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>> Tovo: Good morning. I'm mayor pro tem Kathie tovo representing district 9 and I would like to call this meeting to order, this meeting of the Austin city council is a policy workshop today. This morning we're going to focus on public health, mental health and healthcare delivery and we have a great array of panelists and others to discuss afterwards. So we will -- as we do have a quorum we will begin. I will say that mayor Adler will be unable to attend today and so I would be leading the meeting. Let's see. I believe that we're beginning with Shannon Jones. Mr. Jones, if you would like to start our discussion. >> E thank you for the opportunity to join you today and to talk about the role of public health in our the money community and our society. I'm also going to be joined by Dr. Phil Wong, the health authority and medical director for Austin Travis county, he will help in the presentation here today. I'd like to start off by saying and reminding you that healthcare is vital to all of us some of the time. And but public health is vital to all of us all of the time. And I'd like to repeat that because I think it emphasizes the importance that public health plays in our society. Healthcare, the relationship between us and our provider, our doctor, is vital to all of us some of the time. But public health is vital to all of us all of the time. This is a quote from C Everett coop, one of the significant surgeon generals in our history. When we look about the determinants of health it is important to understand what are the factors that contribute to the health of

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our community. When we look at that issues R. Areas we see 40% of health determinants are those social and economic factors. Things such as poverty, social service status. The whole importance of education. Those factors contribute, or the lack thereof contribute to the health of our community. That's followed by health behaviors where we eat, what we eat, our access to mental health services. All of those things contribute significantly to the health of our society. When we look at the third area that is clinical care which our partners will talk a bit about, 20% of that is really healthcare. The doctors visit. The hospitals. The health services that we actually provide. And then finally 10% of the determinants of health are those physical environment, how do we get back and forth to services. What does our environment look like, our housing and those factors? Those are the things that contribute to the health of our society. And in order to address the issues of health, we need to be mindful, those are factors that are driving the things we'll be talking about today. When we look at our local public health, the things we currently do and not only in our department, but also local health departments to emphasize epidemiology, the data. We collect the data that we share with the community. Vital records, where you get your birth and death certificate. We investigate disease. Clinical prevention. We do have a clinical part in which we provide services such as immunizations. Sexually transmitted disease, tuberculosis. We also are responsible for the environmental aspect of our society, things such as restaurant inspections and permitting.

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Preparedness. We've heard a lot about ebola and the issues of preparedness so we play a critical role in terms of public safety as well as public health. Chronic disease, leading causes of death, topic. Obesity, diabetes. We all play a role in the prevention of those factors that impact those aspect of our society. Maternal and child health. We provide services related to women and infant services. Teen pregnancy prevention, injury prevention and certainly through our neighborhood extras we provide services that focus in on those components of services where people live and play. I'll call now on Dr. Phil Wong, our health authority and talk more about those services we provide here in public health. If you worry about health care and public health, health care is where you deal with individual patients whereas public health is the community as the patient. And healthcare typically focuses on treating patients for their illness, but with public health we focus on prevention of illness again in the community. The institute of medicine defined the core functions of public health as assessment, policy and assurance. Assessment is our analogous situation where we're looking at the data to make a diagnosis for the community. Just as a physician looks at the data and lab tests and things, we look at what data we have. As Shannon mentioned, we collect the vital records, birth records, other data I'll talk about in a minute. And it is the doctor developing a treatment plan. This is where we look at the community, we look at the data and come up

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with a plan for how to address and improve the community's health. So these are the things we do. The inner venges we do to protect the whole community. We work with our partners and one part of the roadway assurance we don't have to do everything, but we see what's being done as part of the partners and that's where we refill it. And we want to do STD clinics and those are unique public health roles that we have because of the control of the spread of those diseases to follow up especially.investigations and contact tracing and things are part after distinctively blink health function. We see with many things as you saw. These are two examples. But how we do the unique roles of public health and how that fits in again with the healthcare delivery system. And the role that the organizations and city of Austin play in the continuum of services. So with data and chronic disease we look at the health certificate data. We look at morbidity like hospital discharge data. We look at behavioral risk factor surveys. We look at the surveys from the health department and look at the physical activity level, smoking rates, things like that. Shannon did some great maps looking at mortality for chronic diseases like diabetes and heart disease by zip code seeing which are the areas with the highest burden or we look at trends in those things. We've been working on the future development, the health information for us as a community, how we can use that data. We just had a meeting with Dr. Hernandez about some of the potential for health information exchanges and development of that. We work with the

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community health improvement plan, we work with our chronic disease, employers. We're working with the mayor's health and fillness council and employer sort of wellness, healthcare and that's where we've worked with integrated care collaborative. The community care collaborative and all these things. What we've done is looking at supporting clinical system change, use of system to -- use of system changes and clinical decision support. Again look for gaps that are needed. Bottom like we're making the easy choice because some of the public health community interventions and support the clinical invention to make them more supportive. Employees want to take advantage of the cessation services more. Like Austin Travis county integral care, their smoking rates have gone down to 10.2%. So that's when it fits had in with the clinical when they go visit their physicians and they're offered the cessation services and they fit together. Similarly we work with planning, development and review, imagine Austin, inspection, public works on making that healthy choice the easy choice. People can in their day-to-day lives have that compact, detective connected, physical activity is part of their daily lives. They have access to healthy foods and things like that. We're working with community health work and only Spanish language assistance to those patients. These are gaps that we identify and tobacco cessation services. Another example is how we work with healthcare on preparedness. From an assessment standpoint, we work with physicians, we work with labs that they report when they see reportable diseases. That they start seeing things like H 1 N run. We work with hospital

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discharge chief complete data in a realtime data basis to see what's happening in our emergency rooms, when there are spikes, when when he need to be monitoring that and be concerned. We do bioterrorism monitoring to see if there are releases concerning agents and vital records. From the policy development standpoint we work closely with city and county regional planning, homeland security taskforce, the public health and medical and public health coalition. We work with the medical society, when there's like H one N one and ebola we disseminated information to the hospitals about what are the current guidelines about diagnosing ebola or hundreds and what other getting them to make sure they ask question about whether there was travel to west Africa. We work with the CDC. When there are other policy development needs like isolation and quarantine to control that that's part of what we do in public health and then the epi response. Question this with automobile, but we do -- ebola, but we do this also with tuberculosis and HIV, syphilis, other things. The assurance, again, we're doing directive monitoring, ebola patients, patients coming from west Africa, traveling that have worked as healthcare workers or any travel from west Africa and we're monitoring each one of them. Working with E.M.S. And the hospitals if anyone developed any symptoms or anything we would work with them to arrange that connection with the hospitals. Medical counter measures, fatality, we work with the funeral homes if we have an ebola case a body needed to be disposed, we work with that. And medical surge, if there's a huge pandemic flu and we have a drastic increase in the need for medical services how do we handle that? We've worked with our healthcare partners in that. Next I'll turn it back to Shannon for the next couple of slides. >> Tovo: Thank you very much. I believe there are a couple of questions for you. Councilmember kitchen.

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>> How can the city of Austin best leverage its investment in healthcare and healthcare delivery with the public and private investors and health and healthcare for increase and benefit the community. Ways we're looking at as Dr. Wong says is how can we work together with our partners to invest to address those things? We look for opportunity to support the preventive efforts in terms of disease prevention as well as all social service activity. These are the types of initiatives we are engaged in and will be engaged in address the public health issues that we face in our community. These are some of our partners. You've seen them. I won't go through the list. But we've worked with other city departments, Travis county and our local health providers as well as educational institutions, hospitals and the like. Regionally we work with capcog as well as many other agencies in our areas. Our federal partners, center for disease control, FBI, transportations, security administration, many other in terms of addressing the issues of health in our community. And as it relates particularly to upcoming council action, you will be seeing on April 2nd the community services block grant additional grant funds to support our community neighborhood centers, our public health emergency preparedness,

supplemental grant funds. We'll be looking at particularly to support our efforts around bioterrorism and the like. And then on April 22nd we'll be approaching you with the summer youth employment program which we partner with Travis county through an interlocal to make sure those activities are up and operating. And that concludes our presentation. >> Tovo: Thank you very much for that helpful context. Councilmember kitchen and then councilmember Garza. >> Kitchen: Welcome. It's nice to see you again and to see you talking with us about this important subject. I'm wondering if you can

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talk a little bit more about the relationship between public health and the built environment? Dr. Wong mentioned imagine Austin and I'm -- the codenext process is what we're doing through now in terms of redoing our land development code and I'm curious about whether your department has been involved with any of those efforts. >> Well, yes, I'd be happy to speak to them and I'll ask Dr. Wong to join me in the response. As you are most familiar, we've been working in terms of addressing the built environment for quite sometime from the health perspective. We are a partner with imagine Austin. We've been engaged, we have staff that work and support those efforts as well. Additionally to those we've done our community health assessment community health improvement plan. If we have not, we will certainly provide each of you with a copy of that. And that outlines our strategies for addressing the health issues in our community as a whole. Part of that includes things such as transportation, access to healthy foods and the like. We have in this community significant areas that have food deserts and food swamps. As parts of our efforts to engage those we are engaging with city of Austin and our partners to incentivize healthy food as well as healthy services in those neighborhoods as well. So yes, we've been at this for quite some time. We are a active partner with imagine Austin as well. Dr. Wong may talk about codenext and some of the other efforts. >> Kitchen: I'm curious whether you're participating in the cag, which I'm not remembering exactly what that stands for, but the cag is the advisory group that's working on codenext, so I'm curious about whether y'all are involved with any of that aspect of it. >> We've been very closely involved with imagine Austin from the start. We originally had some CDC funding for putting prevention work in the community transformation grant that we actually

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funded to staff in the planning, development, review department in. In terms of codenext we've been actively engaged. I know the complete streets policy that has now passed that is now one of the strongest in the country. We've been very engaged in that. The city just received from the American planning association, American public health association a grant that was funded through CDC. We're one of 18 communities in the country working with the transportation department that they're going to

be doing education in the rundberg area to educate them how to use public transportation and increase use of public transportation. But one of the pillars of imagine Austin being health, we were again from the very start have been very actively engaged in that. It's been a fantastic collaboration with public works, transportation, planning, development, review, all of the departments. >> Thank you very much. >> Tovo: Councilmember Garza? >> Garza: I have two questions. One is an extension of what councilmember kitchen just asked because I saw in the partners you mentioned the food deserts. And I thought a good MIX of partners would be economic development in getting a grocery store out to parts of district 2, del valle. Do you ever work with economic development in those kinds of endeavors? >> We've been working with Kevin Johns and dusty Mccormick particular in terms of how do we incentivize and work with grocers to come into those areas, starting by looking at with the small convenience stores, but how do we get healthy food options in those, fresh fruits and the like. With the long-term plan of identifying particularly areas in the eastern part of the city as well as the county to incentivize grocers to come in to provide those. We have areas that you're most family with where people have to drive as far as seven, eight, 10 miles to a gross -- to get groceries from grocery stores. Yes, we have been working with them. We're encouraging them to continue to work with us and strategies to improve those investments. >> Garza: Okay. Seven to eight is a good

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number in my district because they're more like 20 miles away from grocery stores. There's data on heart attacks and diabetes by zip code S there a way to do that by council district now? And where is that information? >> We're working on that. I know the city is working on getting more data by district. We have limited guess capabilities, but that's certainly something that we are examining. I know children's optimal health which you might hear about later, we work closely with them on their data and some of the gis distribution of those risk factors. But it's something we're actively seeking and also looking at partnerships with Texas state. They have a strong gis program, things like that. >> And where is the information by zip code? >> Pardon? >> Where could one find it? >> We could make it available to you. We have done it and we'll make it available to you as well. >> Garza: Thank you. >> Tovo: Councilmember Houston. >> Houston: Thank you so much Mr. Jones and Dr. Wong for your overview of the issues. I just want to make sure that we're clear. This is not new information that you're presenting to the community. As far as I can tell you've been presenting this same information about the disparities in healthcare, like of health -- medical services in 2, 1 and some parts of 4 for a long time. And so I'm hopeful of that this time we'll be able to get traction and be able to get some resources to the communities that have the highest incidents of infant mortality, diabetes, obesity, stroke, heart attacks. And this is not new information. So I just want to make sure that people understand as they listen -- watch on TV that you all have been presenting this data for many years now. And thank you for presenting it again. >> Thank you very much,

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councilmember. >> Renteria: Can you explain to the community -- I know we have a situation in montopolis where we're trying to consolidate the rec center with the -- and put up [indiscernible] From the health department. Can you tell us the difference between the kind of services that you will be providing there at the center and the difference between that and the clinic? >> Yeah, I'll be happy to try and address that. What we're looking at in terms of providing at the montopolis rec center are services that we currently provide as part of public health activity. Those we alluded to as immunizations. Some of our social service activities. In terms of social workers and social services. Those are different than the clinical services that our partners will be talking about, things -- things for primary care, acute care and the like. So that is primarily sort of the difference in terms of the types of services we'll be providing there. Versus at the montopolis southeast hub center. >> Renteria: The reason I was asking is I think there was a lot of misinformation in that community about that they kind of think that they're going to be a new clinic there and they say, well, we have one up the street, which I try to explain to them that there's a difference between a clinic and services -- >> The service is at the clinic in the montopolis area. Our chief administrative officer can speak more to the services. >> Thank you, morning. The project in montopolis is a full service neighborhood center which is not available currently in the montopolis neighborhood, which would include our basic needs services, such as food pantry, clothes closet, workforce counseling, social work counseling, as well as

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some of our preventive health measures, which would be screenings, blood pressure, blood sugar screenings, those type of activities that would be the prevention and we also have the opportunity to bring in some of our social service partners to provide some services at that location. >> Renteria: And thank you, because I just wanted for y'all to explain to the public that it's not that we're trying to build a new clinic or take away from the rec center, but it's trying to bring in services for that community because there's a great need there. And I know that because I have a lot of friends that live in that area. And they're in wheelchairs or diabetes has affected their life, their quality of life. And I try to explain and I said listen, I'll get that information when they -- when the health department makes their presentation here so they will know that we're really trying to reach out to this community and say hey, y'all do need this service. Do not try to stop it or deny it because that's not what we need there. We need those kind of services that you're making a presentation on. Thank you. >> Thank you. We have a great partnership with parks and recreation on this department and the reality is both departments will be able to do more because we're joined forces. There's a lot of economies of scale of building together. So we're actually each able to do more than we could do independently building our own facilities. >> Renteria: Thank you for all the work you do. >> Councilmember, that's one of the zip codes that have high rates of morbidity and mortality, so we certainly agree with you that the needs are greatly needed in that area.

>> Tovo: Councilmember kitchen has a last question before we move on to Trish young brown. >> Kitchen: My question relates to seniors. And I'm not sure if this falls within your scope or not. Are y'all involved in any kind of education or work on fall prevention?

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>> Actually W he do have services for seniors. We'll be talking about more of those this afternoon in our social service component where we provide support services for those as well. >> Kitchen: Well, falls are the biggest reason people -- seniors end up in the hospital and the emergency rooms and it affects their health. So I'm just curious for anyone on the panel about, you know, what we're doing in the community to help people with prevention from falls. >> As I said, most of what we do in terms of inhome services to help support them to maintain their ability are part of our social services piece. We do recognize that injuries, particularly at home, are a significant portion of that. Stephanie might be able to speak a little bit to that now. >> Stephanie Heyden, assistant director of the health and human services department. Our department through our nurses at the neighborhood centers, they provide services to seniors. In addition to that we have contracted services with family elder care that provides those services in the home as well as at their site. >> Kitchen: Okay, but no classes for fall prevention or anything citywide? Not citywide, but across individuals as opposed -- as opposed to individuals, but looking at it from a population standpoint. That's really my question. >> Not from a population standpoint, but from an individual. >> Kitchen: Okay. >> But we can certainly look into that. >> Kitchen: Thank you. >> Tovo: One of our partners here at the city of Austin is certainly central health and we're delighted to welcome Trish young brown here today. She's the CEO and president of central health. Thank you. >> Good morning. Can you hear me okay? I apologize. This spring weather has -- is lovely, but it's taken a toll on my voice. I apologize in advance.

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So we get to talk about the healthcare portion this morning and we really appreciate the opportunity to be here before you and talk about central health. I know we have a short amount of time. I'm going to try to be as broad, but as deep as I can. I think it's really important for us to start out with understanding who central health serves. We focus on individuals who need healthcare the most. Our most vulnerable residents in the community. We typically -- I want to put this in an entire box, but we typically focus on those at or below 200% of the poverty level, but it's not an exclusive criteria, but it is our main focus. I think in order to understand where we're at today it's important to talk about the history of central health and how we came to be, we're a relatively new business. It will be 11 years in terms of when we were created coming this may. Safety net healthcare system in Travis county is very different than other

major metropolitan areas. The city of Austin had responsibility for safety net care along with a collaborative partnership with Travis county that dates back to the early 1900's. The city of Austin operated the university medical center of Brackenridge hospital as the public hospital for the community. It is -- it is now what is now a level one trauma center and it received the region, an 11 county region for quite awhile. An important point about the history, but back in 1995 the city did enter into what we term a long-term lease for the operation of Brackenridge. And that lease was entered into with the daughters of charity now known as the Seton health care family. That was a pivotal point in the history of care in our community as Seton took on the responsibility for operating the hospital as part of its

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healthcare delivery system, but it maintained the responsibility as the safety net facility for Travis county. In 2004 the voters did approve the creation of the Travis county hospital district. I think you all know that we do business now as central health. And it was at this point that central health assumed the statutory obligation to provide safety net care. So we inherented the assess that both the city and the county operated as healthcare facilities which included clinics system as well as the Brackenridge hospital. And also as part of that -- obligation that transferred to central health were the medical assistance programs. We now call we now call medical access program, but at the time it was referred to as the medical assistance program. There were two separate programs. One operated by Travis county and one funded, I should say, by Travis county and one operated and funded by the city. We subsequently merged those programs into a single program for Travis county residents after we were created. Since 2004 central health has been here to provide access to our most vulnerable residents and we do that by connecting them to high quality cost effective healthcare. We do this in collaboration. We have many working partnerships. We have a variety of affiliates and those include Seton health care family, the new Dell medical school which wally hear from dean Johnson here in a a little bit. Of course the St. David's hospital system, the St. David's's system. Planned parenthood is an important partner and other community healthcare clinics such as the federally qualified health centers, community care and the people's community clinic. I'm going to show you a map which I hope you all have great eyesight because it's probably the tiniest font ever.

