

TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS

HOUSING AND HEALTH SERVICES
COORDINATION COUNCIL MEETING

Stephen F. Austin State Office Building
Room 170
1700 N. Congress Avenue
Austin, Texas

February 8, 2010
10:00 a.m.

COUNCIL MEMBERS:

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DONI VAN RYSWYK
SHERRI GOTHART-BARRON
JONAS SCHWARTZ
MARC GOLD
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JIMMY CARMICHAEL
MIKE GOODWIN
AMY GRANBERRY
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PAIGE McGILLOWAY
NICK DAUSTER
JEAN LANGENDORF
MARK WYATT

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P R O C E E D I N G S

(Recording began at 10:37 a.m.)

MS. SCHWEIKART: So please let anyone know if they would like to attend the forum in Fort Worth or El Paso that are upcoming. There was a sheet out front when you came in that has all the information of those future public forums, so in case anyone would like to spread the word, that would be great.

And yes, as Mike said, we want to get as many stakeholders as possible to provide what they know on the ground in trying to increase efforts to provide service-enriched housing.

And we can leave this up, this is what Jonas and Mike both also just said which is the draft definition that the Policy and Barriers Committee came up with to define service-enriched housing, so we'll keep it up there. And I just wanted to quickly say if there's any additional information that you would need, we have a website; that website also has the draft definition on it, and any written comment that you would like to make or if you would like to pass to on to someone else to make written comments, you can fax it, e-mail it, and I can always give you my card afterwards. And we can leave up the definition.

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MR. GERBER: Thank you. Be sure and take a look online, there's a lot of resources available to you there, including all the materials that Ashley just used in her power point presentation.

And there are many of you here today and that's wonderful. We tried in the Houston forum to really keep it as informal as we could. We generally try to stick to a five-minute time limit but we know that there are going to be some areas that council members will have more interest in and they want to probe further, and some of you may have more information that you need to relay to us, and so we'll use five minute as a general gauge but know that my intent is to be flexible with that.

Let me also encourage you to come forward and we know that the council would certainly be very pleased to receive any written materials that you have or other information that you'd like for us to know about, either handing that to the staff or over the course of the next several weeks, we'll continue with our general information-gathering, please feel free to offer additional comments and weigh in with us. There are ways to do that, Ashley and the staff can relay those to you as well as information about that being available online. Also feel free to share any information with council

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members. We're all available to you and we welcome your input and thoughts.

I'd like to open the floor for, again, invited testimony first and we'll try to move through that in fairly quick order. I think there are witness affirmation forms that have been provided to folks, if you could go ahead and fill one of those out before you speak or right after you speak so we have one of these on file for you.

And I'd like to start by inviting Margaret Shaw -- Margaret is the director of Neighborhood Housing and Community Development for the City of Austin -- to speak. Welcome.

MS. SHAW: Thank you. Good morning. Again, I'm Margaret Shaw from the City of Austin, and I do have prepared testimony. I am not going to read it so I'm just going to kind of give you some highlights this morning, and first of all, thank you so much to the legislature for the vision behind this council because I can, after 15 years in the affordable housing and community development field acknowledge that there is a disconnect here, that it's needed both for housing -- as I'll say in my testimony -- from the Federal Government on down, governmental entities have been breaking apart, the capital expenses required for housing and services in

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another one. Which one of the fundamental challenges, therefore, is for our providers and partners to be able to go back and to go to all these different entities from foundations to the state to the cities to try and get monies that can both combine what's needed for in services.

I will say that one size of supportive housing does not fit all, so one of the things that I've learned over my 15 years in the industry is supportive housing means a lot of different things, or service-enriched housing, to many different folks, and part of that is because our clients need a variety of different tools, and so we need to make sure we in government are flexible so that our partners and providers can use our programs and tools in a way to serve on the front line what they need the most.

I would also like to recognize and commend the commission -- the council for looking at the needs of the elderly and disabled. I would also like to say, from my observations your recommendations possibly help all of the Texans who live in a vulnerable situation, and I the way I see it, a lot of that is determined by your income level.

In housing-speak we call it 30 percent and below, so in Austin that's a single person earning about \$15,000 and a

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family earning about \$22-, a family of four, \$22,000 or below.

A lot of the same challenges you'll see in the elderly community as well as the disabled community are factors of income, as well as we see in Austin, for instance, rising populations, families with children, as well as people reentering society from incarceration and the criminal justice program, as well as kids aging out of foster care which for me is one of the most challenging populations we see are kids, through no fault of their own, who are now 18, coming out of foster care and faced immediately with homelessness. So we'd like to put together and look to this council for some of the best practices you find that can be tailored for these other needs populations as well.

I'd also like to highlight, and I'm sure some of the program folks today will talk about today as well, these, cases are very, very complicated. For instance, especially with youth they're coming from anywhere up to 25 placements in foster care so they have trust issues, but it's also true of our elderly population too. It's not exactly coming to organizations with a sense of trust to help so we need to look at how we as entities and organizational entities can help rebuild that trust.

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I'll also go to what I see as probably the highest barrier that we're facing in providing more service-enriched housing is, of course, financial resources. I talked a little bit in my opening that some of the difficulty is needing all these different sources of funding together, but Diana McIver taught me probably ten years ago that these very low income units in properties, these 30 percent units, cannot support debt for the property. So the rents on these apartments can't even support the operation, maintenance and utilities of the apartments themselves, let alone the services that that the folks at that very low income level need.

So I think one of the challenges we have as providers, governmental entities who are major providers for housing is we have to look at being very flexible on how we define these needs for our developers. A colleague from San Francisco who was in a training program with me last year that basically where they allow the applicant to provide case management and operating services as part of their capital budget for 30 percent units -- which I found very fascinating.

Obviously they're not doing it with federal dollars because I don't know a federal program that allows you to do that. But what it does is acknowledge from a

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governmental perspective that to make those 30 percent units successful, you must have services tied to them and that was one of the critical elements to it. So that was one of the creative programs I've seen.

I also want to commend the State for the \$20 million that they've added to homelessness, I think that's a really terrific opportunity to coordinate some of the services that are needed.

In Austin we've actually done a really creative -- my colleagues at the Austin-Travis County Health and Human Services Department -- I work very closely with Mike here, David Lurie -- but most of our efforts are very ad hoc because, again, he gets service money from one side of the silo, I get housing money from another one. The federal stimulus dollars provided us with an equal opportunity to work together, and that was a great opportunity for us.

And with that, I'll end. I'll leave it to Jean Langendorf and some of the other commissioners to talk about some of the specific programs that we've used, but I'm happy to answer any questions that you might have, and again, thank you for allowing me to testify.

MR. GOLD: How much relationship do you have with Medicaid programs and accessing programs delivered

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through HHSC and the Department of Aging Services?

MS. SHAW: We would actually to do that indirectly, so it's really developers, non-profits and for-profits that are coming to us to get the capital funds to actually create their housing, and then they're going to attach Medicaid or educate their clients on making sure they're eligible for Medicaid. So I wouldn't say that we directly interact with them, the Health Department does. That's an example of that silo, but those are essential for the clients to have in order to afford the rents.

MR. GOLD: And do you use any sort of rental assistance, any those type of vouchers?

MS. SHAW: Yes, sir. In fact, we finance a rental assistance program. It's specifically for folks that are coming out of shelter, so what we're seeing now, especially in this economic decline in Austin, is we're seeing just a spike in people who are needing that temporary rental assistance or they need it for utility deposits or they may be behind in rent, we give them a couple months' rent to be able to tide them over. We see overwhelming demand for that so that's one of the things Austin did with their stimulus money -- which came through the Health Department -- is we tapped that for families with children as well as the folks re-entering from the

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criminal justice system

MR. GOLD: Just as an FYI for you, the state funds, through the Department of Aging and Disability Services, 120 waiver slots for children aging out of Department of Family Protective Service foster care program. So if you're not aware of that, there's some linkages, they're limited but they're fully accessible.

MS. SHAW: Great. Thank you so much.
Appreciate your questions.

MR. GERBER: Any other questions of Margaret?

MS. VAN RYSWYK: Yes, I have a question. You mentioned the \$20 million for homelessness, what's the funding source, are those ARRA funds, and if so, will those programs be discontinued once the ARRA funds are expended?

MR. GERBER: It was actually a one-time obligation under General Revenue that the legislature provided to the eight largest cities in the state. TDHCA is administering that but we allowed each community to establish its own benchmarks on what they would like to provide, level of service, or what they'll do with those funds. So for example, in San Antonio they're using their money for construction of an integrated homeless shelter called Haven for Hope. They're doing some more things in

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our most vulnerable residents are our elderly and those with disability who are sometimes living on \$100 a month, if not zero, so those are a real critical challenge and I really appreciate this council's efforts. Thank you.

MR. GERBER: Thanks for being with us. Any other questions for Margaret? Thank you.

Second on the list is going to be Donna Chatham with the Association of Rural Communities in Texas, and after that we'll have Jennifer McPhail.

MS. CHATHAM: Good morning. I'm going to be passing out some testimony, Mr. Chairman. I don't think I brought enough for everybody but I'll be more than happy to forward some more to the committee.

My name is Donna Chatham, I'm the executive director of the Association of Rural Communities in Texas.

Our association represents approximately over 1,192 cities and counties in the state of Texas that are defined as rural, and that's just real important.

I won't read you verbatim my report but let me share with you real quickly. As reported in "Texas in Focus, a Statewide View of Opportunities" by the State Comptroller's Office, Texas still has the nation's largest rural population with more than 3.6 million rural residents in 2000, increasing from 3.2 million in 1990.

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Approximately 80 percent of Texas' total land and area natural resources are in rural Texas. The average per capita income in 2000 for Texas was \$26,834 for the state and \$20,103 for rural communities. Additionally, the poverty rate for the state was 19 percent while rural communities was higher at 22 percent.

Texas rural communities make up about 15 percent of the population in Texas, and here's the key, over 723 making up 89 percent of rural Texas cities have a population of less than 10,000 -- in fact, their average population of 723 was 2,190. So that tells you right there the lack of capacity at that level for all 723 major important rural cities for the State of Texas.

Home ownership is a vital part, obviously, of any community as it is a rural community. Coupled with the demand is the fact that rural Texas communities have a bigger share of older citizens than their city counterparts. To look at this historically, in 1999, non-metro Texas accounted for a sixth of the state's population but was home to near one-quarter of Texas's population over 65. In that year, only 9 percent of the state's urban population was over 65, compared to 15 percent of the population in rural counties.

The concentration of elderly Texans is as great


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as 22 percent, even in the most rural counties in the state. By 2040, according to the Texas State Demographer, projects that Americans aged 65 or older throughout all of Texas will nearly double, so obviously we have some vast needs in Texas.

Our membership indicates that the number one challenge in rural Texas is single family rehab development with a need for senior enriched housing and perhaps cluster homes. The Texas Department of Housing and Community Affairs, in their 2006 community needs survey, showed that 49 percent of the responding communities had home repair assistance as their number one and 24 percent showed assistance to purchase a home as their greatest need.

Going on quickly to our recommendations, they are fivefold. Number one, regional capacity-building. We would encourage you to look at developing state initiatives to encourage regional capacity-building for senior housing with enriched services through community development centers, local housing finance agencies, public housing authorities, and other non-profit groups and private independent sectors to help coordinate the community development efforts.

State funds can encourage such developments


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through capacity-building available for those regions that choose to collaborate in the development of a regional effort. You can only imagine with 723 cities that have an average population of 2,190, they don't exactly have the capacity individually to do it, and that's why we're encouraging to look at regional capacity-building.

Number two is rural housing leadership development. Foster local and regional leaders in rural areas of the state throughout the development of regional such things we just got through talking about in order to encourage service-enriched elderly housing.

Number three, community capacity-building. Go down to that more local level, encourage the development of some cities. For instance, my board president lives in Hughes Springs, Hughes Springs is ready to take this on, they're a population of 1,982 but they have the capacity.

I must say that George Fite, my president, is a little unique rural leader. But that's good if there is capacity there to encourage them through perhaps some funds.

Number four, the development of local housing tools. Encourage local governments to provide infrastructure land banks, housing trust funds to develop senior enriched affordable housing through educational seminars, perhaps put on by TDHCA.

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MR. GERBER: Donna, say that one more time.

MS. CHATHAM: Okay. The development of local housing tools -- and that's number four, Mike, on page 3 of the recommendations that's been passed out -- encourage local governments to provide infrastructure land banks, housing trust funds to develop senior enriched affordable housing through educational seminars. In other words, we're very thankful at ARCIT, just within the last year we have now obtained the database for all e-mails of all 1,100 rural cities and counties. We ourselves are going to start putting on webinars and hopefully be able to partner with TDHCA, TDRA, TDA. In fact, I'm going to a seminar this afternoon at TDA to do that very thing, to start partnering more and more with state agencies to start empowering these local governments of what resources are out there.

And number five was additional capacity analysis added to the TDHCA strategic plan to maybe even start analyzing this more one on one, and I'm surely here to welcome any advice and counsel that you may have.

MR. HANOPHY: Can I ask a clarifying question?

MS. CHATHAM: Yes, sir.

MR. HANOPHY: You mentioned -- let me see if I understood this -- you said the number one issue

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identified in these rural communities was making some rehabilitation to existing structures.

MS. CHATHAM: Yes, sir.

MR. HANOPHY: So these are folks that are living there that can't afford that.

MS. CHATHAM: Yes, sir.

MR. HANOPHY: And where did support services fall in that?

MS. CHATHAM: It's within, and then in addition to elderly housing, but also the enriched services would go off that. As it shows in many statistics, now we've got more elderly but elderly is starting to leave rural Texas because there's not any type of service-enriched housing.

MR. HANOPHY: Is there a correlation between the elderly population and the need for rehab, or is it economics and rehab, or both?

MS. CHATHAM: I think it's both.

MR. HANOPHY: Younger folks can't afford to rehab their property as well as older folks?

MS. CHATHAM: But it's predominantly elder.

MR. HANOPHY: Predominantly older folks.

MS. CHATHAM: Yes, sir.

MR. GOLD: I need a clarification. When you

MR. GOODWIN: Have you all developed any models or demographics that could serve as models, because with the numbers you're dealing with, the economics of it become pretty vast when you're trying to provide either housing or services. I'm just wondering if you have developed any models as to you might regional site regional centers, whether they be, I'll say, physical buildings/houses or services.

MS. CHATHAM: You know, we sure could get that to you, Mr. Goodwin, based on the demographics. I guess you could base it on number one demographic need, what particular regions had more elderly that were maybe in low to moderate income, number one. And then too it also needs to somewhat deal with the capacity that's out there, and I hate to tell you that but there's not much capacity in local housing for rural and that's why we're here. but we'd be more than happy to provide the council with some of those demographics.

MS. GOTHART-BARRON: Also, are you seeing where this is more prevalent in any particular area of the state, or is it pretty much even, like West Texas versus East Texas?

MS. CHATHAM: That's a good question too, I'll be more than happy to provide it. My gut is -- because I

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just remember looking at the overall analysis for the state -- but my gut is it's pretty well on the elderly it doesn't necessarily concentrate in East Texas more than West Texas, but I'll be more than happy to provide the council with that demographic, a breakdown by region.

MS. LANGENDORF: Donna, thank you for coming and talking about it. I think one of the issues that continuously comes up far and above, people who are elderly want to stay in their home or stay close to their home, they really don't want to make a move but sometimes they have to because there aren't any services. I really take the point of capacity-building very much to heart, and I know just from our experience with our agency, we would have never done it had we not had capacity-building funds to hire an expert who could then teach us how to do it. So I think if nothing else, your recommendation on emphasizing the need for capacity in the rural area to allow people who are elderly to remain in their community, be it capacity to have the local services to come to the home or to come to a group area.

We heard testimony in Houston about senior day care centers or day centers that we see a lot in South Texas but we don't see that much around in other parts, particularly rural. So I think one way of looking at

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those models, maybe how they could flourish in other parts of the state. And again, that's a service area from DADS and others to allow people to remain in their homes is really oftentimes very important, and safely in their homes, for elderly who need modifications and then people who have disabilities, they want to remain in the house that they've chosen, so if there's a way to work to create that effort or to enrich the housing they're already in.

MR. GERBER: I would just add I'm struck by the webinar that you're going to hold today and I think there's a lot of opportunities for us and the council to really try to tap into some of the technologies to reach out particularly to rural Texas. I'd also be interested to hear how that works for you all today and what thoughts you have and to build any recommendation to the council.

I'm also intrigued by the idea of strengthening the partnership of the local HFAs and the public housing authorities. There are many, many local HFAs, there are, I believe, well over 250-300 PHAs in the State of Texas alone, and each one has a varying degree of capacity but each one, as they are probably much more familiar with local needs, trying to adapt our programs to help build up their capacity so they can conveniently provide assistance and help in furthering the objectives of the council and

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What we've seen for our members and for the people that we've interacted with is that people are not suffering because there is a lack of services attached to their housing but there is a lack of affordable, accessible housing. There needs to be more enforcement on accessibility requirements. I know here in town the Tenants Council has a tenants' rights testing program, and two-thirds of the complaints that they received for tenants's rights violations are disability related, and oftentimes it has to do with lack of accessibility.

