Health and Human Services Committee Meeting Transcript – 3/09/2016

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>> Good afternoon. I want to thank everyone for being here. Unfortunately, we do not have a quorum, so we can't start yet. So if you'll just either get your parking ticket validated so that you don't have to pay. Who has the -- young lady right there has the magic stamp, then we can do that while we're waiting for at least one other councilmember to come, and then we'll start. Thank you for being understanding.

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>> Houston: Good afternoon. My name is councilmember ora Houston. We have a quorum present. I am calling the meeting of the health and human services council committee to order on Wednesday, March 9th, 2016. We're meeting at the council chambers, Austin city hall, 301 west second streeted, Austin, Texas. The time is 2:11. For those of you all who just came in, if you've not had your parking ticket validated, please do so before you leave, because parking is free. The agenda is -- hopefully, everyone has a copy of the agenda. If not, there should be some extra copies over here by the lady that's standing up with the pretty burgundy on. [Laughter] >> Houston: The first item on the agenda is to approve the minutes from the January 13th meeting of the committee. I'd like councilmembers to please take a moment to review, and I'll entertain a motion to approve. >> Tovo: So moved. >> Houston: The minutes of the last meeting. There's motion to approve. Is there a second? There's a second. All in favor, let it be known by saying aye. All opposed? It's unanimous on the dais. Next we have citizens communication. The general topics, this is for things that are not on the agenda, and we have two minutes to communicate with the members of the committee, and we always have time to hear at least 10 speakers. The only one I see today is Mrs. Hudson about -- who wishes to speak. Mrs. Althea Hudson, or is it Houston. >> Thank you very much. As you said, my name is

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Aletha, hudso, I am here representing the city of early childhood council and I wanted to call your attention to a wreck men daition that the council sent last October to the city concerning a continuity of childcare funding program. Some of you have already heard about this. And we haven't managed to make your agenda yet, so we wanted to just call your attention to it and alert you to the fact that this is a very important program. Low-income parents face a catch 22 dilemma. In order to get a job, they have to have childcare, and in order to get childcare funding, they have to have a job. When a parent loses a job or when they leave job training, they lose their federally supported funding for childcare. And Travis

county began a program a couple of years ago titled continuity of care which provides interim funding for childcare subsidy -- [lapse in audio] -- Then they can resume the federal childcare programs. Travis county ran a pilot program and found that of the people coming out of job training and who needed jobs, 84% of them got jobs within the 90-day period, so they were able, then, to maintain their funding. We think this is an excellent city investment, because it enables families to be self-sufficient, it's a two-generation program trying to attack the causes of poverty. It maximizes the return on investment from job training, which the city spends a lot of money on, but it also requires parents to use quality childcare, so it promotes the development of children and school readiness program -- school readiness of our children, and also maintains continuity, so the children aren't bumping in and out of childcare all of the time. So we hope you will consider our recommendation and pass it on to the city council.

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Thank you. >> Houston: Thank you. Are there any questions? >> I wanted to comment, I will be bringing an ifc to address this and ask the city manager to prepare an item for us to consider during budget to fund this. I think it's -- as someone who has a child in childcare, and that was sick last week, you know, having to -- having to juggle a child, I can't imagine if, you know, when a parent loses a job and having to twrie to find a job in addition to having to go to interviews but not have childcare. But I will be sponsoring an item and I'm happy to ask any of my -- my cohealth and human committee -- health and human services committee to be part of that ifc. >> Thank you very much. We have been trying to talk to each of the councilmembers about this program, and we're happy to do so again. >> Houston: Mayor pro tem. >> Tovo: I wanted to ask you a couple questions that you asked us about it. How did they arrive at that number? I guess I'm wondering since you're asking that the city of Austin do 500,000 -- >> That's right. That's the estimate of what it would take to even begin to serve the need. What they found when they started opening this to up front people coming out of job training or just needing jobs was that they were swamped, so that there are a lot of people who are applying for this program, and they don't -- they can't serve all of them. I don't know how they came up with that particular number. They actually put in $500,000 the first year. >> Tovo: Travis county did. >> Yes. >> Tovo: And what year was that? >> 2014. I'm not sure fiscal year, roughly. It's been going about two years. >> Tovo: I would like some more information. I'm real interested in

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understanding what the history of funding is. And if there's a total cost, can we -- do we know how many -- how many of the participant tion are coming out of the Travis county versus the city of Austin and would it make better sense -- was Travis county, for example, interested in splitting the cost of it. I mean, it looks like it's been allocated differently, and I'm not sure from the 500,000 ask from the city and the 240 of the county is reflective of those different participation rates, but I think that's certainly something I think our colleagues would have questions about. >> They're of course covering people from the city as well as people from outside the city who are from the county. >> Tovo: I'm trying to figure out if the total cost is 700,000, why is the proposal to allocate it this way. I just need to understand that. >> So you'd like to know what -- you'd like to know the allocation between people who live in Austin and people who don't, and also how they came up with that number and what -- what the need is, is that -- >> Tovo: I think you are speaking to -- yeah, that's -- maybe we can correspond via e-mail. >> I'll be glad to do that. >> Tovo: If that's a better -- an easier forum, but I think that -- in terms of the allocations, I'm trying to understand why the early childhood council came up with these suggested allocations of 240 for Travis county and 500 for the city of Austin. Is that based on past participation rates or where they're seeing the need... >> Okay. I'd be happy to correspond with you about that and

get you some more information. >> Tovo: Super. Thanks. And, too, I think, if we're going to make a request of the council, that they include 500,000 in the budget, I think we do need to be able to speak to the need, as you said. >> Right. >> Tovo: The fact that the slots were taken very quickly, that some sense of the Numbers there would be useful, too. >> Yes. >> Tovo: Thanks very much for being here to advocate for this. >> Thank you very much. >> Houston: Thank you. Mr. Jones -- no, I have a question for staff, please.

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Mr. Jones, in the letter that we received, it says 500 -- invest $500,000 out of unallocated health and human services dollars. In the continuum of care program. Do we have $500,000 in unallocated funds? >> No, councilmember. We don't have 500,000 in unallocated funds. We're currently in the process and we'll be coming to council shortly for the recommendations of the 1.8 million that was part of the social service contract. Those have been identified the strategy for that. So we don't have that currently in our budget. We are, as councilmember Garza had mentioned earlier, certainly as part of our next year's budget, we'd be more than happy to consider those kinds of things as things we consider as part of the process, but currently we do not have that money in our budget this year. >> Houston: I just wanted to make sure that -- Garza may I comment on that? When. >> Garza: When. >> When we made that recommendation, we thought those funds would be available, but we found out later that they would not be. So the request really is to fund this program through whatever mechanism it's possible to use. >> Houston: Okay. Thank you so much. Now, we're happy to have -- one of the things that we're doing as a part of the health and human services council committee is to try to bring all of our partners in who have something to do with central health, Seton healthcare, the Dell medical school, and so today we're happy to have dean clay John ton, who is going to -- Johnston who is going to give us an update on what is going on at the Dell medical school. >> Thank you very much. It's a pleasure to be here. Thanks for having me. So the vision, the mission of the Dell med school has not changed since I've -- I last stood before you, so

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we're very much focused on a long-term goal of making Austin a model healthy city. And the vision of the school is to create a vital and inclusive health ecosystem. And in doing this, we're trying to think about what role a medical school should play in that ecosystem. And really trying to reevaluate the appropriate role both in terms of partnering with existing organizations, like the city and countsy, like central health, as well as enabling other nonprofit organizations that economist in the community to rise up and solve health problems for communities. That vision is unique, and that has been great for recruiting really wonderful people into the school, so we've recruited a number of leaders. We have our first department chairs almost completely identified and here, or arriving soon. And we have some great faculty leaders from across the country. The sorts of people that we're bringing are -- are innovators that have thought deeply about how to provide cared better. Some with a little more emphasis on research, some on a little more emphasis on population health, but representing interests and really ready to take ad van tanl of what is unique -- advantage about what is unique about Austin, about the opportunity that's been created for us here. Our students are going to be terrific. We had 4,500 applicants for our 50 slots, and we have identified the 50 that are -- that we're targeting. And many of whom will be here soon, and they are terrific. We used different criteria for students, it's not just the nerdiest nerds, we didn't have any trouble

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selecting out the nonnerds. What we were really trying to select out were the people who had communication stills that were greater, had potential for leadership experiences that suggested a real passion for -- for improving health. And that's what we got in the students. We can -- we'll be able to start talking about the students soon, but we're not quite able to do that at this point. The students will arrive for orientation in late June, so not long. The first building is our education and administration building that's going to be called the health learning building, and that is directly across from Breckenridge hospital. It will be open in early June. We'll move in in early June, so just before the students arrive. The other two buildings, one that's focused on clinical care and outpatient clinical care building and one that's focused on research will -- [lapse in audio] -- The clinic's building, because of all the work that has to happen inside, about nine months after that, around the same time that the hospital opens. In those buildings, they're pretty much on schedule, in spite of the rain, and on -- at budget, so we're good there. As we think about where to concentrate early efforts in terms of services, we've been focusing on what the most urgent needs are for this community. We've worked very closely with central health to look at areas of greatest need. Those areas include access to specialty care and that, I think, has been well vetted in the press. And so that's one of the places where we're focusing