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I realize it's hard to read, but Travis county is a very large geographic area and what we have shown here is a listing or a pictorial of what we refer to as our provider network. Central health contracts -- actually, central health contracts directly with certain providers a and also through our community care

collaborative which I will speak to in a minute. Contracts with a number of providers that provide services throughout Travis county. On this map -- I apologize that it's so tiny to read, but it gives you a sense by looking at the color that those labels that are in red control panel community care locations. And these were previously clinics that were part of the city and the county prior to the creation of central health. They've been transferred to the responsibility to -- to central health. And we have expanded them. There are now 25 locations across the area. A gold color represents other contracted providers that I mentioned, such as peoples and planned parenthood, lone star circle of care, and also you see up there in a blueish purple color, austin-travis county integral care services that are essentially inpatient services managed by austin-travis county integral care for the population in our community. The idea here is to give you some sense of the presence of service delivery in the community. We do know that in terms of service locations our population has changed substantially over recent decades. And many of the facilities that we have inherented and are operating represent decisions about clinical care delivery for our population as it existed many decades ago. So we are in a process

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of evaluating where services need to be in the future. We have a number of aged facilities that will need to be addressed in terms of their appropriateness for care delivery. And so that is an ongoing process and will continue into the future. It is important to note that community care does provide a full array of primary care services in addition to what we might consider to be very traditional pediatrics, internal medicine, familiar practice, obstetrics and gynecology, the community care provides dental, very significant pharmacy access services, some integrated behavioral healthcare and also some specialty care services now within the community care locations. Community care over the past year has served about 70,000 people. And we think this is an important set of services that if you have an interest in touring some of these centers to see what's there and how services are provided we'd be very happy to accommodate a tour for you and we'll connect with you on that. So I'm going to move into the future, where we're at today and where we're headed. It's really about affordability and care transformation. In 2011 Texas received approval from the centers for medicare and medicaid services. We refer to as CMS. I know we're supposed to have an acronym free zone, but some of these titles are too long to keep repeating. I'm going to refer to the center for medicare and medicare services as CMS. That is the federal agency. But CMS approved the implementation of what we refer to as the Texas 1115 medicaid waiver. And this program in particular, it is a statewide program, but it provided our community and central health an opportunity to make significant enhancements to our local safety net

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healthcare delivery system that included creating the community care collaborative, which is a partnership between central health and Seton and it's sole purpose is to coordinate care and to develop an integrated delivery system that better serves the residents of our community that we are focused on. Since the waiver has been implemented and with the support of our local community through an approval of prop 1 in 2012, which provided the what we refer to as the local funds that allow us to match federal funds as they become available through this program, we have accomplished many achievements, we have opened our southeast health and wellness center. Councilmember Renteria, I think you referred to that in your comments about the collaboration and between the montopolis recreation and neighborhood center and the new southeast health and wellness center. That is a large community center that includes a very large community care clinic, but also includes other community partners that provide services in that center. That array of services was developed through a community collaboration where many members of our surrounding community 20 through a planning process and decided what would make that the most effective healthcare delivery service for the community. So we are in phase one, which opened last October and we're presently building out phase two, which if all construction goes according to plan, will be early next year. This is a a new model for us for central health. It reflects a very expansive approach to trying to connect what Mr. Jones was speaking to, the intersection of public health as well as

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clinical care. So we're trying to make the best use of our resources to impact the residents of our community. Adds part of that 1115 waiver program, central health has anchored a six county regional healthcare partnership that coordinates regional transformation efforts. This is a role that we play as -- as the healthcare district for this region, which is referred to as region seven. With regard to our community care collaborative we have 15 projects that are carried -- 15 disparate projects carried out through the fecc and that represents a portion of the total of 34 delivery system perform incentive payment projects. Another long label that we have to use an acronym for. We refer to it as dsrip. But these 34 projects have a total value of $410 million over the life of this waiver. Again, the community care collaborative is performing 15 of those 34 projects. And we are very excited and proud to report that we have succeeded in accomplishing 99.5% of our expected disrip outcomes today. So we're very pleased with the progress we've been making. We continue to collaborate on the community care collaborative with Seton and our partners at the university of Texas Dell medical school, which is an important partner in our delivery system transformation efforts. We are going through a process to redesign how we provide care to link it and to integrate it in a way that it has not been done in the past. It's important in the environment we live in in Texas in women's services. Over the past number of

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years we have seen many external factors that have threatened women's health services, that have taken away funding. And central health has stepped into the breach on those funding gaps. We feel it is one of our highest priorities. We have continued to assure that women's health services are available to this community. Where funding has been taken away we have stepped in and we have strong partnerships with all of the health care entities that deliver health care services for women in our community. That will continue to be and does remain a priority for central health. I want to speak about collaboration because I think this is how central health serves the community. It's through collaboration. And we have some very key partners and partnerships that we've already mentioned today. Central health, the city of Austin health and human services department and the Travis county health and human services and veterans services, has had a long-standing working relationship. And we've recently expanded that working relationship to include collaboration on planning and sharing public data and to align our three agencies goals and activities specifically for critical health issues and to address the social determinants contributing to those issues. This is a new area of work for us and we feel there's great promise in how we create a framework to organize our work going forward. We have jointly purchased a web and data platform that will provide access to key health and quality of life data. It will be continuously updated and will help us to prioritize opportunities and track progress against national and locally identified targets. I think this refers back to the work that Dr. Jones was talking about in terms of understanding the community as the patient and we work -- this is where we're trying to create the intersection with caring for individuals and caring

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for the community as the patient. We have other areas of collaboration that we see continuing to flourish. One example I would provide would be the pay for success opportunity. This is an example of a deeper collaboration that involves the city, the county, central health, United Way and green lights. And this is -- this collaborative group that I just mentioned recently was awarded a national technical assistance grant to pursue the reduction of teen pregnancies among hispanic youth and improve birth outcomes in the African-American population. So again this is an area where we can bring all of our respective resources and knowledge together to try to solve a broader community issue. We are also -- I would be remiss if I didn't mention that we are working on the planning for the redevelopment of the Brackenridge campus downtown with the Seton healthcare family opening the new teaching hospital. That's expected in early 2017. We are going through a process right now to do a master plan for the acreage that central health owns, which is about 14.3 acres. This is the property that was -- that was transferred to central health upon its creation. And with the new hospital being built across the street, we are undertaking a very collaborative and design process, if you will, to understand how best to utilize that property, how to have it best serve the community. Of course the use of the property, the development of the property, that will intersect with the city of Austin and we'll be needing to work

with you on matters pertaining to that development. So you will be hearing from us in -- probably in the near future. This is something that we're undertaking. Presently it's been underway since about this time last year. So we look forward to working with you about that and visiting with

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you. I think I will go ahead and leave it at that and take any questions. >> Tovo: Thank you very much for that presentation. Yes, councilmember Zimmerman? >> Zimmerman: Thank you, mayor pro tem. Thank you, Ms. Brown for coming today. As you might remember I was deeply involved opposing the formation of the hospital district back in 2003 and also very, very much opposed to the 2012 prop 1 issue, which most of us called the medical school tax. I could have hours of questions, but let me be kind of brief if I could. I want to talk to you quickly about the collaborative. The community care collaborative. And I'm referring to a January 31st 2013 article by Mary Ann rosier in the statesman. At the time there was a lot of concern about this being a non-profit, the CCC, that was not open to public meetings law. Texas open meetings law. So would you tell us what the status of that is? It's my understanding the CCC is appointed, unelected board that is appointed by the unelected central health board, which is appointed by the elected commissioners. So we're several layers of bureaucracy removed from the voters. I'm still deeply concerned that millions of dollars of our money is being managed and transfers, big decisions are being made and there's no open meetings law. So could you comment on that? >> Certainly. You're correct that it is a 501(c)3 non-profit organization and that partnership is a 51% majority ownership, if you will, by central health and 49 by the Seton healthcare family. And it is the mechanism through which we're developing the integrated delivery system. It is not subject to open meetings, yet we have adopted the open meetings process for this organization.

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So it's board meetings are open. I think -- to address your question about governance, central health has multiple reserve powers and approval authorities for the CCC. And because it is a partnership there is a board of that partnership and that represents appointees, as you mentioned, from central health, which represents basically the central health executives. We are the members of the CCC board. And there are executives of Seton that are members of the CCC board. The budget of the CCC major expenditures above $100,000, other significant transactions such as that all come to the central health board of managers for approval. We maintain a website, all of the information in terms of the financial information about the CCC is posted on that website and it is available to the public. >> Zimmerman: Okay. One other quick question. You mentioned the region seven and there are surrounding counties that take advantage of the Travis county healthcare system, our trauma center and what have you. So

one of the things I pointed out back in 2003 is that surrounding counties generally don't contribute to the tax base. They don't contribute to the tax base so they end up using services that the Travis county taxpayers pay for, city taxpayers pay for, but they don't contribute. So has that changed? Is there any money coming from from the surrounding counties through property taxes to help offset the costs of what they use? >> No, not in the way that you've suggested, but let me be clear that the funds that central health uses, for example, that support the medical access program for Travis county residents, you have to be a resident of Travis county in order to participate in that

[9:55:04 AM]

program. Your correct that the hospital does serve a level one trauma center in an 11 county region, but that hospital is the responsibility of Seton. It is not the financial responsibility of central health. That was affected in 1995 when the city leased it to Seton. So it does function as a safety net and we -- with regard to services that are provided to Travis county residents, there is support for that through Travis county funds, but the responsibility for what I might refer to as out of county residents is not central health's responsibility. >> Zimmerman: Final question. What is the -- just one more question. >> Tovo: Very brief. We are running behind. [Overlapping speakers]. >> Zimmerman: What has happened to the spending level? It's always benefits, benefits, benefits. What has happened to the spending in central health, hospital district, central health? How much has the spending increased since 2003? >> Since 23? >> Since central health took over from the cities. We were told there would be savings and I argued no, there would be an explosion of new spending, no savings. But an explosion of new spending. So I just wonder what has happened to the budget in the last 11 years? >> I'm not sure I can speak to the concept of savings. But maybe I could capture it in terms of tax rate. When the district was created in 2004 the tax base and the tax rate that was transferred to central health at the time was about seven cents. And it remained about seven cents through the years leading up to proposition 1 in 2012. And at that point the voters agreed to give central health an additional five cents,

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which is used for, as I mentioned earlier, as intergovernmental transfer for the 1115 waiver program. So our current rate is about 12.64 cents. That represents about 4.64% of the total of all Travis county entity tax rates. We represent about 4.64% of the total. And that would be inclusive of the city, the school districts, the hospital district, the county and the community college. That rate compares to other large urban districts. We do have the lowest tax rate of all other urban districts across the state of Texas. The most -- the one nearest to us in terms of rate, again, ours is 12.64 cents per hundred. Nueces county is 13.75. And I will note that nueces is somewhat like Travis county in that its public hospital is operated by

a private entity which helps keep that rate allow. But that compares to other districts across Texas that the district itself operates the hospital and that ranges anywhere from 27.62 cents in Bexar county to 28 cents in -- 28.6 in Dallas and 22.79 in tarrant. So we do feel like we are both managing the tax rate and trying to provide -- we have expanded the number of people that we've served in the 10 years that we've been in existence and while managing that tax rate. And I believe that the -- I'm not sure that we -- I'm not sure that I as the CEO ever expected there to be savings, but we are working towards the ability to serving the growing population that we're responsible for within this fairly conservative tax rate. >> Tovo: Thank you. Noun and then we'll move on to Mr. Evans.

[9:59:05 AM]

>> Houston: Thank you, Ms. Brown for being with for being with us, and thank you, councilmember Zimmerman for your questions. They're some of mine, as well. The people in district 1 have some of the same concerns. They see a percentage of their tax rates going up every year for central health district. They were not aware none of the other counties were participating in this program. So they feel like that's a part of that lack of being able to live in Austin, where they're getting tact to -- taxed to provide services for people who do not get an opportunity to pay the same taxes. But I heard your explanation. I just wanted you to be clear it's not just Mr. Zimmerman. There are people in district 1 that have the same kinds of concerns. But the other thing I want to offer you is that when we do community engagement, I hope that you make sure that people understand what those acronyms mean, and that you don't use them so frequently that they forget what they mean. Because people unlike ourselves who are able to look at it on the screen may not have that opportunity. So, it's very important that we use laypeople's terms and make sure that people understand what it is that we're talking about, even in the most complex cases. One of the concerns that I also have is about women's reproductive healthcare. Could you just briefly explain to us how this is going to be handled under this new system? >> It's not a new system. We've been providing women's health services since central health was created. It's an array that gets provided in the clinic setting, talking about family planning and other healthcare that relates to women's health services. In terms of services that get provided in the hospital setting, which typically relate, of course, to delivering babies,

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typically, and a woman's request for certain services such as tubal ligations, we have all of the services that women could request. And want to obtain are provided within our network, either through our community partners or through the hospitals that we have relationships with, which is St. David's. So, there is not an issue with access to the full range of women's reproductive services, and there's certainly

no issues with access to the totality of women's health services, which is more than just reproductive services. That's provided throughout our network. >> Tovo: Thank you. Our next speaker is David evvans, the CEO of austin/travis integral care. Thank you, and welcome Mr. Evans. >> Councilmembers, good morning, and thank you for including mental health in the heart of this presentation today. It's our belief that good mental health is essential to good health, and I'll speak to some of the questions you asked us to prepare for. Austin/travis county integrate care was created in 1967. This was a result of a federal mental health facilities act that passed under the Kennedy administration in 1963. Currently, we're considered a unit of local government under chapter 534 of the Texas health and safety code. We have a nine-member board of trustees that govern the agency, provide public stewardship, and fiduciary oversight. You appoint three of those, Carrie, and Robert, and one

[10:03:09 AM]

other person are your representatives currently on the board. We've been designated as a local authority for areas of behavioral health. And when I use that term, I mean major brain-based disorders and substance abuse disorders. You can hear how this has changed. Once upon a time, we were known as the mental health and mental retardation center. So, you've asked us who we are, who we serve, and what we do. I'd like to mention that we currently serve or respond to anyone with a major psychiatric crisis. Individuals with serious and persistent diagnosable mental illnesses. The top diagnoses are schizophrenia, bipolar, and major depression. Unlike other areas you'll hear presenting, we really serve individuals on their ability or their disability in the area of functioning, and not income. And so, as an example, if someone calls 472-help in the county -- that phone rang over 71,000 times this last year -- we need to respond quickly. Often we'll respond with ems or the Austin police department, with persons in those psychiatric crises. We don't have time to ascertain the ability to pay in that moment. Also, I've mention that had we serve individuals with substance use disorders. Some examples of outpatient detox services. We operate a large methadone clinic, and also provide for substance abuse prevention activities and work with the

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schools. And also, I'd like to mention that there is a related in some ways, and other way much different, with organic or brain-based disorders, or persons with intellectual and developmental disabilities. I've included individuals with dual diagnoses. Those of you that may be closer to this issue understand that individuals with developmental disabilities also have psychiatric disabilities, or, often folks with major psychiatric disorders will self-medicate with both legal and illegal drugs. So, just very briefly, some of the things that we provide within the community. And we do this in partnership with each member on your

panel here today in one fashion or another. In the first two presentations, we've been referenced as a community partner, and really respect those partnerships. We have to leverage and work closely together to have the best outcomes possible. We operate a 24/7 crisis response. Some of the components of that response I've already mentioned, the 24-hour hotline. Might be interesting to you to note if someone calls a national suicide prevention line, that automatically rolls over, if it's a call from an area code here in central Texas, to our hotline. About half of the time when the phone rings, somebody's found another hotline that then rolls into our hotline. We also provide step-down or residential treatment programs. You've helped us with a long-term lease on the 15th street facility. There we have beds for individuals who have co-occurring or dual diagnoses. Often, there's a time of stabilizing their symptoms while we can plan. They either return to their families, or you'll hear several

[10:07:09 AM]

times how important supported housing is. These are areas we work every day with the city to try to develop additional capacity. In terms of prevention and wellness, you might not right away think of wellness or prevention around mental health services and responses. Tobacco cessation is a big deal for us. Over 90% of folks that have a diagnosis of schizophrenia also use tobacco products. Dr. Wong and the city's leadership, you've already heard mentioned today, we've been very active partners in smoke-free campuses. We're in 46 locations in the county, and each of those we -- by policy -- don't allow tobacco products to be used around the grounds. And then last, serving individuals with housing and supports. This often means everything from shelter plus care vouchers to working on intensive wrap-around services. There may be individuals who are leaving homelessness into housing, and we're participating in those support services. And, again, this is an area that I know that as a council, the city has taken leadership on. We want to applaud and work with you. In terms of planning and building out, addressing gaps we have within services, we're working with several planning collaboratives. I'll mention those in just a minute before I leave my short presentation. Again, often if you just have one part of the service system in place, it's not sufficient if there's gaps and you're trying to address an episode of care. In other words, you can respond to the crisis, respond to the need for hospitalization, but if you don't have recovery services in place in the community, you can see a cycling of individuals. And we're looking at the fact that treatment works, recovery

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is possible, and folks can restabilize their lives after the onset of these major conditions. Also, we believe within this collaborative planning, we're on the board of the icc or the health information exchange, we're working closely with the community care collaborative and partners like St. David's are very

important, and then working with the medical school. In terms of our work within the community, community-wide we provide information and education. Just last year, with one program, mental health first aid, it's a lot like it sounds. We've provided training to teachers, bus drivers at capital metro, and librarians at some of the city libraries. So, individuals can have an education to understand and identify some of the symptoms or characteristics of these disabilities and then have some education as to where referral and how to respond if they're in a circumstance. And then also within training, we work with the Austin police department. We're part of the cadet school, some of the initial training work. We provide community forums around the issues. Tomorrow there's going to be a large community forum, as one example, in where services are and what the needs of persons with disabilities. And then advocacy really takes form around education and information to other governments, city, county, and, of course, we're in the middle of a legislative session right now. We're a public agency without a dedicated tax base. So others have their need for our area of services to be addressed through contracting with us. You contract with an interlocal agreement, and maybe in shorthand that means that government to government, or for

[10:11:14 AM]

common purposes, you don't have to bid out the services you work with us on. But then we have a responsibility to create a best value. So if there's a public or private service provider, we often will subcontract services. If it's a niche that they're particularly good at, and provide quality services. Just very quickly on how we're funded, I would take your eye down to about the middle of the page here. And in this current fiscal year, the city of Austin funds, austin-travis county integral care at about $3.1 million. These dollars I'd like to report back to you are leveraged as part of local match for city and county funds. And we're also with you, addressing currently within the area of housing, an 1115 waiver project around intense wraparound for folks going into supported living. So, just some last policies considerations, some things that you might want to consider working with us going forward is that just against the backdrop or a context that 19% of adults and 20% of children experience some diagnosable mental disorder. This also includes addiction or substance use disorders. In the past year in Travis county. And then a third of individuals that are homeless within our town have some level or have had to live with a mental illness. So, in closing, and in summary, we're trying to keep the scope of our services consistent with the rapidly growing population. There's been times where I think we've been close, and then we've fallen a little bit behind. You've heard this before, but when we have these tremendous large events, and part of our Austin identity, you may see

