Regional Affordability Committee Meeting Transcript – 07/25/2016

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>> Garza: So I knew we were going to have a hard time getting a quorum day and I just got a text that our seventh is not coming. We will not have a quorum. I can't call the meeting to order, but out of respect for our health and human services people who have come, we can have the presentation and discussion. We'll have to postpone the -- the strategic plan vote until our next meeting. So thank you all for being here. I know many folks just got back from vacation so thanks for being here. I'll just call up director Jones.

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>> Good afternoon. Thanks for the opportunity to present. We have a couple of option. We can come back and present it at another time if you would like us as well. If you would like us to do it today we'll be happy to.

>> Garza: If you don't mind since we're -- I think these are important issues to at least hear about right before we start the budget.

>> Thanks very much. I'm Shannon Johns, director of austin-travis county health and human services department. I'm joined by miss cassie Deleon, our chief of planning for our department. I have also joining me in Donna Su mstrung. The data we'll share will talk a great deal about the impact health and human services has on affordability in our unit. -- In our community.

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Go ahead and get started. Austin-travis county health and human services, our vision is that our community will be the healthiest in the nation. Our goal is prevent disease, promote health and protect the well-being of our community. The core purpose is to promote communitywide wellness, preparedness and self-sufficiency. Prevent illness, injury, and disease. And protect a community from infectious disease, environmental hazards and epidemics. So when we talk about that whole piece, we're talking about the holistic approach and not just the health piece. That's why wellness is important in terms of our discussion and our efforts around self-sufficiency. Return on investment or roi, is very critical because the money that is invested in our community makes a

difference in terms of affordability and livability in our community.

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Just some highlights in terms of the impact that public health plays on affordability. On the concerns thereof. Over the last ten years rents have risen roughly 50% while the median income only 9%. Quality child care for low-income working families funding is not sufficient for full day and year round care. 22% of adults in Travis county report poor mental health. Outcomes. 18% of individuals live in households with limited consistent food access. One in four children in our county live in poverty. The local poverty rates for hispanics are 27%, African-Americans 22%, are also much higher than overall which is 17%. Over 7,000 people experienced homelessness in 2015 staying in the streets, cars, parks

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and shelters. In the U.S., health care expenses are a leading cause of bankruptcies in our nation. So today we're going to talk about factors that affect the overall health of our communities. We're going to look a little bit at Travis county population trends. We're going to assess some of the health disparities we see and spend time talking about the health and human services program impact on these conditions. I'd like to start off by giving you a overview of what constitutes health. 10% of health is basically physical environment, things like air and water. Quality, housing, transit. 20% are clinical care which we a lot of time get confused with health. Health care is just an aspect of health, not the whole piece. Things such as access to health care and quality of health care. 30% are health behaviors such

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as tobacco use, diet and exercise, sexual activity, alcohol and other drugs. But 40%, almost half, are determined by social and economic factors. Things such as education, employment, income, family and social support and community safety. If, when we look at Travis county based upon the most recent Texas -- the national health rankings, there are 254 counties in Texas. When we look at them overall from 2010 and 2016, we see some differences, good and bad. Overall ranked in 2010 we were ranked 7th in all of the Texas counties out of 254. In 2016 we had dropped down to number 9. We look at the physical environment, we ranked 181 in 2010 and we've improved to 133.

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When you look at clinical care, and this is always fascinating, we rank second only probably to Harris county in terms of access to clinical care in our community. Health behaviors, things such as we talked about, tobacco use, diet and exercise, sexual activities, alcohol and drug abuse, we ranked 15 in 2010 and that's been reduced to 7. And in social and economic factors, in 2010 we were 32nd, in 2016 we were 75. So we're going up and down as we look at our county overall in terms of the status of our community. Let's look quickly at some of the factors that also affect health in terms of area of improvement. High school graduation rates plays a significant portion in that. Injury deaths, reduction in those, unintentional injuries, motor vehicle, poisoning, all of these are factors that contribute to negative health outcomes in terms of a

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community. Children in poverty, poor education achievement, association with poverty. Children in poverty in highly correlated and overall poverty rates. So when we look at those areas we made improvements, we notice overall in our county we did in areas that do not address the issues of poverty. When you talk about things as a social impact, we see -- we became worse. Those social impacts such as poverty, graduation rates, all of those play a factor. In order to those, violent crime. High levels of violent crimes compromise physical safety. And psycho sociological factors. Pursuing healthy behaviors such as exercise and outdoor activities. And, of course, the physical environments. Severe housing problems and long commutes are factors that contribute to the negative health outcomes that we do see in our community.