If you can't access the bathroom, it doesn't matter how many Walter Moreaus you have in your life or Margaret Shaws, your quality of life is going to suffer immensely. So it's not a lack of professionals that make people suffer necessarily, it's a lack of accessibility and affordability in the community so that you have choice.

We've been on record numerous times saying that if people want services, that's great, they should be provided to them, but there should be a certain amount of flexibility for autonomy. I'm not low income because I lack professional supervision, I'm low income because if I make a lot more money then it affects my eligibility for attendant services and things like that -- let's be


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realistic. If I can't get out of bed, my quality of life suffers as well, and no one will benefit from my being isolated.

So I think that we need to take those things into consideration and having enriched services should be offered as something that they can choose but not necessarily something that they're required to take. Oftentimes when people are in those situations, they're told and they're encouraged quite a bit to take those services whether they want them or not, and that's really not fair to the individual. We value our autonomy just as much as any of the rest of you, and that should be noted and respected.

MR. GERBER: Thank you, Jennifer.

David.

MR. HANOPHY: Ma'am, can I ask a couple of questions or maybe followup?

MS. McPHAIL: Sure, absolutely.

MR. HANOPHY: Can you paraphrase to make sure I got the gist of what you were saying first?

MS. McPHAIL: Yes.

MR. HANOPHY: So oftentimes, if you're a person that requires or needs a little bit of extra service, in order to get affordable housing, you've got to buy the

whole package whether you want it or not.

MS. McPHAIL: Right.

MR. HANOPHY: And what you're saying is give us the opportunity to negotiate for what we want, don't tell us that in order to get this housing, you have to take the whole package; there may be some things we need, some things we don't.

MS. McPHAIL: Right. Another way of looking at it is that I don't need anyone to tell me how to balance my checkbook, I need attendant services and affordable housing that's accessible to me.

MR. HANOPHY: The other question, just in terms of defining accessible and affordable and integrated, it seems that sometimes the three terms become exclusive, that in order to get the accessible housing, integrated sometimes goes away.

MS. McPHAIL: Absolutely. And that's the trend, the new trend is to segregate us even more, and our philosophy is that that is sort of an institution under a different name, and institution by any name is oppressive.

MR. HANOPHY: In the name of sort of the economy of scale somehow it's more cost-effective to do that, but in terms of the impact on your life, that's the opposite effect.

every month and report on what was going on in my life, so it was a mandate. And then after a year I found out well, not really, it wasn't really mandated, it was strongly encouraged. Well, I think that that's start of a slippery slope, what happens is they provide the caseworkers and the job opportunities for people to provide the services and supports, but really it's about the jobs, it's not about providing the appropriate services.

So the definition that you provided doesn't really serve strongly enough to de-link the requirements of housing and provision of services. As Mr. Hanophy was suggesting, it's not really a one-size-fits-all type of opportunity for people, people just need housing, and if they need services, generally the services that are available that would be linked to are going to be in the community anyway, and it's just a matter of finding the proper resources and referrals and jumping through all the hoops and doing all the forms and doing all the paperwork, and some caseworkers can help do that and some caseworkers cannot.

I know my time is up or almost up, but I just want to say real quickly that Jennifer may have misspoken a little bit when she said housing-enriched services, but it got me to thinking that maybe that's really what we're


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talking about. I mean, how would you deal with services required housing in order to breed access to services. It would be ludicrous, no one would ever go find a house based on the services they need, they're going to find the house that they need. Thank you.

MR. GOLD: I have a question, if you don't mind sharing

MR. WITTIE: Yes.

MR. GOLD: Are you receiving any sort of services from the state at this point in time?

MR. WITTIE: I have a voucher-based Section 8 assistance.

MR. GOLD: But that's all, you're not receiving any sort of attendant type services?

MR. WITTIE: I do receive attendant services, and they travel with me wherever I go. But previously I was living in an SRO that provided services that were not the same. And actually, the services that were -- the way the apartment was set up was actually interfering with my attendant services, it's difficult to get those attendants who were willing to go through the process, just entering the building was difficult.

MS. MARGESON: David, I have a question.
Appreciate your comments about the services being

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voluntary, so I was wondering if we inserted the word "voluntary" in that definition before the opportunities to link with voluntary services, would that improve the definition in your mind?

MR. WITTIE: So you're saying integrated, affordable and accessible housing and also voluntarily offered the opportunity?

MS. MARGESON: Offer opportunities to link --

MR. WITTIE: To voluntarily link residents?

MS. MARGESON: Right.

MR. WITTIE: That would be a little more, yes, in the direction that we're thinking of.

MR. HANOPHY: I realize we're not supposed to be word-smithing this right now but I'm curious as to your opinion. I mean, is it voluntary or something that's appropriate to your desire? I've heard from both of you that you're talking about that there's either the overt or covert pressure that if you want the housing, you've got to play ball. And so you volunteered to go see the caseworker, the question is was it really what you wanted, what you thought you needed.

MR. WITTIE: It was not appropriate.

MS. MARGESON: My concern there, Jim, would be that you can't customize services, it just wouldn't be

cost-effective, but if you truly make those services voluntary, then the person would have the right to refuse.

MR. HANOPHY: Yes. I think there's something in between mandating a whole package and customizing, there's some menu options in there that I think sometimes get lost

MR. GERBER: Thank you, David, appreciate it.

Next up is Diana McIver. Is Diana here? We'll go on and ask Walter Moreau, the executive director of Foundation communities to come up.

Many of you who were in Houston had a chance to hear from Joy Horak-Brown with New Hope Housing. Walter and Foundation Communities came up as well. They're two organizations, among several, that TDHCA is very pleased to be in partnership with to provide SROs, mainly through the use of federal tax credits, and really they really put a very fine product on the ground. Walter.

MR. MOREAU: I'm Walter Moreau, the director of Foundation Communities. We're Austin-based, we've been around about 20 years, non-profit. Our mission is to create high quality affordable housing that are successful, and with that as a mission, we really believe strongly in putting together housing and service opportunities.

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So I'd like to talk a little bit about our models and what we has worked. I will echo what Margaret Shaw said, there are many different models, the need for supportive housing is great. What I love about the job I do is that it works. If we can create affordable, high quality housing and services, especially for folks that have been homeless, and provide some supportive services, we can reduce the number of homeless folks in our community.

A couple of stories that I wanted to share, success stories. The woman in the left picture, her name is Ann. She was a nurse here in Austin for about 30 years, nursing was her career, it was how she gave back to the community. In 2005 she had a heart attack and the doctor told her you cannot continue to work. She was never married, didn't have kids, was paycheck to paycheck, and over the course of time, lost the housing that she was living in, lost her car, was on our waiting list, and eventually we were able to get her into housing. Didn't need a lot of support, did some help with getting her Social Security disability income started and now has that, and can't afford the housing that she had before but now has her own apartment and has really been a success.

The other gentleman on the right -- changed the


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names a little bit -- Gene was somebody who became homeless after a series of tragedies: had a son who died, went through a bitter divorce, his wife ultimately committed suicide, he was in a bad motorcycle accident, bad damage to his leg, after all of that became alcoholic and wound up on the street.

Went to the Salvation Army in South Austin, 90-day rehab program, found God, turned his life around, and needed then, after he graduated from that program, a place to call home, and moved into Garden Terrace. He was an electrician before this whole series of events. During the two years that he lived with us, was able to get his electrical license back again, went to work at the Dell Children's Hospital when they were building that at Mueller, and ultimately made too much money to continue to live at Garden Terrace and moved out. So that was a great success story.

Both Ann and Gene lived in three communities that we own here in Austin called -- we call it supportive housing, they're all called Terraces, Garden Terrace, Spring Terrace and Skyline Terrace, 345 apartments, and I could give you lots of statistics. They, on average, cost about \$61,000 a unit to build, they don't support debt; the monthly operating cost runs about \$440 a month, that's


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all bills paid and with desk clerks, and there's a monthly service cost of about \$155 a month per unit. It's gone up a lot because we've been able to add some federal funding for mental health services and substance abuse counseling. So that's one model of supportive housing that we have for individuals, many of whom have been homeless and are extremely low income.

The other piece of what we do is for families and kids and this is really where we have the highest waiting list. We get typically three to four phone calls a day from families in crisis situations; the waiting list is at least three months long. Kelly was a single mom, annual income when she moved in was about \$9,000 because it was part-time work. This is an 18-month program. Services in this program are required so you meet weekly with a case manager to work on education, employment, childcare and set different goals.

This past year we serviced 170 children who typically have been to at least two schools in the prior school year, so now they're able to go to one school for 18 months. At the end of 18 months, in 2009 we had a 85 percent success rate that folks graduated and were able to stay in their apartment, their rent then went up to the normal affordable rent, or they had other alternatives for


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housing. We have 39 new apartments in the works for this program because organizationally this is something we're trying to grow.

I think the challenges that we've got to grow more supportive housing, largely are funding, both the development costs, the rental and operating costs, and the social service costs, and as Margaret pointed out trying to put all those together in the same time and place, it's sort of like if you're going to build 100 unit affordable housing community, throwing a party for 100 folks, inviting them to your house, you want fresh ingredients for your meal and you have to go to 15 different stores that are only open one day a month to get your ingredients.

I really do want to emphasize again that there are a lot of different models. We need in Austin models around reentry for folks that are coming out of prison. There are housing first models that take folks no matter what condition and shape and situation they're and set them up in an apartment and wrap around services. There are some models that are completely a dry house where there's no alcohol allowed, and in Seattle there's a model that's a wet house where there's no restrictions whatsoever, so if you've been alcoholic or have an


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addiction issues, you've been on the street, you can move on in and there's services completely voluntary but otherwise you're free to do what you want.

I will spend some more time thinking about recommendations and provide some written comments to Ashley. I think there are some opportunities potentially this legislative session with the way tax credits are allocated and the way HOME funds are allocated that might loosen up some of those funds for more supportive housing.

Right now there are so many set-asides and there are so many regional/urban/rural pots. HOME money is 95 percent for rural areas which makes it very hard to tap that source of funds.

The \$20 million in new state funding for homeless housing services is huge and a real great commitment from the state, so I hope that there's funding in the budget and that can continue. We're tapping that fund to pen up ten more apartments for families in the Children's Home Initiative starting this month. The Texas State Affordable Housing Corporation, their foundation has put some funding out there for support services in a housing setting.

I want to quickly just end with a story. A few years ago I had a fellowship, a short sabbatical to go to


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London and look at their supportive housing programs, and I met some colleagues and was explaining to them in Austin that on our homeless count -- which we just had this week -- we had about 4,000 folks that are homeless, and their eyes got big. Did you say 4,000 people in Austin? They had just done their homeless count in London, 12 million people, 12 burroughs, they had counted a grand total of 472 rough-sleepers -- that's their term for folks that are homeless -- 472, my eyes got big.

I spent the next weeks really trying to unpack that and understand it and there's many different reasons: they have national healthcare, a substantially lower incarceration rate, much more robust mental health and substance abuse services. But I think the fundamental thing that's happening there is it is offensive to the British sensibilities to see folks on the street, that's just not acceptable, and that's the politician's fault if that's the case.

I think culturally in America and in Texas, we see folks that are homeless and wonder what they're doing to not doing that put them there, what choices did they make. We expect a rugged individual to kind of pull themselves up. And I have folks in twelve step programs that say that is the right answer, that until that person


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required, like recovery programs, like the Oxford Houses, and they're strict, so if you're back on the wagon or back off the wagon, that's a condition of your housing.

We need substantially more variety and types of supportive housing models in Austin and around the state, of all different kinds. There's not one solution that works really well for folks in different circumstances.

MS. MARGESON: Based on your experience, what would you say the percentage of the homeless population is people with all types of disabilities, mental, physical, whatever?

MR. MOREAU: The majority. The majority of the residents who live in our Terraces do have physical and/or mental health disabilities. Precise numbers can be debated for a long, long time, but a lot of folks that are homeless have some challenges.

MS. MARGESON: And the people in the family housing have the opportunity to pay full market rent so they don't have to relocate if they don't want to after they become successful?

MR. MOREAU: Exactly, and we really like this model because Sierra Ridge Apartments is 148 units, at any given time, 15 of those apartments are in this program, but when folks finish the program, they don't have to

move, they can stay in their exact same apartment, pay the regular rent which is an affordable rent, kids go to the same school. There are other transitional housing programs for families where it's like St. Louise House that's 24 apartments and it's 18 months and you live there and then you move when you're done, and the services are a little more involved and engaging the folks.

MR. GOLD: This is a related question. What is your needs test for financial?

MR. MOREAU: The supportive housing apartments and units that we own, for the most part it's 30 percent of median income, so that's the number we use in the housing world. For a single, that would be \$15,000 a year, but the average income of the Terraces is about \$9,000 a year.

MR. GOLD: And they're required to pay a sort of co-pay, is that a sliding scale, or is there a floor associated with that?

MR. MOREAU: The 345 apartments, about half of them we have rental subsidies from six different programs, each one works a little different, but many of them the resident pays at least \$50 or a third of whatever their income is. The other half of the apartments are private pay and average rents are around \$370 a month, all bills

people that specifically need that more accessible unit that are waiting for it?

MR. MOREAU: I'm not aware that we've ever had that situation come up, and I think we have some obligations under Fair Housing to adapt the unit to make it work.

MR. SCHWARTZ: And my other question was for those units in the program where people can choose to stay once they've finished and pay the full market rent, what are your statistics, how many people do choose to stay?

MR. MOREAU: Eight-five percent are graduating successfully. I'd say 75 to 80 percent stay, some move to another apartment, in some cases folks may need to get on the waiting list for a Section 8 voucher if they need additional assistance and they move with that voucher

MR. SCHWARTZ: Thank you.

MR. MOREAU: If there are more questions later, I'm happy to share more details about what we do and how we do it and the services and the cost. We're one model, so I'm happy to share that information.

MR. GERBER: I'll ask Pat Pound to come forward and after that it will be Frank Fernandez. Pat is the former executive director of Governor Perry's Committee for People with Disabilities.

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MS. POUND: Good morning. It's good to be here with you today, and my dog is glad to get to stand up. I think that's what she meant there.

(General laughter.)

MS. POUND: Today I'm testifying before you representing the National Council on Disability. I'm the vice chair of that council and we've existed since the '80s, we're an independent federal agency composed of 15 members, and we do disability-related research to promote equal opportunities for people with disabilities. I live here in Austin, and as Mike indicated, previously worked as the director for the Governor's Committee on People with Disabilities.

I've been on the council since 2002, and I particularly wanted to come and testify because we have just released two reports that I think may be really important to your work. Our reports look at a particular problem, and we've only done housing one other time in our entire history, and then we make recommendations for the federal level in particular, sometimes also at the state and local level. Particularly we did that in the area of emergency services since that's really built from the bottom up.

But the two reports that I'm going to talk to

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you about today, the first is the "State of Housing in America in the 21st Century, a Disability Perspective." We've released both of these reports last month so they're very new. This report is very extensive. We had three objectives: we evaluated the laws and policies that were affecting housing and support services for people with disabilities; we analyzed what housing and support services actually exist; and we developed recommendations to promote the improvement of housing and support services in America.

What I would say, working at the state level, as you are, I frequently used NCD information for inspiration or language or data to support recommendations I'm going to make at the state level, so you may find, as you read these reports, that there are things that spark interest and ways that you want to use the information as you continue in your own work.

This particular report is very extensive, it's 500 pages. On the net, though, it's extremely well indexed and so you can go quickly from one area to another. I will tell you that Texas is mentioned several times because many of you have done a lot of good work and we wanted to see that recognized.

I would also call your attention


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particularly -- and by the way, I've sent an e-mail of this presentation to your staff so that you'll have these links to these reports. There's a topical brief number 5, State Evaluation, and we looked at various different states who do these services in various different ways and described them all to you. We, in that area, discussed housing coordination with services, particularly related to qualified allocation points to increase access and integration, and also, I was excited to hear you talk about no room to work as that's one of the areas that we specifically mentioned.

We made several recommendations in the state section that related to coordination of housing and support services. I would read them off to you but what I would really say to you is there are various derivations of ways that we could figure out that we might be able to get HUD and CMS to work together to create a funding stream that might be better for you and Texas and local communities as you do your work and as you try to create better housing opportunities.

So I would just suggest that you look at those particularly and there might be things that you want to look at. We have a really great rollout anticipated for this report later. Later this month we're holding both a


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private work session with advocates and a public yet-again announcement session at which we will have an assistant secretary for HUD, an Illinois congresswoman who is sponsoring some housing legislation speak. We also anticipate doing an event in D.C., we're approaching the American Planning Association and the National Council of State Legislators. So it's basically we're trying to figure out ways to get interest in the recommendations in our report.

