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[9:39:15 AM]

>> Tovo: Apologize for the long delay today. Thank you all for sticking with us. We are going to go ahead and get started. We have a quorum. Vice-chair Fuentes is on the line as well. I will call this meeting to order and we will start with an approval of the minutes, please. Councilmember kitchen. >> Kitchen: So moved. >> Tovo: Thank you. Vice-chair Fuentes seconds it. All in favor? And that's unanimous on the dais. Mayor Adler and councilmember harper-madison are off the dais. And our only briefing is from central health. Thank you. I know you with some scheduling issuesment we appreciate you beiere today. I will turn it over to councilmember kitchen to introduce this. >> Kitchen: Yes, thank y'all. We really appreciate the chance for you to bring forward what you're discussing today, the health equity plan, as well as the respite program. I know you all have been working very hard on all of these things and this is

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something that from time to time we've talked about. We felt like it was really helpful and important to have you all talk with us here at the public health committee. It gives us a chance to highlight for the public the programs y'all are working on and then just gives us some time to ask questions and have a conversation in a little more depth. Thank you all for being here today. >> Yes, thank you all. I'm president and CEO of central health and I'm joined by chief strategy officer Monica Crowley and our chief medical officer. So it is a privilege to be here today and we're thankful for the time you've given us. And what we'll do is we'll speak to health care equity, which you think about this, this is the framework underwch -- through which all of our work is guided and it's our north star. And what we think about the

community needs assessment for those that are living below 200% of federal government much poverty level and the voices of the

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community that bring context and texture to what we see in the patient data, these things triangulate and that points to the direction in which we are headed as an organization that serves those that are below 200% of federal poverty level and without insurance would not have access to health care. So that's our mission. That's who we are. So heel talk about health care equity and then we will transition into respite care, which is a very important part of the continuum of care for individuals, especially those experiencing homelessness. And you do have some materials that we handed out to you. Of course you got the handout for the presentation. And then the notebook that is at our places. And council member Fuentes, I think this is available to you as well, B we'll get you a hard copy to your office if you need one, is our health care equity plan which has all the information and tables for your review. With that... >> Good morning.

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>> Thank you. Good morning and thanks for the opportunity to engage in dialogue this morning. Central health as a hospital district has been around since about 2004 but it's only been a couple of years as the Texas legislature -- can you hear me okay? >> Tovo: If you would maybe bring your mic a little closer. >> Thanks. Is that better? All right, thanks. But it's only been a couple of years since the Texas legislature authorized the hospital district to practice medicine. And so as we look to the past for the lessons that we've learned and prepare for the future we're looking at objective data, right? Where are there gaps in care? And also reaching out to the communities that we serve in order to understand what their needs are or from their perspective. And our goals are really to build bridges where there are gaps in care, create the road ahead that has a much brighter future for our

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patients based on our build and our practice of medicine. Next slide, please. And as we prepared our direct practice of medicine, we needed to understand what components of a high functioning system are and how that relates to the environment that we sit in today. So this is our graphic of our basic understanding of components of a high functioning system and we know that there are potentially aspects that are missing or that they could be rearranged, but I think the critical aspects of this are that four patients -- for patients to flourish in any system the system has to interlock and engage. So disparate environments have to work together and if they actually interlock and work together, patients

flow more fluidly through that system and have a greater what we've put in that center cog are items that could

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potentially -- or aspects of care that could facilitate or impede care. Electronic system, data system, having a uniform formulary. These affect Austin and tra vis county now -- especially those at highest risk. These are aspects we're paying special attention to in order to increase the success of our patients and I'll turn it over to Monica. >> I'm going to stay on this slide for one second before going to the next one because the thing that's different about taking this planning approach starting after the legislature -- you know passed the legislation to directly provide care is in 2020 the board tasked us -- historically when central health was

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created -- during that period of 2004 to 2012, the hospital focused on the primary system. We focused on building out primary care, lone star peoples, other community providers and, you know, building out the map program. During that time period from 2013 to 2019 with the 1115 waiver delivery system, incentive payment projects we started focusing on ambulatory specialty care and then in 2020 this is the first time from the safety and community perspective central health really started taking this systematic, comprehensive view of assessing the needs and gaps and capabilities and starting to plan across this entire

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system. Next slide, please. So in February of this year, the central health board adopted our healthcare equity plan and the healthcare equity plan -- I'm going to get into the methodology a little more in the next slide but in this slide it depicts how the healthcare equity plan is driving our operational planning and the financial sustainability over this time period. The healthcare equity plan really identified the what of what central health and working with our community we need to be doing to fill the care gaps and to meet the community needs that were identified in the plan. And thenigight now we are work withing -- we are working on the next phase of planning which will be intense until

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April or may of next year that includes operational implementation plans that are one to three year plans sequenced over the next seven to ten years where we're really focusing on how and where and when we are going to be taking on specific initiatives to address the needs that were identified and how that will be prioritized and then the financial sustainability plan and what partners we'll work with -- and then the financial sustainability plan is really a plan for how we're going to pay for it. And like Mike said, this healthcare equity plan is driving what central health's operations are for the next seven to ten years. Next slide, please. This is also a little more detail into the information that Mike provided when he was teeing this up. We really started with the

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voice of the community and trying to obtain insights from people's lived experience about how do they need to access care, what barriers they're experiencing in care today, and how we could be more culturally affirming as we're developing our plans. Then we looked at the first safety net focused community health needs assessment. We are still active participants on all different levels of central health in the process from the steering community to the core coordinating community to all the different work groups but for central health's plans we thought that we needed to focus on the needs of T population that are living with incomes below 200 per cent of the federal poverty level, and, you know, we identified, you know,

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some different needs that show up when you're looking across the care of the entire community. We also looked at the resources that are available and the capacity for providing care to this specific population. And we looked at the gaps that exist today and then also looking out into the future what additional gaps are projected to be. And this safety net community health needs assessment capacity and gap analysis combined with the information we gather directly from the community is what led to the healthcare equity plan that is allowing us to build a comprehensive, high-functioning healthcare system that will improve the health of central health's patients and optimize the use of our community

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resources for improving the health of this patient population by looking at strategic imperatives in four areas, which include access and capacity, care coordination, member enrollment, and engagement in care and system of care infrastructure. Next slide, please. One of the things that we really focused on in the safety net community health needs assessment -- and it's in the back-up materials that you Rece -- is we looked at the population on a census-track level in 14 regions across three focus areas I the community that included the I-35 corridor, east Travis county and west Travis county. We looked at

specific needs and populations of each of those 14 regions. We looked at the services that were available to care for the

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low-income populations in those areas. We looked at specific barriers to care and social determinants of health in those areas, and I think there's 144-page community health needs assessment that has an appendix in the back of it that is broken out by each of those 14 regions that talks about who is providing care that folks with low incomes can access in those areas today. One of the things that we noted and that is still bearing out as we look at -- this was done with five-year estimates from 2019 in the acs surveys. We are almost complete in our annual biennial demographics update that should be available

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by thankses giving. We've discovered while there is wide-spread poverty in almost all the different corners of Travis county, the greatest density of people living below 200 per cent of the federal poverty level remains in this corridor along both sides of I-35 and that although we are seeing there is sur bush -- there is 74 per cent of the population with incomes below 200 per cent of the federal poverty level in Travis county still being along both sides of the I-35 corridor and actually 17 per cent of this population live in the runberg area alone.