[10:13:15 AM]

initially some things like emergency room use go up. But we have kind of an echo effect. In the following week or so, our hotline starts ringing. Often folks that find their way here to Austin in some of these events don't find their way back out, and they may find the need for treatment through our services. Currently, we're working with the city, the county, the healthcare district and others on a comprehensive children's mental health plan. Your staff are signing on to this, so we have consistent, across agencies approaches on how we would address children's mental health. And also, we're about two-thirds of the way through a substance abuse treatment plan. We hope to have priorities for you to consider in your budget process before you're too much further along within that. And that concludes my remarks, and I'm glad to answer any questions. >> Tovo: Councilmember kitchen. >> Kitchen: Thank you for being here. My question just relates to seniors and the elderly, and I know that's a huge subject. I'm curious whether you have -- whether that's a focus area, whether you have done any planning citywide in that area. >> Yes. In terms of seniors and mental health, we were part of the mayor's task force on aging. We've continuously heard from stakeholders in areas like untreated depression amongst our seniors the need for there to be some type of consistent mental health and aging policies. The idea of aging in place would make home health critical, including a mental health component. And then somewhat tragically, we have context, is that the folks that have the diagnoses that we serve, they don't die of mental illnesses or necessarily of intellectual and developmental disabilities, but they do die earlier in terms of KOMO bid comorbid

[10:15:19 AM]

conditions. When we look at an average lifespan, thinking birth to death, providing consistent services, we see a lot of the mental health services tapering off after the person has reached their late 50s and early 60s. The need doesn't go away, but, again, individuals that have co-occurring or comorbid conditions are often either historically in nursing care. What we want to do in response is, whatever possible, jointly plan integrated behavioral health. If there's nursing or meals on wheels, we've heard of other nonprofits in town, and they identify persons with characteristics of mental illnesses, we want there to be access to services, home and community-based. >> Kitchen: One followup question. Do you have information, I don't know if you're involved in this, information related to suicide among the elderly or seniors? >> We have agreements with the health department and their epideemologist and medical examiner, so, we have information on suicide, suicide rates by age, by method of suicide. Across the county and we'll be happy to share those with you. >> Kitchen: Okay, thank you. >> Tovo: Councilmember pool, and Houston, then our next speakers. >> Pool: You had mentioned the 1115 waiver, and I have a fairly typical understanding of that particular federal program. Could you explain the match with the federal government, and the status of it here in Texas. >>> I'm going to double-team with Trish on that answer, but, I will mention that we have 11 individual projects that we are both -- that's called the intergovernmental grants entity. It means we have funds within our budget to match federal

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funds, and then we're the performing provider in 11 projects. Then, additionally, we're only the performing provider with the Seaton and Austin school district, so, the school district is using their governmental funds for match. And then with the city we're providing one project of intensive wraparound in housing, and the city in that case has intergovernmental transfer funds, or general funds. And then those match the federal government. >> Pool: What is the match, please? >> The match is approximately for every one dollar that you would identify, you have to send that dollar to Washington. Then it comes back with $2.46. >> Pool: Okay. >> So, then, you know, place that dollar, there's a dollar and 46 cents of new money. The reason this is different is medicaid is a public assistance program that's federally funded and state-administered. In this case, the state is not appropriated or has no none new money, but, they've allowed within the state plan for the purposes of demonstration and transformation the identified local dollars. This includes school districts, cities, counties, healthcare districts, local mental health authorities, and a few others. So, in this case, we've expanded medicaid by utilizing local public funds to then match federal funds. >> Pool: Thank you. Trish. Could you help me out? David actually gave a pretty excellent answer about how the waiver works. >> Pool: I was remembering when the affordable care act was rolling out, there was a one to nine match mentioned. Because the state legislature and the administrative folks refused to take -- to participate, Texas has not been

[10:19:20 AM]

able to take advantage of that match. And I may be off on the Numbers, but I wanted to get a little bit of information about that and point out that we are working without that additional money to the state. >> That's a very good point. The expectation when the affordable care act was put into place was that all states would be expanding medicaid. And due to a ruling by the supreme court, it was determined that that was optional for states. Texas did not choose to expand medicaid. That has continued to hold a gap for care in our community. For those individuals that would've been covered by medicaid. I think it's -- >> Turn your ringer off. >> It's fair to say that without that medicaid expansion, these local efforts that David is referring to become even more important because we're continuing to fill a breach for coverage for individuals that there is no source of payment. The projects themselves, the district projects themselves serve medicaid patients, serve un-ensured patients, and to some degree, serve all patients in the community depending on the project. So, I think that it has, in fact, become a very important -- the waiver, I mean, let me backtrack, the waiver has become a very important part of how we're not only delivering care, but attempting to change the way we deliver care to a population, to our community, that is, in fact, growing in terms of the number of uninsured. >> Pool: In Austin, a lot of

people move to our city and not all of them are in jobs that provide healthcare. I suspect the pool of people who need access to healthcare under the affordable care act continues to grow. You said we don't have a source for the additional moneys, but that's because we haven't been able to get the waiver through the state legislature, is that

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right? >> Ctually, there are two separate items. Medicaid expansion is separate from the waiver. The waiver is in place. It's a five-year waiver. It will be up for -- it's actually up for renewal now, and there is a process being undertaken by the state, health and human services commission. They are in process right now with the centers for medicaid and medicare services at the federal level to apply to extend the waiver. The medicaid expansion that you were -- that we were just speaking of, that really is a separate part of the medicaid budget, if you will. And so, the waiver project is -- was put in place separate and apart from what was happening within the affordable care act. >> I can build on why this is such an important question. In many ways, we're spending this five years to do demonstration, innovation, that's being paid on the value of the impact of the project itself. However, you're referring to individual eligibility in the medicaid program. And what the federal government offered was rather than meeting two criteria, one is to be poor or be below 133% poverty level, and then also have to have a disability determination that you can't work. The option that was offered to the state was to do away with the disability determination and to create eligibility for the poorest of the poor, those folks below 133% of poverty. So today we find ourselves doing some very exciting work in demonstrating some really real transformation within this community, but it's not a long-range solution, and we'll confine ourselves here, still having those most in need not

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qualifying for medicaid. >> Tovo: Councilmember Houston had a question, and then -- okay, we do need to start moving a little more rapidly. We have still nine speakers waiting to speak with us here today. So, councilmember Houston. >> Houston: Thank you, I'll keep this short. I cut my teeth on Austin Travis county mental health mental retardation, it's always good to have you here and have that continuity. I've got two concerns, one about the lack of beds for stabilization. It seems as though we're using more room in our justice system, in our emergency rooms to kind of help stabilize people who are in situations where they're experiencing some issues. So, at some point, if you could speak briefly to how many beds we have currently that are available to support people, and then how many we might need. And the other thing is a real concern to people in district 1, the use of unregulated boarding care homes. We have 38% of those in district 1. And I'd like to understand, again, briefly, why it is that the city that

claims be the most prosperous city in the united States will allow people to live in the kind of squalor that they live in. >> These are such important questions. I'd like to follow up with you in the in-depth answer that they deserve. And, you know, you put your finger on three things that are really important. One, the unregulated board and care homes. The state in the last -- I think it was two legislative sessions ago -- gave cities the responsibilities to consider ordinances and regulations, and I know you have staff in both neighborhood housing and health and human services that are aware. It's according to how much progress or how fast we can make change in that area. One thing is, you don't want to close down homes without there being some alternative. While providers that are

[10:25:24 AM]

operating something that might be substandard, the folks that are in those housing arrangements may find themselves homeless if there's not alternatives planned simultaneously. In terms of beds, we. Plan this issue consistently with the stakeholders, the group led by central health. They're purchasing through us, on the average of about 24 beds a day. The state funds about 90 beds a day. We purchase a couple of beds per day. So, this, if you add the Numbers up, 26 and 90, maybe have at any given time 116, 120 beds for this, you know, county of over a million people. What we're trying to do is not to create more options at the most expensive, most extensive end of the continuum. There's probably 20 people a day in Austin who may be in the back of a law enforcement car or waiting too long in an emergency room. We don't need hundreds of beds, but we need some additional beds. We had two new hospitals open, they promised to make some beds available to be purchased as part of our program. >> Houston: Thank you. >> Tovo: We have a quick question from kitchen. >> Kitchen: I'll make it quick. I think it's important to recognize that the affordable care act doesn't help everyone, because the premiums are too high for some people. So, if you could just comment on that, Trish. >> Yeah. The affordable care act is -- I mean, it's a good thing, I can say that. It's providing access to coverage that was not available before. Locally, we have plans that

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would be well-known in the community. You know, blue cross blue shield offers plans on the exchange, I think Humana does, but, we have health plans, an affiliate of central health offering affordable products. One of the things we've undertaken is to utilize these products that we've created through sendero and to individuals that would prior have qualified for our medical access program. If they would qualify for the health exchange, we will enroll them in our sendero ideal healthcare plan product, and pay for their premiums. So, it really does help benefit us locally. Instead of paying for all of their care locally through local tax dollars, we're taking advantage of the premium, the payment coverage that's available to the

patient, as well as some of the risk subsidy happening. It's a very good product, but, what you mentioned is important, that affordability is the key. Many of the products, depending -- not to get too technical, but there are multiple levels of products depending on the type of benefit, but we do strive for affordability and try to hit the medium point of good coverage with an acceptable cost. And I think that we're hopeful that the products continue, and the subsidies continue. That's being discussed right now, as well. But, should it continue, we will see that being a larger part of a strategy to get folks enrolled in our community. >> Kitchen: It's a good way to leverage our local tax dollars. Thank you. >> Tovo: Thank you. Thank you very much for that really helpful context about how we work together with our community partners. We do have a very distinguished panel ahead of us, and council, I'd like to ask that we listen

[10:29:26 AM]

to the presentations from our panel and then ask questions, in light of time. I'm afraid we're going to run over as it is, and we do have some community members after our panel. Our first panelist, Johnston of the Dell medical school, welcome, dean Johnson. You'll each have about five to seven minutes. Thank you. >> Thank you very much. It's a great pleasure to be here. I'm constantly reminded we wouldn't be here if it hadn't been for the voters of Austin and Travis county. That really weds us to the community in a way that no other med school is. And it means that in the specific areas that I've been asked to address today, on health disparities and community health, that we have a particular responsibility to address those needs. And as councilmember Houston commented on early on, these are long-standing problems. They are not unique to Austin and Travis county. They are present in nearly every city in the country. And economic growth does not, by itself, resolve these issues. And that has certainly been -- was very clear in San Francisco, where I came before this. And therefore, specific changes are required to address these needs. Curriculum is only a tiny part of how we can potentially affect this. But you all asked me specifically about curriculum, so I'm going to start there. Since this is a piece of our foundation coming from the community and addressing community health needs, it, not surprisingly, is going to be richly integrated into our curriculum. So the students in the medical school, every year have a longitudinal program and classes that relate to cultural competency causes of health disparity, social determinants of health. In addition to that, they do a

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two-year clinic-based experience in the various clinics that are supported by central health. And in that, they follow the same patients over a couple of years to understand the real issues behind the health problems, not just the specific reasons for a given visit. In addition, they have -- in their last year, a

service learning block where they spend a month working with a community health organization to address a specific problem, trying to take a step back and better understand how those entities can be partners in addressing these needs. Finally, most importantly, the students have a full year in an innovation and leadership program which is unique to our medical school. During that time, they can choose one of three areas. Population health, healthcare redesign, or research. We anticipate that most will choose one of the first two, and probably, I would guess, a half will choose population health. During that year, they are learning how to not just deal with the health entity, you know, when it becomes a health problem on a clinical basis, but trying to take a step back and be a part of creating new solutions, creative solutions to the health systems problems that have gotten us here in the first place. In that experience, they're working interprofessionally with students in their schools, but also across the board with partners that you see here and other leaders in the community that are bringing new ideas forward to address these needs. So, that brings me -- the medical school curriculum, I should say we need also curriculum for our residents. We actually have that in several different residency programs here. But it's not universal for all our residency programs.

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We're looking at elevating that part of our curriculum for the residents, as well. And then looking at opportunities for development of the community physicians through continuing medical ex-programs to extend that, too, to the many community docs who are important to the care across the city. Beyond curriculum, we also believe that it's important that we take on a role. We have the opportunity to bring expertise here in a way that should benefit everyone. And we have, we think, a responsibility to help to build some of the infrastructure, not just in terms of personnel, but in terms of designing the sorts of infrastructure that you've heard others already speak of. So that includes information technology systems that allow us to really understand where the health problems are in the city, and also be able to use that to look at the impact of specific solutions that we test within the community. That, for us, is part of opening up the platform so that it's not a top-down approach to addressing these problems, but we can look broadly for entrepreneurs written large. Social entrepreneurs coming from health systems, coming from government, to bring potential solutions for us to then partner with the expertise, and then test their impact directly within our community. So, this is part of where we hope to participate around the table with the partners that you see here, and others in pushing for Austin to become a model healthy city. >> Tovo: Thank you so very much. And again, we'll hold our questions until the end. Dr. Hernandez, the chief medical officer of community care collaborative will be our next speaker. Welcome, Dr. Maxwell. Excuse me, Dr. Hernandez.

[10:35:27 AM]

>> No problem. Can you hear me? Thank you for giving me a few minutes of your time this morning to talk about the collaborative. The questions you asked to me was essentially, tell us about the 1115 waiver projects, and how you're stimulating innovation through them. What have you achieved, and how does it fill gaps in healthcare delivery. I'm going to take all of those and merge them, so I'll talk about all of it in one fell swoop. I will also take the opportunity to say the community care collaborative was formed as our CEO from central health spoke about earlier, to essentially deliver care to the uninsured and under insured here in Austin Travis county. It does that in one way through the 1115 waiver projects, which kind of serve two roles. One, they give us an opportunity to try out different ways of providing healthcare to this population. And allow us to build platforms of stepping stones for healthcare delivery in the future. And the second thing is through the match that Mr. Evans was speaking about when he was answering some questions, it brings additional federal dollars into play that allow us to expand healthcare delivery, and also to continue transformation of the healthcare delivery environment. So, the 1115 waiver is a crucially important part of what we're trying to do in the CCC. It's probably easiest to approach this conversation thinking about where we are and where we'd like to be. And so, where we are with healthcare delivery for the safety net population is an individual-focused delivery model. And that we tend to think about each individual client or consumer as they come into our clinics. And then we provide them the services that they asked for.

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And in specifically, what we offer them are medical services, or dental services. Those service lines for which most of us generally consider healthcare to be. And we do this in a somewhat disintegrated fashion. And by that what I say is, we don't have ideal connectivity between service line providers. One of the things I would challenge all of you to think about is that your insurance cards -- and many of you carry insurance cards or some sort, or you have medicare or some sort of funding source for your healthcare -- you don't necessarily have integrated healthcare delivery, either. Funding does not guarantee integration, by any means. We just note that in the safety net, that we could do better in the area of integration. So what we're really charged to do is, create a new healthcare delivery system that is population-focused. In other words, we need to think about the whole of the population we're trying to serve, and ask ourself, what kinds of interventions can we put into play that will help individuals with some common theme that runs inside of that group, whether that is the elderly. It could be one area of population focus. It could be disease-focused, it could be individuals that have diabetes or depression. Or, it could be able some other social determinant like homelessness. So, you know, what are the commonalties in individuals who are homeless and how might we best deliver healthcare to those groups. This is the way that we really want to approach healthcare going forward, is to be able to use data, to be able to take our whole population and begin to look at that population in smaller groups and design interventions that are optimal for a given group that we identify. So, the second thing I'd say is that we have to move away from a medical services focus. So, early on Mr. Jones with the

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city put up a slide, and Dr. Wang put up a slide that talked about the various social determinants of health. What all goes into somebody being healthy. And the interesting part of that slide is only 20% of your health is based on the clinical care provided you. 70% of your health is estimated to come from both your social and economic factors and your health behaviors. And so, in the healthcare delivery sector, we're going to have to start worrying about those pieces, as well. So it is not merely just what I deliver to you in healthcare services as you walk into our door, but it is also, have I noted that you are engaged in health behaviors that are to your detriment, and how can I help educate you and empower you to engage in health behaviors that are better for you? And also, what social and economic determinants do you have that get in your way of being able to be healthier? So, it does me little good if you walk into my office with high blood pressure, if I prescribe you a medication that you cannot afford. This actually is called the nondelivery of healthcare. I've not actually done anything for you in that case. So we're going to have to create systems that allow us to do that. Now, the waiver. What have we done inside the waiver that helps begin to address these issues. For starters, let me talk about the social determinants issues. We have some programs that are actually looking at those. One of those would be what we call patient-centered medical homes. This is a concept in the delivery of primary care that says that where you receive your primary care should not just be solely a relationship between you and a primary care provider, but it really should be a relationship between you and a place that is your medical home. That involves a healthcare delivery team with team members having a variety of different

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skill sets where an active assessment of your needs is made when you walk in the door. And that would provide the services that you need to optimize your health. And those may be delivered by your physician, but they may be delivered by the dietitian or the social worker, or a community health worker, any of a number of individuals that are on that healthcare team. What our patient-centered project strives to do is create patient-centered medical homes in every one of our primary care clinics that provide care to the safety net population in Austin Travis county. Another example might be our navigation project. So, as you all know, moving around through the healthcare delivery system is difficult. One of the things we want to do is create ease for the patient. They should be able to engage our system without having to have a 50-page manual and a ph.d. In order to be able to receive their healthcare. So, we're building navigation services so we're able to provide the individual an assessment to find out their needs and direction towards the services they need, without them having to figure out how to traverse the maze of healthcare we've traditionally delivered. Other things we're doing in the air

-- area of population health, we have a mobile healthcare team. Actually, we have three different teams operating now. These mobile healthcare teams go into the community and provide services outside of a traditional bricks and mortar clinic. And so, originally our conception for these projects were that these mobile healthcare teams would go into the more sparsely populated areas of Travis county, namely east and west, where we tend to have less-than-favorable actual bricks and mortar clinics. And to provide services to individuals in those areas. And we are doing that, and that

