Health and Human Services Committee Meeting Transcript – 2/19/2020

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[1:35:00 PM]

>> Harper-madison: All right, folks, I believe we have a quorum. Good afternoon, I'm city councilmember Natasha harper-madison. We are meeting in city council chambers at city hall, 301, west second street, Austin, Texas, on Wednesday, February 19th, 2020. This is the health and human services committee meeting. It is now 1:35 P.M. And I call meeting to order. For anyone needs to have your parking validated, please see the clerk. All right. Citizen communication, give me just a second while I pull this list up. >> Tovo: Chair, apologies for being late. I serve on the police retirement board and they are still meeting so I left early, but apologies for being a few minutes late here. >> Harper-madison: I appreciate that. Thank you.

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Your staff came down and let me know you would be a little bit behind and I confirmed we were all running late from somewhere. >> Tovo: I just wanted the audience to know the reason. >> Harper-madison: Is there anybody in the audience who signed up to speak? Mr. Pena. Just the one. Mr. Pena if you would like to approach. Thank you. Is so now we'll take up citizen communication. Each speaker will be allowed three minutes for items not on the agenda. The first speaker is Gus Pena. You have two minutes. >> Thank you, chair.

[1:37:05 PM]

Board members, Gustavo Gus Pena, native east Austin 8. I wanted to make quick comments. We're still having people who come over to city hall to testify about the bad areas, the stench, the roaches, etcetera. They're being retaliated against. Some of the people who came over here to testify were retaliated against. That's not appropriate. To me that's criminal. And staff -- some of the majors are disciplining some of the people who live there, some of the people who came over to testify. So I wanted to make it real clear that that is not acceptable. That's criminal, okay? And I tried to talk to Kathie, the administrator of the Salvation Army. I didn't get any return phone calls. Nor at the arch. I know all the people over there, but I see the conditions that are bad. And I will wrap up with saying this central health board I want to thank y'all very much. And you do a good job and

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hard work and without pay. And I appreciate y'all very much. But we still have that problem with homelessness. And I don't want anybody to say that we are -- we don't have any more homeless individuals because we have services for the homeless people. A body is a body. Body count is a body count. I'll leave it at that and thank you for allowing me to speak. And I look forward to speaking to y'all manana. And y'all please, please, have staff look at the arch and the Salvation Army. Nobody should be retaliated for anything over there. Thank you very much. >> Harper-madison: Thank you very much, Mr. Pena. Was there anybody else who signed up to speak this afternoon? Okay. And with that we're going to move to item 1, approval of the minutes. Do I have a motion to approve the minutes for the regular December 11, 2019 meeting and the special called meeting on December 19, 2019? We have a motion from mayor pro tem Delia Garza. Is there a second? Seconded by councilmember

[1:39:09 PM]

kitchen. The motion to -- can we take a vote? >> Tovo: Just one correction. My name is spelled incorrectly. >> Harper-madison: Oh. >> Tovo: Other than that they look good. >> Harper-madison: Thank you for that. I'm assuming the clerk took note of the spelling correction. Thank you. So if we can take a note on the approval of the minutes for the regular meeting on the 11th and special called on December 19th. All in favor? That motion is approved to approve the minutes, it passes on a 4-0 vote. We have two briefings. So next on our agenda -- I'm sorry, three briefings. Next on our agenda we have three briefings. Our first briefing we're going to receive an update from central health on hour 2019 annual report and current health care services provided to individuals experiencing homelessness.

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Good afternoon. Please introduce yourselves. >> Good afternoon. Question, Mike gi esling, president of central health. >> I'm the director of medical management with central health. >> Madam chair and

members, thank you for having us here today to provide a sneak preview on our upcoming annual report as well as some updates and some of the work that we're doing to help those that are experiencing homelessness. Also joining us today are board members, our chair Sheri Greenburg, or secretary Cynthia Valdez and a board member. So on the first slide what you'll see is an . Overview of central health's -- not only just our boundaries, but it gives you a sense of where our key providers are located, including hospital -- I'm

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sorry. Thank you. As you can see your boundaries are contiguous with Travis county, but this map shows our hospital, our primary care, urgent care and partners and eligibility locations. And these are certainly -- the spots on the map are certainly not all inclusive because we have several dozens of contracts with specialty care providers and other types of providers that are all throughout Travis county. And the shaded areas, the darker shaded areas, represent those that are with the largest enrollments in the medical access program. So for instance, up and down the I-35 corridor you'll see the darker shaded areas. And as you move further east a little bit lighter shaded, but I would point out with the changing demographics in Travis county that's one reason why we're continuing to locate new resources in the eastern part of Travis county. Next slide. For fiscal year 2019 I'd like to point out two

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categories of highlights. One is our access to care and the other is access to coverage. On access to care we have over 183 provider locations. And we funded care for one out of every seven Travis county residents. Overall we have over 444,000 primary care encounters and these are preliminary counts, but that would include both physical as well as mental, behavioral health and other dental encounters. We have mobile services in colony park and the creedmoor communities. You may have seen our mobile clinic and for those who helped promote it in your offices we appreciate that promotion. That helps to get the word out. And access to coverage. Our medical access program also known as M.A.P., we saw over 47,000 enrollees. Now, on average each month because of unfortunately lapses in coverage and so forth, we have approximately 29,000 enrolled each month, but for the year we had over

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47,000. We also had the launch of M.A.P. Basic. M.A.P. Basic is the new terminology that we use for our sliding fee scale. We implemented a new streamlined program across all of our main clinical partners -- primary care clinical partners to have a common map basic program which took the place of multiple sliding fee scale programs. And over 27,000 enrolled in the M.A.P. Basic. Also in fiscal year 2019 we had over 200 high risk patients enrolled in sendero affordable care act plans or ideal care and this was

through a board initiative at central health to fund the premiums for individuals that were high risk so they could enroll in sendero. I would point out that for fiscal year 2020 over 250 additional individuals were rolled into sendero ideal care through the premium assistance program. Now, as we focus on

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individuals experiencing homelessness, we estimate that over 10,000 individuals on the medical access program are homeless or experiencing some form of homelessness or housing instability. I'll point out that that figure, that 10,813 M.A.P. Homeless patients self reported is much larger than perhaps other count numbers that you've seen. Veronica, please provide commentary on this as needed. When we talk to individuals and we record data it ranges from those that are experiencing chronic homelessness on the street to those that have some other form of housing instability that may be less severe or they just don't have a stable address at this point so it could be individuals that are staying with friends or family and moving around from place to place but they're lacking permanent address and certainly addressing housing instability.

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Pulled note that from a race and gender identity standpoint, as you'll see, white or other tend to be the largest race and ethnicity categories for individuals experiencing homelessness. And the gender identity reported trends predominantly male. I would point out that as gender identity as we move into more advanced and improved electronic health records, but also in our enrollment systems we're working with our vendors to make sure that we capture all gender identities not just in a binary male-female type configuration. So I think that's something that we'll be able to report on this in the future with more clarity. With respect to age and language, the age distribution is similar to our overall central health population. Keep in mind central health

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we don't cover the health care for adolescents or children which are covered by medicaid or championship or adults covered by medicaid or medicare. So as you see the 18 to 45 age cohort, comprises the largest group of those individuals experiencing homelessness, which attracts what -- which tracks with the overall central health population. Language is the overall predominant language spoken. You can see we're four percent reported Spanish, whereas your overall population reports 49% as the language of choice. So with this I'll turn it over to Veronica. >> So the coverage for the homeless, the map benefits also referred to as map H and also called map zero co-pay, we've provided over 25 million of health care

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services value provided annually to map members through the central health enterprise partners and ascension Seton, including 70,000 prescriptions, 26,000 primary care visits, 2,000 specialty care visits at community care and then about 1200 inpatient hospital stays. Our care opportunities for the homeless -- >> Harper-madison: Sorry, I was slower than the flip. >> Let me go back. >> Harper-madison: Thank you. >> In addition to the slide I wanted to note that we are seeing our spend on map homeless patients increasing specifically for the map homeless patients who have used services, the spend increase was about 10% over the past year. Care opportunities for the homeless. We have a recuperative care program which provides skilled nursing and skilled physical therapy services

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on-site with case management through our partner with front steps for map patients that are experiencing homelessness. We have a residential rooming service which provides rest and recuperation for map patients experiencing short-term injury or illness and many times through the recuperative care program we may get patients out and move them into our residential rooming service to decrease the length of stay that they have in the skilled nursing facility. Community care health centers accept map at all locations, including the Austin resource center for the homeless, also known as the arch. We have our care connections clinic right here on south first with enhanced reimbursement for expansive community care clinic. And that provides wound care services to our map homeless population, podiatry, hep-c treatment. We also have on-site echo and integral integral care to also address any behavioral health concerns. But also with echo patients are able to walk in and get a coordinated assessment as well.

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Community care street medicine team has enhanced reimbursement for this service. Acute care, they address chronic disease management. Sometimes they also do lab work to address any chronic disease issues if patients can't make it to the lab. And prescriptions and more more services. We've also launched our own central health medical management programs and also support programs launched by community care. Clinical case management for the homeless, these are transition of care teams. So we actually have in one of our partner hospitals a transition of care staff member who identifies map patients when they arrive to the emergency department. From that point the patient is able to be connected to outpatient resources, get connected with a medical home, also in most cases gets connected with the care team who can help navigate them through the system. And these patients, our care team also manages these patients if they're

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inpatient going to the sniff and going home or wherever they do go. Resource disability social worker trained using the s.s.I./ssdi outreach access and recovery, which is also known as the soar model to help facilitate enrollment into programs including s.s.I./ssdi for M.A.P. Members. Our collaboration. Central health enterprise members participate in an echo membership council and enterprise led health care for the homeless work group which was spearheaded by central health. Integral care and community care worked together for the health delivery system as it treats persons experiencing homelessness. Continued involvement and pay for success proposals. And then collaboration with austin-travis county ems community health paramedics to support the pop-up resource clinic.