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One of the things we've discovered by looking at these different areas is when we focus eligibility in and enrollment it can have an impact. So we look at the impact of enrolling populations that are eligible for central health in the east side of Travis county and although families in poverty in that area foe -- focus area make up 19 per cent of the total families in poverty in Travis county, 28 per cent of the enrollment come from those neighborhoods and I think that reflects the intense effort that we put in to trying to enroll as many people as we possibly can in this kind of severely underserved area of Travis county. We put a lot of effort into focusing enrollment in the

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areas where we'll have clinics coming online and where a lot of our service expansions are focused. I think, you know, one of the key take-aways that we want you to focus on before I H hand it back to talk about the unmet needs is that central health hasn't been doing this work alone and we don't intend to do this work alone. We're working with the people that we are currently serving and people in communities that we are not yet serving but that we want to bring into care and that we should be able to care. And we're working with providers and stakeholders that we C currently work with and that we would like to work with in developing the gap analysis, and we are continuing to work with the communities, to work with our provider partners, and

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to update the data that we're bringing in as we are developing the programs to meets the needs that have been identified. Allen. >> Next slide, please. Thank you. There are care gaps across the care continuum. These care gaps are broken down into moderate gaps and significant gaps. When there's a moderate gap it means we're meeting per cent or less of the community need. With a significant gap it means we're meeting less than 50 per cent of the community need. We have significant work efforts planned for the future that will address all of these areas but what I'd like to do is just touch on a couple of the significant areas and behavioral health as well. Giving an example of work that

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has been underway over the past year and that has affected and changed and improved lives and end with respite. When I first got here and I met with the cmo's of the hospital the number one challenge they faced that they couldn't affect is what we call compassionate dialysis where people who presented to the E.D. Because of their in-stage renal disease that they were so sick -- we call that compassion dialysis and then they were treat sod they were ab to return to the street. We haveneen able to solve that problem and still have work to do but central health set up a program for transitional dialysis in which

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case patients with in-stage renal disease have -- for up to a year until we transition them to kind of an indefinite dialysis program. To date 30 patients are receiving -- or are on that list. 21 patients have a seat and are receiving that predictable dialysis, which obviously improves quality of life and just day-to-day functionality. That program is going to well. The hope is that patients then transition, you know, to a permanent dialysis and that makes room for additional patients. When we look at behavioral health, though stated -- the objective information -- the objective data that was pulled really puts us in the moderate category but when we look at addiction disorders there are

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significant needs here. Prior to the pandemic, Texas sat behind the national average as far as opioid use. Through the pandemic we're ahead. I think we're aware of the pandemic that sits within our midst. Ur to five years ago central health partnership set up a medical assistance program and that program has been built out with wrap-around services, you know, increasing over time and number of patients increasing over time. Currently about 600 patients are being served through that program. About four to five months ago the program split to where community care is caring for patients that are appropriate in a primary care setting where they're either stable or they've got mental health DI

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-- diagnosis. The goal is to try to destigmatize and also if we are looking at our integral care friends their estimate is about 80 per cent of their patients have both an smi -- severe mental illness and opioid use Dier so the goal is splitting the program so psychiatric addiction specialist can care for the -- that the partners can expand their care so we're meeting R more of the community need. In addition of the past year we have partnered with Oun organization and are about to partner with another to create access to Methe. Individuals do better based on their own physiology -- some do better on one medication than

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another and some switch. I think the M more access that we provide the better for these patients in addition to wrap-around services so I wanted to touch on that. As related to dental we've provided more specialty dental and more dental chairs. Touching on hospital care -- I want to focus on the ambulatory access, we have started to provide access for tube ligations for women who choose to have them. This allows us and provides an opportunity to keep women out of the hospital where there may be other political or just administrative challenges to get to that end point and so they can have their tubaligations in an ambulatory

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setting. We've had some brief conversations related to respite in the past. I think the problem that exists or has existed here in Austin -- I know you're aware -- is that individuals experiencing homelessness and other underresourced individuals are often discharged from skilled nursing facility from the hospital

directly to the street. There was a critical need for respite environments to be built so that patients could heal in a safe environment. Next slide, please. Our program has been running I think about six months as well and if we think about respite on the care continuum with the right side of the continuum being more complex care for skilled nursing facilities and that kind of environment and on the left side of that care continuum kind of residential rooming with case management

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and social care services being provided, we have started on the left side of the inuum and we created a phased approach as we -- with the on set of this program, more so to wrap the care of our patients to allow for that learning curve and to create better end points for the individuals that would be within our respite environment. The first patients that we started taking in were individuals who were discharged from skilled nursing facilities. I think we started with about five beds, and we have -- we transitioned I think about three months ago to working with individuals who were living on the street but were cared for by either the paramedics or the street and mobile teams and working with those teams we're able to directly admit people into respite to avoid them needing a hospital stay -- hopefully to catch their illness or wound or

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whatever it was early so they could be discharged back to their environment. The reason the hospital transitions were number three is based on the shear number that the capacity at first was five beds. We're up to ten now and potentially have capacity working with a new entree who is our partner with this environment to -- there's such a critical need for respite. We're at 10 beds now. 20 beds is not going to meet the need. We have a need between 30 and 50 for respite care. Next slide, please. So as related to some of the data -- just the information -- the patients who have worked their way through respite over the past seven months or so, we have 29 patients.