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some initial attention. So we hope to -- you know, none of this stuff's easy, but we hope to develop new plans around specialty care, domain by domain, and we've been recruiting in the right people to lead that, and joint pain is going to be the area that we do that in first, and then soon after that, or maybe around the same time, women's health in organizing access to women's health and making that -- creating a stronger system that reaches into prenatal care more than our current system does. If we're going to make Austin a model healthy city, the most important way to achieve that is to address disparityies. Healthcare for those with insurance is actually quite good in Austin. Healthcare for those who are not as fortunate is not as good. It's not just in the delivery of care, it's in the way we take care of people before they get sick. And so we're addressing that head-on to say, okay, where are these -- where are these opportunities again and how do we bring in the partners who are currently patching folks up that could have been cared for much more efficiently, effectively, humanly before they got sick. How do we bring those partners who were dealing with those consequences, that includes the city, the county, the prisons, police, as well as the hospitals and central health, how do we bring them together to move the dollars to where they can more effectively and efficiently be used to keep people healthier. Those are complex discussions, as you might imagine, but I think everyone recognizes that the current system is not sustainable, nor is it optimally matching what

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society would like from the healthcare system. So we'll continue to have those discussions through this year. Again, these are complicated things that we're asking to do, because we're basically requesting that money spent one way gets spent a different way, but, you know, we're willing to step up as well and take risks and say, okay, if we didn't save money and produce better health outcomes, and we're one of the partners in that as well, and have that impact the way that -- that, you know, we participate and that we're reimbursed for additional activities related to that. So that is a very quick update on where we are, and I'm very happy to answer any questions you may have. >> Houston: Thank you so much, dean Johnston. You will probably hear last year, I -- you were probably here last year, I think. Could you remind us where you came from before you moved to Austin to take on this roll. >> Sure. Yeah, I've been here for just over two years, and I came from San Francisco before I was here. >>

Houston: Okay. >> Yeah, I was at the university of California San Francisco, and I led the center for healthcare value and the stroke service, and also was associate vice chancellor for research. So I'm a stroke neurologist. >> Houston: Thank you. Any questions. >> Tovo: No, I'm excited. Thank you. >> Houston: Well, I actually have some. >> Okay. >> Houston: On the front page of the paper today was an article about the teaching hospital cost rising. That may not be you, because that may be Seton, but how -- again, I'm trying to understand the financials of this very complex and complicated -- >> Very complicated. >> >> Houston: -- System. >> Yes, ma'am. >> Houston: So will this increase have anything to do with rising taxes for the citizens of Travis county? >> No, the hospital and the hospital costs are Seton's

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burden. So, you know, it is -- [lapse in audio] >> Houston: Okay. >> The relationship between Seton and central health, in this formation of the CCC -- >> Houston: So tell everybody that's watching on television what CCC means. >> Yes. Ccc is community care collaborative, it's the entity that is acting as the primary safety net in Travis county, and in that, there's an agreement about who's responsible for which activities and a sharing of costs and responsibilities associated with the delivery of care. And this is part of Seton's half of that. The contribution that Seton makes in this partnership. They agree to provide some other aspects as well, so, you know, they agree to provide ongoing support for the education of our residents, so after medical school, you go to -- you become an intern and a resident, and so they agreed to cover those costs as well for this community, and then they bear costs for the direct provision of care for the indigent that happen in the hospital and around specialty care. And central health picks up the rest, provides some support to Seton for some aspects of care, but also provides some support to St. David's. St. David's also provides indigent care that's unfunded as well. But is not currently a member of the CCC. >> Houston: Thank you. And one last question. Is the medical school on target as far as the budget goes, because that does

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impact Travis county residents. >> Yes. Well, we're going to make sure -- well, that it doesn't impact Travis county. Our -- the monies that we get from Travis county, it's a fixed dollar amount, so, you know, it's $35 million a year, and that -- for each taxpayer in Travis county goes down every year, because more and more taxpayers move into Travis county, and it goes down as a percentage of property values, because property values are going up. So, you know, that -- the way -- we have no intention of coming back to the taxpayers of Travis county to request additional tax fees. >> Houston: My colleagues would be happy to hear that, and I'm sure the taxpayers would be, too. Thank you so much for coming. Periodically, we'll have you come back again and tell us who the 50 are and when they're starting and maybe meet them so that we know who that this new crop of creative innovative healthcare technicians will be once they get on the ground. >> Well, thank you very much. >> Houston: So thank you so much. >> Look forward to introducing them to you. Yep. >> Houston: I now have on item no. 4 is the staff briefing and update on the city of Austin's equity office. Thank you. >> Good afternoon, madam chair and committee members. I'm ray ber chief of staff in the city manager's office and today I'll be providing you with an update on staff's process with the equity office. Let me just say at the out set that those of us who are working on this project are very excited. Of what we believe this office will bring not only to our organizations, but also to our community. So to let you know that because we're working as fast as we can to make this a reality. So let me first begin with a little bit of history. If you'll remember during the budget development process last September,

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council, upon the recommendation of the hispanic quality of life commission, approved the creation of an equity office and allocated $183,000 in funding from the fiscal year 2016 budget. Soon after council's action, the city manager appointed a four-member project team consisting of two assistant city managers, the city attorney and myself as chief of staff to research and assess equity practices in other peer cities and recommend a timeline and resources that would be needed to create this office. In addition to attending the equity summit in Los Angeles last October and interacting with leading experts in the field, the team conducted a review of the nine largest U.S. Cities with equity offices, which included a methodology for assessing the peer city information we had gathered. Our methodology very briefly called for a survey of equity offices in -- [lapse in audio] -- Websites, their funding streams, their publications, their org charts and the services that they provide. We also conducted a broader search of equity offices in cities smaller than the top 25. And once we gathered all of this information, we selected the most promising offices, and then interviewed them by either phone or by e-mail. And what we learned from our research is that very few cities have fully developed equity offices. In fact, we only found four. Seattle, Portland, Washington D DC and Toronto. There's a growing trend, especially in the past year with creation of offices in Boston, Tacoma, Minneapolis, and our neighbor to the south, San Antonio. You can also now add the city of Oakland to that

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list. They're now in the process of creating an office, just like we are. What we also found in our research is that most existing offices tend to report directly to the city manager, although in a handful of cities, these offices do report to the mayor, like they do in Washington, D.C. And in Seattle. On this next slide, we provide some of the key information that we were able to capture about each of the nine offices we interviewed. I know it's a lot to take in, there's a lot of data there, but there are three key takeaways that I want to bring to your attention. First, you can see that the four offices above the black line provide a broad range of services in their organizations and to their communities. This includes advisory or consulting services on equity and social justice issues to city departments, they also provide education and training. Some even provide an online dashboard for the reporting of equity outcomes. Second, most equity offices, except for Washington, D.C. Average six to seven employees with an average annual budget of $1.5 million. And, third, while equity offices are rather rare, you'll see that in some cases, they've existed as far back as the 1960s, in this case San Francisco. So as we learned about what it takes to create an equity office, we realize the need for experts in the field of equity and social justice to help us, guide us in our work. So in the past few weeks, we finalized the hiring of two consultants, first we hired the Hawkins company, an executive search firm with extensive experience in hiring talent to -- related to diversity and equity issues. They'll be assisting our human resources staff in the recruitment of the chief equity officer. Most recently, they led the successful recruitment for the equity officer for the city of Oakland.

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The Hawkins company is a national leader in diversity hiring, equity and social justice are core values of the firm, and 75% of their executive placements are either gone to women and/or people of color. The second consultant that we've hired is the government alliance for race and equity. They're a national organization that focuses their equity and social justice work at the local government level. They currently have over 100 members, mostly cities, in over 30 states across the country. And their leadership was instrumental in the foundation -- or in the founding and formation of the office of civil

rights in Seattle, which is considered the municipal model when it comes to equity office programs around the country. So as we move forward in creating the equity office, our work is going to be moving in two parallel but collaborative tracks. In fact, because of the expertise of our two consultants on equity issues, we've set it up so that they're partnering together to share information. They've integrated their timelines and deliverable, and they're collaborating on a community engagement strategy as well. And you'll see on this slide that I've underlined the words "Equity assessment." I just want to mention that this work that they're going to begin, it's part of their initial work for the city, is going to involve an inventory of the city's current equity practices, which will help to identify any gaps that we might have. And the deliverables that we've also sent the contract with the government alliance race and equity includes concentration on a city wide internal equity tool. On this next slide I've provided the timeline for the equity officer recruitment. You'll see that this month we're kicking off the recruitment process. In fact, the Hawkins company has been here since Tuesday, here at city hall, and has been meeting with the city