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has been a useful service that we're providing. But we've also found that those populations that might benefit from mobile health teams can be found in downtown Austin. Can be found in densely populated areas, as well. For example, providing healthcare to the homeless has become a focus of one of the mobile healthcare teams. We've used our relationships with echo and other organizations to identify the enclaves where homeless individuals congregate, and go to those areas and deliver healthcare services to people in place. Because we know that transportation is such a difficult issue for individuals who are homeless. Other innovations would include -- I'll pick on one of our projects. I would offer that several organizations in town are doing this, because it's generally a good idea, which is why we've all decided to do it, telepsychiatry. There's a dearth of services, the ability to connect an individual with a psychiatrist to provide services. We, along with other organizations like integral care, have created telepsychiatry projects that create the ability to connect an individual with a psychiatrist through the use of telemedicine. Patients have a high degree of satisfaction with being able to do that. But an unintended consequence of that is that we have to go through and actually fit our clinics with telemedicine equipment, that had not been previously in place. As part of that investment, we're looking to see what other specialties that tend to be in short supply in our community could be serviced through the use of telemedicine. We've made the investment in the equipment already. Its use can be for more than

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just psychiatry, how can we restructure it to other key delivery needs. I think I will conclude my comments there, and be happy to answer questions at the end. >> Tovo: Thank you very much. And our next speaker is earl maxwell, CEO of St. David's foundation. Welcome, Mr. Maxwell. [Off mic] >> Is it on now? Okay. So, today I'm going to share a little bit about the role of St. David's foundation in our network grant partners playing in meeting the healthcare needs of the community right now. And then I'll share some things that are on the horizon. First let me tell you who we are. Through a unique partnership, the foundation re-invests proceeds from St. David's healthcare system with the goal of

building the healthiest community in the world. That's the vision of the foundation. We have seven hospitals, deliver six out of every ten babies in central Texas, and provide charity care in the region. While my focus today will be on the impact our grant partners and our foundation are making in the city, you should know that St. David's foundation invests in nonprofits in the five-county region. But in Texas, we help -- I mean, in Austin, we help people in every corner of our community through our signature programs and collaborations with more than 60 local nonprofit partners. For example, this year we're investing over $65 million to connect more than 200,000 of our low-income neighbors to a full range of health services. We also operate the largest mobile dental program providing charity care to school children in the country, and we're

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helping to train and recruit the next generation of healthcare providers through several scholarship programs. We're able to do this work by collaborating with health leaders in our community, including many departments of the city, the county, as well as my fellow panelists. One example of this type of collaboration is the recent community health assessment process led by Shannon Jones and his team at the health and human services department. This is a health provider road map for us in the community to help meet the health needs in Austin and central Texas. I'd also like to highlight some ways we're addressing needs that have directly involved the city, or will significantly impact the city in some way. We operate the St. David's dental program. If you're not familiar, the vehicles travel to schools in five districts, including the Austin school district. We provide free on-site dental care to elementary school children so they don't have to miss school to see the dentist. This program was actually started about 15 years ago by the city of Austin with one van. And recently, we've increased that fleet from five vans to nine vans, and with this expansion, we're able to serve 10,000 low-income children a year at school. And when school is not operating, we serve adults during the summer and Christmas holiday vacation through health clinics such as people's and elbuen samaritano. We participated in central health psychiatric services stakeholder group, alongside the city and many others. It identified the gap in mental health services. Last summer, they announced an $8.9 million grant to build a

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new mental health center. Central health donated the land for this project, which will give ems a more appropriate place to take people who are having a mental health crisis rather than jail or the emergency room. We know the Austin area is experiencing a huge growth in the older adult population. Providing and expanding services for older adults is a priority for us. Those include working closely with Austin parks and recreation to build -- we've already built seven community gardens for seniors at rec centers.

The garden club, seniors with maintain the garden and enjoy fresh produce. We support meals on wheels to deliver meals to help our parents and grandparents live independently in their homes longer, or aging in place. And we're also providing funds so the Texas ramp project to build wheelchair ramps at the homes of older adults who can't climb steps anymore. Most recently, we stepped up to help people's community clinic respond to the healthcare needs of a growing population by granting $10 million toward their new facility, which will more than double their capacity. And lastly, we were proudly joined with the city and the trail foundation to finish building the beautiful boardwalk that now connects east and west Austin. I can think of no better symbol of healthy living in this community than the trail. So, at St. David's, in summary -- yeah, this is in summary. We are a catalytic investor. With our resources and ability to gather diverse partners like you and like members on the panel, we can accomplish great things. We have valued our collaborations with the city on

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many projects, and look forward to identifying areas where we can work together to find solutions to our city's healthcare challenges. We'd like the chance to visit with each of you over the next several months to drill down on some of these issues. And in the meantime, let us know how we can be of service. Thank you. >> Tovo: Thank you, Mr. Maxwell. And our last panel discussion speaker is Mr. Clint Smith of the panthers, welcome, Mr. Smith. >> Good morning. I'm not sure -- at least I'm here. My name is Clint Smith. I'm with the great panther organization. I appreciate having an opportunity to be here, and thank you for your service. I am particularly glad because I've been able to have the opportunity to work over a number of years with people like Trish brown. And others. And in terms of medical care and healthcare needs and so forth, and David Evans, we've been very much involved and concerned about going back a number of years to the 2001 public safety task force. It's interesting how it's either a tragedy or maybe an opportunity, or maybe we turn one into the other, that we had to get together. So thank you for listening. And I wanted to be responsive to what we have to say. I might add that my background, after being discharged from the military Marine Corps in 1960, I went to work for the federal government. The San Antonio housing authority, and then for the federal government, the civil service investigations inspects. That was about 20 years overall,

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100 inspections, including the office of management budget. I mention all that because I've been asked to pass around a copy of this guide. It's a caregivers guide, a publication that was first inaugurated by the panthers in this area, I think in the 1980s, the late 80s, early 90s. It's called care-giving, a family guide. It's really more than that. For all of us who have elderly people in the family, we have need for

services, which is what we're talking about here today. One of the things -- this is online, by the way. I sent each of you a memorandum around 7:48 this morning, save your time, so you know what we're going to talk about. In three areas. Number one, I think this guide is great. It's online. It represents a one-stop shopping center, in a sense. But it also reflects something else, going back to the audit background. When you look at the services, the goods and services offered here, we really are looking at a more regional approach. It's not just the city of Austin or the county, but really -- this goes back, again, to some of the issues we were involved with back in 2001. Whether it was a matter of healthcare, law enforcement, whatever it basically came down to. Basically, there are issues that interrelated. Health, welfare enforcement, and so on. And they really need to be approached in that sense. So, I think while this is helpful, it also re-neglects what I would consider to be a certain amount of duplication, overlap, and fraggation of functions -- fragmentation, that you ought to be concerned about. That brings me to the second issue. You have this in what I sent you this morning.

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There was another commission that was established in the year 2000. The equity commission, Austin equity commission. David, you remember this. Trish, you were involved in that, we all were. And when you look at that link and realize that was 18 years ago, we're revisiting many of the same issues. I think it can be very helpful. Because as far as what I was asked to talk about, areas of access, any problems, I think an awful lot of work was done. And it was led by a former secretary of labor, ray at the university of Texas, who's still very much interested. And so if you take a look at that, and particularly the sections on healthcare, I think much has been done. But we also -- there's some areas in which there could be more improvement. As far as housing is concerned, I think it's page 105. You'll see an introduction there -- again, it's like deja Vu, because we were looking at urban renewal, as it was called. And whether it should be called urban removal, today we call it gentrification. So, this is not to blame people or individuals, but it is to say, in your interest in looking at the system, I think these kinds of -- looking at it in this context would be helpful. The other thing in here, again, councilmember Houston helped to educate me on the elder care board. She was a member when I came aboard. And here, again, things that are interrelated. Housing, healthcare, and so forth, all need to be looked at within this overall context. And finally, as far as current and future, the panthers are very much concerned with overall economic inequality. Federal reserve chair Janet has said that is probably the number one issue of concern in the United States, the rich getting

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richer, poor getting poorer. We talk about the general public. I guess my final point is, going back to the audit and enforcement background, we are very much concerned -- and I've had some discussions with councilmember Zimmerman about this -- saving money, taxpayers concerns and so on. We all are. But our position is, certainly, I feel as a former federal employee, it's not a matter of cutting human services. It really is a matter of looking at fraud, waste, abuse of the taxpayers' money. And we brought a number of these issues to the attention of the council before. And in the past, particularly I would say and thank councilmember tovo for being supportive in looking into some of the issues we brought forth. But there are some that still need to be addressed. This is not a matter of individuals, it's about the system. So, in final analysis, I'd like to say I think that our greatest contribution can be as a kind of a cost-cutting organization to help to try to honestly and with a great deal of integrity -- because we have nothing to gain or to lose either way, except we want to have the public trust. In order to support you. But, we feel that these areas in which you could usefully look. It really is a matter of looking at where we might go in terms of the overall economic inequality that affects everybody. Glad to answer any questions. >> Tovo: Thank you very much, Mr. Smith. Colleagues and panelists, I know we have some -- we have about five speakers coming up later. They have all graciously agreed to stay until 11:30. To the extent that our current panel is able to stay, we would appreciate it if we can do that,

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we can confine it to 10-15 minutes. We understand if you need to leave, and thank you for your participation. Colleagues, are there questions for our panelists? Mr. Smith. >> I'm sorry. Mr. Richard franklin is here, who is the current chair of the Texas panthers. If we have two or three minutes on economic inequality and issues of youth, particularly with a background on the Ferguson situation of problems and what it might represent here. If you can factor in some time, I'd like for you to do so, if you could. >> Tovo: We will certainly try to make time for that. Perhaps the council may have some direct questions for Mr. Franklin in light of the fact that we have some other speakers after you, I think we'll proceed with them and then see if we can get to Mr. Franklin. Councilmember kitchen. >> Kitchen: I wanted to thank you for handing this out to all of us. And I would like to work with you further. And we'll get in touch about what we can do from the city's perspective to address the kinds of issues that are raised by this. >> Thank you. >> I might have missed it, but, my question is for Mr. Jones. Is there a way to know how much the city -- what the city's investment in all these collaborations and partnerships is? >> Yes. We can give you that information. I don't have it handy. We have a variety of different ones, both in health as well as social services collaboration. >> Okay. And thank you for everything that all of you do for our public health and for our community. I strongly believe in as much preventative measures that we can do, because those of us who are -- there's talk about tax

[11:01:45 AM]

cuts and homestead exemptions which greatly concerns me. It concerns me that these are the first programs that get cut when that happens. And we need to all be aware of that. As a former firefighter, many of our medical calls were mental health issues. And I think it's the wrong direction when we're sending million-dollar fire trucks and four firefighters, plus two ems people, plus whatever that costs, to help in a way, because these people have fallen through the safety net. So I just wanted to make that comment. Thank you for the work you do. >> I've had the honor, actually, or working with most of you in years past. You all know that I have done a lot of healthcare over the years. So I'm excited about the opportunity for the city to continue to be your partners and see what we can do moving forward to improve the system even more. So, thank you so much for being here. >> Mayor pro tem tovo stepped away briefly, and now she's back. >> Tovo: Councilmember, did you have a question? >> I was going to note you stepped away and move to the other voices. >> Tovo: Are there any last questions for this group of panelists? Thank you so very much for all of your time, and all of the tremendous work you do in our community in the areas of healthcare and public health. We certainly appreciate that partnership with the city. Our last section are our other voices. We welcome up to the podium maria Talamo of the recovery-oriented system of care. Our second speaker, Mauer Maureen of children's optimal health. >> Good morning, members of council. Here we go, good morning, members of council. My name -- are we on yet?

[11:03:46 AM]

Very good. Okay, good morning, thank you for inviting me to speak today. I'm a registered nurse, professional healthcare administrator, I co-chair the Austin policy and funding work group. The acronym roc stands for recovery oriented systems of care. Local initiatives are underway in 28 areas in Texas, begun by the Texas department of state health services in 2010 under a grant from the federal substance abuse and mental health services administration. The initiative is an evolving, growing group of stakeholders in fields of mental health and substance abuse disorder treatment, including healthcare providers, healthcare scholars, representatives of law enforcement and the courts, as well as peers who are committed to supporting a process of transformational change as we move our system of care delivery for persons with serious mental illness and/or substance abuse disorders from one that has been oriented to an acute care model to one that is a truly recovery-oriented system of care. So, what is a recovery-oriented system of care? A recovery-oriented system of care of rosc is a network of services developed to sustain long-term recovery for individuals and families impacted by mental illness and substance abuse disorders. Mental illness and substance abuse disorders are all around us. One in four Americans will experience a mental illness at some time in their lives. One in ten will experience a substance abuse disorder. The better we understand the disease of addiction, the better we'll be able to deal with tobacco use and obesity, a disease which affects over a third of our population, had many

healthcare professionals will tell you is ultimately a disease of addiction. All diseases of addiction require recovery-oriented chronic disease management approaches. Recovery from mental illness and

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substance abuse disorders is a process of change through which individuals work to improve their own health and wellbeing and strive to achieve their full potential. Recovery is personal-centered, self-directed, strength-based. It includes the participation of family members, caregivers, and includes supports including acute care, residential treatment, partial hospitalization or outpatient services and individual therapy, as well as community-based services and supports. Our addiction treatment system has historically been built on an acute care model. Short-term treatment expected to cure a problem. The chronic care model places emphasis on the lifelong work of maintaining health and recovery. A recovery model focuses on long-term personal engagement and on system support for achieving and maintaining health. If we truly believed that addiction and mental illness were chronic disorders, we would not create the expectation that full recovery should always be achieved from a single treatment episode. We would not terminate the service relationship following a brief intervention or view prior treatment as indicative of poor programs. We would not require a person to fail a lower level of care before providing the appropriate level of care. [Beeping] >> And we would not exclude clients for being symptomatic. What can you do? To build on Dr. Wong's comments, you can consider making all licensed chemical dependency treatment facilities and psychiatric hospitals in Austin tobacco-free and require that they assess all patients for addiction and begin cessation used treatment guidelines. This is not currently the case. Despite overwhelming well-documented evidence in the medical literature that tobacco

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cessation should be initiated at the time of other cessation, and with management and therapy persons with substance abuse disorder are much less likely to relapse if they abstain from tobacco, it is not the case in our community because nobody wants to go first. Number two, you could support the establishment of the sobriety center in Austin as an alternative to incarceration for persons with public intoxication in the name of not only jail diversion, but an opportunity to engage in screening and referral to treatment, and assess an individual's readiness to change. I serve on the sobriety center task force and I urge you to support this recommendation when it comes before you in the next few months. Number 3, to build on some of David Evan's comments, continue to find ways to have central health collaborate with chemical dependency treatment providers to integrate physical and mental health services so they are more likely to attain a state of health and wellness. Most chemical dependency

treatment providers are funded to provide a narrow scope of services. A person-centered approach treats the whole person simultaneously. And number 4, adopt the Asam criteria for the treatment of addiction, and sub-stance related conditions. The criteria is a multi-dimensional bio-psychosocial assessment, considering the withdrawal management potential, bio-medical conditions and complications, emotional, behavioral, or cognitive conditions and complications, readiness to change, continued problems potential, and recovery living environment to determine the appropriate service planning and a recommended level of care. The Asam criteria were published in December of 2013 and have been adopted statewide by 30 states.

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Our state of Texas has not had a chance to do this, they were not in session until just now. This would give us all common language and allow us to adopt the standards of the addictions medicine profession as ours. I want to thank you for the opportunity to share my thoughts today. I'm available as a resource, reach out to me if I can assist you. They have my contact information, and she has my permission to share it with each of you. I will give her a typed copy of my comments so she can share it. I'd be happy to take any questions. >> Tovo: Thank you very much, and thank you for that willing willingness to serve as an ongoing resource. I understand Susan will present on behalf of children's optimal health. Thank you. >> Hi. Thank for the invitation to come, and thanks for your stamina this morning. The mission of children's optimal health is to enable communities to visualize the health of their neighborhoods, to identify assets and needs, and then to unearth opportunities for collaborative change. We do that primarily through the analysis of geographic data, and then we use that information and collaboration to improve operations, impact policy, inform research, and engage community in creative problem-solving. We are firm believers in the use of collaboration and those methods as mechanisms to create efficiencies and improve the quality of outcomes that are achieved. Our board members -- and I believe you have a handout in front of you, do you? Okay. Our board members reflect the diverse sectors that impact a child's life. They include healthcare, housing, education, economic and business development, and agencies addressing social and emotional well-being of

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children, youth, and families. There have been others on the panels this morning that have referenced the use of mapping and the use of data. And I think one of the values of this community is moving more and more towards the use of data to inform the decisions that are made in public policy and in practice. I think one of the value-as of children's optimal health has been our ability to not just use publicly-available data, but to really put the effort into developing good relationships and negotiating legal

agreements for data sharing that can allow us to leverage the benefits of geographic mapping analysis, which include the ability to pull really divergent types of data together in a same picture and create some understanding of what's happening as a subcounty level, at a neighborhood level. The relationships that we negotiate are relationships that focus -- when we can -- on person-level data and on data that is closely held or protected under hipaa, ferpa, or other legal requirements. The kinds of projects that we've worked on have spanned prenatal care and birth outcomes, early childhood development and school readiness, child obesity, youth behavioral health, and substance use. As you see projected and on the back side of your handout, I've provided two maps as demonstrations of some of our work. The first of these is a map of the economically disadvantaged students in the Austin school district. It represents over 52,000 students, and I want to note that we work with multiple school districts in the area. This particular map did not

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include either manor or Dell valley, so, if we included those, we would see more pockets of low-income families in those areas, as well. But it does represent the distribution of children who are already disadvantaged, and their life course is going to be impacted by that lack of advantage compared to their more middle-class and more-advantaged peers. The second map, if we could show that, please? [Beeping] >> And can you project that? Is now taking a look at the students who have a health risk related to high body mass index, which is an indicator that that student may be vulnerable to diseases associated with obesity, either currently or later in their life. And what I want to point out there, that map represents nearly 19,000 students just in grades three through five in the Austin school district. Overall, about 54% of the students are healthy. The hot spots that you're seeing on the map are identifying hot spots reflecting the 43% of students in those grade ranges that are either overweight or obese, and therefore at health risk. And the thing that I wanted to point out there is that there's a good correlation between the location of low-income students and those pockets of students who have a health risk. So that is of concern. Lastly, I just want to point out that when we can use these maps in time series, in other words, look at outcomes over time, we can look at what it's intermediate scale. Not just a research program within one agency or one school, or, you know, one clinical setting, but really trying to