Now, the second report I wanted to talk about you may find a little bit strange but I have a real reason for why I want to tell you about it. It's called -- I'll be quick -- "Workforce Infrastructure in Support of People with Disabilities, Matching Human Resources to Service Needs." You've heard that our population is growing older, that means we're also going to have a great deal more people with disabilities. We know now there are many professions lacking the human resources to provide adequate services. This is only going to get worse because at the same time as our population gets older, many of us baby boomers like me are retiring and therefore, there will be many fewer people to provide services.

So I guess I would encourage you in your work


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to include the workforce issues as part of what you're talking about simply because if we don't have workers, there won't be services to coordinate.

So I'll wrap up and be happy to answer any questions. Our website is www.ncd.gov, and again, my testimony sent to staff link to both reports.

MR. GOLD: Pat, this is Marc Gold from DADS and it's so good to hear your voice again. We miss you on the Governor's Committee.

I just want to emphasize, certainly through the [indiscernible], which is a large federal initiative looking at the relocation of individuals from institutional settings to community-based programming, there's a big effort to be working between CMS, Centers for Medicare and Medicaid Services, and I'm familiar with that, and so far we've heard a lot of promises and we've heard some conversations so we certainly hope that you'll continue to push that conversation. I think we're at a point where CMS and HUD are at least talking, maybe for the first time, together, and that's very, very exciting.

The other part, though, I'm really glad you brought up the workforce issue. Without workforce, there are no community-based programming, whether it's enriched housing -- however that ends up being defined -- and I

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just wanted for all my colleagues to notice that Executive Commissioner Tom Suehs with the Health and Human Services Commission has put together, not quite at the level of this council but a similar sort of council looking at workforce issues, he's charged DADS to do that, so it's a way we can share information with what the Workforce Commission is doing also, because again, we can talk about housing all day long, we can talk about services all day long, if there's one to deliver them, then the whole system comes apart.

So thank you very much.

MS. POUND: And Marc, I might also mention in that workforce report, I've never seen one done specifically on disability issues that goes across professions, this one does, and it also identifies crossover tasks or talents so that you could see how someone not be able to move from area to area within disability professions. Also, Manpower did that report for us and we're really excited that they did because they tend to incorporate research they do into their own work.

MR. GOLD: And it's so hard because it really does charge what this council is supposed to do. If you're talking about a change of workforce, then there's different types of service-enriched housing -- again,

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however that definition comes about -- whether you have some more congregate housing versus just single apartment housing, that really depends on where you're going to have the staff -- again, mainly looking at efficiency in scales. So they're very much timely.

MS. POUND: One other thing that I wanted to mention, NCD has a vast background in working in terms of emergencies and people with disabilities, and one of the chapters in the housing report deals specifically with that issue. But as you do your work, whatever interface you can do and recommendations you can make as to how it fits into emergency planning would be of great impact to people with disabilities.

Any other questions?

MR. DAUSTER: Could you elaborate a little bit more on that last point, emergency planning?

MS. POUND: Yes. People with disabilities attempting to recover from disasters find even greater difficulties in finding affordable, accessible housing. We know it's hard already. Oftentimes when people can find it, if they can, it's very much way away, it may be 60-70-80 miles from where they work or where they need their services. So there's some work going on federally, the Access Board is doing work on accessible trailers and

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as well as homeless families, and also I have now taken on working with TDHCA on some of their voucher programs around persons with disabilities and veterans. So that's one hat.

I think the primary hat for me testifying would be I also serve as the current chair of the Texas Supportive Housing Coalition which is a coalition of housing and source providers that are focused on supportive housing and working with different homeless populations. Our membership is pretty broad, we have folks in Houston, New Hope Housing -- you may be familiar with -- SEARCH, as well as in Fort Worth and Dallas, Life Net, Samaritan Housing, Foundation Communities, ourselves here locally. So it's a pretty broad group.

What I wanted to focus on was just a few recommendations, I think, as you guys get started. The first thing I'll say it's very heartening to see this council come together because I think it's a good recognition of the important linkage of housing and services which has been absent, I think, for a lot of folks in the community and seeing this has, I think, helped strengthen that.

So the three things I would recommend or have you guys consider, one is look at the things that you all

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and the legislature have already done in the last session or two which I think have been good. And the things Walter referred to, the HHSP funds, that \$20 million for the biennium which is now being disbursed in the community and is going to be hitting the street here in Austin, it has already in other cities, and I think looking at that closely and making sure we can build on that support. Some of the things that have been done around changing some of the tax credit stuff which have made it more conducive for supportive housing.

Just to give you a sense, we didn't apply this round for credits but we did the prior, and when we applied I think there were 250-odd applications of which only four or five were supportive housing projects, and the need is vastly larger than that. So some of the changes that were made were really beneficial.

The last one is the pilot project that's going on right now with TDCJ around reentry -- which folks may or may not be familiar with -- which they're doing with existing funds and trying to partner with supportive housing providers throughout the state to work with folks who are exiting the prison system as opposed to going to halfway housing but going to supportive housing so that they can stay housed and stable for a longer duration and

not go back.

So that would be the first recommendation, looking at these things and really trying to see what we can do as we go forward, especially around funds to support that.

A second one would be -- there are a lot of different groups here you're discussing and focusing on, whether it's folks who are struggling with homelessness, the disability community, mental health, seniors, and the thing that always strikes me is when you're looking at policies and when you're looking at different things is oftentimes they're often the same person. At least for our residents, they'll be a veteran who is older, who has mental health issues, who is also homeless. And so I think that is something you'll see a lot with folks who struggle with challenges, they're going to have multiple categories and we need to be flexible in our policies and what we develop for them to account for that.

And the last thing I would urge you to consider, really try to push for is to do a demonstration or help fund a demonstration project around supportive housing because I think we have a lot of good national data, but often locally and at the state level, folks say well, that's in California or Chicago or somewhere else,


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or Seattle. They want to see local data here in Texas, and I think you have enough folks who are doing good supportive housing and are willing to do a pilot project or a pilot study so that you can demonstrate here in our cities how this benefits the individual, the community, as well as the broader whole.

With that, I'll open it up for any questions you all may have.

MR. SCHWARTZ: Mr. Fernandez, thank you for coming.

Since you are extremely familiar with supportive housing, as you look at our draft definition for service-enriched housing, do you have anything you need to consider as we move forward in drafting this definition?

MR. FERNANDEZ: From my perspective, I think you're capturing a lot of the richness of what is there. As several people have said, there are a lot of different models. This is something we, as a coalition, struggled with when we were coming together a couple of years ago: What is supportive housing? It's the same kind of basic thing, and for some folks it's a very strict definition, for others it's a little broader. And I think what you have there is something that allows folks to have

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different models. What I always tell folks, for example -- the way to answer your question, we have some scattered site housing as well as more concentrated housing where you have apartments all together, and for some people, scattered site housing really works well in terms of they're a little more independent, they don't have as many challenges struggling with their mental health or substance abuse and that works. Whereas, for others they need a more supervised environment, at least initially, to help them get past that period to where they're more stable on their own.

So I think having that flexibility is important because not everyone -- it doesn't work for everybody. Like these people that talk about housing first or what housing versus the traditional kind of carrot-and-stick approach in terms of dry housing. And I'd say dry housing works for most people, but there is a certain segment of the homeless population who they've tried that and it's failed numerous times and they've been on the streets for decades, and that's just the reality -- whether it's morally whatever you may think, that's just the reality of that individual's situation, and do you want to create a situation reduces harm to them as well as reduces costs for society, or do you want to just leave them out in the

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streets.

So to me, it's having that flexibility to tailor to the needs of the individuals that you're trying to serve.

MR. GERBER: This is that Seattle model?

MR. FERNANDEZ: Seattle is one example but there are other models of that, and even within the Seattle model it's not completely slated where they can do what they want. I actually visited there a couple of years ago. Say they're in an apartment, if they're going to drink, they can do so in their rooms but they can't do so in the common areas, they can't loiter out front. So you try to find a balance.

I remember that particular model, it's 75 units and what they did, they went to their version of Brack, the local indigent care hospital and said, Can you give us a list of the hundred top who use your system in ER, and they had to get to 78 before they filled it, so basically only three people turned them down because they didn't have restrictions. And they have done some studies and looked at how much they've been able to reduce ER visits, how much they've been able to reduce folks being locked up for PI, those types of things which really benefit, again, the individual but also the broader society because we're

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MR. FERNANDEZ: Yes. We've had this discussion with the disability work group several times.

From my perspective, our developments, our residents there is a mix, but I don't want to impose on other folks, okay, you have to have particularly this rule because to me integration needs to be thought of a little more broadly in terms of if we do -- for example, we're looking at a property right now for our next development that's a little bit west Austin in a good neighborhood, X number of units, and we'll probably do a mix of some supportive housing with some affordable housing.

Now, say it's 50 units, say we want to do about 25 supportive housing, 25 affordable housing, now, technically if we were to go after state funding, that potentially could run afoul of the integration, but from my perspective, you are integrating within a kind of middle class neighborhood with a bus stop right there -- that's pretty key for any development -- having a bus stop there, having a Randall's not too far down the street, you're embedded in the community.

And I don't have what the right answer is because it's a very tough issue, but I think when we look at it, we need to really be open to kind of thinking about integration, not just about that particular development,


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are going to start to present time crunches this afternoon, so if that would be acceptable, I would like the public as well to bring lunches in here, feel free to join us. But if that's acceptable to everyone, so we'll go with that and why don't we plan to reconvene, try to get back as close to 12:20 as we can. Thank you.

(Whereupon, a brief recess was taken.)

first one is the county designations. The counties in yellow are metropolitan, the counties in green are not metropolitan. Out of 254 counties, 177 of them are considered rural for our purposes. I'm just going to pass these out.

So our services are based on the metropolitan area. Also, we provide services based on whether an area is a medically underserved area in the state, and we have -- well, the state is in red and that means that there are that many medically underserved areas, so that's another map I'm going to pass around.

And then finally, health professional shortage areas, and health professional shortage areas are similar to medically underserved areas but they're based on different ratios and different compositions. Health professional shortage areas are updated every three years by the Primary Care Office which is housed at the Department of State Health Services.

These maps are also used for the purposes of determining Medicaid services. We do not provide direct services to our constituents, but our hospitals and the funding we give out for recruitment retention to primary care providers, they have to accept Medicaid, so that kind of is our tie.


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As far as there was a question about physicians in rural areas. We have, at any given time, 20 to 25 counties in the state with no primary care physicians, none. Primary care is defined as family practice, OB/GYN, pediatrics -- and gosh, I've forgotten the other one, it's very basic, though.

If you look on our website, we have a whole lot of other maps and we have similar maps for the number of physician assistants in each county and nurse practitioners in each county and dentists in each county and medical health professionals in each county.

Rural, of course, is hurting at a greater percentage than the rest of the state which is urban. The problems with rural areas are, number one, they just don't have the services. If they have the services, then they may have transportation problems, they may have the ability to pay problems, they may have -- with mental health there may be a stigma because they have mental health problems in a very small area and they don't want people to know about it. So there are several things that go on in rural areas that make it hard for them to be able to access services.

We also provide funding to the state's 77 critical access hospitals -- we have 77 of them in the


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state, they're spread out pretty much all over the place, all in rural areas -- and we provide funding to them so that they can, in turn, provide better services to their areas. Several counties that would have no services have to go either to the next county or the county after that for their services. I've heard several times, anecdotally, you want to be careful in a certain county when you're driving through, you don't want to get in an accident because there are no services in that area.

A lot of funding is coming through from the federal government to federally qualified health centers, and while that is a much needed program, it falls more into urban areas than into rural areas. The safety nets in Texas are the critical access hospitals and the rural health clinics and they just are not seeing an increase in funding that's comparable to what they need to get.

And I know that's my time. I'll be happy to answer any questions.

MR. HANOPHY: Can you tell me what is a critical access hospital?

MS. CRUZ: A critical access hospital is a hospital that has 25 beds or less, they have to be at least 35 miles from the next healthcare provider. So a couple of years ago we were able to waive the 35-mile rule


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so we tried to get all our smaller hospitals to convert; we got 77 of them to convert; we still have some that wish they had. When they are a critical access hospital, they are able to receive a higher percentage of cost for Medicaid for their services, so it does make a big difference to them, to their bottom line.

MR. GERBER: Theresa, can you talk a little bit about the funding for your program, just to get a sense of the dollars we're talking about?

MS. CRUZ: Sure. My total program funding is about \$5-1/2 million a year. It's broken up into two pretty distinct areas. We have five recruitment retention programs that are designed to assist healthcare professionals to either go practice in rural areas or stay in rural areas where they're practicing. Three of those recruitment programs are geared specifically to primary care physicians, and then the other two are pretty much open to any healthcare profession. The dollars per grant are not big but they sort of count on them.

Our biggest and probably our highest dollar recruitment is a grow-your-own rural scholarship program where a community and TDRA put up each half of the funding and they will provide complete funding for a student from whenever the community wants to pick them up, whether it's

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in undergrad or med school or whatever path they're following. And basically, the student will get a free ride, if that's what the community wants, but they have to go practice in the community on a year-for-year basis after that.

And several of our programs require a service in order to get the funding. Some of that funding comes through our federal grant, not too much of it, most of it comes from the General Revenue funds from the legislature.

We also have Tobacco Endowment funding of about \$2 million a year. It's for capital improvement loan funds for small hospitals, hospitals in counties of 50,000 or less, and it's for capital improvements. They can use it for equipment, parking lots, air conditioning systems, redo bathrooms, whatever it is they need to do.

We get three major grants from HRSA, from the Health Resources Services Administration. One is because we're the State Office of Rural Health, and underneath that grant we have several little initiatives that we do.

We do nursing skills enhancement, we pay UT Arlington, they go out and provide training to nurses in the rural facility and they don't charge the nurses but like \$10 and we pick up the rest of the costs on that.

We have the Flex Program which supports our


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critical access hospitals. Underneath that we have some quality improvement initiatives for them to start reporting to CMS as they will be required to do over the next couple of years, and if they don't report certain core measures to CMS, then that starts hurting their bottom line, so we're trying to get them onboard with that.

We also have a small Rural Health Hospital Improvement Program, it's a very small grant. Texas has the highest allocation because we have the most small rural hospitals, we have about 123 that qualify and HRSA caps us at 120. We haven't quite met that 120 in applications, but they each get \$8- to \$9,000 a year and they can use that for quality improvement, capital improvement, or HIPAA compliance.

So that's kind of the basic funding, and it totals about \$5-1/2 million a year -- which is not very much for the entire state.

West Texas has 45 frontier counties which means that they're -- I think it's five persons per square mile.

MR. HANOPHY: So there's not many doctors.

MS. CRUZ: No. There's more cattle than people, and more people than doctors, by far.

MS. MCGILLOWAY: I think providing these maps

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is a wonderful tool for us because I think a picture says a million words.

MS. MARGESON: Not for me.

(General laughter.)

MS. MCGILLOWAY: Now, this is my ignorance, is this including only public hospitals, this is including private hospitals as well?

MS. CRUZ: Yes, private as well.

MS. MCGILLOWAY: Wow.

MS. CRUZ: Yes, private as well, all the hospitals.

MR. WYATT: Theresa, could you just briefly touch on looking at the definition in our charge -- and I know you didn't bring necessarily data, but can you describe those rural areas, how people with disabilities and persons who are elderly realistically get treatment and what treatment does not occur, and how do they go about reliance with such limited services.

MS. CRUZ: Well, they depend a lot on other people. There are some faith-based services out there that will maybe provide transportation to them. Several of them have to travel two or three hours just to get basic healthcare. So they have to depend on somebody, it's either a family member or a government agency or

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needs what, and they're actually pretty good about doing what they have to to get help to those people or bring them in or whatever, and in that way, they've got a great support system. But how many areas overall is that, I couldn't tell you

MS. LANGENDORF: Can you provide us, you mentioned the community health centers.

MS. CRUZ: The federally qualified?

MS. LANGENDORF: Do you have a map that shows those?

MS. CRUZ: We do. Actually, if you look on our website under Rural Health, we have -- I've got a great map guy -- I don't think he's in here but he does good maps. There are about 80 federally qualified health centers and we have 216 rural health clinics. It's a different certification for each. Several of the rural health clinics are tied in with a hospital, with a rural hospital, because it works out better for their funding to be able to pull the money in through their clinic to support the hospital.

MR. HANOPHY: Is your health professional shortage area defined by population, because I notice you've got some pretty populated areas.

MS. CRUZ: For the professional health

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MS. CRUZ: Right, if they have that, if they can get that.

MR. GERBER: Any other questions for Theresa? Thanks for being here Theresa, appreciate it.

MR. GERBER: Diana McIver, and next up will be Nancy Case.

MS. McIVER: Thank you so much. My name is Diana McIver and I'm pleased to be able to address you all and commend each of you for volunteering to have this service commitment that we all appreciate so much.

I actually have been involved in senior housing for, what feels at this point in time, my entire life. I did the staffing for the U.S. Senate Committee on Aging of Congregate Housing for Seniors about 35 years ago, so it's subject near and dear to my heart. And most recently I've been involved as an owner/developer/manager of affordable senior housing.