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manager's executive team, various department directors, and they've also had an opportunity to meet with the mayor and several councilmembers today. [Lapse in audio] Town hall meeting that we're scheduling for April. We anticipate having the job profile for the equity officer finalized later that month in late April. And then we'll advertise it nationally. In may, we'll have the pre-screening of job candidates with finalists selected for in-person interviews. And those interviews will occur in earl will I to mid June. And finally, it's our goal to have a final candidate selected later that month in the late June time frame with the onboarding -- [lapse in audio] -- Here on this slide, I've provided the timeline for the equity assessment that will be led by the government alliance for race and equity. One of our first tasks, which is set for early April, is to create an internal equity core team with representation from every city department. This will also include representation from city council offices. The core team will serve at the primary departmental contact with the equity office. And in some cases, the way it's been described, is these are the early adopters, these are the change agents. They're going to bring the equity work into their respective departments, and they'll be doing that under the supervision of their department directors. You'll see that we have equity workshops planned for city leaders and staff in early April, with a town hall being scheduled for mid April to collect feedback on the public's vision for the equity office. In may, the government alliance for race and equity will survey city employees to assess their understanding of equity issues, like institutional and structural racism, as well as their knowledge on the extent that their

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respective departments are building equity into their programs, policies and budget decisions. That data will be collected and will help our consultant in drafting short- and long-term recommendations. The government alliance race and equity will then gather that feedback, an additional round of feedback from staff, the community and council, and they'll integrate that into a final report with distribution of that report scheduled for mid June. I do want to emphasize that a primary driver of success is, as we develop the equity office, is acknowledging the need for a robust community engagement process. It is staff's goal to include as many community voices in this process, and we've -- we've endeavored to provide you with a list of stakeholders that we've identified so far. I don't know if you have a copy of that, but as you take a look at that list of stakeholders, if you see some that have not been included, if you will let us know, that would be very helpful. I know that right now with the adoption of the resolution having to do with food access last Thursday, we're also trying to bring the food access

community into that stakeholder list, so we want to continue building on that. We're planning for multiple way force the public to get involved and the government ally rans -- alliance for race and equity is going to help us build,s as I said, the engagement strategy, along with a possible partnership with the university of Texas, which we'll be pursuing along with others. And I wanted to emphasize, even though we're looking at national best practice, we're not going to be importing the Seattle or Portland program here to Austin. Our goal all along is to create an office that is tailored specifically for our community. I know there's been some interest in moving forward with an equity tool, and we're working with the government alliance of race and equity to do just that.

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For those who want to know what this tool looks like, I didn't know about it until I started getting involved with this issue, but it's basically a set of questions, and sometimes these questions are self-reflective, that you pose at the point where policies, procedures are being modified. And in its sim lest context, they involve questions like what are the equity impacts from a new or modified program policy or budget decision. Who's going to benefit or be negatively burdened by that decision. And finally, have you put into place strategies to mitigate any unintended consequences? So these questions are going to help to provide us with a structure so that we can operationalize or institutionalize the consideration of equity in city operations and policies. And finally, while there are equity tools that we can borrow from other cities, it's our goal, again, to customize this specifically and exclusively for Austin. Madam chair, committee members, that's the end of my presentation. We do have staff from the human resources department to answer any questions you might have about the recruitment. Health and human services staff is also here as well, and with that, thank you. >> Houston: Thank you so much. Councilmembers, are there any questions? Councilmember Garza? >> Garza: Yeah, we met with the Hawkins group yesterday. I appreciate the opportunity to provide our feedback. And I voice the same concerns with them regarding the timeline. I know that the are group is -- is also going to go out and seek community input and stakeholder group input. >> That's correct. >> Garza: But I'm not clear on the timeline of when the actual drafting of the job of -- [lapse in audio] -- because I'm concerned if there is no stakeholder input before any drafting of

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the job description of the equity officer, we could be setting ourselves up for failure if the community doesn't feel like they had input into that job description. >> So my understanding, councilmember Garza, is that both gare and the Hawkins group are going to be reaching out into D -- the community even before we get to the community or tawn hall meeting in -- hown hall meeting. >> Garza: Before the job description is created. >> Oh, absolutely. Absolutely. Absolutely. >> Garza: I said this to them, too, but I just want to say, I think it's very important. They were so impressive when I met with them yesterday, understood the issue very well, but there's always concern when it's an outside group coming from, you know, New York City -- >> Right. >> Garza: I know they're not from New York, I think they're from L.A., but there's always concern when you have an outside group coming in. >> That's correct. >> Garza: -- Addressing an issue so sensitive and so important to many minorities here in Austin, so I just want to also express it would be great if they could meet with all the quality of life commissions that we have, because I think it's important for them to understand the history -- the race history here in Austin. I think that would greatly inform their work. >> That's a very good point. Absolutely, we'll do that. >> Houston: I have just one question. I didn't get the stakeholder list that you sent. >> We have it here, and we'll just give it to you now. >> Houston: Yeah, that would be helpful. >> Absolutely. >> Houston: And thank you for the report. What I would like to ask you to do, if you could send that, and the stakeholder

listing to the councilmembers that are not part of this committee so that they already have this information. >> Absolutely. We'll do that madam chair, absolutely. >> Houston: Okay. Thank you so much.

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And now we're going to have a staff briefing on the zika virus, and I'll ask Mr. Shannon Jones director of health and human services and Dr. Language to come up up -- Dr. Lange to come up and tell us it's getting scarier and scarier every day. >> Yes, Shannon Jones. Dr. Phil Wong will give you the overview but we want to remind you as we're responding to zika, we're also responding to all kinds of vector-born diseases in our community and we want to encourage the public, as Dr. Wong will indicate, whether it's zika, whether it's chikungunya, whether it's west nile, that we need to be addressing those. So his overview will be on zika virus but recognizing some of the strategies we incorporate here, we incorporate with all of our areas as well. So Dr. Wong. >> Phil Wong, I'm -- >> Houston: Thank you Dr. Wong, I don't know where my head was at that moment. So thank you for being here. >> Great. My pleasure. I wanted to first start out with just background on the history of the zika virus. It's actually been around since 1947, it was first discovered in the zika forest of Uganda in a monkey, and since then up until before 2015, the virus outbreaks have actually been primarily in Africa, southeast Asia, pacific islands. But then in may 2015, and I apologize, we missed this acronym. We saw it but we thought we changed it. Pan American health organization, paho, issued and alert regarding the first confirmed zika virus infections in Brazil, and that was in may of 2015. So now currently outbreaks are occurring in many countries and territories. And in February of this year, the world health organization declared an international emergency

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because of the concerns. I'll talk a little bit more about that in just a few minutes. In the continental United States, there has not been any local vector-borne transmission of zika virus, meaning where local mosquitoes have been infected and caused infection in citizens. So -- however, as of -- and these Numbers are constantly changing, yeah, but March 2nd, a total of 153 laboratory-confirmed travel-associated zika virus disease cases have been reported to the CDC. From 29 U.S. States. And in Texas, there are now 15 -- or actually, now, I think that's now 18 zika virus disease cases. So if you look at this math, that shows -- [lapse in audio] -- So primarily, central, South America, Mexico, also like U.S. Virgin Islands, Puerto Rico. And one thing about zika, it's a different type of mosquito that transmits this. It's the same as transmits chikungunya and dung irks -- dungi fever. But in particular, adees egyptty, they're more efficient as spreading it among humans. They like to live in and around houses, so they're actually also rest indoors in dark places, in curtains, underneath tables, things like that. So one implication of that is, you know, when people talk about spraying campaigns and things, there really not as effective as this type of mosquitoes. Another difference is that they're actually aggressive daytime biters.

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They can also bite at night, but they are primarily in the daytime. So typically we give the message dusk and dawn, but these are also very active during the daytime. This is the distribution of where these aedes species mosquitoes are occurring. So you can see central Texas and Austin is included for both of these types of mosquitoes, so that's why it is certainly of concern. So some of the key facts about zika virus transmission -- zika virus. The transmission, as I mentioned. The aedes species of mosquito bites, that's the primary way of transition for zika. However it can be spread from pregnant mother to baby,

sexual cases, actually one of the cases in Dallas was where they documented a sexual transmission of zika virus. Also anticipated possibly through infected blood products and the fda has issued recommended screening and travel history prior to collecting blood donations. The symptoms of zika virus usual liquor within two to seven days of infection. The symptoms are fever, rash, joint pain, conjuct viet is, or red eyes and also muscle pain and headache. But -- and 80%, or four out of five people, though, that are infected, actually don't even know -- they have no symptoms and don't even know they're infected. So the illness itself is usually very mild, symptoms usually last only a few days to a week. But the main concern, the reason why it's getting all the concern is because of this association among pregnant woman who get infected with this birth defect of microcephaly or abnormally small heads. There's also concern about a neurologic condition where the immune system attacks some of the nerve cells and causes pir ral sis. There are no treatment, no accepted treatment, it's

