TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS

HOUSING AND HEALTH SERVICES COORDINATION COUNCIL MEETING

HHSC - MHMR Center
Room 164
909 West 45th Street
Building II
Austin, Texas 78751

May 10, 2010
10:12 a.m.

COUNCIL MEMBERS PRESENT:

PAULA MARGESON, Vice Chair
FELIX BRIONES
AMANDA BRODEN (for NICK DAUSTER)
KENNETH DARDEN
SHERRI GOTHART-BARRON
MARC GOLD
MIKE GOODWIN
AMY GRANBERRY
JEAN LANGENDORF
PAIGE McGILLOWAY
DONI VAN RYSWYK
MARK WYATT

I N D E X

P R O C E E D I N G S

MS. MARGESON: Let's get started. I'm sorry I'm late. I was Starbuck-ing. Time got away from me, I was having such fun.

(General laughter.)

MS. MARGESON: I believe we're supposed to start with roll call, so Ashley, will you do that for us?

MS. SCHWEICKART: Sure.

MS. MARGESON: I don't have the list, do I?

MS. SCHWEICKART: It's the next page.

MS. MARGESON: Well, do it anyway.

MS. SCHWEICKART: Okay. So I will start roll call with Mark Wyatt?

MR. WYATT: Here.

MS. SCHWEICKART: Paige McGilloway?

MS. McGILLOWAY: Here.

MS. SCHWEICKART: Jonas Schwartz?

MR. SCHWARTZ: Here.

MS. SCHWEICKART: Jim Hanophy? And Jim actually told me he can't attend today, unfortunately.

Marc Gold?

MR. GOLD: Here.

MS. MARGESON: Nick Dauster?

MS. BRODEN: Hi. Amanda Broden here for Nick

Dauster.

MS. MARGESON: Thank you, Amanda.

Sherri Gothart-Barron?

MS. GOTHART-BARRON: Here.

MS. SCHWEICKART: Doni Van Ryswyk?

MS. VAN RYSWYK: Here.

MS. SCHWEICKART: Jimmy Carmichael?

(No response.)

MS. SCHWEICKART: Michael Goodwin?

(No response.)

MS. MARGESON: Amy Granberry?

MS. GRANBERRY: Here.

MS. SCHWEICKART: Felix Briones?

MR. BRIONES: Here.

MS. SCHWEICKART: Kenneth Darden?

MR. DARDEN: Here.

MS. SCHWEICKART: Jean Langendorf?

MS. LANGENDORF: Here.

MS. MARGESON: Great. And then I believe we have visitors in the room, and we'd love it if you'd introduce yourselves so we know who you are.

MS. BOSTON: I'm Brooke Boston, I'm with the Agency.

MS. YEVICH: Elizabeth Yevich, also with the

Agency.

MS. MOORE: Kate Moore, TDHCA.

MS. ASHMAN: Steve Ashman with DADS.

MS. HARTMAN: Marilyn Hartman from NAMI Austin.

MS. HENKE: Tegan Henke with DSHS.

MS. VANONI: Laura Vanoni with DSHS.

MS. EZEKOYE: Nnenna Ezekoye with DSHS.

MS. DALEY: Leah Daley with Sunset Advisory Commission.

MS. DOWNIE: Michele Downie with Sunset.

MS. MARGESON: Well, we're glad you all came. We're such an exciting committee, you won't regret it.

I'm dealing with two agendas or something, I don't know what I'm doing, actually. Mike has got to stop doing this to me.

(General laughter.)

MS. MARGESON: Oh, yes, we have to approve the meeting minutes. I flew to North Carolina yesterday and flew here today and I think I have some kind of jet fatigue.

Is there a motion to approve the minutes from the meeting on March 2?

MS. GOTHART-BARRON: I move to approve.

MS. MARGESON: Thank you. Second?

MS. GRANBERRY: Second.

MS. MARGESON: So I'm assuming no corrections, deletions, modifications, et cetera. All those in favor say aye.

(A chorus of ayes.)

MS. MARGESON: Opposed, no.

(No response.)

MS. MARGESON: Good.

Does that bring us to committee reports?

MS. SCHWEICKART: We have public comment.

MS. MARGESON: Oh, public comment. We would like to hear from anyone from the public.

MS. SCHWEICKART: We didn't receive any witness affirmation forms.

MS. MARGESON: Do we really have to have them?

MS. SCHWEICKART: Technically.

MS. MARGESON: You could do it after the fact, we'd be good with that if someone wants to speak. It could liven up the meeting, guys.

(General laughter.)

MS. SCHWEICKART: No one is speaking up.

MS. MARGESON: Well, if you change your mind, let me know.

So then we have a presentation by DSHS.

MS. SCHWEICKART: Do you want me to introduce it?

MS. MARGESON: Yes.

MS. SCHWEICKART: Okay, great. So I'd like to introduce -- and I'm going to pronounce your last name wrong, do you want to say it for me, Nnenna?

MS. EZEKOYE: You can try. Most of the time if you panic, you get it out correctly.

(General laughter.)

MS. SCHWEICKART: All right, Ezekoye. And Nnenna is a senior policy analyst for the Texas Department of State Health Services, and she's here to represent the Mental Health and Substance Abuse Divisions Continuity of Care Task Force. So basically the Continuity of Care Task Force which I believe first convened in February, is that right?

MS. EZEKOYE: Yes.

MS. SCHWEICKART: They have goals that overlap with some of the charges of the council and so I thought that would be great to have her here, specifically talking about overall continuum of care for individuals with severe mental illness, examining the barriers to discharge for individuals in state hospitals, and to resolve the barriers to discharge. And so we'd like to learn more

about the work of the task force and see what overlaps with this council and hear what potential recommendations they will be making to DHHS.

So Nnenna, thank you for coming, and I'll turn it over to you, and you can just let me know when you want me to change the slides.

MS. EZEKOYE: Well, thank you for having me here. I will say that Ashley did a very good job of sort of introducing our goals which is slide 3, so we're going to skip over that. And slide 2 is a little bit of background of why we need to do this and it's just that the state hospital system is nearing capacity. We have, I want to say, about 500 people, maybe more than that, 500 people on the waiting list and we have about 600 people who have been in the state hospital for more than a year, and increasingly, over the past couple of years, it's been that the admissions have turned on from being equal forensic and civil to mostly forensic, and that has become a problem because now people who no longer have criminal charges against them can't get access to the state hospital care.