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look at a neighborhood level if we're making innovations. Are we seeing change in a target the community? Thank you. >> Tovo: Thank you. Our next speaker -- >> Mayor pro tem, may I ask a question? Thank you so much. You strung together about three acronyms, all at the same time, talking

about hipaa. What are those three? >> Okay. Hipaa is the -- [chuckling] Hipaa is the health law. It's the health information patient privacy and protection act. And so, that is the law that keeps patient information private and requires patient consent for the use of information, except in some particular circumstances that are defined in the law. Similarly, family education and right to privacy act pertains to educational institutions, and it similarly protects the privacy of student information, again, under circumstances that are defined by the law. And ferpa was actually some of the legislative ground work upon which hippa was originally Ba based. >> Houston: What was the third one? >> Maybe dsa, data-sharing agreement. And those are the legal agreements that we negotiate with different partners to share their data in ways that we can protect. >> Tovo: Thank you, next, Regina of the people's community clinic. Thank you for being here. [Off mic] >> Press that. Ah. Okay. Thank you, councilmembers for having this panel, and for inviting me to be on it. As a former member of the Austin -- imagine Austin task force, I'm very excited to see

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that that's being integrated, it wasn't just put on the shelf, you're looking at how it's being implemented. I'd like to thank you, also for the recent waiver of construction fees in our expansion project, and I have to always when I have the opportunity thank St. David's for the commitments they have made to people's and this community. Our mission is to improve health by providing high-quality affordable healthcare to central texans who are uninsured our under served with dignity and respect. In 2012, we became a federally qualified health center. In 2014, we became patient-certified level three, the highest-level certification. And so we're very proud of where we are. We're very proud to be part of this network. We're very excited about the moment in history that we are at in terms of our growth and our opportunity to serve many more people in our community, and do it on a much larger scale. We also are aware that we are part of a network. That we alone do not deliver the great volume of care. That we are one piece of a much larger puzzle. And I really appreciated having Mr. Jones' first presentation about the four factors, the social determinants, the overall determinants of health and dividing them between social, economic, health behaviors, clinical care, and environment. I thought about that. I realize sitting here that in fact, people's community clinic addresses all by environment, and maybe our new facility will help us address that within our own facility, at least. We address all of those in a variety of ways. And I'm not saying this is unique just to people's. I think all the clinics attempt to address these in multiple ways. We may do a few things that are somewhat unique or different,

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but I think that's the exciting part of having competition in this marketplace, of having multiple providers who are all trying to excel and do right by our patient populations. One of the unique services that we do offer is called the medical-legal partnership, bringing together a collaboration between a legal resource and our health services. Because so often the underlying problem that the patient faces is not purely medical, but is of a socio or economic or legal aspect, and so that is one of those areas where we would love to see that as a program that grows. We think the opportunity exists within the medical and legal school to generate some synergy there that would bring additional resources to our low-income population. At people's we provide cooking classes. I'm sure other clinics do, and we'll hear more about the importance of nutrition and good food. But, again, this is not a traditional health clinical service. This goes to the health behaviors that our patients have, and ways that we can find to help them improve those. And at our new facility, we're very excited, we will have a full teaching kitchen, as opposed to a hot plate where we do our cooking now. We provide nutrition and counseling, because the best food for newborns is their own mother's milk. We are unique in having a program for pregnant and parenting teams. Our goal is not to prevent parenting, it's to prevent subsequent pregnancy. The girls are already pregnant, we provide them with case management services that are wraparound and help prevent them from engaging in behaviors that will produce subsequent pregnancies. The national repeat pregnancy rate among teens is 22%, our

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program is under 5%. We're very excited about being able to expand those services. We offer a comprehensive family planning program. We are the only program in central Texas that offers title 9 services, getting confidential family planning, that's very important. We offer a complementary medical practice in terms of acupuncture. For some patients, that's the best alternative, especially in trying to manage chronic pain. Of course you've heard a great deal of conversation about behavioral health. It is critical that there be a successful, integrated model, St. David's has been very forward-thinking about supporting integrated behavioral health for adults and children. We are introducing a new program for the youngest of our patients to address toxic shock. This is a program called circle of security. We're very excited to be doing that. An overlay that affects everything is health literacy. It's one of those areas where it is not clinical. And it's not necessarily a health behavior. But so often, people simply do not understand the information that they are being presented with. And being able to offer materials and communications that are accessible and understandable is critical to the outcomes that our patients experience. So, those are some of the services. Obviously, there are many others that we also offer. We're particularly excited about the growth I just mentioned. We will be going from roughly 25,000 square feet to around 75,000 square feet, and we are looking to accomplish that by the end of this year, early next year. Of course that could not happen without the support of the St. David's foundation. They impact so many elements of

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our community, and so many aspects of care that we deliver. Something I think was mentioned and is important, there was a little conversation about the healthcare workforce. It is really critical. We have a shortage of providers, but we also have a shortage of nurses. And it's a very competitive market to hire in. And the fact that the St. David's foundation offers loan forgiveness, there are intermediary workforce programs in Austin that the city supports, like capital idea are very important to the overall workforce that's available to provide care. I guess I would just conclude by saying that I think one of the challenges we face is not that we lack for innovation and the ability to come up with new ideas, but ultimately, the challenge is how do we take those new ideas to scale? How do we implement them in a way that are accepted after they've been proven to be successful? How do we disseminate those ideas? I hope that's one of those places the medical school will be able to help us with, by helping to identify what is working, what's not working, and then helping find ways that those good ideas that we can all agree are worth expanding and building on get implemented and taken to scale. >> Tovo: Thank you. And our next speaker is Dr. Steven pont of the Texas center for prevention and treatment of childhood obesity, medical direct for Austin aisd health services. >> Thanks for having us and your enthusiasm in hearing about health, such an important topic. Given we have a short moment, I'll throw out a few seeds and be more than happy to talk with you in length about anything.

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I'm a pediatrician at the medical center, wearing my childhood obesity hat, I have an appointment with the medical school, at our childhood obesity center. They've benefitted from the 1115 waiver program, we've expanded dramatically. My other hat, the school district. We have a unique national relationship, all school nurses are employed by the hospital. That allow us to leverage those resource in a collaborative manner with the city and public health, and other agencies to help the kids in the broader community be as healthy as possible. Mainly, regarding obesity and health and wellness, we pride ourselves in thinking Austin is a healthy city. In many respects it is, but, it is not a healthy city for everybody. Given the magnitude of resources we have here in Austin -- I'm an austinite, I hope to retire here, but, it's embarrassing we can't do better for everybody, given the resources we have in this beautiful town, like a running trail behind us. Not everybody uses it, some folks can't get there. Regarding childhood obesity, it's so scary because it sneaks up on us. We think our kids are big and healthy. And then before we know it, they're accumulating medical complications. Some of the kids I treat might have prediabetes, and they're only five years old. I can guarantee those things will get worse without specific, intentional efforts to reverse the trend. We feel good until we have the complications, then that waves into family history, it doesn't have to be the history of every family to have diabetes and amputations and people dying in their 50s. I had a patient in another state who died at 19 from complications of obesity. Once they die, they don't talk anymore, you don't hear the story, but it's real

and happening. It's going to affect our American dream. Kids are supposed to live longer, be more productive, live happier lives. If we don't really try and reverse this focus on health and

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wellness prevention, that leads to health, it's really going to affect us in that way. The challenge with that is that it has so many causes. There's no silver bullet. That can serve to paralyze us, it's overwhelming, or we can be inspired because we can do something to make a healthy change. Hopefully some of us with more influence, there's more than one thing we can do. But trying to think about any way to make the healthier choice the easier choice. That's a general thought for you to have. Whenever there's a policy, how can we make the default healthy return unhealthy. When we have meetings about foods, how to model behaviors of having healthy choices when we're eating, or other policies we're weaving in. We work with families to empower kids and families to live healthy lives. It's not what we can do for folks, but, what we can do with folks. That can be individually and in the community, as well. I can work with individuals and believe that individuals can make change, but to some degree, it's like providing swimming lessons and throeing them into a hurricane of unhealthy choices. Some can do okay, but most will drown. We need to work in both areas. With the child obesity center, we work on the individual level, primary care providers, and community initiatives, as well. In whatever capacity we can be helpful, I'd love to talk with you all. We're seeing positive change in some communities. The foundation maid a substantial investment and built up a huge amount of community support to try and make positive changes which are very encouraging. We had a grant with the school of public health, starting to see meaningful change. This should be a call to arms to push forward with more momentum rather than pull back, because then we'll fall back. A couple of important take home points is number one, obesity is a medical diagnosis and disease is not covered by insurance providers for the majority of plans in the state of

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Texas, public or private, so that means it's going to take us a little longer as health care providers to get our act in order, to be as successful as possible where we can advocate for that to be recognized the better as well. Again, if we didn't pay for a cancer treatment it would take us some time to have effective interventions from that from a clinical standpoint. The other one is recognizes that weight bias is out there. The fault that we hear is personal responsibility. I think for sure individuals can make personal choices but if we surround them with everything unhealthy it makes it less likely to happen. I think we all agree that austinites are hard worker, Austin housing finance corporation nights who have -- all austinites who have kids want to have healthy kids. It has to be something other than laziness, we

have to encourage and empower individual change but also to work on the community level. Another key final point is just think about where we can continue to connect resources. We do have a lot of resources that are out there. We for sure need more, but there's also a challenge as far as connecting folks with programs that are there. That's one initiative that we're working in partnership with some other folks to create a website and an app that will be free for people to put information on, free to download and use that basically type in your address, says what's going on at the local parks and rec center, ymca, where's a healthy cooking class to try to connect those dots. It's free for everyone to use, I would love in whatever capacity if y'all can help publicize that, get as much information and user. Connect people that have things out there. Another highlight to help make that thing happen. Finally, we're going to have a 5 K and health and wellness symposium at the circuit of Americas track on the 18th. We are shooting to have at least 50 non-profits out there for folks to engage with. There's a family one and a half mile walk and a 5 K for walking or running, if you any of you guys would like to be out there, that would be awesome. >> Tovo: Thank you very much, doctor pont. Our final special is terry

[11:32:00 AM]

brewsarb Williams from the American heart association. >> Thank you for being here. Hopefully we're last because we're closest to your heart. [Laughter]. Good morning, mayor pro tem tovo, councilmembers and staff. I'm one of the three board of trustees that David Evans spoke of earlier. I'm sitting on the board of Austin Travis county integral care. Thank you so much for your support of that organization and David did a fabulous job presenting. I am here today to talk to you about the American heart association. I serve as the vice president of advocacy and government relations. We want to share some information with you about the aha that you might not be familiar with. So we are part of the southwest affiliate, which is comprised of six states. Arkansas, Colorado, Oklahoma, Texas, New Mexico and Wyoming. But the affiliate headquarters is right here in Austin and we have about 100 people in a northwest Austin office. We would love to have you all there for a tour. Currently, heart disease is the number one killer in Texas as well as here in central Texas. As well as the fourth killer is stroke. We invest about $700,000 here in central Texas for research and in the state of Texas a total of about 24 million. So that takes me to our 2020 impact goal. We're looking to improve cardiovascular health for all Americans by 20%, by the year 2020, and reducing death and disability by 20%. The metrics that are collected to see if we will hit that goal, there's actually a three-year data lag, so they will pool the -- pull the Numbers from 2017 and 2020 to see if we hit that goal. For that reason the aha has an extremely aggressive public policy agenda for the next three years. We think that by working and getting public health interventions on the books we can really do some good for the state of Texas and

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the country. So for that reason I want to focus on public policy today. We do a lot of work in Austin in regards to health equity as well as work site wellness, but I think some of the work that we're interested in, in regards to public policy, is something that you will also be of interest in as well. Dr. Pond mentioned Austin is known as being a very fit city. We have bike trails, walking trails. Yet our waistlines still need to be trimmed. About 20% of austinites are obese. With small investment from the council from our community that can help move the needle forward. One of those is procurement, healthy vending machines, healthy food at all meetings and in cafeterias. These nutritious vending options, there's guidelines to make sure that there are nutrition that goes into place. City workers, that eat while visiting here, just maintain an ideal caloric intake that's needed and over time have a healthy weight, that will help reduce obesity. Also one that councilmember Garza mentioned earlier is food deserts. We are seriously interested in having some type of impact when it comes to food access. There are so many families that do have to drive between 17 and 20 miles to hit a grocery store. If it's raining that day, they are probably with those grocery bags getting on a city bus or taking a cab to get home. So we really feed to do better to -- we really need to do better to get food to those families. We have policy solutions to that. We can look at one for grocery stores, one for corner stores, that would make it easy for not only those families to get food, but for people who are interested in starting a small business to maybe be a part of a loan program or have some grant funds that would allow them to start

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these businesses in communities such as del valle. We are actually working at the state legislature this session on a state-wide initiative. But, you know, state-wide initiatives aren't one size fit all, as you as a body know. So there are still ways that we could do some work here in Austin and create something that is Austin centric and that could work for our community. So we welcome the opportunity to have a more detailed conversation with each of you about these public policy issues. We will really be focused on physical activity, obesity prevention, anything that will help improve preventative health. So you do have a folder that outlines our local policy agenda and some things that we can meet with you and provide even model ordinances that we would look at or talk about programs from other cities that worked and how they could be tailored for Austin and have some impacts here in central Texas. I'm happy to return some time and maybe you can grab some lunch and just know that we are also here to help. >> Tovo: Thank you so very much. I want to thank all of our panelists from this morning that have provided us with just a wealth of information, we appreciate all of the work that do you in your community and we appreciate that you took time out of your work to come and share this information with us. Thank you so very much. Colleagues we are back here at 2:30 for social services, we have a very -- excuse me. 12:30. From 12:30 to 2:30 and we have a large number of speakers lined up for that, too. So I hope that we can all be down here at 12:30 so we can start on time, that will provide us with more opportunity to ask questions of our panelists as well. Thank you, we stand adjourned until 12:30.

[12:34:13 PM]

>> Tovo: Good afternoon. Thank you all for being here. This afternoon session will include social services and access for those with disabilities. We have speakers lined up. We are grateful for you spending time with us to sort through these critical policy issues. We're going to start with Stephanie Hayden, our assistant director of the Austin, Travis county health and human services department. Stephanie and Dolores Gonzales, our Ada coordinator for the city of Austin, they're going to provide us with general context to start us off. Thank you. And ... Mr. Jones. >> [Indiscernible] I'm going to introduce her. But before that, I wanted the opportunity to emphasize to the council that as part of health and human services, social services are one of our major and critical part. As you saw today in our presentation, earlier, 40% of all of the determinants of health are determined by those social and economic factors. So Stephanie and others are going to be talking about what the city's commitment is in terms of addressing those social and economic factors and things to address that. I did want to come forth and connect that to the health and human services aspect of what we do. I will turn it over to Stephanie Hayden, the assistant director for community services. Thank you. >> Good afternoon. I am Stephanie Hayden, the assistant director of the health department. I am the assistant director of the community services division. The social service contracts are housed within the community services division as well as the maternal child and adolescent health division under the leadership of Dr. Rosa Mario and managers are maria Allen, Greg Bolds, Robert Kingham and Ron

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Hubbard. We would like to thank you for this opportunity to present the information about social services. I will start out by just providing you a little bit of history about the social service investment. 30 years ago, elected officials and city management looked at ways to address critical gaps and needs. In 1989, 6.1 million in investments were made by the city of Austin. In 2001, Austin energy provided an additional $80,000 in funding to health and human services, and in 2009, economic development depend provided $1.3 million. Today, health and human services, as well as Austin energy, and economic development provides funding for social service contracts through the health and human services department. The next slide is going to just give you a little bit about the social service framework. For the health department, we start the core as our strategic plan. In this illustration, you can see we move a little further out. Keep in mind the imagine Austin plan as well as work we do with agencies, coalitions, plans and task force reports. The social service framework here -- I'm going to go back to the illustration before -- where the health and human services strategic plan and priorities and goals are listed here. When we are serving as an exemplary model or promote and raise the visibility of public health locally, regionally and nationally. About three years ago, the department undertook a strategic plan, and we considered our community health assessment as well as our community health

improvement plan. We looked at imagine Austin, and here you have listed the vision statement as well as the core principles.