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When we look at our community in terms of race and ethnicity, it's important to note particularly where we have pockets of our activity, I would just like to highlight those for us. 12 census tracts with population of 30% African-Americans in our community. Those are primarily in precinct 1 in our county or in -- primarily in district 1 for -- in our county, in the city districts. There are five census tracts with populations of at least 80% hispanic origins. All of these are within precinct 4 for the most part and represent approximately 20,000 residents of hispanic origin. This just tells us where the concentrations are. By no means does it tell where all populations are. And there are five census tracts with populations of at least 20% asian-american, four located in precinct 2 with a population of 4700 Asian population.

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Let's look at poverty. This chart probably better than any other chart clearly says there are line of demarcation in terms of poverty in our county. Roughly east of -- pardon me, east of 35, interstate 35 or mopac, all the way to the county line. There are significant levels of poverty. In Travis county ten census tracts have 40% or more of their population living below poverty and those are primarily precinct 1 and precinct -- and southeast Travis county. When we look at age mortality rate for the leading causes of death in our community, there's good news and bad news over this period of time. The good news is that the number of deaths in our county continues to go down. That's the good news. The bad news is that the difference between groups continues to exist. Where we're making head way in

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all population, that gap or that disparity or that inequity in those populations continue to exist. And this just clearly illustrates this when we look at diseases such as cancer, heart disease, accidents, Alzheimer's, stroke. All of the leading cause. We look at health disparities in terms of birth, particularly teen birth. This slide represents the total live births for ages 15 to 17 in Travis county between 2009 and 2012. This indicates a roughly 81% of the moms between ages 15 to 71 were hispanic. I mean, I'm sorry, 15 to 17 were hispanic. We'll go back and look at those numbers. But so what that tells us is where the births are occurring in our community.

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And what the population will look like over the next five, ten, 15 and 20 years. Infant mortality

rates. The good news here is the infant mortality rates for the most part are declining or maintaining. The bad news is that the gap still exists, and particularly in the African-American community where it's almost twice that of the hispanic and white community. Next area is prevalence of people living with HIV and AIDS. Good news/bad news, there are more people living with HIV and AIDS in our community which means there are more people living which means they are not dying. The bad news is that despair rate exists and the numbers are gradually growing. We're still having the transmission of HIV and AIDS

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and numbers need to be addressed in terms of comparison. This chart maps clearly indicates the disparity in terms of location. This chart basically tells us where community care clinics, the hospital systems and the wic locations by precincts are locate. It clearly indicates that most of them are located in or along a line adjacent to I-35 and mopac. And yet as you remember in the data we presented earlier based upon disparity, poverty, we clearly see that's not where the locations are. So as we look at policy, we need to make sure that we address where populations are in order to make a difference in terms of service delivery. The next slide is sort of a busy slide, but what it tells you is sort of the impact of our investments. And roughly I won't go through it, but national studies have demonstrated a return on investment and reduction in more expensive intervention if

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we're going to make a difference. So currently we have basic needs. Roughly $8 million we currently invest in our social service contracts in this area. Behavioral health, over three million, children and youth services 6.7 services, HIV service, 603,000, homeless service a little over 5.5 million, workforce about 3 million. And then a little for administration and planning. It's important to know every dollar invested in work farce has a return of $2.74 over ten years. Per individual. Every dollar invested in high quality pre-care education returns up to $17 per participant. Substance abuse treatment returns up to $4 to $7 for every dollar. And permanent supportive housing saves over

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$1.1 million aggregate. These are numbers that have been provided, of course, by one voice, which is one of the leading voices for social service advocacy in our community and one which is a strong partner of our efforts. When we look at health and human services program delivery ourselves, and these are not our contracts as we just previously mentioned, but we also provide services, emergency food pantry, our wic location, snap investment for outreach, case management, self-sufficiency, which transitions 54 households out of poverty in 2015. So there are strategic efforts in our budget that are working towards those numbers. Keeping in mind those numbers are increasing so these numbers to even maintain our level of investment we have to continue to work hard to address the increasing numbers. We look at some of the health

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impact, particularly infant mortality and low birth weight. A pre-term birth costs roughly $55,000 to maintain compared to a healthy birth of 5,000. A teen pregnancy cost in $201,010,000,000 in health care and foster care costs including incarceration rates among parents and teens. Parents lost revenue. All of theosophic stores contribute to the high cost that it takes in terms of maintaining

these populations over time. When we look at maternity infant outreach, family planning education and counseling, we're working with our various programs to address this infant mortality and birth rate and teen pregnancy issues. With the recent investments we've had. We have community workers and other outreach groups that

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work in communities to incentivize. And health education so beyond health care and social services we also do mentoring services to focus on adolescent health through various initiatives and programs with peer and young folks. Comprehensive sexual education is part of the mentoring efforts. And, of course, teen pregnancy prevention working with our partners to educate but also do referrals into the community care clinics for services. We look at chronic disease which is the leading cause of death in our community. Roughly $571 million have been spent in Travis county to -- during 2012 to address hospitalization due to chronic disease. $571 million. That is a significant