As I said, Ashley did a very good job of describing our goals and that was slide number 3, and so I'll give you a little bit of background into the time

line of the task force, and that's slide number 4. And our first meeting was convened February 5, we've had three meetings so far, our final meeting with all the task force representatives will be June 18 at the Texas Council Conference, and we're hoping to have a report that we'll publish and distribute to the legislature and also on our website by August 31, 2010, so we'll be prepared for the upcoming legislative session. We also have a number of exceptional items and pieces of legislation that we've developed around the task force which I'll get into a little bit more.

Slide number 5, we've had a couple of public forums. The first one was March 3 in La Grange; we just had one in Harlingen which went very, very well. Actually, we had Representative Lucio come to the meeting which sort of surprised me. I used to work legislatively and they're very, very busy and he was there for about half an hour which was a shock.

We also have some additional public forums if any of the members of this committee would like to come. We have one in Dallas tomorrow so if you guys would love to hear more about this tomorrow if you're from the Dallas area you can come, and that's at the Dallas County Health and Human Services building. We have another one in Big

Spring -- which I can't imagine anybody here is from Big Spring -- on May 21, and we have our final public forum May 27 here at DSHS at the West Auditorium.

So I'm going to give you a little bit of background into the global issues of the state hospital system, and that is slide number 6. And as I said, we've seen an increase in forensic commitments and that's both sort of a positive and negative development, and it's positive because it signals and increased awareness on the part of law enforcement and the judiciary in terms of sending people to get mental health care rather than just putting them in prison, but unfortunately, in the sense that they may be overusing the state hospital instead of some of the community options that might be available.

MS. McGILLOWAY: Can I ask a question, and I'm sorry to interrupt. You were talking about forensic versus what was the other category?

MS. EZEKOYE: Civil.

MS. McGILLOWAY: So can you just explain the differences to me, I'm not sure what you mean by forensic versus civil.

MS. EZEKOYE: A forensic commitment, what it is is when someone commits a crime and they are arraigned and they're going to be put on trial, the judge says is this

person competent to stand trial, at that point when they find that they're not competent, that's a forensic commitment and they commit them to the state hospital. A civil commitment is just someone who is sort of a danger to themselves, they haven't committed a crime and so they commit them to the state hospital so that they're well, and then they can leave whenever a doctor says you're well, you don't need to be here any longer.

MS. McGILLOWAY: Okay. Thank you.

MS. EZEKOYE: Any other questions?

(No response.)

MS. EZEKOYE: I'll just move on. Additionally, we've also some challenges because there is a difference in how rural communities use commitments and urban communities use commitments, and the funny thing is that we have more commitments from urban communities but we also find that in rural communities they tend to, it's sort of hard to say but they sort of over-commit in the forensic capacity because they don't have the resources to take care of the people that way that the urban communities might. And of course, we would love to have better treatment and care for children and adolescents.

So slide 7, of course there are all these environmental perspectives and global perspectives about

disease management and un-insurance which we're going to touch upon in the report but it's not the main focus, I will say that. And also the same thing with slide 8, the importance of having an integrated care system but actually the back half of slide 8 which is lack of residential alternatives which is something that we definitely will address both in the report and in our recommendations.

And we will also discuss some of the co-occurring disorders, such as substance abuse and head injuries, and I don't know how aware you guys are of this group, the Rider 66 Group which is working on acquired brain injuries and it was from last session. There was a rider, of course, from last session about determining the feasibility of a waiver for acquired brain injuries. So I'm not sure exactly how that report is shaping up, but it does seem likely with that that they will recommend, at least they'll touch upon the acquired brain injury population in the state hospital because that's a population that we pay nothing but GR for, and if we could have a Medicaid waiver for it, at least we'd be able to decrease some of the funds that spend on brain injury in the state hospital system.

Slide 9. So some of the data that we've looked

at to determine our recommendations are data from Harris County around their jail treatment prior to a finding for competency, so Harris County has this program, I'll say, it's not entirely formalized but it allows them to treat people prior to bringing up the issue of being found incompetent to stand trial. So what they do is they treat a person in jail for 21 days and usually they find that that person is able to achieve competency and that they never have to go to the state hospital. So we're looking at perhaps a legislative fit for that. Ours would probably not be as long as 21 days but closer to 7 to 14 or so.

We've also been looking at data around individuals who have been admitted more than three times in 180 days for a forensic commitment which really shouldn't happen. So what it tells you is that a judge is committing a person to the state hospital, they quickly regain competency, they get out, and they have sort of no supportive environment and what they end up doing is committing another crime, and then the judge will then once again commit them to the state hospital. So they're using it sort of as stop-gap for services and housing and employment because they don't have anything there. So that is actually one of the things that we're really

looking at in terms of permanent supportive housing because those are individuals who probably really need it.

We're also looking at the outpatient competency restoration pilot and perhaps linking those to supportive housing. And we also looked at data about individual with a length of stay more than 365 days, and those people could also benefit from housing because there are a couple of reasons why people are in for 365 days, longer than 365 days in the state hospital.

One of the reasons is because they don't have a supportive environment for them once they leave the state hospital so they might have guardians but their guardians are unsure of what kind of care they could get or support they could get out in the community, and so they're resistant to have the person leave the hospital. So having permanent supportive housing or some sort of transitional service might assuage the guardians and allow and they would give consent to have this person leave the hospital.

Another reason is because they're sort of medically fragile, so it might be that they might need assistive living care or nursing home care because they're not in the midst of any sort of psychiatric crisis or they're not actively psychotic, but they have diabetes or

they have a brain injury and they just can't care for themselves so they need to be somewhere else but they don't necessarily need to be in a state hospital.

And then the final group is a group who a judge would never, ever let out, unfortunately, and those are people who are either intensely psychotic or they've committed such a heinous crime that no one would ever let them out.

MS. MARGESON: What percent of the population would you say falls into that category?

MS. EZEKOYE: It's not huge but I would say it's -- well, I'd have to look for you but the last time I looked I wouldn't say that it's more than like 20 percent, but it's still a lot of people.

MS. SCHWEICKART: Of those that are in the hospital over a year, is that what you're talking about?

MS. EZEKOYE: Yes.

And so slide number 10 just sort of breaks down some of our recommendations, so first is housing, and as I said, we are going to be developing both exceptional items and possibly legislation around housing.

The second one is community supervision which would probably go hand in hand with our housing recommendations, especially for permanent supportive

housing, because there are definitely some patients in the state hospital that the judges, especially in the rural communities, they're very afraid that the person is going to re-offend, and so if you can create something is coupled with the housing so that the person, for example in an outpatient commitment, instead of committing them to the state hospital, they commit them to outpatient treatment.

And if you can do that, you can commit them with outpatient treatment and to supportive housing, sort of say it's a condition of our outpatient instead of your commitment that you have to be in housing and this is the housing that we recommend for you. A judge might be more receptive to do that than just send them to the state hospital and hoping then to jail and then prison.

