TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS

HOUSING AND HEALTH SERVICES
COORDINATION COUNCIL MEETING

Stephen F. Austin Building
Room 1104A
1700 Congress Avenue
Austin, Texas

April 12, 2017
10:12 a.m.

COUNCIL MEMBERS PRESENT:

TIMOTHY IRVINE, Chair
DONI GREEN, Vice Chair
SUZANNE BARNARD
MICHAEL GOODWIN
MICHELLE MARTIN (by JOYCE POHLMAN)
VERONICA NEVILLE
MICHAEL WILT

SUPPORT STAFF:

TERRI RICHARD, TDHCA

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I N D E X

P R O C E E D I N G S

MR. IRVINE: I tell you what, everybody, since we don't have a quorum, we cannot hold an official meeting, but since this is predominantly presentation and discussion, I don't see any reason why we can't at least gather and talk about stuff. So with that said, we'll still record the proceedings.

One just housekeeping thing, anybody that feels the need to participate in the discussion, I ask that you do a couple of things: one, come to the table; two, identify who you are; and three, if you're talking on behalf of some other entity or organization, just identify who they are. You also have access to witness affirmation forms, so we can have a record of who's providing input. We always strongly encourage input from anybody and everybody. Our agenda indicates that public comment is really at the end of the meeting, but I think it's always effective to include public comment as the meeting occurs. So if you want to come to the table, you're cordially invited.

Since we don't have quorum, let's dispense with calling roll, we'll skip over approving the minutes because we can't take action, and let's go straight to Magdalene Blanco for a discussion on Health and Human Services transformation.

MS. BLANCO: Good morning, Chair Irvine and members of the Council. My name is Magdalena Blanco. I'm the deputy associate commissioner for the Rehabilitative and Independent Services Section at HHSC, and I want to thank you for the opportunity to speak before you today. I'm here to provide you just a really high level overview of transformation at HHS, and particularly the department that my section is housed under, and answer any general questions if I can for you today. If not, I can follow up at a later time.

So it's the same page, the first page there, the second slide. On September 1, 2016, HHSC underwent the phase one of transformation, pulling together like programs under a new organizational structure that would allow for more functional, efficient and effective and responsive organization. The consolidation and restructuring is part of Senate Bill 200 under the 84th Legislative Session, with the goal of transforming service delivery.

Slide 4. The goals of transformation are, again, ease of access for clients to services, aligning like programs within the HHS system, to also coincide with the mission, business and statutory responsibilities of the agency, breaking down silos, and encouraging a collaborative and cross-functional business operation,

create clear lines of accountability and develop improved performance metrics for all areas within the organization.

On this slide -- and it's pretty small for you because it's a dual slide on your page there -- this is our organizational structure. It is also available on our website and is part of the transformation plan that is posted out there if you want to see a larger imprint of it. But basically, the system now has two divisions, if you will. The Medical and Social Services is where all of the programs reside under, predominantly Medicaid and CHIP services, but there are two departments that house all the community services programs, and one of those departments is where my section is housed under. So those are health, developmental and independent services and intellectual and development disabilities and behavioral health services.

If you go to slide 5. So the health, developmental and independence services department that my section is housed under, and our vision is to improve services to help the people we serve. Our mission is to improve access and services to individuals and their families to improve health outcomes in Texas. And you may not be able to read that statement there, but it says: Meeting the client's health care needs that

directly impact their ability to have a future healthier life. That is our focus within our department, within all of the 34 programs that reside within the department.

Slide 6. Our goals for the department are to increase awareness of services offered, establish effective HHS system agency collaboration and communication, be innovative with outreach activities in order to reach program-eligible populations, and increase provider education through training.

Slide 7. The organizational structure of HDIS -- that's the acronym for the department -- includes three sections: there's Health and Developmental Services, Family and Social Services, and then my section, the Rehabilitative and Independent Services. Again, our focus is really individuals with disability, not developmental, to help them increase their independence into the community. Again, as I stated earlier, there are 34 programs spanning the three sections.

Slide 8, this is my organizational structure. RIS is the acronym for my section. I have four offices. We serve clients with traumatic brain injury, traumatic spinal cord injury, individuals needing guardianship, blind children and individuals with significant disabilities. The four offices include office of

independent services, and that's where we work with individuals with significant disabilities but also blind children. And then I have office of deaf and hard of hearing services in the deaf and hard of hearing community. Office of guardianship, we do guardianship services as well as surrogate decision-making. And then we have the office of comprehensive rehabilitation services that works with individuals with traumatic brain injury, traumatic spinal cord injury, we also do brain injury education for the acquired brain injury field.

Slide 9, this is just an organizational chart. If you have access to the electronic version, you can see this a little bit larger, but this is just my organizational structure here.

And if you go to slide 10, again this is just an overview. If you would like additional information about transformation and the changes going on within HHS, you can visit our website at HHS.Texas.gov, and that's here up on the screen. So on the website you can access the final transition plan that talks about all of the changes that are taking place. Phase two is scheduled to take place on September 1 of this year and that will move over regulatory services and some other programs from DADS.

So within the medical and social services

division, that predominantly houses medicaid and CHIP services, community services programs. And if you need any additional information, I did provide Terri with a contact sheet for some various programs that have been of interest to this Council, so she can had that two-pager out to those that are interested. And you're welcome to contact me at any time as well, and I can leave a couple of cards so you have my information. It is also on the last slide.

So again, I thank you for the opportunity to speak before you. I look forward to continued partnership with this Council. Again, do not hesitate to reach out if you have any questions. I know the transformation is large and there's a lot of moving parts at HHS, but part of the customer service model that we're trying to employ is that you can contact one person and we will get the answers for you and get you in contact with the right folks, so there's no more having to go search for people.

Thank you so much. Any questions?

MR. GOODWIN: I just want to say seven years I was learning the acronyms and now they've changed them.

(General laughter.)

MR. IRVINE: Michael, you've got a question?

MR. WILT: Yes, Tim. Michael Wilt, Texas

State Affordable Housing Corporation.

On slide 6 you mentioned one of the goals was innovative outreach to reach the eligible populations. Can you give us some examples of what you're doing?

MS. BLANCO: So currently we're still transforming, we're still working towards bringing those like programs together, and one of the activities that we did for our department was actually develop a new section, and that was our family and social services department. We serve women with women's health care and family violence and refugee affairs, and so we decided to move those programs together because they serve the same population. So right now that's the extent to what we're doing as far as bringing like programs together.