I want to make it clear that my remarks today are going to be focused exclusively on seniors. I believe seniors have an entirely different set of issues than people with disabilities, and my experience dates back to when HUD, in a moment of lack of wisdom, decided to add the definition of handicapped so they could integrate people with disabilities into senior housing, and it was a

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huge mistake, and I think we've almost recovered from that but not necessarily.

What I'd like to address a little bit is how we're providing the housing part because to me that is the simple piece when you talk about housing, service-enriched housing for seniors, housing to me is the simple part. In Texas we're fortunate to have a huge allocation of housing tax credits under the Housing Tax Credit Program and that's our affordable housing tool. And last year, as an example, we were able -- in 2009, the state, as Michael well knows, was able to fund 3,400 units, apartment units of senior housing under the Housing Tax Credit Program, and that's about 40 percent of the housing that was actually funded last year in 2009 out of that program. So that's very successful, but what we have to do with that program is to make sure that we design it successfully.

What we have been doing recently in the smaller cities, and which has been very popular, is to get as much flexibility as we can to our senior population and our residents, and what we have been doing is taking and doing two styles of housing on one site. We're doing a two-story -- what I call high-rise -- a two-story elevator building -- there's no reason it can't be three or four, but the size of the communities we've been in, two stories


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has worked best -- a two-story elevator building, and in that building which is extremely safe and has all of our common areas and all of our leasing offices, and then we surround that with independent cottages.

And what that is giving us is that we are able to serve frail elderly in that two-story building while not having what would be considered an institutional environment. More well elderly come in and live in the cottages and the frail elderly live in the two-story elevator building.

What happens with us, if you think of our housing -- and it has to be fully accessible -- but we end up with a lot of our seniors who their mobility impairment requires them to use a walker or a cane, not necessarily a wheelchair, and the design differences are so different. It is much safer in a senior facility for someone to actually live in the cottage and be in a wheelchair and get over to our program service area than to be in a walker or use a cane. That is a huge at-risk population for us. It's not safe, the distance is so far that they find it difficult. So we're serving a lot of frail in those buildings. And all of those areas need to be designed to be friendly, they need to really encourage things, people to come out.

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But we've also found that it doesn't cost money to be nice and have common sense, and so, one, we design things appropriate to our senior population, but two, we provide them with certain social services. Now, when you're talking about healthcare, that's a different thing, but with elderly, one of the key problems we have is isolation, and some of that is from the death of a spouse or from limited mobility, but also vision losses and hearing losses, and so the population becomes very, very isolated.

It costs you no money to bring them out, to have welcoming coffee hours and to have potluck suppers, to have movie nights, to have all those kinds of activities, and when you bring people out of their units and you help them make new friends, you also are able to see who is having a problem. So basically that's our way of figuring out where the residents are and being able to address other services.

I have written remarks so I'll just move quickly through the rest. Basically, we do all the social services in-house, we even use the programs of the Older Americans Act and mostly local governments to do more caseworker kinds of services and access to transportation. We make that available, the caseworker office onsite, and


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so we tap into those local resources. Again, it's not costing any money, it's just a little bit of effort.

The big challenge that I think we all face in this state, as it affects senior housing and the ability for people to age in place, is that concept of healthcare services, and that health piece is expensive, and you're hearing, it's very expensive. So what I have done is to provide you with a couple of ideas from other states, and I'll give my handout to the staff here and they can help you access these websites.

But the ones that I thought would be of particular interest are, one, the Robert Wood Johnson Foundation a few years back funded the Coming Home Program, and under that they were able to use the Medicaid waiver and combine it with housing tax credits and provide -- for lack of a better word -- affordable assisted living. We have that ability in Texas, we're not using that ability because of the way our Medicaid waiver program works, but we could work with that. The key is to be able to make that Medicaid waiver project-based so that lenders who are lending under the Tax Credit Program will recognize it as income, but the Medicaid waiver is a big piece.

The other thing that attached some information


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on is a brand new concept that's being pioneered by NCB Development -- they're the same ones that were involved in the Coming Home Program -- and they have something called a Green House which addresses very, very frail elderly who need a care element as well as a service element in six to ten-unit complexes, and they've got a private bedroom and bathroom and then a common area where their meals are prepared and they take their meals there which I think is an innovative approach to treating seniors in this setting, and so I think looking into that would be good for the council to undertake.

The last thing that I will address and that is the PAICE, the Program of All-Inclusive Care for the Elderly, and again, it operates with the Medicaid waiver premise but Texas hasn't approve very many PAICE programs and I don't know the reason for that. I think there are actually only two, there's definitely one in El Paso and I think Amarillo was recently able to set one up.

And if do any site visits, I would recommend this one. If you go to El Paso, El Paso has an older Section 202 that actually their senior center developed a PAICE program as part of that site and actually co-located with the 202 senior housing but across the street they also have tax credit senior housing which are able to


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participate in that. And the PAICE program is like a big adult health center that folks can go to during the day and then back to either their homes or their apartments in the evening. So that's another one that I think would be a good research for this particular council.

So in closing, I appreciate the ability to be here and wish you all well on your journey to address these problems for Texans. Thank you.

MR. GOLD: Just FYI, there's a third PAICE open now in Lubbock that just opened about a week ago.

MS. McIVER: Oh, okay, great.

MR. GOLD: And I think it's a great program.

You mentioned there are issues regarding the Medicaid waiver and assisted living, I'm just curious, because we do allow individuals to choose, if they so want, assisted living and receive their services in assisted living, so what problems are you thinking about?

MS. McIVER: The problem, as I understand it, really gets to the seniors and matching a senior that might have a Medicaid waiver certificate to an appropriate living setting. We can make those linkages but the bigger problem is that the state, in its Medicaid waiver program, has never agreed to project-base those so you can't use it as a financing tool, and that makes it different from the

programs that you would see in like Illinois or Oregon or someplace like that. So you can't take advantage of that as a resource because you don't know that it's a long-term resource to that development so it can't be used in your financing program. That's the big difference.

MR. GOLD: Thank you for clarifying.

MR. GERBER: Any other questions for Diana?

MS. VAN RYSWYK: I have another question. I'm interested in your partnership with the AAA, you mentioned that there's a AAA case manager onsite.

MS. McIVER: Yes, it's different in every single community, but for instance, our smallest property is a 48-unit senior development in Llano, and we actually get our services and case management out of Hill Country Community Action Agency and they send someone to our site every other week and stay there for a certain amount of time on a Friday and provide those kinds of services. We also tie into their transportation services as well.

MS. VAN RYSWYK: So that's actually separate from the AAA through Hill Country.

MS. McIVER: Right. And then in Texas City, for instance, it's with the Nessler Senior Citizen Organization. So some of those are getting those umbrella funds under the Older Americans Act, others are getting

come forward.

MS. MILLS: I am Sara Mills and I am with Advocacy, Inc. and I know quite a few of you all on the council, but those who do not know me or know my organization, we are the state's protection advocacy organization for Texas, we protect the civil rights of people with disabilities in our state and we work on a myriad of issues. I am the policy specialist for Advocacy, Inc. and one of my chairs is housing which is why I'm here today.

It's been actually kind of nice, I'm glad that I'm going later in the invited testimony because it's been interesting to hear a lot of my colleagues within housing discuss service-enriched housing to you all, and I'm just going to be brief but I do like the definition that you all have drafted. I think it is very broad, it's well rounded, and it has the three things in it that, as an advocate for people with disabilities, which is kind of our mantra which is affordable, accessible and integrated.

And something else that I want to touch on is that we talk about 30 percent and below for area median income, and actually when you talk about people who are on Social Security, that's really more like 16 percent and below. So affordable housing for folks with disabilities,

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accessibility is being able to get -- and if you use a wheelchair, getting in and out of, it's the physical access.

MR. GOODWIN: The concern I have -- and I brought this up once before and I guess I'll be the naysayer -- is when you get to the regulators, if we stick to that definition, then we will negate an awful lot of housing that will be available to people with disabilities that have other than mobility disabilities. And we specifically, for example, talked about townhouses. I handle a property that I'm getting ready to rehab and we will have fully accessible units, but I have townhouses that by definition are not accessible but if I had someone with a mental disability or a hearing impairment or a sight disability who might want one of those townhouses, they sort of get excluded because that unit has been excluded. And that's just the concern I have of taking units out of the possible inventory by putting too strict of a definition on it.

I guess what I'd like it to be is accessible to the needs of the individual, and then we would cover a range of disabilities as opposed to locking in to the definition.

MS. MILLS: And I think it's definitely a two-

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sided coin, heads on both sides, but you've got to look at the other way too in that you've got to also be careful that you don't [indiscernible]. I think at one point there was something with townhouses.

MS. LANGENDORF: Yes, townhouses are exempt from Fair Housing, and our state is really good with Tax Credit Program in developing a whole lot of townhouses which basically were not at all accessible.

MS. MILLS: Then you go the opposite way, it's really limited to the number available, so I think there is probably something there but you've just got to be careful which way you go.

MS. LANGENDORF: And I think there has been some movement in the past where with townhouses there were provisions in the tax credit developments that they would have to have one bedroom, one bath downstairs -- I don't know if that's still in there, to tell you the truth -- but I think a lot of it we look at whether or not it's going to have visitability, and whether or not a person that lives in the community is going to be able to be treated equally to visit their neighbor.

Oftentimes, you'll see a lot of the designs of townhouses where I think those of us in the disability communities have become so adamant about townhouses is

Is George Linial here? George is president and CEO of the Texas Association of Homes and Services for the Aging. Thank you.

MR. LINIAL: Thank you. I'm passing out written testimony so I'm not going to read that, I'm just going to kind of highlight. I think everything that you've heard today is concerns that we've had over the years.

Let me tell you a little bit about our association. We represent a lot of the not-for-profit providers of healthcare and housing for seniors across the state. About half of our members are strictly housing members, a lot of them are funded by HUD, and a lot of them provide services in their buildings through a service coordinator. Some of them have funding through HUD to provide a service coordinator to coordinate services through existing agencies in the area.

We're going to go through a pretty amazing transformation over the next few years in terms of the aging of the population, not just in Texas but across the country. I'm sure you've all heard the statistics about we're doubling the number of seniors by 2030, and then by 2050, one out of every four seniors is going to be over 85. And so those folks are going to age in place and our


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existing healthcare system isn't going to be able to handle just the sheer numbers of folks who are going to require services. And the idea is to keep folks in the least restrictive environment as possible, so people want to age in place, they want to stay in their own homes, or they want to live in a place that provides them with a lot of choices.

So this has been a challenge and I applaud this council for coming together because historically there has been this silo effect, not just at the state level but certainly at the federal level. I think that up until a couple of years ago, CMS and HUD didn't even converse with each other about a lot of these issues. So I think this council is a great step in the right direction in terms of opening the communication and combining services.

Most of the material that I've presented to you comes from our -- there's a research arm of our national organization which is the American Association of Homes and Services for the Aging -- there's a research arm called the Institute for the Future of Aging Services, and they're looking at housing with services as basically the future of long-term care, that as technology improves, as medical advances improve, improvements in pharmacy, et cetera, people are going to be able to live in their own

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homes for the majority of their life and even as they reach advanced age.

So there's all these opportunities in terms of economies of scale in order to put people together in some sort of congregate living arrangement and providing some sort of service coordination, a person there who can help people who need services. Some may not, some may be fine living on their own, but if there are services needed, they can coordinate that with existing agencies in the area. And as Diana said earlier, just bringing people out and congregating with other folks just gets them more socially engaged and does seem to have a lot of positive impact on their lives.

So this framework is basically things that you've already heard today about basically linking services with housing. Our national group has not even come up with a term called service-enriched housing, they're simply calling it housing with services. You've come up with, I think, a really good definition of what it should be, and you've got a lot of challenges ahead of you because I think there's a lot of bureaucracies and a lot of rules that need to be adapted.

One example I can cite is that HUD a few years ago put in money for assisted living conversion to convert

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some of their HUD housing into assisted living, and they faced a lot of problems because their rules did not match up with the CMS rules, and some of that has been worked through but it's been a long road in order to get that.

Some of the other programs that I think Diana mentioned, the PAICE program, some of the managed care programs, having onsite nutrition programs and wellness programs alongside housing, those all have real positive impacts.

So I've also added in the addendum in the blue pages, these are some illustrations of some successful programs in some other states, and I think Illinois is one of the ones that was cited earlier -- Illinois has what's called a Supportive Living Program. But also Maryland, New Jersey, Massachusetts and California all have programs that seem to be working quite successfully.

I'll be glad to answer any questions you might have.

MR. GERBER: Very helpful, and I think staff is actually -- correct me if I'm wrong -- you're spending some time looking at each of those different state models.

MS. SCHWEIKART: And that was part of the very first document everyone received on the pending decisions for the council was best practices, and we have a larger


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version of that. We boiled it down for you guys but we have a large database of best practices that I would love to add that information to it.

MS. LINIAL: Sure, absolutely.

MR. GERBER: Any questions for George?

MR. WYATT: Mike, can I ask one? Your institute, does it provide a lot of research data on the cost of the various models or the magnitude of the cost even for the country? I know, depending on the definition of the services, the costs will either go up or down, but can you enlighten us a little bit on any type of data that puts the whole picture into monetary terms?

MR. LINIAL: I don't have the data off the top of my head but I can certainly get it to you, provide some of that data to you. I think, again, some of the earlier testimony talked about cost per unit and then cost per year in terms of services. The idea is that Medicare and Medicaid are going to bankrupt the country and Texas because the cost of building nursing facilities, assisted living and all those facilities are quite expensive to folks; strictly providing housing and services is a far more affordable venture. But I will be glad to provide that information to you. Thank you.

MR. GERBER: Thank you.

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Rose Dunaway. Welcome, and if you'd say your name and introduce yourself.

MS. DUNAWAY: Hi. I'm Rose Dunaway with Texas Association for Home Care and Hospice, and we represent over 1,200 licensed home and community support service agencies in Texas. And I was telling Ashley that I will be providing you with a brochure. We added Hospice to our name effective January 1, and so all of our brochures that have our old name have been pulled and we don't have our new brochures yet, but I'll be sending that to her so she can disseminate that to you which describes home care and what we do in Texas.

We provide services in the community in independent living situations, in assisted living and in nursing facilities under different payer sources from personal assistant services which provide bathing and assistance with dressing and that kind of thing, all the way through high-tech infusion therapy. So I'll be glad to get that information to you. Thank you.

MR. GERBER: Thank you very much.

Next up is Ken Martin and Greg Gibson, both with the Texas Homeless Network.

MR. MARTIN: Good afternoon. I'm Ken Martin from Texas Homeless Network and I'm very pleased to be

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here. Thank you for sharing your time with us. I'm going to make my remarks very brief. I believe Greg has a lot of statistics and more formal remarks, but I do want to talk to you about service-enriched housing, or supportive housing, as we call it in the homelessness field.

Texas Homeless Network fully supports this council's efforts to increase service-enriched housing. We see a great need across the state for a wide variety of housing, including short-term and long-term supportive housing or service-enriched housing, and to me that means not only individuals with disabilities but any individual or family who needs some short-term assistance in order to not be homeless anymore, and also, there's a great many at-risk people that without some help will become homeless.

Research has shown over and over and over again, as you've heard from everybody that's come to speak up here today, that service-enriched housing is the way to go and it's the cheapest way to go and it's also the most humanitarian way to go. In homelessness with service-enriched housing, we see a 56 percent decline in emergency room use, we see 37 percent reduction in hospital inpatient stays, we see a near total elimination of residential mental healthcare outside of hospitals, we see


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an 89 percent in days spent in residential alcohol and drug treatment, and we see a 44 percent reduction in days sentenced to incarceration. All of those not only provide help for people who desperately need it but they save money coming out of our pockets. The highest services are those emergency services that we reduce with supportive housing.

Of course, elderly are a big concern to us because, guess what, the homeless population is getting older and older, and we need desperately to come up with adequate housing for the people who are homeless and elderly or elderly at risk of becoming homeless.

Also, people with mental illness and chronic substance abuse issues face challenges that the rest of us can't even imagine, and this type of housing certainly helps to keep them from living on the streets.

Also, formerly incarcerated individuals often find it very difficult to access the affordable housing that we have available to us and many places in Austin and around the state will not take people into their programs if they have a criminal record. So formerly incarcerated individuals, especially sex offenders, are increasingly living on the street where we can't keep an eye on them. And I understand the problems with sex offenders being


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housed, but my point is we would rather be able to keep an eye on them and know where they are than for them to become homeless.

Youth is another often overlooked population that needs this service-enriched housing. One study that was done several years ago interviewed 18- and 19-year-old homeless individuals. Sixty-two percent of them had been in foster care, so we have a big problem -- and I'm speaking as an ex child protective services worker also, I understand the problems that face CPS workers -- and we desperately need to do something to help that.