As I said, the next thing, step-down levels of care, so perhaps some transitional services that you'd provide to step people out of the state hospitals and then into the community ultimately. And then we have funding for non-crisis services which I don't know how familiar you are with crisis mental health services.

MS. SCHWEICKART: I think some people are more than others.

MS. EZEKOYE: Really quickly, it's just for

people who are in the midst of an active crisis and you send them to a crisis treatment center so that they'll get care in the immediate situation so that they're not committed to the state hospital or they're not going to jail. Sort of really briefly, that's essentially what they're trying to do so that they can get through the crisis in a couple of days and then go back out to their job or their house and their life. That's basically crisis as short as I can possibly do it.

MR. GOLD: Can I ask you a question regarding funding? Are most of your recommendations or are all of your recommendations going to be based on General Revenue versus some federal match?

MS. EZEKOYE: Almost all of them. We are also possibly thinking of some waivers. I know that we've been talking to not just you but other people at DADS about some waiver options for perhaps a brain injury group or some other smaller populations but for the most part our funding recommendations are going to be straight GR.

MR. GOLD: Straight GR.

MS. EZEKOYE: And the thing about it is the state hospital costs $420 a day, so even if it is GR, it's probably less GR than what we currently spend now.

MS. MARGESON: Is that including construction

of housing?

MS. EZEKOYE: Well, the other funny thing is that for the transitional, every state hospital has the physical capacity to have a transitional unit there, so have space galore, we don't really need to construct anything, we just sort of need the money to be able to do it and to be able to share all the support services so it wouldn't need the intense type of healthcare that you get at the state hospital, you'll have nurses there and doctors but not as intensely staffed as a state hospital but they'll also be able to use the same facilities for food and garbage and electricity and all of those things so that we'll be able to benefit that way.

MS. LANGENDORF: So help me, I think I'm understanding this, so you're saying like say -- can I use Austin State Hospital as an example?

MS. EZEKOYE: Sure.

MS. LANGENDORF: That you have a building or something there that could be converted to what one might consider to be transitional housing.

MS. EZEKOYE: Almost every state hospital just has room galore.

MS. LANGENDORF: But it would be temporary.

MS. EZEKOYE: Yes, and so our hope is that we

would be able to pick that population and have supportive employment and other courses that they might need to help them transition from the state hospital to the community.

MS. MARGESON: But didn't you say at the beginning of your presentation that you're nearing capacity?

MS. EZEKOYE: Yes.

MS. MARGESON: So how is it that you have room galore?

MS. EZEKOYE: It's just capacity based on what we've been funded for.

MS. MARGESON: Oh, I see. And what is the overall population for all state hospitals?

MS. EZEKOYE: It's about 2,500.

MR. GOODWIN: Just sort of a side question on you non-crisis services, what's the threshold between crisis intervention, we'll say the two-day stay that you mentioned, and non-crisis service?

MS. EZEKOYE: You know, I don't know. Do you guys know?

MS. VANONI: (Speaking from audience.) Can you repeat the question?

MR. GOODWIN: The threshold between crisis and non-crisis as far as if we're needing funding for the non-

crisis services, what is the threshold that says that is is a crisis situation, a person is in for two days or three days?

MS. VANONI: We define a crisis episode as the person is a danger to themself or others or at risk or at risk for further deterioration, so generally in the community when someone goes into a crisis, the episode is considered for seven days unless the treating local mental health authority or provider determine that the crisis has passed and they feel pretty confident that the person isn't going to go into crisis yet the next day, so they have like a seven-day window, but then they can get them into ongoing services beyond that.

MR. GOODWIN: So what you're saying is short of being an actual physical threat to themself or someone else, there's no in-between level.

MS. EZEKOYE: Well, I don't know. What do you think?

MS. VANONI: The crisis services that Nnenna spoke of earlier, because of the 80th Legislative Session, we got money, $82 million, to have a request for proposal, not really an RFP but more the local community mental health centers, they bid to potentially open up a residential crisis setting in their community, but there's

17 of them statewide so there's not a whole lot of residential locations for crisis services throughout the state. A lot of communities didn't get anything, so their crisis services are more just still the mobile outreach teams and things like that.

MS. LANGENDORF: So there doesn't necessarily have to be imminent danger in order to qualify as a crisis.

MS. VANONI: There should be, otherwise, if you don't do that then we've gotten so many crisis services, we've had such an increase that they definitely have to do the placement.

MS. LANGENDORF: So you are looking at imminent.

One more question o the concept of transitional, what time frame are you all thinking of in your proposal to say create transitional supportive housing on the campus?

MS. EZEKOYE: Like how long would somebody be in transitional services?

MS. LANGENDORF: Yes, because I mean, in the homeless funding there's a specific amount of time of what's considered transitional.

MS. GRANBERRY: It's up to two years.

MS. LANGENDORF: Up to two years.

MS. GRANBERRY: That's for homeless.

MS. LANGENDORF: Have you come up?

MS. EZEKOYE: We haven't, and to a certain extent it might just be because the state hospital system is very much a medical -- it's a more medical model than the homeless system, so think two years is probably definitely a good starting place. It may be less time or more time, sort of depending on how the social workers and clinicians in and around the state hospital or who are working in the transitional services see a person progressing.

MS. LANGENDORF: And at this point they are committed.

MS. EZEKOYE: Right.

MS. MARGESON: Do you think that the Mental Health Parity Act is going to change and lessen the referrals that you get from crisis type centers? I'm thinking a lot of times insurance will limit a person's stay and they still need treatment and so they end up being transferred to the state hospital, but now with that new act, will that impact referrals do you think?

MS. EZEKOYE: You know what, I don't know. I'd have to investigate that, but I'd say my sneaking

suspicion is that there's a decent possibility that it might go up.

MS. BRODEN: Our population is mainly indigent anyway.

MS. EZEKOYE: It is mainly indigent.

MS. BRODEN: We don't have a lot of third-party billing already, so I think that would be a very small percentage of patients.

MS. GRANBERRY: It's indigent, and I live in a county where we have the highest per capita forensic commitments in the entire state, and we work constantly on jail diversion and with our law enforcement to convince them to stop sending them. Can we get to a point that we can do outpatient restoration and competency, and there big thing is well, you don't have enough services. But it's going to be cheaper if you help us find money for these services than send them to the state hospital because we're on a 90- to 120-day wait right now out of our county for first aid hospital beds, and 86 percent of our commitments are forensic -- I mean, it's ridiculous. And the majority of them are felony, there's very few misdemeanors, so the law enforcement is not willing to do anything with felony other than send them to the hospital.