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>> A lot of people are not homeless because they want to be, they have to be because they -- like money is tight. Some of us felons can't get a job, people don't want to hire us because we're a liability. So it's like -- it's either we've got to live how we got to live. And people shouldn't frown upon us because we're still human, we just don't have a home. That's it. [Music] >> So this is I think the second anniversary of the pop-up resource clinics. They were started by austin-travis county ems two years ago, and central health has been pleased to participate for a number of those years. So far we've served about 2500 persons experiencing homelessness in Travis county. We've enrolled nearly 400 people in the medical access program and printed cards for them on site. Our community care enterprise partners, they've served almost 400 people through these fairs and we're serving even more

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today. After folks get served here, they're enlisted into case management services, gotten folks into housing. We make central can bees for the central connections for people living near us in Travis county so they can be healthy and move off of the streets. >> Oh, yeah, wife used a lot of these -- I've used a lot of these services. >> Incident Cal care? >> Integral care, coordinated assessment. I've used pretty much every service here. >> You know, it's interesting because for a lot of them we've started to settlementedly at clinic after clinic. So we talk and we know that they access medical care, they access mental health care, clearly they're partnerships, but they seem to look forward to the clinics to reconnect and to reestablish their needs throughout because a lot of their needs aren't a daily need. Sometimes it's up and down and sporadic. So we're able to get them connected to their resources and reestablish what is lost. It's hard to maintain things when you're not living in a

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fixed site location to maintain your medications, your identifications and things to help you get what you need. >> So members, that concludes our formal presentation. And let me say with the video you just saw with Richard, it is a privilege and an honor that these individuals would let us into their lives. We presented a lot of numbers and dollar figures and statistics to you today, but it all boils down to the human side of this and what can we do. And so we're privileged and I want to thank -- to serve. I want to thank the many staff and the great minds like Veronica who are helping to put these programs together and also thank the support of the board and you all as we're out there working in the community. Thank you. >> Harper-madison: Thank you very much for your presentation. Thank you for all that you all do. And I'm pleased to see some of the members of the board here today because we want to offer a consistent thank you and our gratitude for the hard work you all put in. So thank you very much.

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Any questions? >> Garza: On the 10,000 number that you gave you said there's a range. I'm assuming you have more detail as to the ones experiencing -- and you don't have to provide it now, but could you provide us with the information of those that are Longley homeless versus those that are staying with -- those that are chronically homeless versus those that are staying with friends kind of thing? >> I would have to see how we could break that out. Do you have any insight? >> I think a lot of it is self-reported and a lot of it is eligibility. I think we can possibly look at that a little deeper. >> We'll look at it and get back. >> Garza: You said it's an eligibility. In order for them to be eligible they have to say that they're homeless? >> Itself-reported. So they'll say that they're homeless or it's really what the eligibility criteria can is on what they identify as homeless. So sometimes if -- most of the time if a patient comes

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in and says I'm homeless, then they'll usually qualify for map homeless, but also there's some eligibility in there that talks a little bit more about what their definition as couch surfing or instability. >> So these are the number of people that checked the homeless box basically. >> According to our eligibility criteria. >> Garza: But then you're able to see like in further fields where the range exists? Or if they decide to fill that out? Or is that another check box? You said the couch surfing thing. >> I can't speak confidently about it because I don't do the eligibility piece. I think that's -- it's an eligibility question for our director of eligibility services. >> Garza: Okay, thanks. >> Harper-madison: If I may, if I'm understanding correctly, your question is about getting some clear delineation between the housing instability and unhoused. And so that's what we're

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asking for in terms of numbers. And I'm certain that that's as close as you can get. Those are numbers you can provide? >> Yes, ma'am. We'll certainly look into it. >> Harper-madison: Any other questions? Councilmember kitchen. >> Kitchen: Thank you all so much for being here. I really appreciate the services that you're providing. I have a couple of questions. And I'm wanting to explore a little bit that -- the intersection or collaboration with housing. So I'm assuming that the residential rooming services is a temporary place for people to stay as opposed to more permanent housing or a shelter. >> That's correct. >> Kitchen: Okay. So they stay there only while they're ill, is that right? >> Yes. >> Kitchen: Have y'all explored or considered -- have you explored or considered providing some resources for housing vouchers?

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The reason I ask for that is because I know that the central health is focused on health care aspects. But I'm just asking about that because of the -- well, I've seen in the medicaid world, for example, that medicaid managed care companies are starting to pay for housing because it reduces the cost of health care services, particularly hospital room and inpatient hospitalization. Because obviously we all know that when people have a place to live they can recover better or they don't get as sick in the first place. So just a question for y'all, have y'all had conversations about that? Have y'all explored or examined or analyzed whether that would be helpful from a cost standpoint for central health? >> So I'll answer that question in two parts. We are currently -- in fact,

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I was on the phone with social finance this morning, continuing to work with social finance on the pay for success. And I think that's a pilot project which will provide not only management teams, but the board with much needed information over the five-year period of that project to be able to answer some of these questions, councilmember kitchen. The second part to that answer is the way that we're structured statutorily, the way that our funding is set up, all of our organizational structures, we are so focused right now on access to care. And looking at how do we make sure that we are pushing resources into eastern Travis county in underserved areas, for example? Because we understand that health care, that's part of the anti-poverty equation and by definition it's part of a stable housing situation as well. And not to say that future boards couldn't come in and

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start looking at this housing voucher, but right now just in terms of not being a housing agency, long-term supporting housing agency that is, we just haven't gotten into that arena other than what we're talking to pay for success about. >> Kitchen: Okay. Do you know if sendero has looked into that? The

reason I'm asking is because I've seen that trend among medicaid managed care agencies. >> Sendero is no longer writing in medicaid managed care. They're simply providing an affordable care act product. When they were I wasn't advise fire department they had looked at the housing voucher or not. >> Kitchen: Okay. I can understand that. I do think it's -- I would encourage you all to look at it at some point or at least do the analysis of whether it really does produce a return on investment for you. Because I notice the page -- this is the last question much the page where you have coverage for homeless, where

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you talk about 1200 inpatient hospital stays, there's potential at least. And I really want to applaud y'all for participating in the pay for success program. I think that that's -- that is innovative and I appreciate the participation of central health. I would just encourage you all at some point to think in terms of that intersection with housing vouchers. And then the last thing, there page doesn't have er visits on it. Is there data related to er visits? >> The data that we have is approximately 8900ed visits as a utilization rates. >> Kitchen: 8900. Okay. Chair, I have a few more, but I'll see if anyone else has one first. >> Harper-madison: Councilmember kitchen. >> Tovo: Tovo. Thank you. Thank you, councilmember kitchen, I think that's -- I think those are really

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interesting areas of further exploration. There was a very good housing works conference, a few housing works conference that really talked about that nexus between health care and housing. And I think that that's a very good conversation to engender. I had a couple of questions about the slide that talks about care opportunities for the homeless. I'm not sure what page it is. Where are the rooming services, the residential rooming services for the most part? And do you have a sense of are they in scattered sites? Are there various locations, and how many beds are available through that rooming service? >> So currently right now it launched as a pilot because we needed to find a partner. We find a partner with fresh start and it's actually they own approximately three boarding homes that are all managed on site.

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We have two beds also because of the -- it's really being managed by one person who has house managers on site. Currently we have two beds with the intent to expand to four. >> Two beds total or two at each of the three sites? >> Two beds total. So we could put anybody no more than two beds at any of those homes. It really depends on the fit, the best fit. Each house kind of has their own population and so this particular boarding homeowner usually makes sure that it's the best fit. That that resident is a good fit for the current patients that are staying there, the current residents that are

staying there. >> Tovo: So you may have answered my next question, which was the extent to which the capacity within that program matches the need for it. >> Yeah. It's very small, very small.

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>> If I may, I'm sorry. If you compare last year's budget structure and this year's budget structures, the board has invested and staff -- we're gathering information through this pilot work, additional monies for respite and recuperative care for the full range of care. And I think again as we gain more experience under these pilots and we understand what's the best fit and what works best from an outcome standpoint, then we'll continue -- again, I can't speak for future boards, with you we'll continue to bring those issues forward in our budget development. >> Tovo: I know I've spoken with at least one of your board members about the need for respite care and certainly I've heard from individuals experiencing homelessness and others about the friends of theirs who they know who have been discharged from the hospital, sometimes with IV's and other kinds of need for ongoing medical treatment. All of these different

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voices have urged that we look toward more respite care solutions. Do you have a sense of what the need -- what the total need is in terms of number of beds at any given time? >> I would say on average at any given time we need approximately 30 beds for respite care. And I can tell you right now what we are currently doing is if patients don't have a skilled need and they're too sick to be in the hospital, we will put them in at a lower level, which is a custodial level of care in a skilled nursing facility so they don't get discharged to the streets. >> Tovo: Great. Thank you. That's very helpful. With the residential rooming service, what is the average length of time? >> Currently right now we're experiencing about 30 days. >> Tovo: And I think my last question for the moment was you mentioned one of the clinic, the clinic on south first street offers coordinated assessment on echo. Are there others -- I know

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obviously the one collated with the arch has that ability too, I would assume. >> I think it's the arch and care connections, both of those. >> Tovo: How about your other clinics? Is it just there an individual can seek medical assistance as well. >> Let me go back and check because at I know at one point we were doing assessments at our southeast health and wellness center, but let me verify that. >> Tovo: You can follow up. I was just interested. Thank you very much and also thank you for the video of the pop-up clinic. That was very useful. >> Harper-madison: Thank you. Councilmember kitchen. >> Kitchen: Did you have a question? >> Harper-madison: I do but I can hold mine until the end. >> Kitchen: Are you sure? >> Harper-madison: Absolutely. >> Kitchen: I have a question about the transitions of care team. So am I

understanding that that's the team that works with individuals with discharge from a hospital, is that right? >> Correct.