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About 10 patients have come from the street and mobile teams. The average age is about 47. The majority of the patients have been men and then you can see the race and ethnicity break down there. Tough diagnoses -- the diagnoses change when we transition to majority of patients coming from hospitals but coming from skilled nursing -- fractures tend to be the number one diagnosis. Nobody in the respite environment has only one diagnosis. They'll normally have one or two fractures with a disease as well. These are complicated patients. Next slide. As related to the disposition of the patients, about seven patients have either been placed in transitional or

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permanent housing. I'll -- there are two patients I'll talk about and tell their stories. It speaks to the success of respite and the need for additional respite. 40 per cent of patients chose to leave a little sooner than our teams would have discharged them. They would have received social services. They would have gone to various appointments but our teams would have liked them to stay in that environment to heal and progress and connect them to more social services. This is a different environment for people used to living on the street. Sometimes it takes multiple tries so that -- just the cultural change of being in this environment takes a little bit of getting used to. Twenty per cent of patients were re-admitted into the hospital. This could be looked at as a negative statistic but these are individuals who potentially would have been discharged back to the street and whether they weren't ready or appropriate to go to respite or whether they

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were suddenly getting sick in respite at least they weren't discharged back to the street where they had a chance of dying or their disease process progressing to where when they made it in the system they were much more advanced. There were 15 per cent with an administrative discharge. These are folks in need of acute detox and declining being transported to acute detox. There's a critical need for that. Average length of stay is 23 days. One of the benefits is the social services we can bring when we have them in one place. Those are listed there. Next slide. Mr. P is a 64 year old male who had experienced homelessness about 15 years. He was hit by a car and broke multiple bones. Spent three months in the hospital and in skilled nursing

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faciiies and another 50 days with us. While with us, he was signed up for quite a few social services and actually we were able to house him at community first. This is him standing proudly in front of his tiny homes. His life has been changed. So a huge success story. This was our first patient so it was a great precedent to set and our teams still speak about him. Next slide. Mr. W. Ended up experiencing homelessness. Tragically he was in a fire about a year earlier and his wife passed away. He found his way to arch and they found that he really couldn't see, that he had bilateral cataracts -- cataracts in both eyes but because he lived on the street there was no methodology to do that surgery.

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He has now had one cataract removed and has great vision in that eye and the second cataract surgery is scheduled and he will go for that surgery and hopefully he can progress from that point on. You know, there are multiple other stories of people who have done really well in respite. Our plan this year is to go from that kind of left of the care continuum phase to hiring a nurse and an ma. We rolled out our electronic health record this week. While we were given the authority to practice medicine, it takes a while -- first of all, it happened right before the pandemic and I was actually with community care at that point. Obviously the pandemic was busy. Now we have built policies, procedures, committees for the practice of medicine, rolled out the electronic health record this week and we'll have nursing and M.A. Staff within the respite environment within the next three Ms and we'll

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be able to take care of more advanced patients at that point. Next slide, please. Some of the advantages and the uniqueness of our respite environment is that it's not a unilateral kind of referral. Patients can be referred from providers so they can avoid hospital stays. The paramedics and street mobile teams can refer them. We can take patients from skilled nursing facilities and the hospital. As this builds out, you know, we'll have moreaccess. Because we partnered with a new entry individuals with addiction disorder are able to get the counseling they need. The piece of the acute detox is still missing. Many respites, if not the majority, focus on clinical care.

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Whether this was was our choice would have been because we're still building the ability to practice medicine, we've been focusing on social services, which as we progress with the practice of medicine now we have a wrapped care environment where hopefully fewer patients fall through the cracks and more progress and do well. Next slide, please. Mike, I'll turn it over to you. >> We are thankful you have given us this opportunity to present. We're here to answer any questions that you may have and just thankful for the committee's focus and your advocacy around health equity. >> Chair: Thank you. This is really very valuable information. I'll open it up for questions. I know I'll have a few eventually. Council member kitchen, would you like to start us off?

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>> Kitchen: I will start with one set of questions and then pass it along to my colleagues and then we can circle back around. So I'm going to ask about one aspect of the respite program. I wantoo say thank you for really working on respite and sounike you've got a good progress going on that and you've got -- sounds like you have a path. So I want to talk a bit about the -- I want to focus in on what you said about the need. I think you said from 30 to 50. Could you talk to us a little bit more about that? My guess is

what you're seeing -- you know, tell us what the data is that you're seeing. If I heard you correctly, that need is going to fall primarily in the hospital discharge area, do you think, or is it really across all those three areas? Talk to us a little more about what you're needing from a need

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perspective, what path does central health have to address that need and what challenges. In other words how far can you guys get and what kind of partnership do you need in the community to get to a point where you are addressing at some point the 30 to 50 need. >> Great question and I think I'll share the answer with my colleagues here. If I say something wrong, just smack me, but the numbers come from the fact that on any specific day we have between 18 and 26 patients in a skilled nursing facility. The majority of those don't necessarily need skilled nursing care. They need a clinical respite environment. So when you look at that and look at the fact we're maxing out, you know, at 10 patients and really holding because even if we increase in the way that we are working now to 15

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patients, we still need nursing care. We need medical assistant care and potentially a clinician. If you look at the numbers and we say, you know -- this is just a very, very basic estimate but you can take 15 patients or 18 patients from a skilled nursing facility, 10 patients that we're housing in respite -- we haven't turned on hospital discharges yet, so the estimate is somewhere between 30 and 50 as related to respite. That's how we got to the numbers. As far as partnership, I'll start and, Monica, hand this off to you, the lessons we've learned in and functionality of new entry, we're so grateful they were interested in partnering with us and that has been a god send because of the addiction disorders that tend to accompany homelessness and a lot of the individuals we care for. The detox environment, the

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acute detox environment is pretty challenging and there's little and difficult access for patients. We focus on opioid use disorders. We're starting to see should we work in that space. The mental health authority, that is part of their scope. We have to partner -- I think the answer -- I'm not an expert in addiction use disorders but the thing you hear all the time is no wrong door. So whether it is mental health and instant access to mental health or providing care for the patient where they are, housing is critical because unless we house these individuals it's a cycle that will continue. I'll turn it over to Monica. >> I -- you know, all the people on this committee are well aware of the complexity of

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the issue and how having supportive housing after people leave the respite environment is a key piece of this puzzle to, you know, kind of stop the, you know, the cycle of people, you know, kind of going back into illness and being able to thrive but, you know, I think looking at partnerships with organizations like integral care with the city and county in figuring out the place, working with private businesses like the large hospital systems in the community that in many communities are, you know, large funders of, you know, respite build-outs and private philanthropy with groups like community first village and other providers in town -- I think one of the things that