MS. EZEKOYE: Well, we found at our first

public hearing, I wish I could remember the judge's name but he said who would ever send somebody to the state hospital on a misdemeanor, and then others were like, well, I would. It's very different how it's practiced around the state, so in your county they never would because they need all the beds that they have, and so it just seems like a waste of beds to them, but other places they're like yes, sure, just get them out of my hair for a while.

MS. GRANBERRY: I think there's a great deal of overuse, and I think that the big thing I didn't know until several years ago when this came in was that the MHMR center pays for it but law enforcement is sending them and the local center has no control over what's happening, but they get the fine if you're overused, and so there's a real disconnect there. So we've tried to do a lot of education with law enforcement to stop that but not working.

MS. EZEKOYE: Which is actually another one of our recommendations that we improve the education to -- well, let me see if I can find that slide, well, doesn't matter -- that we improve the education for judges and for law enforcement, both about the services that are available in the local region and also just about sort of

the appropriate use of the state hospital, especially with the judges because we find that they're using it very differently around the state, that there are a number of them who are sort of filling out the commitment orders incorrectly.

We've also found that they weren't notifying if the charges were dropped, so we've had some instances of state hospitals keeping people past the commitment time because the court didn't let them know that this person no longer had charges pending. So it doesn't seem like it's a huge part of our recommendation but it's actually very significant because it's very important.

MS. GOTHART-BARRON: Is there a way for you to recommend, I mean, if the MHMR centers are the ones fronting the fines, transfer the fine from the MHMR center to the judicial system?

MS. EZEKOYE: It's possible, it's something we've talked about, it's one of those ones that I don't know.

(General laughter.)

MS. GRANBERRY: I'm sure the judicial doesn't want it.

MS. GOTHART-BARRON: I'm sure they don't, but if they're the primary reason why, then it would make

sense, just as a recommendation from the council.

MS. EZEKOYE: I'll make a note of it, but it is something that we've talked about.

So we can move on, actually we can skip slide number 11 because there's sort of no point in talking about medical clearances, it's probably well beyond the purview of this committee.

So slide 12 is probably the best one to start up again, and those are recommendations, and our first one is clarify the maximum time commitment, includes time served in jail from the date of booking, and so typically how it goes is that you have like 120 days when you commit somebody and usually they start that clock from the moment that person enters the state hospital but the entire time they could be in jail. This is why we're hoping that we can marry it with our other recommendation to begin treatment while they're in jail.

So they can stay in jail for who knows how long until a state hospital bed becomes open, an coupling the time that they're in jail and then the time in the state hospital, they could have been in there for months or pushing a year, and if they were there for a misdemeanor, it's just so pointless, like they just served a year for a crime that they were never convicted of and that they

dropped the charges on. And so that's one of our recommendations.

Another one, sort of speaking in terms of how we would like the courts to better interact with the state hospital, we would like the courts to issue commitment expiration dates in the court orders so that when they get to the state hospital, there's no point in the state hospital sitting there with this person in there and has no clue how long the commitment is supposed to last and they might be in there for longer than the term of the commitment. So that's another one of our recommendations and that's a legislative recommendation.

Slide 13, we'd like to limit the maximum commitment period for misdemeanors for 90 days just because, as we said, it's just sort of pointless to keep a person who is charged with a misdemeanor possibly in jail and in the state hospital for a year for trespassing.

Another one is to restore provisions for forensic experts, and previously -- I think this was from three or four sessions ago -- in Chapter 46(b) of the Code of Criminal Procedure, it allowed forensic experts, once they got into the state hospital and they were in there for the 120 days, to say this person going to restore, if you're trying to charge them with a crime, it's not going

to happen, this person is not going to get much better in 120 days, 180 days, like it's just not happening.

And so they could go back to the court and the court could say we'll drop the charges or should we convert this to a civil commitment, and that had been taken out but we'd like to see that put back in because it could be very helpful.

MS. LANGENDORF: Do you know why that was taken out?

MS. EZEKOYE: You know, I don't know.

The first one that I slide 14 is the jail treatment which I've already talked about, and Harris County does that, and so we'd like it for a little bit shorter but with Harris County they find that like 3 percent of the people that they do this restore in that time, so we think that that would actually alleviate some of the inflow that we get from the jails.

MS. MARGESON: Are they in the infirmary when that occurs, or are they just in with the general population, the general jail population?

MS. EZEKOYE: I believe they're in with the general jail population. Harris County is really strange in the fact that they have this humongous jail population and they actually do have about 2,500 people on

psychiatric meds at any given time.

MS. MARGESON: Seems like that could be a risk situation.

MS. GRANBERRY: Harris County has an amazing jail diversion and mental health situation in their jail. I mean, it's a model that's used nationwide to replicate. They do a great job with their crisis stabilization and their jail population and their jail diversion and all of their different options that they use there. It's actually a pretty amazing program.

MS. EZEKOYE: Yes, I'm sure if they're actively psychotic they probably have them isolated, but for anybody else, I believe it's just medication and they're in the general population.

And then the other recommendation is to clarify judicial authority for compelled medications, and there was a bill last session allowing the courts to compel medication for a person who had been committed to a state hospital but hadn't been transferred yet. And it's a little weird because when you look at it, the judicial authority is probably the criminal courts but the probate court has more experience with compelled medication, civil commitments, and a lot of judges have been unwilling to use this because the criminal courts feel like they

probably don't have appropriate jurisdiction or experience to do it and the probate courts feel that they do have the experience but they don't have the actual authority to do it under that statute.

MS. MARGESON: Explain compelled medication for me.

MS. EZEKOYE: Essentially it's the court saying you're a danger to yourself or others, you're deteriorating, we're going to make you take medication.

MS. MARGESON: Okay, forced.

MS. LANGENDORF: Do you have a list or could you give us a list of who's on the task force?

MS. EZEKOYE: Yes, I can.

MS. LANGENDORF: That would help me kind of understand some of the recommendations.

MS. EZEKOYE: I can give you a quick rundown of people that I can recall. It's Steve Schnee from Harris County, Sylvia Muzquiz from Harris County, Joseph Penn from UTMB, Shelley Smith from Big Spring, Sheriff Stan Parker from Big Spring, Judge Brent Carr, Judge Guy Herman.

MS. LANGENDORF: Is there a representative from MHAC corporate?

MS. EZEKOYE: No, but we do have two from

MHPAC. We have Mike Halligan from MHPAC and we have Robin Peyson who is NAMI and MHPAC. Let's see, Camis Milam from San Antonio, Leon Evans from San Antonio, Alex Smith from North Texas Behavioral Health Authority, I'm sure I'll remember more but I'll just send the list to Ashley.

MS. SCHWEICKART: And it's on your website too.