What we're planning for the future is to look at ways to branch out and see what other types of funding mechanisms we can capitalize on: is there private-public partnerships that we can do, are there toolkits that we can develop so that we can arm our counselors or individuals that are doing either direct service delivery or it's being completed through a provider, trying to develop toolkits that will educate those populations so that we're better equipped with what is our whole spectrum of services that we can offer either internal or external. Because there's a lot that

we're not doing as far as capitalizing with other state agencies on resources, so I would say that would be our phase two transformation. Phase one was coming together on September 1, 2016, bringing like programs together and starting to blend what our application processes look like and how to serve a consumer/client through one front door, they don't have to go through various stages. And kicking off this September will be that next step, looking at what are our options in the community.

MR. WILT: I had another question but I think if you just scroll down it will be answered. I just wanted to see the timeline for when the second transition starts.

MS. BLANCO: If you click on September 1, 2017.

MR. WILT: Well, 2018 would be phase two. Is that correct?

MS. BLANCO: That would be phase three.

MS. RICHARD: So September 1 of this year.

MS. BLANCO: Those are the programs that will be moving.

MS. RICHARD: And then in '18.

MS. BLANCO: That's just our recommendations of the plan.

MS. RICHARD: So one thing that I thought many

of you might interested in, the population that the Council is interested in is persons with disabilities, that's intellectual and developmental, physical and mental health, and then also older Texans, and so correct me if I'm wrong, but most of the programs, like the home and community based services program, the Texas home living program, a lot of the waiver program that were at DADS, they're all pretty much in the IDD and behavioral health division. Right? Like the Yes waiver from DSHS, so most of the programs that we're the most familiar with would be in the IDD behavioral health division.

MS. BLANCO: It crosses, there are some, and that's what that contact sheet that I provided you has. It does cross over between the four departments, so we'll have access and eligibility, we'll have a lot of the aging and elderly access points out in the community, and IDD behavioral health with manage some of those programs that came over from DSHS predominantly. And then we do have Medicaid and CHIP services that is managing the large Medicaid waiver type programs.

MS. RICHARD: So for older Texans, like the centers for independent living.

MS. BLANCO: Centers for independent living will be under mine. But again, we want to make sure that you're getting served and so I could be your entry point

to the four departments.

MS. RICHARD: So the aging and disability resource centers are entry points.

MS. GREEN: They're under medical and social services.

MS. BLANCO: This is a whole division, so there are four departments within the division and it's split up by access and eligibility, we have health, developmental and independent services, the IDD behavioral health, and then we have Medicaid and CHIP services. And so within these four departments we've got all these programs disbursed. The majority of community services based programs reside within two of those departments.

MS. RICHARD: So access and eligibility, so the aging and disability resource center, front door for IDD, is that in access and eligibility?

MS. BLANCO: Access and eligibility.

MS. RICHARD: Okay. And same with centers for independent living.

MS. BLANCO: Centers for independent living would be under my section, so that would be health, developmental and independent services.

MS. RICHARD: That was what I was trying to figure out. So the area agencies on aging, those are?

MS. BLANCO: Access and eligibility.

MS. RICHARD: Okay. Did that answer your question?

MS. BERRY: I just had a question for clarification purposes. Joy Berry, City of Austin.

Traumatic brain injury, is that under you as well?

MS. BLANCO: Yes.

MS. BERRY: So the recent funding that was cut for the housing at Mary Lee, is that going to be under the next phase of funding or point of entry for clients, or who do we contact? Because I have like two clients through our program at the City of Austin.

MS. BLANCO: Comprehensive rehabilitation services?

MS. BERRY: Yes.

MS. BLANCO: No.

MS. BERRY: Thank you.

MS. RICHARD: The comprehensive rehabilitation services went to Texas Workforce Commission. Right?

MS. BLANCO: I received all the DARS community service based programs that split from vocational rehabilitation services that is now at Texas Workforce Commission.

MS. RICHARD: It's vocational rehabilitation

is at Texas Workforce Commission.

MS. BLANCO: Thank you so much.

MS. RICHARD: Thank you for coming today.

MR. IRVINE: Great. Thank you.

Next up, Health Community Collaborative Project.

MS. BOWER: Good morning. My name is Nicole Bower, and I am under the Medical and Social Services Division with Adult Mental Health and Substance Abuse, and I do all things housing in my department associated with getting people appropriate housing, such as the HCC program that I'm trying to network nicely with the 811 project and also with our PATH program. So we're really trying to meet everyone where they are when it comes to housing needs and make sure that they're getting all of the integrated services that they require such as medical, substance abuse and mental health, and then anything else that may come up as an optional additional service.

If we could go ahead and turn to slide 2, this is just going to be the program overview. So I'll be doing a pretty high overview but I want to get into the details, I just wasn't really sure how long you guys would allow me to talk about the program, so please stop me at any time in the middle or I'll try to stop at the

end of each slide just in case anyone has questions.

So we'll go over the legislative history and intent of the program, our funding strategy, target population, the target population supportive services, and that's sub-sectioned out because there are required services and then you have optional additional services. The outcomes required by legislation, our participating sites, the criteria to be a participating site, and then the future program projections.

So slide 3, so the HCC program stems out of Senate Bill 58 out of the 83rd Regular Session and was amended to add Chapter 539 of the Government Code which implemented the Health Community Collaboratives, as well as the program requirements. So the gist of the program or the goal is to establish or expand community collaboratives that bring the public and private sectors together to provide services to persons experiencing homelessness and mental illness. And so what that basically means it is sectioned out into state services/ private services, insured/uninsured.

So the goal of the program is to really bring together those private and public services to network together and to form this partnership where a lot of our state funded programs can start to become a little more self-sustaining through match, in-kind match, in-kind

services, and things of that nature, volunteering, just trying to get the resources all connected. Some of you may have noticed we do have a lot of programs for programs, a lot of programs that kind of do the same thing that other programs are doing, so we're trying to bring all of that together in specific areas according to legislation.

So our funding strategy, we're funded through the legacy DSHS general revenue, so my section in DSHS is now part of HHSC, and so it's actual the general revenue which is pretty good considering we get $25 million per biennium and the funds are distributed among the participating sites and require a dollar-for-dollar private cash match, meaning if we partner with the City of Dallas, for instance, they are unable to leverage their own funding for the match because they're a government agency, so they are required to leverage funding from private sources either through interview or other means that they can found foundations, fund-raising, all of those things. It just can't be any kind of government or federal funding.