So what are the crucial needs for these special populations? We need outreach, we need to be able to go out and find them where they're at and engage them in services; case management, of course, to help them stay in housing; healthcare including mental health treatment and substance abuse treatment; job training or retraining; and childcare in the case of homeless parents.

I think there's some barriers that we need to consider also. Many people that have come up today have mentioned funding in silos and I really want to stress that it is difficult when you have to go to two different agencies, one for housing and one for services, if you don't get one or the other, then you don't have a complete


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MR. MARTIN: I'm sorry, ma'am?

MS. MARGESON: What percentage are you reporting for people with disabilities of all types?

MR. MARTIN: Of all types, including chronic substance abuse and mental illness, we see about 60 percent, and that number goes down to about 45 percent when we take chronic substance abuse out of the mix.

MR. GERBER: Any other questions or thoughts? Ken, thank you.

MR. MARTIN: Thank you.

MR. GERBER: Next up is Linda Litzinger -- oh, I'm sorry, Greg, come on up, sure, please.

MR. GIBSON: Thank you for the invitation to provide testimony today before the Housing and Health Services Coordination Council. My name is Greg Gibson, I'm the programs manager for the Texas Homeless Network, and I have over 25 years of experience working with local, state and national organizations that focus upon the development, implementation and operation of health and human services. This experience includes case finding, direct care and programs management.

I support the mission and creation and operation of the Housing and Health Services Coordination Council and I applaud your efforts to develop and

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implement policies to increase state efforts to offer service-enriched housing for the coordination of housing and health services.

As you are aware, federal and state housing service programs operate independently, often resulting in different eligibility requirements, funding mechanisms and regulations, and there has not been any single entity until today that exists to coordinate and reduce barriers as a result of a number of entities involved in developing service-enriched housing.

Senate Bill 1878 was intended to enable people to age in place instead of receiving long-term care services in a nursing facility by providing them with housing and access to health and human services. As a representative of an advocacy and support organization for homeless individuals, who often have a co-occurrence of mental, physical or emotional disability, I would like to speak to the need for affordable and accessible supportive services in a community setting as opposed to an institution, and perhaps to identify some gaps in the service delivery by state and local providers.

We know that older adults do prefer to live in their own homes for as long as possible and research demonstrates that people who age in place often have more

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favorable clinical outcomes when compared to similar individuals receiving long-term care services in a nursing home. To age in place an individual must have both housing and access to health services.

Combining housing and services outside of institutional care is an opportunity to expand the long-term care continuum by creating more options between the two ends of the continuum: independent living and institutional care. Creating more alternatives allows more older adults and individuals with disability to age in place resulting in better clinical outcomes for them, and in most cases at a cost less than that of a nursing home. Such alternatives are known as service-enriched housing which is broadly defined as living arrangements that include health and/or social services in an accessible, supportive environment.

The need for service-enriched housing is already here. Between 2002 and 2008, Texas's population increased by approximately 14.6 percent. The total population estimate for January of 2009 was 23,705,962 people in our state, and that's expected to grow with projections putting the state's population at 35.7 million by 2040. The population of Texas is also becoming older. In 2009 the percentage of the population that was 65

years or older was 10.3 percent; that number is expected to increase to 18 percent by 2040.

Additionally, the American Community Survey found that 45 percent of those 65 and older have a disability. Furthermore, 56 percent of older Texans spend more than 30 percent of their income on housing. Based on the state's need assessment, the expected rise of Texans over 65 years old will increase the demand for affordable senior housing and barrier removal and home modification programs.

Low income housing is scarce. Five out of six low income Texas families who qualify for government housing assistance do not receive it, they do not receive it because of Texas's shortage of subsidized housing. In Texas 27 percent of renters and 14 percent of homeowners pay over 35 percent of their income for housing. This situation is even worse for households that earn less than \$20,000. Among that group, 62 percent of renters and 47 percent of homeowners pay more than 35 percent of their income on housing.

There were 1,192 families, almost 4,000 adults and children who slept outdoors during January of 2007 because there was a lack of shelter beds. Almost 67 percent of individuals who experience homelessness in


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enriched housing program or plan for persons with disabilities. What services, you ask, would be crucial for this special needs population. Research and practical examples repeatedly demonstrate that wellness, work and household retention services to follow the affordable housing ends homelessness and improves lives and saves tax dollars. Psychiatric, medical and supportive housing services, including job readiness training and job placement services, must be robust and accessible.

Model programs, several that you've heard about today, have found that by providing permanent housing with support services to these individuals helps to stabilize their lives. These programs achieve cost savings through reduced use of other public services, such as jails, hospitals and mental health institutions. Thanks to these savings, the net cost of providing chronically homeless persons with supportive housing is minimal.

These services must include: outreach activities provided to reach and link services to individuals who have difficulty obtaining appropriate behavioral health services due to such factors such as: acute behavioral symptomology, economic hardship, homelessness, unfamiliarity with difficulty in accessing community behavioral healthcare services and support

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services, fear of mental illness and related factors. This service must be provided in a variety of settings including homes, schools, jails, streets, shelters, public areas, or wherever the person must be found.

It should also include activities with the client or any family member or natural supports that they have, in accordance with confidentiality requirements, of course, but we need to develop a therapeutic treatment alliance and rapport with the client and include activities such as enhancing the individual's motivation, providing an explanation of services recommended, education on service value, education on adherence to the recommended service packages and it's importance to recovery, and short-term planned activities designed to develop a therapeutic alliance and strengthen support.

Supportive housing -- that's what I call it -- service-enriched housing, varies widely in its approach in regard to consumer choice, whether it's typical or normalized housing, resource accessibility, consumer control, and provision of individualized and flexible support. Supportive housing is activities designed to assist clients in choosing, obtaining, maintaining regular integrated housing.

MR. GERBER: Greg, go ahead and start wrapping

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up.

MR. GIBSON: I will, sir.

In addition to supportive housing, I would also encourage you to consider including psycho-social rehabilitative services and also respite services.

There are many barriers that have been mentioned here this afternoon. Local governments and non-profits have done a great job but they are overwhelmed and they need your assistance. There's also other information with regard to how HUD has shifted its service dollars away from services into housing, and I'd be happy to provide that information to you.

MR. GERBER: And Texas Homeless Network has a wealth of resources available to the council as well, and we appreciate all that Greg and Ken bring to the table. Are there any questions for Greg? Thank you for coming and sharing that, and we'll have additional questions for you.

I'd like to ask Linda Litzinger to come forward from the Texas Parent Advocates Consortium.

MR. GIBSON: I would like to add that we would be happy to continue to be a resource for the council in its work.

MR. GERBER: Appreciate it. Appreciate you

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so that she didn't need an attendant at a middle hour. But she still needs to keep her class attendant care because she studies all the time, she's a college student, she takes 19 or 22 hours a semester and she doesn't write with her hands. From 6:00 p.m. to 2:00 a.m. she studies and she needs to hire her own attendants during that time because no agency really can find anybody for those hours. She's back up at 6:00 a.m. showering.

The silo thing is a real problem. She needs to keep what she has but she needs a couple of these other things that would make her life oh, so much easier. For example, she lives at college four nights a week and they will not allow a student to get her out of bed during a fire, so I do the homework shift from 6:00 p.m. to 2:00 a.m., sleep there for a couple of hours with her and get her ready in the morning. And let me talk about a different kid I know who might need some financial help or might need some nursing help but that's all, so that it really does need to have a huge flexibility.

Mainly what I'm here to talk to you about is transportation because I don't see much transportation representation here on this board, and it's a difficult problem. And I'm also here to give you the perspective of not an elderly person with a disability, not an adult with

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a disability but a teen turning into an adult with a disability.

The yellow school bus stops coming and it's time for a job or a trade school or college and suddenly the family finds out that they don't live within three-fourths a mile of a bus line so therefore their child doesn't qualify for special transit services. That's a federal guideline. Special transit services is what my daughter needs because of her depth perception issues, she needs a van to come to our house, and we live two blocks too far away.

So we looked at moving and we looked at negotiating with our local Capital Metro, and so we asked can we buy in, can we pay an annual fee or can we pay extra tickets per ride so that she could get to college or to whatever else she needs to do, and the answer was no. And she even got on their special access advisory board for two years just to try to help negotiate this problem.

Some of our friends in Texas Parent Advocates, they didn't have any more kids at home so they could move, so their son needed to try some jobs like working in a grocery store and various things. They moved to an apartment near the grocery store so that he could walk a half a block just because they didn't have transportation,

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and they moved several times. They had to take a capital gains loss on everything to do this because he was still waiting for attendant care and waiting for housing for himself and yet he couldn't even move there without them paying for the supports because he's got about eight more years on a waiting list for support services.

In our family's case, after we failed at trying the buy-in to Capital Metro, we looked at moving to some neighborhoods that are famous for being ranch neighborhoods, and the one I'm thinking of that I'd like to talk about is at Mesa and Spicewood Springs Road, just boocoo neighborhoods everywhere around there that are one-story. And so Capital Metro even discussed it in one of their meetings, they're not willing to remove their three-fourths mile rule for a neighborhood like that that they know has people with wheelchairs in it, nor are they willing to even work with us, even though we're the only one-story in our neighborhood and we're two blocks from the line which they redrew after we built this accessible house.

So my recommendations to you are a couple of things. One is Capital Metro, all the metros I know we're a statewide group -- negotiate with them. You're going to keep people off your waiting lists if you can find a way

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for them to stay in their accessible homes that they already are in. My other suggestion for you is that just if you could also consider the plight of the child in transition who needs to find a job, needs to find transportation, needs to find housing, has all kinds of things they're trying to build in their picture and they just can't make it work.

And to summarize, my daughter said, I don't think Texas really wants me. And she said that because there are so many different things she cannot make work right now.

Can I answer any questions?

MR. GERBER: I'd like to say on behalf of the council we appreciate you sharing that testimony.

MS. LITZINGER: Thank you. And there's copies coming, I didn't bring enough.

MR. GERBER: That would be great. Appreciate it. Thank you very much, Linda.

Next up is Cynthia Humphrey.

MS. HUMPHREY: Good afternoon. I'm happy to be here today and I appreciate the opportunity to provide input to the council on the important work that you have in terms of supportive housing -- I guess it's service-enriched housing. And I am here representing the

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Association of Substance Abuse Programs which is an organization representing chemical dependency treatment and prevention organizations across the state. But I'm also here wearing a different hat or a second hat in that I am an individual actually in long-term recovery from addiction with 17 years clean and sober. So I'm coming here to provide some testimony from both of those perspectives.

Addiction, according to NIDA, the National Institute on Drug Abuse, basically defines addiction as a chronic relapsing brain disease that is characterized by compulsive drug or alcohol seeking and use despite the harmful consequences. And so that's kind of a definition of addiction that's been kind of evolving over the years, and we do have effective treatments to combat addiction now and those continue to evolve and develop in research as to be highly effective.

The reason why I bring that up is because addiction is kind of like the elephant in the room, it's not necessarily considered, under traditional disability terms, a disability, and yet certainly people who are early in recovery from addiction, they have basically very debilitated lives and it's a disabling disease. But ultimately, if you track right and you have the right

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support and you're given the right treatments, you can be fully integrated back into society as a fully productive and participating member.

And so as we look at the definition or we start considering the definition, I just wanted to bring to your attention that the disability piece may need to be looked at a little bit more as it relates to addiction because what happens with addiction, especially in the service area, is if you're trying to look for other service supports, you typically can't gain access to them on a diagnosis of addiction alone.

So usually you have to be identified as chronically homeless or you have to have another kind of concomitant problem, you can't just say I'm a young lady with a child with an addiction problem and have access to a lot of services, you usually need to have a mental health problem or chronic illness of some sort. I would like for the committee to kind of expanding or at least making really clear that addiction in and of itself is considered a disability in terms of the housing needs.

Individuals suffering from addiction and the people that our association serves are usually those who are medically indigent, they have basically spun down all their resources, they've alienated all their family

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members, they are episodically homeless, they come with a myriad of problems, and they also usually come with a criminal history. Lots of them have gotten in trouble with the law for drug possession, PIs, and even family drug convictions that could be just minor dealing of some sort, and so this creates a lot of difficulty in terms of housing.

And the individuals that I see in the communities, the ladies -- and I work predominantly with ladies and that's, in my opinion, a very difficult group because these ladies are very vulnerable -- a lot of times they are not professionals and they're only able to get minimum-wage types of jobs, and what happens to them, they get sober, they get in the community, they find out they cannot support themselves, and they end with another man to help support their needs. And so I think that ladies in recovery have a special need for housing to protect them in the vulnerable time before they can get self-supporting and self-sustaining.

And so there are a couple things. Housing is definitely an extremely important part of what individuals coming out of treatment -- and I know that you're fortunate to have Amy Granberry on the council who is a treatment provider and can answer any of the clinical

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questions and certainly that some of the problems that counselors at treatment facilities face when they're trying to discharge a patient who's been in residential treatment -- that there is no housing available in many instances.

The Section 8 housing, many of the housing authorities just kind of put a ban across the board on anyone with a drug felony conviction and so one of the recommendations that we would like to leave with this council is to try to consider how it might be able to educate and facilitate some policy changes within the public housing authorities that would make them be able to individually consider those people with a felony drug conviction based on time lapse since the crime, based on the seriousness, based on the relevance and conviction to the tenancy, and also evidence of treatment and rehabilitation, and if they could make those considerations.

The other thing is there is a lack of sober housing, but the good news is a lot of the individuals in the recovering communities as private landlords are developing recovery homes that provide a safe, stable and sober focused environment for individuals new to recovery to live, but these people coming out of treatment or

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entering into twelve step groups often have no money, and so one of the things that they need assistance with is vouchers or some kind of low rent housing assistance that would give them one or up to three months of rent assistance to allow them to get a job and get rooted back in community.

And the other recommendation that I would like to leave with everyone is the need for recovery case managers. Like I said, in community there are various different services, some are services that you could access as a result of your addiction, others because you need to be homeless or others because you need to have a mental health issue, others there are recovery houses around.

But if there would be support to put recovery case managers in communities and the ability to do some community mapping of recovery supports that are available in communities that individuals either coming out of treatment or already integrated into the community into twelve step recovery groups could access that to find out how they could get their needs met in some of those supportive services in their community.

I can't reiterate how much this recovering community needs access to housing and needs access to

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supports so they can get along on their way to living productive lives in community, and so again, looking at that definition, I would like to make the recommendation that we kind of maybe add in something that might say individuals with disabilities and rehabilitative needs or something that might expand that to certainly indicate that we are talking about people with substance abuse problems and addictions.

Are there any questions?

MR. HANOPHY: I wanted to follow up on the recovery case managers. Is that sort of a clinical hybrid between an LCD and a case manager, or is it just strictly case management, and what other states have tried it?

MS. HUMPHREY: In the field there is kind of a new movement called Recovery Oriented Systems of Care, and in that a case manager could be a professional social work case manager or something that they're actually calling recovery coaches, and what those recovery coaches are able to do then is basically help people that are already in community access services, deal with some triggers that they have may have to deal with to help them from having a relapse, and they would be centralized in community. In some systems they're actually in a recovery resource center where they could go to and access their own case

manager and also have listing of all the services that are available.

So they aren't counselors and they aren't an AA sponsor but they're somewhere in between and they're right now developing a certification for recovery coaches that could function as recovery case managers.

Anybody else? Thank you.

MR. GERBER: Thank you very much.

Next up is Ms. De Mayo.

MS. DE MAYO: Hi. My name is Mandy De Mayo, and first of all, I'd like to thank you all for pulling together this coordination council because I think it's very important work that you all are getting ready to do, and I look forward to hearing about your progress in the coming months and years.

Again, my name is Mandy De Mayo, I am a consultant for non-profit and for-profit organizations that are developing affordable housing. I also have a background in public policy; for the past nearly 20 years I've been working on affordable housing in both a policy and on-the-ground effort. My policy research has included local policy related to affordable housing, a lot of work with the City of Austin on affordable housing and transit-oriented developments, their Affordable Housing Incentive

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Task Force, and their preservation policy as well as national policy which I'm going to talk about in a little bit, particularly related to affordable housing for people with disabilities.

As some of you may know, the federal government's response to the housing needs of people with disabilities is the Section 811 Program which is entitled Supportive Housing for People with Disabilities, and it's a federal program that's administered by the U.S. Department of Housing and Urban Development, it's been around on its own since 1990. Diana McIver mentioned during her testimony that it used to be Housing for People with Disabilities used to be coupled with an elderly housing program, and in 1990 they were separated out.

The 811 Program provides a dual subsidy to non-profit organizations that are developing affordable and accessible rental housing, so it provides funding call capital advance funding for the actual sticks and bricks for developing the housing, and then it also provides a rental subsidy known as a project rental assistance contract so that the non-profits can serve the very low income, but a rental subsidy, the difference between what it costs to operate the project and then the actual funding that the very low income tenants with disabilities

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are providing toward rent.