MS. EZEKOYE: Yes, it is on our website.

MS. LANGENDORF: It's on the website? Okay.

MS. EZEKOYE: Where was I? Oh, slide 15, on to housing. So as I said, we'd like to link permanent supportive housing to OCR, that's Outpatient Competency Restoration, or sort of enriched community services like that, and we would like to use that for misdemeanor defendants. I don't know if I mentioned this, but we don't have a great number of misdemeanants because we're also, once again, from the courts getting bad data on that so they're sort of indiscriminately filling out who is a misdemeanant and who is a felon when we get the person committed to us, but just based on what they've given us, we spend about $17 million a year on misdemeanants who go through the state hospitals. And so some of those are loitering and trespassing and clearly those are people who just sort of need supportive environments out in the community and don't necessarily need to be in a state

hospital.

Slide 16 is extended outpatient commitment, and right now, outpatient commitment, I believe, is 90 days and then you can ask for it to be extended additionally, and there are some people who just need, much like the housing, they need two years, there are some people who need more time than that, and so we'd like it to be the option of doing it one year if you have clinical indicators that this person might need a little longer than 90 days to restore to competency and get themselves situated in the community.

Slide 17, I'm going to skip the medical clearance recommendations because that's really more about the state hospitals. As I said, the permanent supportive housing for misdemeanants would be one of our short-term, and the other one would be for residential care so that might be the transitional care for people who are in the state hospital for more than a year and need supportive employment, other supportive programs to help them transition out of the state hospitals. It also might be assisted living for some of the people with acquired brain injury or who are medically compromised. So that's one of the ones that we're developing an exceptional item around, and in fact, we have a facility that DSHS recently

reacquired from TYC on Vernon's campus, it's called Victory Field, and that could be a 50-bed transitional unit. But as I said, we have space galore in a lot of the state hospitals so there are just building that we could, if we had more money than we had, we could turn those into transitional units to allow people to transition out of the state hospitals elsewhere around the state.

MS. VAN RYSWYK: Although there's a problem when folks who need active treatment go to either assisted living or nursing homes because they're really not set up to provide those kinds of supports and there really aren't any facilities that specialize in that population.

MR. GOLD: Well, more importantly, in an assisted living facility if it's private pay, then that assisted living facility, as part of the regulations when we talked about barriers and obstacles to housing -- and I know we're not really talking about assisted living in this group -- but an assisted living facility is not allowed to accept somebody for whom they cannot meet their needs. Also, an assisted living facility, by definition with the Chapter 247, is not allowed to have any sort of nurses or that sort of professional staff, or are certainly not required to, and so medication administration and supervision, that wouldn't be occurring

either, that would have to be brought in on a third-party basis.

MS. EZEKOYE: Well, we can do it actually under the hospital's JCAHO licensing.

MR. GOLD: Well, assisted living the way it's defined in statute. So I mean, it would be some difficulty there depending on the level of staffing that they have but they're not required to have that sort of staffing, but you could bring in third party.

MS. EZEKOYE: Yes. And there actually is a facility that's operating in Texas called Hospitality House that is sort of a nursing home-ish kind of facility that is just purely mental health, they don't take Medicaid, they don't take Medicare, so there is that and that is actually a model for us if we wanted to do that as well.

MR. GOLD: And that's a licensed nursing facility, it's one of the very few in the state that's actually licensed only and doesn't have some sort of Medicare and Medicaid certification.

MS. SCHWEICKART: So for your permanent supportive housing recommendation, what kind of housing are you envisioning for this purpose in terms of is it something that's already on the ground currently

available?

MS. EZEKOYE: It is not something that's on the ground, it's something that we could develop with a community or a number of communities who would sort of be, I guess, in an RFP process. Even though, as I said, San Antonio, they are sort of a model for a lot of these things because they already have homeless, I think they also do some veterans.

MS. GRANBERRY: Yes, there's 75 agencies co-located at their big center.

MS. EZEKOYE: Yes, so they a lot of them already.

Slide 18, and so, as I said, one of our other recommendations is some of that training that we talked about that the judges and the law enforcement and the prosecutors and the defense attorneys and everybody who is just sort of unaware of what is available, what are the best options, what they should be doing. We've also talked about an online sort of peer consultation for judges, defense attorneys, prosecutors because we found that a lot of the judges have said I'd love to do something else but I don't know of anything else, I only see one or two mental health cases a year. And they have no clue what they're doing, and if there were some sort of

online community for them to say what do I do in this situation, somebody would say, well, you can commit them to the state hospital or there is also an outpatient service in your area. And they're like oh, okay, maybe I'll do that instead. And so we think that that might be very beneficial.

MS. GRANBERRY: We're hearing a lot of defense attorneys coming in and saying since the wait is so long for a state hospital bed, let's just go ahead and dismiss these charges and they're claiming incompetency just to get them dismissed.

MS. EZEKOYE: Yes.

MS. GRANBERRY: And then the judges aren't happy about that either, so then that's where we end up with all of our forensic beds out in Nueces County.

MS. EZEKOYE: And so slide 19 is some clinical recommendations that we'd like to develop, perhaps clinical recommendations in the state hospitals that might decrease the time of commitment, improve their ability to restore competency -- that's probably the best way to say it. We also have some other ones involved in salary analysis because state hospital doctors are generally underpaid -- actually, all state hospital medical professionals are underpaid and we have just have a lot of

vacancies that we cannot fill.

Some recommendations around trauma informed care, cognitive rehab and co-morbidities and resiliency in disease management, and expanded time for testing, assessment and record analysis, because, as I said, the data that we have about some of the co-morbidities, also some of the charges is just absolutely atrocious, so that's something that we'd also like to improve and that's something that we're going to recommend from the committee.

And slide 20, some more of our recommendations, perhaps an interim study around the Mental Health Code which is just garbage and Swiss cheese. It was mostly written in like the '50s and it's been sort of piecemeal updated as we've gone along and it has sort of a very bizarre understanding of how the mental health system worked then. It's very outdated and I don't know that we could put full recommendation for it until we do a study of it to better understand what's wrong, what's working, what isn't working.

There are also some consideration of Medicaid waivers that we've talked about with Marc and with other people from DADS and also that Rider 66 group. A study of clinical issues around long-term hospitalizations, and

then, as I said, the data systems.

And that's about it.

MS. SCHWEICKART: Thank you very much.

MS. MARGESON: Any other questions, comments?

MS. HARTMAN: (Speaking from audience.) Yes, in terms of Medicaid participation, what about something like the 1915(I) that I believe is a state program that would help to pay for the support services in supportive housing?