Currently we have Rider 49. It allows unused funding to be carried forward into the next fiscal year for the same purposes but it may not cross bienniums. And that comes in extremely handy when we're in ramp-up

time and then we lapse funding, so we're able to go ahead and turn it up forward, complete any construction that we may not have completed on time, and then move forward with providing services and we just have more funding for that year to provide more services.

So our target population for this program are homeless adults and families with a mental illness or a co-occurring mental illness and substance use disorder. And what's really interesting about the target population criteria is that it can be self-report, so if an individual were to come through any of our coordinated access points for intake, they don't have to have anything proving that they've been diagnosed with a mental illness or a chronic medical condition. If they just tell us that they have a mental illness, then they qualify for the program, and they do have to be homeless. So as long as they're homeless and they tell us they have a mental illness, then they are part of the HCC program and we then integrate them into all of our networking services in the area that they enroll in.

So some of the required supportive services are coordinated assessment and intake service, meaning depending -- I know City of Dallas have the most partners at this time, they have five partners outside of themselves, and each of the five sites have an intake

point where every door is an open door. They don't have to go to one specific place to be enrolled, they don't have to be redirected to a different spot to get enrolled into the HCC program.

And at that point that's where they're all entered into HMIS which is the federally mandated Homeless Management Information System, so we can track them across sites where they're getting services. If they were to forget and leave a service out and forget who their last case manager was, we can always look into HMIS and it will tell us where they stayed last, what meds they received, what services they received, and we're able to build on that so we're not starting over with services because that happens sometimes with a transient population.

So emergency shelter is a required service, mental health crisis facilities, mental health services, of course, and assistance accessing benefits. And with assistance accessing benefits, that's where we really encourage our providers to use the SOAR process since it does prioritize the homeless population. With SOAR it's just wonderful. There's less appeals and less denials, they're able to get in and receive services a lot sooner.

MS. RICHARD: Could you briefly tell what SOAR is? I don't now if everybody is familiar with that.

MS. BOWER: Well, so fortunately, SOAR is specifically for the homeless population and every center has those special folks that assist individuals with application after application for Medicaid, SSI, SSDI, vouchers, all of that good stuff. And so what SOAR does is it's actually that but it prioritizes those who are homeless and it goes to a separate section within the Social Security office and the Medicaid folks to where they're prioritized and they're not going to have a long wait before their application is processed. There's special training for SOAR and it kind of cuts down on the errors and mistakes that made be made on an application. That way they receive approval sooner or even denial sooner, but even if you get denied sooner, you're able to correct those errors or whatever explanations that they're asking for sooner so they can receive services sooner.

MS. RICHARD: Thank you.

MS. BOWER: Sure. And the unfortunate part is we don't fund our sites to do that, so we encourage them to do that but unfortunately we don't have the funding to actually employ SOAR workers. We try to kind of maneuver around the various programs and find funding in that way, and if not possible, we always encourage them to take their existing benefit coordinators and get trained in

SOAR so that they can do that process. So I'm hoping that we can get funding soon to fund some SOAR workers.

MS. RICHARD: So in the coordinated assessment, do you work with TDHCA's Emergency Solutions Grants subrecipients?

MS. BOWER: No, not to my knowledge. Now, our individual sites may very well. We have several individual sites. I'm not real sure who every site works with, so they may very well, because we're really trying to get them to integrate, I've really been pushing 811 lately with our LMHAs on the behavioral health side for 811, and they may very well on that side work with some of those folks.

MS. RICHARD: Thank you.

MS. BOWER: Sure. More required services: substance abuse treatment services, integrated medical services, housing services, and education, job training and/or employment services. So the integrated medical services piece, we look for individuals, it's required they have to have an MOU or some kind of agreement worked out with the local hospital, with stand-alone emergency rooms, urgent care places, physicians that will come to their crisis units or the residential crisis units to check these folks out. And the word "chronic" was kind of left out, but they mainly focus on those with chronic

medical conditions such as asthma, diabetes, anything that's going to require long-term care.

And recently I've actually had the fortunate opportunity to work with Tomas, and we are working on getting approval right now to add some TB prevention into some of our HCC contracts. There was a strand identified in two homeless shelters -- four shelters now, so they can actually identify where you receive TB from down to a person, so they can actually track who's giving it to who now. And it turns out there's a cluster in some of these shelters that that's alarming. So when a person comes into the shelter we'd like to have them screened before they're integrated into the general population, just for everyone's safety, and so we're really working on that.

I'm really hoping to fund a health department liaison type of person. That way when someone enters a homeless shelter and we're in the process of figuring out how we're going to keep these folks housed or sheltered with services, even though they will be separated from the general population until they can have their TB test read. And if it comes up positive, the liaison steps in and they get the treatment they need to recover from that and to treat tuberculosis before entering into the general population. So we're really excited for that, and the contract changes are going through approval right

now. As long as we maintain the scope of work and the legislative intent, then I think we'll be okay.

MS. RICHARD: What do the housing services entail?

MS. BOWER: So housing services entails anything imaginable. I love this program because it's inclusive of everything, there's so few restrictions. We can use the housing services for if you have an electric bill that wasn't paid and now you can't get electricity turned on but you have a voucher, we'll pay that one electric bill and get your electricity turned on. We'll buy you groceries, we'll buy you furniture, we'll pay your rent until your voucher kicks in.

And it is kind of a housing first model, although we also prep the client to be able to be successful in that housing placement so they don't lose it. So housing services doesn't just stop when the client is in the home, the services continue whereas we come and we teach them basic living skills such as cooking, and it may have been a while since they've had to do that for themselves, cleaning. If you name it and it can be considered a housing service and it is in their detailed budget, then we definitely approve it before the contract executes.

If they run on hard times and they haven't

found that job they thought they were going to find by now, we'll continue to assist them with food, clothing, we provide interview clothing. If they have an interview coming up, we make sure they get haircuts, we make sure they have proper interview clothing, definitely hygiene. It's like a wraparound support to make sure that these clients are successful in their new housing, to ensure that they get to stay there. And meanwhile, they're still seeing their SA provider, they're still seeing their MH provider, the primary care doctor, as long as they're agreeing to, of course.

And of course, if they decide to come to the HCC program and they say I do have a mental illness, however, I'm not comfortable with receiving treatment for that, I just want housing, we do that too. I can't say that it's been as successful without treatment, however, it's the client's right to refuse services, so we do provide the housing. If they just want general case management services, then we'll do that, and we do encourage and try to engage those clients in the other services that they may need such as mental health treatment.