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Austin is a beacon of sustainability, social equity, economic opportunity. Where diversity and creativity are celebrated, where community needs and values are recognized, where leadership comes from its citizens, and where the necessities of life are affordable and accessible to all, according to the imagine Austin plan. The social service framework, also, we have various plans and reports that identify significant needs in our community. Gaps in services and or best practices for strategies that foster suspect self-sufficiency for individuals and families. You can see on the slide, from the work of the community advanced network, dashboard and strategies, down to e-3 alliance, which is equation equals economics has a blueprint with four goals, ready by 21, the school readiness access strategy and overall focus plan. Priority outcomes for children and youth and the permanent supportive housing strategy, just to list a few. You asked the question, how are social service organized in the community? They're organized according to issue area, whether it is administration and planning, all the way to basic needs, behavioral health, which includes mental health and substance abuse. Children and youth, human immunodeficientyy virus, H.I.V. And workforce development. The next slide provides the breakdown of the current investment. And each of the services are aligned by issue areas. The next slide provides you a list of performance measures for the social service contracts. We had a goal of 47,000, and there were 50,522 persons that

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were served. When one thinks about the amount of money that is spent on social services, you wonder is there a return on investment? Is there a cost avoidance? Yes, there is. Data shows that social services have a social and physical return on investment. There are cost avoidance savings that can be tied to social service investments. According to the slide, for every dollar invested in early childhood services, between $4.10 and $9.20 are saved. Various ones here, that you can see, from high school graduates making more money, whereas a dropout will spend about $292,000 -- and this is a northeastern university study that estimated that a high school dropout will cost taxpayers $292,000 over his or her lifetime. And savings for schizophrenia treatment as well as persons exiting or avoiding homelessness. Our success stories, we included just a few, but capital idea, which is a workforce development, since 1998 over 140 -- 1,040 have entered. There are been 54 units of permanent supportive housing. That is for safe housing for chronically homeless or homeless individuals with supportive services, such as case management. These are a few of the many success stories. The question is asked: What is the role of the

city of Austin and other organizations that play in the continuum of services? Initially, service delivery. When we think about service

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delivery, we have multiple community nonprofit partners, which work on a continuum from behavioral health to basic needs to homeless services. We have the arch and women and children shelters, to name a few. Then we have direct services provided by the neighborhood centers. Those are basic needs and case management centers. We have disaster response, which is case management services, and when we look at our youth, we provide the direct services to youth through Austin youth development and community youth development. Our African-American quality of life unit also partners from community-based organizations and faith-based outreach. We have our day labor center, which is a safe place for laborers. Planning, collaborative with broad away of stakeholders and community conversations and planning efforts. There is research as well as committees and work groups and a funder. We have foundations that we work with, Austin community foundation as well as St. Davids, Travis county and United Way. What is a stay -- is the city of Austin doing to help homeless populations and other vulnerable populations? We are ensuring that our service delivery and contract programs are based practice, evidence-based promising practice. That our services are culturally and linguistically appropriate as per federal guidelines and assuring as a health department that our level of quality for our youth programs we have quality assessors that are trained on our staff, customer service, always looking to improve our quality. So we look at our surveys and make improvements. We administer and manage social service contracts and we're able to provide technical assistance to those that have social service contracts and those that are

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wishing to have social service contracts. As well as collaborations. We work with other city departments and just to name a few -- this is not an exhaustive list -- Austin energy, neighborhood housing community development, human resource development, economic development, parks and recreation, library department, code, and Austin police department. Our community partners are very, very many. The last question that was asked were the items health and human services that were coming to council. The community services block grant, which is a state grant from the Texas department of housing and community affairs and it funds our neighborhood centers. And we have a social service contract for meals on wheels and more that provides meals and supportive services to seniors and disabled people. At this time, I'm going to turnover to Delores gon -- Dolores Gonzales. >> Thank you very much. Again, I'm Dolores Gonzales. I'm the A.D.A. Coordinator for the city. I've been the only person to serve in this

role since the law became effective in 1992. Where is my -- so brief introduction to the law as soon as my -- my presentation comes up -- is that the Americans with disabilities act prohibits discrimination to people with disabilities. It was signed in 1990, July 26, 1990, which is going to be 25 years this coming July by former president George H.W. Bush and it is the first civil rights law protecting people with disabilities. Ok. We'll move ahead. And there are two titles

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sections of the law that impact the city of Austin. Title one prohibits discrimination and employment practices and the city's goal is for employees to be successful in their current or other city position and will make every effort to accommodate. Title II prohibits a public entity from discriminating against people with a disability in all services, facilities, programs and activities that are provided or made available by the entity. Some examples of city accommodations for employees under title 1 include, teleworking, moving furniture, assistive equipment such as screen reading software for computers to help employees that are blind or low vision. Or volume-controlled phones for persons that are hard of hearing. Sign language interpreters are providing to employees that are deaf for meeting, training and attendance at events. And flexible hours allow those who need to attend therapy sessions. There is title 1 for undue hardship. That must be made at a high administrative level, taking into account all financial city resources as well as the - impact to the business operations, including the ability of other employees to do their job. If we determine that an accommodation is an undue hardship, the city will work to provide an alternative, but effective accommodation. A couple of other compliance components, under title II is the notice of compliance you might have noticed in the city council agendas, where we give notice to the public that they can request accommodations. We provide accommodations allowing a qualified individual with a disability the opportunity to participate in or benefit from the aid or service offered by the city that is equal but not different or separate to those

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offers to other individuals. Citizens communication -- accommodations come from a variety of sources, we come -- they come to us from 311, the city notice in the public meetings, we have a notice poster that is displayed in all public lobbies, the internet, other departments and direct calls to my office. And the Ada office works collaboratively with city departments to resolve citizen accommodation issues. We also have to provide effective communication. The city will take appropriate steps to ensure the communication with individuals with disabilities are as effective as communication with others, and that it is provided in a timely manner in accessible formats that protects the privacy of the individual. Auxiliary AIDS include sign language interpreters, braille agenda or captioning services. According to

Ada, the city will give primary consideration to an individual's request when determining AIDS or services necessary for communication. Some communications for citizens include, like the aviation department added a service animal relief area. And accessible directional signage for travelers with disabilities. The convention center provided mobility scooters for rent and installed a touch-operated bathroom doors for visitors with disabilities. The health and human services added a special needs area for citizens with mobility issues during annual flu clinics. Austin resource recovery provides service to citizens with mobility and sight impairments in managing their trash carts. The parks and recreation department formed an inclusion unit to oversee specialized programming for people with disabilities and created an accessible Ada trail heads along lady bird lake. The public works department has a sidewalk program that

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oversees the repair and building of city sidewalks to be fully accessible to citizens with disabilities and works with the Ada sidewalk task force for community feedback. The city leads the way in success. I'm proud to note these are a few examples. The city's been providing captioning to city council meetings since 1998, which is probably one of first cities to do that. We provide accessible software throughout the library department, we provide sign language interpreting and captioning services as requested. We created an aggressive Ada curb and sidewalk program. We developed an audible traffic signal program and provided disability awareness training to the entire police force. We were a winner in the 2005 national accessible America campaign. And the neighborhood housing community development through the smart housing program has built over 3,000 visible homes. And that's all I have for you today. I did want to also add that my office produces an Ada implementation report every year. I can provide a link or a hardcopy to you at your request. Thank you so much. >> Thank you both, very much, for that really and helpful overview. Council member Zimmerman. >> Zimmerman: Thank you for being involved in that program. Over the years how many millions of dollars do you think is spent? I think about cost-benefit analysis. We have a benefit of Ada compliance. To know if we get a good deal out of that, how much has been spent compared to what we receive. >> Well, I think it would be hard to say. I know that the public works department probably has a big chunk of that, because they spend money on sidewalks. As far as spending on like accommodations, I can tell you

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this: My budget for this section of the law is only like $31,000, and we normally spend just about that amount of money. That is not a lot of money citywide to spend -- you know, this is inclusive of sign language interpreters and equipment for employees and so forth. So it is kind of hard to make a cost

analysis per person or per situation, but, you know, our obligation under Ada is that the services that we provide to everybody should be available to people with disabilities. >> Zimmerman: The reason I'm asking is because we have a terrible problem with taxation in the city. And I think that we're at the level now where we have an undue hardship of taxes and unaffordable cost of living. A lot of these regulations contribute to that. I know you don't know the exact number, but it will be millions, tens of millions, maybe hundreds of millions. There is a lot of money that is put into this. So in order to figure out if there is an undue hardship, we need to figure out how much money is being invested in the programs, as you said through public works and other areas. I think it is. >> Like for example, public works, if they're making a sidewalk accessible, it is not just for the wheelchair user. It is for everybody, the senior citizen, the woman with the rolling cart. It is for everybody walking on the sidewalk. I would think that public works has a big chunk of that, but it would be hard to estimate that it really is pertaining to people with disabilities. >> Tovo: Member Houston. >> Houston: Thank you for that information. I want to point out the more of our citizens that have disabilities or differing abilities to have employment and the accommodations that we provide means that they are able to then provide for themselves and their families; is that correct? >> And be taxpayers, yes. >> Houston: Thank you.

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>> Tovo: Other questios, colleagues? I have a quick one. I think it would be really useful to see that link that you talked about. I hope that we can make that available to the council about the different programs and resources -- >> You mean my report? >> Tovo: Yes, thank you. I have -- I would be interested, too -- this is not the venue for it, but I would be interested in getting more information. From time to time we get questions from constituents about programs accessible to children with intellectual disabilities both at our recreational facilities, summer programs and you know, the array of other programs that the city provides. So really, I know that has been a priority for the parks and recreation department, making their programs accessible and even more so in expanding opportunities. I would appreciate getting more information about that. Perhaps there are -- >> They created that inclusion unit which is only three years old, but they have specialized staff to deal with that exact thing. Specific -- it is specifically for children. Although it does include adults as well. But we can get you some information about what they're doing. >> Tovo: Thank you. >> It really allows us to be more specialized in being able to aloe any child to participate in their recreation program. >> Tovo: Yeah. Thank you. I think that is really important. >> Sarah has been very proactive about that. >> Tovo: Great. Thank you very much. We will move on to our key policy issues, panel, and we will begin with Amy price from the United Way from Austin navigation center. They will talk about trends and what to do to help cooperate with them. Thank you very much. Ms. Price? >> So the navigation center at United Way is made up of two primary core services. And those include 211, which is a partnership between the

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Texas health and human services commission and united Way and is a dialing code for health and human services information. And the second core service is our healthcare navigation program, which is a partnership between United Way and central health. We have several new partnerships that are helping expand access to healthcare. And for most of these, we serve as the front door for services offered by an organization. The most recent partnership is with bluebonnet trails, which is the mental health authority for a few of the counties we serve. We provide screening and eligibility and intake for some of their programs. Last year, the navigation center, which is housed with United Way, we took about 328,000 calls from the 10-county region. About 2/3 of those were 211 calls and a third were calls to the healthcare navigation program. So 211, it's a free, multilingual service available 24/7. It is staffed by professionals. Our staff include people who have been case manager, social worker, so they really are experts in navigating the social service delivery system. The service is confidential, although we do collect several pieces of information from callers that allow us to serve as a barometer for community need. That includes, age, gender, zip code, needs to the caller, and services we connect the caller to. This is a map showing the 10-county region in central Texas. There are 24 other 211 operators in the state, all funded by the Texas health and human services. Some really common types of

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calls we get -- unfortunately, the second common one we get every day, I lost my job, have a child, can't afford to pay my rent, is there anyone that can help? Sometimes people will call with a seemingly urgent need. Maybe they face eviction. Once we talk to them, they face eviction because they're behind on utility bill, maybe because of a job loss that was a result of a healthcare or mental health issue. Or maybe they are unable to work or having trouble working full-time because they can't afford child care. Our staffer experts at helping -- our staff are experts at helping prioritize needs, deal with the most urgent needs first. Sometimes we will address multiple items on one call, sometimes we will call the callers back to make sure they got the help needed and then follow up on additional issues. We serve as a centralized point of contact for social service and community information. We have three full-time staff that work together to keep our information up-to-date. So it's not just basic needs information. We have information about education and youth services. Services for older adults, criminal yesterday and legal information. Child care, transportation, and it's not just a phone number, it's not just an address. We're telling our callers everything they need to know to access the service. So intake information, what documents they need to bring, if it is Ada compliant, if -- what language the service is offered in. Really, everything they need to know to get help. So the top needs of our callers are for basic needs assistance. That includes food, utility bill assistance, housing information. This is consistent with 211 across the countries. Our basic needs calls are

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pretty significantly higher in proportion to others in the country, we believe this is due to housing costs. As people don't receive that food and prescription assistance is related to housing, but a person has spent a greater amount of income on housing, they have list to spend on other necessities, suchas prescription assistance and food. We have seen increases in basic needs calls. And in proportion to our call volume over the past eight years. Initially, we felt like this increase might have something to do with the economic downturn. Now we are seeing that it might be closely more correlated to housing cost increases. The bulk of our call volume still comes from where the greatest population lies. Talking about along the I-35 corridor, hays county, Williamson county. We're seeing significant shifts in the call volume. Still seeing lots of call volume from east Austin. It has stabilized the last two or three years. Seeing huge increases in the outlying areas, pflugerville and other areas outside of Travis county that are in the surrounding area, Maynard, San marcos, not just people being displaced. A lot of calls are from people that moved here from other areas of the country or state, but if they had medium or low income, found these other areas to be more affordable to live in. Here's the top 25 referred to agencies from 2014. We referred almost 18,000 people to Travis county health and human services. About 17,000 to foundation communities. If you look at this list of services, kind of just interesting to note, most of them fall within -- are

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located within central, east Austin, as the call volume is starting to shift outward. About 79% of our callers are female. That doesn't change much from year-to-year. I think sometimes people feel like maybe that is because women are more often the caregivers for their family, that is probably partially true. We all know that women or single parent headed households are more likely to live in poverty. A lot of our callers are single moms calling for services for their families. Majority of our callers are in their 20s, 30s, 40s, 50s. We're talking about working families. I want to end by first just making sure that you are all aware that 211 can be a point of contact for you at your constituents who are in need. [Alarm sounding] >> Wow. >> And also, we have the ability to provide customized reports for your district. We collect information by zip code, but we can usually correlate that to the districts easily. We can show you the top needs of constituents, where they're referred and concentrations of need. Let us know if we can provide assistance for that. >> Tovo: Thank you for that valuable resource. Council member kitchen would like to take us up on your offer. >> Kitchen: If you could just provide that, that would be great. >> Tovo: Thank you for the service you provide. I attended a recent capital awards luncheon. One of the award winners said she found her way to capital idea through 211. She placed a call. She was facing some of the situations you were describing of really struggling. So it was a very nice, personal example of how 211 has worked in the lives of so many individuals. Our next speaker is Sherrie Flemming. And Mrs. Flemming serves as

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the county executive for the Travis county health and human services and veteran service. Thank you for being here today. >> Thank you, mayor pro tem. [Indiscernible] And I think I turned myself off there. [Chuckling] Ok. In the slide deck that you have from us, we wanted to give you just a bit of information about the health and human services department on the county side. The next slide is a pie chart that represents the -- I'm sorry. I'm supposed to do something. This is a pie chart that represents the over-$30,000 investment that Travis county has in health and human services. I'll talk to you more specifically about public health and social service contracts in just a minute. The remaining areas, family support services, community services, office of children services all represent direct services to clients in the county. Our family support services division is a -- one of the largest basic needs providers as evidenced by the speaker before me, indicating how many referrals were made to our department from 211. Our community services. Division is a diverse group of units that provide capacity building for seniors looking to make contributions to the community through our coming of age program, all the way to our weatherization and housing, home repair program, in our office of children services, focuses significantly on children's mental health and everything from community-based care to those kids who require placement outside of their home for more significant behavioral health needs. We wanted to give you a visual of the breakdown of our budget. This chart reflects both

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social service contracts and the public health interlocal from the previous slide. Travis county meets public health mandates through an interlocal agreement with the city of Austin and your health department. Our total investment in public health, 4.9 million is the interlocal agreement with you for these services. You will see the issue areas as Ms. Hayden described, on the city's side. These are the issue areas that Travis county invests in. The last one on this chart, holistic family services is going to be one I give you a little more detail about, because I think it reflects how we see the need in Travis county. We'll talk about that in just a minute. Our overall investment strategy, over the long-term, is to implement -- is to implement a regular cycle of issue-focused procurement processes to better assess, plan, and establish priorities, to be more open and transparent and consistent and allow better quality standards for programmatic performance compliance and be strategic and have a planned opportunity to evaluate to investments in order to respond to changing needs and higher cost. The procurement processes may include competitive services and special circumstances. This is our action plan, you see there, we started this process in fiscal year 14 and we expect to be completely through the county's portfolio by fiscal year 18. You see there, our programmatic and administrative process requirements for

our participants, within the issue area, scope of work defines the outcomes that we hope to see for our investment, the quality standards and the population groups and geographic areas that should

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get priority for the service. From an administrative perspective, before funding a provider must successfully complete an administrative and fiscal review, which includes an independent audit, I.R.S. Form 990, have an active board of directors, minutes and fiscal and administrative policies and procedures. For the county, we're trying to design and implement a system that will function within our current staffing. To make this possible, we're looking for efficiencies in a number of areas, including but not limited to our renewal process, contract monitoring, our performance tracking and reporting and we will continue to be working with the court and our budget office to recommend increases to our investments in services to address population growth, rising cost, and gaps in service, because I must say that the strategy we have now does not reflect across the board increases. So when you look at that list of investments, it is the investments that we currently have with the exception of the increase for the holistic family services, which is what I'm going to talk about now. One of the interests that you had was to talk about what we saw as key considerations for improving access for our vulnerable populations. So to that end, the Travis county commissioner's court invested an additional million dollars in the fiscal year budget 14 process and directed staff to work with providers and the community to identify priorities for these funds. The volume of input supported services for children and youth and also indicated the need for more workforce development and housing services and a broad range of other needs. We also heard an interest in more coordinated and comprehensive service delivery. The design of the request for services, which resulted from this process bills on that community input. We work we're doing in the

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county to better understand and address the needs in the outlying areas, where population is growing in number and share and promises practices for coordinated holistic services underway in the department and the community. So here, you see the service design. Home center services, which began with a family assessment, centralization, centralized coordination of services, family driven system of care that includes family in the discussions to determine the best interventions for the family. Culturally and linguistically appropriate service delivery. Access to a network of services in at least five issue areas. Periodic assessment to measure progress. And need for additional services. Step down planning and community integration, which we have found to be key in many of the programs that we have delivered through the years and evaluation of the status at exit and at 6 and 12 months following the family exit

for the program. And as you can imagine, as our residence present for services -- [alarm sounding] We have determined that no family has not one need but multiple needs that requirement assessment. Thank you. >> Thank you very much, Ms. Flemming, we appreciate all your work. Next we will hear from -- there -- are there questions for Ms. Flemming? All right. We will move on to Mr. Todd Marvin who is the voice of one voice central Texas. >> I'm the current chair of one voice central Texas. That is my full-time job this year. I keep a hobby as president and CEO of Easter seals central Texas until my time as chair is up this calendar year. A little bit about one voice central Texas. Who we are -- there we go. We are the largest coalition of social service

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organizations in central Texas, representing about 75 agencies right now that bring in, in excess of about $100 million to the community, federal, state, and foundation funding. Collectively, we employ about 6,500 people, which would make us a top-ten employer in the region. We provide critical network of services for our most vulnerable residents, helping them move out of poverty and avoiding costly services like emergency care, hospital and institutionalized care. We have basically three focus areas. First is we hold our members accountable to standards for excellence. We have a committee that is focused on that. So every year, every member has to subscribe to those standards of excellence so that we can ensure that every penny of the hundred million dollars that's invested in our membership year in and year out is used to the greatest impact possible. We advocate for vulnerable populations in a variety of ways. And our coalition drives a great deal of collaboration which is efficiencies. A few partnerships with the city of Austin that we enjoyed the last couple of years have been around the request of operation task forces for funding of city social services. After each process, contracting process is concluded we work closely with Stephanie and her team and provide feedback into improvement of that process. We also participated in collaboration with the city around creation of the social service calculator. In the past six months we

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collaborated with the city around the imagination Austin plan. We hosted meetings with Google fiber and identified local families with minimum wage jobs for a local summit with president Obama's senior staff that happened here recently. We also participate actively with the Austin energy discount steering committee and supported passage of the affordable housing bonds. Just within the past couple of months. One of the things that one voice does is we also seek to educate the community on some of the key issues that we are facing. And about a year ago, we launched the tale of two Austins campaign. And have been discussing that around the community for a good, long while now. Really highlights how, in

many indicators, Austin, as we know, excels in a lot of different ways. When it comes to the most vulnerable populations, there are trends that we feel need redirecting. And redirecting in a pretty serious way. This was, we believe, confirmed by the recent study released that Austin community foundation has been a key partner in chairing that shows Austin as number one in the nation for major metro cities in terms of income and equality. In terms of critical public policy issues to address, first of all, in terms of planning, we would like to identify a process that we can use collaboratively to engage in comprehensive health and human services planning to determine health and human services priorities that can then flow into the social service contracting process. In terms of social determinants of health, we're strong advocates that inside the health and human service department, that there is strong collaboration between both when you understand how

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socioeconomic factors determine and drive health, particularly in terms of housing, education and economic stability, that we want to be sure we're leveraging every health dollar for the good of human services and vice versa. In terms of coordinating with Travis county, we would like to identify how the city and county can coordinate more closely to use available research, fund collaborative efforts, not because we think Sheri and her staff are terrifically awesome, but because we think it is a really good thing to do. When you consider the suburbization of poverty, which Ryan Robinson, the city demographer so powerfully demonstrated in the presentation provided all over the community the past year. This is a disturbing trend that is accelerating quickly, that will require a joint effort to be able to address. Uh-oh. Is that it? No, there we go. It jumped a slide. A few more public policy issues to address. Prevention and diversion. We would like to review how the city can move focus to prevention and diversion. More costly outcomes in institutionalization, hospitalization, and incarceration. When you consider that for a person with a disability, the annual cost of institutionalized care is about $33,000 a year versus that individual being able to live independently in the community, the annual cost being about $3,000. We feel like there is terrific opportunity not only in terms of personal benefit driven to the client and in terms of economic impact in the region. The social services index. Sometimes we refer to this as the social service calculator.