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investment in our community that could be better allocated if prevention efforts were undertaken. Heart disease is the leading cause of death among trims and cancer is the leading cause of death among our hispanic population in our community. In Travis county obesity, tobacco use, diabetes and cancer disproportionately affects populations of colors and those making less than $25,000 a year. So the effort to address the issues of obesity, tobacco use, diabetes and cancer has a financial impact in terms of return on investment. Our efforts so far are we provide free diabetes education classes targeting medicare and medicaid eligible population as well as the medically indigent populations of color as well as others. Free tobacco cessation programs for 18 to 24-year-old, that group impacted by those population we talked about. Nutrition counseling, free

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community education program. And our quality of life and provide chronic disease services around education and out reach targeting all populations of color, asian-american, African-American, hispanics as well. Hiv/aids, in terms of impact in our community, the estimated annual cost of HIV lifetime care is roughly almost $400,000 in 2010. So for each individual we're investing that much with those who have a lifetime impact of HIV. Travis county HIV rates are among the highest among African-Americans. African-American population here in Travis county is the sixth largest in the state, but it has the third highest prevalence rate in the state. In 2012 the new infection rate

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was third, we're ahead of Fort Worth, tarrant county and San Antonio, Bexar county. Our efforts in terms of outreach testing and screening, so we go out into the community and do a variety of screening and testing, HIV treatment reduces spread of the disease. We're able to reduce those individuals viral load. We have to get to them and make sure they understand that so we're looking at efforts to do that. In terms of our community. We have outreach efforts but we need to expand those efforts as well. Medicare -- medical case management ensures individuals with HIV gets treated. So if we've got someone who has been identified, he or she can have a natural long life if they got into medical treatment and case management. Beyond the health and human services impact on other areas, we also impact public health emergency preparedness.

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We want the emphasize this because it is important to understand that we are -- play a critical role in response. Events of 2011 has clearly indicated the anthrax attacks that followed highlighted by strong local public health and federal public health systems to address those are part of our effort. In 2009 to 2010 we had the H1N1 pandemic. Responding not just to the general population but responding to all population. It is important that we make sure not only our wealthiest but also the least among us are able to respond to these kinds of threats as well. In closing, I just want to talk a little about public health is return on investment. It is prevention. Intervening in both the social determinants of health, we make a big difference in terms

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of the health of our community. It is essential in terms of the well-being of our society. It affects our environments from everything we do where we live, where we work, we learn, we play and we pray. Addressing the social determinants focusing on health days spare tease and ensuring our community is safe from public threats, our entire community addressed and not just elements. Austin is a very healthy and fit community. It's among the healthiest and fittest in the nation but we have to ensure that occurs for all parts of our community and not just one element. With that said I would be happy to entertain questions about our presentation or any other questions you may have.

>> First I just want to say thank you. This is really a great report and I'm really glad we're looking at public health

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particularly in the context of affordability. Do I understand this is a reflection of the city of Austin and Travis county, it's the combined city, county --

>> Investment reflects some of it, some of it may not. Depends which item we're talking about.

>> Yeah. I was curious about the rankings and it looked to me like under the social and economic factors that we -- we saw a very substantial drop, we went from being 32nd in the state in 2010 to be 75th in the state in 2016. I wondered if you could just unpack a little what caused that drop. You've got four big areas, if those are the four -- actually there's five big areas under social and economic factors. If you would give us a sense of what contributed to that significant drop.

>> Many factors.

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One is this was during a growth period. Everyone that came into Austin was wealthy and that has gnat been the case. A lot of the factors that drove the population growth is U. In immigrants or new residents that have moved here who do not have those type of factors. They moved into areas where the infrastructure was thought there. So therefore things such as education, employment, income, family support systems that we have in place were not there. And so those factors contributed to the last responsiveness of our health care and human services systems to those

resulting in lack of access thereby resulting in a diminution in the ranking. Those are some of them. Not all of the factors, but those are some of the factors.

>> Is the rail wood Johnson support available and does it unpark for of that analysis? That would be interesting to see.

>> Yes, that report is. Let me give you a little about

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it. It in concert with CDC has a national ranking of all health departments around the country and state by state. It provides data based upon that and we can make available the link. The university of Wisconsin has contracted to do this study. They've been doing it for -- yeah, since 2003, approximately. And so that information is available over this period of time. And we'll be happy to send the link so you can see all factors that do into that.

>> And if there's a page reference. I'm assuming if it's every county health department in the country it's a lot so if you could give the page references.

>> The county health rankings has a nice interactive website so you can -- you can look at Travis county and compare Travis county to other counties within Texas, with other counties that are similar in other states.

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So it's a very dynamic website and we could definitely drill down and get more specifics into each one of these social economic factors. In any of the areas that are listed.

>> That would be fabulous. Thank you so much. I just had a couple of other questions O the health disparities particularly around the teen births, do you have the numbers? It's alarming to see 81% of teen births mothers aged 15 to 17 are hispanic. So I'm assuming that tracks with other socioeconomic factors for health. What are the other numbers.

