# CAN Community Council Meeting Minutes, 07/18/2016

**Community Council Members in Attendance:** Hunter Ellinger, Nancy Gilliam, Laura Griebel, Monica Guzmán, Anne Harutunian, Kirsha Haverlah, Carmen Luevanos, Ara Merjanian, Elizabeth Moore, Laura Poskochil, Leslie Puckett, Eileen Schrandt, Paulina Urbanowicz, Michael Willard, Terry Wilt, Michelle Zadrozny

**Members not present:** Celso Baez, Michelle Casanova, Rolando Delgado, Rhonda Douglas, Courtney Horm, Molly Latham, Stacey Mather, Blythe Plunkett, Caroline Reynolds, Gloria Souhami

**Staff in Attendance:** Raul Alvarez, Mary Dodd, Carlos Soto, Catie Bialick

**Speakers**: Kathleen A. Casey, Sarah Cook, Terri Sabella

**Other Guests:** Marium Murad

**Call to Order and Introductions:** Chair Eileen Schrandt called the meeting to order at 6:05 p.m. Members introduced themselves and shared announcements. Monica Guzmán announced that the next Restore Rundberg meeting would be on July 28th at the ARC Community Church. She also noted that HousingWorks is teaming up with the Federal Reserve Bank of Dallas and Children's Optimal Health to host a one-day summit, Housing + Health: Building Blocks for Equity and Opportunity, on Thursday, November 17th.

**Citizens' Communication:** none

**Approval of Minutes:** The minutes of May 20, 2016 were approved with one correction.

**CAN Executive Director Update:** Raul Alvarez shared updates on CAN's work over the past month. Last month the CAN Board of Directors continued their series on bridging the economic divide with a focus on housing in Austin and Travis County. The next Board meeting will take place in August; transportation is the theme. The Dashboard Steering Committee met last week. They are taking a look at each goal area to see if there are any goals and indicators that need modification for the 2017 CAN Dashboard report. The City of Austin is in the process of forming a work group around language access (lead by City Manager Ray Baray). CAN hopes to work strategically with the City of Austin on language access efforts moving forward. Planning for the Central Texas Regional Summit continues. This week CAN met with the Round Rock Mayor, who will help open the event, which will be held at the Dell Diamond United Heritage Center. CAN has started a book study and the Community Council is invited to participate! The first book is *Shadows of a Sunbelt City* by Elliot M. Tretter. Finally, CAN is available to give dashboard presentations to organizations and groups. Please let staff know if you are interested.

**Chair Eileen Schrandt Updates**: The Community Council is accepting applications for the Community Council through September 15th. CC members with expiring terms, who wish to continue serving must re-apply.

**Building a person-centered community:** Nancy Gilliam introduced panelists and invited them to share their ideas on what it means to provide health and behavioral health services in a person-centered care way.

**Kathleen A. Casey**, Ph.D. is the Director of Adult Behavioral Health Systems for Austin Travis County Integral Care. ATCIC provides community-based services for Travis County residents with brain-based disorders. The organization's programs include Adult Behavioral Health, Child and Family, Intellectual and Developmental Disabilities, Psychiatric Crisis Services and Jail Diversion. ATCIC employs people in 46 different facilities across the community. ATCIC's standards of care adhere to Texas Department of State Health Services and Texas Department of Aging and Disability requirements. In FY15 ATCIC received 41,000 crisis calls and provided 457,520 services.

Person Centered Assessment and Care Planning is key to engaging and maintaining individuals ATCIC serves. The organization works to achieve a balance between the traditional medical model and meeting the holistic needs of each individual. Their focus is on recovery. In person centered assessment and care, recovery is directed by consumers and produced in partnership with care providers and natural supporters. Person centered principles allow individuals to take control as much as they can. Other person centered models and tools used by ATCIC include peer specialists, strategic community partnerships, person-centered language, self-identification, motivational interviewing, trauma-informed approach to service, and cognitive behavioral therapy.

Person-centered efforts ATCIC has embraced include Permanent Supportive Housing and Mobile Crisis Outreach. Permanent Supportive Housing is an evidence-based intervention for those experiencing chronic homelessness. PSH sometimes takes a "Housing First" approach in which people are housed without pre-requisites, then provided support services at the clients' request. This approach has the benefit of not only being consistent with what most people experiencing homelessness want and prefer, but is also associated with consistently high outcomes across a variety of communities. ATCIC's Mobile Crisis Outreach is provided in partnership with Austin Police Department and the Travis County Sheriff's Office. When a law enforcement officer encounters a person experiencing a mental crisis, they contact the Mobile Crisis Outreach Team to respond. The goal is to divert patients from emergency rooms (77% have been diverted) and jail (80% have been diverted) by connecting people to the mental health services they need in a more effective, less traumatic way.

**Sarah Cook** is the Director of Integrated Delivery System Strategy and Planning for the Community Care Collaborative. The goal of the CCC is to develop an integrated delivery system (IDS) for patient care. The IDS will offer coordinated health care to targeted patient populations across the full spectrum of primary care, specialty care, hospital and support service providers. The IDS will also provide financial accountability while identifying best practices in health care delivery. At the heart of the CCC's mission and vision is providing high quality and cost-effective person-centered care. According to the CCC, being person centered means being responsive to the needs and interests of the people that they serve - about 30,000 Medical Access Program (MAP) recipients and 65,000 to 70,000 sliding care patients each year. Cook cited four ways this is done:

1) Better engagement of MAP eligible patients. This includes extending hours of operation and ensuring patients understand their eligibility and benefits.
2) New Medical Management System, which includes a team of nurses that accompany patients to their visits, helps with knowledge transfer, as well as other support services. The Medical Management System will also use the data it collects to help clinics improve services. One example of this is the new patient portal, which provides patients access to their own information, and helps to ensure better transfer of information from the hospital to community care providers.
3) Providing more tailored care and improving medical access.
4) Moving from fee for service care to value based care through funding contracts and partnerships.

**Terri Sabella, RN, JD** is the Chief Operating Officer for CommUnity Care. CommUnity Care's mission is to work with the community to provide the right care, at the right time, in the right place. The organization is a federally qualified health center, jointly held with Central Health, and turns no patients away. In FY 2015 their 22 health centers across Travis County saw approximately 88,000 individual patients. For CommUnity Care, the patient centered approach is strongly influenced by social determinants of health. This means taking care of the whole person and their family. One example of a unique model of care delivery implemented by CommUnity Care is its partnership with ATCIC, which provides integration of mental health services in community care sites. The organization also has a street medicine team who goes out to see people where they happen to be. They also have specific efforts around Patient Navigation including care coordination, call center with nurse triage, referral coordination, proactive ER/Hospital follow up and other advanced tools.

Person-centered projects CommUnity Care has embraced include Integrated Behavioral Health, which integrates primary care with behavioral health services. The organization has seen stark improvements in depression and diabetes through this effort. The Patient Portal, a smart phone compatible, soon to be two-way messaging device that allows patients to reach providers. The Patient Navigation Center has centralized appointments, centralized referral management, and nurse triage expansion. This focus on referral management helps to ensure individuals are able to follow up and access the care they need. Finally, the Southeast Health and Wellness Center Expansion allowed CommUnity Care to open a large site for primary care and specialty care providers. The organization is currently building community partnerships with those that specialize in nutrition education, counseling and other services to provide a one stop shop to healthcare and wellness in the community.

**Adjourn:** Eileen Schrandt adjourned the meeting at 7:55 p.m.