of health care, and commitment to care for the underserved population.22 Medical students would benefit from a curriculum that includes community service learning and health development skills such as required classes about social determinants of health and grant writing.23,24

This study has several limitations. The retrospective chart review was initiated as a descriptive study to learn more about the patients who receive mental health services at St. Vincent’s Clinic. The study also has a small sample size, which limits the ability to generalize

### Table 1. Demographic and clinical characteristics of uninsured psychiatric patients at St. Vincent’s Student Clinic, September 2013 to August 2014.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Psychiatric Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patients</td>
<td>117 (16.5%)</td>
</tr>
<tr>
<td>Age mean (SD) years</td>
<td>43 (12.8)</td>
</tr>
<tr>
<td>Female</td>
<td>77 (65.8%)</td>
</tr>
<tr>
<td>Race / ethnicity</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>47 (40.2%)</td>
</tr>
<tr>
<td>Black</td>
<td>21 (18.0%)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>20 (17.1%)</td>
</tr>
<tr>
<td>Others</td>
<td>19 (16.2%)</td>
</tr>
</tbody>
</table>

#### Five Common Diagnoses
- **Depression Disorders**: 64 (55.2%)
- **Anxiety Disorders**: 49 (42.2%)
- **Bipolar Disorder (1 and 2)**: 28 (24.1%)
- **Insomnia**: 14 (12.1%)
- **Abuse Disorders**: 13 (11.2%)

#### Encounter Types
- **Patient Encounters in one year**: 264 (15.0%)
- **New psychiatry patients**: 43 (36.8%)
- **Established patients**: 72 (65.1%)
- **Patient with 1st psychiatry visit and no further follow-up**: 44 (37.6%)
- **Number of psychiatry visits**: 2.2 (1.6%)

#### Top Five Comorbidities
- **Hypertension**: 40 (34.2%)
- **Diabetes Mellitus, Type 2**: 14 (12.0%)
- **Hyperlipidemia**: 13 (11.1%)
- **Psychogenic Non-epileptic Seizures**: 8 (6.8%)
- **Hypothyroidism**: 7 (6.0%)

#### Five Common Medications
- **Fluoxetine**: 34 (15.0%)
- **Citalopram**: 30 (12.8%)
- **Tradodine**: 21 (9.6%)
- **Risperidone**: 20 (9.2%)
- **Bupropion**: 12 (5.5%)
- **Counseling Services**: 39 (33.3%)
- **Controlled/Uncontrolled (N)**: 55 / 38

Values are presented as mean ± standard deviation (SD) or N (%).
study results. The uninsured population comprises one-fifth of the population of Texas.' Advantages of our study include the mental health service utilization data of uninsured patients, which is not commonly evaluated.

CONCLUSION
Due to a high prevalence of uninsured psychiatric patients, mental illness is one of the leading factors increasing the burden of disease in the state of Texas. Uninsured psychiatric patients treated at St. Vincent clinics have chronic mental health problems and need medication and counseling services. The majority of psychiatric patients have multiple comorbidities that require integrated primary and mental health care with more frequent follow-up. Despite limited financial resources, St. Vincent’s Clinic plays a significant role in providing mental health services to the uninsured population in response to a shortage of outpatient mental health services in Galveston County. Replication of the model used at St. Vincent’s Clinic to provide mental health services represents a means to bridge gaps in access to mental health services that may be useful in other communities, especially those with a medical school.

REFERENCES
19. Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW). Texas Department of State Health Services. 2013. Medicaid and Indigent Children Receiving Mental Health Services from the Texas Department of State Health Services by Diagnosis. Austin, Texas.
Mini-Grant Demonstration Projects: A Community Approach to Increase Physical Activity

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5Brazos Valley Community Action Agency
6Texas A&M AgriLife Extension
7Emory University Rollins School of Public Health