>> We didn't include it in the presentation for the time and the length of the presentation, but we have another table that shows the actual counts. And it is -- it is very concerning as well, the number of teen births.

>> And I know there's a program that's a joint city county effort, I think it's

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healthy families or something like that, but it's specifically targeting in-home visits with social workers or caseworkers who are literally going to the homes of families with new babies to help them better care for their babies and make sure that they get the best health, the best start they can get. I think that's an example of a great collaboration around this.

>> We have two programs. One to focus on the hispanic Latino population and more recently the African-American population and it does exactly what you said, commissioner. The goal is look at what

has been the outcomes of those investments and those are kinds of things we're looking at in terms of evaluation.

>> That would be great. And then on infant mortality, teen pregnancy, the teen pregnancy cost number says? 2010, 9.4 billion in health care and foster care, increased incarceration rates. Is that a national cost?

>> Yes.

>> That's a total for the

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nation.

>> Yes.

>> On the chronic disease, and I know this is one of these things where our new medical school and the whole Dell complex is really looking to help us target this. There's a really interesting story on NPR on other night where they did some analysis of chronic users of hospitals and health care in the community and there was one person who had I think 450 visits in one year. And obviously that's more than once a day and so they did some very detailed analysis of what was happening with these chronic patients, so I wondered -- what is the definition for chronic disease hospitalization. Do you have a working definition so we can understand what that means?

>> We do. It's a mix of different household discharge codes, we call them icd9 codes.

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It's codes depending on the diagnosis when the person is discharged from the hospital, what they had, if it was diabetes, asthma, whatever it was that's chronic disease related they look at those codes and apply costs to that discharge dollar amount.

>> In this case it may not be somebody who is chronically using the hospital, it's someone with a chronic disease.

>> Right.

>> That's a different understanding that I had for what that meant. Do we have data that reflects chronic use?

>> The hospital -- we're working particularly with central health and with medical school to look at that. Ems also has some of that data so we're looking at aggregating that to get a picture of. We do know there are, quote, frequent users of our hospital system that drive costs up and in fact many of the ems has done a lot of work with a lot of those individuals that have an impact and we're working in

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terms of how do we address that from a preventive side in terms of education with family members, a lot of that is mental health and not just chronic diseases as well so all of those factors are underway to be looked at.

>> That would be great. Maybe have all of those in an update in the future. And then you have information on that, that would be great.

>> What's happening with that, but anyway, yes, that is something that central health is working on with our various partners including Dell medical school and criteria that we are looking at to look at not -- to look at chronic diseases, to look at specialty care is another one we're working on and this issue of the frequent users. So it might be good in the future to ask somebody from central health along with somebody from the medical school and community care to come speak and to give details.

>> That would be great,

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especially on that frequent flyer category. The last thing I'm really glad to see the natural disasters included because that clearly has a profound effect on community health. We see the effects of it in the commissioners court, we have a standing item that we've carried for many months after the floods and people are coming and telling us they have homes that are full of mold and are literally falling apart, but they are in this sort of weird catch 22 where they can't really knock the buildings down yet, but they are worried that they present both a health threat and a safety threat if kids went and played in the -- you know, busted up shells of the building and something should happen. And then to me there's the whole mental health component of what happens to people after natural disasters. And I don't know how we look at that, I don't know how we

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evaluate it, but I just know it's a -- it's a real impact on the community and I'd be interested in any information that you have on that as to how we track it, how we understand it, how we can provide any support or services. It's clearly a trauma to people and we're at a loss for how to help in that situation.

>> This is a classic intersection of public health and public safety. One of the things we're looking at and we're partners at the table in response is ability to respond not only after the fact but also prior to the fact. And so one of the things we're doing in our public health preparedness process is elevating that role so it can be proactively. In terms of the housing and other aspect of it, we need to be part of it at the table of addressing those issues. Where is the -- is this the best location for housing development? What are the public health

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impacts? We're raising those elements. The other thing is the threats we face. Every day I remind people is we could get a call about having to respond so we need to be prepared. So we're looking at that. Part of that is helping the citizens understand not just the general citizenry, but those east of 35 to know they need to prepare to what they need to have at home, in their refrigerator, what kinds

of supplies they need to have stockpiled in the case of an event. That's part of the education education -- component. I'm not here to tell you we're there, we have a long ways to go, but working with public safety partners and others to build that capacity while also building the education and preventive part.

>> I would love to talk with you further off line. That's a big initiative at the county to try and get ahead of these so citizens can be better prepared. We'll never have enough

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emergency responders to take care of everyone. For instance, we're trying to understand through census maps and even voting registration maps where are our elderly who may need assistance if they need to be evacuated in case of a fire or flood. We're trying to cross preference those maps with the first responders. I would love to have a separate more detailed conversation with you about that. Thank you.