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was talked about is this kind of backing into a model in our community that actually could be vyy beneficial for the patients in the system because we're starting, you kn,, here on the wrap-around services piece with organizations that have been, you know, heavily supported by, you know, the other -- by the city and the county and philanthropy and bringing the medical kind of nursing, social services part to that, learning what people need, what gaps are as we build out towards something that is a more comprehensive medical respite type facility, being able to take those learnings. But, you know, I think continuing to build on, you know, the learnings, working

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with, you know, the private partners and working potentially together to build out this more, you know, medical/clinical-based facility -- I think we're going to need it on all the different levels so just making sure as we, you know, kind of turn to the next phase that we can continue, you know, to support organizations like a new entry and comnity first village and some of these organizations that historically have served the population that we need to be working with. >> Kitchen: Do you have a time line in mind to open it up to discharges from hospitals. >> So I think we've done that on a very small -- I think we had one or two that are not on these metrics. We will do that very slowly. Again, for this fiscal year that just began for us within our budget is the nursing

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staff. That is the next phase. The challenge is -- I think we could increase by one bed but it's that as we start increasing the complexity will sit there and we need nursing staff. So it was setting up the policies and procedures. The hire is planned for this first quarter of this fiscal year. The next three to six months we should not only increase the number but change the way we care for the individuals. >>E three-bubble Venn diagram that showed how we're going to meet the needs and pay for it, as we continue to

develop that plan for operational implementation, th within the next, you know, probably six months or so we should have a stronger -- I think a more clear definitive time line for when we might be able to, you know, invest in a

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facility the size of that facility, how much it will cost, what resources we might need for working with partners and where the best location for that is going to be. I know one of the things they start asking as they start doing interviews with people working in the community and with staff as you start doing these planning efforts and respite continues to rise to the top, so I think that is going to be something that will be on the front end. Of course, you know, I hate to skip ahead as a planner. I don't want to skip ahead through that process but I do see this is something that is rising -- that continues to rise to the top of the needs that we're seeing. >> Kitchen: I'll turn it back to you guys and ask more questions later. >> Chair: Sounds good.

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Thank you. Vice chair Fuentes. >> Fuentes: Thank you and thank you for this presentation. It is helpful in understanding the health equity plan and the gaps we have in serving our most vulnerable. I have two questions -- one around reproductive health and better understanding what plans are in place toddddress the gaps you recognize. For reproductive health, you mentioned -- thank you for mentioning the tubiligation. What are we doing as far as vasectomies and other types of reproductive health services knowing the state of reproductive health in the state of Texas and knowing central health and our healthcare distris set up to serve our most vulnerable and the disproportionate impact our communities will have as

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result of recent legislative action that has happened. Could you touch a little more on what else central hh has done when it comes to reproductive health services. >> Great questions. I'm going to share some of what we're doing. I'm going to tell you that it's going to -- it's hard to combat some of what's happened in our community and across the nation. We are in the process of contracting for vasectomies. The -- there were various providers within some of our primary care partners that have potentially been doing them, but the need I think has been so sparse over the past few years that we really haven't utilized those providers, and so there are urologists within the community that are interested in contracting with us and that is the direction we're pursuing now. Specifically there is additional energy behind that because of everything that has

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gone on over the past three months or so. In addition we're looking at our most vulnerable within the vulnerable populations and so there is a Dula program just initiated within community care because for African-American moms -- there are huge disparities in outcomes there and there's data that shows partnering with dulas and creating environments for care and monitoring actually increase the chance for positive outcomes. So we're trying to focus on individual communities and cultures in order to do a little more hand holding to help our moms help through this tough time and I think providing education. Education, information, and it's being challenging. I mean, there is -- providers are anxious, care teams are anxious, what can they say? What can't they say? So this is a unique time to be

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a women's health provider I think in our country and especially in Texas. We haven't figured it all out but we've pulled subject matter experts together and we're talking not only in the state but also in the country so we're still working on it. >> Fuentes: Thank you for that. I know central health recently adopted a budget. Did that include any increase in funding for reproductive health services -- or the tra vis county recently. >> Yes. We have over $90 million increase in our healthcare delivery services. That's the full spectrum of care, including reproductive services as well. >> Fuentes: Was there any increase that went towd reproductive health. >> I'll have to look at the specific line items and get back to you on the precise number. >> Fuentes: Okay. Thank you. Then the other question I had was around -- y'all laid out

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the significant gaps and they were particularly on -- or focused on hospital access, dental, post acute and specialty care. You know, I have long pointed out we don't have a full-service hospital east of 35 to help our community in the eastern crescent. What other plans -- now that we know this is a significant gap what are some of the strategies central health is taking or conversations you might be taking to help close the gaps. >> Yes. Thank you for the question. So there's really two points of conversation, if you will. One is in our operational planning that both Alen and Monica expounded upon where we look forward one to three years -- how do we start operationalizing to fill the gaps in healthcare you saw on the chart.

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As a healthcare district in Texas under chapter 281, there is no limitation on when and where and how you can converse about what are the future hospital needs for Travis county and that is something that is an on going conversation at the board level -- not just at the staff level. We have board members that are also leading that conversation. The second conversation point is in a five-year performance review the county commissioner's court passed a performance audit. Within that framework that is another place we can have a discussion around when we think of hospital needs and filling gaps in care -- you know, what does that look like going forward. It's a lot of the same types of analysis, if you will, but again, going back to the healthcare equity approach start withing the voices of the community and lookin at the community needs assessment and looking at the capacity currently for the different types of hospital care and

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backing into -- thinking forward in the future multiple years, what does that look like for Travis county? So that's something that is -- I would characterize it as beyond ideation and it's getting down to brass tax to say what do we need and where and what time frame. >> Another great question. I'm just going T I think give some nuts and bolts of next steps because the examples that I gave were just a few examples of work that has been done in the past fiscal year and I think they were 42 clinical initiatives we were working on that weren't just contractual. I think I cited three or four of them. Moving forward we've got -- if we're looking at moving out the infrastructure, which is why we showed that cog slide -- so what are the critical gaps that

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without building a hospital right now that we can start to build towards so our patients don't fall through the cracks and whatever the future has in store, wherever we end up, we have that infrastructure built. I'll give some examples. Specialty care is a critical need. We're working on rosewoods aragosa which was useful to our communities during the height of the pandemic. That will become a specialty clinic within the next year. There will be six specialties run out of that clinic. And the reason that those specialties -- we're adding those is because if you look at the wait times for our patients, the highest wait times are for those specialties. There will be diagnostics, wrap-around care, expanded