ABSTRACT

The CTxCARES Program at the Texas A&M University School of Public Health established a mini-grant initiative with the goal of engaging community-based partners in identifying a research project, launching partnerships, implementing and sustaining strategies for increasing physical activity as a means of cancer prevention and control. Based on dissemination research and guided by prior experiences with mini-grants from partners in the Centers for Disease Control and Prevention’s Cancer Prevention and Control Research Network, CTxCARES initiated a mini-grant competition through the Brazos Valley Health Partnership and awarded five mini grants of $10,000 each to community-based organizations in the Brazos Valley of Texas in the fall of 2010. Grantees chose from the following Community Guide strategies: enhancing infrastructure, increasing safety, and improving access to places for physical activity. Three sites working in partnership with other local agencies made infrastructure improvements to walking trails or city streets, one site fenced an outdoor area for children to be physically active, and the last site equipped elementary schools to link a behavioral nutrition program with community-based physical activity resources. Community-based mini-grants resulted in successful implementation of evidence-based strategies for increasing physical activity and increased community-capacity to translate proven strategies into practice. Key to the success of projects was organizational leadership and identifying strategies that fit within the context of each community, thus promoting additional partnerships and community buy-in. Program sustainability continues through creative approaches.

Keywords: cancer prevention, physical activity, mini grant, community health partnerships, community-based participatory research

Introduction

Communities in Texas face a number of chronic health problems including cancer, heart disease, and obesity, with heart disease and cancer being the top two causes of mortality in the state.1 Those living in a community that supports physical activity may experience a reduced risk of developing chronic disease, and they may also be better equipped to manage chronic disease if they engage in regular activity.2,4 Evidence-based practices, programs, and strategies have been shown to improve physical activity in older adults5,6 and in other age groups.7 Despite good intentions to make positive changes in physical activity at a community level, community organizations aimed at improving the health and wellbeing of constituents often lack the resources and capacity to address health issues using evidence-based strategies.8

Academic-community partnerships allow for implementation of evidence-based strategies in ways that recognize community needs and are relevant to community stakeholders. Recent studies have shown that interaction with community partners and solicitation of their participation are effective methods for disseminating evidence-based strategies.9,10 Success has been demonstrated in promoting community-based healthy eating and physical activity initiatives when community partnerships are developed with the additional benefit of seed funding.11,12 Consistent with the national Centers for Disease Control and Prevention (CDC)’s Cancer Prevention and Control Research Network (CPCRN) mission to accelerate adoption of evidence-based cancer prevention and control in communities,13-14 several CPCRNs have used mini-grants as an effective approach to provide seed money to support capacity of community organizations, as the funding opportunity stimulates community synergies to address needs and promote health equity.11,13-17

The prior experiences of the Emory CPCRN guided the Texas A&M University School of Public Health CTxCARES Program’s employment of mini-grants to enhance community capacity by building a Prevention Support System. Focusing on building capacity, a Prevention Support System is just one of the three connected systems that make up the Interactive Systems Framework that informed the mini-grant programs at Emory University.18 From 2007-2008, Emory’s CPCRN Center evaluated the feasibility of implementing mini-grants alongside technical assistance as a method of evidence-based program dissemination among faith-based and other organizations in southwest Georgia.19 They found this multi-modal strategy to be effective. In addition, since 2007, the Emory Center has reached more than 23 organizations in 16 mostly-rural southwest Georgia counties with their mini-grant program.17

CTxCARES sought to engage community-based partners in increasing evidence-based strategies for increasing physical activity (PA) to accelerate cancer prevention and control. Based on expanding research that supports the relationship between physical activity and cancer prevention14 we wanted to help community organizations in identifying a research project, establishing needed partnerships, implementing and sustaining their projects in order to achieve their stated goals. Evidence-based strategies were identified from The Community Guide, a collection of systematic review findings by the Community Preventive Services Task Force on interventions for health and well-being.20 Approaches recommended by The Guide to improve physical activity include the following: enhance infrastructure, increase safety, and improve access to increase physical activity.21 This paper will describe the methods, results, and lessons learned in the implementation of a community mini-grant program tapping into three evidence-based strategies to improve physical activity in a local setting. As such, it provides a model of practice for other communities.

METHODS

Partnership Activities

Given the nature of our study, this research was designated as exempted research by the Texas A&M IRB. CTxCARES researchers met with local community leaders through the Brazos Valley Health Partnership (BVHP) to shape ideas for a mini-grant program. The BVHP is a collaborative network of community members from four rural counties in the Brazos Valley with the goal of improving health and well-being in local communities.22 To utilize a community-based
participatory approach, CTxCARES sought guidance and feedback from the BVHP. The geographic scope of the project was widened as a result of BVHP participation. Community stakeholders such as the Brazos Valley Community Action Agency (BVCAA) attended these meetings and were helpful in identifying other potential partners, such as the Children’s Museum of the Brazos Valley. The Brazos Valley Community Action Agency, in existence in the Brazos Valley of Texas since 1972, is part of the larger group of Community Action Agencies started by Lyndon B. Johnson to help every member of a community reach their full potential.22 A request for proposals was created and distributed through the BVHP, BVCAA, and local CTxCARES email contacts in the summer of 2010. A training session for potential grantees was held at the Texas A&M School of Public Health to discuss the benefits of evidence-based programming and proposal writing. Six proposals were received and reviewed by a team with five CTxCARES representatives and four representatives from community organizations. Selection criteria included the detail of the plan, organizational capacity, budget justification, and proposed impact.