>> Be happy to.

>> Thank you very much for this information. I had some questions about -- well, first a comment about the clinics, hospitals and other service. You pointed out that there's I think pointed out that there's an obvious concentration of these services along one corridor and I'm assuming that's the I-35 corridor and very few hospitals east of that. Is there some kind of a plan to work on that? Are you all thinking about that? Because I understand that the need for transportation, ease

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of transportation, that kind of thing, but any thoughts going in that direction?

>> Well, we have been in dialogue and continue to be in dialogue with both central health and with the various hospital systems about that issue. We have a planning group that we look at these pictures. We're right now actually in active talks -- it's not just the hospitals. One of the challenges with the hospitals is the infrastructure, the cost to build that. We're talking with them to see what their plans are and it would be good to have them come and address what their long-term plans are for hospitals. We are working closely with central health. Particularly because if you look at the clinic locations, east of 35 there are very limited locations for clinics. Particularly as the community has grown both southeast and northeast. And so we're -- we're working with them to identify locations and we have a working group to identify a couple of strategies to build capacity in those communities particularly. Because if you overlay the

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poverty data and the educational data and the health out come data, these areas are the areas in which those high more built and mortality are. The question how do they build that into their capacity on every the next year to add services.

>> Right, and that from the central health standpoint, we're in the midst of doing a new strategic plan. And certainly we are looking at all of those demographics. One of the things we've all seen is people being involuntarily displaced and moving further and further out and east because that's

where they can find housing. That is affordable to them. And as that has happened, we now need to look at those demographics and take that into account when we're looking at locating, relocating clinics. And we're in the midst of doing that as well as looking at new contracts for additional providers for those

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kind of clinics that are the 24-hour clinics that people can attend. And we just had a presentation within the past couple months from staff who are looking at, as I said, more contracts with providers of those types of clinics.

>> And are you all in conversation with transportation providers like cap metro, because that's a key piece.

>> Yes. We fully realize that there is a transportation piece to that and in fact with the location of the southeast health and wellness center, that was one of the factors is having that in a location where we had not just the populations but the transportation coming into that particular center, which is a new model and kind of all-encompassing center.

>> One of the things we also as part of our community health assessment and

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community health improvement, one of those priorities were clearly transportation. And people in the community told us they couldn't get to the health care, they couldn't get to their grocery stores, so their doctor's offices or even to work in many cases. Transportation is the key to this. We've been involved and actively engaged with cap metro particularly in terms of developing routes that are applicable. And a good example is that in the manor area recently cap metro developed a flex system where not only did they have a service that ran from Austin to Elgin with a stop in manor, but they went from Austin to Elgin and had a wrap-around services in manor so people who didn't necessarily need to go to Elgin to get to one side of manor to the other side to get to their doctor, food, otherwise. Those are factors they are taking into consideration as they plan and continue to do so those things.

>> One thing I would add and this is something I added into the document at our next meeting on the strategic plan is to get a briefing on the

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city of Austin smart city, the department of transportation smart city challenge proposal where we were one of the seven finalists. And I worked with Katherine Greger, who is with the city of Austin transportation department on what we call the ladders of opportunity and specifically looking at strategies to connect transportation as the thread for this nexus of having health and wellness, decent affordable housing, education and a good paying job. And certainly the intention I know, and there's a meeting scheduled in August, is to continue with the collaborations and efforts that were behind that proposal.

>> And I would love to have conversation with both of y'all about the rundberg community innovation

because we're looking at those factors and right now I'm part of the health care work group for rundberg and we are looking at all of those factors right now and collecting data so it

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would be helpful to share information.

>> Well, in fact, yes, we met with -- in putting that proposal together various folks who were involved in that rundberg initiative and it was slated to be one of our smart stations.

>> Wonderful, wonderful. A few other questions too. You've got programs, I'm looking at your slide impact direct social services, you have neighborhood centers. How do you determine how those are located?

>> That's a great question. Historically they were located adjacent to the communities that did develop. We receive csbg funding through the cdbg funding to federal funding. Those are located in high poverty levels. They have veteran this way for many, many years. And if you notice our location, they are adjacent to I-35, which historically had been to communities where those populations lived. So those neighbors, that is why the neighborhoods had to pack up and move because of affordability, those centers are still there.

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We're looking at how do we be able to address those issues as communities have moved out to be able to provide those either through mobile locations or through work with partners, through schools and others to provide those services while we look at a long-term capital campaign to look what does it take jointly, not just the city of Austin, but Travis county, central health and others to co-locate in regions of the district that makes it one-stop shopping so people don't have to worry about going here for one service and here for another. That's part of our planning efforts underway now but that's how they've historically been located and as we look to expand we look at more co-locating.

>> If I can elaborate, in the proposal the idea behind the smart station was don't necessarily think of it all as a physical building station but as a one-stop shop where in fact we would have everything from healthy food

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available and mobile cooking classes to all types of mobile health available because we know central health is doing mobile health, St. David's is, with dental, we know Dell children's is, so that was part of the one-stop shop with the smart station concept.