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So do you have statistics on where they discharged folks to? Or can you give us an idea of what you -- where you end up discharging homeless individuals? >> Most of our homeless individual parents if they have a skilled need will go to a skilled nursing facility so they will go into our recuperative program or they will go into another skilled nursing facility that we're contracted with. Even if they don't go to another skilled nursing facility, even if they don't have access to heritage park, we will put them in another skilled nursing facility that we're contracted with and still provide managed care services through our central health medical management teams. >> Kitchen: Okay. So what about-- owe what's the -- they have to need skilled nursing, is that right? What happens to homeless individuals that don't need that level of care? Where are they -- where are

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they transitioned to? >> So we work with our community partners and there is -- there are care management services through the arch. If they have a medical M.A.P. We make sure we coordinate with the front step staff over at the arch and we would discharge them to the medical M.A.P. Or to the afternoon. Many times our patients are too sick to go back to the arch or go to a shelter or go to the street. So we try to find the best placement possible. I think this fiscal year, this last fiscal year we got very creative in ways to not discharge them to the street. So there's those patients that may need just some medication management and we know that that's going to keep them out of the hospital. Those are the ones that we'll put into a lower level of care at a custodial rate with our skilled nursing facility. If they qualify, if we have one of our open beds at our residential rooming then we will be more than happy to place them there as well. >> Kitchen: Okay. I'm just trying to understand, I don't expect -- my questions are not expecting that you can

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fix everything, but I do -- I am trying to understand the extent of the unmet need. Sue if you're able to -- so if you're able to never transition someone on to the street again that's fabulous, but if that's not what's happening I want to understand the tonight which it's not happening. I mean, really what -- what I'm trying to understand is where is the unmet need so that maybe there's some potential that the city can be helpful. So I'd like to have some statistics. And at this point in time what's the order of magnitude that you have to transition people back to the street? >> It's more often than we would like to. >>

Kitchen: I understand that. I'm not trying to put you on the spot. I'm just trying to figure out what the scope of the need is. >> I think the big gap is really in medical respite

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care. I think it's really in medical respite because we have patients who are really too sick to go to the streets. You can look at them, you know their medical history, you know you don't have the family support, you know they don't have support systems out there to help keep them off of the street, and these are the patients that end up three times sicker into the Ed and become inpatient admission stays. If we had a place for them to go and get adequate negotiation and get social services and a warm bed to stay in at night I think that that would really help -- it would really help with the problem that we're seeing with our homeless patients being discharged to the streets much sicker than they need to be. >> Kitchen: Okay. And so what would -- what would it take? If you can't answer that right now that's okay. But my question to central health is what would it take to match up the need for

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medical respite care? So like I said, you don't have to answer that right now, but I really would like to see that. Is that something that y'all can provide? >> I think we could -- let's go back and look at the data and see what we can provide today. But what I would also offer up is that as we start our budget development process, and that will be coming up before we know it, this is one of those issues that in order to build up our budget for recuperative and respite care we'll need to have this information. So our information is good and we'll share that as it is developed. Let's see what we can provide now with the understanding that we may need to come back later in the spring and early part of the summer. >> Kitchen: The reason I ask that is what we're trying to do from the city's perspective is -- we've done it to a small extent, but not completely, is we're trying to identify the -- what the scope of the need is. You know, so that we can have a conversation about

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how can we best meet that need in a way that is collaborative across the whole community. So if we don't have the analysis of what we really need, you know, in terms of what ear able to serve right now and what we can't serve, I think you did give us an idea that you needed like 30 beds, I think you said. So if you can provide that kind of information that would be really helpful? >> Harper-madison: Thank you, appreciate it. Mayor pro tem Garza and then councilmember tovo. >> Garza: Yeah, I appreciate those questions, councilmember kitchen, because as we're talking about buying more hotels possibly, we've talked about the roadway inn and I feel like the presentation yesterday we're learning so much about

like the most vulnerable amongst the vulnerable and yesterday there was discussion about women and then today is this one. And as we were having that discussion I thought the

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next -- if the city buys a hotel that one should be for women and then this seems to provide another opportunity to understand how we can best work with echo and, you know, reach the most vulnerable of that obviously very vulnerable population. So I think this is a good discussion and to have this with echo as we continue that strategy, possible strategy of continuing to buy hotels because obviously y'all have limited resources as we do and where we have those resources to be able to match up to help that incredibly vulnerable population. >> Harper-madison: Councilmember tovo. >> Tovo: Yeah. Just maybe a final question on this particular topic. So thank you very much because this has really been -- it's been having that was suggested a lot but

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I don't know the scale of the need. This has been helpful. If you had a location or a facility that could provide that respite, would you have the funding that provide that level of service? I guess that's in amidst all the other questions that we've asked to get back to you on, I guess that would be another one. I'd just add to the list that you don't need to add toyed, but would you have the financial support yesterday to provide that ongoing service if we removed the location piece of it as a challenge? And again, you can get back to us. >> I will, and thank you for that allowance because as we start to develop our budgets and we get smarter each year with the experience that we gained, we gain more on the financial side of this and what it's going to take. It's not just standing up the services, but it is

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providing outcomes where it is outcome bas, but also the long range operational cost. We want this to be sustainable. Whatever it is that we put on the ground we want it to be there year in and year out, but also be flexible too. Homeless -- people experiencing homeless populations can move and shift around so we need to make sure that we've got some flexibility built into this and as you point out there's financial implications there. As we develop that we'll certainly share that with the council. >> I assume some of those costs are already being incurred when you have the residential rooming service and others you're paying for that ongoing care and may be paying for it some of that ongoing care if some of the individuals are he returning through the er visits so that would be interesting to get a sense of what of those costs are already incur and how much in addition if you had access to a 30-room facility. Thank you very. >> Thank you. >> Harper-madison: Thank you for all the questions. It actually answered some of my questions and as a

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follow-up to councilmember tovo's question about location, I think more specifically I think the question you asked was if you had a facility would you have the ability by way of financial resources in order to cover the cost of operations and maintenance? So just to get a general idea of what the overall costs would be I guess would be very helpful for me to sort of think about that situation between sort of the capital investment and then the operations and management, that would be helpful for me. Like I said, a lot of my other questions were answered, but something that came to mind as you were speaking -- and I really appreciate and I think the lbgtqia-plus community will be interested in you making the delineation in gender identity. So I'm curious to know if y'all are working specifically with some of the organizations that are working with that population of folks, most especially

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super high risk, black trans women, for example, who generally speaking are hiding in the shadows because of safety concerns, particularly black trans women who happen to be experiencing homelessness. I wonder if you're working with the trans education network of Texas, out youth Austin, some of those other organizations that have that established trust with those individuals who find that it's beneficial for them to remain sort of hidden. >> So I'd like to go back and talk to our community engagement and outreach team. I know through our health champions program that there's quite a bit of dialogue and conversations ongoing, but let me find out more specifically what efforts might actually be underway. But if you'll permit me to get back to you on that. >> Harper-madison: Absolutely. I appreciate that very much. And to sort of piggyback on what mayor pro tem asked about sort of a gender

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specific facility, as we're recognizing points of vulnerability, we had a really good presentation during the course of our work session that talked specifically about the dangers of women experience when they're subsequently experiencing homelessness. And so I had the ability to visit a facility that's doing good work, but one of their complications is how they have to separate people by way of gender so a shared courtyard, for example, literally has a piece of yellow tape down the center of the courtyard to separate people by gender. And just recognizing some of the limitations that are inherent to taking gender identity into consideration and real specific safety concerns around gender and consideration just have me thinking through who do we need to make certain that the municipality and the various partners that we have are partnering with to make certain that we're taking every bit of the

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nuance there into consideration. So as you ask that question with your community engagement folks, I'd like to see the evolution of that conversation. Along those lines, on the slide that talks specifically about benefits, I think the number was 70,000 prescriptions. >> Slide 6. >> Harper-madison: So out of the 70,000 prescriptions, something that you said that caught my attention was -- and I understand that sort of privacy concerns prohibit some disclosure here, but I'm just curious about -- I think you said there was a 10,000-dollar more spend? >> 10% increase.