So some of our optional services -- and let me just explain why these are optional right now. So some of the sites can provide services that are beneficial to

clients in their specific area, so the needs are different in each specific area. So centers for food is an optional service. Obviously they're all going to provide centers for food, whether it be a food bank or they give them grocery vouchers or they take a case manager and they go grocery shopping together. Centers for provision of clothing, grooming services and hygiene products, that's optional.

Criminal justice needs is also optional and not all of the sites have chosen that, but the two that have are doing really well with the criminal justice needs. It's really difficult to house a client with a felony or that is on the sex offender registry, so we try to work with landlords. Private landlords is when we try to get those involved because most of the time with an apartment complex or a HUD-owned property, you still have the corporate rules that you have to abide by for HUD and for that private apartment complex community, it's not just the person in the apartment, it goes all the way up the chain and they have certain rules they have to follow.

So that's when we try to get with individual landlords who may own a duplex, who may own an actual house, and that's when we try to get those clients into those kind of scenarios where they can actually be housed without

having to stay in a shelter due to their criminal history.

We work with their probation officers, parole officers. We make sure they need they have everything they need for court, we make sure that they have legal aide if they don't or that they have representation if they don't. But like I said, only two of the sites chose that but they're doing pretty well with it and I'm trying to encourage the other sites to get involved as well.

MS. GREEN: Where are those sites?

MS. BOWER: In Austin and San Antonio.

And then of course, we have our veterans services, and I'm not sure why that's optional but it's optional. They're all doing it, though, they're all providing veterans services.

So optional services continued, we have our mental health services with PSH. So mental health services in general is a required service, however, the mental health services and PSH, permanent supportive housing is optional because once the client is in the house, they may prefer not to receive mental health services anymore, so that is an optional service.

Micro-businesses is an optional service, and again, Austin and San Antonio are the two that are doing the micro-businesses. San Antonio, Haven for Hope is our

shelter that is participating in the HCC program. They actually built, with our money, a call center to provide full-time employment, and they are paying a little over $12 an hour, I believe, to start out for these clients, and it's a call center and they're doing telemarketing, but they're doing things like Guideposts, Highlights Children's Magazines, things like that that they get contracted with from individuals to do. And I've seen it grow and they are actually expanding it now, so it's really become extremely successful for these individuals to start having a little nest egg sitting aside, that way when they're ready to move out of the shelter, they're going to have some funding available to them to really maintain and stay on their feet.

And then our peer services, of course, I wish that was a mandatory service as well, but it is an optional service for now.

Comprehensive services is really inclusive, it's really for families. That would include child care while the client is attending school, it could include any kind of mental health care for any member of the family to really heal and make whole the entire family unit because that will help make the treatment of the client more successful if we're kind of wrapping around the entire family. That could be if one of our clients

has a parent who is older and needs services also, to make sure that parent receives services. So anything that will keep the family unit together and assist in successful treatment an recovery of the client, then we really try to make sure that happens.

And then tobacco cessation is another optional service.

So we do have some mandated outcomes for the HCC program that came out of legislation, and they are to increase the number of HCC participants who reside in supportive housing, and I do believe we're hitting that one pretty well. Like I said, we can use HCC dollars to actually build housing, so we've built housing at every site that we have except for in Dallas and that's in the works, but we've actually built housing. So we've put a small dent in that we've actually increased the amount of housing resources available, so where there was none, there is now some, and it's pretty awesome.

ATCIC is actually about to complete their 50-unit housing apartment complex in Oak Springs and they're almost done with that. It was supposed to be done at the end of March, and of course, we're running a little behind with that, but they're getting there. And San Antonio has built some housing. Houston built -- actually did not build housing, however, Houston did

build a brand new shelter, they rehabbed another shelter, and they also have an administrative building where there are services provided out of that building and it also houses their administrative staff.

So I love this grant. I've never had a program before where it allowed us to use state funding to actually do construction. So the rules are crazy but it's worth it.

MS. RICHARD: So the construction that you've done, has it all been similar, like multifamily, one, two, three bedroom?

MS. BOWER: Actually, they're mostly single occupancy units. Haven for Hope has actually built on dorms for the LBGTQ population. If they identify and they say I don't feel safe in the general population, they're more than welcome to stay in the dorm. So the shelter has actually expanded that and they've also added on an urgent care piece to reduce the amount of emergency room time used by homeless individuals, because that's another one of our outcomes. They've also did the micro-businesses because another one of our outcomes is to do gainful employment. So we've really tried to use this money just for things that normally Texas wouldn't pay for.

And it's difficult and it can be really

challenging because we have to find someone -- I don't know if I'm going to be in this position in 50 years, and so we have to make sure that that building is being used for the exact same purposes that we built it for for the limit of 50 years or until it's sold, and at that point we get to step back in and make sure that we're getting our share out of it. And so there's just a lot of moving pieces to that and something that everyone wants to jump into and be part of, so I'm really grateful that this program is allowing for that and that our contract managers are awesome enough to follow this for 50 years and just keep passing it down the line, hopefully. Hopefully it will never be sold and will just keep being used for these purposes, that's what my hope is.

MR. WILT: Is it a mix of new construction and rehabilitation?

MS. BOWER: Yes, definitely.

MR. WILT: Have you seen any creative rehabilitation developments? Like you mentioned the dorm rooms. What were those dorm rooms prior?

MS. BOWER: Well, they didn't exist, that's brand new. So the dorms are brand new, the urgent care is brand new. Houston is the only one so far that has actually renovated, so they renovated that shelter, and they brought it to code, for one thing, and then number

two, they rearranged it to where it just made more sense. It was easier access for individuals coming in, there wasn't such a long line wrapped around the outside of downtown Houston anymore, and there were several points of entry into that one shelter.

They made the first floor completely like an area for just kind of hanging out and watching TV, and they took all of the main services, because it was so loud on the first floor, and bumped it up to the second and third and fourth floors, such as laundry, where they would get their mail, where they could sleep and where they could receive additional services, the integrated medical part. Most of the other services, like social services, was provided on the first floor. And they made it really nice and it smelled so clean after they were done with all the renovations. The laundry service and the showers there were added, they were able to come in and take a shower and get clean clothes to wear and wash their other clothes and it made them feel really good about themselves. So those renovations were really, really meaningful.

And then Austin so far is brand new construction.