>> So I invite you all to have conversation with Austin independent school district and our family resource centers because I think that would be a good synergy to co-locate.

>> Absolutely.

>> I don't know I have a map where the neighborhood centers are. Is that on the website?

>> Yes, but I think that's on the map --

>> Is it on the --

>> [Inaudible].

>> It's hard to see exactly where they are located.

>> We'll be happy to get you a copy.

>> That would be great just to kind of know where they are now and it's great that you all are having conversation. That leads to the other questions I had. You've got on your -- your infant mortality, teen pregnancy programs, are those located in the neighborhood centers right now or in your diabetes education, how is

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that information disseminated out to the public?

>> Well, do you want to come and talk -- they are both in neighborhood centers. We also contract some of those services out to providers that provide some of those services as well. But as Donna Sunstrom talked about, health services we may have.

>> I just need to know the typical locations and how people get -- have access to this information.

>> Definitely. So again, Donna Sunstrom for community services division. Our teen health services are provided in a variety of locations. That includes schools, that includes partners that have locations, you know, nearby with schools. We are also coordinating with pard, parks and recommendation department, and we also are providing some -- so we use a lot of our partners, communities in schools, we use a lot of our access to

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schools, recreation centers. So it's a combination of sites. The same thing with diabetes education classes as well.

>> Okay. And do you have a specific outreach to neighborhood organizations? Like for example we had a presentation by Dr. Wong at north Austin civic association. I mean is that something you consciously do where you invite the various neighborhood groups or tell them about things that are available, presentations that can be made? Or do you just wait to be invited?

>> It's a combination of both actually. It's -- we're definitely willing to go out to the neighborhood centers on request, but we also really work closely with our partners, with our neighborhood centers in working with the neighborhood associations to really be connected and a part of that. I'd say it's a combination of both.

>> And the quality of life mobile van, chronic disease screening, that's a long description, where does that van hang out? Where does it go?

>> It goes to the targeted

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areas within the county. We've identified the highest rates of mortality zip codes in Travis county and so those are the areas that we focus on. Basically what we call the eastern crescent, which starts on the north, it goes around. We go to locations such as -- I'm drawing a blank -- schools. We go to locations in apartment complexes. Thank you. I'm drawing a blank. For instance, events, health fairs and those kinds of events. We also are looking at working in some of the targeted park and recreational facilities. Those are the various locations. We have times locations we did go. The goal is because there was nothing there in the first place, this is with our beginning efforts. We're trying to build that capacity, as a result of a budget we're able to expand those locations.

>> And generally speaking how

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does the word get out to people so they know the van is going to be somewhere?

>> We use multiple methods. Flyers, we work with neighborhood associations, we work with community groups, we do media campaigns, we have a radio show that we provide information on. So we have multi -- various ways. One of the best ways is word of mouth. As we meet with people, we let folks know to let their families and friends know. Work with faith based organizations and all the voters of networks in varieties of networks.

>> I'm assuming your community organizers have this information so when they go door to door they are disseminating this information which is a good way to do it on the ground.

>> We have to do a better job and we're working on to make sure we -- one of the challenges is we have a lot of funding and funding drives what mission is. So what we've tried to do is incorporate whether you are doing something for chronic or infectious disease you share information about both.

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All populations are at risk for the types of things we address and we incorporate it in all of our efforts where possible.

>> Thank you very much. Appreciate that.

>> Mayor adler:the factors that affect Heather where did that come from? The 10%, tent%, 30%, 40%?

>> These percents were developed by the county health rankings so that's the Robert wood Johnson foundation in collaboration with the university of Wisconsin. They designed that percentage to give a sense of when you're looking at a whole population, that are the largest impact and factors that affect health and what cargo does that come from.

>> They were using CDC guidelines. Center for disease control looked at all the causes of death and what are the factors that are attributing to those. And those are what they use

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to -- use for these criteria.

>> Mayor Adler: I found it interesting because one can easily argue social and economic factors affect all that other stuff like, you know, the neighborhood you can live in, the air you breathe, the access to a clinic, whether you are educated on, you know, sexual activity or not. So yeah those are interesting.

>> I know. I think that's correct. This is not a complete definitive answer but this is sort of a aggregate of what CDC identified, recognizing that all of these factors impact all -- each of the other ones as well.

>> Garza: Yeah. So the general takeaway I'm getting with regards to the discussion on return on investment is it's essentially it's cheaper to keep people healthy than it is to pay for their emergency care, correct?

>> Absolutely.

>> Garza: Okay. And you do -- and we have interlocals with other

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surrounding jurisdictions?