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>> Harper-madison: 10% increase. I'm curious about what the implications there are? What is that attributed to? Is it an increase in population? Is it an increase by way of the cost of the medication? Is it the types of medication? And if it's helpful, the line of questioning there, I always sort of come back to this prevention component. So is it maintenance medication or -- I'm just curious about the increase? >> I think most of it is probably maintenance medication for our chronic -- most of our patients have two-plus chronic diseases. >> Harper-madison: So I think the second half of that question is you discussed specifically chronic disease management, so along the questioning around how we can be more helpful as a body around the housing component, the respite care component, how can we be more helpful around the prevention and

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management component as well. >> I think the prevention and management really comes from how to activate and get patients engaged. What sort of efforts are we doing to really engage patients. I think we do a good job at making sure patients have access to their medication, making sure they pick up medications, but it's that active engagement that really makes patients comply with their providers to take their medication. I think that's where we see -- you know, our homeless patients just experiencing homelessness in general, there's so many societal factors and social issues around their condition that the last thing they want to do is take their medication. Or we're starting to experience patients who go ahead their medications stolen. So those are the patients that we really want to make sure are connected and we want to make sure that we navigate them appropriately. And whatever we can do to -- whether we find resources at

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the arch to store medications or can they be stored somewhere do you have a safe place to go, those are the sort of things that we really look at. But I think we do do a good job of making sure that patients have their medications, but again it's how to you get a patient to take their medication and make sure they stay compliant with it? And it's peeling off like an onion layer, right. It's making sure that you have addressed all of these other issues and then let's get to the bottom of why you're not taking medication. >> Madam chair, if I may, I'd like to commend the community paramedics, because I've ridden with them before and they're very thorough about asking about medication and medication regimens and certainly been helping in that regard beyond measure. I want to give them a special shout-out for their work in that area. >> Harper-madison: Thank you. I appreciate that. I'm certain they will too. Along those lines and in district 1 by way of conversations with our constituents is patients attempting to stretch their

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medication. There's a specific regimen that they're supposed to follow, but by way of the fear of insecurity around medication they're trying to stretch and that's a problem and I appreciate that you brought up sufficient nutrition. That's a problem. So many of the medications are specifically prescribed to be taken with food, but with the food insecurity component or sort of access to some of the other issues around sort of properly executing the direction for the medication, we're running into those issues, so I appreciate that you brought it up because it's something I would really like to dial into as a part of the conversation. It's not just access to the medication, it's not just access to medical care providers, it's all the sort of ancillary items that are points of consideration. I don't have any other questions. Anybody else? I'll make sure I don't have any other questions. I may have actually had one more. No, that was it. Thank you very much.

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We appreciate your presentation. Thank you for the follow-up. >> Kitchen: Wait, I'm sorry. My question was just I found this document pretty helpful. This is just your one pager on the homeless services overview. Is that available on your website or can you send it to us? >> We will send it to you and if it's not available on the website we will get it available on the website. >> Kitchen: Thank you. >> Harper-madison: One more question. Councilmember tovo. >> Tovo: Could you elaborate a little bit on the street medicine component of community care? Where it operates? What parts of the city or county? How you collaborate with some of the other outreach teams. We had a good presentation yesterday about echo's navigation outreach team as well as integral care's path team and of course the city has the host team which is also collaborative. I'm trying to line up how all of these different research teams work together. And I believe that Dell also has a street medicine program. I may be wrong about that,

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but if you could just give me a little bit of information about the street med. >> So from what I understand the street medicine team goes out and I think part of the team also works very closely with the host team and so they're connected with integral care and they're connected. They work really well together to make sure when they do identify patients experiencing homelessness with a medical issue that they are also connected to those other services as well. >> They're actually -- so when the host team or the path team or potentially echo's navigation team identifies an individual with some medical issues, the medical assistant, they contact as often the community, the street medicine program? >> Uh-huh. >> Thank you, that's helpful. >> Harper-madison: Thank you very much. We appreciate you. >> Thank you. >> Harper-madison: All right. We have another briefing.

[2:26:32 PM]

Our next briefing is an update on the austin-travis county success by 6 coalition strategic plan. Please introduce yourself. >> Good afternoon. My name is Kathie mccourse and I'm the vice-president for success by 6 be united Way of greater Austin where I see the implementation of the austin-travis county success by 6 community strategic plan. Madam chairman, mayor pro tem and councilmembers, thank you very much for the opportunity to share with you this afternoon about our progress on implementing this strategic plan. I wanted to let you know that for the sake of time I am going to omit a few of the background slides that we shared just to keep the pace of the meeting going for you and hit the high points. So to call your attenti to the context of our community, in austin-travis county one in three children under age six living in Travis county live in households with low income and that's 34,000 children

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in our community. And 90% of these are children of color. The overall goal of our strategic plan is to ensure that all children in our community have the opportunities and access to resources to ensure that when they enter kindergarten they are school ready. And what do we mean by school ready? We mean that whole child development. That they have reached the developmental levels and have had the opportunities to be successful with the curriculum that's offered when they enter the school door. We know that children who enter kindergarten school ready are three to four times more likely to be on grade level for third grade reading and to graduate -- which is predictive of graduating on time. I have a slide here to demonstrate the progress of our strategic plan. And what we want to call attention to is the goal of closing that gap between

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those non--- those low income children with their more advantaged peers. And you can see over the past four years we have -- the past three years we have started to really show some progress in closing that gap, especially in the 2015 to 2016 year was when we launched pre-k-3 in our community. And the two years of really rich high quality pre-k has obviously made an impact in our community. However, when we disaggregate our data by race and ethnicity, we see we have disproportionately low rates for our children of color. This is an area -- I'll be mentioning later that we're particularly leaning into in the next year this addressing issues of equity systemic racism and how we can work with partners in

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the community to dig into what are potential solutions in elevating the school readiness particularly in our young children of color. So it's important to note children who start school behind are much more expensive in the educational system. We incur expenses with special education, intervention, retention, so if we invest early and assure our children start school on even ground, then they will progress at the rate of their peers. Despite the work of our plan to strategically use the resources that we have, we know that in our community only 34% of children under age 4 from low-income homes are receiving any early American services at all. And these are children who are income eligible to qualify for services, but we lack the capacity and resources to provide those in our community.

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There's some history of our strategic plan, but I wanted to recognize the coalition leadership and this is the group that oversees the implementation of the plan and I wanted to call attention to the city of Austin as a key partner in implementation and especially give thanks for the tremendous effort by the Austin public health team who play a key role in many of the different work groups and areas of our plan. We have a robust framework for our strategic plan and it's shaped in a circle because we keep chirp and family at the heart of our work -- children. And we have four pillars to our plan, healthy beginnings, supportive families, high-quality care and education, and safe and stimulating communities because high-quality early childhood experiences involve both the families and the children and their environments. It is not a single stream.

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With improving program and policy. So taking a deeper dive into each of our pillars, I wanted to highlight some of our successes over the past few years and point out some chances and opportunities that we're facing. In our healthy beginnings pillar that focuses on health and mental health services for families with young children, we've launched our family connects program which is the newborn, universal newborn home visiting program that is taking place at St. David's south. All families who give

birth there are given the opportunity to have a follow-up two to three weeks after birth from a public health nurse, and in our first year we served over 760 families. In several of these cases the nurses found families in crisis and were able to intervene within that moment to prevent infant death or maternal death. >> Harper-madison: I'm sorry, can you repeat that

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percentage? >> Multiple cases, 11 emergency cases. >> [Inaudible - no mic on]. >> 15 emergencies, 11 families that needed emergency care upon the time of that visit. We received the attention of a national funder, the children's learning initiative for the work that we've done in our community as a community to elevate and improve the outcomes for young children. And we've been invited to apply for a continuation grant for that work. We are continuing to seek more robust engagement with the health care system to expand our work to ensure that health and mental health services are afforded for families with young children. And our opportunities that we are leaning into in the next year are to really focus on the pre-natal to three period because we've had good success in building systems for our three and four-year-olds to expand the

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family connection Pam and help expansion of centering programs that have really robust outcomes for especially families of color. And we hope to create a system to ensure that when children have developmental screenings with their pediatricians that we can make successful referrals to services in the community. We find that a lot of children are screened, but then the referrals don't end up -- they are not successfully closing the loop on the referral whether families are not following up on the referral, the referral gets lost in the system and we want to create a better process for making sure families can access those. In our supported families pillar where we seek to ensure that families have the support, resources and knowledge to nurture their children in the earliest years, we appreciate, greatly appreciate the funding through the ready families collaborative for

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home visiting programs and serve almost 650 families through this collaborative. And we've secured some additional fill and tropic grants to expand visiting and parent services. We find Austin affordability issues is making it harder to retain qualified staff who work for relatively low wages and we continue to see some other issues as barriers for families participating, especially transportation has been a big issue. We are continually looking for new partners to bring into this work. We started working with mama Sana and other groups and we are bringing in new home visiting providers. High quality care and

education refers to our work with child care, pre-k and head start. With our goal of ensuring that all children have access to high-quality early care and education environments. Our biggest wins are an

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expansion of the pre-k three program with aid and ensuring moving the quality of our centers. We've increased the number of children served through subsidies and enrolled in high-quality centers by more than 80%, but I would caution that in our community we only have 3,000 slots for subsidized child care for all children in our community. So it's a limited pool. We this year launched an innovative partnership where we support child care centers and partnering with Austin independent school district to leverage pre-k state dollars into the child care centers to blend with the child care subsidy funding. This was resulted to date of almost half a million dollars that would have been unspent for pre-k funds that wouldn't be accessed but are now leveraged through aid into the child care centers and increased the half day enrollment by over 450 children.