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mainly supportive treatment for any of the symptoms. So now moving to that concern about the microcephaly, and this shows the rates of that microcephaly, the first picture on the left from 2010 to 2014, that's -- with the purple dots sort of indicate by size the rates of microcephaly that occurred during that period. And the size of the dot, larger dot indicates a larger rate. So you can see between 2010 and 2014, very low rates of that, whereas after then the zika virus local spread occurring in Brazil and those areas, marked increases in that rate of microro cephaly. And there's -- microcephaly. There's growing evidence showing zika virus infection and these birth defects. So CDC has issued specific recommendations for pregnant women. And so at this point, CDC recommends that pregnant women who are considering travel to any of the areas that have active transmission where zika virus is spreading that they consider postponing that travel. Also because of the sexual transmission of the zika virus if they have a male partner who's traveled to any of those areas, that when they return, that they use condoms or abstain from sex during the remainder of that pregnancy. For women trying to get pregnant, they advice that before them or their male partner, to talk to their healthcare providers about their plans to become pregnant and the risk of zika virus infection if they do travel and along with the male partner should strictly follow steps to prevent mosquito bites from the trip. So from a prevention and control standpoint as I mentioned, there's Novack scene to prevent -- no vaccine to prevent zika virus disease [lapse in audio] If you think about it, to protect pregnant

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women from this. You know, the recommendations that we typically -- and so it's to prevent mosquito bieds really. The recommendations that we awld give us the 4-des, dress, to wear long sleeve shirts and long pants, drain standing water, stay in places where air conditioning and fix any tears in window screens, things like that. Use deet or any other epa-recommended insect repel Lents and it should be noted that deet, the epa-approved products are safe in pregnancy. Also the fourth D is, as been typically again dusk and dawn; however, now, we sort of modified it with daytime, perhaps because these mosquitoes do bite during the daytime. Now, one thing during the first week of infection, the zika virus can be found in a person's blood, and then can be passed from an infected person to a mosquito through mosquito bites, so, again, that recommendation, sort of that universal recommendation about protecting against mosquito bites is very important from a couple of standpoints, thus, first, you know, just preventing getting illness, but also someone who's returning, say, from an area where there's active transmission, if they are infected and they come back, during that first week, if one of our local mosquitoes then bites that person who's infected, they -- that mosquito can get infected and then transmit it to other people here, and that's when we actually get local transmission. And that's what

we're trying to prevent. And so the integrated vector and mosquito management, and I'll go into a little more detail of that in a second, are some of the key, again, strategies for preventing this. So the current situation in Austin, Travis county, as of March 3rd, we've sent specimens from 45 persons for zika virus testing. We've had results back from 11 persons, and two of them have been confirmed positive. And both of those persons

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were ill after traveling to Colombia, so they were not local transmission but they got infected over there and then came back and we tested them positive. Nine persons tested negative. Five of those persons who tested negative were pregnant. We still have pending results on 29 persons K and 18 of those persons who we're waiting on are pregnant women to get those -- who reported travel to a country where zika is occurring. Again, there are no real -- there are no reported severe illnesses, hospitalizations, or death related to this. So the activities -- and if you think about sort of where we are right now, we know -- we've had some local cases that have been travel-related, but we know as the weather heats up and we get more mosquitoes, you know, we sort of have this window of opportunity to really do everything that we can to prevent the mosquito population from growing as much -- trying to reduce that population as much as we can. So, you know, activities that we've been doing are general education, we issued and provided information about the travel advisory recommendations from CDC, we've issued general press releases about this, we provided weekly situation updates, sort of updating the Numbers of cases that we've had, and any other information we have a website devoted to this, social media messages, we've been working with our health -- other healthcare partners, other providers with the physician community. We've issued information to the Travis county medical society giving them updates on the is it weighs, recommendations on testing, how they submit lab specimen and guidance for management of pregnant women. We work with them also a as they get patients traveling from those countries returning, we work with them determining if they need lab testing and submitting those specimens with the state health department and CDC. We work closely with the first responders, they've issued information to their staff regarding the zika

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virus, I know they've talked about recommendations for them keeping their doors closed on their units. We also conduct human disease surveillance, again, that's where we're monitoring for any of the illness and conditions of zika infection. Integrated vector mosquito management, that's one of the key things that we need to do and what we need to be focusing right now during this time where we have some cases but before the mosquito population. So the pieces of integrated and vector mosquito management include surveillance, so typically we do start as mosquito season gets underway, we will start collecting mosquito specimens, testing them. Although for zika in particular, it's not as important to get the testing for zika, but seeing the populations of those aedes species, and as we start to get more of that particular type of species [lapse in audio] Preduction, and that's what we're really trying to get the word out about that, to get rid of those places where mosquitoes can breed, standing water, those areas, again, vegetation management, again, getting rid of the sources where mosquitoes can breed, biological controls, we actually do larvacide and put those in areas and pools of water that it would be helpful for eliminating the larva. Chemical controls, bie logical controls, also -- biological controls we see if there are national predators for the mosquito and larva in some of these areas. We had a meeting last week with multiple city departments, parks and rec, code and compliance, resource recovery, Austin water, Austin energy, several others to really try to go -- maximize our efforts at this source control. We know that as the meter readers are out in the neighborhoods, you know, to get them to be looking for

areas where there might be standing water, or old tires

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lying around, again, working with code compliance on really beefing up our efforts with that. We've also been working with 311, trying to, you know, get the reporting so that even staff who see areas of concern report it to 311, and those are then referred to our environmental health staff that can go out and check out, assess the situation and see what sort of measures we can do to reduce the mosquito population. You know, the messaging to staff that we've been working on sort of twofold. One, to the staff that are out in the community to protect themselves against mosquito bite, to follow the four D's, but then also that other piece, to be really looking out for how opportunities for identifying places where there's stagnant water and where we can maximize our efforts to prevent that. So I think that's all I have. Any questions on this one? >> Houston: I have one. How long will the virus stay active once you're bitten if you don't have any symptoms? >> You know, after infection, it's typically out of the blood within seven days, within a week. Now, it lasts longer, now, in semen, and that's what, I think, some of the studies have shown 62 days and even longer, they're still looking at that, so that's -- but in blood, it typically stays around for about a week. >> Houston: Okay. And then is there a way for when pregnant women come into the hospital or go to their primary care physician, how do they test to see if they have the virus? >> So, again, we're working with physicians. If there are women who are pregnant who've traveled to some of these areas with active transmission, then actual actually -- and asymptomatic women with no symptoms that have traveled to that area can come back and we will work with them on getting that testing. So our staff work with physicians on the specimen collections and getting those specimens. And now I think this past week the state health department has the capacity to do some of the testing

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for zika virus. >> Houston: Okay. One last thing, if you all could put some of those suggestions on a -- just one kind of little sheet, and then we could share with the housing authority, all the properties that the housing authority has, so that people who may not be able to go to the website and do all the other things that you referenced, might have something in hand about mosquitoes and how to make sure that they're safe from dawn to dusk. >> Absolutely. We'll get that information out. I should also mention we produced a video, and I know our public information officer working with channel 6, that's very practical recommendations on what to -- places to look for around the house, how to get rid of the standing water, and that's, I think, probably a link on the website, and that information's -- it's going to also be Spanish translation shortly. >> Houston: Great. How long is the video? >> A couple minutes. Two to three minutes. >> Houston: So it's something that we could put a link on our Facebook or our -- >> Absolutely. >> Houston: Okay. Thank you. >> Great. Thank you. >> Houston: Any other questions? I thank think you're up again, Dr. Wong. We have a staff briefing on HIV prevention. >>. >> Okay. Let's see, so I appreciate the opportunity to give the briefing on pre-exposure prophylaxis or prep, and it's an important strategy for preventing HIV in austin/travis county and in addition a new tool we have. So what is prep? It is an HIV prevention strategy, and so it's actually taking anti-hiv medications before coming into contact with HIV. It's a single pill taken once daily, and in 2012 is when CDC approved prep for the prevention of HIV transmission. It's recommended by the world health organization,

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the international society of infectious disease, Texas department of health has come out with supportive

statement and our austin/travis county human services department, certainly supports all efforts to promote this. How effective is it? It's been shown in many studies and real world situations when it's used -- when the patients regularly take the medications, that it can reduce risk of getting HIV infection from sex by more than 90%, and among people who inject rugs, reduce the risk of HIV more than 70% again when it's used consistently. So the guidelines on may 14 of 2014, the U.S. Public health service came out with the first comprehensive clinical practice guidelines for prep. They have -- include recommended prep be considered for people who are HIV negative and at substantial risk for infection. So some of the types of substantial risk include having a sexual partner that's infected with HIV, having had a recent bacterial STD, having a high number of sex partners, history of inconsistent or no condom use, commercial sex worker, if they live in a high prevalence area or network, and then among IV drug users, those that have HIV positive injecting partner, sharing injection equipment or history of recent drug treatment but currently injecting. And there's a whole table of recommendations regarding assessment of that. So some of the key points also about prep is that it is only for people who are at ongoing substantial risk of HIV infection and it must be -- it's part of a comprehensive prevention strategy. We're not saying this is the, you know, end all be all solution but it's part of a broader strategy, that people who use prep have to commit to taking the drug every day and seeing their health care provider for follow-up every three months, and that's an important part of that maintenance and having that three-month check. It must only be prescribed to individuals that are confirmed to be HIV negative