MR. WILT: Right.

MR. McCLINTON: James McClinton from Metro

Dallas Homeless Alliance.

What's the status on trying to build in Dallas?

MS. BOWER: So previous to Cheryl, when Cynthia was, they were looking into building actually family housing which is I'm really, really hoping for that because most of it is single occupancy units. So what they're waiting on to buy this land, it's a tax credit property -- and you may be able to talk to Patricia more about it -- so it's tax credit property so there's certain rules that go along with buying a tax credit property, and then TCEQ has to come in and clear it because underground the land that they're looking at used to store gas but they're the old aluminum tanks, so they're concerned about the rust and the leakage and they just have to clear the land. So the timing hasn't really quite worked out as far as our new biennium, the tax credit property rules, and then the TCEQ thing, but as soon as all those work out, we're really looking forward to getting some multiple like family, two, three, four bedroom units built.

MR. WILT: Where is it located?

MS. BOWER: I don't know the address of the land in Dallas. I know it is downtown somewhere, I just can't remember.

Do you happen to know? Do you remember the huge building by city hall that has the portrait of the homeless gentleman painted on it? I'm sorry. I want to say it's around Ervay, but I'm not completely sure of the address.

And then another outcome is increasing our HCC participants access to medical, psychiatric and substance abuse treatment in the community in order to decrease criminal justice involvement for persons served by the community cooperative, resulting in fewer arrests and decreasing the use of jail beds. And that can be a little confusing considering that's a mandated outcome yet that's an optional additional service, so we're working on some of those little bumps right there.

So we will provide alcohol and substance abuse treatment to HCC participants participating in the community collaborative to maintain viable employment. We'll help start social enterprise businesses in the community or engage in job creation, job training or other supported and funded services to enable participants in the community cooperative to maintain viable employment.

We'll increase viable affordable housing for families which will result in a decrease in calls to the Department of Family and Protective Services, child

welfare providers or children's shelters for children who are homeless. So that's an interesting one. It's very difficult to track that because we would kind of have to know who would be involved -- to actually decrease the amount of referrals, we would have to know who was going to be referred before they actually were, so it's kind of a challenging outcome to actually be able to measure, I should say.

There's only one site right now working with families where they're actually supervising their hours that they are sometimes required to get parent classes, all that good stuff, to get their children back or to maintain custody of their children. We only have one site participating in that right now because it is so challenging, but we're working on trying to make that easier for the sites so they can make a bigger impact.

And then increase integrated primary and urgent medical health services for HCC participants in the community cooperative an decrease in the use of emergency room services.

So currently we have four participating sites: Austin, San Antonio, Dallas and Fort Worth. Houston is no longer participating at the moment, but I am in the process of trying to get them on board again.

So the criteria for participating sites is

local governmental entities, nonprofit community organizations, faith-based community organizations, and five municipalities with a population of more than one million, so that kind of tells you who they are already. So we did a procurement anyway but we kind of already knew who the five were going to be.

So the future projection -- and this has changed just in the last week -- it's no longer just House Bill 4110. So one of the new things that's going on this legislative session is House Bill 4110 is requesting up to $10 million of the $25 million that we have to be used in rural counties with populations less than 50,000. It also includes the contiguous counties that also have less than 50,000 in population. But just last week, I did another quick bill analysis for House Bill 2701 which is verbatim House Bill 4110 except it adds additional deliverables for jail diversion requirements, meaning that the five sites that we already have -- or the four that we already have, they will not be held responsible for those additional jail diversion activities but the new rural sites will be.

And then just yesterday I was informed that House Bill 13 is not only taking House Bill 4110, it's taking House Bill 4110 along with the jail diversion restrictions but also adding that populations less than

50- have to come up with 100 percent of the cash match, and then as the population increases, the match increases from 100 percent to 110, -15, -25, all of that good stuff. So that's going to be rather challenging getting into rural areas and having them meet not only 100 percent private cash match, but then as the population goes up, you have to surpass the amount of funding that we're getting.

So it remains to be seen if any of these are actually going to pass. I would love to get into the rural areas, there are resources that don't exist that we need to certainly help with in the rural areas, but the private cash match is a challenge with my big four, so I can imagine what it would be like with the rural, but I will do my best for sure.

MR. WILT: Are those moving, 2702 or 4110?

MS. BOWER: You know, I think 4110 was no. I haven't heard about 2702, and I just found out about 13 yesterday. I just found out about 2702 last week.

MR. SAMUELS: Eric Samuels, Texas Homeless Network.

And when I saw that, I looked it up, so I'd like to talk to you more about this afterwards, and also, I wanted to make sure that we saw each other face-to-face since we've only spoken by phone, because I want to catch

you, I don't want you to run out. So I think I would love to work more with you on this, I can we can strengthen connections even more.

And I just want to say one more thing, and you and I have talked about this, if there's any way we can bring in in-kind match to fulfill that matching requirement, that would make a huge difference.

MS. BOWER: I've tried for 25 percent and I was informed that was not happening.

MR. SAMUELS: Because I love the idea of giving the rural areas some assistance in this way but that's going to be a huge burden for them to come up with the one-to-one match, as you know it is for the five cities.

MS. BOWER: Which is why Houston is not participating exactly.

MR. SAMUELS: So if there's anything we can do to ease that burden.

MS. BOWER: They took all my ideas and left out the in-kind part and then just kind of morphed it into whatever is written right now, and I didn't recognize most of it.

MR. SAMUELS: I guess I'm offering my agency's help to do whatever we can.

MS. BOWER: Yes, definitely.

MR. SAMUELS: We've asked the questions.

MS. BOWER: I really appreciate that, definitely.

MR. SAMUELS: That's all I wanted to say.

SPEAKER FROM AUDIENCE: Do you know who's carrying the bills?

MR. SAMUELS: Garnett Coleman is carrying the 4110.

MS. BOWER: And 2702, and I think Price is on 13.

MR. SAMUELS: I just looked it up and 4110 was just heard Monday.

MS. BOWER: So I wasn't really sure, and that's when I heard about 2702 when I got a quick 3:30 Friday afternoon bill analysis.

MS. BARNARD: 2702 is pending in committee as of yesterday.

MR. WILT: Did you see if any of this language got attached to the budget?

MR. SAMUELS: I did not see.

(General talking.)

MS. BOWER: And I'll definitely be paying attention to these bills and seeing what passes and what doesn't, and whichever one passes it has different requirements.