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Challenges continue to be lack of access to quality-rated programs for families that rely on child care subsidies. Barriers to the child care subsidy due to state policies and practices that have an impact on nonenglish speakers, and early childhood workforce is struggling in our community. The university of Texas completed a culture of health steady that found 23% of our early care and education workforce rely on public food assistance, 42% of our early care and education workforce are food insecure, and 40% of our early care in education workforce showed clinical signs of depression. And it is incredibly important that those workers, those providers as teachers who are truly the architects of young children's brains are healthy, for themselves to be healthy and engaging in warm, care giving relationships with our youngest children. This also disproportionately

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impacts in our workforce, it's disproportionately low-income women of color. Opportunities that we see on the horizon, we do hope and encourage the council to explore the use of economic development corporation as a vehicle to provide tangible support to access to high-quality child care centers which has been done in our communities. To export expansion of the pre-k partnerships provides so childhood care providers can improve the compensation of their workforce, and support for family child care providers. I did want to call attention that we are aware that with the last legislative session child care licensing created a new unit that is charged with seeking and enforcing child care regulations. Seeking out unregulated operations. And so they are charged with going, looking in the community, looking on

social media and finding providers who are caring for children but do not -- are not considered -- have not gone through the operations

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process of becoming a listed registered or licensed family home. We've established a working relationship with the administrator of this new unit and we're exploring opportunities to partner so that instead of dismantleing this form of care that we believe is highly prevalent in our community and is relied upon by many parents of infants and toddlers, especially for people who need untraditional hour care, weekend and evening care so that instead of dismantling and shutting these providers down, they will hand them -- they will introduce them to our coalition and partners that we are working with including gave, African-American youth harvest foundation to work with these providers to become listed, registered or licensed care providers and help them through the process. But I did want you to be aware that they are actively enforcing in our community as of this month. There will be opportunities down the road to see if

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there may be funding streams we would like to consider to support these providers for overcoming some of the barriers to that regulations. And safe and stimulating communities is our last pillar where we really think about the other institutions, organizations and opportunities in our community to ensure that families are wrapped with -- around with a warm, nurturing environment where families can thrive and it's safe and healthy for families with young children. We've worked tirelessly this fall in building relationships with a quality of life commissions and we are pleased to be joining the joint inclusion committee, the early childhood council will be joining the inclusion committee. We are launching connect atx, which is supplement to the 211 system at United Way that will support close referrals for other

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resources for families with young children and launched a robust business alliance called early matters greater Austin where business leaders are becoming informed and engaged in effort to improve early childhood outcomes. Our challenges continue to be that early childhood is often invisible or forgotten between the sectors of health and education and it's cruelly a cross sector of health and education. And the system isn't really a system. It's inheritly fragile and fragmented and our coalition has created a system for our community. It's complicated by systemic in equality. We looked to redistribute investment to reduce in equities and we also encourage our community to look at using aid and other

city-county facilities to expand early childhood programming. 80% of the costs of child care is staff and 20% is facilities.

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Our priorities moving forward again reiterating pre-natal to three, elevate family and community voice and focus on equity. We're also working closely with our counter part at United Way to ensure complete count, children age birth to five are the most overlooked in the census. And our ask for the city of Austin to consider, we recognize limitations imposed by revenue caps, but given the strong return on investment of investing early, we ask the city to consider hiring one additional full-time staff member at Austin public health to coordinate early childhood initiatives programs and services with other city departments. There's currently only one staff member dedicated solely to early childhood. We urge you, the council, to explore using the property tax revenue from the manana fund to be early childhood

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initiatives as noted in the resolution in June to explore that opportunity. To preserve the current and future funding for parent support specialists within aid that I understand is voted on every year. And if we could ensure that wasn't at risk every year. And again encouraging you to explore creating economic development corporation as a vehicle to early childhood care. The city of Austin has been essential to help address opportunities to meet the needs of families across various departments, parks, recreation, libraries, even economic development. And so we're very thankful to have the Tuesday as an integral partner in our coalition work and we look forward to continuing to partner to keep families with young children at the center of priorities of our community. Thank you. >> Harper-madison: Thank you very much. Do we have any questions?

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Mayor pro tem. >> Garza: Hi, thank you for all your work in this area. You mentioned there are families eligible but the lack of resources, are you talking about pre-k three classes or -- >> It's more focused on child care subsidies. Home visiting programs and slots, those kinds of things. Especially child care subsidies. >> Garza: And that's state funding? >> It's state funding through the Texas workforce commission. >> Garza: So it's -- we have -- it's not a situation where we're leaving money on the table like snap, for example. Sometimes we have people eligible and they are just not applying. This is -- >> Correct. We currently have a wait list of over 1,000 families for child care subsidy. So there's tremendous need. Our state doesn't supplement what the federal government passes through, and then our state, the workforce

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commission allocates how many seats are needed to be provided in each community based on the pot of money coming and based on the quality of the child care provided. >> Garza: Okay. >> Fortunately we have higher reimbursement rates than many communities because we have moved so many providers to higher quality, but that -- instead of making our pot bigger for that, it leaves our pot the same size and serves fewer children. So there would be an opportunity should our local community choose to supplement that funding that could serve many more families. And that was -- that is one of the potential ideas that could be used should the manana funding come to fruition, another consideration is that when families -- when they graduate from workforce programs and their income increases, they become ineligible for child care

[2:45:57 PM]

subsidies, and sometimes that -- often the increase in their salary doesn't cover the loss that they experience as a family from that child care subsidy, and so they end up having a lower family income because they then have to cover the cost of their child care subsidy that they used to rely on. >> Garza: Okay. >> I don't know if I articulated that very well. >> Garza: Do you know the demographics of the -- you said there were 11 families with 15 emergencies. >> I could defer to shalen, our director of family connects. She could give you information about that. >> Garza: And the the -- do you want to do it now? Okay. Thank you. The support for family care providers, this new enforcement wing, do you know what the motivation -- was it the CPS backlog thing? >> I think it stemmed from the unwatched series that the statesman had last fall

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that exposed -- several years ago there was a unit that was charged with searching. It was disbanded and they refunded that department. >> Garza: Okay. Okay. And then -- those are all my questions, but thank you for reminding us of the manana fund and I will look further into that because that was one of the reasons we gave for -- in the resolution was for early childhood. >> Thank you. >> Harper-madison: Any further questions? Councilmember tovo. >> Tovo: Just a quick question and then a couple quick comments. With regard to the manana fund, I have some information we can talk about that we've gotten from our financial -- our financial staff. You had cited a statistic that I didn't capture on slide 17 about the percentage of child care staff who are food insecure. >> Yes, I'll be happy to send that study that was

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produced. It's the first of a three-year study. 23% rely on public food assistance programs and 42% report being food insecure. >> Tovo: 23% -- >> Of our early staff. 42% of those staff reported being food insecure. >> Tovo: Thank you for highlighting the challenges and the real -- the real very significant issues for staff. And thank you also for talking about the importance of looking at the economic development corporation. Ashley Richardson on my staff came up with the idea, I think it's an excellent idea, and I want to credit you as well because it happened and was inspired by a conversation that happened at early matters, so thank you for hosting those really important times for people to come together and really

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focus on early childhood education. I think the edc offers us a good opportunity of potentially impacting early childhood education here in Austin and in Travis county through a couple different means from potentially providing some of those gap subsidies for child care vouchers potentially impacting salary, providing some financial support for salaries for child care workers as well as really making sure that we have policies going forward for our city-owned buildings and other tracts we might acquire for partner with to have access to child care. Thank you, I think that's a fruitful area of exploration. >> Harper-madison: Thank you very much. I actually have a couple of questions. Councilmember kitchen, did you have any? Along those lines, I'll sort of piggyback on where you were. You said something about community contributions towards child care subsidy. And specifically my curiosity is around the

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workforce commission subsidy. I'm assuming you mean like ccms. >> Yes. >> Harper-madison: So when you talked about the importance of the opportunity by way of the edc, is that what you meant as that as a vehicle being able to -- >> To generate funds that could supplement that to serve families on waiting lists to increase the rate for infants and toddlers so that centers aren't at such a deficit for every family on subsidy that they serve. >> Harper-madison: Uh-huh. Okay. And then along the lines of the mayor pro tem's question, specifically you made reference to the enforcement of -- >> Unregulated operations. >> Harper-madison: Frankly troubling for 2:20. From a commentary perspective, I'm thinking through how my mom was able to have five kids and be a single mom and work between two and three jobs and all of the aunts and friends that took care of us, you

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know. They weren't regulated child care providers but they loved us. Just sort of thinking through, I really appreciate you all thinking through, taking the opportunity to create a coalition and a partnership and bring people along throughout the course of that process. We recognize that some of the barriers about being registered or licensed or some of the other things are just that, they are barriers based on lack of access and education. So I really appreciate hearing that that's something that's happening. So I do have a couple of questions. And so, man, it's so troubling to hear about the food insecurity component for the people we really are relying on to be responsible community assets, you know, our young people. >> Absolutely. >> Harper-madison: And so one of the statistics that I'm looking at here, the 62%, it's the slide number 5, a large percentage of parents in two-parent families are not working.

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The 62% number seems glaring for me and, you know, by way of our discussion, I think the assumption is you make this careful sort of cost benefit analysis, can you afford to work based on the cost of child care. Does it make sense for you to work outside of the home. Just wanting to get confirmation from you that that probably is in large part contributing to that number. >> Yes, very much. >> Harper-madison: And just thinking through what do we do? >> That's the -- if we had a silver bullet answer, we would be here with that. But that is -- that is the challenge that many of our families face and our families who meet eligibility requirements for head start or child care subsidy, you know up to a certain level and then we have very much a kind of missing middle for families who just simply make too much. $10 too much to qualify for a subsidy, but, you know, there is no sliding scale on either end for the subsidy.

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So some -- I hear anecdotally of families who are offered a pay raise and decline it because that would remove -- that would make them ineligible for a subsidy. Most of our early care and education caregivers who are parents have to apply for a subsidy to take their own child to child care with them because they can't afford otherwise to be working there. >> Harper-madison: Wow. >> But the expenses on the -- on the side of running a child care business are staff and facilities, and with the low unemployment rate we have, we have many providers who are not living in Austin and they are becoming -- deciding they can make more where they live doing something different despite whether they love the job. And, you know, rent is -- the cost of property here to rent or have new space for

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providing child care. And many of our child care providers are small business owners. >> Harper-madison: Right. >> And so they really struggle with these issues. >> Harper-madison: Not complex at all.