MR. GOLD: 1915(I)? Well, 1915(I) was put in with the Deficit Reduction Act of 2005 and there's been some significant changes to it in the Healthcare Reform Bill, and currently we don't actually have in 1915(I) where there's been an application for one program, but the whole process is being looked at, so I know there's been some consideration with individuals, but Jonas is right, it's just all over the map at this point in terms of what's being considered.

MR. SCHWARTZ: Yes, but one good thing with healthcare reform, it does allow the state to have more than one 1915(I) and basically what a 1915(I) is, it allows you to provide home and community-based services in your Medicaid state plan as opposed to applying for a waiver, and so it's going to be another vehicle for

providing home and community-based services, so in the future it could be an option.

MR. GOLD: I mean, the good news and bad news about that is it becomes an entitlement, meaning that all individuals who meet the eligibility criteria would have to be served which means it would have a fiscal impact to the state. Now, whether that offsets other expenses in the state, that's for other brains to make that determination, but I mean, that's certainly another option that's out there. And you can write the criteria very stringently so you can really target it for the specific population, but it is one of those that remains to be seen. You must have no life if you're knowing about the 1915(I).

(General laughter.)

MS. MARGESON: So Jonas, are you saying it's a waiver program, or no?

MR. SCHWARTZ: It's not a waiver program, it would allow you to put waiver-like services in the state plan, but as Marc said, then it becomes an entitlement and so you have a harder time controlling your costs.

MR. GOLD: The weird thing about the (I), Paula, was it started off like a waiver-like services under the Deficit Reduction Act and sort of morphed into

this other phenomenon. That's where I think even CMS right now is trying to determine what is it.

MS. SCHWEICKART: Any other questions?

MS. VANONI: Yes. I work for DSHS in Mental Health and Substance Abuse Adult Program Services, and I've lived in a few different states, and I think one thing that I would really hope that we would get going here, aside from the permanent supportive housing options that Nnenna has outlined, is we don't really have anywhere for people to live that don't have -- we don't want them to live in institutions and they can receive pretty intensive services in the community in our ACT services or in Psycho-Social Rehabilitation Service Package III, but a lot of them don't have anywhere to live that sort of embraces them while they're receiving services on an outpatient basis.

And I think there are quite a few people that are on civil commitments in the state hospitals that if we can just get some three- and four-bed group homes together, they would be able to go to the community clinic and receive services, pretty intensive services as long as they're being followed by an ACT team or what-have-you, yet they would be living in their own environment in our communities, and I just hope that we can go in that

direction as well while we're exploring all these options.

MR. GOLD: You know, and under the Promoting Independence Plan, individuals who have been hospitalized three or more times within 180-day period is entitled to that higher level of the resiliency in disease management, or RDM process, so they're supposed to be getting more intensive services, and we have noticed through Promoting Independence a number of individuals who their length of stay in the state hospital system for more than a year has been increasing. For a while there it was taking a dip and it seems to be going back up again, and I don't know if that's due to the forensic population or not.

MS. SCHWEICKART: Any other questions?

MR. SCHWARTZ: I have a comment. Nnenna referenced in her comments several times the Rider 66 report that is looking at services for individuals with acquired brain injury, and we are in the process of drafting that report, and it's due to the legislature by September 1. If the committee would like a presentation similar to this on the issues that that report deals with, I can see if that's a possibility if folks are interested.

MS. SCHWEICKART: Thank you, Jonas.

MS. MARGESON: Is that something that the council would be interested in? What do you think,

people?

MS. LANGENDORF: Any recommendations?

MR. SCHWARTZ: We haven't gotten to the recommendation stage, they're just now putting together the first draft, so I haven't seen recommendations yet.

MS. LANGENDORF: Okay. Yes, I'd like to know more about it.

MS. SCHWEICKART: Nnenna and Amy, because you both mentioned this San Antonio example, I just wanted to ask you a question about how, with their model which I guess is seen as a best practice, they transition individuals into community-based housing settings. I don't know if you guys know about that.

MS. EZEKOYE: You know, all I have to say about San Antonio is that it's been done through like clearly personality and sheer force of will that they've managed to sort of transform everything around there, so they have this very much integrated system that they work with law enforcement and the judges and everybody around them so that, as you said, they have this complex with all the agencies there.

MR. GOLD: They're phenomenal, I mean, they are absolutely extraordinary, and this may be a little offside, but the Department of Aging and Disability

Services, in conjunction with HHSC and State Health Services, we have a program where we're relocating individuals from nursing facilities back into the community, and we believe that those services that were tested are being very, very effective in terms of breaking that cycle of going through from the community to homelessness, back to the state hospital system, back to a nursing facility, back out again.

And so we have a pilot program in Bexar County -- actually, we're looking to expand it under -- it's under the Promoting Independence MFP demonstration, providing two services, cognitive adaption training which really works with that individual in setting up certain parameters, and these are very cheap services too, these are not expensive services, and some substance abuse. So this is what Center for Healthcare Services is working with us on, and so they're getting their feet wet in terms of relocation and understanding, at least with that population, and that population doesn't necessarily look very different than the population in the state hospital system, but that's one of the things that we've learned there.

And they're phenomenal, they have good relationships with the San Antonio Public Housing

Authority, with state agencies, with everyone, I can't say enough about what they're doing, but they do have some expertise now in relocation and what's needed.

MS. GRANBERRY: Ashley, I'm not sure that there would be any possible way for us to tour as a council, but anybody that can get to San Antonio, Haven for Hope has finally opened, I believe last week officially opened. They have between 60 and 70 agencies co-located in one place, substance abuse, mental health, veterans, dental, medical, everything you can imagine in one place, 900-bed shelter, there's emergency, there's transitional, and then San Antonio Metro Ministries owns a number of housing units that they use for permanent supportive housing throughout the community as well.

It's an amazing place, and what they've done in that community and how they brought everyone together, I mean, they ended up with city council on the board of this and city council directed funds toward them. It's truly an amazing collaboration, it's well worth the trip to San Antonio to see it if we could ever arrange that.

MS. SCHWEICKART: And how do they fund the Haven for Hope?

MS. GRANBERRY: There's many, many, many funding sources. Haven for Hope itself is the building

and the corporate owns the building. Well, then all of the agencies bring their operating budgets into it and they move their facilities into so that everything would be centrally located, and so it's just an amazing collaboration. And it has been at sheer will. I know a number of people that work at different agencies there and it's been pretty amazing getting that off the ground and taken a number of years, but it's open and operating now and truly amazing.

MS. BOSTON: Actually, TDHCA funds them with, I think, three sources at least.

MS. GRANBERRY: So there's just probably more funding sources than you can count between all the different agencies and everything and more projects, but it's a true testament of what a community can do if they pull together and make it easier for the clients to access services.