MR. WILT: But they all have the match requirement?

MS. BOWER: They all have the match requirement. House Bill 13, the one that has the increasing match requirement depending on population is probably going to be the most concerning for me as the program specialist just because, again, if Dallas, Houston, San Antonio, Fort Worth are having difficulties at one time or another during this program meeting private cash match that I can't imagine a 70,000 population county meeting 125 percent of cash match. So I can probably deal with the other two but that one is going to be very challenging.

MS. BARNARD: House Bill 13 was placed on the general state calendar today.

MR. WILT: And that's for Price?

MS. BARNARD: Yes. Price, Turner, White, Hardy and Moody.

MS. BOWER: And I'm also interested to see how Senator Nelson reacts considering she was the author of Senate Bill 58, the amendment when HCC was first implemented.

So questions?

MS. GREEN: Is there points of entry for the program?

MS. BOWER: Yes, ma'am. So the points of entry, it depends on where. In Austin they have the Caritas, the Arch, United Way, Salvation Army, different points of access, not to mention all of the clinics that they have around the Austin area. Anyone who is in these criteria when they're being screened, they may say it sounds like these are the programs that you qualify for, let me explain each of them to you. And then if they so happen to feel that HCC is the right program for them, they're enrolled into that time into our DHS system and then also to our HMIS system.

And it's different for every site. Forth Worth, same thing, they have multiple -- all the sites have multiple entry points and then they all do VI-SPDAT, a vulnerability index is what it is, and it basically measures the likelihood of this person to die on the street, where do they measure on that, and then they'll be prioritized to be enrolled into the program and given services immediately. So they all receive an MSAD for mental health services, and they all receive a substance abuse treatment manual and they let us know if they want to receive SA services or not, and they all receive a physical health screening to take care of any primary medical issues that they may have identified.

MS. RICHARD: The population is mental

illness, but I assume somebody who is dual diagnosed, like with IDD, you also work with them?

MS. BOWER: So also what I like about this program, anything in the DSM is a mental illness and it's not the bigger diagnoses, the big three anymore, it's anything in the DSM. And again, it could be self-report and they could just really want in the program and they say they have ADD and they really don't, and they're in. We just want to get them served the best way that we can, and that's why they allow self-report instead of that hard and fast diagnosis.

SPEAKER FROM AUDIENCE: Is there a wait list and what does that look like?

MS. BOWER: That's interesting. HCC doesn't technically have a wait list but in every area there is a wait list for a particular service. In San Antonio our LMHA is CHCS, they do have a wait list. But all of our sites are doing things to kind of lessen the wait time or assist during the wait time, such as Haven for Hope now has a telemed provider that provides services to HCC clients until they can get into CHCS. So we're really trying to work with that as much as possible. So if they end up scoring like a LOC-1-S, obviously they're not going to be waiting that long as long as someone who would be LOC-3 or 4, but we're really trying to minimize

that wait as much as we possibly can, just kind of intervene and bridge that until they can get in to the mental health provider.

SPEAKER FROM AUDIENCE: I'm sorry. Caren Zysk with Millennium Health Care.

MS. RICHARD: Thank you, Caren.

Ms. GREEN: So you have services for those at imminent risk of homelessness?

MS. BOWER: Sure. That's' when we incorporate our PATH team, and our PATH team is Projects to Assist in the Transition from Homelessness, and the PATH is actually a homeless outreach team and they are serving the homeless or imminently at risk of homelessness. So they will bring clients into the HCC program, and so the HCC program really does provide all housing services such as like the permanent supportive, shelter, transitional. I know they don't really say transitional anymore but, I mean, what else are you going to call that? They're transitioning them from homelessness, they're intervening. They'll pay some rent if the client is getting evicted, they'll catch them up, try to help them get back on their feet. So PATH is our prevention people but the clients that they are serving in that way can be enrolled in HCC as well. You could receive PATH services and be enrolled in HCC at the same time being housed with

811 funding, so we're just kind of trying to network all of that together.

MS. GREEN: Occasionally we get desperate calls from hospitals where they're getting ready to discharge someone who has no place to go, and so they're looking at sending somebody with a recent stroke to a shelter. We work with nursing home residents who sometimes lose Medicaid eligibility and have no place to go.

MS. BOWER: And I think 811 comes in for that type of situation, because 811, they also work with folks exiting institutions to find homes, exiting hospitals and nursing homes. They have those housing coordinator people that will assist in that process.

And I also work closely with parole and probation officers who will call and say they've served their whole time. Because they've served their whole time, they're not eligible for their services when you exit to make sure that you're successful upon integration into the community. They're exiting to Dallas, what do we do? So we'll call HCC provider in Dallas. It may be the Bridge Steps, it may be City Square, it maybe Austin Street Shelter. So this person wants to discharge on this date, can we have them met, can we get the PATH team in that area out to talk with them and see what services

they need, and we just try to really get them housed into an ideal situation until even better comes along.

MS. GREEN: And I was interested in the two projects for the criminal justice, and you mentioned that they have resources on private landlords who will rent to people. That's a population we serve as well, who are not homeless at the time we're engaged but oftentimes at risk of homelessness. And we engaged a consultant to try to assemble an inventory of that kind of housing. We don't have as many options as we would prefer.

MS. BOWER: So what I really like about what ATCIC is doing is that they, as well as San Antonio, they have a landlord outreach team that actually engages landlords, builds relationships with them, builds rapport with them. They may not be found on a bigger list but they're on, say, ATCIC's private list. They'll take it upon themselves to reach out to a house that's says for rent, they call: Hi, this is who I am, do you think you'd be possibly be interested in, they're receiving services, you can call me, I'll work with you, I'll work with them. And they may pass out a fruit basket or two or a card or just really maintaining that strong relationship to where even if something does kind of why is there all this furniture in the front yard, it looks like they had a party, anything like that.

They try to work to make sure that the client is integrated well into their new environment with renting and learning the rules and just kind of getting back into the role of being a good tenant, as well as helping the landlord understand where this person is coming from and let's work together, kind of a liaison and advocate to make sure that the tenant isn't turned out on the street again, because that's so detrimental to recovery when you try so hard and you're thrown out again, you don't want to try again. But that's what they need to do. I encourage all my sites to really get a landlord outreach team together.

MS. RICHARD: Thank you. Great discussion.

MR. IRVINE: I think it's great to dig into that. We've got a number of things and we've got some people who need to get their presentations done. Sorry.