>> But they are a small business owner, not public services. >> Harper-madison: Right. >> And I think that's fundamentally the biggest challenge. >> Harper-madison: I appreciate that and I think I'll leave you with this last one. I have some questions -- or not questions, I just wanted to contribute, you were making reference to the complete count. >> Yes. >> Harper-madison: I just wanted to make sure, I know the Austin urban league is engaged in a really robust comprehensive campaign to make certain -- I think they are calling it make black count, to make certain that connection has been made. >> Yes. >> Harper-madison: Thank you. Any other questions? >> Garza: Just a comment. What we have found in this

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space is public investment, the lack of public investment or subsidy in such an important area, and you know the previous conversation about trying to find resources to house our most vulnerable, it's -- you know, if we had invested in the beginning, we might not be in this situation. And it just seems like the easiest connection to be made, but I guess I will say it's great to see that we have presidential candidates talking about this exact thing. It's so important and I hope we continue. It's because of the work of United Way that, you know, this conversation continues to be elevated. So thank you for all that you do. >> Thank you. Thank you all very much. >> Harper-madison: Thank you. I'm sorry, one more question. On slide number 20, the one new fte, can you give us any indication about what that expense looks like? >> My -- my estimate is about $75,000.

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I look to my -- think so. 95, sorry. 95. And there really has been a -- because of the opportunities that we've been taking on to coordinate and expand services, there are many, many demands and opportunities that we feel like could be achieved with more capacity at the city level. >> Harper-madison: I can appreciate that. Thank you very much. We appreciate your presentation. >> Thank you all very much. >> Harper-madison: Thank you. All right. Our final briefing, the Texas campaign to prevent teen pregnancy update on the state of teen pregnancy and youth access to reproductive health care. Thank you. I can pass them down. Sure. Thank you. All right. Please introduce yourself. >> Good afternoon and thank you so much for having us

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out on this cold and rainy afternoon. Jennifer, director of policy and data for the Texas campaign to prevent teen pregnancy. And we are a statewide nonpartisan, nonprofit organization. We were founded in 2009 to reduce the rate of teen pregnancy in Texas. We don't provide direct services to youth. Instead we work towards statewide systems change through research and data, advocacy and public policy, strategic collaboration and training and events. We are a statewide organization, based in Austin, and

we're proud to participate in several local collaborations and partnerships. We serve on the sexual and reproductive committee, on the Travis county adolescent health collaborative, and several Austin clinics participate in our Texas youth friendly initiative. And we also serve on one voice of central Texas. Before I get to deep into this, I would like to talk about the evolving narrative around teen birth. So in previous decades we

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saw a lot of information and narration around the dangers of teen birth and the ill effects, and we saw things like these bus stop ads where the crying baby is sighing I'm tries as likely to not graduate high school because you had me as a teen. This is a message shaming to any teen mom. What we're seeing is intentionality, we want to support teen parents and help them live their best lives. We're seeing a focus on removing the barriers to accessing reproductive health care and accessing the information that youth need to make informed choices. We're seeing a new nuanced understanding of the correlation versus causation around some of these negative outcomes associated with teen births and much more awareness of the underlying disparities and the structural racism that shapes some of these outcomes. I wanted to start with that framework. So the data. So Texas consistently has one of the highest rates of

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teen birth and repeat teen birth in the nation. We have the highest rate of repeat teen birth. However, rates are on the decline. Tremendous declines, more than 50%. Travis county as the lowest teen birth rate of any major metro county in Texas. About 2% of Travis county teens gave birth in 2018. Which is down from 6% in 2006. From a public health perspective, that's a tremendous decline. A the look of Travis county's lower teen rate is a function of demography and we'll get to that in future slides. So why are these teen birth rates declining so dramatically. Human fertility is a complex subject. We see that access to contraception, especially the most effective forms are

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one driving factor. We're also seeing some behavioral change. This generation of teens seems to be more risk averse than prior generations. They are waiting longer to have sex and having less less, but by their senior year of high school, 63% of Texas teens do report having been sexually active. We're also seeing cultural shifts. Young women seem to be more focused on completing their education, forming workforce attachments before starting families. A lot of that can be tied to a sense of economic opportunity. We're seeing other factors like access to information and increased smart phone usage which can lower risk behavior because snap chat cannot get you pregnant. There's research on this. So diving a little more into the Travis county data. So in 2009, ten years ago, based on our most recent year

of data, there were just under 1600 teen births in Travis county. And about two-thirds of those are 18 to 19-year-olds.

[3:01:12 PM]

A decade later, 2018, our most recent year of data, there are just 754 teen births. Really a tremendous decline in less than a decade. And the good news category, there are so few that the data are suppressed so I'm not allowed to say the actual number for privacy reason. We talk about the age of the mother, but of course it takes two. As far as the age of the father goes, that data came from birth certificates and about a third of the cases the father is not on the birth certificate. If the parents are not married, the father is required to sign an affidavit of paternity. In approximately a third of the cases we don't have that data on the father. In about a third of the cases the father is also a teenen a then in another third of the cases the father is significantly older, older or significantly older. And this is just a map showing the teen birth rate by county. You can see definite geographic includes user

[3:02:12 PM]

ting. Teen births are much higher in rural counties. So of all the major urban counties, only Dallas county has a teen birth rate higher than the state average. However, these declines in teen birth rates still show a lot of disparities and in equity. And we see these in literally every aspect of reproductive health from maternal mortality to infant mortality and despair reduce in early and unintentional pregnancy. So as we've already seen, teen birth rates in Texas and nationwide and Travis county are higher among older teens. They are also higher among teens who have already had a baby. The biggest risk factor is a prior teen pregnancy. As we mention, text Texas has the highest rate of repeat teen births, about one out of five are not the teen's first. Texas does not allow teen parents to consent to their

[3:03:12 PM]

own birth control if they are a legal minor which could have contributing factor. Travis county's rate is slightly lower than the state as a whole. We also see despair rate outcomes among youth of color, youth living in poor communities and rural counties as that heat map showed. We also see very high rates of teen birth among youth with adverse childhood experiences, child trauma and especially youth in the foster care system who by definition have a history of trauma, and youth experiencing intimate partner violence also have higher rates of teen birth. All of these things are tied together and closely correlated. Let's look at some of the disparities within Travis county. So the teen birth rate in Travis county among hispanic youth is ten times that of white youth. That's a much larger gap than we see in the state as a whole and he reflects some of the other in equities we see within Travis county. The teen birth rate among hispanic, black and white

[3:04:13 PM]

girls is decreasing rapidly in the last decade, but the rate of decline has been fast tore for more privileged youth. One to be factor could contribute -- is the fact that more births in Travis county were to mothers who were born outside of the U.S. We have a higher proportion than the rest of the state. And we know that this population can face significant barriers in accessing health care, economic opportunity and other key resources. And about two-thirds -- 80%, sorry, are teen hispanic girls. Now let's talk about the current policy at the federal and state level. So two of the primary areas that the Texas campaign works on are access to education and access to health care. Those are two of the key pillars to our work. So around access to education, tas is one of the 26 states that don't require sex Ed for high

[3:05:14 PM]

school graduation. That was a policy change from about ten years ago. And as a result, we see that 25% of Texas ISDs teach no sex education at all. Almost 60% teach abstinence only, and 17% of school districts in Texas teach what we call abstinence plus education. This says that abstinence is the safest and best choice, but also provides medically accurate information on risk reduction such as contraception, healthier relationships and other key topics that we think are so important for our youth to have. One tremendous advocacy opportunity that's coming up in this year, the Texas state board of education is preparing to revise the minimum curriculum standards that govern health education in Texas. Advocating for positive revisions that could result in better equal sex Ed across Texas. There's immense local control in Texas ISDs.

[3:06:16 PM]

Offer sex Ed at the high school level, and if they do, they have a large amount of control over what they choose to offer. So we see a lot of variation, and what we see is the larger urban districts typically offer high quality sex Ed and the rural districts may offer abstinence only. Of those within Austin, Austin aid offers a curriculum adopted last year. As a mother of two boys, I was pleased to see the outcome of that vote. We see that hays ISD which edges into Austin teaches a strong abstinence plus education, and round~rock abstinence only and Leander teaches ab time stimulating communities fence only. Within Travis county and Austin tremendous variation as to what students are

[3:07:17 PM]

receiving. Let's talk about health care access. We know youth access to reproductive ce is tremendously complex. In two of the most complicating factors are consent and confidentiality. Texas has some of the most confusing and complex laws in the nation around our youth legal right to consent to medical care especially reproductive care. In Texas a youth can consent to family planning if they are at a title 10 clinic, served through the medicaid program or certain other situations such as if they are 16 living on their own and managing their own finances, they can consent to their own health care. Otherwise if they are an unemancipated minor they need consent from parent or other adult. We also see access to financial coverage for reproductive health care is immaterial immensely complex in Texas. Texas residents with income below poverty level are eligible for pre

[3:08:18 PM]

reproductive health care in tax. You are probably familiar with the decisions in 2011 to 2013 attempting to limit abortion access that resulted in the loss of access to general reproductive health care, we saw more than 80 clinics close. In 2016, Texas did attempt to rebuild that safety net and launched two revamped reproductive health care programs. But many Texans aren't aware of these programs and don't know they are eligible for them. We also rerecent changes to title 10 program rules which have resulted in a lot of instability in our title 10 provider base, nationwide, statewide and Travis county. While we do have access to family planning services, of course access to full health care coverage remains challenging in a state without medicaid expansion. Additionally, our Texas chip program doesn't cover contraception, one of two states in the nation and we are working to change that. So the programs that

[3:09:18 PM]

specifically provide reproductive health care are the healthy Texas women program, the family planning program, and title 10. We'll talk more about local options on the next slide. So access to reproductive care in Travis county. For title 10 we are down to one title 10 location following the gag rule which does not allow title 10 providers to refer from abortion services. We now have one clinic left in that program. Our state family planning program is served buoy the clinics that you will recognize as being affiliated with central health. Aen the family planning program serves low-income people with an income below 250% of the federal poverty level regardless of citizenship or gender. Our healthy Texas women program which serves citizens -- has almost 50 providers in the greater Austin area. Planned parenthood of course no longer receives state or federal funding but does offer sliding care at three

[3:10:20 PM]

clinics in Austin. For general health care coverage we medicaid, chip and a strong M.A.P. Program. That concludes my presentation. I'm happy to answer any questions and thank you so much for having us here today. >> Harper-madison: Thank you very much. That was a great presentation. Can you remind me how to pronounce your last name. >> You can say biendo. >> Harper-madison: Do any of my colleagues have questions? I have a few. I'll keep it brief. I know there's some folks that have to take off soon. I'll start with one of the last statistics you quoted, which was we are one of two nationally where chip doesn't cover contraception. >> Serves low-income children whose families make too much for medicaid, so every other state besides North Dakota covers birth control for purposes of pregnancy prevention in chip.