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immediately prior to initiating treatment to make sure that -- because if they did, were infected, it would cause perhaps drug resistance and things. So they test the patient for HIV before initiating prep, at least every three months during use. You know, we're very fortunate with lot a lot of local prep and support for this. There's strong community support from AIDS services of Austin, HIV planning council, many others in the community and we're very fortunate with that. We also have the Austin prep access project that started in April 2015, they opened their first clinic in may of 2015. They currently have three after-hour clinics a week. I think the latest number I just heard a couple days ago, I think 400 patients now seeing their volunteer providers, accessing this medication at no cost to them. And then also other community providers, community care, other physicians are also offering this. But you know what is important? They've also found and reported that insurances are -- seem to be covering this, and when there is not insurance access, the drug company has a patient access program that they've been able to take advantage of to get the patients on the medication. >> Houston: So let me ask you a question right there. How much does this cost? >> You know, it's like a thousand dollars -- but again, the insurances have been covering -- does someone know the latest cost on that? >> Depends on insurance but it would be anywhere from 1,000 to 1500. If you're insured. If you're uninsured (indiscernible). >> Right. And that's a thousand per -- per year -- per month. >> Houston: A thousand per month? >> Yeah. But again, what's been again is the insurance companies have recognized this is a good investment, you know, because if you get an infection then that costs a lot more. One other thing, we do in the upcoming -- I think

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Travis county medical society journal, we have an article that will try to educate physicians in the physicians community also about this and provide more information about the volunteer prep clinic that's available with, I know Dave offered -- they've offered to train other physicians that are interested it in their own practice. So -- that's it. >> Houston: Are there any questions? Mayor pro tem? >> Tovo: Thanks very much for this presentation. I really appreciate your staff's work on this issue. I missed the

journal citation that you said. >> Oh, that in the upcoming Travis county medical society journal, we do have an article that will be coming out. And we can get a copy to your office. >> Tovo: Yeah, that would be great if you would distribute it to the offices. So council member Casar's office -- staff and mine have been talking and learning more about this and working with staff, and likely will bring forward a related resolution if it looks like council action might be needed. Other communities like San Francisco have worked and supported the creation of getting to zero campaigns and others, and I know that the HIV planning council is working on efforts like that. And so I'm interested in looking toward ways that we can support those, both those planning efforts, but also perhaps a more direct support method from the city. So thanks so much for your work. And chair Houston, I know that Ben walker of the Austin prep access project is here, and if -- if it's all right, could we invite him to ask a couple questions? >> Houston: Let's see if there are other questions for staff, because I have some. No? Council member Garza. >> Garza: The funding that was -- I don't know if this would be you or director Jones, but the funding that was allocated for the health equity, I think we funded at

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one point 05 million. Could that be used for this had medication? >> Shannon Jones, health & human services. No, those dollars are $1,050,000 have been allocated for contract services to provide targeted intervention efforts with this, so those will not be -- could not be used for that purpose. >> Garza: And do you -- I don't know if you can, is there plans to maybe allocate some funding in your proposed budget for next year for these -- for this medication? >> We are looking at, in terms of preparing a budget, a variety of menus in terms of recommendations. This would be certainly one we would be considering, but certainly at this point in time we can't make that recommendation, though. >> Garza: Okay. Thank you. >> Houston: And I have a question, Dr. Huang, about the compliance rate. Do you have any history about what the compliance rate is? >> With the medication? >> Houston: With the medication, mm-hmm. >> There are some studies that are out there. I mean, with the data show that those that are compliant, you know, that you do have to take the medication regularly to get those 90% success rates. I think it -- maybe -- >> Houston: Okay. >> I'm Ben walker, Austin prep clinic. What was the question? >> Houston: The question is the compliance rate. Of the people who are on the prophylactic, what is the compliance rate? >> Absolutely. So that's a question that we ask both clinically from our medical providers and nonclinically from prep navigators. And it's been reported as very high adherence rates. I'd say -- and that's actually nationwide we're seeing very high adherence rates for prep use. It's very rare that we see a patient that has -- is not adhering correctly or has decided to discontinue the medication, actually.

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>> Houston: I'm not sure -- both of you stay there because I'm not sure who this question is for, but a lot of people who come from the criminal justice system come back into our communities maybe not HIV positive. So what do we do -- how can we use this prophylactic to ensure that they don't get HIV while they're in the criminal justice system? I guess that's the question I'm trying to pose. >> That's an excellent question. So we're doing two things. Number one, our medical director, Dr. Cynthia brenson works in HIV in the prison system, so we're putting up posters in the prison system talking about our program and how to contact us. Two weeks ago I had a gentleman that took two buses from the arch to our program that was recently released, and we had him on prep a week later. So we're -- that's something that definitely we believe in and we're excited to be serving people that were recently released and it's important to reach that population. >> Houston: What about their partners who are asymptomatic? Do we provide the medicine for them as well? >> Anyone that's at risk of HIV,

absolutely. We have men and women, all in our program, transgender men and women as well. >> Houston: And so you're reaching out to the females to say it's available. >> Slu. Yeah. Approximately 5% of our patient base is female right now but we're excited to try to expand that, for sure. >> Houston: Okay. I think that's all. Thank you, Dr. Huang, and since you're here already if you'd like to make a statement we'd be willing to listen. >> Thank you, I really appreciate the opportunity to speak with you today. Talk about our clinical program, the Austin prep program and give you facts, what's been almost a year of our prep program in Austin. As you heard from Dr. Huang it's a HIV prevention that are at risk of HIV. Men, women, anyone at risk of HIV. There's a popular

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misconception that it is intervention for gay men. It is an intervention for anyone that is at risk of HIV. We are just reaching about 400 patients that have been served by our clinic so far in under a year. Unfortunately, we have been -- we are booked up for about two months out because of the high rate of interest in our program. So we're very excited that Austin has been so supportive of prep and that people in Austin are so excited to get on this intervention that has been shown to be at least 92 to 99% effective. Actually the more studies that come out the more we see that it's looking at 99, and how many 9s are after that 99% of effectiveness. I'll give you a few more statistics of our program. 100% of our patients have a reported experience barriers to accessing prep. We see approximately 50% of insured patients, 50% of uninsured patients. We're one of the very few places someone that's uninsured can go to access prep. Our program is completely free. The patient see a doctor for free. They get their labs done for free, and they get the medication for free. Right now 100% of our patients get the medication that can cost a thousand to $1,500 for free. Not only that, we're part of what -- we're passionate about providing comprehensive sexual health. Every three months our patients come in and get a comprehensive sti panel. What that means is they have a blood test, that's testing HIV, hepatitis, and a complete metabolic panel, and as well as a syphilis test -- a syphilis test and bacterial swabs that test three places that bacterial stis can be, your throat, your anus and your urethra. So it's very important when you're testing for stis you test all three locations that bacteria can be. Those tests are expensive and we're very appreciative for the state of Texas for supporting that testing. Additionally, we partner with the city of Austin with the adult safety net vaccination program, and we've been able through that

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collaboration, we provide over 500 vaccinations for our patients, so we're excited about that too. So you were asking about statistics before. Well, we want to do more targeted outreach because of how -- our capacity is met with the people that are coming to us right now. We're actually -- I'm happy that we have had the penetration into the communities in Austin that we have had. It's fluctuated right now between 10 to 15% African American, 25 to 30% of the population that we're seeing is hispanic. And we're -- and both of those have been on the increase since the beginning of our program. So I'm excited about those trends and doing further target outreach to those populations. Another important population to be looking at is a full quarter of our population that we're seeing our client base is under 25, and populations of color, and especially -- and youth, and especially youth of color are the highest increasing HIV incidence rates on the whole. So the very fact we're seeing 25% of our patient base being under 25 is exciting. Additionally, what's -- it sets -- what sets us apart is that we are a volunteer clinic. We have about 40 clinical volunteers, eight physicians, two physician assistants and three nurse practitioners. Almost all of our clinical program is there on a volunteer basis, which allows us to really expand what we're able to do with the small dollars that we have. We are completely funded by private

donors and by very small grants right now, which is -- have really stymied our capacity and our ability to see more patients. I just want -- I want to close with two recent CDC guidelines that have been put out. Last year the CDC put out, late last year, that one in four msm should be on prep,

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has indication to be on prep. One in four. That's another 18% of injection drug users have indication for prep. And about half of 1% of heterosexual people, sexually active heterosexual people have prep. Looking at the Austin population and seeing how quickly our city population is growing, seeing those huge Numbers of people that have prep indications, it's really important to be able to increase our city capacity for bringing this extremely important prevention tool to more people. So one in four msm should be on prep according to the CDC. Additionally, the CDC just in February came out saying that an increase in prep access has the ability to decrease HIV incidents nationally by 20%, simply increasing prep access. When you combine that with quicker access to care for people that are tested HIV positive and greater retention of care, that increases by 70%, a 70 decrease in HIV incidents. Over the last nine years Travis county has seen approximately a 3% decrease in HIV incidents. Texas has seen approximately a 1% decrease in HIV incidents. And the CDC is foreseeing with these -- with these things expanded a 70% decrease. So it's -- the -- it's the first chance we really have to see -- those three things are part of what's getting to zero program. Quicker access to care, tested positive, for retention of care and increased access. Thank you for letting me speak to you. I'll answer any questions you have. >> Houston: Thank you. Colleagues, any questions? Mayor pro tem? >> Tovo: Thank you so much, Mr. Walker, I appreciate the work that you're doing in the community on this really critical issue. Can you just for us, I think I heard you say that the wait list right now is one month? >> It's pluck waiting --