MS. MARGESON: Is the ADRC enfolded in that, or not?

MS. GRANBERRY: I don't know.

MR. GOLD: There is an ADRC in San Antonio.

MS. MARGESON: But it's not part of this?

MR. GOLD: Well, I think they probably are a part, I would think, or at least there's certainly a

liaison connection there.

MS. GRANBERRY: If we can't pull up a tour, I could probably get somebody to come do a presentation at a council meeting and I know they've got pictures and stuff.

MS. SCHWEICKART: Sure, that would be great. Thank you.

Any other comments or questions for Nnenna?

MS. LANGENDORF: When is our next meeting?

MS. SCHWEICKART: We're not there yet.

MS. LANGENDORF: I was going to say we could have it in San Antonio.

(General laughter.)

MS. MARGESON: Well, thank you so much for a very enlightening presentation.

MS. SCHWEICKART: Thank you.

MS. EZEKOYE: Thank you. And as I said, we still have our public forum in Austin on May 27, another one in Dallas, and if you guys happen to be at the Texas Council Conference June 18, that will be our final Continuity of Care meeting and you'll be able to see the recommendations, hopefully, in finalized form, and we'll have, also, public testimony if you want to get a better sense of how the public reactions to some of the recommendations are.

MS. MARGESON: Good, thank you.

MS. SCHWEICKART: Thank you.

MS. MARGESON: All right. That brings us to the report from the Policy & Barriers Committee. Mr. Schwartz.

MR. SCHWARTZ: Okay. Since our last meeting on March 2, the Policy & Barriers Committee has had, I believe, three conference calls and we are in the process of drafting different chapters of the biennial report. We've looked at a preface section and we looked at Chapter 3 which, Ashley help me, what does that deal with?

MS. SCHWEICKART: It's the Defining Service-Enriched Housing and supporting terminology.

MR. SCHWARTZ: And so we're looking at our terminology chapter, and then we're looking at Chapter 5 which is the barriers chapter, and so we're just knee-deep in the biennial plan with the chapters that we're responsible for

Additionally, the service-enriched housing definition that the council approved at the meeting on March 2 was posted in the Texas Register for 30 days, the comment period has concluded, we received no public comment, and so it is on TDHCA's Governing Board's agenda to be adopted on Wednesday.

So that's what Policy & Barriers has been up to.

MS. MARGESON: That was short and sweet.

Okay, Sherri

MS. GOTHART-BARRON: Unfortunately, I had to miss our last council committee meeting, so I'm going to defer to Ashley.

MS. SCHWEICKART: Sure. For the Cross-Agency Committee, they've also had, I think, three conference calls now -- or wait, has it been two? Two, you guys have a third one coming up.

So the first one was an extension form the April 6 in-person meeting where the discussion centered around Chapter 8 which is training and technical assistance to local entities, and we had a series of speakers come that were local providers, come to speak with the Cross-Agency Committee, and so the first conference call dealt with those recommendations for training and technical assistance to local entities. And the second conference call was for Chapter 5, identifying barriers, as well, since there are coordination barriers that are required of us statutorily to look at so that committee as looking at those coordination barriers.

And we have upcoming conference calls for both

committees. The Policy & Barriers has one this coming Thursday the 13th, and then Cross-Agency has one the following Thursday.

MS. MARGESON: At what time?

MS. SCHWEICKART: 10:30 a.m. And the agendas are always posted on the Texas Register and they're open to the public, the participant code and all-in number are always available on the agendas, so we welcome public input at the conference calls.

MS. MARGESON: Do you send reminders, because I don't remember seeing it.

MS. SCHWEICKART: I sent you something while you were on vacation.

MS. MARGESON: Okay. I'm curious, give me an idea of who these entities were that came and talked with the committee.

MS. SCHWEICKART: Do the members of the Cross-Agency Committee just want to mention April 6, who we had come? Well, we had Tom Wilkinson from Brazos Valley Council of Governments, we had Christy Feir who spoke about the aging and disability resource centers, Marc spoke about the area agencies on aging. Let's see, I'm trying to think. That's right, we had Sherry Hammock come speak about the community resource coordination groups,

and we had Jodie Park there for TACIL.

MR. GOLD: Who's that guy from College Station area?

MS. SCHWEICKART: That was Tom.

MR. GOLD: He as pretty incredible.

MS. MARGESON: All right, well, I guess that's the committee reports then. Now we're into discussion of the biennial plan.

(General talking and laughter.)

MS. SCHWEICKART: Well, I think that that was basically beyond what the committees have been doing, just to discuss that we are in the middle of crafting and composing the chapters of the plan, and so during the conference calls, one of the thing is once the staff creates a draft of the chapter that's been discussed, to present it to the committee, get feedback, create more drafts, and kind of continue this process until our July meeting.

And so as everyone has been e-mailed out, the working meeting for the council is Friday, July 9, and I will send out, once we get a location and time finalized, information about that. But that will the time that the committee can come together, see each other's work, and make recommendations/edits to chapters maybe that their

committee was not a part of but are obviously necessary to get the entire council's input. So that's kind of when we'll all come together once again to discuss a more fully realized version of this plan because right now, obviously, we're working from the outline and working on making those recommendations into draft chapters.

MS. LANGENDORF: I have a question which I think would go across the two committees. Since we have had the hearings and the drafts that I've seen that the Policy & Barriers Committee is looking at, which I think is a really effective tool to use some of the comments or use the comments that we heard from people to support our recommendations or to add to the recommendations, the discussions that we have, but my question is should we not, or don't we have to, or isn't it a good idea to attach those quotes to who made them? Because the review I have just have the quotes, the draft I have just has the quotes and I really think it's important that it be attached to, say, Jodie Park from the TACIL. I mean, I didn't know everybody's kind of feeling on that.

MS. SCHWEICKART: We talked about that.

MS. MARGESON: That was my question.

MS. SCHWEICKART: So Doni asked that question during the Cross-Agency Committee conference call last

week when they were reviewing one of their chapters, because I make all the chapters have the same format with the quotes toward the beginning of the recommendations, and I was waiting on speaking with our legal department to know the exact rules for using testimony and how you label it, how you title it, and I got a response last week saying that if it's on public record, then it's fine having the person's full name, title, organization, and o we can do that, and that is an option if everyone wants it. I didn't know the legal ramifications yet so I had to figure that out.

MS. LANGENDORF: That's kind of what I was reading: are we supposed to list people, can we list people, how would they feel about it. When you read some of them, I was going I don't know that I would have wanted my name attached to that.

MS. MARGESON: That was going to be my question.