>> We have an interlocal with Travis county, we also have interlocals with some of the school districts in which we do things with them. We have interlocals with some of the municipalities we provide child care inspection services for. We have a variety of activities. We have a contract with the state to provide wick services in bastrop county so we are sort of the hub of public health in this area. Most of them are through interlocals.

>> Garza: Okay. Thank you. Does anybody else have any --

>> Couple quick questions. Most of you asked the questions I had, but I do depreciation I think if this were actually flipped the other way around, put 40% at the top and you would really address a lot of the problems with social and economic factors, education and all that but I did think it was interesting what you said on the second page, third page about rents have risen 50% in 10%, incomes only 9%. There's a lot of ancillary

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costs as well, transportation, child care, all of the rising costs, everything is taken away a dollar or something in time, also a family would go and invest in a clinic or health, preventive health care. In Round Rock there's St. Williams catholic church has a huge facility on their campus and I can't remember the name of it but I've been in there once before, I'm going to go back again. They provide a lot of health care, free, at least at reduced costs so I'm glad to see that with

interlocal agreements. The rest of this was very interesting and I think it would be enlightening -- it's astounding to see this number here, teen pregnancy and so much of that, how much extra cost there is with, you know, child care.

>> [Off mic] [Laughter]

>> Anyway, thank you very much. Very good.

>> Garza: The teen pregnancy, they're declining, right?

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I thought -- that was my understanding, that --

>> The rates -- well, do you want to speak to that?

>> Garza: Not so much the percentage but the number is going down, even though hispanics make up the bulk of whatever the number is, I thought that they were declining. Yeah.

>> That is correct. And they are declining but the numbers -- the gap, the disparity is what we're talking about.

>> Garza: Okay.

>> I think it's important to not forget also that whenever you look across the county there's definitely certain pockets that have higher rates of teen pregnancy, which on the national level are a lot higher than what you would see, but when you look at it combined it looks like we're doing pretty good but when you drill down into certain areas and concentrations, that's where you see the increases.

>> Garza: Is there -- and I thought we also increased our funding for some of the teen pregnancy programs. Do we have enough information so far to be able to say, you know, when we invested more,

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the numbers went down or do we not have that kind of information?

>> No -- we're not at that point now. We hope to be able to give certainly at budget time, within the next week or so, sort of an indication of where we are, what we're doing towards that area.

>> Garza: Okay.

>> Would the Robert wood Johnson study perhaps shed more light on that? Because the health behaviors category, which includes sexual activity, we improved from a ranking of 15 to a ranking of seven in the last six years. That might have a little more detail in the interactive --

>> Once again, as Donna just said, it's important to understand this is countywide so when you look at the overall county, we're doing quite well as this indicates. When you dwell down into what we see is

that certain parts of the county are not only doing bad, they're doing bad compared to other parts of the state as well. So we have to be cautious when we say some of these health behaviors are a reduction. They may be reduced overall but when we look at particular

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populations, for teens, for sexual activity and some of those type of behaviors, overall we may be doing well but in particular populations we're not. HIV is a classic example of that.

>> So I think what you're saying is it's similar to what we see as far as the economy and income. You would say, oh, Austin is booming but not everybody is sharing. We had this huge economic segregation and you could probable correlate that economic segregation with what we're seeing with this health disparity that you're pointing out.

>> That's exactly the point.

>> Comment real quick. A group a couple hours west of San Antonio, they're just now getting clinics there. They really don't have -- my sister is an R.N. But commutes and works in a hospital. They don't have any clinics of any kind for 50 miles anywhere. There's a few so I really think that's interesting, all of that. I also think this sexual activity and alcohol, every month in the paper there's always a list of the highest

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selling alcohol places around here and roughly $2 million a day in alcohol is served in all these bars around here. And, you know, there's not a direct correlation by any means but you think of all the people who stumble and break something or whatever, end up in the hospital, but that's just what is sold in bars and restaurants. That's not counting what you get at HEB and liquor stores. Anyway I think that's always interesting to read that, how much, $2 million a day in alcohol sales roughly in this community.

>> That's part of the reason why we're doing the sobriety center, because we recognize. I think we're ranked the drunkest city or something like that. It's clearly a problem.

>> Yeah.

>> It would be helpful, do you have a spreadsheet of your programs and where they're located? All the [indiscernible] Rooms snuff.

>> We could give you a spreadsheet of all the programs we have, zip codes, council districts, commissioner districts.

>> That would be great.

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I'd also like to know who your partners are. You said you partnered with various groups. I know the Y is one of your big partners, cis, that kind of thing. It would be nice to know who handles what as we're

looking at maximizing dollars it would be helpful to know where these services are, who is doing what, so that -- I'd appreciate that.

>> I'd be happy to get you a profile of that.

>> Garza: Go ahead.

>> We are actually in the midst of our budget process right now, and one of the things we're really struggling with is a program, funding for essentially community and family and student wraparound support services in aid. It was a request of the joint subcommittee, the city, county, and aid, that we help fund it. And part of it is this enormous problem the community is struggling with, which is

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under the recapture of robin hood formula, the state is literally taking $400 million of our community's property tax money and using it almost like a bad upon and I scheme to cover their obligations to poor school districts. So someday is left with this.