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fluctuating from one month to two right now it's two. >> Tovo: How many individuals does that equate to who are waiting for treatment? >> It's approximately, right now three months -- I would say at least we're seeing about 50 people a week -- four weeks -- >> Tovo: A lot. If you want to let us know afterwards,. >> Absolutely. >> Tovo: But especially as we evaluate the appropriate city support I think it would be very helpful for know how many individuals in the Austin community are waiting for that access, which we know would make an important difference. >> We bring in approximately 10 to 15 new patients a week, so 10 to 15 new patients for that two months. If there's no one that's interested and we're booked up we take a wait list. We're happy that it's -- well, happy, we haven't -- we haven't had to have a wait list past those two months for some time now, but we've also had to cut down on our outreach, on our targeted outreach because we were at full capacity based on the people that are coming to us. >> Tovo: Right. Thank you very much. >> Thank you. >> Houston: Thank you so much. And I'm glad the demographics are looking a little different since the first time we spoke. >> Thank you. I am too. >> Houston: I just have a quick question for Dr. Huang. Are we providing this medication in our clinics and in community care or is it just in private physicians? >> You know, we understand community care is offering this. We had discussions early on about us offering it in our STD clinic, but it was mentioned that it really takes a lot of case management to make sure that the patients get the insurance coverage, things like that, that we don't currently have in our clinic setting. So it was better for us -- and we do very aggressively and actively refer appropriate patients to the clinic, and that was recommended to be the best strategy for us to participate.

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>> Houston: Thank you much. We have -- does anybody else have a question? We have some speakers signed up to speak. >> I have a question. >> Houston: Hold on, I'll call you by name. Paul -- >> (Indiscernible). >> Houston: No, no, I'm sorry, Brandon woolman? >> Woolerson. >> Houston: Woolerson, couldn't see that. >> Thank you, council members. My names Paul Scott. I'm executive director of AIDS services of Austin Ann I'm one of the people here that are in support of prep as a key prevention strategy for our community, both here in Austin but nationally of course. And we consider this kind of like a one, two, three punch in terms of addressing HIV and reducing HIV infections. Prep is one of those pieces of the toolkit in terms of making sure that people can get on the medication and prevent contracting HIV. The other is continuing with testing and safer sex education and access to safer sex tools so that people were prevent HIV infection that way. And the third key strategy as well is the work that we're doing at AIDS services of Austin, is prevention for positives where we are able to work with people, get them early into care and we know the earlier we get people into care, we have about a 96% kind of rate -- less infection rate when people are in care, so they're not going to pass the virus on to someone else once they're identified as positive and into care and on medications. We have a great referral relationship from our prevention program where we do about 1600 HIV tests a year, but those people that we identified as HIV negative that are high risk, we have a referral relationship with the Austin referral access project, as well as we have a great working relationship with the young gay men's Austin, which is a very diverse group of young gay many around some of the issues with health disparities, African American, hispanic,

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and white men in our community as well. I think the key thing, as I mentioned about that one two three punch, is really a need for a comprehensive strategy and integrating this in terms of bringing everybody to the table to have this conversation, including the city of Austin, health and humidity services department. You had asked about about the provision of medication. I think anything we can do to expand access to the medication first of all, with signing people up for the affordable care act, obviously, if they're qualified, as well as making sure that doctors are educated about this. I'm glad to hear that Dr. Huang has the article coming out in the journal, because I think that's one of the barriers we've seen in the community, is that doctors do not -- first, doctors don't know about this as a prevention strategy and prescribing prep, and secondly they don't know -- they're not apt to prescribe it for people as well. >> Houston: Thank you so much. I was going to ask you a question about -- I forgot. It will come back to me. It will come back to me. >> Really quick. The last thing I want to say is it's important -- >> Houston: We try to respect people's time. Your time is up now so maybe somebody will mention that when they come up. >> Health disparities. >> Houston: And then -- [laughter] >> Health disparities. >> Houston: There you go. There you go. And then the next person is going to be Todd Logan. >> So yes, my name is Brandon woolerson, that's w-o-l-l-e-r-s-o-n. I'm sorry for my spelling there. I wanted -- I am a social worker and the administrator of the David Powell clinic, which is part of the community care system. We are the local safety net HIV provider. I wanted to acknowledge the great work of Ben and his team at the Austin prep access project. They're really pushing a lot of us to have these conversations within our organizations about how we continue to grow our access for prep for patients. At community care specifically, I did want to highlight that we are

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expanding our prep offerings for our patients, and just keep in mind we serve annually 80,000 patients a year within that system, so that is additional access for a safety net population. We have been piloting essentially a prep clinic for existing community care patients, with Dr. Brendan Demarco, also one of my

physicians, David Powell, that works on Monday afternoons at our north central location. We are happy to announce that we're continuing to roll out prep for the larger system, so we will essentially have three prep hubs in the community care system so we'll have one at our north central location, one at our block black stock location with Dr. Wright, and one at our south location with Dr. Nicholas shagoda. It will take a collaborative effort to curb new infections and make sure the entire community has access to the prevent tif strategies. I want you to be aware of the work in the community. >> Houston: Thank you for that and I have remembered the question I was going to ask the last time. Do you reach out to private funders? I've heard some small grants, but do you reach out to try to get private dollars to -- to help support the funding of the medication? >> Yeah, I mean, I think Ben and his group could probably speak best to it. I know giliad, the manufacturer of travada, heavily supports folks having access to that medication. So I think that's one -- that's one funding source, but I know that there are additional private funding sources as well. But I can't speak to that specifically. >> Houston: Okay. Thank you so much. >> Thank you. >> Houston: And after Mr. Logan, Dorothy Jenkins is the last speaker. If you'll come on up to this. >> Hello, my name is Todd Logan. I've lived in Austin since 1987, and I work for a

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nonprofit here in town. I want to simplify this just a little bit, that -- and take us to San Francisco, which was mentioned earlier. They implemented just three interventions, and in less than five years they cut their HIV infection rate by 60%. Less than five years, three interventions, 60% reduction. My colleagues have been talking about it a bit. It's widespread testing, treatment as prevention, and prep access. So let's say you come in to be tested for HIV. If you are positive, you immediately go into HIV treatment and get on medications. If you are negative, then you move to prep and go on prep. Okay? Presently we've got a lot of really great testing happening in Austin. We also have decent uptake on treatment as prevention. What we don't have is good access on the prep side. And with respect to my colleagues, well-healed austinites are not getting HIV as much as those in lower socioeconomic, and the access for lower socioeconomic is next to none. And presently there is no federal, state or city grants or moneys that support the cost of the medications. Thank you. >> Any questions? I'd be willing to try to stand with you to get those well-heeled austinites to give us some money. [Laughter] Ms. Jenkins? >> Hello.

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I'm Dorothy Jenkins. I'm the executive director of Austin outreach, and I actually have a question. And when they were speaking about prep, I wanted to know, what were they doing to make the public aware of the prep medication? Especially in the areas where we go out and do HIV prevention? My program since 1992 is primarily targeting African American men and women with HIV prevention and education, and now we're targeting African American heterosexual women at risk as well as msms, and we're out in the housing developments as well as the gay bars. So how do we get that information to those people? Because we definitely see high risk individuals. And that's what I was going to ask Dr. Huang. >> Houston: Ms. Jenkins, first let me say we appreciate the work you've been doing in the black community for a very long time, and what I'd like to say is if you could meet with Dr. Huang and the other people, they can -- they can probably help you understand what kind of outreach efforts they're doing, because I know you're going into where people live. >> Every day. >> Houston: Every day. >> And I was hoping there were some brochures, literature, and also, you know, how can I refer people to this program. >> Houston: I think they'll be able to help you right after we get -- after you finish. >> Thank you. >> Houston: You're quite welcome. That's the last people who have signed up to speak. We have mark Ewing, who signed up, who didn't want to speak, and Douglas plumber, who signed up and didn't wish to speak. Any other comments on the dais? Well, thank you so much for presiding, all of us that

information, and as I said, I'm willing to help those well-heeled austinites give up some money to help

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further this effort. It's very valuable. And so the last thing on our agenda is item no. 7 is the staff briefing on service delivery and performance measures. >> Good afternoon, I'm Shannon Jones with the austin/travis county health & human services department. And today we are coming to provide an update about the funding that was added to the -- by council and associated performance measures and outcome measures. We want to again always thank you for the opportunity to enhance our efforts in public health in this community. Per the HHS committee's meeting in November 2 of 2015, and in keeping with transparency, I provided an update on funding for the areas of public infrastructure, health equity and social service contract. During this meeting I discussed that we would be returning from time to time beginning this spring to outline the outcome in performance measures related to the new funding and services related to the health & human services department. Particularly because council member Houston, you and others had indicated you'd like to see what were our performances and what are outcomes. So this is our effort to begin an ongoing dialogue with the committee on those. Just a reminder, HHS funding is roughly $85 million. Of that, $62 million is from general fund, which is roughly 73%. And 22 million of that is grant funded or roughly 27% of our budget. Per council resolution,