Although there are a lot of great things about the program, there are some downsides to the program. The first is that it's segregated housing, and one of the things that you all are looking at is something I'm very interested in which is integrated, affordable and accessible housing. The 811 Program is designed to put housing on the ground that is primarily small apartment complexes or group homes that are specifically for people with disabilities and it's also segregated by disability.

So typically non-profit sponsors will say they want to develop housing for people with mental illness or housing for people with developmental disabilities or physical disabilities, and so we end up with a lot of segregated housing in communities which, on the one hand, it is providing additional affordable and accessible housing, but on the other hand, it is segregated from the rest of the community.

Another large downside of the program is the impact that it can have. Nationally right now the program provides about 700 units a year, that represents a 50 percent decrease in units that have been available over the last ten years, and in the State of Texas there are only about 50 units available each year. So there's not

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really an opportunity to make much of a dent in the affordable housing needs for people with disabilities in the State of Texas when really all you're allocated funding-wise is enough money to develop 50 units, in the State of Texas.

One of the things, as I mentioned, I'm interested in, having worked with a lot of disability organizations and disability advocates, is affordable, accessible and integrated housing, and right now, as I mentioned, under the Section 811 Program, it's next to impossible, the federal regulations really are geared toward developing this stand-alone product that is segregated housing.

I have worked with Jean Langendorf, with formerly UCP Texas, now Easter Seals of Central Texas, and working with Jean over the years when we first came together, she said, I want to use this 811 Program that provides funding for affordable and accessible housing, I think it's fabulous, we want to do integrated housing, how can we make it work. So over the past five or six years, we're now on our third project, and what we're doing is purchasing condominiums using the Section 811 funding.

So we're kind of twisting the regulations a bit using 811 funding to purchase condominiums within a larger

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condominium complex so we may have six units in one complex that's 120 units, and ten units in another complex, so we have a small percentage of units that are serving people with disabilities in a larger complex, thereby increasing the tenants' ability to integrate with the larger community.

It's a great model but it's time-consuming and labor-intensive and it's not the way the Section 811 Program was set up, and it's also not particularly cost-effective, and again, as I mentioned before with only 50 units a year that are available, we're making a small -- we think it's an important impact but a small impact on increasing affordable, accessible and integrated housing in the State of Texas.

Back in 2007 I did a policy research project and report for the federal government for the U.S. Department of Housing and Urban Development called "Section 811 Reform and Demonstration Program" and what I was hired to do was to look at the 811 Program and find out how we could better leverage 811 funds to make a bigger impact with a smaller amount of money.

One of the first things I did was looked at best practices across the country for leveraging 811 funds, and in all of my discussions with multiple non-

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profit organizations, disability advocates, think tanks, affordable housing providers, everybody kept talking about the North Carolina model, you've got to talk to the folks in North Carolina, and I did spend a lot of time talking to the folks in North Carolina.

Basically, in the State of North Carolina in the early 2000s, the North Carolina Housing Finance Agency and the state's Department of Health and Human Services came together to brainstorm -- much like you all are doing -- about how to have greater collaboration between the two organizations. They were working in silos, the housing department was doing the housing stuff and the health and human services was doing the health and human services stuff, and they didn't speak the same language and they thought they were doing kind of their mission but their mission was that there was so much crossover in their mission because they were serving much of the same needs.

So as a result of a lot of the brainstorming and the collaboration, in 2004 the North Carolina Housing Finance Agency instituted a 10 percent set-aside -- it's a threshold requirement -- for supportive housing in all of its low income housing tax credit projects. The advantage of this, as I mentioned previously, the 811 Program makes

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a small impact, there's only 700 units a year nationally so it's not a huge production program, but as you all know, the Tax Credit Program is the largest affordable housing production program in the country, and so by instituting that threshold requirement, that 10 percent set-aside for supportive housing, it had the potential to make a big impact across the State of North Carolina, and it has made a big impact -- I'll mention that in a minute.

The way the program works, the state housing trust fund provides the rent subsidy so that the organizations doing these tax credits can do the deep income targeting that's required for supportive housing. As many people mentioned before, if you're targeting that 30 percent median family income, that MFI, you need some sort of rent subsidy because the rent that folks are bringing in is not sufficient to even pay the operating costs on the project.

So the state housing trust fund came up with the money for the kind of bridge, the gap financing so they could do the deep income targeting, and then the local non-profit organizations coordinate both the tenant referral and the supportive services -- that are voluntary, not mandatory -- for the tenants who are living in that 10 percent set-aside in each and every one of the


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girls, taught them things that they never learned at state school -- many of them had been there since they were children -- and one in particular that I have come to know of those four original girls said she was so excited to learn how to run a vacuum because she had never learned how to do anything before.

So anyway, from those four girls, Mary Lee Foundation has now been around for 47 years, we're located in kind of a quiet neighborhood off of South Lamar that is very strategically located to provide accessibility, really, to the community at large. Even that little small two-bedroom house that Charlene started with was chosen specifically because of its location, across the street from a grocery store and other businesses that were around at that time.

I think location is a huge part of where supportive housing should be located because even though we have a full neighborhood of multifamily buildings, but we are a part of the community at large, so we are somewhat integrated into the community and to Zilker Neighborhood Association there. Actually, Mary Lee Foundation was there before the neighborhood association started, and so as soon as they started, we went over and talked with them and we meet with them every single time

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we start to have any major reconstruction or building over there, bring them into the loop and they've always been supportive and helpful, and I think that's important to remember those types of things.

One of the things that I did at the board meeting in July was I passed out a chart and I'll send around copies of it again. At that time, although it's changing now, I had become aware of the fact, when I went to all the different meetings, that they were talking about 30 percent of median family income as being low. Well, I kept thinking 30 percent, our folks live at -- I guess I was thinking what percent do they live at because they live on \$500 a month, typically, for everything, some of them may get a little more than that.

So I sat down and figured it out and it ran about 14 to 15 percent of the median family income and that was not shown on any charts which kind of led me to believe, well, gosh, nobody even believes that somebody lives on that amount of money, but they really do, a lot of people do. I have more charts if anybody needs one.

And so anyway, at that time I put together my own chart and brought it before the TDHCA Board meeting and it shows there if someone brings in \$500 in disability payments, they're living at between 14 and 15 percent of

places that might be strategically located and might be a good model already but does not really have the support services that they would like to have, maybe some of those facilities should be looked at and just provide support services to them so that we could get some models up and going quickly to show others what could be done. It's a thought on that.

And then one other thing that I have begun to realize, we are in the process of building right now -- we haven't actually started the building itself, we've got the site ready -- 64 units for extremely low income folks, most of them live on disability payments, the building is going to be 100 percent accessible, every kitchen, every bathroom, everything. And I really think that affordable housing that is being built with taxpayer-type money should be 100 percent accessible. It's all about disability, it's about aging in place, and we've got all these programs now to go back and retrofit units to make them accessible. If we all had accessible living, we wouldn't have to go back and retrofit, and those of us in the baby boom, we're going to need them pretty quick. So I think it's something that we should begin to think of and just require, we could begin to set the model for all housing to be accessible.

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(No response.)

MR. GERBER: John Meinkowsky. Come on up, John.

MR. MEINKOWSKY: Hello. I'm John Meinkowsky, I work for ARCIL which is the Center for Independent Living in Austin and much of the Central Texas Area, and ARCIL and other centers for independent living provide assistance to people with all types of disabilities and all ages, helping them access services and resources to live independently, and that means different things for different people, but what we've come down to the basic parts of life: a place to live, the transportation, access to the support services like personal care and things, medical, financial, et cetera. We work a lot with people transitioning out of nursing facilities and other institutions, and of course, affordable housing is a big part of that.

I did some submit some comments and then realized that I didn't bring enough copies so I apologize for that. We are following on the lines of integrated, affordable and accessible, but I want to spend my time talking about affordable, that seems to be the 800-pound gorilla in the room. Every time we have discussions in public, we talk about affordable and those of us in the

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disability advocacy world now say real affordable housing that is affordable to people at the extremely low income level.

I spend most of my time helping people apply for and understand what's available in affordability for people at that income level and telling people I can't pay their rent for them because that's where the issues are. I don't think we have a huge difficulty with accessibility, at least not to the extent that affordability is the issue. This is an ongoing crisis. Most of what is done with public funds, federal, state or local, doesn't make the housing affordable to people living on SSI, below that 30 percent income level.

And regardless of what your definition turns out to be or what's actually included, it's the affordability that's the problem, and until we have a place for people to live, we continue to have more and more people in institutions that don't need to be and don't want to be, we have people stuck in living arrangements where they are subjected to abuse and exploitation, and no option to get out of it.

We don't have people asking us to develop more restrictions and more rules about where they live, I don't hear that. I hear I can't afford the rent in this town or

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anywhere with the income I have, and until I have affordable housing, I can't deal with work or other things to stabilize my life.

So if you heard me talk before about any of this, you're hearing exactly the same thing. It's the people living on Social Security, in many cases SSI at \$674 a month and that's all the income there is, and even in affordable housing programs, they're not well off financially but they get by. The services are just not the issue that keeps rising to the top, it's all about affordable to people at that income level, and I'll stop saying that and ask you if you have questions for me, or else I'll go away.

MR. HANOPHY: So did you say it's affordable?
I'm just kidding.

(General laughter.)

MR. MEINKOWSKY: Real affordable. I thank you for your time.

MR. GERBER: Hey, John, let me ask you a quick question before you go. You work a lot with local housing providers as well. Are there any models that sort of stand out for you?

MR. MEINKOWSKY: The ones that are affordable.

(General laughter.)

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MR. GERBER: Are there any PHAs or local HFAs or others that are doing it right that stand out?

MR. MEINKOWSKY: There are things it allows PHAs to do that are nice in terms of allowing the affordability, in terms of allowing people to use that lump sum for a down payment when they want to be homeowners. Having a preference for people with disabilities on the waiting list is probably -- if I could make every housing authority do one thing, I would say that, get through those waiting lists faster.

The things which what is now Easter Seals Central Texas has done with their integrated Section 8 is brilliant and I admire the other local people that have done good things from Foundation Communities and Mary Lee Foundation and several others. People need services, people need housing. I think if we make that our priority, then the services tend to find them and people tend to find the services if they're stable, if they're stable and they can afford it.

MR. GOLD: John, along that line, I do want to give -- since Doni is here -- a shout-out to the Fort Worth Public Housing Authority. They've been very cooperative, we've met with them, they're about the only one that has actually put together some special set-asides

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programs that support older adults and people with disabilities through Groceries to Go, Medi Wheels, Handy Wheels, Care Calls, a brand new social respite program, and also a housing repair program.

You've heard today that one of the challenges facing agencies that serve older adults is this demographic shift, and the graying of America and the graying of Texas. Between 1990 and 2005, the Austin-Round Rock Metropolitan Area went fourth in the nation for the rate of growth among older adults. In Travis County the population of older adults is expected to double to nearly 400,000 by 2040.

Older adults face many challenges. Oftentimes these challenges are related to changes in their lives, transitional changes, issues of retirement, declining health, forced relocation, death of loved ones and support. The health, longevity, quality of life and functioning of older adults are influenced by many factors. Providing service-enriched housing opportunities will be challenging.

Family Elder Care here locally in town, with Austin Meals on Wheels and More, the Area Agency on Aging, Care Communities, Austin Groups for the Elderly came together and started a new collaborative. We just


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received the Administration on Aging Grant for Community Innovations on Aging in Place. In this grant we're focusing on specific issues. One of the issues is to look at how older adults can maintain or improve their physical and mental health. Programs need a component that develop easy access to health and wellness programs that promote healthy behaviors, both physically and cognitively.

Some of the programs that are in this grant include: a Matter of Balance that the Area Agency on Aging have been instrumental in doing; problem-solving therapy interventions for individuals with depression; health aging fairs; senior-wise programs that focus on memory interventions; nutrition education workshops; disease prevention workshops; assistance with medication management.

We know that research shows that those who remain actively engaged in life and connected socially to friends, they're happier, they're physically and mentally healthier and better able to cope with transitions in their lives.

I just wanted to give you all an anecdotal example too. We also are overseeing the rural programs for Travis County and receive funding through the Area Agency on Aging. There's a gentleman named Jack who was


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married for 40 years and went through a divorce, and basically after his divorce he said he didn't want to see anyone and didn't like anybody and he spent two years in his trailer alone, depressed. But now he comes to the Manor congregate site, he's socially engaged, he's active at the site, he volunteers at the site, he has a girlfriend at the site. He is back enjoying his life.

In a study done by Carolyn Turvey at the University of Iowa College of Medicine, it was reported that depression, poor sleep quality and limited social support were identified as risk factors for death by natural causes.

A couple of other major issues, of course, is nutrition. Meals on Wheels is very concerned about nutrition and nutritional well-being. Nutrition and dietary choices can prevent or prolong the onset of many chronic conditions. Poor diet is an enormous contributor to five out of ten of the leading causes of death in our country.

Atherosclerosis, heart disease, stroke, cancer, diabetes and bone health can all be either improved or ameliorated through good nutritional intake. If we can alter nutritional behaviors through education, increased awareness and food choices, proper food choices, we can

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better attack and combat poor health outcomes.

For low income folks it's harder. Thirty-three percent of Travis County residents who are older adults report that they need help to get food delivered to them and also assistance with meals. Engagement in work and community activities is essential to healthy aging. Opportunities need to exist in our community for older adults to engage in meaningful activities. They need networks, they need social networks, they need support networks and they need care networks.

Lastly, does the environment in which a person lives linked to well-being? Is the home falling down around the individual? Thirty-one percent of older adults in Travis County reported that they needed help and ongoing help with home repairs and maintenance. But how do you find someone who's reliable? And as you age, you're more vulnerable, so trust is a critically important issue. How do you find someone to do a quality job? Can you afford to live where you're living? Is a person safe in their own home?

We talked about people living in their homes and condominiums. In our community, 84 percent actually do live in their own homes; 30 percent report that they have difficulty maintaining their homes and doing heavy

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housework is very difficult. Dorothy, at age 85, said, I never use a bedspread anymore, it's just too draining to do all that tugging and smoothing and pulling.

Older adults are proud and reluctant to ask for any type of assistance, but when new challenges arise that potentially threaten their independence, we as a community need to be ready to offer assistance and to do so by focusing programs to help those most vulnerable. Thank you.

MR. GERBER: Thank you.

MR. DAUSTER: Mr. Chairman, unfortunately -- I apologize for this -- I have to get back to the office, but I know there are some presentations coming up and I'll work with the staff.

MR. GERBER: Appreciate you being here. Any questions for Mary?

MS. TEETERS: Thank you all very much.

MR. GERBER: Just to give everyone sort of a sense of where we're going because I think others are going to run into the same problem, including myself, we're going to proceed through the rest of the testimony and my hope is that people will not feel obliged to use the five minutes that's allotted to them. If we can, I'd like to get through it in the next -- I think we've got

going to have a disability, they're not going to have an alcohol problem, but they're going to die, everybody -- except me, I've decided it doesn't it doesn't look like fun.

(General laughter.)

MR. FARROW: However, looking at your definition, we're not in the housing business, we're in the business of providing services to people wherever they live. Ten year ago the feds came out before -- earlier when I first started working with hospice, we were stuck going only to the families' homes providing our services. They redefined home to be where the patient resides. That opened up nursing homes, assisted living facilities, this is going to be a home where people reside.

Medicare and Medicaid, we're fortunate both of them fund hospice care but both of them have a major fallacy in their programs. When the original laws were written, the definition was or the assumption was we all had a family member, a spouse, a child, a close friend, someone is going to be there to take care of us 24 hours a day. Our wives had divorced us, our kids have moved away, and that person is not there.

I get families calling me -- in fact, if you call 1-800-MEDICARE, you either get somebody in a cave

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on my reading glasses so I'm going to have to get this a little closer if you will indulge me.

Under the federal definition, people with developmental disabilities are persons whose disability occurs before they're 22 years of age. It can be a mental or a physical impairment or a combination of both that results in a substantial limitation in three or more major life activities: self-care, language learning, mobility, self-determination, economic self-sufficiency.

This population, long isolated in institutions, has been able to move into the mainstream of society due to publicly-funded low income housing, Medicaid-funded long-term services, accessible transportation systems. Real movement to coordinate housing and services is already taking place. Project Access is a collaborative effort of the Department of Housing and Community Affairs, the Department of Assistive and Rehabilitative Services. TDHCA provides the housing piece for consumers who have been institutionalized; DADS coordinates the provision of the long-term services and supports. This is all part of the money follows the person that's a result of a Federal Supreme Court decision in Olmstead.

Project Access vouchers are based around 30 percent of an individual's income, where our affordable

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housing -- and I'll just echo what's been said over and over and over, the biggest issue is affordability -- a housing voucher you pay 30 percent of your income, but affordable housing, the deepest we really go is 30 percent of area median family income. So individuals with developmental disabilities on SSI are going to make around \$674 a month that affordable housing is not affordable to them. So a first barrier for a service-enriched housing model is you're going to have to address the affordability issue.