Five community partners from a variety of types of organizations (Table 1) received $10,000 each to identify a strategy, establish needed partnerships, implement, evaluate, and sustain a PA intervention in their communities for a one year period. Funding could be used for staff time and small capital expenditures such as signage, fencing, and lighting. Based on local contexts, organization champions chose among the following three evidence-based PA strategies: enhancing infrastructure to support walking, improving access to outdoor recreation facilities, and enhancing personal safety in areas where people are, or could be, physically active.20

A kickoff event was held where all partners could interact and share project plans. Meetings and phone calls were held regularly throughout the grant year so that partners could discuss their expectations, progress, successes, and challenges. Grantees also submitted quarterly reports that outlined summaries of activities and accomplishments, updates to the project timelines, adjustments to the budget, and facilitators and barriers. Technical assistance was offered on program implementation and dissemination as well as evaluation. Methods of assessment were self-reports through surveys and interviews as well as observations to measure increased awareness, satisfaction, and physical activity behaviors. Organization leaders gathered at the conclusion of the grant year to meet with all partners to present their programs and learn from findings of other projects.

### Community Partners: Outcomes

City of Temple Parks and Leisure Services Department. This project was proposed to enhance infrastructure to support walking by making improvements to an existing community resource: Friar’s Creek Trail. The City of Temple installed road signs with directions to the trail, water fountains for trail users and their pets, a pet waste disposal system, and educational signs describing local plant and animal life. The City of Temple administered pre- and post-improvement surveys to 16 trail users and found that ratings of good or excellent increased from 67% to 100% for signage, 47% to 100% for distance markers, and 10% to 76% for drinking water.

Texas AgriLife Extension Service - Leon County. The Walking Map project was created to increase PA in Leon County by improving access and enhancing personal safety. Using new maps and leveraging participants from existing AgriLife programs (e.g., Balanced Food and Play and Walk Across Texas), Leon County AgriLife promoted safe areas in rural communities that families could be physically active. Community residents self-reported the number of miles they walked using the AgriLife website; several met with AgriLife staff for post program interviews. Results showed that 227 adults and 382 youth walked a combined 45,534 miles in Walk Across Texas and participation in the Balanced Food and Play program increased knowledge of the benefits of PA.

Brazos Valley Community Action Agency, Inc. BVCAA encouraged residents to walk in and around downtown Bryan, Texas and to increase PA among Brazos County residents. The mini-grant enhanced infrastructure and increased access by creating walking trails by installing signs, providing trail maps in all downtown businesses, and referring walkers to a guided tour through the use of Quick Response codes for smartphone applications. A “best sign” contest was held to promote the walking trail and allow for community buy-in of the project. Local students surveyed and counted downtown pedestrians before and after the trails were created, and they discovered that walkers were more common along the trail route once signs and maps were in place. However, it remained unclear from survey data whether PA increased in the short-term, as only 13% of 101 pedestrians surveyed were aware of the walking trail two months after school program use of the trail.