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2016, 128, adopting a formal policy goal of investing $11 million of additional funding for social service contracts and investing $10 million for additional funding for health and human services over the next two to four years, so consistent with that we want to be transparent in reporting back what we are doing with those funding efforts so the council and the community understands what we are -- where we are with regards to those dollars. As indicated, in that, we're going to focus today on the enhancement we're giving, so this presentation will outline city investments and corresponding performance measures and outcome measures related to the three areas that investments were made in. The first one being, of course, public health infrastructure and programs. The second one being health equity/quality of life initiatives. And then the third area is social service contracts. We'll start particularly first with the investment on our public health infrastructure. We'll start with improving maternal and child health and adolescent health results. Investment for 2015 was roughly $20 million. Investment for 2016 are roughly 2.5 million. In terms of performance measures our performance measures for this area are actually outcome measures, and so towards that effort these are the areas in which we are moving to make outcomes and improvement. Ensure 95% of women enrolled in the wic program during pregnancy breast-feed their children. We know the importance of breast-feeding and the impact it has on early childhood development and lifelong outcomes. Secondly, certify 6 to 8% of full-time early childhood centers that serve at least 10% of low-income children are quality rated, 68%. In other words, not just to have child care but to have

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quality child care rated centers. 3, establish 90% of the children served (indiscernible) Next development, academic development, so enhancement in that area, and then reduce the incidents of reportable cases of measles, pertussis, mumps, rubella to 28 -- so we're talking about reducing the rates we currently see. These are just some. These aren't all the outcomes. But with these kinds of investments in maternal and child health activities, these are the types of results and outcomes we will be venturing to achieve in fy '16 and future investments. Improve quality of life due to preventible

chronic disease and we've talked a lot about chronic disease, so investment in 2015 was roughly a $900,000, as a result of your investment -- significant investments in '16 is 2.5. Our performance measures here, these are just some of them, these aren't all of them, but some of the highlighted ones are reduce the number of tobacco-related deaths below 690 per year. We've talked in presentation here many times about the number of tobacco-related death. We're trying to get that number down and those investments will help us to achieve that. Right now we have roughly -- in 2015 I think we're 720 deaths, and so we're talking about reducing those down. Ensure the quality of life initiatives and public health nursing client, follow through with referrals of a health care provider. In our community we see thousands of individuals through our quality of life initiatives and through our neighborhood center public health nursing efforts. We want to make sure that they are referred to providers, they're not just coming and getting a test result and then go forth. They need to be connected with providers, so this is the efforts of ensuring -- 85% of those that we see are referred. When we looked at the area of maximizing public

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exposure to food-borne illnesses, you see roughly 5 million was invested in 15, and in '16 we're talking about $5,388,000. What we're talking about here is to ensure that we conduct inspections -- on average two inspections per fixed food annually. We know the impact that food-borne illnesses have and the importance of being at each restaurant or certainly thought as risk twice a year is very important. So these investments will help us do those. Provide routine safety inspection for at least 60% of the temporary events established. We're about to have sxsw. We've had acl, and so we'll talk about making sure that 60% of those venues are inspected on a routine basis. And then additionally review new commercial construction within 35 days. I'm not sure if you're aware of that, but part of the one-stop center is the health department, and part of our role is to make sure that we have those permits, commercial construction completed within 35 days to be able to meet the goals of the city. And so by giving out of the investments it will help us to achieve that goal. We have been as high as 60 days. So we're reducing those Numbers down. In the area of spread of communicable disease and infectious disease investment, I won't go there you all of it but you see 3 million and we have increase in 16. The goal performance measures are provide 100% of active tb patients with complete therapy in 12 months. We don't want them to extend beyond the 12 months. We want to do it within the time frame that CDC recommends. Arrange 90% of newly diagnosed HIV positive clients linked to hiv-related services with medical care. We just talked about prep. This is those that are actually positive, so part of that effort would be also to ensure that clients who are at risk because of their HIV partners are aware of prep services and how we can

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work to do that, would be certainly things we would be looking at in next year's budget but under this one we want to make sure that the 90% of the newly diagnosed HIV patients are linked to related medical care. Ensure 90% of our STD clinic clients are examined, tested and treated the same day. One of the things we want to make sure is we don't have to send people back or ask them to come back, and to reduce our waiting time. So we're talking about making sure at least 90% of them are ensured on that day. Strength and public health infrastructure, improve health outcomes. In this one we have specific performance measures that we want to make sure we achieve, provide over 42,000 birth and death certificates per year. And this is critical because we want to make sure that every child that's born in the city in our jurisdiction gets that timely and anyone who dies, that we have those turned around within a timely manner. Consistent with state law as well. And part of this outcome and achieving this as well as

others is to achieve and maintain public health accreditation, so by doing this and other activities, we will ensure public health accreditation efforts. So those were the public health infrastructure. We want to talk a little bit about social services. As you know, we're a health & human services department, so as part of our social services or human services part, our performance -- here's our investment for '15, 27 million, in '16 we had roughly $3 million additional investment, 30 million. Received roughly -- performance we want to serve, and these performance measures are basically widget sort of -- in terms of things we want to do. So serve 62,000 unduplicated pensions persons with barrack needs, and serve 45,000 clients through social services contracts. These are the combination of both activities. Serving them are one thing. Outcomes of that

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intervention is ensure 30% of homeless clients residing in shelters will receive case management services. So those who are in our shelters, that they get case management services to improve their outcomes. 75% of homeless served through the city of Austin social service contracts maintain house are or transition into housing from homelessness, so we want to make sure that they continue their success in those areas. 85% of clients enrolled in self-sufficiency case management report a reduction in elimination of income barriers, and so working through our social workers and others we ensure that their self-sufficiency as well as providing services for them as well. The next part of the presentation will roughly review the previous social service investments, because the question was raised, what have we done with the investments we've gotten so far? So we want to review some of those. We want to review the outcome achieved by the social service categories, and outcomes are calculated based on actual individual served through social service contracts, and then outcomes measures reflect the result of a total investment. And I'm not going to go through all of these, just highlight them. In our issues areas particular basic needs, per year roughly $4 million. The goal of that investment was 82% of those households at risk for homelessness that maintain housing, and roughly that number was 11,000 individuals maintained housing. Behavioral health, so our mental health types of -- 85% of individuals meet their treatment plan and goals, roughly 92,000 individuals were successful in doing this during this rfp period. Children and youth, roughly $2 million. 86% of children progressed to the next developmental or academic level. And roughly 29,000 individuals progressed within that evaluative

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criteria. Homelessness, roughly a million and a half dollars, 80% of the population of households served maintain housing or transition housing from homelessness. Roughly 16,000 individuals fall into that category. And then workforce development, roughly $5 million, 69% of the population -- of individuals maintain or increase incomes in the workforce, so improving their -- their outcomes in terms of salary for their household. Roughly 47 -- 4700 individuals. These are examples not by any means all of them but gives an indication of what has been achieved with the investments made and the goals that we look for. Just anecdotally, just -- I won't read through all, give you an example. One agency provided 54 units of permanent supportive housing using the housing first model with a 70% retention rate and was successful in housing the hardest to serve. Criminal history -- backgrounds of criminal history, poor rental history, utility histories and the like, and we know in our own environment these are the types of individuals we see every day and these investments help turn that around, 70% retention rate is pretty good. A student was referred to a youth program for his antisocial behavior. After working with the agency his behavior changed. He got caught up with all of his course work and interacted positive with others. One of the teachers stated he was the most changed senior. So there are real life stories behind these investments that are manifested by the Numbers that we're talking about as well. Just quickly we

want to give you an update on some of the other things we're doing with the investments you've made. Hhsd developed a plan to implement $1.8 million of allocated dollars for social service contracts. And you remember as part of

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the investment we were able to identify that. I'll just share quickly with you some of the things we've done with that. Based on the feedback from the social service providers as well as city managers at one voice and other stakeholders, HHS developed the following allocated categories for funding approved by council. Increase existing social service contracts by 6%. So those agencies that currently had them were able to increase those by 6%. Issue a solicitation for new agencies with remaining funds for capacity building and services. Approximately 390,000 was available from that, and the reason we wanted to do that was because we saw that -- to use your word, council member Houston, legacy agencies, that have been doing this for quite some time, and in order to enhance the ability of agencies that are not part of those groups, we were able to -- were developing a capacity building program, so we can train new ones to apply for city resources and be successful in getting those dollars and making those successful. This is solicitation to agency not currently provided for social service agency will secure to provide a capacity. So we're looking at contracting this out, having someone come in and work with us to do that training and activity. The secondary was health equity solicitation. As you remember, we had one million, referred to earlier $1,050,000 that was made for health equity for the first time, and of that we've identified the areas that were identified in the resolution. So we're at $390,000 for maternal and infant health. We'll be -- will be contracted to the university of Texas, while the mamasan initiative to work on issues of infant health and maternal health. Roughly 4 10:30 thousand for African American health disparities. Of that, that's broken down,