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hours -- all the needs our patients have that we've been able to provide through contractual relationships. What happens too often is organizations wetner with change the strategic plan or funding is low. Patients affected first are our patients. We are taking profound steps to fill those steps. Another

bucket is transitions of care. The big purple cog -- all those factors, we can control a lot of that. If we can do more hand holding in transitions our patients we don't have to set up an electronic healthcare record for that. We don't have to build a building for that. We can put nurse navigators into hospitals. We can start managing our patients, start talking to each other a little more and making sure the people don't fall through the cracks. I think on the last slide that was up -- just work areas we're working on but we have a

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medical executive board based on health equity. Within that we have director of transitions of care which is a job title we made up but what we thought was the most critical aspect and environment we needed to concentrate on. You don't have to worry about capital infrastructure. You can improve patient health right then and there, whether enrollment or engagement. Many of our patients, the electronic access internet is difficult. For other patients if they can maintain their job and get on a video call or phone call, it means we can engage them in care. Not only who are we enrolling but how are we engaging our patients I think is another aspect. We have a step-wise approach that respite, care at home -- it's not home health but many of our patients if we look at the care continuum from hospitals to skilled nursing facility to respite and mobile

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and street, there are patients that don't need to be in an environment and have a home and we can provide skilled nursing or provider care for those patients that may have challenges with transportation but need episodic visits -- that is something that I think is scheduled for us. Monica? >> Fuentes: Thank you for that? I would love to set up a meeting with you. I know the central health is in the process of building out the clinics -- I would be curious to know what are being considered for those clinics located in the eastern most communities. Also about how we coordinate with the city of Austin. We have added some kiosks in libraries -- the southeast

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branch has a telehealth kiosk available and I would love to talk about how we can sync that up or link that up with central health and community care. The other thing I want to mention is our community health workers program. We certified and graduated over 30 individuals who are primed and ready to help our community navigate the healthcare community and social services. If there's opportunities to link our graduates, those individuals getting certified through our program to job placement. There are a lot more conversations that could be had and it's an exciting time for us because we are seeing a better

and more robust approach to how we develop public health and healthcare in Travis count and would love to be part of

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that. So thank you. >> Certainly we would welcome those conversations and just to maybe have a paradigm moment that have we all need to be thinking about in this community, he can talk about this in more detail than I but if you think about providers practicing at the top of their license and completing that high-functioning healthcare system and all the pieces that go in between there is so much about our current thoughts about how healthcare is delivered that will change rapidly -- in a short period of time such that as we get people to the right care at the right place at the right time the old will give away to the new. That's the beauty of health equity as your focus. Now you're doing what you need to do to eliminate disease disparities and seeing the

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provider teams are as effective as they can be in empowering the teams and that relationship. It's more for thought but you'll start to see it manifest in the coming months. >> You brought up healthcare workers. I can't let that go. They have to be central to everything we do. The dialysis program and part of the set up was organized by a community health worker and a community health worker oversees that. Heart failure patients and the management -- managed by a healthcare worker. We have an education department we set up. We have two workers who provide education and navigation through the system is best done through community healthcare workers. We had an opportunity about

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creating career paths, especially the rock stars that can learn and then reinvest their knowledge and help educate others. I think lots of opportunities. >> Tovo: Great. Thank you very much. Any other questions? Before we move back to respite care I have questions related to that. Do we have any other questions. >> No. Why don't you finish -- go back to that. >> Chair: Sure. I'll kick us off on additional respite care. Looking at the chart, which is valuable, the various elements and partners and pieces that you need of a high-functions healthcare system it strikes me that it would be useful to fill in the blanks about the various partners throughout our community that are helping to fill this. I think that would be a real -- very visually useful to see where some of the gaps are.

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You've identified a few of them -- respite care which you're committed to and working on. >> Kitchen: I do have one question that's not respite >> Tovo: Sure. Acute detox which we've heard again and again. There others in our presentation that I missed that you feel as a community we need to focus on addressing. >>. >> I think to say no would be silly. There are significant areas. I think whether it's cancer care, radiation -- there is a, you know -- I think we could fill out a long list of opportunities >> Tovo: Right. >> I don't want to short-cut that. Very happy to get some of that information back to you >> Tovo: It would be interesting and I take your point. There are many gaps throughout and council member Fuentes' questions pointed the way to some of those as well. It would be interesting to know what are the top five to ten

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needs in our community that we need to focus on meeting as a system. Couch kitchen? >> Kitchen: Just a quick -- in the non-respite area. I'm also intrigued by the data that you have put together as part of your listening to the community. I think it would be interesting to have access to that data down to the neighborhood level for council members just to -- and actually that -- youknow, there's data available through the health department also -- our public health department. What came to mind for me was one of the things we do on the city side is we partner with housing works to have a score card on a rulular basis of how we're doing on housing. But it would be interesting if we had something similar on health equity that's short and one page kind of tracking of how we're doing on health

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equity issues. That's a big ask and it's just an idea at this point but -- and in the meantime, can you just tell me what level of detail do you have geographically in terms of your health needs assessments? Let me get a little more specific than that. So you had talked earlier about low-income communities and that that was one of the things that you were tracking in our needs assessment. And I could see in the background you have some maps, but do you have maps down to the neighborhood level or the census-track level or how granular are the maps available. >> So we have -- the granular in the community health needs assessment there are 14 regions. The information that goes into each region is based on

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census-tracked level data and we have that granular information about the needs, the disparities, the social determinants in for each region. We grouped the regions by kind of area. You know, geographically -- are the -- do the communities go to the same grocery stores? Do they use the same

clinic? Are the roadways surrounding the neighborhoods -- things that facilitate or create barriers so we wouldn't have something that crosses an area. Kids don't go to school across a roadway or, you know, folks don't use the grocery store across the roadway. That's how we grouped the census-tracked areas into the 14 regions. I -- we are also, as we're updating our demographic report that looks at health conditions, poverty, social

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determinants that will be updated by Thanksgiving -- we look at that on a census-track level. I think they're carrying it over with this 14 regional areas, although as the census changes and the different -- you know, that's one of the reasons that instead of it being done in October it's taking until November -- it's because since we did our last demographic report and the community health needs assessment, the census results have come out and of course you look in communities like pfluggerville in Travis county -- you know, what used to be large -- densely populated but large census-track areas are split. We'll probably have to have a key so that people can map over time, you know, what you're talking about -- area by area. And I think the idea of trying