MS. BOWER: No, no, that's just fine.

MS. BOSTON: If I could suggest maybe we should work on the resource guide the next time.

MR. IRVINE: Yes. Just a little bit of juggling.

MS. RICHARD: So that leads us to Alyse. Glad you could join us.

MS. MEYER: Hi, everyone. My name is Alyse Meyer. I'm director of public policy with LeadingAge

Texas. We are an association that represents not-for-profit aging services providers. We have about 250 provider members and about half of those are actually senior affordable housing communities as well as senior market-based housing. So I first want to thank you for inviting me here, I've already learned so much. I look forward to becoming more involved in housing-relating initiatives as they relate to the Texas senior population. But as an association, we have been focusing more on strengthening housing plus services across senior properties, and this is also a very large focus at the national level, so I wanted to just talk today about some of the resources that we have available for those looking to incorporate housing plus services into their properties, how they can form partnerships, and just give you a quick update about some of the goals we have in terms of making some potential policy changes to help encourage housing plus services in the State of Texas.

I didn't really know what to share because we really do have such a wealth of information about some of the research we're doing, some of the projects that LeadingAge members are engaged in really across the country, as well as Texas, and I have some handouts I'll leave with you. One thing that I wanted to just point

out was if you go to LeadingAge.org, so our national affiliates's website, we have created over the last few years a research center focused on housing plus services, and there you can find a wealth of information, case studies of different programs that are happening across the country, tools for integrating housing plus services in your community, such as resident assessment tools, on how to form community partnerships, on how to leverage different funding mechanisms, both public and private. So there's really a wealth of information there.

I also brought a couple of examples of what some of members are doing in Texas that I'd like to leave behind for you. One of our properties in Plano, Plano Community Homes, they are in the process of building a veterans clinic on their property through a partnership with the VA and HUD. So they actually received some funding that they were working on since I've been around, so probably six years or so, to get this off the ground, and they finally did get some funding to get that off the ground and that will be available to both their residents and then veterans living in the community. So that's sort of a new project that we're really excited to watch and see the success of.

We're also really focused on driving some policy changes. We've been talking to leadership,

legislative leadership for some time now about how to really measure success of integrating healthcare and non-healthcare related services into affordable housing. You all know we're in the middle of a really tight budget, likewise in ever session we kind of go in knowing nobody is going to get a blank check for all these great ideas we have. But one thing that we've been asked to do, and we will definitely help drive and are looking for any avenues to do so, is to show the state cost savings with regard to providing services to seniors living in some of these housing properties.

So we've been talking more about potential pilot programs, how we can partner with managed care organizations and the health plans that are participating in Star-Plus and I'm really happy to find out that many of the health plans are moving into housing plus services, so really eager to see how residents are served. We have a lot of national data that shows pretty substantial cost savings in terms of both Medicare and Medicaid, but we really want to have something robust in Texas to be able to share. So that's really one of our top priorities in terms of what we're doing to encourage housing plus services.

But with that, I'll just leave behind some resources. We have several members that would love to

talk to other groups and other providers to come up with some type of partnerships, whether that's done outside of policy or outside of the state, so we're pursuing that as well. But for me we've mainly focused on long-term care in terms of the work I do, so housing plus services is more new to me, so I really look forward to getting to know everyone and what we can do as an organization to help encourage and expand housing plus services across the state.

MS. RICHARD: Thank you, appreciate it.

MS. MEYER: You're welcome. And I'll leave this behind and I'll also send you the link to the website. The research center that is available through LeadingAge.org is really great and really starts with the basics and we have some really great programs that are happening nationally.

I don't know of you've ever heard of SASH in Vermont? It's looked at sort of as a national model in terms of integrating services and housing. I brought a handout for that, but it stand for Support and Services at Home, and it's funded both publicly and privately. It started out one property and now they're serving, I think, over 1,000 people in Vermont and it's proven to be really successful in terms of cost savings and just providing a better quality of life of residents, just

things from large decreases in hospitalization and falls and just really starting at the basics like providing home modifications, things that HUD 202 properties now don't have any additional funding to really provide.

So it's really interesting seeing the minor changes that can be made in some of these properties, like keeping people out of more costly and institutionalized care, and that's our goal is to keep folks aging in place and as independent as possible.

So that's my spiel, but thanks for inviting me.

MS. RICHARD: Thank you. We appreciate it.

MR. IRVINE: Ready for the Disability Advisory Work Group.

MS. HOLLOAWAY: Good morning. I'm Marni Holloway. I'm the director of the Multifamily Finance Division at TDHCA.

The draft that we're passing around is actually of a rule that's up on our website -- Terri, could you pull up our website for just a moment? -- of a rule change that we're proposing around visitability for multifamily developments. We don't really have a rule right now that speaks to visitability for all units, it has this 20 percent of otherwise exempt and it's been very difficult for the development community to

understand it.

So what we've done is we've taken a look at a multitude of visitability rules from across the country and tried to pull together the parts and pieces that made sense. This rule will apply both for new construction and for rehabilitation moving forward if, in fact, it is adopted by our Board this fall as part of the 2018 rules.

We wanted to point out that it's up on our website right now posted in a forum, the text of the rule, and Patrick can run through it really, really quickly so we're not using a bunch of time, but wanted to encourage all of you to share this information with the communities that you work with so that folks have an opportunity to take a look at this changed rule and let us know if it needs a little refinement or if it needs some tweaking so that we can gather that input before we head into the formal rule-making process.

MR. RUSSELL: I would just encourage you to comment on the online forum; we've already taken into consideration that feedback. And whenever you have a rule that's going to affect several thousand units on an annual basis, I think it's helpful to read through the rule, so bear with me as I read through this. I'll make it really quick.

So just look at items (a) through (c). The

first part is all common use facilities must be in compliance with the Fair Housing Design Act Manual; (b) there must be an accessible route from common use facilities to affected units; and then (c) there's all these sub-parts -- and again, all of these design specifications can be found in the Fair Housing Design Act Manual -- a. At least one zero-step accessible entrance; b. At least one accessible bathroom or half-bath, and there's some design specifications for that; c. The bathroom or half-baht must have the appropriate grab bar; d. There must be an accessible route from entrance to bathroom or half-bath and the widths of those doors must be usable; and then e. Light switches, electrical outlets and thermostats on the entry level must be at accessible heights.