### Table 1: Community Partner Contributions

<table>
<thead>
<tr>
<th>Community Partner</th>
<th>Project</th>
<th>Strategy</th>
<th>Implementation</th>
<th>Evaluation</th>
<th>Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Temple Parks and Leisure Services Department</td>
<td>Friar's Creek Trail</td>
<td>Enhance infrastructure</td>
<td>Installed directional and plant signage, distance markers, drinking water, and pet waste disposal system</td>
<td>Pre- and post-surveys to trail users</td>
<td>Adopt-a-Park and post-program use of the trail</td>
</tr>
<tr>
<td>Texas AgriLife Extension Service Leon County</td>
<td>Leon County Walking Maps</td>
<td>Improve access</td>
<td>Created new maps and used existing programs: Walk Across Texas and Balanced Food and Play</td>
<td>Online self-report and post-program interviews</td>
<td>Maps at Chamber of Commerce and promotion through existing programs</td>
</tr>
<tr>
<td>Brazos Valley Community Action Agency, Inc</td>
<td>City-BEAT Walking Trail</td>
<td>Enhance infrastructure</td>
<td>Created walking trails by installing signs and providing maps and mobile app guided tour</td>
<td>Pedestrian interviews and counts of pedestrians</td>
<td>Distribute of maps and promotion through decals and community events</td>
</tr>
<tr>
<td>City of Navasota Parks and Recreation Department</td>
<td>Hillside Park Lighting</td>
<td>Improve access</td>
<td>Installed trail lights and new trail signs</td>
<td>Surveys and pre- and post-counts of park walkers</td>
<td>Establish walking club and annual Explore Outdoors event</td>
</tr>
<tr>
<td>The Children’s Museum of the Brazos Valley</td>
<td>Enclosed Outdoor Space</td>
<td>Enhance infrastructure</td>
<td>Created outdoor space with fencing and shade structures for programmatic use at the museum</td>
<td>Post-intervention satisfaction survey</td>
<td>Improve space and increase programming</td>
</tr>
</tbody>
</table>
City of Navasota Parks and Recreation Department. A Hillside Park lighting project sought to increase PA within Navasota by enhancing infrastructure and increasing safety by supporting walking at a local park facility. Navasota Parks and Recreation Department installed new signs and trail lights, and the park became the first lit walking facility in the community. Local health care organizations partnered with the city to promote the new lights and evening hours with an Explore Outdoors event. The parks department conducted interviews and counted the number of walkers using the trail. They found that 88% of the 16 persons interviewed reported increasing their minutes of PA per week as a result of trail improvements. Also, park use at night increased from an average of 12 to 21 walkers as observed on week nights between the hours of 5:00 and 10:00pm.

The Children’s Museum of the Brazos Valley. This infrastructure project increased access by expanding outdoor play space to give the museum a fun, safe, and creative outlet to implement a Healthy Kids initiative and keep visitors physically active. The Children’s Museum worked with students from the Department of Architecture at Texas A&M University and with “handyman” friends of the museum to design and build fencing and shade structures. While museum staff were very positive the infrastructure changes, a brief parent satisfaction survey of summer camp attendees provided mixed results (e.g., 15% responded that outdoor space helped with PA activity and 46% indicated the outdoor space did not make a difference).

Community Perspectives, Sustainability, and Continued Partnership
As part of their original grant activity, each community organization was expected to plan for project sustainability in future years. Two years after the funded mini-grant activity ended, each grantee discussed their project with CTxCARES. The following provides a highlight of sustainability successes and challenges.

The City of Temple Parks and Leisure Services Department Adopt-a-Park program encourages residents and local community groups to steward park resources at several sections along the trail. Through efforts of these groups and of the City itself, the funded additions are still enjoyed by trail walkers. Additionally, an after school program has utilized the Friar’s Creek Trail for exercise and educational purposes.

The Texas AgriLife Extension Service in Leon County distributed safe walking route maps to Chamber of Commerce of Downtown Bryan Association who took it upon themselves to create and distribute walking trail maps. The Downtown Bryan Association continues to print the maps monthly for distribution at local businesses. Walking trail decals are displayed in storefront windows. PA events regularly use the trail; for example, the local Sexual Assault Resource Center held a “Quidditch” competitions in the fenced area with University students who came to play with the children.

Lessons Learned
All five community organizations were able to identify strategies, establish partnerships, implement their projects successfully, and achieve many of their stated goals through the mini-grants funding, training, and technical assistance offered. This shows the importance of the Prevention Support System in helping community organizations use evidence-based strategies. It became clear throughout the process that within each project an organizational leader emerged who championed implementation. It is believed that the leaders’ optimism and drive helped bring about successful programs. These leaders were asked to share how they framed their projects to their communities and within their organizations, and they offered useful perspectives that reflect the voices of community partners. These perspectives are illustrated in Table 2.

Several other lessons emerged from this project. Partnerships can enhance use of evidence-based strategies. Each organization utilized the grant seed money to leverage partnerships and resources. For example, the Brazos Valley Community Action Agency, through their mini-grant project, developed a partnership with the Downtown Bryan Association who took it upon themselves to create and distribute walking trail maps. The Downtown Bryan Association continues to light Hillside Park trail during evening hours. The City conducts the Explore Outdoors event annually in October with kayaks, bicycles and canoes to promote the trail.