[3:11:21 PM]

Texas does not. And we made really good progress on a bill last session, we got it through the house with bipartisan support. The bill had no fiscal note, in fact the fiscal note projected cost savings due to averting unintended pregnancy and we were just having conversations with representatives this morning and we're going to be working on that bill again next session. >> Harper-madison: I appreciate that. If you wouldn't mind sort of keeping my office in the loop. >> I would be happy to. >> Harper-madison: About legislative movement you guys are making, and generally speaking, I would like to reach out. So we had an opportunity to talk to some parents recently who are running into the unintended consequence of your daughter getting her period at ten. There are no period support essentialists and no -- no period products. That steam rolled into a conversation around menstrual equity and justice and reproductive health. I'm going to have the opportunity to tour the

[3:12:22 PM]

center for child protection and got the startling statistic that of the 1557 youth that went through their facility last year, 74% were there because of sexual molestation and/or abuse and having them give me background on how we get there. So I think everything we're talking about, the prevention part is what we need to put focus on. My office along with some of my colleagues and public health, we're looking to put together an event for later on this year. >> Wonderful. >> Harper-madison: That's going to talk about sexual health, reproductive health and menstrual equity and grooming behavior and some of the other things that aren't being discussed. A lot of this is going to be helpful information so I would like to follow up. >> We would love to participate. >> Harper-madison: Awesome. Thank you. One of the other questions that came up for me, just in terms of how to -- I guess how to speak to it when I'm having these conversation

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with our constituents. You said 80% of our teen births are by way of poem who identify as hispanic. >> Uh-huh. >> Harper-madison: I'm just trying to wrap my head around that disparity. It seems massivelyly despair rate. >> And more in Travis county than many other counties. We see teen birth as an expense of economic opportunity in a lot of cases and think it's possible that may speak to some of the in equities we're seeing on the ground in Travis county. Some of the income levels get higher and higher and other income levels don't. Opportunity seems to be a key here. >> Harper-madison: Thank you. I appreciate that. I don't have any other questions. Anybody else? Councilmember kitchen. >> Kitchen: Just a quick one. I really appreciated this document is very helpful to

[3:14:25 PM]

understand and to share with others. Is that available on your website or where can we find it? >> I'll email it and they are also on the website. >> Kitchen: Last quick question, it's really heartening to see the number of births falling among teens, and thank you for sharing y'all's thinking in terms of reasoning behind that. What do you think is most important to do from a policy standpoint to help because it sounds like a lot of cultural changes perhaps has contributed to this. What else should -- do you think we should be doing? >> Absolutely. You know obviously it's hard to pull policy levers to affect cultural change, so that's happening. On the policy end, we do whatever we can to support sexual education and Austin is doing a wonderful Joplin of that in aid. Then Austin again is doing a tremendous job to support

[3:15:27 PM]

access to health care. And any additional work that can be done to support that. Those are what we typically do. >> Kitchen: Okay. >> Some of our other policy priorities center around minor consent to health care. We've worked a bill for a few sessions that would allow teen parents to consent to their own contraception. That is another policy change we would like to see made. >> Kitchen: Thank you. >> Garza: Kind of addressing the large -- I guess the hispanic and the 80% number is a friend of mine was a former E.D. And she said there was this unspended part in the program that none of the girls, I think like 99% of the girl in the program did not become a teen mother and how -- so I mean maybe touching on the question how do we address that. It is like you said women

[3:16:30 PM]

realizing I can go to college, I can better my life. And so, like, the funding of those kinds of programs. Those kinds -- which is city has provided funding. >> That's a wonderful program. >> Garza: They also provide -- there is I believe city funding for our teen prevention programs as well. I know that was something -- I remember hearing the startling statistic when I was in my first campaign for city council and it was -- there were like five births that year to teenagers under 14. And four of those were from the

78744 zip code, which is an area I represent. So I know that something that we have worked on and so it's great to see the decline. It's amazing how all these things connect. Every single one of these presentations today connects in some way, but thank you for your work on this. >> Thank you so much. >> Harper-madison: Any other questions? Thank you very much.

[3:17:30 PM]

We appreciate your presentation. So moving on to item number 5, discussion and possible action, we're going to discuss selection of two health and human services committee to participate in the joint city county work group for appointment of a member to the central health board of managers. The committee will select or has selected two members to participate in the city-county joint working group. This work group will meet in person or via phone conference to discuss applicants. These applicants will move forward into the interview process. The staff is still working on the date for the working group to meet, but it will likely meet -- likely be the week of March 23rd with interviews being scheduled in April. I think at this point we need to identify two volunteers of the four of us who would like to work on this -- this working group for this selection process.

[3:18:32 PM]

>> Tovo: I just have a question. >> Harper-madison: Sure. >> Tovo: I'm trying to remember the last time we did this, I think the entire committee was involved with that decision. Was there a reason we're proceeding -- >> Harper-madison: I would ask public health by way of advisement. It was two and that came directly from the public health folks. >> Tovo: Am I remembering incorrectly? >> Kitchen: I don't know. >> Tovo: I thought it was all of us huddled around a phone talking about our -- I think we had identified our nominee and they identified, you know, we identified our top three, they identified their top three and we conference with Travis county to come to an agreement about who our one joint was, but I don't remember it being a subgroup of this committee. >> Loose I Thompson, government affairs -- Lucey Thompson. >> Stephanie and Julie wheeler with the county. This is a new process so I would let the clerk and Julie speak to it. So we did discuss selecting

[3:19:34 PM]

the two members that would be part of the group, but I'll let them share the additional information. >> This the Stephanie from the city clerk's office. Partly this is to make it easier to get together with the county. The idea was you would have two representatives that would go through the applications just to select who you would interview and both bodies would be interviewing. As well as the county commissioners would be interviewing. We would compare the top. If we need to do meet again to discern who out of the top we were going to bring forward as top candidate, we would do that. I don't

know historically what they didefore that. >> Julie wheeler, Travis county intergovernmental relations officer. So the rationale for it being two and two, as you know the commissioners court is a much smaller body so we can only do two before we meet quorum. You are a larger body, but that's why we had two selecting from each entity. It's a smaller group, like

[3:20:36 PM]

Stephanie mentioned. There will be appointment interviews so those would be held by your full committee and the interviews with the commissioners court would be held with the full commissioners court. I'm happy to answer any other questions. >> Harper-madison: Absolutely. >> Tovo: I'm sorry. I'm not completely grasping how this subcommittee works. And that's fine if we want to do it differently. I think the last time Travis county had a different process than the city of Austin so we didn't necessarily follow the same process. But it doesn't need to work the same way we did last time, but I'm not sure I understand. The two people from this committee and the two people designated by Travis county would together review the applications and winnow down that list? >> Correct. So we did model this off the process we used for the last joint appointment which was Abigail Aiken. Two from this subcommittee, two from the commissioners court, and so right now that looks like the members of our health and human services subcommittee.

[3:21:37 PM]

The four of you would come together, look at all the applications, pick consensus candidates. The point is trying to get both entities to use the same starting point. So rather than get all the application can't that we have, the commissioners court interviews maybe a set of five. You interview a different set. This will allow us to actually make true comparisons with the same starting point. >> Tovo: What would be the rationale for not just sticking with that group as the interview committee? >> So with the commissioners court the way they do it, they do the full court interviews. You all would have the option on your end if you want to just have the two members selected to do interviews or the four of you to do that. That would be up to you. >> Tovo: Thanks. >> Garza: Councilmember kitchen. >> Kitchen: While I appreciate -- I'm not sure that I agree that this is the way to proceed.