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to have, you know -- I like the idea of one page -- maybe front and back one page. >> Kitchen: I know it's always difficult. Thank you. >> Council member, in response to your question, the materials that are on your desk and, council member Fuentes, again we can get this big notebook -- hard copy to your office if you don't have one. But if you go to tab three and starting on page 59 that shows you the social vulnerabilities scores. That's the jumping off point and it breaks it off by neighborhood. Going into section 7 it covers not only social economic issues but it starts to get into the types of facilities, the disease and health condition burdens that people bear. So it's -- again, it's not the one-pager. >> Kitchen: That's good. Thank you. >> But it's very detailed information that really gets to the point and the heart of your

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question. >> Kitchen: Thank you. That's very helpful. >> Tovo: Thank you. Good suggestion and thanks for pointing us to some of the areas in the binder where we can find that more detailed information. In looking at the dashboard, I see this is -- a healthy community is one of the areas where they measure as well and it might good for those council members who serve on there to reflect this back as a request of the dashboard to really get at some of the health equity -- measures for health equity and make sure those are starting to be reflected on the dashboard as well. I had a couple of questions about the respite -- well, many but I'll start with a few. Can you help us understand, what does respite care look like? We

talk about it a lot and it sounds like there's a real spectrum of that from meeting what I would guess would be around the clock nursing care to maybe a lighter medical approach. Can you share with us what that

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spectrum looks like, where you are now, and as I understand you're hiring skilled -- hiring those nurses with this year's budget so it might look different. What does it look like now and how will it evolve in terms of individual patient care. >> Another great question. Right now we are -- people are housed in a safe environment and we are case managing those individuals and providing the social services to them. The fact that we are partnering with a new entry means the -- you know, the addiction disorder aspect, lot of times we can provide counseling right then and there so I think that's been a bonus. The the next phase for us is really going to be providing the ma, the mursing -- it's -- nursing. It's wound care, physicals, communication with providers, more appropriate triage that

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can't be done when you're not actively practicing medicine. That's the next phphase. I think ultimately where we would like to live is if there's a skilled nursing facility need, which means you have a lot more monitoring and that -- that's probably not the environment. We're looking at one step short of that to where individuals can house for as long as they need to house -- we have clinical teams that round where there's access to therapeutic approaches and so is it, you know -- do the physical therapists come and work with the patients in a respite environment? Absolutely. Could it be housed in an area accessed to a clinic so the clinical team can see patients the rest of the time, potentially maintain those individuals transitioning through respite but only utilize their services in need

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be. So we're not looking at the highest acuity respite but somewhere between wound care and skilled nursing. I think you the person who oversees the care for high-risk populations at community care and serves on the medical executive board for the hospital district and does the same thing in our environment. She's the respite expert. Most of what -- her scope of knowledge is much more broad than mine. That follow-up visit for a deep dive into the next step of the environment is probably more appropriate. We'd want to pull her in >> Tovo: Thank you. Do you have a sense of what that middle level acuity care costs per patient. >> I do not. I think that is part of the work that we are currently, you know, engaged in. Part of it -- part of it are

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aspects that we may not think of, like a cafeteria. They are wrap-around services that are needed when you're thinking about housing individuals for an individual period of time and that is what we're currently working on. >> Tovo: Do you have a model from another community O another few communities you're working toward and if so, what communities? The models -- she comes from the San Jose area in California and she speaks of a model -- I think there was kind of a Denver model as well. But within San Jose I think all the partners -- hospitals partnered in order to create a respite environment and, you know, I can ask her and we can share kind of what that model is. But I think that is most of -- that's the direction she's modelling this after >> Tovo: Thank you. I assumed if we looked at those

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cities we would get a sense of what it looks like. As people have talked about this concept through the years sometimes they've suggested city buildings or other facilities that might serve so thinking toward that too -- what would a facility look like? Do these tend to be built from the ground up, are they built along a side an of a clinic. >> Those are great questions and considerationings. If you're looking at a skilled nursing facility is there a wing so you can transfer patients and have a step-wise discharge approach as may be appropriate. Is there medication assistant -- a program -- access to methadone, can you bring in specialty care? Community care has a clinic called care-co which is a k078

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mreks clinic whereby individuals who are discharged I -- who need wrap-around services can go and receive all those services. Do you locate a clinic like care-co in an environment like that? If there's remote care -- I think there are lots of ways this can be designed >> Tovo: Thank you. Lots to think about. Council member kitchen? >> Kitchen: Two things just to follow up a bit on what you asked, council member tovo. I think it would be intting as we proceed with this to have conversations about partnerships with the city in terms of facilities. So, for example, if the city has a better idea or in those discussions about what it would take we could look at some

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partnerships. If the city were to provide a facility or space in a facility that we have -- like we have bridge shelters now, for example. Would there be potential for a partnership where central health contributes the dollar amounts necessary for the medical care and the actual bricks and mortar -- something the city

could contribute? That's one possibility and I think council member tovo is -- was talking about that kind of thing as well in terms of identifying what the facilities are. So there's that. So I don't know -- I don't know that any of those conversations are happening yet, right. >> Yeah. That -- >> Kitchen: I think it would be helpful. >> Sorry. Go ahead. >> Kitchen: I think it would be helpful to have conversations with our homeless strategies office about the

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potential for partnership there. It sounds like one of the challenges now and what you're thinking about is what kind of facility do you need, you know, and how do you get to that point. So I think exploring partnerships with the city would be useful. That may not be where it ends up but I think it would be useful to have that conversation. >> Agreed and I think, too, as we build up the programs and the capacity to make sure when we make a commitment to an individual that we're going to provide care for you in this respite environment -- he mentioned earlier the learning curve. There's a lot we're learning, including how and what to measure. I think we can feed that into those conversations and I think that will help inform when and where and how those facility partnerships might evolve. The other thing I would like to posit with this committee to think about is there is --

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there's a lot of opportunities when it comes to programs and ordinances and other city-funded programs -- or city-effected programs where if we have a health and wellness center we're constructing somewhere and -- you know, does it -- is it okay it's in the etj? Are there some opportunities there? And so I think looking at the different things that come before the council -- if it involves people and place, which is a lot -- probably describes 99 per cent of what comes before you but looking at it through the lens of we know there are other provider partners that have these that they're building up. Is there something we can bring forward and accelerate to be able to get that physical space and have it pace with the program? I think one of the perils we