The Children’s Museum of the Brazos Valley planned to improve the outdoor space by extending safety flooring and planting shade greenery, though staff turnover led to a delay. In addition to the museum’s regular outdoor PA programs in Winter Camp, Spring Break Camp, and Summer Camps, local groups have visited the museum to utilize the space. A Boy Scout Day utilized the space and a summer camp had “Quidditch” competitions in the fenced area with University students who came to play with the children.

### Table 2: Community Partner Perspectives

<table>
<thead>
<tr>
<th>Community Partner</th>
<th>Project</th>
<th>Leader Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Temple Parks and Leisure Services Department</td>
<td>Friar's Creek Trail</td>
<td>“City officials were hearing positive feedback within the first week that the educational signs were installed. Not only was the information interesting but the overall quality of these full color signs attracted attention of individuals using the trail.”</td>
</tr>
<tr>
<td>Texas AgriLife Extension Service Leon County</td>
<td>Leon County Walking Maps</td>
<td>“A plan is never perfect and a plan involving schools and community people is never what you think it will be! The Leon County CTxCARES project was full of challenges, but great results came of it.”</td>
</tr>
<tr>
<td>Brazos Valley Community Action Agency, Inc.</td>
<td>City-HEAT Walking Trail</td>
<td>“People will choose the easiest option. If driving to McDonald’s is the easiest option, that’s what people will do. We want to make the easiest option the healthiest by increasing physical activity.”</td>
</tr>
<tr>
<td>City of Navasota Parks and Recreation Department</td>
<td>Hillside Park Lighting</td>
<td>“With limited options for physical activity that are free and accessible, this park has easily become the most important walking facility in Navasota. By increasing opportunities for walking, we have in turn increased the minutes per week in which members of our community are physically active (walking).”</td>
</tr>
<tr>
<td>The Children’s Museum of the Brazos Valley</td>
<td>Enclosed Outdoor Space</td>
<td>“The fence will offer a safe barrier from the parking lot and will provide an area where kids and their caregivers can be led in physical activities . . . .”</td>
</tr>
</tbody>
</table>

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Sustainability planning is critical and occurred in each partnership. At the end of the project, it was clear that continued project success was made simpler for partners “enhancing infrastructure supporting walking” and “improving access to outdoor recreation facilities.”

Finally, organizational turbulence or competing demands are factors in implementing and sustaining changes in communities. In the project that sought to “enhance personal safety in areas where people could be physically active” (Leon County AgriLife), the continuation of the project hinges entirely upon community staff members to continually deliver program components, leading to discontinuation of the project with staff turnover. Staff turnover of a project leader occurred in all community partner organizations except the City of Temple, though programmatic infrastructure of projects was not lost during staff transition in projects that paired programmatic components with newly created environmental infrastructure. While drive of the organization leader helped in the success of implementing each program, losing the leader due to turnover hindered sustainability.

**Limitations**

The five organizations in the mini-grant program came to the project with different levels of experience and capacity in implementing new programs. Even though technical assistance was provided by CTxCARES, within the limited resources available, organizations were not able to evaluate their programs comprehensively in a twelve month period where energies were devoted to partnership building and project implementation. Future programs would do well to help community partners develop evaluation plans that work in conjunction with the program plans. Also, timelines may need to be extended to accommodate unforeseen issues that affect implementation schedules. For example, during the summer of implementation, Central Texas experienced a severe drought that delayed work during summer months due to intense heat.

Due to limited resources, the mini-grant program was limited to just the three Community Guide evidence-based strategies: enhancing infrastructure to support walking, improving access to outdoor recreation facilities, and enhancing personal safety in areas where people are, or could be, physically active. We recognize that larger scale changes in the community environment and local policy, such as a comprehensive community plan that incorporates green space and access to other forms of physical activity and nutritious food outlets, are likely to have an even greater impact on health and prevention of chronic diseases. Future directions for mini-grant programs such as these should include more attention to the built environment and planning policies in communities.

**CONCLUSION**

Translation of evidence-based resources in communities can be achieved through mini-grants programs especially when paired with technical assistance from community-based public health researchers. A process that builds the capacity of communities to use evidence, engage leaders, establish partnerships, implement chosen practices, and consider sustainability can contribute to community achievement of their goals and maintenance of evidence-based environmental changes to promote PA.

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