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This is something we discussed with council last fall. In order to increase the social service index in order to increase the social service for residents. A few things that came out in that conversation. Number one, historically, we have been on a bit of a fits and starts funding approach as far as the city is concerned. We'll go three to five years with cuts or no increase while still delivering on the expected

outcomes on the contracts year in and year out. And when you consider the accelerated issues that I discussed earlier, around tale of two Austins, we have some catching up to do. [Alarm sounding] We feel like creating that calculator will put us on that path more quickly. I think that's it for my time. Thank you very much. >> Tovo: Thank you very much, Mr. Marvin. All right. We are going to hear next from Sabine -- or Sabina? >> Sabina. >> Tovo: Sabina foster who is the coordinator for our ready by 2040 commission. >> Thank you for the opportunity to be here. On behalf of ready by 21. We are a coalition1 commission. >> Thank you for the opportunity to be here. On behalf of ready by 21. We are a coalition that is a contact list of over 400 individuals that represent over 100 organizations as well as community members, really anybody can join and participate in the conversations. Our vision, which was created by in 2003 around the time the coalition was created is that all youth in our community are prepared and supported to be ready for higher education and learning, ready for work and

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career advancement, ready to lead healthy lives and ready for positive social and civic connections and engagement. And I'm looking to the screen and wondering if I need to ... Press a button or something to get the slides. >> Tovo: Can we get some assistance for Ms. Foster? Thank you. >> Ok. Great. Ok. So we skipped the vision slide. Good. So in terms of needs and trends, one of the most alarming trends amongst children and youth is that as the population of Travis county has grown by about 35% over the period of time that is about 2000 and 2012, the child population has also grown by about that same amount, about 35%. But the child -- the rate of children in poverty has grown by 129%. So that is over four times the rate of population growth that we are seeing children in poverty. Over a third -- about a third of those children ages 5 to 17 speak a language other than English in the household. And population shifts, as you have seen in some of the previous presentations here today, population shifts have made it difficult for peoples with children to access services easily. Especially as they're moving to outer lying areas where transportation systems don't necessarily connect, but they may work in town. So their children are significantly at a distance

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from where they are carrying out their lives, which can lead to issues. And then, overall, positive communitywide outcomes are being achieved on behalf of children and youth. We do have the ready by 21 dashboard that is on line. There are an array of indicators, basically data points of the children and youth well-being that are measured from time to time. We release an update every year. If you go to the website, there is a dashboard at a glance page where you can easily scroll up and down and see have we improved or remained about unchanged or moved in a negative direction in terms of that particular

data point. Although we're doing well, out of about 33 indicators, there were about seven that moved in a negative direction. And all the rest were either positive or steady. There is still, we know, a lot of work to be done. I'm trying to advance. What is being done? It is hard to sum that up in a short period of time, but overall, there are over 200 service organizations -- and I'm trying to click -- [chuckling] Thank you, I may have to do a verbal prompt. Over 200 organizations listed in what we call the youth services mapping system that is online at ysm-austin.org. And they cover spectrum over holistic framework of youth services from academic and workforce, physical health and safety, social and emotional as well as social and civic engagement as being outcomes they're working towards.

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There is no shortage of organizations as well as the city, the county, and the systems that also deliver programs in order to address the need that is out there. More groups and agencies -- you have probably encountered this before -- are implementing system building type of approaches, comprehensive and holistic approaches to youth development and that we coordinate at a systems level. If we can click forward? So you may have heard the words "Collective impact." This is basically, simply stated, systems working together with systems and collaborating at the systems level, in order to create efficiencies. Ultimately, for families and young people. That is what that is ultimately about, but also coordination across systems and sharing of data and ongoing communications are also elemented -- elements of the collective impact approach. Next slide? Key considerations are that the system building efforts that are out there, and we have many in the children and youth sector, there is the early childhood coalition, mental health, mentoring, out of school time, that's not an exhaustive list, but I know there are a number of groups that are working to do the system building type of work. It can optimize coordination and create efficiencies for families and leverage resources. And at the same time, there are commonalities across these system building efforts that we should be exploring, such as we all emphasize that we all need good data and data sharing needs to occur.

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So at the same time we're doing the system building, we want to ensure that our systems groups are also connecting in that way, sharing data, whether it is referral systems, better coordination, even across funding groups. [Alarm sounding] As you have heard before -- is that my time? Basically as you have heard before, another key recommendation is that we encourage the whole family, culturally competent approaches that are critical to the achievement of sustained communitywide outcomes. >> Tovo: Thank you very much. Our next speaker is Mr. Martin currethy, the coshare of -- co-chair of -- [stammering] Aging services council of central Texas. Thank you so very much for being with us. >>

Thank you. My name is martin currethy and I'm the chair of the aging services council of central Texas. Obviously I'm not a senior, but I work hard for these folks. But the aging services council, before I even begin to talk about the council and what the council does and some key considerations, key thoughts is -- I want to take a moment and paint the picture of what the senior population, the demographic issues around the senior population are at this time. The austin-travis county area is the fastest growing presenior population in the country. That is ages 55 to 64. Recent studies have us at the third fastest growing population of age 65 and over. We're currently at about 8% of the population. Our -- are older adults by 2044. That will be 20%, so tell

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effectively double. So as we move forward, we know we're experiencing the baby boomer phenomenon in the way other communities in our country are not. The aging services council vision is that central Texas older adults have the opportunity to live healthy, safe, and meaningful lives in our community. We have a mission statement that we're a strong network of both individuals and organizations who work together to ensure that older adults and caregivers have the information and resources that they need to support themselves and their families. You know, as they continue to age. This isn't just impacting the older population, but it impacts the entire family unit. Did that move forward? Is that a list of aging services, council members? >> Not yet. >> Tovo: Let's try -- >> There you go. >> There we go. Ok, who is the aging services council? We're a member organization of groups and individuals, many of them are nonprofit service providers in the community. We have some of our local partners who are here, Travis county, research and planning, city of Austin parks and recreation. The area agencies on aging, to name a few. But our social service non-profit providers include age of central Texas, hand, family elder care, sava, which is an organization which works with south Asian older adults and many more as you can tell. We have a deep knowledge of the issues around aging at the federal and state level with the members and those folks

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who participate with us and all their subject matter expertise. We have a broad reach of members that represent the continuum of aging services in our community. And we have a strong track record of experience in delivering and accomplishing things that serve the older population and their quality of life for both themselves and their families. All right. So these are a few areas we work in. The continuum of services for health and wellness, these include things like fall prevention and fall prevention classes. Chronic disease management to prevent the cycle of emergency services. Benefits counseling. Support groups, home delivered meals. And a range of other ones, just those are a few to name a few. Also

services for aging in place, which is an important mission of the aging services council to make sure folks can stay in their home as long as they would like to stay in their homes and that includes demand response transportation, volunteer driver programs through organizations like drive a senior, home modification and repair programs so we can add accessibility improvements and any other things that are needed to allow a person to continue to stay in their home. Inhome care and certainly home attendant services, which are critical for folks who need home health services in their home. We also have service and supports for caregivers because we know as our population begins to age it will be a significant importance that we have services for those folks who have to care for them. So we have a care Christopher resource center for our members.

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Adult day care members through some of our members and caregiver education through a caregiver symposium that we put together. We also have professional development along the same lines of that symposium. So our 2015 priority areas include advocacy and policy work, meeting with legislators and obviously having an opportunity to speak to council. Development of a speaker's bureau just to make sure that we can get the word out about our services and our members and the aging population in general. Transportation is a big issue. One of our members, age of central Texas, is working in collaboration with the basic transportation needs through capital metro to do a demonstration project on the vanpool sharing type services so we can see what solutions we can come up with in our community. Advanced care planning to ensure that folks have planned for their future in terms of -- and their future needs in case they should become unable to take over and handle their medical issues and some of those other issues associated with aging. And cultural competency, making sure that we're providing services to the -- that are culturally sensitive, but also trying to reach out to those different cultural communities, the Asian community, the hispanic population, African-American community, to make sure that there antler needs in those areas and those committees that we haven't heard of or that are not meeting. And also supporting the adrc, which is the aging and disability resource center, which is housed in the area agency on aging, which is part of the council of governments, the capcog, which is sort of a one stop shop for information and resources for folks. [Buzzer sounds] And I will show you that

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slide, which is the mayor's taskforce on aging recommendations, and just highlight a few that include age inclusive policies as focuses on areas as home repairs. Transportation is a key issue. I would be happy to answer any additional questions that you might have at another point. Thank you. >> Tovo: Thank you very much, Mr. Surr thy. And our last speaker on this panel is Ann Howard, who is the

executive power of the ending homelessness coalition. >> Thank you, mayor pro tem. Echo is the big tent organization for stakeholders working together to end homelessness. We have about 12 paid staff, but we have hundreds of volunteers working from local businesses and churches, from partner non-profits, from city and county government and from healthcare and criminal justice. All working together to help people experiencing homelessness both attain and maintain housing. We're the liaison agency to hud for about $5.6 million that is showered among 10 local non-profit agencies. Hud holds us accountable for reviewing agency outcomes and for recommending new programs should there be new funding. Hud funding today is laserly focused on ending chronic homelessness of families, veterans and other individuals. Echo is a young organization formed in 2011. At the time city and county leaders along with local non-profit executives determined that a standalone agency able to work 24/7 with a soul purpose to end homelessness was needed.

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I'm the first executive director of echo and I believe we are on the cusp of a sea change when it comes to homelessness in Austin. There are three Numbers you need to familiarize yourself with. How do you do this? There we go. The first number is 1877 or 1,777. That's the number of individuals that we found on January 23rd with the help of councilmembers Casar and kitchen, out in the cold, in the wet, throughout Austin and Travis county. The second number is 6,703. That's the number that hud estimates to be homeless in austin-travis county based on the shelter and housing we provide or support. And the rate it turns over to new clients in a given year. The Ralph big number is 12,999 and that's the number of individuals receiving some kind of help that's documented in the homeless database that echo manages. There is a fourth number you need to know and that's my cell phone number. I want you to call me when you get called about homelessness. Echo purplishes a data report every week. You can either look at it online or we can send it to your email box or to your staff. It tells about the number of shelter and the number that changed from week to week. The number moved into housing and it's broken down by subpopulations on various issues that that population is dealing with. This next slide should be of great interest to each of you. That cold wet night we found people who we believe to be homeless across this community, in each of your districts. This is an austin-travis

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county issue. It's not a downtown issue. We found the majority of people in one spot downtown. It was a very cold night. We believe many had come seeking shelter. It wasn't cold enough to open extra shelter so they were sort of stuck on the street. Thankfully this number is down from last year as far as the number we found outside. It's down by 13 percent. From the map you see we need to address

homelessness all over Austin. I hope next year we'll have representatives from all our offices and neighborhoods helping us to identify where people are sleeping outside. And I trust the number will again come down. So what do we do about this challenge before us? I'm glad and nervous to tell you that we are in year five of a 10-year plan to end homelessness. And this plan has four focus areas. One is to prevent it. That's really hard, you know. How do you prevent a cold before it comes? But we know there are signals like loss of job, family breakup, that are going to signal housing instability. The second is to address short-term homelessness. And that cute cowboy is about to get back on the horse. We need to get families and individuals back into housing as soon as they fall out of it because if they know how to be housed, they know how to maintain housing, they know how to be good tenants, we need to help them get back into housing. Third is to address chronic homelessness. We want to replace the er and shelters with front doors that lock so people can regain health and stability. And fourth is effective collaboration. And that's what echo is about. We engage you, your colleagues at the county. We engage healthcare and

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criminal justice, business leaders and volunteers to make sure this community is aware of the very best practices and implementing only those practices that should produce results. The next slide represents the lion's share of the work we've been at the last couple of years with this collaboration. We're leveraging a hud mandate to do coordinated assessment or coordinated access that a community works as a system when it comes to meeting the needs of individuals experiencing homelessness. So that green bar on the left, sort of the mint green, reflects an assessment that we have implemented since October downtown and starting to take it across the community. It's one set of questions that every person who is homeless is asked. We've now done nearly a thousand assessments and that assessment as it gets underway and is completed identifies the housing intervention the client needs to get permanent housing. The idea of transitional housing is sort of pass say. The concept that somebody would improve real quick or improve knowing they're going to be facing the street if they haven't has just not really worked across the country. So when we talk about housing somebody, we want to make sure they're going to get into housing that they can stay in. It doesn't mean we have to pay for it forever. But it means that they would have the choice to stay. They would have a lease. [Buzzer sounds] I guess I'll quit. The last comment I'll say is that I believe that you are facing a tsunami of opportunity to be the city council that really helps end homelessness. And I've named four things, if this thing would work, that I think

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you guys need to do. You need to be vocal, you need to talk to landlords and property owners in your district and encourage them to work with non-profits who are housing the homeless. You need to invest strategically. And every time there's an investment decision or a policy decision, ask yourself does this forward the plan to end homelessness? And you need to support that coordinated assessment, that pretty picture I just showed you because that is really going identify and prioritize needs. Thank you. >> Tovo: Thank you, Ms. Howard. I appreciate that you put your cell phone as your fourth recommendation on that last page. So thank you very much. And it's -- as mayor Adler sometimes says when we open these, it's always frustrating in some ways because we would love to hear from all of you for much longer periods of time, but we're trying to get a broad overview of the issues. So we do have about 15 minutes for questions this time. So I appreciate all of you for allowing us to hold you to limited minutes. Councilmember Zimmerman. >> Zimmerman: Thank you, mayor pro tem. Just a quick question. Again, I'm going back to the cost factor. I went through the -- I've got the hand-helds here and not to be disrespectful, but we've had thousands of years of poverty and performance. So when you tell me it can be ended in 10 years, I don't believe it. Thousands of years of history, you don't reverse that in 10 years. But I would like to know how much money is being spent on these various programs and how much money -- what are we looking like as we put more people in shelter? What's happening to our budget and the taxes we need to pay to subsidize this? And there's not one single word in here that I can see about what this is costing us and what the future projections would mean. And if people are housed, you know, somebody has to pay. At what cost, for what

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term and why wouldn't -- if the word gets out that you show up in Austin homeless, you get a permanent place to stay. Sounds like a program to attract people from all over the country, but again it won't happen -- but if it happened we would just attract more and more homeless people, I would think. >> Tovo: Councilmember Zimmerman, did you want to direct your question or was that just a comment? >> Zimmerman: I did have a question about the cost. The cost is not on here. Is it because we don't know? >> The cost -- this morning you had heard from healthcare professionals talking about the need to reduce healthcare costs. Ms. Heyden mentioned that nationwide we estimate about $44,000 per person on the street. So if you can avoid that by housing, we say that it costs about $10,000 to support somebody with rental subsidies if you're paying for the full year. And it costs about $15,000 for very intensive support services. So if somebody needed the full package, permanent supportive housing, we're talking about $25,000 a year, and that's in comparison to many nights in and out of jail. E.m.s. Rides alone are just a drop in the bucket. So echo also is a national award winner just this past month for a pay for success study. And we're going have the best minds in the country working to see if it's feasible for Austin to use a social impact bond to really help folks like yourself and to help limited public dollars by taking private investment, housing people, demonstrating the savings and allowing those private investors to get a return on their

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investment. Housing works. We can do nothing. And I'll tell you that the echo board of directors discussed should the plan be to end homelessness or to reduce homelessness? And what we know is for the individual experiencing homelessness we need it end it and this community can do that. >> Tovo: Thank you. Councilmember Casar. >> Casar: Thank you all for coming. I was going to suggest first that we address some of these concerns in the housing committee and I would be very open T doing so, but giving councilmember Zimmerman's questions and also the savings that housing the homelessness can provide on our public safety budget, which is a very significant portion of our general fund dollars, this is something I would be very open to having a discussion about in the public safety committee so we can really see how much -- how the dollars and cents work out. And also the public safety benefits of having folks housed. I wanted to comment briefly that that's a conversation that I'm excited and open to have and would be excited to have y'all at that public safety committee hearing because even though it is partly a housing issue, I do think there's a lot we can learn in the context of addressing the homelessness and other social services in the public safety realm. >> Tovo: Thank you, councilmember Casar. Of course it cuts over to health and human services so at that point we've involved almost our whole council and it might make sense to have as a briefing a the our work session. Councilmember kitchen. >> Kitchen: I think the bottom line is you can't look at cost in isolation. This is not about the cost to house people. You have to look at what happens if you don't house people. And it's very, very expensive to the private sector. It's very expensive to people in our community when you end up with people running in and out of the emergency room as much as once a week, twice a week, five times a week. That's expensive and it impacts all of our healthcare costs including the health insurance that we pay. So there's a lot of -- a lot of costs that we