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need to try to avoid -- selling a ticket for an airplane but you don't have a full crew to make it an operable flight. We need to make sure that's in place. I wanted to -- appreciate your conversation here and we agree. Just putting finer points about how the planning could occur jointly. >> Kitchen: This might be applicable to my next comment. The idea of the respite care -- and I'm going to age myself has been in this community close to 15 years. There was a program that was operated and it never got very far and so I know that you all know that and so I'm sure you're -- and I would want to make sure -- I'm sure you're doing this, is understand why

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that program didn't continue, what happened -- what were the barriers there. I don't know all the details. I was there when it launched and I wasn't there for the middle part of it. I'm not sure what the barriers were. I suspect one of the barriers had to do with where do you locate it? I know during some of that time there were contracts for skilled nursing facilities for beds. That was how the respite program was working. The other thing I was aware of that never got fully launched was the whole continuum -- like you just mentioned. In other words there wasn't a place where someone was ready to be discharged that kept them from going back on the streets. I want to make sure -- I'm a little anxious and a little bit impatient, I guess, that we're at this point almost 10 to 15

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years later and we're still talking about launching a respite-care program at what is a very beginning level. D so I find that frustrating but I'm also encouraged because of the way you all are approaching it. You know, it really sounds to me likeouou've thought through it and you've got -- you're operating now and thinking about what it's going to take to make it Su stainable. I put that challenge out there to say let's not do that again -- let's make sure that this really gets to scale and gets to scale in a reasonable time line. I just would put that challenge out for y'all. >> That's we embrace with you. I'll circle back with you off line to maybe get a little bit more on the prior respite

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program but we appreciate that. I'm intrigued too. Was this a city or private foundation? I was here 15 years ago. >> Kitchen: If I'm remembering correctly, it was front steps that operated it. >> Yes, yes. >> Kitchen: Maybe Monica knows. I'm not certain. It was launched through the icc -- integrated care collaboration. It was a collaborative effort. I know there were funding issues at that time. So there was a pilot and I don't know how it was funded after that. There was also space questions, where was it going to be. But I don't know what finally -- I don't know what the big barriers were. >> That recollects it for me. Thank you. >> Tovo: Thank you, council member kitchen. I think we've been talking about this for as long as the two of us have served here on the dais. It is -- to the extent that we can be supportive in these last

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couple of months and our colleagues after our departure -- I know this is a high priority for city council, to make sure we lend support as appropriate. I'd like to look at together -- at the page that talks about outcomes. I know you addressed this in your presentation. As I look at the disposition of the clients you served, 25 per cent moved on to transitional permanent housing. I assume you did that with partners? I'd like to talk about the 40 per cent who left. Can you help us understand what some of the challenges were? I think you alluded to some of them in your earlier comments but I'd like to make sure I understood it. >> Where to start? For the 40 per cent who transitioned out, I think this

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is usually shooting for the moon as well. Potentially we recollected have qualified in any of those individuals actually had follow up with their pcp, received their meds, were tied into the system or registered for housing -- whatever -- we could have accounted for success. The the only way we're counting the total visit as a success is if people end up housed and their end point is kind of a terminal successful end point. For those individuals, their social services needs were just not completely wrapped and met and it may have been that someone had a diagnosis of pneumonia and was still -- the individual just wanted the freedom to be back, you know, on the streets and we would have liked to see no fever and, you know, someone doing much

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better. So for that 40 per cent there were a lot of successes there but not terminal success. >> Tovo: That's very helpful. So there -- because the measure of success for all of them was to be permanently housed. >> Permanently housed or there were some individuals that were underresourced -- the majority of them experienced homelessness but there were a couple of folks that are underresourced individuals but, you know, actually do have a place to live. And I think for those individuals just seeing that they were well enough and their home environments is not necessarily secure enough for them to heal and do well, and so I don't think the end point at this point is hundred per cent housing for all these folks. I don't think that's possible but for them to be connected to social services and/or housed.

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>> Tovo: Do you know if all of the individuals who participated in the program are part of our -- have gone through coordinated assessment? Is that something you do early on? So that they're in the queue for housing. >> Yeah. I would have to check that. I think that is part of the -- start working on that there, but my guess is many of them do not or have not been. I would have to check that >> Tovo: I would regard that as a high priority early on so they're in the queue for housing. Yeah. Do you want to jump in there? >> Kitchen: I was just going to say -- okay. Caveat that I understand the complexities and it's

difficult. But ideally you would have attached to your service the vouchers or the other resource that says that there's housing available for everybody that goes into that program. If you have ten beds, you have

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ten vouchers or -- you know that you can use. I know it's more complex than that. Ideally that would be something to work towards because I think that everybody that goes into respite -- nobody should go back on the streets ever. >> Completely agree. There is -- this is where Audry has better expertise than I. But there is a subsection that don't want to be housed yet. >> Kitchen: I understand that part but I'm talking about if they're ready to accept services. >> If I may put another question on the table. Is there a time line mismatch? So there's the medical respite and so we're bringing coordinated assessment and housing referrals to the table. We're making those connections for those resources, but that potentially -- that fulfillment of those resources is on a different time line than the

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medical respite. Does that occur? >> Tovo: And just to clarify, are you saying that there are -- that the resources for housing may not be ready by the time an individual may be able to receive the medical resources? >> It's actually a question I'm posing because I'm not intimately familiar with -- coordinated assessments and housing referrals and the other connection points. I know what we're doing but on the other side -- >> Tovo: Yes. I would say absolutely because the housing resources are so scarce but -- >> Kitchen: Sorry >> Tovo: I was going to say the coordinated assessment is kind of the first step in that process so making sure that those individuals are part of our system I think makes this really critical.

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>> Kitchen: Yeah, and connecting the dots is what I was going to add so that if someone is in respite that they then have a place to stay until their housing is available to them. So that may be that they're discharged from respite to a bridge shelter or it may be that you have a certain number of units or dollars available that's just set aside for folks that are in respite. I don't know what the solution is, but that's a really good point, you know, that you raised, council member tovo. Those dots need to be connected. That's not something that you all can do. That's a connection with our whole system. You know, our system of allocating vouchers and housing and stuff like that. I thinkhat would be important

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to do so when someone goes into respite they have a place to stay when they're ready, assuming they're ready -- that they have a place to stay, whether that's a bridge shelter or actual housing. The timing may not work -- you know, the other thing that would be interesting about that -- and we're getting beyond what we need to be doing here, but that's one reason there might be opportunities to coordinate with our shelter program, with our bridge shelter program. So that there's either space in a bridge shelter that can be respite or that there's a discharge to a bridge shelter from respite if permanent housing is not available. Any way, there's lots of opportunities that need to be discussed but that's a really critical piece of it because as we all know and you all know and I'm just preaching to the

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choir, one thing that's important is that there's a break in the continuum that they fall off and part of what we really ought to be doing as a community is really addressing those gaps so that someone can be served all the way through. Again, I know I'm preaching to the choir, but because then they go back into that cycle. >> Greatoints and I think as we continue to mature in our developments, you know, we absolutely need to fill some of those gaps. We are working on other aspects, such as -- once individuals are back on the street we can't connect with them anymore. Even if -- so it's exactly to your point. Even if some of the social services have started to be connected, how do we connect them back into care? So we're -- a program that's about to go live is providing cell phones to individuals.