MR. GOLD: But it is open record and it is public comment. The concern I have, and I wrote back and some of you may have seen it or not, was more of a concern that I felt the quotes were sort of picked out here and there and either we do a content analysis of all the quotes, of all the statements and just say these are the

categories versus some specific quote, or you type a quote under one of the content subject matters. My impression was it was sort of hit and miss and there was some selective choosing there.

MS. LANGENDORF: Well, and I think we should, though, actually, to bolster our recommendations to show that we received these recommendations from people who came to testify, because we spent a lot of time.

MR. GOLD: Right, but all I'm suggesting is that there be a real content analysis of everything that we heard, and you may want to quote under one of those sort of subject matters, but what we heard was all over the map, or else, again, it feels more biased to me.

MS. SCHWEICKART: We will have a chapter that is on public feedback. That was a chapter that was added to the biennial plan when the Coordinating Committee met, and I believe it was Jonas's recommendation that we have a chapter that's specifically on the public forums as a whole. So I think what you're saying, this content analysis that you're looking for would be in its own chapter and then those quotes that were taken out of the transcripts would be in each chapter where they pertain to that chapter's directive.

MS. MARGESON: What's your feeling about that

approach, Marc?

MR. GOLD: It still felt a little biased to me, that we were selectively choosing which quotes to be there. I mean, the report should speak for itself, that's just my impression.

MS. MARGESON: I could be wrong, but I went to all four forums and I don't remember necessarily any contradictory comments,

MS. VAN RYSWYK: Well, in Dallas there were several folks who talked about assisted living, and I know in the definition it says this excludes assisted living.

MS. MARGESON: That's true.

MR. GOLD: In fact, there were a lot of people across all the forums that addressed that, not to say there was contradictory but there was a larger range, a broader range of issues being presented.

MS. MARGESON: Any other feedback from council members about that issue? Is it better to have the quotes scattered throughout in chapter or just a chapter that basically summarizes the testimony that we received at all the forums.

MR. SCHWARTZ: I think that you need the quotes scattered throughout the chapters because it adds validity to the points that you're trying to make and the

recommendations that you're trying to make. My suggestion on having a chapter specifically about the public forums was so that we could put the testimony that people gave us in written form in that chapter in its entirety so that the reader could refer to that if they wanted and it would be fair then because everyone's comments would be recognized equally, and then use the quotes throughout the chapters.

MS. MARGESON: That's interesting, because in the issue of assisted living, we probably had more quotes pro assisted living than we had con, and yet our position is definitely con.

MS. LANGENDORF: And this is what I've struggled with, as many of you have heard, assisted living, I guess I need a definition of it, but I keep being told that some assisted living actually meets what we would think of, but other does not.

MR. GOLD: Right.

MS. MARGESON: Are they classified in some way so that we could make a distinction if we decided to consider that option?

MR. GOLD: Well, all assisted living, by definition, or services to individuals was the form where unrelated individuals who are needing assistance with

activities of daily living. With our CBA and Star Plus waiver contracts, which we see as community living for the specific purpose, may have certain definitions of what that assisted living must look like. It has to be in an apartment-like setting with a private bathroom and there's certain categories that would probably look very much like, I suppose, an SRO on some level. But yes, we can certainly have that information available to you.

And that was even the point of my overall comments as just that I think the totality of the comments need to be articulated someplace, and then if there's certain positions that this council has chosen to take and they want some comments to sort of bolster that direction, I suppose that's okay, but at the same time, to see where that is within the context of all the comments that were made because obviously this council in this report is going in a very specific direction versus everything that was said during the forums.

MS. VAN RYSWYK: I think the ideal is to have both.

MS. SCHWEICKART: That's the idea to have the chapter specifically on the public forum feedback is to hopefully be able to show the wide variety of comments that we received.

MR. GOODWIN: And there would be some validity in expanding on why we didn't take some of the suggestions.

MR. GOLD: Yes.

MR. SCHWARTZ: I mean, I think as a council, to be fair, we need to address the assisted living issue and why we took the position that we did.

MS. VAN RYSWYK: Yes, because I don't know that it would be fair to say that we took a con position with assisted living, I think the heart of the issue was in fleshing out integration, what does integration mean, and it looks like the council defined integrated as mixed housing, and under that definition assisted living didn't qualify. But I do like the content analysis to show that the folks that provided testimony that their comments were taken into consideration, and I think at that time we'd not yet kind of operationalized the definitions, including integration, and I think that's where the division lies.

MR. GOLD: And there may be other funding sources for that particular provider base. And again, that's where the other part of the committee that you are doing research on other funding sources which I know Ashley and I had a long, and to me, very informative conversation about that they're doing other work, because

my impression was the other part of this puzzle here is that they're looking for identifying other funding sources in the State of Texas that support housing. For example, the department probably has more money to it than HUD does in terms of housing, and maybe that's the place where assisted living then has more access to that sort of development. Again, I don't know, that's not my area of expertise.

But certainly we need to be able to address that and to say what the qualifying statements, what the trigger points were. And gain, that's why I brought it up and that was my discomfort when I first read it.

MS. MARGESON: Any other comments on that topic or on the status of the report?

(No response.)

MS. MARGESON: Okay, now we're doing next steps.

MS. SCHWEICKART: So next steps for the council are the conference calls that will continue and please let me know if you didn't receive the e-mail. I sent out an e-mail at the end of April with the March conference call meeting schedule for the committee.

MS. MARGESON: You mean May?

MS. SCHWEICKART: I'm sorry. May schedule.

And so please let me know if you didn't get that or if you need me to send it again. And everything is being posted on our website and we are recording each conference call so the audio transcripts are available on the council web page. If you happen to miss one, if you can't make it, those are available to catch up. So I believe that in terms of what we're doing, those are pretty much the main next steps. And as I said before, Friday, July 9 is the working meeting for the council that is going to be bringing together all of the recommendations that have been drafted with everyone to discuss.

MS. MARGESON: Sounds good. Can you just tell me the direct website address for the council?

MS. SCHWEICKART: Yes. I believe it's tdhca.state.tx.us/hhscc, and that should get you there.

MS. MARGESON: Okay, thank you.

MS. SCHWEICKART: And then it's under the committee meetings tab that all of the transcripts/agendas are present.

MS. MARGESON: Great. I didn't know I could just listen to them. I've been reading the print summaries that you send out, but it would be interesting to hear everyone's comments.

Is there any other business or issues that

you'd just like to discuss because we have time and you can?

(General laughter.)

MS. MARGESON: Well, then is there a motion to adjourn?

MR. GOLD: I move to adjourn.

MS. MARGESON: Second?

(Several members seconded.)

MS. MARGESON: All right, then, bye-bye. Thank you all for coming.

(Whereupon, at 11:33 a.m., the meeting was concluded.)

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