The waiting lists are closed for housing choice vouchers. The City of Austin has over 5,000 people on their waiting list for housing choice vouchers and their waiting list is closed. So again, most affordable housing is around 50 percent area median family income.

The second is -- and we've heard this over and over today -- location, location, location. The lack of accessible transportation, available and accessible transportation has been identified by people with disabilities as one of the largest barriers to community integration. So for service-enriched housing to link residents with services and supports, we're going to have to locate where there is some public transportation available.

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According to TxDOT, there are eight large urban and 30 small urban, and 39 rural transportation systems and over 135 operators of transportation services for elderly and individuals with disabilities, so we need to look when we talk about where we're locating these options that they have to be where there is transportation.

Third, the housing has to be unbundled from services. Texans with developmental disabilities get a lot of services through Medicaid long-term waiver programs or Medicaid waiver programs. Some of those are connected to the housing. The council does not support that as any kind of new development, we want the housing separate from the services, we want consumers to be able to have choice and control over where they live, where they get their services. So we do support your definition up there, integrated, affordable and accessible housing models.

I guess, you know, the only word "independence" has been talked about in so many different ways today, what does that mean to anyone. In some of these SROs I think the services sort of kind of sound like they're required, but I looked over your documents, your HHSC decision document where they put together some models for you, and I agree with someone else who talked that the North Carolina model really is the one that really comes


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the closest to meeting your definition up there.

It requires three things: capital, operating subsidy, and access to services and supports. But so I think we can't just really lay that model down over Texas but one of the things we can do is we could adopt a requirement that new tax credit developments be located within easy access of public urban or rural transportation, because as someone else said, people can go find their services if they're living in the right area, you can find your hospitals, clinics, et cetera.

Then we have the urban/rural problem. We have elderly flight from rural areas because the hospitals, the services aren't there. So I'm not going to talk about changing that percentage of where we have to allocate funds under TDHCA housing programs. Bring up the percentage that we can put towards urban development.

The operating subsidy piece, North Carolina provided a subsidy to the housing unit to provide for the physical needs of the tenant. We have the new Housing Trust Fund Architectural Barriers Program that can make those architectural modifications that wouldn't necessarily be included in 504. When somebody needs specific accommodations to their disability, our Housing Trust Fund Architectural Barriers Program could help with


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that.

Another thing is North Carolina had funds for this and we don't have funds for the development of this model, but we could -- and I hope I don't get shot in the back on this -- but without creating a new rental subsidy, it seems like we could get developers, require developers, give them a bonus points to set aside a certain number of units for deeply affordable rents below 15 percent area median family income and absorb that cost in their operating revenue.

So finally, let me close out. I think the cross-agency part, the collaboration, I think we're seeing that happen. TDHCA with DADS and with the Department of State Health Services, the transition for homeless programs, so I think we have some cross-training as well as collaboration going on already and I think that you can further that, those relationships.

Let's see, my final thing I want to say is I don't think that this is -- we've heard a lot of developers, this is not about bricks and mortar, this is not about building a separate unit, we don't support that, some new kind of institutional model. I think we can do this in multifamily housing, let's set aside a certain number of multifamily housing units to where we're going

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situation, we're highly accountable to our community, we were approached by our county commissioners and our city council to develop affordable housing for our clients as they come out of our program. Our clients come in, we have them for 14 days, we have to reapply every 14 days for their treatment. At the end of 30 days they come out of our program. We have a 36 percent success ratio coming out of our program. The reason is we work very diligently trying to find locations for our clients to go to that doesn't put them back in the middle of what they came from.

Now, again, we're in a unique situation. I have a city council, I have a county commissioners court, I have the Neighborhood Works Association -- which is funded by the state -- coming to us and saying can you build us affordable housing, can you integrate that within your program.

Let me tell you what our problem is. I'm 97 percent state funded, I don't have any excess money. There isn't anyone out there that's inexpensive as consultants that I can hire to tell me how to deal with all these agencies. I mean, everyone of you represent somebody different, pretty much, and when I go to look and say okay, I've got capital, I have a third of my 25-person

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board are independently wealthy, we write checks all the time to keep all the excess money going, we can raise the capital, but we don't know where to go to get the funding that's also available, because I have to go to this agency and this agency and this agency and this agency and this one, and everybody has a different rule, nobody can interface, nobody talks to each other. And you want to talk about barriers, there's the barrier.

More important is, I don't have any staff people that I can afford to send and educate for two years to learn how to do that. If you guys as a group, as a council could put together a training for EOs, executive officers, for board of director members that could come down and understand the intertwining of all this council's individual agencies, I will tell you, you will get a huge amount of people applying that are quality, competent and capable of offering the integrated housing, of offering the services to go with it

You know, your definition is wonderful, but it still comes down to the resident has to talk to the provider, the provider of the houses and the provider of the services. And if those providers of housing and services are one and the same and they're accountable and they're quality and they're competent and they can do what

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needs to be done, that's who you want to be granting your monies to. But there's no way to get to you -- I'm telling you that from my side.

September is when our government agencies came to us. Jim Dunham is my state rep, he came to me and said, I'll sign any letter you want endorsing you; Doc Anderson came to me and said, We're there too. My city manager, our mayor, our county judge, they're all saying: What do you need. And we're going: We don't know what we need because no one can steer us in the right direction.

And we've got an \$80,000, we've got a \$40,000 consulting group that says front the money to us and we'll tell you what to do. I don't have \$40,000 or \$80,000 laying around that doesn't need to be going to services, and there's no guarantee I'm going to do the program, so that's \$40- to \$80,000 I'm going to invest that I may not even be able to use.

Well, I've got too much need on the ground of people there. More important than that is, as we look at how people come through this, the project that they asked us to develop wasn't just solely for us, it was a 200 to 250 unit complex, compound, whatever you want to call it -- campus in which 50 percent of it was going to be solely affordable housing. Of the 50 percent remaining,

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as you guys, as a grouping of agencies, can put something together, I think you will lower more barriers to the people who can provide the services and provide the housing and make your jobs easier.

So that's my testimony and that's why I waited around. I thought it was pretty valuable because all the other information that everybody gave today is facts and figures, but on the ground I'm one of those guys that are out there that really wants to do what you want to have done, but I don't know how to get there, and if you can help me get there, we'll do it.

If you have any questions, I'll be happy to answer them.

MR. GERBER: That's very helpful and appreciate the insight. Any thoughts or questions, council members?

I think that's going to be the subject of additional discussion as well, so thank you very much.

Marilyn Hartman.

MS. HARTMAN: Almost last, but hopefully not least.

MR. GERBER: No, there's one more person. Go ahead.

MS. HARTMAN: Hearing about all the elderly makes me feel that I know I'm getting there pretty fast.

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I'm Marilyn Hartman, I'm from NAMI Austin, that's the Austin affiliate of the National Alliance on Mental Illness, and also a new member of the Texas Disability Advisory Workgroup, called DAW.

The statistics for the mentally ill, I'm here to talk on their behalf, mental illness is the leading cause of disability in ages 15 to 44 and 6 percent of our population has what's considered a serious mental illness, so I appreciate a chance to speak on their behalf. These are people with significant brain impairments who may not share our same reality. Many are not able to care for themselves and yet our society has neglected this population since the mental institutions were closed decades ago, and alternative housing and care were not provided.

They do face barriers, yes. SSI, at \$8,088 per year is only 16 percent of the area median income. Stigma abounds and their strange behaviors do not work in their favor. Convicted felons are shut out of Section 8 housing, and even if there were safe, affordable permanent housing, the government has not paid for care or many other supports which are a crucial part of their treatment plan, thus they have not gotten what they need. So it's not surprising that the mentally ill are cycling through

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and overcrowding our jails and prisons, ERs and mental hospitals, or that they're homeless on our streets.

More than 150 homeless died here in Austin last year and 130 or so the year before. Well, that's really unacceptable. They're dying from our society's neglect. So the bottom line is that the mentally ill have really created a crisis in all of these places because they haven't gotten what they need. Yet studies conclude that it would be far less costly in taxes and quality of life if we provided housing and supports to these very ill people and we would also be giving them a chance at recovery. We need to recognize that the most disabled may need long-term care and support, but right now they're getting nothing.

My 35-year-old son has a chronic mental illness through no fault of his own. He's a wonderful person, bright, with an engineering degree from Yale, but ten years ago he was diagnosed with schizophrenia and he is highly disabled. For three years he was in and out of mental hospitals 13 times, at great cost to taxpayers and at great detriment to his long-term prognosis, and he was kept in three times for the maximum three months, the last time at Austin State Hospital. But a greatly impaired mind cannot see that it is impaired and he consistently

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probably needs the highest level of services possible for the mentally ill. There is a wide spectrum of what's necessary but my son is very, very disabled, he needs to have food given to him, he needs to have his appointments made for him, transportation to those appointments, people working with him on his hygiene -- which is one of the very first things to go for the mentally ill -- and this is all despite his being compliant on meds for seven years. So meds are not the total answer, it's a very debilitating situation.

MS. MARGESON: I was just curious if you have heard of the Fountain House model that's, I think, in New York.

MS. HARTMAN: Yes, I have. And there are some people here from NAMI Austin trying to get what's called the Club House movement going here. Those would be for much more functional mentally ill people, people who really can live much more independently. They still might need some supports. One of the very basic supports that I see for people with mental illness is that they need to have somebody ensure that they're taking their meds. One thing, particularly with schizophrenia, it's part of the illness itself that they cannot see that they're ill and they'll go off their medications, they'll cycle down and

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they'll be back to ground zero again. Studies also show with schizophrenia that the more times a person cycles down, the harder it is for them to get back to that place where they were and the worse the long-term prognosis for them.

So again, early intervention. Nobody should be allowed to cycle down 13 times and go in and out of mental hospitals, nobody.

MR. GERBER: Thank you for sharing your experience.

Is there anyone else who wishes to testify?

MS. SCHWEIKART: Norman is here.

MR. GERBER: Norman, do you want to come forward and testify? Norman is the chair of Mayor Leffingwell's Committee on People with Disabilities. Do you want to say a word? We're glad you're here.

MR. KIEKE: I'm sorry, I didn't know that I had signed up to speak. I'm Norman Kieke, I'm the chair of the Austin Mayor's Committee for People with Disabilities.

I'm very honored to be appointed to that position. We had our monthly meeting today, we had a heck of an agenda, actually speaking about transportation issues, and I was not able to get consensus on a statement since we are appointees of the city council, I have to get statements

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approved by the city council.

Just to give you an idea of my history, though, I also serve on the Easter Seals board of directors which was mentioned previously by John Meinkowsky as kind of a model program that's doing good things with housing for people with disabilities. I'm in a new career now for two years, but prior to that for 27 years I was the executive director of the United Cerebral Palsy of the Capital Area which segued into an independent organization, Disability Assistance of Central Texas, and we did some groundbreaking things with people with disabilities in terms of supported employment as well as in terms of helping people get out of institutions and state schools and move into the community. So we had a very hands-on program moving people with significant and severe disabilities into independent living situations.

Some of those situations are similar to what you're describing here, and I'll admit I've had limited time to look at your verbiage, but based on the knowledge that I have with the folks that we moved into primarily apartment complexes that were working with the City of Austin that had federal fund subsidies that agreed to provide support services for their residents with disabilities, what we found was turnover was a problem,

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and by the time you educate an apartment manager or somebody on duty about services that specific residents needed, by the time you went back, that person had moved on to another apartment complex, they were no longer there.

So we found ourselves for a little bit of time doing repeated orientations for people at these apartment complexes that we were hoping were going to help our folks, and the next time you went to meet with them, the meeting room was full of boxes of toilet paper or something like that because they needed storage room and didn't really know how to provide services. So just basic education is really important for the people in these apartment complexes that might be willing to help.

What we did, kind of as a band-aid fix, I was an active player with the Developmental Disabilities Group, a coalition of local agencies, ARC of the Capital Area, Easter Seals, United Cerebral Palsy, MHMR, and we developed a community guide to describe the types of services that we had and which agency offered them so that we could give these to these apartment complexes to, if they could, help the residents when they needed these services. So it was just a very basic guide, and unfortunately, within about a year that guide was out of

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We currently have nine women in our program and they have their children with them in treatment. These ladies are in definite need of affordable housing when they leave. Most of them, it's very unsafe for them to return home, most of them don't have a home to return to, they lack job skills, most of them lack educational opportunities. Affordable housing for them is just almost a must.

I would like to reiterate what Carolyn said about the disabilities of substance abuse being considered a disability. I spent 35 years researching the field of addiction and alcoholism before I became a counselor, and I can tell you with firsthand experience that addiction is a disability, so I'd like for that to be considered by this board, and help these women out.

One of my women had her baby two weeks ago while she was in treatment, and I have another who is scheduled for delivery next week with her baby. So they've got a lot of issues, they have a lot of needs, and they could use your help on this. So with that, thank you.

MR. GERBER: Thank you. Any other comments from the public? Thank you all again for sharing that, and I know for those of you may have been at the end and

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didn't get a lot of questions, I suspect what happens with our eight-hour TDHCA Board meetings is a certain amount of fatigue sets in and so I appreciate the council bearing with us and we might likely have questions for you at a later point in our deliberations and discussions.

The next item on the agenda is the adoption of the Service-enriched housing definition, and I'm going to let Ashley and Brooke take over and walk us through the decisions that we need to make today.

MS. LANGENDORF: Could I ask something? Do we have to do this today? And the reason I'm questioning it is only because we have two more forums ahead of us and I'm just kind of feeling like we're getting some really good input, I think, from individuals as they are responding to the definition. Unless we adopt something tentatively until we have the other two forums.

MR. HANOPHY: And going back to my original point, again, I think we can wordsmith this thing to death but I'd like to hear what the rest of the feedback I, and then also, I hate to cite Senate bills and House bills as a model, but that key piece there in that definition section or that value section I think might be important for us to really consider. The whole notion of do you put the word "voluntary" in there or do you put the word

"choice" and all that, well, maybe you describe that somewhere else.

MR. GOLD: I totally agree with you. I mean, I think we have those other two forums, and I know if we had to be put to a vote, I couldn't vote for the definition, it would be impossible.

MS. BOSTON: If I could just share with you guys time lines and you can make a decision based on this information. We owe the legislature a report September 1, so we need to be done in August, so part of having that done will include having a definition, and if you guys vote in May, we have to take it to the TDHCA Board who will approve it in a draft form, it will go out for public comment for 30 days, and then it will have to go back to TDHCA's board for approval. So from whenever you guys vote, we have to account for two TDHCA Board meetings with a window of time in the middle for public comment and getting that done before the August meeting.

I'm not saying you guys have to do it today, I don't know if you want to contemplate another meeting.

MR. GERBER: Is it fair to say we could hold it till the February 24 meeting in El Paso and do a full committee meeting in El Paso as opposed to just a forum out there?

MS. BOSTON: Sure, you guys can call any meeting you want

MS. SCHWEIKART: That's up to you guys.

MS. LANGENDORF: Do we have a quorum or a majority going to El Paso?

MS. SCHWEIKART: I don't have all of the state agency representatives decisions about those that I can tell you right now. I know most of the governor or all governor appointees will be attending, so I'm trying to figure out who of the state agencies -- I know Paige will be there, Jonas will be there.

MR. GOLD: I'm not sure at this point.

MS. SCHWEIKART: The thing is we'll have to have a quorum so we'll have to have nine or more representative in order to make that decision.

MS. GRANBERRY: I would even be willing to come to Austin for an extra meeting. Jean just hit her microphone before I did because I was going to ask the same question.

MS. SCHWEIKART: Yes, so that's another possibility if you guys want to decide on an additional council meeting between this one and the next May meeting.

MS. BOSTON: Or we can accelerate it.

MS. SCHWEIKART: Or we can accelerate it.

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MR. GOLD: Yes, I agree, I think there needs to be some other discussion. My real concern is this isn't a policy or procedure, this is a rule promulgation that's going into the Texas Administrative Code meaning that, meaning that if we want to change it, we'd have to back through the whole rule promulgation process. And certainly I think what we're hearing, I'm still not sure what service-enriched housing is, to be perfectly honest, at this point, one, because of all the various things that are being said here. Obviously it would have been done a long time ago if it was really easy, this is really complex.

MS. LANGENDORF: And I think one of the other things that I think changed from the committee meeting we had is the feedback from the authors that maybe we aren't just limiting it to people with disabilities and the elderly, maybe we need to be broader on that end. After reading what you got, the interpretation, I'm kind of like maybe it needs to go back to the committee or maybe the whole group.

MS. SCHWEIKART: What Jean is saying is in your packets, and also you received electronically, is along with the draft definition there was a conference call that took place with members of the staff of Senator Nelson's

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guess it's a decision of the TDHCA Board to decide how they want to handle the approval of the draft rule. Kind of my presumption a little bit about how this will proceed would be that you guys would recommend out a definition, and based on your expertise, our board would probably be very receptive to the draft that you've put together and would release that draft, I would hedge my bets unchanged -- although I can't speak for the board members, of course -- but then once they hear all that comment and testimony, it will be the TDHCA Board who will have to approve the final rule.