>> Speaker2: I gran tick hole. The mayor has tried to challenge this in the courts. One of the few paths available for getting some better common sense around school funding but in the meantime, they're looking to their community partners to say, activities that are crucial for us in the school but not directly related to the classroom, can you help fund? I know they're short in their budget of funding for the family resource centers and the parent support specialists. So one of the things Ann Teich and I just discussed this, and it's been part of the process of trying to figure out how to

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cover the shortfall we're trying to understand what programs already exist in different areas that provide these kinds of comprehensive family support services, where we might be able to get some economies of scale. We already discussed here using the family resource centers as a place to plug in, for instance, the mobile van that provides these additional health screening services or to link families up with other services that are currently available through programs through the city/county health department. But is there a way to get some kind of a look, a budget-level look at what programs provide wraparound support services for families and where we might be able to better coordinate them or see if we can get of scale -- economies of scale on it?

>> That's a very --

>> That's a hard one I know.

>> No. It's a very good question. Yes, to answer the first question, we can give you a

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profile of what we current do. Part of the dialogue goes back to geography. In an effort to try and address what you just mentioned, we have a the love players or partners in our community doing a lot of different things. The question is where does that overlap occur and where can we work

together to make sure it's maximize. Part of that discussion is having providers understand I may not be able to continue to do as much as I want dod in this area because there's limited funds but perhaps I can do more over there. Working with us they need to synergies where are those areas because there's a finite amount of money available to be provided and there's a increasing number of individuals who need these. So the question is how did we maximize the utilization in the areas where needed. That's a battle we're struggling with ourselves. Certainly we can engage with those partners, how do we address that particular issue as well.

>> That would be helpful piece of data for us because we're just going through the budget

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process now at the county and the funding for that is not included in the first cut on the budget so we've got to figure out if there is anywhere that we can carve out to try and help the school district, and it's not looking real Rosie at this point so. . . Any additional data like that would be helpful.

>> That's a difficult issue because even if nonprofit X provides the exact same service you can get from a parent support specialist nonprofit X is usually capped out already so there's gonna need to be more resources to help nonprofit X do what, you know, parent support specialists were doing. So it's just a matter of -- I'm not aware of -- of a nonprofit that is usually not capped out on what they can provide and have a waiting list of people that they could provide for. So, yeah it's an unfortunate situation we're in.

>> I was going to add this -- my friend came down, he was on the school board with me in routine rock and a parent

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support specialist and on the way down we rode the train and he's telling me the same thing. You mentioned roi a couple times and I think a parent support specialist it's hard to measure roi, everything we say we're data driven. A parent support specialists is somebody out in the community, reaching everybody in the community, you mentioned faith based, these other things. Anybody that has a child in the school they're really connected to that school and I think that's a great roi because hopefully they're turning around and giving us feedback, saying, you know, guess what? There's a lot of teen pregnancy. If we just reached out -- he was saying something about they say, hey, I can make a thousand dollars a month for every child I have. Maybe that's driving their interest in having children. I don't know if that's true for everybody, but is it an issue and can we emphasize more about you might have more profit -- more -- not profitability in life but prospects, I guess. Anyway, I just think when we talk about roi sometimes we just have to say I think it's

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a good idea to invest over here. It's hard to measure it, but it may help prevent drinking. It may help prevent teen sex, pregnancies, sexually transmitted diseases, et cetera.

>> I think that usually gets emphasized for some of our more conserve, uh, colleagues.

>> Yes. [Laughter]

>> We know it's a good thing.

>> It's hard to measure but you can have stand-ins, you can have outcome measures that are not necessarily the kinds of roi and data you would think of typically but are stand-ins, if you're talking about health and housing, it could a reduction in the none six children going to the emergency room with asthma because they're in a -- they're in a healthier environment as far as the air in their home. Same thing with some of what you're talking about, there are outcome measures that you can look at.

>> One -- I'm sorry, I just wanted to emphasize we're population based.

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The same individuals who have one issue have multiple issues. So the interaction in terms of outreach education, service delivery, we need to look at how do we maximize that when we have them as opposed to just episodic visits because I think that goes a long ways to try and address some of our issues we face.

>> I just want to echo what councilmember Garza said about the need being greater than what we have and the resources we have. It's an ongoing need. I think that's something people forget about. We talk about overlap and all that kind of thing and that's great but the need is growing and I think that people need to get that in their heads also in addition to asking for efficiencies. So --

>> Garza: Yeah, absolutely. All right. Thank you for the presentation. We appreciate it -- we appreciate it and we will discuss the strategic plan and do the minutes at our next meeting. So thank you all for being here.

>> Thank you.

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[Meeting adjourned]