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sickle cell association received roughly 224,000. The university of Texas working with aahci, got 112,000, and the Austin revitalization $73,000 to work with HIV and AIDS in the African American community. In the area of elderly we've identified $50,000 for senior services, and so meals on wheels and more will be contracted to provide those services once approval has been made here at council. And then lgbt people of color, sexual health and wellness, will get $100,000. Our recommendation is to be able to provide services to focus in on that population, particularly as it impacted by sexual health as well as wellness program. And immigrant menlt health services, catholic charities is an agency identified for recommendation for $100,000 for the services related there. And then of course rental assistance solicitation, catholic charities, agencies has been identified as for recommendation for those services as well. So next steps, we want to assure you that -- remind you that we received 37 new positions, that money became effective on January the 1st. This is March the 9th. And our staff, much credit goes to them, they worked hard and diligently to hire and get on board 25 of those 37 positions so that we began this year to begin to make differences in terms of some of these outcomes. We still have a few positions to go, and we're looking forward to making sure that we get those, hopefully no later than the end of April. Execute the new health equity contracts. We talked to you about that earlier. We'll be coming to council to get your approval on those recommendations and hopefully have that in place by April 20 of this year. Amend existing social service contract. We mentioned that also. We'll be coming to you on

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April -- to talk about -- give you that approved also so that we can begin April of this year. And develop a budget recommendation for fy '17 according to resolution. We are in the process, of course, going through city managers to make sure that we submit our budget on time and appropriately, and we're -- in terms of those recommendation part of the strategy in terms of putting forth our budget for 2017, recognizing the city manager's budget will make the final recommendation of those. And then conduct performance analysis and develop fy 17 performance goals and outcome measures. Today I've given you a retrospective look of what we've done. It's my hope that going forth we'll give you a prospective goal so you'll see what we're doing on an annual basis in terms of achieving our goals with the investments you've made. And with that I'll be happy to answer any questions you may have. I also have staff here to assist us in any specifics that you may have. >> Houston: Colleagues, are there any questions? Mayor pro tem? >> Tovo: I wanted to go back for a minute to the groups that would -- are proposed to be funded through the health disparity. >> Yes. >> Tovo: -- Money, and I don't know if we can bring back that slide. That would be helpful. I've lost track of which page it is. Thank you. Page 14. So one of the things that we talked about when we were having that discussion you is the fact that -- is the fact in recent history the city and the county worked together on -- or at least the city, had an Asian American health assessment and it revealed some real disparities for our Asian American community. And we had discussed when we were talking about the health disparity work, that that would be -- that would certainly be an area that could be an area that could be addressed through these grants. Are there any organizations or any initiatives you've listed here that are

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specifically targeting the Asian American community? >> Well, they aren't specifically targeting. One of the things we gave direction to is to go out based upon the rfps and the resolution that went forward. So particularly Asian American community, we're -- there are several areas that cover those. Keeping in mind that immigrant mental health services would be appropriate, that lgbt communities of color are there, but specifically to your question, there's none specifically targeted at the Asian American community. Having said that, though, part of our outreach effort with our public health infrastructure is to build that capacity, so our quality of life efforts, we do have outreach efforts, and those staff that will be part of those efforts will be focusing in particular on the Asian American community for developing centers, for developing -- hiring staff. It will focus in on the Asian American community. So that is part of our inculcation -- it's not part of the social service contract this year, but certainly as we go forward we'll look at how do we subcontract with agencies that will focus on those communities as well. >> How woot subcontracting -- would the subcontracting work? I agree that certainly the immigrant health might be part of -- I don't know that catholic charities is specific -- there are organizations that are working more directly with the Asian American community that are not named on this -- >> Well -- >> Tovo: And we've had a lot of discussion about, I think certain organizations just are more trusted organizations within particular communities and that's really an important consideration. So as you -- I think you suggested that maybe there could be other kinds of contracts. Would you elaborate on that, please? >> We are looking at as we propose for '17 particularly, not '16, because '16 is halfway through the year anyway. So as we look forward, is to identify particular programs and focus in on the Asian American community. It was not part of this rfp effort, and I remember specifically your question being raised at that time. And so we'll go back and look at if we have the

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opportunity to do that this year, but certainly our goal is beginning in '17, with the '17 budget, our anticipation is focusing in on that. Having said that, though, we do have, and I emphasizes we do have

efforts in our -- efforts in terms of hiring some of the positions we've talked about, I just want to emphasize, is looking at focusing in on the Asian American community as part of our overall public health quality of life efforts. So here particularly we're talking about the $2.5 million investment we have. Part of that is going toward public health nursing activity. Those will be in particular neighborhoods, particularly rundberg, in Austin where Asian American communities are. We're talking about hiring staff reflective of those communities. We've worked with outreach through the Asian American resource center and the Asian American quality of life initiative to talk about how do we do more of that. So yes, we hear you very clearly and it is our intent with this year's dollars to do some of that and with future year's dollars, particularly in '17, of looking at contract agencies that are nor reflective of that community. >> Tovo: Thanks I. I appreciate that. The hiring is important as you've indicated but too, I think that other piece which we talked so much about in some of our earlier meetings about partnering with -- partnering with community-based organizations I think really makes -- gets that -- makes that outreach more successful, so I hope that's a goal you'll revisit. >> Another thing I want to remind you is that in all of these, all agencies -- I mean, these are open to anyone who wanted to rsp. So these were -- I get your message very clearly. We need to do some focusing and target. >> Houston: I just want to say catholic charities is involved with asian-american communities. At the asian-american catholiccenter there's a support system

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in district 1. So, the catholic Vietnamese catholic church, and they have a whole social service component. So I think catholic charities -- I toured them last year. They have the resources there to move this forward. >> Tovo: I'm glad to hear that. Thank you. >> Houston: Anything else? Councilmember Garza. >> Garza: I just want to thank you for this presentation. And we make a lot of decisions as councilmembers. And I'm really proud of the work that we did to fund health and human services more. And it's great to see concrete -- where that money's going, and how it's helping folks, and adding more ftes means we're reaching more people and we're helping more people, so thanks for giving us concrete examples of that. >> It's our hope to at least, once a year, to update you on where we are on our deliverables and achieving the outcome measures. >> Houston: Thank you. And I want to ask you to do the same thing. Would you make sure that your backup is sent to all of the councilmembers so that when this comes up again, they have the backup that we received at the council committee meeting. >> Yes. >> Houston: Okay. Thank you so much. >> Thank you. >> Houston: We have one speaker signed up, Jo Catherine Quinn. >> Good afternoon, I'm Jo Catherine Quinn, executive director at Carrie's house of Austin, and secretary of one voice central Texas. I'm here on behalf of our 80 members of one voice to just say we appreciate the collaborative relationship that we have with health and human services staff. We very much support the plans and the strategies that the staff has articulated today with regard to the increased funding

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that you all supported and brought forth -- made a reality. We appreciate that. And with specifically, regarding the social services contracts. We look forward -- as well, to our work together in the future to continue to increase investment, to very clearly identify the needs in our community in an objective way, and implement effective practices to serve the most vulnerable populations in our community. Again, I appreciate the opportunity to speak to you today, and just look forward to our continued partnership to be sure that these investments are spent in the most appropriate ways. Thank you. >> Houston: And thank you so very much. That ends our agenda for today. And I'd like to remind everyone present that the committee meetings are held every other month. So the next meeting of the health and

human services committee is going to be Tuesday, may 24th. Tuesday, may 24th. And the office meeting will be Tuesday, August 23rd, 2016. And beginning at the may meeting, individuals may sign up electronically, just like you do at council committees. That'll give us time to figure out and be trained on how it's done. At the may meeting, you'll be able to sign up electronically. And I want to just speak briefly about last week, I think. God knows they run together now. We changed the committee process so that in order for the council committee to hear an item, we have to have two councilmembers to put it on the agenda. So I just wanted you to make sure that you understood that that process has changed. Possible items for the may meeting include an update from

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code on plans for unregulated homes. Perhaps we can have a briefing from the Seaton family of care. We've not heard from them in this healthcare, health school district, Dell medical school partnership. And let's see. Anything else that we need to consider for the next meeting in may? >> Chair. >> Houston: Yeah. >> Tovo: Possibly -- so, I believe in the original resolution for the bringing together the stakeholders to look at public toilets downtown, I believe they were supposed to report back at this meeting about some of that work. And I know that work is going on. But I guess they weren't at that point. It's possible that that could be a topic on may. My hope is that we'll have that news before may, and can move forward if we need to move forward with any particular actions at the full council in the interim. But I just want to let anybody know who's following that issue that we'll get some information soon, I hope. >> Houston: And since I cosponsored that with mayor pro tem, I will put that on, too. So that's two of us that will talk about public toilets in may. So that's on the agenda. As you look at the may and August agenda, we've got lots of work sessions. So we're going to try to keep those as light as we can, even though we've changed the date from Wednesday to Tuesday. It's still a full Wednesday budget session. So we'll try to keep those as light as we can. If there's something really urgent that needs to come up during those times, just let me know and we'll add it to the agenda with another sponsor. Anything else? Well, thank you. Let's adjourn this meeting at 4:03. Thank you so much for coming, and we appreciate your time.