I would think at that meeting, that may be a meeting where as many of you as possible would want to be there to have dialogue with the TDHCA Board so that the final approval of that is something that you guys have full input into. I'm sure there could be variations on that, it could be that the TDHCA Board would want to wait and have it come back to you guys and then they would only approve a final after you guys have commented on all that comment.

MR. GERBER: We're hoping for a more straightforward way.

MS. BOSTON: I think there are a lot of ways to make sure that the TDHCA Board is very responsive to what

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you guys' desires are. That being said, it's all going to take time.

MR. GERBER: There are infinite possibilities, but the intent is if we can -- and since we're TDHCA, we undoubtedly will go through many of them, but hopefully not on this one -- my hope is that if we could get to a point where we could come up with a definition. I think Jim's point is well taken, it would be preferable to get to our March board meeting, that might not be possible, in which case -- when is our next meeting after the March one?

MS. BOSTON: Our TDHCA Board meeting? We aren't doing April, we're doing March and then May.

MR. GERBER: So then you get May, and we've got one in June and two in July. It's just that it's cutting it close.

MS. GRANBERRY: Can we hold a meeting through like a conference call?

MS. SCHWEIKART: No. Due to Open Meetings Act, that is not allowed.

MR. GOODWIN: Why can't we set our goal to bring this thing out on the 24th of February. Let's set a date and say let's use that meeting to try to solidify, and then that gives us two weeks, if something goes wrong,

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hearings in Austin on a regular basis, the thing that I hate most is when I drive four hours for a public hearing and it testify when the decision has already been made, and if we make that decision prior to the other two public forums, we have just discounted everyone's time and taken for granted that they're going to show up, and I've been on the receiving end of that and I don't want to do that to people.

MS. SCHWEIKART: So I guess there's two options here: there's either we turn the El Paso public forum into a council meeting, if we can have quorum, or we turn the Policy and Barriers Committee meeting into a full meeting and we think that we can get it in by the 11th for the board?

MS. BOSTON: Yes, we can get it in the book.

MR. GERBER: Even if we need to do a three-day posting on it, we can make it work.

MS. SCHWEIKART: So where do people want to go with that?

MS. GOTHART-BARRON: I'd go with the Policy and Barriers meeting.

MS. SCHWEIKART: So March 2. Are people okay with adding that as a full council meeting?

MR. GOLD: Can I make a recommendation, though,

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too? If some of us have some concerns, can we be encouraged to send them to -- Jonas is in charge of that committee, sending some of those comments in about what some alternatives to the definition may or may not occur, or at least have some ideas. I'm sure it's not against the rules that we do some e-mailing and looking at some other information, so it can make that meeting a little more clear or at least you can focus the conversation.

MS. MARGESON: Could the committee meet in the morning and have something to present at the full meeting, say, in the afternoon?

MS. BOSTON: We could do that.

MR. SCHWARTZ: That way that would give the Policy and Barriers Committee an opportunity to come forth with a revised recommendation based on all the input and then give it to the council and then have discussion with the council and then a decision be made

MS. BOSTON: I think on the e-mails they would need to go to Ashley.

MS. SCHWEIKART: Yes, to stay within the Open Meetings Act. I could compile feedback and present that at the Policy and Barriers Committee meeting that morning

MR. GOLD: I'm just trying to think of a way of making it easier and faster so we don't spend hours.

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MS. SCHWEIKART: Right. I think that's probably the easiest way to do it is that if you have feedback on the current definition and changes to be made, to be able to send that to me with enough time for me to be able to send it electronically to the Policy and Barriers Committee, so give me 48 hours before the meeting. So then they can discuss it maybe in the morning and then the afternoon would be the full council meeting.

MR. GOLD: And Amy, just another thing, I don't know as far as the other state agencies go, but I certainly want to discuss this with my commissioner. I don't feel comfortable just making that decision by myself.

MR. GERBER: And I think we want to do some vetting on our end with our board and make sure there are not going to be any problems when we get there, and I think others will have similar issues.

MS. SCHWEIKART: And just so everyone is aware -- I know the Policy and Barriers Committee has already aware of this -- the 2nd is a state holiday, so if everyone is all right with that.

MR. GERBER: What's the state holiday?

MS. SCHWEIKART: Texas Independence Day.

(General talking and laughter.)

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MS. MARGESON: Will space be a problem on that day, Ashley?

MS. SCHWEIKART: I think we should be fine, we should be more than fine, actually, because it's a state holiday.

So do we still want to do the integrated housing rule presentation? It kind of goes along with how we're going to be clarifying our definition. I don't know, how do people feel?

MR. GERBER: I get the impression that maybe people have had enough for the day

MR. WYATT: Could I acknowledge just one more, because I know you've hashed this out and I've heard the use of the word -- just help me think about it -- integrated, I initially thought it meant integrated services with housing and I know that word can have multiple meanings, but does it mean that or does it primarily mean also integrate the housing within the community, or both? --

MS. SCHWEIKART: That's the reason why I was going to make this presentation is because I know there are a lot of people out there who don't understand it and I can always e-mail out these power points that you can have a clarification of what it actually says in the Texas

Administrative Code as to what integration and what integrated means.

MR. WYATT: I figured there was a lot of knowledge here and you've hashed it out and it would just be helpful to know that up front because otherwise, we may just send you comments or whatever that's not really helpful or maybe just rehashing old ground or something like that.

I know it's late in the day but I know you can't vote on something if you don't know the full definition of the terms, you're basically just putting out a new starting point.

MR. HANOPHY: And I believe some of it that's the issue is that we may have to operationally define some terms in addition to what the intent is

MS. MARGESON: How long is the presentation?

MS. SCHWEIKART: It is six slides.

MS. MARGESON: Can't we do six slides -- not Six Flags.

(General talking and laughter.)

MS. SCHWEIKART: All right. Well, I'll just go through very quickly. When people have been discussing the integration rule, it's the integrated housing rule which is part of Title 10 in the Texas Administrative

Code. I've laid it all out where you guys can find it yourselves even, Rule 1.15 in Subchapter A, Chapter 1.

So "Integrated housing is defined as normal, ordinary living arrangements typical of the general population. Integration is achieved when individuals with disabilities chose ordinary typical housing units that are located among individuals who do not have disabilities or other special needs. Regular integrated housing is distinctly different from assisted living facilities or arrangements."

So the basic what you need to know about this rule is a housing development that receives funding through the TDHCA may not restrict occupancy solely to people with disabilities or people with disabilities in combination with other special needs populations. And how that breaks down into specifics is procedurally large housing developments of more than 50 units can provide no more than 18 percent of the units of the development set aside exclusively for persons with disabilities, and then on the small housing development end, that's 36 percent of the units, no more than that can be set aside exclusively.

Now, it a little different in that units that are restricted to being provided with persons with disabilities, so it does not prohibit the property from

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having occupants that are disabled elsewhere in the development, these are talking about units that are specifically set aside for persons with disabilities. And obviously, property owners cannot market the development solely to persons with disabilities.

Now, there are four exceptions: first are scattered site developments or those with tenant-based rental assistance; the second, transitional housing is exempt but it must be time-limited; the third, housing developments designed exclusively for persons who are elderly; and then the fourth is designed for other special needs populations and that's defined in the Texas Administrative Code as those different special needs that are listed below that. Can everyone see it all right?

MS. MARGESON: No.

(General laughter.)

MS. SCHWEIKART: Let me read it out then. Other special needs populations are defined as "Persons who are experiencing a unique need for decent, safe housing that is not being met adequately by private enterprise, including: persons with alcohol or drug addictions, Colonia residents, victims of domestic violence, persons with HIV/AIDS, homeless populations, and migrant farm workers." So those groups are included under

other special needs populations that are exempt from the integrated housing rule. Does that make sense?

So this slide is kind of just a beginning of what could be further conversation, but housing models that are eliminated from receiving TDHCA funding due to the integrated housing rule, this is a short list, I know there are more out there that would be eliminated.

MS. MARGESON: So help me understand this. Integrated housing, when it pertains to people with disabilities, is limited to a certain percentage, but if it's these other groups, then the full project can be composed of whatever target group it is. Right?

MS. BOSTON: Sure. If, for instance, someone had proposed a property that met one of the other -- let say someone had proposed to do a property that was serving people who were victims of domestic violence, if they did that and they chose to set side more units in the property for people with disabilities than the limits that we have restricted in the integrated housing rule -- so say it's a small property and they want to exceed 36 percent -- they can do that. So essentially for properties who are going to serve one of those other populations, if they choose to have to have percentages higher than this definition, they're allowed to, it's one of the current exceptions.

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A couple of things I'd also like to mention about this definition for the integrated housing rule, it's something that the Disability Advisory Workgroup -- which is another advisory group that advises Mr. Gerber -- has requested that we bring back up just to kind of revisit, make sure they're feeling like the exceptions are all still working, that maybe there's an exception that we don't want to have and we have it now.

Also, by definition, this rule is not automatically triggered by the word "integrated" being in your definition. You would need to specify that. This is, right now, how TDHCA defines integrated housing, and when we release any rule or NOFA for the agency, we say you have to follow our integrated housing rule, but it's a defined term in a certain part of our administrative code.

And so if you guys chose to think of integrated in a different way, you have that opportunity.

That doesn't mean that on one of our properties we would waive the integrated housing rule, but the policy that you are setting with your definition may touch a lot of properties, in theory or in hope, that isn't directly funded through TDHCA. If we're able to look at models that deal with private funds or public housing authorities, direct federal money, and so whether you do

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or don't want to trigger this definition on your definition is really up to you. Don't feel as though this is kind of forced onto your definition.

I hope that wasn't more confusing.

MR. GOLD: No, that was actually clarifying.

MR. GERBER: Let me also offer, it's a complex area of rulemaking and law, and to the extent that it would be helpful to have some additional staff briefings, Brooke is certainly available, as are others at the department to give you some insight as to sort of how we got to some of the places we're currently at. So I would just make that available to you.

I apologize, but only because I've got to be at the Governor's Office would I leave this, but I'm going to turn it over to Paula. And I know many of you will be in Dallas and many more of you will be in El Paso -- or Fort Worth.

MS. SCHWEIKART: It's Fort Worth, technically.

MR. GERBER: And I regret that I won't be in Fort Worth but Brooke will be in my stead there, but we'll, of course, see everyone in El Paso and then back here as well and hopefully to get some decisions made.

MS. MARGESON: I don't think we can do this because you assured me that you would always be here.

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heard that today in testimony, so if it could, if our word "integrated" meant the same thing that you mean -- meaning TDHCA means, I think that might be helpful.

MR. GOLD: So by definition, does that mean that issues like adult foster homes and assisted living would be excluded from the discussion from this council?

MS. BOSTON: I don't think so. I think that just because it may be an exception to the integrated housing definition, as it relates to a funding exception for TDHCA, I mean, it doesn't mean you guys shouldn't or couldn't discuss those as possible models for achieving service-enriched housing, if that's what you guys decide.

I think it just says that if you were to get funding from TDHCA, that that is a type of a model that couldn't probably be funded.

MR. GOLD: I think what I hear you say is that our definition should be consistent to use the word "integration" that has a connotation for TDHCA and to have like a separate connotation, that would be problematic.

MS. MCGILLOWAY: And are the exceptions, are they incentives? I mean, it seems like it's almost an incentive to work with the special needs groups because then you can go above and beyond those percentages. Or should I not look at it that way?

MS. BOSTON: You know, that's a good question, and in practice, ever since it's been approved, I don't feel like people have seen it as an incentive, but we have only had one entity ever who I think has even requested an exception to the rule or asked the board to waive the rule so that they could exceed it. Our board has taken the rule very seriously and the public knows that, so people don't even ask. But I wish I could say that people have seen it as a great way to point them to do these other activities, but it hasn't done that either.

MR. SCHWARTZ: Brooke, I was around way back when when this rule was adopted; I happened to be chair of the Disability Advisory Committee at the time this rule was adopted. How many years now has that been?

MS. BOSTON: Oh, that's such a good question. I would say it's probably been like maybe 2002. Does that sound right to you?

MR. SCHWARTZ: That's kind of what I thought.

MS. BOSTON: And so another question, I guess, too, I went back to the slide that is the definition of integrated housing from this rule, and I guess one thing to ask for the council to think about is are you wanting to trigger the entire rule or are you wanting to trigger the definition in this rule, the distinction being that

the whole rule is what gets into the exceptions of percentages based on the size of the multifamily property, but if you just want to use the definition, that also provides you, I think, you were looking for without needing to pull in the entire rule. And if you like, I can reread that rule.

MR. HANOPHY: I think the issue is with the definition, that if we can be consistent with the definition because that's really what we're talking about is looking at our definition, we've got a definition that we can work from.

MS. BOSTON: Paula, would you like me to read that?

MS. MARGESON: Sure.

MS. BOSTON: It says, "Integrated housing is defined as normal, ordinary living arrangements typical of the general population. Integration is achieved when individuals with disabilities choose ordinary typical housing units that are located among individuals who do not have disabilities or other special needs. Regular integrated housing is distinctly different from assisted living facilities or arrangements."

MS. MCGILLOWAY: What would the downside be of adopting this rule? And that's just my ignorance. I'd

want the negatives pointed out to me, I don't know if I get it yet.

MR. HANOPHY: I think the tricky part is going to be the service-enriched part because by its very nature, some of the things in that definition don't fit service-enriched. And so that's where we may have to be true to the philosophy of integration but at the same time allow for moving even a little further in one direction or another when we start talking about the enriched services.

MS. MARGESON: Right, because I was thinking I fit that definition, I'm integrated in my house and I'd like someone come there and provide services.

MR. HANOPHY: It says regular integrated housing is distinctly different from assisted living facilities or arrangements. Well, service-enriched might move a little closer to that, and so I think we have to allow for our definition.

MR. GOLD: That's a concern, it's not like it's negative to me, but I'm just saying just for information, whatever service-enriched housing means, a lot of people do receive services and housing through an assisted living arrangement and through adult foster care or through home sort of settings where people do that, so those are being excluded by definition.

MS. LANGENDORF: And you know, what I'm thinking if it's licensed, that's a facility, and I really hope we can look at housing and services, not licensed facilities. I think it would help us a lot if we can make that distinction. Having been a houser all my life, it's a housing issue, I think, not facility. Something that's licensed, I think then it becomes some different than service-enriched housing.

MS. MARGESON: I think I see where the original committee was going, Jonas, but it appears to me that in reality it relates to multifamily housing as supplied through this organization or through TDHCA, perhaps, as we interpret it, because certainly if you're in single family housing that you bought yourself, you're integrated and that definition does apply, but it's what we're working with there I think is multifamily. Right?

MS. BOSTON: Yes, that's correct, the definition was designed primarily to address the multifamily activity of the agency.

MS. MARGESON: It gives us a lot to think about. Are you ready to go forth and think?

(General laughter.)

MS. GOTHART-BARRON: Ashley, can you go ahead and send this to us so that when we get back to our

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agencies, we have that.

MS. SCHWEIKART: Sure.

MS. LANGENDORF: Can I ask one additional thing for El Paso, and I don't know if it's possible for those of us that are going out, it looks like our flight is really late --

MS. SCHWEIKART: Delayed?

MS. LANGENDORF: The only opportunity for those of us from Austin to come back is late.

MS. SCHWEIKART: Yes.

MS. LANGENDORF: Is there any way you could check to see if we could do a drive by or go by the PAICE property that was described today? We're going to be in El Paso and I don't think we have that much invited testimony -- I don't know -- but I don't think it's going to be like Austin.

MS. SCHWEIKART: Right, it's going to be definitely less than what was here, and I have contacted the PAICE program to discuss having some people from their organization come and speak to us at the forum, so I can certainly see if they are willing to have us to go by.

MR. GOLD: She's always willing to show. It's a cool place.

MS. LANGENDORF: And we're talking about the

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housing that has been developed right around the community. I know people come from their own homes but it is a really interesting model.

MS. GRANBERRY: There are several interesting things in El Paso that it would be good to see. Through the homeless community they've co-located a bunch of services and different types of housing for veterans and several special populations, they're co-located a number of services and El Paso just kind of stands alone because they're out there by themselves.

MS. SCHWEIKART: So I will look into that, Jean, and I will let you guys know if we can maybe add on a tour because we will have probably less testimony than in our other locations.

So I will send out an updated time line for us with the Policy and Barriers Committee meeting sometime during the morning of March 2, and then going into the full council meeting on March 2, so we will craft an agenda for that, we'll go out in the Texas Register. And then I know you all know this but I'm going to say it again, Wednesday 10:00 a.m., Fort Worth Central Library Chappell Room, and the 24th El Paso Library auditorium, 9:30 a.m.

MR. GERBER: So is there a motion to adjourn?

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(Motion and second were made.)

MR. GERBER: All in favor?

(A chorus of ayes.)

MR. GERBER: And on behalf of Mike, thank you.

(Whereupon, at 3:25 p.m., the meeting was concluded.)