[3:22:38 PM]

You know. >> Garza: I was trying to remember, I thought we were all there for Abigail Akins. >> Kitchen: I thought we were too. >> Garza: I can't remember the application part. Regardless, so if he -- the entire committee can get the applications and be part of the interview process. Is that right? >> Yes. >> Kitchen: I would rather do that. I want to participate so I would assume you all would want to participate also. >> Garza: Yeah, I want to participate. >> Tovo: I think what would we -- I think the piece

that then complicates it for them is would we as a four get together with their two and come up with a list? >> Kitchen: I personally don't think it's necessary to do that. >> Garza: I guess the only thing I thought the way we've done in the past, we seem to come up with the top

[3:23:38 PM]

four pretty quickly. So maybe if we had the special -- a special call where we just meet and come up with that group and then maybe Natasha as the chair meet with the other two? >> Kitchen: Here's my suggestion. I think -- we obviously need to agree on the selection, you know, with Travis county, but I don't know that we have to agree -- I think inserting the agreement at the point where we haven't even started to interview yet is too early in the process. And I don't think it's necessary for us to get to a process. I mean to get to an end. So I think it's okay if -- I mean I would imagine that we'll probably overlap in who we interview, but I don't even know if that's necessary completely to do that. I think that it broadness our ability, both the county and the city, to determine the best applicant if we don't insert a process where

[3:24:39 PM]

we have to agree on who we're interviewing first. >> So -- sorry. Not to complicate it, but the rationale for doing this is create parity between the two bodies. That's why two and two. It's the model that we've followed in the past. As far as who gets to sit on that committee to look at the applicants and screen them. You have obviously more people who may want to have a hand in that. We're limited by being allowed to have two members at a time weigh in on something. Our subcommittee structure is different because if we have three, we meet quorum. >> Kitchen: I don't see given the different size of the bodies that we need two and two. It's not a matter of parity in the number of people, it's a matter of our respective decision-making processes which are different. >> Again, we're modeling it how we've done it in the 3569. It also the way we did it during the sobering center. >> Kitchen: No, we all

[3:25:39 PM]

participated in that. >> What I'm speaking to at least is when we were looking at the initial board members, I believe you were on -- councilmember tovo, you were part of that selection along with one other member from this group. It was quite awhile ago. So when we created this process again, it wasn't something new we were trying to create, we were trying to follow the same model we used the last time. >> Tovo: I think we -- I think we may have -- I think what is confusing is that Travis county for those joint appointments, in my recollection, has always done their process differently than we've done our process. Know there were at least three of us involved in the decision for the sobering center,

councilmember kitchen and Casar and I were involved and possibly one other. In any case, I'm trying to come up with some proposal that -- I mean I guess -- I guess what we're trying to

[3:26:40 PM]

prevent is this committee interviewing a set of nominees, a set of candidates that may be different from who Travis county reviews, and then we have two nonintersecting circles of candidates. That hasn't happened before. I don't see it as likely to happen again. >> Harper-madison: If I may, I apologize for having to step away. Let me get caught up on what it is that we are attempting to reconcile currently. I'm gathering from what I heard on the tail end of councilmember kitchen's commentary that there's some hesitation to proceed as proposed with the current process. With the process as proposed. >> Correct. >> It seems there's an issue of how many of you would be part of that initial -- or the initial part where the applicants are reviewed and then short listed. So what's being proposed is there will be two members from the commissioners

[3:27:41 PM]

court, two members from your subcommittee who will get together, come up with three consensus candidates so both bodies will be interviewing the same three finalists. >> Harper-madison: I guess what I'm asking, are you asking if we approve of that process or are we being informed that this is the new process and this is how we intend to move forward? >> My apologies. It's the process we've used in the past and it was the process I assumed you all were going to go forward with. I'm sorry if I Ms. Understood that. The commissioners court has already voted. >> Harper-madison: It's news to all of us in which case for me personally I'm just trying to get caught up to what it is that we are attempting to accomplish here. >> I guess. >> Ideally it is the process we have used in the past and we would like to maintain that to make it easier all the way around if you guys have -- it sounds like you guys have some discomfort with that process. So I'm open to hearing how -- >> Harper-madison: I don't personally have any discomfort, but I'm feeling from some of my colleagues

[3:28:41 PM]

that there's some discomfort. I'm going to call on mayor pro tem Garza for commentary and then follow-up, but ultimately I think what we're trying to figure out is how to proceed and not have this hang us up. >> Perfect. >> Garza: I know we get to decide. But again with Abigail, I don't remember us interviewing candidates where not all of us were involved in the screening of the applications. So with regard to -- who is on the human services? >> That would be commissioner Shea and Gomez. >> Garza: And so I guess one thing that's great about the makeup of this is there's representation from different minority groups on this board. So I don't know what -- I don't think anything precludes us from meeting

as four, whittling it down, we send two that represents our decision and say here are our top four and then we hope that there is a -- and

[3:29:45 PM]

usually it always works out that way. There is a common group. So that's what I would suggest is we all meet together. The way we've done it in the past is we don't have to even meet. The clerk sends us applications and then we can send them the names of -- no, we would meet. We would meet and we would go through and we would come up with like the top four or five names, but that's -- I guess that's what I would suggest. >> Harper-madison: Councilmember kitchen. >> Kitchen: Well, I guess I have a question. I'm not sure why it's necessary -- my goal, of course, as is everybody's goal, is to get the best candidate. Obviously. So I'm not sure -- first off, I wouldn't limit it to three at that stage of the game. >> [Inaudible]. >> Kitchen: She had mentioned three, not you. Because we haven't even talked to them yet. So that's not enough people, I don't think. The second thing is I'm not seeing it as necessary that

[3:30:45 PM]

we interview the same people that the county does. Now, that may be the point at which I'm differing. So I just see that as potentially unnecessarily limiting our pool before we've even talked. >> I'm interested in hearing what you have to say, but I am curious if you all do start from a different place, how you would recommend that you guys reach a consensus candidate if you're interviewing -- maybe the county is interviewing people and you're interviewing a completely different set of three. >> Kitchen: The reason I'm -- the reason I don't think that matters is because we have to reach consensus at some point anyway. We will either reach consensus on point we decide to interview and who we select or just who we select previous so it's not any different. I'd say to reach consensus before we even interview as

[3:31:46 PM]

unnecessarily limiting the field, that's all. >> Harper-madison: I appreciate that. Councilmember tovo. >> Tovo: With regard to that issue, I think I can see it going either way, but if our process is typically, which I believe it has been in most cases,, if not all, that we meet together, we come to our recommendations and our short list of candidates. I appreciate that the health and human services committee at the county is smaller, but I would suggest we just meet as our health and human services committee and have that conversation with the Travis county health and human services committee and our joint phone call or whatever and then we whittle down -- I know that that may be a point of disagreement with you, councilmember kitchen, but in terms of the other variance from your typical process, I would say we do what we usually do, which is all four of us meet, we come up with our short list and then we

can communicate that, we can have that joint meeting with our Travis county representatives. I'm not sure that I understand why we would need to be only two in that conversation versus four. It may be that that's what

[3:32:47 PM]

happens in the end anyway. Maybe all four of us can't can and two can or three can. I don't know why we would artificially manage that. That's how our committee usually works. I could probably live with that -- with the proposal part of our agreeing on the universe as long as there's an agreement that we're not going to be limited to three or something much smaller than we usually do. >> Harper-madison: I appreciate that. Barring any objection I would say that given sort of the complexity of the -- that the conversation has taken on I'd like to table the issue and have us be able to discuss amongst ourselves and get back to the clerk S that. >> Yeah. I would say if we do want to keep the committee together to do the applications we would have to call a meeting sometime in your executive session, which is totally fine, but if we did try to meet all four with the county, I think we would have a problem because then it would be a quorum

[3:33:47 PM]

situation so I know that was part of the reason why we were just doing two and two, but that doesn't mean we have to do the joint meeting that way. >> Kitchen: That's not -- >> I didn't say it the right way. If we met with the whole committee it would have to be posted as a committee meeting and this was trying to function as more of a grouping so that we could -- more of a working group so we could chilling down the applications. >> Harper-madison: So the informality was preferable to a formal announcement of an official meeting. >> Yes. But I could see you as a committee setting a meeting for that and in executive session going through the applications, picking some individuals and at that point we could either select two that wanted to go meet with the county or we could just send our list over to the county and go on from there. And then of course you would still do your interviews as the whole body. >> Harper-madison: From what I gather we're leaning towards the latter, but I would like to hear from my colleagues if there's any objection to us having a special meeting where we make that determination and then move forward from

[3:34:47 PM]

there. >> Kitchen: Yeah. >> Harper-madison: Okay. Sounds like we'll be in touch. Thank you. >> Harper-madison: All right. Future items. Does the committee have any future items they would like to identify for future consideration? Councilmember kitchen. >> Kitchen: I don't know ifing this helpful or not, but we had a really good conversation with central health today and I'm wondering if this body would like to

drill down into the situation impacting homeless women. So if that's something that would be useful for folks, then that might be a follow-up. >> Harper-madison: Barring any objection I actually -- absolutely agree with that. >> Kitchen: Okay. >> Harper-madison: And then -- >> Garza: When is our next meeting? And the only reason I ask is if it's -- I'm assuming it's before -- anyway, what I was thinking was to talk

[3:35:48 PM]

about -- >> Harper-madison: April 78th. >> Garza: Maybe we could have a budget item discussion. So -- we've never really done this, but we're doing the budget a lot differently and the discussion about early childhood and, you know, asking for a full-time fte and the manana fund and to understand maybe -- maybe the health and human services could have a list of budget recommendations to the city manager before he sits down to come up with his budget. >> Kitchen: I think that would be a good idea. >> Harper-madison: In which case we're talking central health for a drill-down presentation and/or discussion about how people experiencing homelessness, specifically women experiencing homelessness and how we can be supportive. >> Kitchen: Yeah, it may not even be central health. It may be like salvation Army. I'm not certain who the right people are to invite. >> Harper-madison: But during the course of the consideration I'll get with public health and we'll have that conversation. >> Kitchen: Okay. >> Harper-madison: And then as an addition to that

[3:36:49 PM]

as we're having conversations around ftes, subsidized care, manana care, subsidized care, budget folks? >> Did you have any considerations? >> Kitchen: Sorry, guys, I have to run. >> Harper-madison: I understand. So for me the one that I would add is the conversation which I know a lot of folks are already having. So as opposed to reinventing the wheel, really just sort of I'm going to spend some time putting together what resources are already putting some time and effort into the conversation around menstrual justice and menstrual equity and that's something I would like to add as well. I'll be asking staff to bring forward presentation from tent, and from eph on videotaping and e-cigarettes. And without -- with vaping

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and e-cigarettes. And without objection I believe I'm going to call us adjourned. With that it is 3:37, February 19th, and we are adjourned. Thank you.