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have to think about. You know, I -- I think that councilmember Zimmerman is correct to ask about cost. I think that's important. But I think we have to look at the whole picture of cost. >> Tovo: Councilmember Houston. >> Houston: Thank you all again for providing so much information. I would like to know if anyone knows how much it costs to house a person in our criminal justice system for a year. >> I won't present myself as an expert. I have heard on the low side 35,000, on the high side about 42,000. Per year. >> Houston: Thank you. >> Tovo: Mr. Currethy, I have a question. We had a in our earlier session this morning about prevention programs for seniors, fall prevention programs. I know you mentioned that in the course of your presentation and I wondered if you could provide us with some more information about the kinds of fall prevention programs that the agencies are represent are providing to seniors. >> Yeah. And they're member organizations so I won't speak entirely on their behalf, but fall

prevention classes, balance related classes. I believe one of our members offers a course called the matter of balance. Just helping people maintain that balance and be able to keep their footing because we know that falls can be pretty significant health considerations as you age. But I want to say there are two or three members that offer those, but I would hesitate to say exactly what they're programming is, but I believe they're focused

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on balance and things like that. >> Tovo: Thank you. Colleagues, other questions? All right. Again, thank you so very much for all the work you do in the community and for being here today to talk about it. So we will hear now from our other voices in the community and these officers will each have three minutes to come up and share their thoughts with council. We'll begin first with Libby volente of the American association of retired people. Ms. Volente. And then after Ms. Volente will be Darla gay from the re-entry round table. Actually, we've had the good suggestion that all of our other voices come down and seat themselves at the panel and we'll move through from there. We'll give our current panelists a few minutes to relocate. So that includes Charlene justice of the central Texas after school network and also Angela Joe Medina from immigrant resources of Austin. If you could join us in the front, please. And refused franklin of the gray -- Richard franklin of the gray panthers. >> Tovo: We're going to change the order just a bit and begin please with Darla gay. If you would please kick us off. Thank you. >> Is that on now? Thank you. Good afternoon, I'm Darla gay and here as a representative for the planning council for the Austin Travis county re-entry round table. Thank you, mayor pro tem and city councilmembers for including the round table in this really

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important discussion around social services, particularly as it relates for serving vulnerable populations. The round table was formed in 2004 and is a coalition of public sector and criminal justice system leaders, service providers, advocacy organizations and formally incarcerated persons and their families who work collaboratively to promote public safety through effective re-entry and integration of formerly incarcerated persons and individuals with criminal histories here in Travis county. The round table is jointly funded currently by the city and the county and Pete Valdez of the downtown community court sits on the planning council as the representative for the city. As you likely know over the last four decades the rate of incarceration in the U.S. Has more than quadrupled and the size of the prison population has grown. In fact, it is estimated that roughly 4.5% of the adult population in Texas, that's one in every 22 adults, was under some form of criminal supervision in 2008. More than 12 million individuals have a criminal record here in Texas. Here in Travis county approximately 2400 persons are

released from prison each year, returning to our community. There are more than 2800 persons on active parole with more than 16,000 individuals on active probation. In 2013 the Travis county jail had more than 53,000 bookings in their jail. Many of these folks are leaving our jails and prisons and returning to our community and they have the added issue of the stigma of a criminal record that creates significant barriers as it relates to access, to stable housing and employment opportunities. Currently the round table is focusing on three primary areas of need of people who reenter from our jails and prison.

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Housing, employment and behavioral health services. And we are also currently working on a women's re-entry initiative dhs satisfiesing available services targeting at justice involved women and we will be issuing recommendations soon to help improve access to the services for the population. We know you have limited time today and so we didn't want to bring any specific policy recommendations. We just wanted to make sure you knew about the round table and that it has a strong collaborative body to it and it's very important to recognize the impact of criminal background barriers are having on a wide swath of our vulnerable populations that you've talked about over the past few weeks. We know that successful re-entry and integration benefits our entire community. It keeps families stable, it leads to saver neighborhoods and it reduces the need for public assistance. So we just simply ask that you keep us in mind as you have these conversations and invite us to participate in helping you talk about issues impacting re-entry. >> Councilmember Houston. >> Houston: Still haven't gotten the hang of it. Thank you, Ms. Gray for that information. Do you know anything about the cost of housing prisoners in our criminal justice system or -- >> It varies because the criminal system includes the Travis county trail attend you have state jails and prisons. >> Houston: Let's talk about Travis county. Do you know what that might be. >> I have the state Numbers, not the local Numbers. The average daily rate is around $45 a day. The number that we've looked at with a lot of intensity is around those with special needs and higher needs. So people with mental illness or physical health issues, those are the ones that are

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starting to cost on an average about $150 a day for those kinds of services. In fact, a recent report that was released last week shows that the Travis county jail is reporting 100% increase in the number of people that are receiving mental health services on a daily basis since 2002 in their jail. So the mental health issue I know y'all heard a lot about in the intersection of how the jails are becoming the major provider foremental health services is really weighing on the taxpayer as far as what it costs. At the prison level it's the same thing. They can be in general population and the average cost could be 35 to

$40 a day. Again if they go into a higher need category or with treatment that per day cost goes up. But the average as Sheri mentioned is between 35,000 and $41,000 a year to house somebody. >> Houston: Do you know how that compares to how much we get per student in public education? How much it costs to educate a child in a public school per day? >> I'm trying to open my file cabinet because I know there's a number that we have looked at, particularly at the C.A.N. Dashboard. I can't pull that out. I can tell you that the tdcj budget is $1.3 billion. As it relates to funding that is begin like the city the bulk of a state funding strategy. >> Houston: I ask that for two reasons. One is to see the comparison. The other is when people come back to their communities they also cannot get education. So it's not only housing. >> Zimmerman: I'm curious about what you said about criminal backgrounds. I'm very concerned about people that have been put into prison and they get stuck with something on their record that

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then prevents them from getting a job. And so has your group looked at you David Simpson put in the legislature to decriminalize marijuana use. So that could greatly reduce the prison population. And have you looked into that? Have you got any policy observation on the war on drugs in general? >> Yes. The most -- highest percentage of people from Travis county going in to correctional facilities is around drug related offending. It's not violent crime. I think you've seen the data that our violent crime has gone down significantly and as a result the majority of the people that are going to prison, even across the state is all related to drugs. The types of policies that we're looking at are things like adoption of what has been the call to ban the box, but now we're calling second chance employment strategies which the city and county are the only jurisdictions in Texas and is leading in that area, which is reducing that on their skills and talents and to be this criminal background to be later in the process. So that you're actually getting the best person for the job and not screening out people simply because you see that. It's easy to toss that aside and not consider. We're also looking at the eeoc guidelines. There are new guidelines that eeoc has put out about hiring practices so it's not looking at having forever look backs, so in other words, never saying never consider somebody that has a criminal record. It's being able to have reasonable look backs and have those like the city has done is attach the look back even tied into the type of job. So if you will be

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working with children your level of look back will be a lot more strenuous than if it's somebody that is sorting books in the background for the library. And I know that is a specific thing that's come up in the past. The other thing we're looking at policywise at the legislature is the -- we can pull all these things in place, but because we have the ability to economically people buy these criminal records and so now

they can make that a commercial thing where they can do your criminal record check for you and so even if you get -- even if you get an expungement that criminal history has been bought into the commercial entities so they'll identify that anyway. So we're looking at ways that the state could actually reduce the look-back period even without criminal records search, not reducing it for law enforcement to be able to see, but reducing it for employers and landlords to be able to see. >> Zimmerman: Mayor pro tem, is that something that you would see the council would pick up as a policy issue to reduce that look-back for the city of Austin to mitigate this problem we've got with people getting one non-violent drug offense and now they can hardly ever get a job again? >> Tovo: I believe the -- what Ms. Gay talked that about as the ban the box initiative was a council initiative. It was an act of prior councils. >> And you're probably doing it way beyond expectations of which most governmental entities do because you actually identify every job has an assessment of what that criminal background looks like. Every job. So when you -- it's not a one size fits all criminal history. I would say because I think you opened the door. There are communities across the United States that are attaching the same policy to your

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contractual providers. And it's something that we have dabbled in having that discussion because that's one way you can influence other providers and other entities to adopt something similar. And we've actually created this year a presentation to go and talk to employers about this kind of thing to start opening that door. >> Tovo: Very interesting. That might be something that one of our committees wants to take a look at, that presentation. Next we will hear from Charlene justice of the central Texas after school network. Welcome. >> Thank you. Good afternoon. My name is Charlene justice and I'm a volunteer with the central Texas after school network. I'm going to give you a quick overview of after school time programs and tell you what's going on in the community to address the issues around out of school time. After school and summer learning programs are providing essential services to students and families who are most in need of support. The need for these programs is especially vital in our low income areas. In Austin we are committed to building the strongest education system in the nation that benefits every child in our community, however low income students simply have feature opportunities to learn than their more privileged peers. By the time a low income student is in sixth grade he or she is far behind her middle income peers and opportunities to learn by 6,000 hours. During the summer poor students with fewer learning opportunities not only don't move forward, they actually experience what we call summer slide. According to research cited by the natural summer learning association, by the time [indiscernible]. They are likely to be two and a half to three years behind academically their middle income peers simply because of the summer slide. The past two years the coalition of individuals has been meeting to

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develop strategies to address this issue and the more coordinated approach. The group represents providers, private foundations, city, county and district staff and other community organizations such as the central Texas after school network, United Way and the E 3 alliance. We've collectively call this initiative schools out central Texas. The coalition for after school and summer learning. Based on our research we know that if you're to address out of school time programming in a coordinated systemic way there's some components that need to be in place. We need to find quality standards and good professional development and training to support those standards. We need to support that success and a strong data collection infrastructure to evaluate programs and improve services and we need a strong intermediary organization to order coordinate the citywide strategies to build this system. Three committees in place that are aligned with these three components. The quality committee, and this committee is charged with developing and supporting the implementation of standards, reinforced by cultural of improvement training and professional development. We have an outcomes committee and you heard talk about this earlier. She's chairing that committee and she's with Austin ISD and the ready by 21 coalition. And this committee is charged with building agreement on student system and system level outcomes in developing a process to track information and share data. We have an identification and selection committee which I chair and it's charged with assessing the functions needed for a coordinated entity in selecting an organization that is best suited to fill the rule through transparent and inclusive process. [Buzzer sounds] So by working together we think we can serve more students in a more cost effective way and we think coordination is important because we know resources are scarce. Thank you.

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>> Tovo: Thank you for your longer presentation on a related subject at the joint subcommittee of the city, county and aid that councilmember troxclair, councilmember Houston and I serve on. If you're interested in this topic, those are archived meetings and available online. I would commend that particular presentation as well as the others for further information. Our next speaker is going to be Angela Joe Medina of immigrant services of Austin. Welcome. >> Thank you. My name is [indiscernible] And I'm the chair of the immigrant services network of Austin. Founded in 2003, it is a working group of over 30 diverse community stakeholders and immigrant service providers that operate together to coordinate efforts, increase public awareness and inform policy in order to better serve the immigrant community. We offer a forum to address a broad range of immigrant issues. We are a non-political, neutral convener where all parties can engage in dialogue. We're inclusive in membership and scope, which means any person or organization who embraces our values platform has a right to participate. And by this what I mean is that our values platform is that we respect the dignity and humanity of all immigrants regardless of status. It promotes the wellness of immigrants to ensure the wellness of the entire community. Since 2007 we have taken the lead role as a planning and action body to address

immigrant issues in austin-travis county. Many of the issues that have been mentioned throughout today's session cross pollinate with the issues the immigrant community faces. Although there is the challenges and the barriers that are faced are probably compounded by linguistic barriers, cultural barriers, documentation barriers, the fact that there is a lack of trust in many cases on behalf of the immigrant community towards authority for a variety of reasons, whether refugees arriving from third party countries where they've been persecuted by authorities or whether they're

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individuals that are in this country undocumented and they're not aware of what their rights and responsibilities are. To that effect we have worked -- actually, I'm going to highlight some of the things that isna has worked on in the past to address some of these gaps that might exist. In collaboration with the Austin police department we developed the refugee and immigrant safety education program where law enforcement goes out and talks and teaches immigrants and reaches them through service providers in the community to inform them of what their rights and responsibilities are to help build trust and facilitate the process of community policing. We've also -- we also created a family safety planning toolkit and this is a PDF toolkit that families can use that's available both in English and Spanish in times of crisis or emergency. It's also available in case of mass deportation where families are separated so people can plan for that. Isna holds quarterly meetings where we address a variety of issues. We bring together the stakeholders to discuss what initiatives they have underway, how we can work together, what provide immigration I am dates. We frequently have United States customs and immigration services come and speak to us about changes in policies. And we also publish a monthly newsletter which I will take the liberty about e-mailing you all to. In terms of -- [buzzer sounds] Wow, that was quick. >> Tovo: Feel free to finish your thought. >> It hasn't been mentioned as of yet is isna son convened an unaccompanied children's taskforce to address the needs of 477 unaccompanied children placed here, that have been placed here as of January 2015. These children are

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generally central American children fleeing from a crisis over the summer. Over 20% of these children are receiving post release services from the office of rejew gee re! The additional 80% are receiving no services at all. So we -- that's one thing that -- a very important gap that we are seeking to address right now. >> Tovo: Thank you very: And Richard franklin, thank you for sticking around from our morning to our afternoon session. We appreciate you being here. Mr. Franklin is a member of gray panthers. >> I am the convener for the gray panthers of Texas. I'm also the CEO and president of youth unlimited, a group motivational program for young men and young women that forces them to recognize and

increase their value to themselves and their community. The gray panthers is an organization that is intergenerational. If the young people get lucky and really, really lucky they get to be old and wise. And it is a unique position to be in this position, juxtaposition myself with all the things you're talking about right now. I keep hearing people talk about addressing problems, but not solving them. Councilmember Zimmerman. I do believe we can get rid of homelessness and a bunch of the other things that we're talking about right now, but not by continually throwing money in the wrong directions. It has to be -- it has to be used in a proper fashion. I had a conversation a young man for lunch today who doesn't have a job. The first thing he told me was, man, I got through school and now what? I had another gentleman who said the exact same thing to me. I have kids who don't know what to do once they graduate from school and by the way, I can tell you having been a school board member myself in del valle, the Normal school year for a kid is about $5,000 per child. 5,000 # hundred, up to $13,000, depending on what the weighted

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average amount is for each child. These children wind up here after 12 years and not have anything to do. We don't teach them how to become entrepreneurs. We try to get them to pass to test to get out of school for 12 years and don't address the fact that they didn't get a quality education that forced them to be entrepreneurs and business owners and understand how to make something for themselves. If you want kids to stop self-medicating, which is what they're doing with drugs, then you have to understand they have to have something else to do. Two of the kids who out of my program went directly into selling drugs out of school because they had nothing else to do. They were no other jobs out there. They said they could not find employment. I'm talking about a mcjob. At some point in time we have to realize what we're doing to ourselves is going in the wrong direction. It is a boleti continually defeats itself. If we don't address the issues when they're young, especially in the age group when they realize they're moving away from mom, they're moving from home, starting to look to the streets for role models. Then we continue to have the same problems we're having right now. They don't know what it means to be a business person. They self-medicate. Then we start tying to the fact that self esteem is tied to the fact of whether they can get a job or not. And the kids start experiencing depression and that's where the medication comes in. We have kids getting fat behind stress not getting jobs. All these things tie in together. The problem is we don't see them. We see them in silo processes. My primary kids in my program are Latino kids. We've got real issues out here that need to be addressed in a fashion that solves the problem, gent just address it. [Buzzer sounds] We have to stop paying. >> Tovo: Thank you very much. Mr. Zimmerman? >> Zimmerman: Yeah, one quick comment on that. I'm going to be 55 years old next weekend, this coming weekend, and when I was about 5 years old, I think it was Lyndon Johnson

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started his great society, 1965, and they started this massive new welfare system that we're still in today, and some people estimate we -- United States government, national, local, we've spent somewhere around a trillion dollars, right, trying to solve chronic problems of unemployment, homelessness, all the societal ills, remember? We were going to fix all these societal ills back in the 1960s. And depending on how you carve up the statistics, most people say we're pretty much right now in terms of overall poverty and homelessness, we're pretty much where we were back in 1965, a trillion dollars later. So that's where my skepticism comes in, that the money hasn't been spent right, we can do better things with it or we need to spend more, try something different. You know, we've tried this for a generation, more than 50 years, and we're kind of where we started. Yeah, but I get your feedback to that. >> Yes, I'd like to address that specifically. I do believe that in most cases there is the idealistic mind-set when people start without understanding they're on the wrong track at the beginning. The doctor stated it's not good enough to work hard, know what to do and then work hard. Oftentimes we're on the wrong track from the beginning. The welfare state should have been -- we should have been creating entrepreneurial mind-sets in the beginning, not we're giving you money and see what you do with it. That doesn't work. It should have been tied to an entrepreneurial mind-set in the beginning, talking about business ownership. No one came to this country to vote. They came here to make money. Let's talk about that in a realistic fashion. So what we've done is we want everybody to go out and vote without understanding that politics is controlled by money, not the other way around. Get on the right track. >> Tovo: Other questions for our panelists? Other issues any of you would like to discuss related to this topic?

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Okay. Well, thank you so very much. We appreciate your participation, and if there is -- are -- if there are no other questions -- ah. Thank you, that's a good suggestion. We do have an agenda -- a place in the agenda for staff to provide any additional feedback or to answer any questions that arose earlier, so since we do have a few minutes until we're scheduled to adjourn, I invite any of our staff, if they'd like to make a comment, to please come up to the podium and address us. >> Just briefly from this morning, we didn't have the opportunity to really respond in terms of this feedback, but briefly I would just like to say that the department is engaged in working through a partnership to address the issues -- many of the issues that are here in our community today. It will take the support of policy makers like yourself to be able to help us to implement these things. We recognize what the data says and we're in the process of trying to address those things. But we have to be -- we have to have a partnership in doing that. And certainly as it relates to health & human services, the resources necessary, the support from a policy point of view are going to be the types of things we'll need. Over the next year or so as we go through the budget process and as we go through the policy development process we ask your support as we use the information that's been shared here in the deep dive to help make the case for the health &

human services issues we'll bring to the council. Thank you very much. >> Tovo: Thank you very much. Council member Houston? >> Houston: And I want to thank everybody for being here today and for providing the information, and just when you called my name, mayor pro tem, it just left me just that quick. [Laughter] Isn't that interesting? >> Tovo: Perhaps it will come back to us.

[2:19:09 PM]

Ms. Hayden, were you hoping to make a comment too? Okay. Well, without further ado, we again extend our great thanks -- >> Houston: Oh, oh, I got it now. I got it now. I think -- I think one of the things that was very helpful is that we were able to see today in our panel how accommodations and assistive devices are able to make people productive, and I was hoping that everyone saw how beneficial that is to have the Americans with disabilities act so that people can participate in the process and do a very great job in doing so. Thank you for allowing me to get my brain back. >> Tovo: No, thank you. Excellent point. All right. Thank you so very much.