That second part of this rule has to do with the waiver process. Note that waivers will not be considered for new construction, waivers will not be considered for developments built before 1991, however, there is a possible route towards a waiver and that has to do with structural infeasibility, usually with rehab units, so we're foreseeing that might happen and that's what that second part of the rule is for.

MS. HOLLOWAY: So we actually rolled this out with the DAW at their last meeting which is why we're

taking on to Brooke's DAW update, but also wanted to bring it to this group so that you would know what we're working on. We anticipate that we'll be discussing this with the development community at one of our monthly QAP planning sessions over the next few months and are anticipating that it will appear in the draft rule we present to our Board in September.

MS. POHLMAN: Joyce Pohlman with Health and Human Services.

I'm not clear, is this applicable to rehab also, any rehab?

MS. HOLLOWAY: Yes.

MS. POHLMAN: But it's not retroactive, just new projects that receive funding.

MR. RUSSELL: This would be starting for the 2018 cycle for housing tax credits, direct loans and bonds. And from the beginning, it's applicable to all proposed developments. Now, if a rehab wants to seek a waiver, that's what that part of this rule is for.

MR. IRVINE: The real simple version is we're paying for it so we would like for you to make your units visitable. Pretty simple.

MR. GOODWIN: From a practical standpoint, how do you make sure that nobody rents on the second floor that has somebody that needs visitability?

MS. HOLLOWAY: Well, our compliance division monitors these properties regularly, every three years at least. If a tenant has requested a visitable unit and they are not able to get into a visitable unit when they move in, we would expect that the owner of the property would allow them to move when that unit became available, and that would actually be a reasonable accommodation.

MR. IRVINE: And visitability, of course, is distinct from accessibility, and there is the traditional wait list approach for accessible units. As far as I'm concerned, everybody needs a visitable unit, you never know who's going to come to see you.

MR. RUSSELL: And this is not replacing the 5 percent rule for accessible units, it's expanding it with this bigger catchall of visitability.

MS. HOLLOWAY: It actually mirrors a lot of what we're seeing in local building codes for the larger metropolitan areas that already have these kinds of requirements. If you're building a multifamily property in Austin, you're likely having to meet these requirements.

MR. WILT: Is 20 percent a common number when you compare with the other states?

MS. HOLLOWAY: The old 20 percent rule is going away, this is all units.

MR. WILT: Got it.

MR. RUSSELL: All ground floor and elevator served.

MS. HOLLOWAY: So it's up on the forum if you would like to make comment on it later or you can reach out to me, Marni Holloway, or Patrick Russell, our Multifamily research specialist, if there are any questions at all. Thank you.

MR. IRVINE: Okay. Getting near the end here.

MS. BOSTON: I just wanted to tell the group that I know who comes to this group has changed over the years and in the beginning I think a lot of people participated in this and our Disability Advisory group, so I just wanted to kind of remind this group that that group exists. And the primary distinction is while you tend to focus on interagency issues that are more specific to just supportive housing, we have a separate group, the Disability Advisory Workgroup, who provide feedback and input primarily on our programs specifically of TDHCA, and whenever we're going to be releasing notice of funding or rules or program design changes or for instance the visitability proposal that Marni just laid out, that's something we presented to our DAW. And to the extent that people have an interest in that side of what we've got going on, you can participate in that as

well.

MR. GOODWIN: Should we task her to find a member from the served community that has been vacant?

MR. IRVINE: We've provided information to the appointments office on all of the vacant positions.

MR. GOODWIN: It would sure be nice to have someone back from the community.

(General talking and laughter.)

MR. IRVINE: Our next meeting is currently scheduled for July 12, but there's a possibility that we will reschedule that. Part of that possibility is the fact that life is a series of changes, and we have a change coming up. Terri Richard is going to be moving on to the next challenging phase of her life and will no longer be the mainstay of this committee.

And personally, I'm just so thankful not just for you doing the work but for your heart and soul engagement, always digging out information and issues and working to share and working to inspire us to make the relationships better and more impactful for the people they serve. It's all about serving Texans. So thank you so, so, so, so deeply.

(Applause.)

MS. RICHARD: Thank you. It's been my pleasure, I've really enjoyed it, and gosh, I've learned

so much from everyone. So thank you.

MR. IRVINE: And also, one of the things that you've brought, especially over the last year, is inviting folks in to make more in-depth presentations, and I think that Nicole, you're probably going to become new best friends from a lot of people in this room. You obviously have got a lot going on; Alyse too. I think that the introductions that are effected in this committee are hopefully just the beginning because the real work happens on the other 361 days a year when we aren't meeting, so let it carry on outside.

Anybody else got anything?

MR. GOODWIN: Just in relation to her is that I think when we made the last app change everybody said, oh, gee, what are we going to do, look at all this stuff that we've been given, and I think we have actually stepped up a significant amount from there in the quality of what's been given to us as far as support and I'll say what -- we probably shouldn't take much credit, but what the committee has accomplished, if you will, with the training that's been out and the resource guide that's been out.

MS. RICHARD: Thank you so much.

MR. IRVINE: I agree. Brooke and Elizabeth will be tasked with keeping us on that trajectory.

(General talking and laughter.)

MR. IRVINE: I think it's important, too, that we do always remember that this about trajectory. As I was listening to Marni talk about the visitability issues, I think we're on the trajectory. Ultimately, every unit should be accessible, every unit should be visitable, it's that simple.

I've got nothing else.

MS. BARNARD: One small comment if you have a moment. Just related to our program, we don't do a whole lot of housing, the Community Development Block Grant Program, we did just accept our major source of applications for the next two years, did not get any housing applications in that. The communities are prioritizing infrastructure.

Our Colonia Fund, by the time of our next meeting the communities will need to know what their Colonia Fund applications are and be on their way to developing those applications. When we're talking about small units and small landowners, we've restructured some of our program rules to make that more feasible for duplexes and fourplexes to be part of rehab funds that can be used for accessibility. If you have communities that want to put such a facility in a colonia area, that is coming up and should be released June 1-ish.

MR. IRVINE: We're adjourned, not that we ever convened.

(Whereupon, at 11:36 a.m., the meeting was adjourned.

C E R T I F I C A T E

MEETING OF: Housing & Health Services Coordination Council

LOCATION: Austin, Texas

DATE: April 12, 2017

I do hereby certify that the foregoing pages, numbers 1 through 59, inclusive, are the true, accurate, and complete transcript prepared from the verbal recording made by electronic recording by Nancy H. King before the Housing and Human Services Coordination Council.

4/18/2017
(Transcriber) (Date)

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