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They have to be prescribed by a provider and there's certain criteria. They're loaner devices. Whether it's by appointment or social services we can keep them engaged to get them into housing, into their end point care. >> Tovo: That's terrific. That seems like a -- how soon. >> I think we're looking at a vendor, which for on argueization like central health can take a little time >> Tovo: That sounds great. One other data point I wanted to ask about -- I'm still on number four, the disposition, the 15 per cent administratively discharged -- those are individuals you would have liked to have stayed longer so their care needs could have been met but for some reason they were asked to leave. >> There were a few number of people and from my understanding is majority of those really needed active

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detox. To find an active detox environment is just very, very challenging. And so the individuals if they -- if they want to go back to the street, they go back to the street. Potentially their transition to the E.D. -- But that is where the partnership -- those patients, it's dangerous to themselves if they acutely detox in

a nonclinical environment and it's not appropriate. Our partnership -- that is one of the aspects that they can't stay >> Tovo: Thank you for that explanation. Other questions? Yes? Council member -- let me just turn to vice chair Fuentes. >> Kitchen: Sorry >> Tovo: Council member kitchen? >> Kitchen: One last question. Housing is impacted in one of the social determinants of health. What are y'all thinking in

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terms of funding for housing? And other social determinants of health? That's a broader picture -- question for central health's role and central health's budget. >> I'll start off the answer and then ask colleagues to chime in. Right now when we focus on the healthcare equity plan and needs assessment, we are so focused on filling those gaps in the healthcare system, especially in a very challenging work force environment when it comes to healthcare providers -- and that's everybody. Nurses, nurse practitioners, medical assistants, admitting clerks, community healthcare workers -- that there is -- there's a lot we need to build out in a high-functioning healthcare system.

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Although there are notirect dollars for housing other than what we've talked about with respite -- you know, on average 22.6 days. It's making sure people are connected to those resources so that we can across the spectrum of the social determinants of health help individuals get access to resources and have the follow-through necessary to make sure that we're all -- when I say "We" I mean everybody in the community -- city, county, nonprofits -- that everybody is doing what they can to wrap the social determinants of health around the individual. We've all heard and seen data that there's so -- so much of your health is only affected in four walls of an exam room. It's what happens outside the four walls. That's big picture where we are. If you go back to the cog slides and social determinants

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of health being center of that and making sure the resources are always going to be there as long as the board keeps ratifying that approach and the county commissioners approve it, we're going to keep doing that. >> Thank you. I can touch on some specific aspects of the social determinants and then I can hand it to Monica. As far as people having the opportunity to heal and do well, transportation is a factor. So we do work on transportation whether they are vouchers or we fund transportation. That infrastructure, as we build out our clinical -- direct clinical practice of medicine, part of our -- I think we're calling it patient access and service center, part of that center will be geared towards ensuring transportation is not the reason people don't get into services. We're providing it now and that is a direct focal point. In addition, I remember my time

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at community care as their cmo -- number one when we did health risk assessment was affordability of meds. Even within a 340 B -- the pharmaceutical program it was still at the top. Between central health and community care we were running a pilot program where we looked at individuals that have uncontrolled diabetes and we waived their co-pays and they got some of the newer meds out to see if we remove that barrier are we more likely to see them succeed in their health. HEB has a courier service for medications. We're working with partners to provide a courier service and focus on what that means moving forward. If patients can afford their meds but can't pick up their meds. So we're looking at one social

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determinant -- note at a time. Focusing on as many as we can. If you look at food deserts. This is where I have to talk to my colleagues because there are some environments where it's appropriate for central health. A mobile food pantry -- do we set up food pantries in some of the clinics. This is where we have our legal experts here and I have to keep looking over to make sure I'm not getting in trouble. >> Currently there is partnership. I'm not sure exactly but on last Friday -- or last Thursday at community care southeast health and wellness center we have partnerships with some of the local food banks to make sure there is accessibility for fresh foods in some of our clinical hub settings. I think that's something that Mike and the teams we have

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working on developing our programming and Hornsby bend and Dell vally -- that we're already doing at the northeast health resource center, that we are looking at these social determinants and also programming around there's a community kitchen that southeast health and wellness so we do have places for there to be programming around, you know, diet, exercise. Some of these other prevention -- in addition to making sure that medications are affordable and that there's accessibility, at least transportation to get to healthcare appointments and then really just continuing to look at how we can partner -- you know, we're still -- we're

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still working with folks at social finance on the at-home initiative to see if we can bring that home with central health, really focusing on how do we bring the medical piece to the table for housing initiatives as they're developed and how do we continue to work as additional permanent supportive housing is brought online in the community, what's the best way and best model to make sure that folks who are in -- who become housed in that new housing, that if they are ready to make sure they're connected and have access to clinical care in clinics if they need -- you know, this level of touch that he was talking about with maybe the care at home, that that's available in the appropriate settings when there's a large enough density

[11:15:29 AM]

of folks that would require kind of regular interventions from our mobile team and then also making sure that we're still focusing on people who are in encampments or are still, you know, living on the street or sleeping rough that are yet to be housed, that we are still focused on the needs of, you know, those neighbors and those individuals. >> Tovo: All right. Thank you. Do you have any closing remarks or any additional things that you would like to share before we Cude our conversation. >> First of all, we very much appreciate this dialogue and you providing this forum to have these discussions. Thank you for your service. We appreciate it. Wish you well. >> Tovo: Thank you. >> Thank you, council member Fuentes >> Tovo: Thank you. This has been a terrific presentation with a lot of

[11:16:31 AM]

information and excited about some of the directions you discussed. So all right. Committee members, that being our last item, I will call this meeting adjourned at 11:16. Thank you all. Thanks to our tremendous staff as well.